Lewisham Local Health and Care Partners Strategic Board – Part I
Date: Thursday 26 March 2026, 14.00-16.00hrs (includes 5-minute break)
Venue: MS Teams (meeting to be held in public)
Chair: Ceri Jacob, Lewisham Place Executive Lead

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 22 January 2026 (for approval) & Action Log**	Verbal/ Encs 1 & 2	Chair	To Note/For Approval	14.00-14.05 5 mins
2.	**Any questions from members of the public**			Appendix A	14.05-14.10 5 mins
3.	**PEL (Place Executive Lead) Report**	Enc 3	Ceri Jacob	For Noting	14.10-14.15 5 mins
	Delivery *(1)				
4.	**Primary Care Group – Terms of Reference**	Enc 4	Chima Olugh	For Approval	14.15-14.25 10 mins
5.	**Grounded Report: Community-Led Reflections and Solutions to Systemic Health Inequalities**	Enc 5	Sabrina Dixon	For Approval	14.25-14.35 10 mins
6.	**ICB/VCS Infrastructure Support Impact Summary**	Enc 6	Gulen Petty/ Mottie Omideyi	For Discussion	14.35-14:50 15 mins
7.	**Lewisham VCS Neighbourhood Contract**	Enc 7	Abbi Greene	For Discussion	14.50-15:05 15 mins
	Break – 5 mins				
	Governance & Performance				
8.	**LCP Performance data report – February 2026: Focus on Flu, Vaccination uptake and interventions**	Enc 8	Ceri Jacob/ Dr Catherine Mbema	For Discussion	15.10-15.25 15 mins

9.	**Risk Register**	Enc 9	Ceri Jacob	For Discussion	15.25-15.35 10 mins
10.	**Q3 Quality summary**	Enc 10	Annette Fogarty	For Noting	15.35-15.45 10 mins
11.	**Finance update**	Enc 11	Michael Cunningham	For Discussion	15.45-15:55 10 mins
	Place Based Leadership				
12.	**Any Other Business**		All		15.55-16.00 5 mins
CLOSE					
13.	**Date of next meeting (to be held in public): Thursday 28 May 2026 at 14.00hrs via Teams**				
	Papers for information				
14.	**Minutes/Updates from:** • **Primary Care Group Chairs Report** • **Place Executive Group meeting** • **Integrated Quality and Assurance Group meeting Action and Decision Log**	Enc 12			

*** To strengthen the integration of primary and community-based care**

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 22 January 2026 at 14.00 hrs

via MS Teams

Present:

Neil Goulbourne (NG) (Chair)	Chief Strategy and Transformation Officer & Deputy CEO, LGT
Ceri Jacob (CJ)	Place Executive Lead Lewisham, SEL ICB
Vanessa Smith (VS)	Chief Nurse, SLaM
Dr Helen Tattersfield (HT)	Chair of the Primary Care Leadership Forum
Fiona Derbyshire (FD)	CEO, Lewisham Citizen's Advice Bureau
Sabina Dixon (SD)	VCSE representative, SIRG
Anne Hooper (AH)	Community representative Lewisham
Michael Kerin (MK)	Healthwatch representative Lewisham
Dr Catherine Mbema (CMb)	Director of Public Health, Lewisham Council

In attendance:

Cordelia Hughes (CH) (Mins)	Borough Business Support Lead, SEL ICB
Lizzie Howe (LH)	Corporate Governance Lead, SEL ICB
Laura Jenner (LJ)	Director of System Development, SEL ICB
Ashley O Shaughnessy (AOS)	Associate Director of Primary Care/CBC, SEL ICB
Charles Malcolm-Smith (CMS)	Associate Director of System Development, SEL ICB
Michael Cunningham (MC)	Associate Director of Finance, SEL ICB
Fiona Mitchell (FM)	Designated Adults Safeguarding Nurse, SEL ICB

Natasha Crawford (NC)	Programme Director – Elective Pathway Improvement. LGT
Patrick Nwachukwu (PN)	Commissioning Officer – CYP, Lewisham Council
Sayha Sam (SS)	Commissioning Officer – CYP, Lewisham Council
Ann Guindi (AG)	CCPL Lead – Children and Young People

Apologies for absence: Denise Radley, Pinaki Ghoshal, Dr Simon Parton, Karen Sadler, Kenny Gregory

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 27 November 2025** Neil Goulbourne (NG) (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. NG advised attendees of the housekeeping rules and apologies for absence were noted as detailed above. Declaration of Interests (DOIs) – Updates in progress. Minutes of the Lewisham LCP Strategic Board meeting held on 27 November 2025 – these were agreed as a correct record. Action log – The Board reviewed the action log and updates on progress: • Main Grant Funding - NG confirmed the main contact for the voluntary sector is James Lee – therefore this action can be closed. • Damp and Mould - CMb advised that this action remained outstanding, but work is underway and an update would be brought to a future meeting. Matters Arising – None.	**CMb**
2.	**Questions from members of the public**	

	The Chair confirmed that no questions had been received from members of the public and no questions were raised during the meeting.	
3.	**PEL (Place Executive Lead) report** CJ presented the Place Executive Lead report: **<u>NHS Changes</u>** CJ reported that progress has been made with the voluntary redundancy programme, which concluded on 14 January 2026, with applicants receiving confirmation of whether their application had been accepted or not. Across SEL, 83 applications were received. Staff will also be given a second opportunity to apply for VR when the consultation is launched in early March. Work is now underway to finalise agreement letters with affected staff. To achieve the £19/head operating cost target and meet the requirements of the ICB blueprint and 10-year plan - SEL ICB and SWL ICB boards made the decision to formally cluster in their December 2025 Boards. The ICBs will remain as two separate statutory bodies with separate Boards and financial allocation, however, there will be a single Chair, Chief Executive and executive team. **<u>HSJ Award: Reducing Health Inequalities</u>** North Lewisham Primary Care Network (PCN) and Red Ribbon Living Well were named winners of the Primary and Community Care Innovation of the Year award for their initiative, Health Equity Partnership: A Symbiotic Approach to Tackling Health Inequalities. CJ commented that this showed the importance of partnership working and sustained investment in prevention-focused initiatives to allow time for impact to be achieved. HT asked for clarification on the difference between a “clustering” arrangement and a merger and what would the practical implications be for frontline services and primary care. In response, CJ provided assurance that clustering was intended to increase resilience and capacity while maintaining a strong local focus. In addition, there would be a single Chair and Chief Executive across the cluster, which is intended to improve resilience and efficiency. It should not result in services feeling more distant from primary care. **The Lewisham LCP Board noted the PEL report.**	

4.	**2026/27 Lewisham LCP System Intentions** LJ introduced the paper and sought approval from the Board outlining the proposed system intentions for 2026/27. The presentation highlighted: • Achievements delivered during the previous year 2025/26 – such as Lewisham and Greenwich Trust (LGT) and adult social care setting up a home first service, procuring the new virtual ward service and delivery of a proactive care service for Children and Young People (CYP). • Ongoing performance, capacity and financial challenges, such as reducing waiting times for MSK (musculoskeletal) and improving cancer screening uptake, although there is still a way to go. • Key areas of focus for the coming year include prevention, neighbourhood working and a full review of SEND pathways, particularly ADHD and ASD, noting continued growth in referrals, despite recent investment. It was noted that the system now has a clear and shared direction of travel, with agreed priority areas and a strong understanding of where improvement efforts should be focused in the year ahead. HT asked how the system would reconcile the requirement for same day GP access with continuity of care, particularly given the impact of triage activity on GP availability. CJ advised that would be addressed as part of ongoing work with the primary care access plan, with further consideration of how national requirements could be implemented at a local level. SD asked how much engagement was taking place with schools and SEND community officers to ensure that they and any parents, are aware of improvements to the Education Health and Care (ECHP) assessment pathways. LJ acknowledged the importance of this issue and confirmed that further work was required and would be happy to take this question offline to respond more fully. MK emphasised the importance of alignment with the Health and Wellbeing Strategy and around effective public engagement. AH raised the need for clarity on how neighbourhood development co-production activity would be sustainably funded and supported over	

	time. LJ confirmed that funding had been earmarked to support co-production activity and that it was expected to support work over the next couple of years. CJ reflected on the value of having agreed system intentions, noting that they provided a shared framework for decision-making and prioritisation, particularly in a constrained financial environment. **Actions:** • LJ to revise the 2026/27 System Intentions paper to strengthen alignment with the Health and Wellbeing Strategy. The update should also clarify the duration and sustainability of the budget allocated to support expenses for people with lived experience involved in co-design activities. • Also, to provide a response to SD regarding EHCP assessments and engagement with schools. **The LCP Board approved the 2026/27 Lewisham LCP System Intentions update.**	**LJ**
5.	**Five Year Strategic Commissioning Plan: Lewisham Template update** CMS stated the item linked to the System Intentions 2026/27 and was being presented for approval. The template represented the local contribution to the ICB 5-year Strategic Commissioning Plan and had been shared with members of the Integrated Neighbourhoods Committee for comment. It is a high-level summary covering a wide range of areas, with further detailed planning to follow up - particularly through the development of the Integrated Neighbourhood Health Plan. It would also be the point at which links would be strengthened to the Health and Wellbeing Strategy once guidance is received. AH asked that, given workforce reductions and financial pressures, how realistic was the delivery of the ambitions set out in the plan. CMS advised that the purpose of the plan was to set clear priorities so that limited resources could be deployed most effectively. CJ added that new ways of working and integration would be essential to managing capacity constraints and that this represented a significant cultural change for the system. HT noted that prevention would be critical to long-term sustainability and this is the direction of travel. CMb agreed and advised that	

	prevention and the wider determinants of health were more strongly articulated within the Health and Wellbeing Strategy, but further work was needed to ensure the themes were clearly reflected across all system plans. **The LCP Board approved the Five-Year Strategic Commissioning Plan: Lewisham Template update.**	
6.	**Options Appraisal and Recommendation for a Direct Award of Contract to Kooth** PN presented the options appraisal for approval and the recommendation for a direct award of contract to Kooth for the provision of digital emotional wellbeing services for children and young people. The direct award to Kooth was under the NHS Provider Selection Regime (PSR) for a further two-years. By doing this, continuity of care would be maintained and it would also avoid disruption of services. Financial overview is; • **Financial Overview:** Current Contract Value: £1,105,000 (incl. VAT) – approx. £92,000 per borough annually. • **Proposed Direct Award Value:** £1,135,000 (incl. VAT) – approx. £95,000 per borough annually. PN outlined the rationale for a direct award was to ensure continuity of care with a well-established service with evidence of strong service user feedback. The proposed contract period would also undertake a full review of the digital emotional wellbeing market and co-production with young people, with a view to future competitive procurement. AH asked that at the end of the proposed two-year direct award, would the service be subject to a competitive procurement process. SS advised that they would undertake a full market review and competitive procurement following the two-year period, rather than extending the direct award. SD enquired about how this would affect young people who rely on the system (Kooth). SS said that the proposal to return to the market was because there is now a wider range of providers compared to when the service was first commissioned. Also, there was a need to better understand what is currently available and whether alternative offers could better meet the needs of young people. That included considering developments in technology, such as AI and feedback from young people about wanting more real-time information on availability.	

	The LCP Board approved a two-year direct award of contract to Kooth.	
7.	**Lewisham GP Access Improvement – Updated Plan** AOS presented an update on the Lewisham GP Access Improvement Plan. This included detailed data on appointment volumes, NHS app as a digital front door to the NHS, workforce composition, enhanced access provision and the role of community pharmacy. Also, an update on Same Day Urgent Care (SDUC). The plan aims to: • Empower patients around self-referral pathways and community pathways. • Implement a new model - 'Modern General Practice Access' • Pharmacy First • Expanded GP teams. There was also a comms and engagement campaign to highlight the above services throughout the borough. In terms of SDUC, there was a subset of work that focused on access and some of this was implicit within the wider programme, while some is more distinct, with a specific emphasis on improving same day urgent care. HT mentioned the Did Not Attend (DNA) rates, particularly for extended hour appointments and possible contributing factors such as patient behaviour and appointment timing. Also, the challenge of balancing urgent same day access with continuity of care and the management of long-term conditions. AG asked if the reported DNA rate was specific to face-to-face appointments vs telephony and if it is increasing or decreasing over time. AOS said that this can be tracked over time and by face-to-face appointments versus telephony. The information is shared with Primary Care Networks (PCNs) to help inform their plans around how they might tweak some of their delivery models. HT asked if the high DNA rate (17%) is primarily associated with nursing and screening appointments, not necessarily GP appointments. AOS acknowledged that this was consistent with	

	experience in some practices and that variation in how enhanced access appointments were used, which warranted further review. CJ asked for comparative data with other Places for future reports. NG mentioned the importance of future reports providing clearer performance assessment, including benchmarking and more of what was working well and where improvement was needed. **Action:** AOS to return to a future meeting with comparative data and organise a seminar if needed to explore the findings in more depth. CH to add to forward planner. **The LCP Board noted the Lewisham GP Access Improvement – Updated Plan.**	**AOS/ CH**

8.	**Planned Care – Outpatients Transformation and Elective Improvement**
	
	NC reflected on the 10-year plan, as it sets out a bold and ambitious vision for the coming period. A major element was outpatient transformation, centred on the three strategic shifts: from hospital to community, analogue to digital, sickness to prevention. Some key areas to highlight:
	
	• Need to recover to NHS constitutional standards by 2028/29, specifically 92% treated within 18 weeks (RTT).
	• LGT's delivery against the Long-Term Plan include:
	  ○ Launch and rollout of the patient portal with strong adoption.
	  ○ Redesign of the ENT booking model in a highly challenged service.
	  ○ Introduction of a selective improvement programme.
	  ○ Early work on AI opportunities aligned with the digital ambition.
	  ○ Preparation for a new EPR to support streamlined, standardised pathways.
	• Waiting list reduced 70k → 55k
	• 52-week waiters halved
	• On track for 62% within 18 weeks this year
	• Significant reductions in first-appointment waits across multiple specialties.
	• Diagnosis performance improving (above last year) and investment in Oncology.	

	• A patient portal launched. • Broad rollout of Referral Assessment Service (RAS)/Advice and Guidance. There has also been a lot of developments regarding interface work across acute and primary care. AG noted the improvements across the system from a Lewisham resident's perspective and HT echoed this but queried if the ambition for increased digital outpatient appointments mainly apply to follow-up appointments rather than diagnostic or first appointments. NC confirmed that digital approaches were intended to support clinically appropriate pathways and not replace necessary face-to-face care. **The Board noted the Planned Care – Outpatients Transformation and Elective Improvement update.**	
NG advised there would be a 5-minute break. The meeting resumed at 15:23 hrs		
9.	**LCP Assurance Performance data report – December 2025** CJ presented the performance assurance report for December 2025. There had been year on year improvements for Serious Mental Health checks (up around 8%), LD health checks remain strong with work underway to assure quality and CHC assessments had significantly improved. However, flu vaccination rates - and to a lesser extent children's vaccination rates - remain very challenging despite considerable local effort. GP appointments had been reviewed and whilst there were some data quality issues, there had been some improvements, especially in increased face-to-face appointments. A fuller deep dive was scheduled for the next Board meeting. HT added that it is worth noting the flu rates look worse this year partly because vaccinations could not start until 1 October, a full month behind last year. CMb noted cultural resistance to vaccination following the COVID-19 pandemic, changes to national vaccination timetables and the potential role of health visitors and community organisations in improving uptake. However, there had been recent improvements in breast cancer screening and suggested that lessons learned could be applied to other screening programmes. **Action:** It was agreed to bring a deep-dive report on vaccination uptake, including targeted interventions and any learnings from breast	**CMb/**

	cancer screening campaigns to the next public meeting. CH to add to the forward planner. **The Board noted LCP performance data report – December 2025**	**CH**
10.	**Risk Register** CJ presented the Lewisham risk register. It was noted the register would be subject to a full reset in April 2026, as it had been in previous years. Most risk scores remained broadly static, which was not necessarily good or bad. The main exception was risk 644, Adults and CYP Neurodevelopmental diagnostic pathways (Autism and ADHD), which had worsened only because Lewisham had aligned scoring with the rest of southeast London. Significant system-wide work was underway to improve pathways, including better triage, oversight of private providers and streamlining local NHS pathways. CHC was showing slight improvement: although still over budget, the position was much better compared to last year. This was attributed to tighter controls and increased population need. **The LCP Board noted the risk register update.**	
11.	**Annual Adult Safeguarding report** FM presented on the Annual Adults Safeguarding Report, outlining statutory responsibilities, partnership arrangements, training delivery, and assurance mechanisms. The report highlighted key areas of focus: • Multi-agency working • Workforce development and supervision • Learning from safeguarding adult reviews and domestic homicide reviews • Governance and Accountability arrangements • Asylum and Initial Accommodation Centres • Primary Care and Safeguarding Training • Care Homes Older People • Serious Violence Duty including Domestic Abuse Violence Against Women and Girls and learning from statutory reviews • Learning from Adults Deaths and statutory review • Modern Slavery • LeDeR Learning from the lives and deaths of people with a learning disability and autistic people All acknowledged the importance of safeguarding activity and of sustained system-wide collaboration.	

	The LCP Board noted the Annual Adult Safeguarding report update.	
12.	**Finance Update** MC gave a finance update for M8 for financial year 2025/26. **ICB Lewisham** Lewisham delegated Place budget reported a break-even position YTD and on a forecast outturn basis at Month 8. Key pressures continued to be Continuing Health Care (CHC), prescribing and mental health, with ADHD assessments (£2.2m over budget), representing £1.7m more expenditure than last year. This was a major concern for next year's planning. **ICB** The ICB reported a breakeven position YTD and on a forecast outturn (FOT) basis against its revenue resource limit and financial plan. **Wider ICS** The ICS is reporting a YTD deficit of £25.8m which is £2.4m adverse to plan. Key drivers include £14.7m net efficiency slippage, notably £5.1m private patient income behind plan and £3.3m clinical transformation slippage. There were also timing issues, specialised commissioning pressures and legal costs linked to last year's cyber-attack. The ICS is still forecasting break-even for year end. **Lewisham Council** Lewisham Council's financial position is included in the report for noting. **The LCP Board noted the finance update.**	
13.	**Any Other Business** No items raised. NG asked members to note the additional papers for information and thanked everyone for their contributions to the meeting.	
14.	**Date of next meeting** Thursday 26 March 2026 at 14:00hrs (Teams).	
15.	**Minutes of previous meetings/updates** The LCP Board noted the documents attached for information.	

Lewisham LCP Strategic Board Action Log

Date of meeting & agenda item:	Action:	For:	Update:
1.System Intentions 2026/27 (item 2) 22/01/26	LJ to update the system intentions paper 26/27 with clearer links to the Health and Wellbeing Strategy. In addition, clarify the duration and sustainability of budget allocated for expenses for people with lived experience to participate in co-design work. LJ to provide a response to SD re EHCP assessments and school engagement.	**LJ**	
2. Lewisham GP Access Improvement – Updated Plan (item 7) 22/01/26	AOS to return to a future meeting with comparative data and organise a seminar if needed to explore the findings in more depth. CH to add to forward planner.	**AOS/CH**	CH – added to forward planner.
3. LCP Assurance Performance data report – December 2025 (item 9) 22/01/26	It was agreed to bring a deep-dive report on vaccination uptake, including targeted interventions and any learnings from breast cancer screening campaigns to the next public meeting. CH to add to the forward planner.	**CMb/CH**	CH – added to forward planner.

4.Damp and Mould project (item 6) 27/11/25	CMb agreed to write an update on the damp and mould activities including key contacts from LGT and primary care who have been involved and circulate to board members.	**CMb**	An update will be provided at the next meeting in March 2026
Main Grants Funding (Item 8) 27/11/25	Due to there being less availability of funding for the voluntary sector and the impact that this would have on service delivery - who should they contact about this. JL agreed to provide contact details.	**JL**	Closed
LCP Assurance (performance) Report (Item 9) 27/11/25	It was agreed to bring a performance update on Flu and Childhood Immunisation uptake to the March 2026 meeting. CH to add to action log.	**CH**	Closed – CH added to forward planner
Lewisham Neighbourhood II & Central 24/7 Community Mental Health Centre (Item 4) (27/11/25)	LB agreed to develop some core co-production principles such as defining who is involved, capturing evidence, tracking its impact on decisions and creating a feedback loop to help monitor and influence, and would come back to a future meeting with an update. CH to add to forward planner.	**CH**	Closed - CH added to forward planner
Risk Register (Item 9) 27/11/25	Work underway in SE London include *Improve NHS access and manage patient flow. *Introduce single point of access to direct patients to correct assessment (ASD, ADHD, or alternative) and reduce unnecessary appointments. Agreed to provide a full update at a future meeting. CH to add for forward planner	**CH**	Closed – CH added to forward planner.

Appendix A

Sent by email

[redacted]

9 February 2026

Dear [redacted]

RE: Patient Involvement in GP Practice Patient Participation Groups

Thank you for raising this important question about how good practice around Patient Participation Groups (PPGs) can be strengthened and shared across Lewisham GP practices.

All GP practices are required under the Standard General Medical Services (GMS) Contract to establish and maintain an active PPG and the Integrated Care Board (ICB) has a role in supporting practices to meet this requirement and some opportunities have been identified.

Appendix A sets out the requirements of the Standard General Medical Services Contract.

The purpose of a PPG is to

- obtain the views of patients about services delivered by the practice.
- enable ongoing feedback from registered patients.
- ensure that membership is reviewed annually so that it is reasonably representative of the practice population.
- agree improvements with the practice based on patient feedback; and
- make reasonable efforts to implement those agreed improvements.

Effective participation is a key part of ensuring that services are responsive, inclusive and shaped by the experiences of patients who use them.

In addition to the standard GMS contract requirements, Lewisham has a locally commissioned services contract which includes a specific focus on patient experience, which provides further encouragement for practices to work meaningfully with their PPGs and demonstrate how patient feedback informs service improvement.

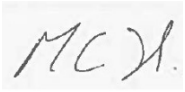
The ICB recognise that PPGs vary in how they operate, and that some may need more support, either because they are newly established, have low capacity, or struggle to engage effectively with their practice and having clearer contacts and shared learning might be helpful.

A number of resources already exist to support practices and PPGs develop effective ways of working and strengthen relationships. The Patients Association has developed a comprehensive PPG toolkit, including videos, templates, and guidance on recruitment, running meetings, and strengthening participation. Other national resources, such as those from the National Association for Patient Participation, offer further practical advice.

Lastly, there is an opportunity for the ICB to play a role in supporting good practice and strengthening networks across PPGs and will consider how best to do this through our local Primary Care Group.

I hope the information provided is helpful and addresses your questions.

Yours sincerely



Ceri Jacob
Place Executive Lead (Lewisham)

Appendix A – Standard General Medical Services Contract (Extract)

5 PART 5

5.1 Reserved.

5.2. Patient Participation

5.2.1. The Contractor must establish and maintain a group known as a "Patient Participation Group" comprising some of its registered patients for the purposes of:

(a) obtaining the views of patients who have attended the Contractor's practice about the services delivered by the Contractor; and

(b) enabling the Contractor to obtain feedback from its registered patients about those services.

5.2.2. The Contractor is not required to establish a Patient Participation Group if such a group has already been established by the Contractor in accordance with any directions about enhanced services which were given by the Secretary of State under section 98A of the 2006 Act before 1st April 2015.

5.2.3. The Contractor must make reasonable efforts during each financial year to review the membership of its Patient Participation Group in order to ensure that the Group is representative of its registered patients.

5.2.4. The Contractor must:

(a) engage with its Patient Participation Group, at such frequent intervals throughout each financial year as the Contractor must agree with that Group, with a view to obtaining feedback from the Contractor's registered patients, in an appropriate and accessible manner which is designed to encourage patient participation, about the services delivered by the Contractor; and

5.2.5 review any feedback received about the services delivered by the Contractor, whether by virtue of clause 5.2.4(a) or otherwise, with its Patient Participation Group with a view to agreeing with that Group the improvements (if any) which are to be made to those services.

5.2.6 The Contractor must make reasonable efforts to implement such improvements to the services delivered by the Contractor as are agreed between the Contractor and its Patient Participation Group.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 3
Enclosure 3

Title:	**PEL Report**
Meeting Date:	**26 March 2026**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

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

Summary of main points:

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

NHS changes
The ICB launched its staff consultation on 5 March and concurrently launched a second voluntary redundancy (VR) scheme. South West London (SWL) ICB launched their consultation and VR scheme at the same time.

A second VR scheme has been launched to allow staff who wished to see structures before deciding, a chance to apply for VR thus reducing the number of people made compulsorily redundant. The window for applications closes on 2 April 2026.

The consultation closes on 20 April 2026. A range of support offers remain in place for staff through this very difficult time.

Sustainability Investment Fund
The SEL ICB has made available funding to support development in two areas at Place:

- Development of neighbourhoods, including delivery of the SEL frameworks for frailty, multiple long-term conditions and Children and Young People.
- Implementation of the SEL ICB Prevention Framework.

As host to the Lewisham Integrator Partnership, LGT will hold the funding on behalf of the local system however, the Integrator Partners will work together to agree how to utilise this funding, working with the parameters set at a SEL level and in alignment with local Lewisham LCP aspirations.

	National Neighbourhood Framework On the 17 March NHSE published the Neighbourhood Framework https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework This document includes key national metrics, priorities and expectations and immediate 26/27 actions for ICBs which they will be assessed against this year. The SEL ICB strategy and plans are aligned to the requirements of this framework already. The immediate 26/27 actions are: • agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis • agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements • agree neighbourhood footprints around natural communities for the future development of INTs • agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area • start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the referral to treatment (RTT) standard and how they would use a devolved commissioning budget for outpatients for their population • confirm plans to meet 18-week community waits and eliminate 52-week waits. • confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance (noting that any funding decisions must also be consistent with the national conditions for the fund, including the required increases in ICBs' minimum contributions to adult social care over the next 3 years) • continue to improve the primary and secondary care interface in line with the red tape challenge • confirm organisational ownership of planned deliverables • confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation The Lewisham LCP and its Integrator Partnership is well advanced in many of these areas and will now work together to ensure there are no gaps in existing plans to progress against these requirements.
Potential Conflicts of Interest	All ICB staff are potentially impacted.
Any impact on BLACHIR recommendations	No

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

	Equality Impact	In relation to the ICB Change Programme, this will be carried out once for SEL and will look at the impacts on a function by function basis and overall. An EIA has been carried out in relation to the Lewisham neighbourhood programme.
	Financial Impact	The ICB must achieve a 35% reduction in it's running costs.
Other Engagement	Public Engagement	Public engagement has taken place to support the neighbourhood programme including working with people with lived experience.
	Other Committee Discussion/ Engagement	Not applicable to this paper.
Recommendation:	The Board is asked to note this update.	

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 4
Enclosure 4

Title:	**Revised Lewisham Primary Care Group Terms of Reference**
Meeting Date:	**26 March 2026**
Author:	**Chima Olugh, Neighbourhood Development Manager**
Executive Lead:	**Ceri Jacob, Place Executive Lead (Lewisham)**

Purpose of paper:	The purpose of this paper is to formally seek the approval of the Local Care Partnership Board for the revised Terms of Reference (ToR) of the Lewisham Primary Care Group (PCG).	Update / Information	
		Discussion	
		Decision	✓
Summary of main points:	The ToR define the overarching responsibilities of the Primary Care Group in relation to all primary care matters and form a critical component of the governance framework through which the Integrated Care Board (ICB) discharges its delegated primary care functions. The ToR ensure that the Group operates with strong governance, transparency, and clear accountability, supporting robust and evidence-based decision-making in line with the Primary Medical Care Delegation Agreement. The ToR were discussed and reviewed last year by the Group. As part of the review process, the key agreed amendment is the addition of a new core member to the PCG. A representative from Community Pharmacy South East London has been included to the core membership to strengthen multidisciplinary input and to ensure that community pharmacy perspectives are appropriately reflected in planning and decision-making. It should be noted that once the new ICB structures and governance arrangements are confirmed, the Terms of Reference will need to be reviewed and may be subject to further amendment.		
Potential Conflicts of Interest	There is a conflict of interest in relation to Anne Hooper who is the chair of the Primary Care Group, and Dr Helen Tattersfield who is a member of the Primary Care Group.		

	Mitigation: Anne Hooper and Dr Helen Tattersfield should be excluded from the decision-making process, however, can participate in any discussion to provide relevant insight and expertise.			
Any impact on BLACHIR recommendations	Not Applicable			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
Impact	Equality Impact	Including community pharmacy representation could advance equality of opportunity, improve access for underserved and protected groups, strengthen preventative and community-based care and support reduction in health inequalities.		
	Financial Impact	Not Applicable		
Other Engagement	Public Engagement	Not Applicable		
	Other Committee Discussion/ Engagement	Endorsed at the Lewisham Primary Care Group in December 2025. Endorsed by the Lewisham ICB Senior Management Team in March 2026.		
Recommendation:	**The Board is recommended to approve the revised Terms of Reference.**			

South East London Integrated Care System

NHS South East London

South East London Integrated Care Board (Lewisham)

Lewisham Primary Care Group

Terms of Reference

May 2025

Approved by	The Local Health and Care Partnership Strategy Board
Date approved	
Name and title of originator/author	Chima Olugh, Neighbourhood Development Manager
Effective date	May 2025
Review date	April 2026
Target audience	Members of the Lewisham Primary Care Group
Stakeholders engaged in development	Lewisham Primary Care Group, Senior Management Team and The Local Care Partnership Strategy Board.

Version Control and Document Review Information

Version	Summary of changes	Date	Author/Reviewer
1.0	Initial Review	19/09/2024	Chima Olugh, Neighbourhood Development Manager
1.1	Updated following discussion of the working group.	21/11/2024	Chima Olugh, Ashley O'Shaughnessy and Anne Hooper
1.2	Reviewed by members of the working group and including feedback from our Place Executive Lead.	21/02/2025	Chima Olugh, Ashley O'Shaughnessy and Anne Hooper
1.3	Review of the financial statement.	04/02/2025	Chima Olugh, Neighbourhood Development Manager
1.4	Reviewed and agreed at the March 2025 Primary Care Group.	20/03/2025	Chima Olugh, Neighbourhood Development Manager
1.5	Updated to include community pharmacy representation as a member of the Primary Care Group.	01/12/2025	Chima Olugh, Neighbourhood Development Manager

South East London Integrated Care System

NHS South East London

Terms of Reference

1. Introduction

1.1 As part of the development of the South East London (SEL) Integrated Care System (ICS), the Integrated Care Board (ICB) has agreed a mandate and an arrangement of delegation with each of the Local Care Partnerships (LCP) for the planning, delivery and associated decision-making for primary care and out of hospital services including general practice.

1.2 The Lewisham Primary Care Group (the Group) has been established as a sub-group of the Local Care Partnership Strategic Board.

1.3 The group will have effective, safe and efficient arrangements for the discharge delegated functions related to primary care. This includes, but is not limited to, GP practices and/or organisations providing core general and primary medical services (GMS/PMS/APMS), Primary Care Networks (PCN) and out of hours GP services.

1.4 In time, when the ICB takes on further delegated responsibilities related to pharmaceutical, general ophthalmic dental services the Terms of Reference will be reviewed to include these services.

2. Purpose

The purpose of the Group is to:

2.1 Provide oversight, scrutiny and decision making for primary medical services;

2.2 Make decisions in relation to the commissioning and management of primary medical services contracts;

2.3 Have oversight of quality and performance in primary medical services;

2.4 Provide oversight and assurance of certain primary care funding allocations from NHS England.

3. Duties and Responsibilities

The Group will:

Oversee and co-ordinate the delegated arrangements and ensure delivery of the delegated functions in line with the statutory framework.

It will consider and make decisions for the commissioning and management of primary medical services contracts, including but not limited to the following activities:

Decisions in relation to its Delegated Authority;

- GP core contracts and directed enhanced services;
- GP practice service changes including boundary changes, establishment, mergers and closures of GP practices;
- Primary care access related areas including enhanced access;

- Planned primary medical care services in the area;
- The management of poor performance, which could include use of remedial and breach notices and application of wider contract terms;

- The management of poorly performing GP practices and including consideration of possible contractual action as a result of receiving an adverse Care Quality Commission rating.

Decisions in relation to its Delegated Financial Responsibility;

The group will consider options around utilisation of primary care funding and make recommendations to the Lewisham Senior Management Team. Decisions on funding utilisation and commitment of expenditure must ultimately be taken by the Place Executive Lead who holds the budget delegation.

Key areas of responsibility include:

- Local Incentive Schemes and any associated funding;

- Delegated primary care funds e.g. the Service Development Fund;

The Group will also;

- Support the development of primary medical services in Lewisham by providing the right strategic and operational forum to improve commissioning plans and opportunities for the delivery of high quality local primary care services.

- Oversee the implementation, development and transformation of local primary care delivery and quality improvement in line with national guidance, ICS priorities and local need.

- Bring together the right people with relevant expertise to consider, challenge, guide and oversee the planning and delivery of primary medical services in Lewisham.

- Ensure there is appropriate oversight of local primary care procurements.

- Provide leadership and oversight for the mobilisation of integrated primary care services and assurance of primary care service delivery.

- Ensure application of the Premises Cost Directions in the planning, approval and funding of primary care estates.

- Endorse the elements of ICB estates schemes that pertain to primary care rent, rates or patient access.

- Provide advice and guidance on local workstreams and programmes to ensure they achieve rapid and dynamic change. This will include advice on proposals relating to investment, finance, commissioning, delivery and performance management, to enable a consistent approach with commissioners.

- Support commissioners to make transactional contractual decisions within the scope of their remit and the scope of the Primary Medical Care - Policy and Guidance Manual.

- Provide the right strategic, operational and environmental conditions for contractual and transformational primary medical services topics to be considered in a timely manner, and informed recommendations for decisions made to the LCP.

- Provide assurance to the LCP and ICB for the accountability of a resilient general practice that delivers high quality services in Lewisham.
- Identify risks and issues relating to primary care and monitor mitigations, escalating risks to the LCP as appropriate.
- Support the LCP Strategic Board to coordinate a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies.
- Provide oversight, assurance and support of the vision and some of the key elements within the Next steps for integrating primary care: Fuller Stocktake report.
- Assure itself that any service change reflects the views and experience of Lewisham citizens, service users and member practices.
- Support and monitor quality improvement and effectiveness of primary care provision to inform continuous improvements.
- Ensure successful initiatives are sustainable and rolled out across primary care, and/or close down unsuccessful ineffective initiatives.
- Support the enabler workstreams for workforce, working at scale, resilience, estates and IT systems.
- Support other ancillary activities that are necessary to exercise the delegated functions.

4. Membership

The core membership of the Group is outlined below.

	Role	Organisation
a.	Lay Member (Chair)	ICB
b.	Associate Director of Community Based Care and Primary Care	ICB
c.	Clinical and Care Professional Lead for Community Based Care and Primary Care	ICB
d.	Neighbourhood Development Manager	ICB
e.	Chair The Primary Care Leadership Forum	PCLF
f.	Assistant Director of Medicines Optimisation	ICB
g.	A representative from the Quality team	ICB
h.	Primary Care Nurse Representative	CEPN/PNF
i.	Local LMC Representative	LMC
j.	Healthwatch Representative	HW
k.	SEL Primary Care Contracting Team	ICB
l.	Public Health Lead	PH
m.	Lewisham CEPN Training Hub Lead	CEPN/TH
n.	Community Pharmacy South East London	CPSEL

Members may nominate a deputy to represent them in their absence.

Other persons may be invited to attend, as appropriate, to enable the Committee to discharge its functions effectively. The Group may also invite guests to attend to present information

and/or provide the expertise necessary for the Group to fulfil its responsibilities.

5. Role of the Chair

The Chair of the Group will be a Community Representative on the LCP Strategic Board.
The deputy Chair of the Group will be the Associate Director of Community Based Care and Primary Care.

The Chair will preside over all meetings of the Group. If the Chair is absent, then the deputy will preside.

6. Quorum

The Group will be considered quorate when at least 50% of the members are present, including the Chair or deputy Chair.

If any representative is conflicted on a particular item of business, they will not count towards the quorum for that item of business.

The Group will make decisions by consensus.

7. Accountability and reporting arrangements

The Group is accountable to the LCP Strategic Board.

The Group will advise and assure the LCP on Lewisham specific decisions.

The Group will make recommendations to the Place Executive Lead from time to time.

The Group will report to the LCP on matters within its duties and responsibilities via the Chairs report.

8. Conflicts of Interest

Any Conflicts of Interest (real or perceived) will be managed in accordance with the ICB's Standards of Business Conduct Policy.

Compliance will be overseen by the Chair of the Group.

9. Meeting frequency

The Group will meet monthly and no less than 8 meetings should take place each year.
Key recommendations will be taken to the LCP at the earliest opportunity.

10. Administration

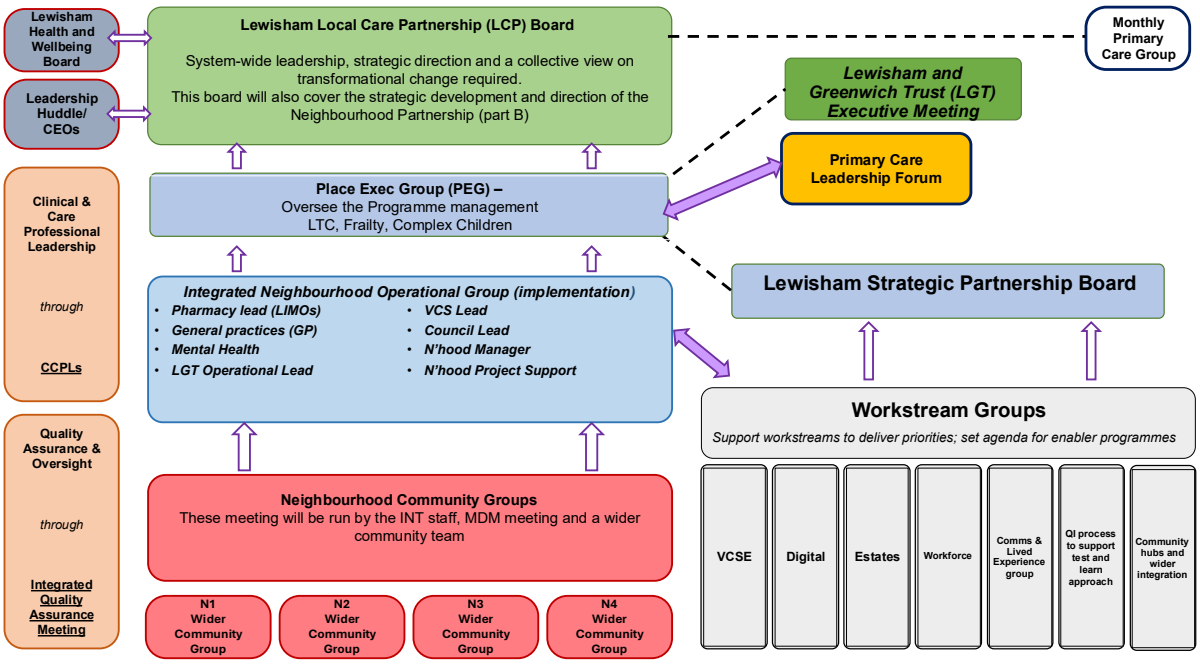
Administrative support will be responsible for completing minutes of meetings and the action log tracker.

Draft minutes will be circulated to members together with a summary of actions within five working days of the meeting.

Administrative support will be responsible for writing the Chairs report to the LCP for onward reporting as required.

11. Integrated Neighbourhood Teams

The diagram below outlines the INT governance and relationship with other key groups.



12. Monitoring adherence to the Terms of Reference

The Chair will be responsible for ensuring the Group abides by these terms of reference.

13. Policy and Best Practice

The Group will operate within the framework of the ICB's local policies including Standards of Business Conduct Policy and Procurement Strategy where these relate to the discharge of its functions.

The Group will enact its responsibilities as set out in these Terms of Reference in accordance with the Nolan Principles for Standards in Public Life.

14. Review arrangements

The Group shall undertake a self-assessment and evaluation of its effectiveness on an annual basis.

These Terms of Reference will be reviewed from time to time, reflecting the experience of the Group in fulfilling its functions.

Date approved:
Date of next review:

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 5
Enclosure 5

Title:	**Grounded Report**
Meeting Date:	**26th March 2026**
Author:	**Social Inclusion Recovery Group- (SIRG)**
Executive Lead:	Dr Catherine Mbema

Purpose of paper:	To present the Grounded Report and seek endorsement of its findings and priority recommendations, which provide community-led evidence on the progress and implementation of the BLACHIR Opportunities for Action in Lewisham, and to inform future system-wide planning and decision-making.	Update / Information	
		Discussion	
		Decision	*x*

Summary of main points:

This paper presents the *Grounded Report: Community-Led Reflections and Solutions to Systemic Health Inequalities*, commissioned to assess progress on the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) Opportunities for Action (OFA).

The report is based on engagement with over 270 Black African and Black Caribbean residents in Lewisham through forums, interviews, and podcasts between 2023 and 2025.

Key findings highlight that:

- Health inequalities remain persistent across healthcare, education, housing, and public services.
- Structural racism, economic inequality, and culturally inaccessible services continue to shape lived experiences.
- There are significant gaps in race-based data, service design, and long-term community engagement.

The report identifies four priority areas for action:

1. Delivery of services through trusted community settings
2. Sustained investment in health literacy
3. Increased Black leadership and decision-making power

	4. Embedding continuous, community-led engagement in service design The report provides system-level and local recommendations for Lewisham Council and the South East London Integrated Care Board (SEL ICB) to improve accountability, equity, and outcomes.
Potential Conflicts of Interest	SIRG is the commissioned organisation delivering this work; however, findings are based on independent community-led engagement
Any impact on BLACHIR recommendations	This report directly builds on and evaluates the BLACHIR Opportunities for Action (OFA) from a community perspective, confirming their continued relevance while identifying gaps in implementation. It strengthens the BLACHIR recommendations by: ● Providing updated, community-led evidence on lived experience ● Highlighting where OFA require adaptation or stronger accountability ● Proposing practical, system-level actions for delivery

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

	Equality Impact	High. The report specifically addresses racial health inequalities affecting Black African and Black Caribbean communities in Lewisham, who continue to experience disproportionate disadvantage across multiple systems. It promotes equity through: ● Community-led design and decision-making ● Improved use of race-based data ● Culturally competent and trauma-informed service delivery.
	Financial Impact	The report highlights the cost of inaction, including increased demand on health and public services due to preventable inequalities. Implementation of recommendations will require:

		• Long-term, sustainable funding for Black-led and community organisations • Investment in prevention, engagement, and culturally responsive services However, these investments are expected to reduce long-term system costs and improve outcomes.
Other Engagement	Public Engagement	This report is based on extensive community engagement, including: • 9 public forums • 160 community interviews • 9 podcast episodes • Ongoing collaboration with community organisations and Health Equity Teams
	Other Committee Discussion/ Engagement	N/A
Recommendation:	**The Lewisham Local Care Partners Strategic Board is asked to:** 1. **Note the findings of the Grounded Report** 2. **Endorse the priority areas for action identified through community engagement** 3. **Support the integration of recommendations into local health and care planning** 4. **Commit to strengthening community-led approaches, accountability, and Black leadership within system decision-making**	

Grounded

Community-Led Reflections And Solutions To Systemic Health Inequalities

Insights on BLACHIR Implementation Progress in Lewisham (2023–2025)

S.I.R.G

Putting you first

Commissioned by

Lewisham

NHS

Contents


Lewisham
108
208
DLR


Lewisham
DLR

Acknowledgements

Social Inclusion Recovery Group CIC (SIRG) extends its heartfelt gratitude to everyone who made this community engagement possible. This work is grounded in the voices, wisdom, and lived experiences of Black African and Black Caribbean residents across Lewisham and Birmingham. It stands as a testament to the strength, resilience, and leadership that exists within our communities.

This report was made with the community.

We are deeply grateful to all who took part in interviews, workshops, discussion forums, and podcast recordings. Your stories, insights, and experiences are the foundation of this engagement report. Thank you to the youth, elders, grassroots organisations, community leaders, and everyday residents who trusted us with your truths.

We also honour the exceptional efforts of our volunteers, outreach facilitators, youth mentors, and local partners who brought care, commitment, and cultural integrity to every stage of this process.

In Dedication to Lisa Fannon (1969–2025)

This report is dedicated to the memory of Lisa Fannon, whose unwavering commitment to racial justice, compassion, and community voice helped shape this work. Lisa was a powerful advocate for equity in Lewisham, a trusted collaborator, thoughtful public health professional, and consistent ally in community-led efforts to challenge systemic injustice. She listened deeply, acted with integrity, and always centred the dignity and wellbeing of those most affected by inequality.

Lisa championed grassroots knowledge and helped lay the groundwork for authentic, resident-led learning through her support of the Birmingham and Lewisham African Caribbean Health Inequities Review (BLACHIR).

Her legacy lives on in the principles guiding this report: truth-telling, accountability, and community-led change. We honour Lisa by continuing the work she believed in, justice that is real, sustained, and led from the ground up.

Rest in power, Lisa.

Foreword

Since its inception, SIRG has taken on the role of community advocates. Part of that advocacy work has involved engaging the Black community on BLACHIR, two years after its publication and specifically, its own community commissioned engagement work. This report is more than an extension of BLACHIR; it is a declaration of truth, testimony, and transformation. It reflects the lived realities of Black African and Black Caribbean communities in Lewisham Borough, who have long been experts in their own experience, but too rarely architects of systemic change. The fundamental premise of this work relies on the simple but powerful truth: that the people most impacted by injustice already hold the knowledge to dismantle it.

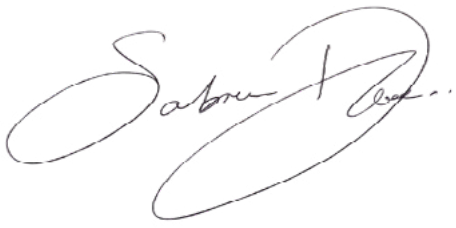
When we invited communities to engage with the Opportunities for Action (OFA) as set out in the original BLACHIR report, we knew we had to do things differently. We could not repeat the extractive models of engagement but needed to actively listen, not for policy soundbites or endorsement, but for wisdom that will challenge the norm. That is exactly what we received: bold, grounded, and urgent calls for accountability, visibility, and real foundational change.

What you will find in these pages is not simply feedback. It is a blueprint for a community-authored mandate for equity. Our communities are not asking for charity, they are demanding justice that will disrupt the status quo.

I carry a deep sense of responsibility and gratitude for the honesty shared with us. These conversations were often painful. They raised difficult questions for all service leaders, policymakers, and professionals. And rightly so. If we are serious about racial equity, we must sit with discomfort, confront complicity, and invest in co-designed, long-term solutions.

This report is certainly not the end of a process, but a recommitment to one. It is our duty to make sure these voices are not only heard but acted upon, with transparency and care. We invite everyone reading this to do the same.

Healing requires more than listening; it requires action.



Sabrina Dixon
Chief Executive


KEY RECOMMENDATIONS
Health bodies should work with Black African and Black Caribbean communities to co-develop accessible services
BLACHIR REPORT 2022
KEY FINDINGS
RECOMMENDATIONS
and discrimination should
gnised as drivers of ill health.
BLACHIR REPORT 2022
BLACHIR
KEY RECOMMENDATIONS
Data collection around ethnicity should be improved to help tackle health inequalities.
BLACHIR REPORT 2022
KEY FINDINGS
Black people are
4 X MO
to be detained u
but less likely to

Executive Summary

This BLACHIR Engagement Report presents findings from a community-led engagement on the 2022 BLACHIR Opportunities for Action (OFA), focusing on Black African and Black Caribbean residents in Lewisham. The report examined whether these OFA continue to reflect lived experience and what further action is now required.

Between June 2023 and May 2024, over 270 community members (elders, youth, parents) and experts shared lived experiences of health inequalities through forums, interviews and podcasts. Their evidence provides a detailed picture of how health inequalities are experienced across generations.

The report shows that the priorities identified in the original BLACHIR report remain grounded in lived experience. Residents continue to experience unequal access to healthcare, education, housing and public services. These inequalities are shaped by racism, economic insecurity, cultural inaccessibility and systems that are difficult to navigate.

Across all themes, community members described how these barriers accumulate across the life course. Children and young people face unmet educational and emotional needs. Working-age adults experience delayed diagnosis, financial strain and limited access to appropriate care. Older residents encounter isolation, digital exclusion and difficulty navigating health and care systems. These experiences reflect structural challenges in how services are designed and delivered.

Several system gaps were identified consistently, including the absence of robust race-based data, fragmented service pathways, cultural barriers within health and mental health provision, and engagement models that do not build long-term trust.

Groundwork for Change

Community members highlighted three essential foundations for making the OFA real in practice: research, training and resources.

They questioned research that repeatedly gathers their stories without visible change, calling for disaggregated, action-oriented, community-led approaches that help dismantle inequality rather than simply describe it.

They emphasised that training must be anti-racist and trauma-informed, grounded in lived experience and delivered consistently across sectors so that it changes everyday practice in services.

Finally, they were clear that without long-term investment, even the strongest ideas cannot be sustained: systems rely on community-led care while offering little stability, recognition or funding in return. Sustainable funding for Black-led and grassroots organisations, trusted spaces, infrastructure for participation and staffing that reflects community needs are therefore essential.

The Priorities

Together, these findings show that health inequalities persist, not because of a lack of policy intent, but because services, data, leadership and engagement models do not yet operate in ways that communities can access, trust or shape.

From this, four priorities should guide future action:

- Services should be delivered through trusted community settings.
- Health literacy requires sustained and properly resourced investment.
- Black leadership must have decision-making authority within public systems.
- Community engagement must be continuous and embedded in delivery.

These priorities set out how public services, commissioning arrangements and partnership models need to function if they are to reduce inequality rather than reproduce it. They provide a framework for aligning statutory systems with the community-led approaches that residents already trust and use.

A Call for Collaboration

The recommendations in this report set out how the identified priorities can be implemented across health, education, housing and community services. Delivering them requires coordinated, long-term action across systems.

While some recommendations require national action, this report prioritises actions within the direct influence of Lewisham Council and the South East London Integrated Care Board (SEL ICB). National recommendations are included to ensure structural alignment and long-term equity.

These are some of the key actions that can be taken to support delivery:

- Sustained partnership with Black communities, so that lived experience continues to shape priorities, delivery and evaluation.
- Funding models that support long-term collaboration, rather than short-term or project-based engagement.
- Governance arrangements that give Black leadership decision-making authority within health and public service systems.
- Commissioning approaches that embed community-led organisations as delivery partners, not consultees.
- Service design that reflects cultural realities and local context, improving access, trust and uptake.
- Performance and accountability frameworks that include community-defined measures of success, alongside clinical and operational indicators.

This engagement identifies the structural causes of continuing inequality and the conditions that public systems need to put in place to address them.

Introduction

The Black African and Black Caribbean communities make up 23% of Lewisham (BLACHIR, 2022).

These communities are often marginalised and overlooked within broader societal discussions. In this context, residents came together to share insights into their lived experiences and reflect on the implications of the BLACHIR report. Through a series of community forums, podcasts and interviews, they voiced pressing concerns about health, community life, education, and overall wellbeing. These engagements moved beyond one-off consultations, creating space for honest dialogue and generating practical, community-informed solutions.

The OFA, as proposed in the BLACHIR report, provided a framework for these conversations, allowing the community to engage with policy proposals and directly influence the discourse on health disparities and social inequalities.

At the heart of these discussions was the shared understanding that systemic racism and discrimination feature in all aspects of their lives. From healthcare to education, public service interactions to housing, residents of these communities face barriers that are not just individual but structural.

They are fully aware that race-based inequalities are a deep-rooted and long-standing lived experience for most in their communities, often spanning generations. Despite their generational persistence, community members firmly believe that these challenges can be dismantled, and that meaningful change must be community-driven, supported by service providers, local organisations, and policymakers.

Shaped by the voices of the residents of Lewisham, this report offers practical recommendations for change. These recommendations are grounded in the real experiences of community members and reflections of their daily reality.

The input of community residents has guided both the structure and content of the report, building on the findings of BLACHIR and continuing the conversation, one that started prior to 2022, between the community, policymakers, and commissioners. It calls for action that addresses root causes and removes the barriers that stand in the way of equity and justice.

About the BLACHIR Report

In 2022, BLACHIR set out to understand why Black African and Black Caribbean communities continue to face some of the starkest health inequalities and to identify what could be done differently.

The review brought together published evidence, professional insight, and lived experience to expose how racism, poor housing, limited access to care, and systemic neglect, shape and impact people's health throughout their lives. It described the problem of health inequality and offered 39 OFA, based on eight themes, to guide local change.

This engagement report returns to those OFA, to bring them back to the community for reflection, challenge, and insight. We asked; Do these opportunities still speak to people's experiences? What do they feel is missing? What needs to be rethought or restated?

Scan the QR code to view the BLACHIR Report

Methodology

Our methodology was grounded in a participatory, community-led approach that prioritised trust, highlighted the lived experiences of residents, and removed barriers to ensure the process was inclusive.

Data collection spanned a mix of methods including:

9 public community forums

Held across Lewisham, these sessions engaged a total of over 270 participants (average of 30 per forum) and were intentionally designed in a way that encourages open dialogue with residents, making it easy for them to participate and share their views.

8 thematic podcast episodes

These episodes featured subject-matter experts from public health, education, housing, elderly care and mental health sectors.

1 podcast episode with a public health official

This provided a response from national public health bodies to community concerns and helped situate the findings within current policy frameworks.

160 community interviews

The community interviews were semi-structured and remained very conversational to gather insights from across generations, genders, and ethnicities, and covered different migration experiences and housing situations.

Participant Profile

To reflect a broad spectrum of experiences, participants were engaged through a purposive, relationship-based approach. Community facilitators worked through trusted networks, grassroots groups, and local leaders to involve elders, young people, parents, carers, frontline workers, students, and long-standing residents. While formal demographic data was not collected in every session, facilitators actively sought generational, ethnic, and experiential diversity, consistent with the project's open, community-led approach.

Approach to Analysis

Data was analysed using an inductive thematic approach. Rather than applying a pre-set framework, themes were drawn directly from the issues raised by participants. These were then mapped against the original OFA to assess where community feedback aligned, expanded, or challenged the original priorities. The analysis used the language and framing of participants themselves, incorporating verbatim quotes to reflect their lived realities. Triangulating across multiple data sources strengthened the consistency, viability, and credibility of the findings, while maintaining the integrity of the community voice.

The Cost of Inaction

Delaying addressing health inequalities not only incurs a human cost but also has significant and long-term economic, social, and institutional consequences. In the UK, successive reports have evidenced that inaction on systemic disparities in healthcare, education, and economic conditions disproportionately affects low-income families.

This chapter brings together recent research and parliamentary evidence to present a clear picture: the longer inequality is ignored, the higher the cost, financially and socially.

The Poverty Divide

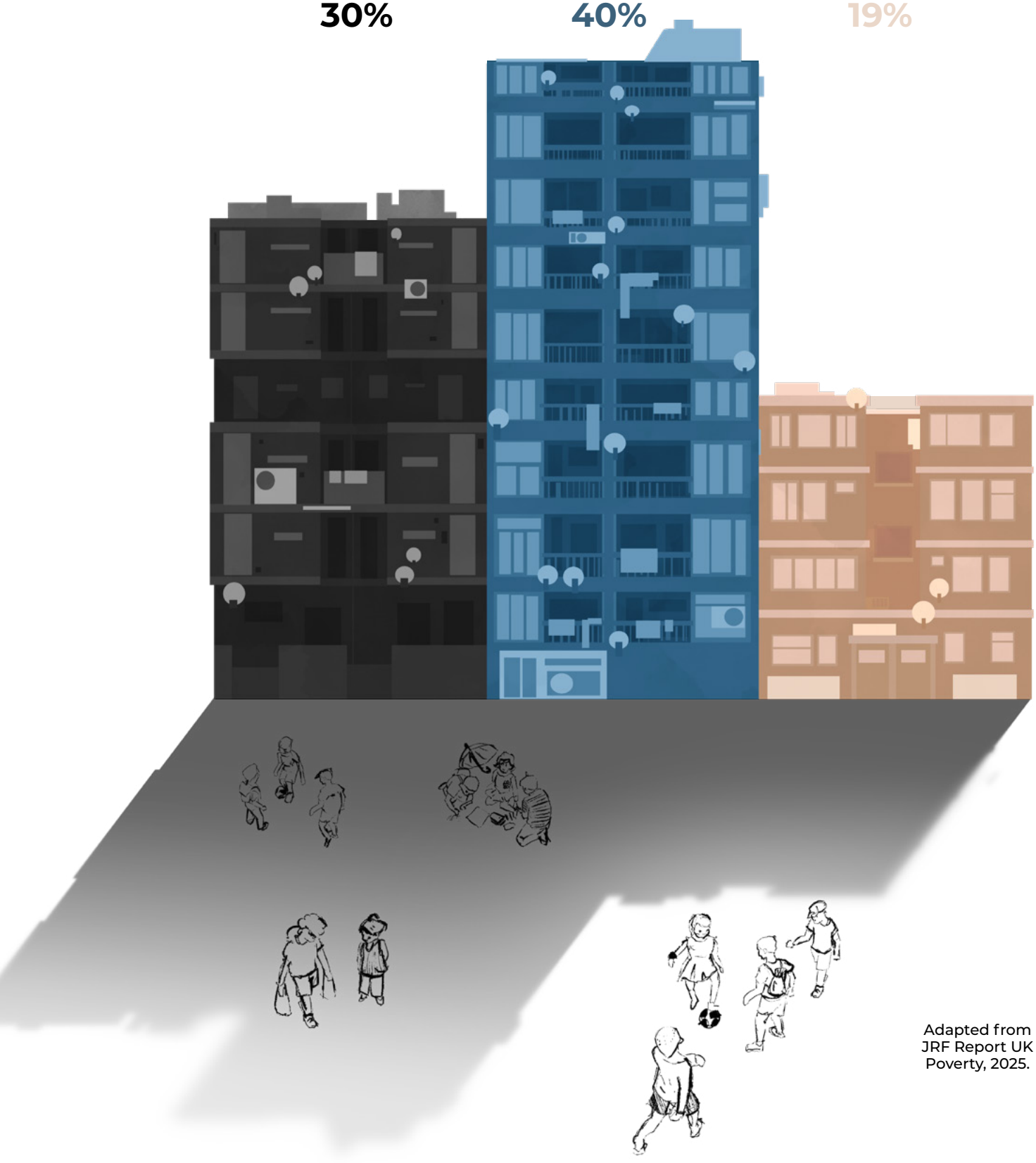
Child poverty rates in the UK are rising, with particularly stark consequences for racialised groups. According to the Joseph Rowntree Foundation (2025), children in Black Caribbean households faced an elevated risk of living in poverty (38%). More than one-quarter of Black African households (26%) and other ethnic groups (28%) were also in very deep poverty, defined as income below 40% of the median, compared to 8% of children in white households.

Persistent very deep poverty, defined as lasting at least three years out of four was five times more likely to occur among Black African and Bangladeshi households (10%) than among white households (2%). These disparities are not new, nor are they improving significantly. Poverty rates among Black African headed households increased only one percentage point since the last decade, but they have consistently been approximately twice as high (between 46% and 51%) as poverty rates among white households.

These figures are not marginal, they are systemic.

As a result of these and other drivers of poverty, deeper and longer experiences of poverty can lead to worsened life outcomes such as poorer health and early mortality.

Households in poverty by ethnicity



Adapted from JRF Report UK Poverty, 2025.

The Compound Risk

Poverty intersects directly with educational disadvantages and health risks, particularly among children and people with caregiving responsibilities. Azpitarte & Holt (2022) note that England's school system is failing children with Special Educational Needs and Disabilities (SEND), with exclusion and lack of support disproportionately affecting children from the lower-income strata and ethnic minority backgrounds.

Carers, many of whom belong to these low-income or racialised households, also face compounded health risks. As reported by CarersUK (2021), a high proportion of carers struggle with mental and physical health problems. The cumulative impact of stress, overwork, and financial insecurity adds significant strain on an already overstretched health and care infrastructure.

The Institutional Cost

The Health and Social Care Committee (House of Commons, 2025) identifies health inequalities as a direct cost to the NHS and to the wider economy. Its findings show that unmet social determinants of health continue to drive avoidable differences in health outcomes and that these differences are likely to have increased further following the COVID-19 pandemic.

The Committee estimates that health inequalities account for £4.8 billion in NHS expenditure each year and approximately £30 billion in lost productivity associated with ill-health, reduced workforce participation, and early exit from employment. These figures reflect the economic footprint of preventable disease, long-term conditions, and uneven access to effective care.

The Marmot Review (2020) provides national-level estimates of the same cost burden. It places productivity losses linked to health inequalities at £31–33 billion per year, with a further £20–32 billion arising from lost tax revenue and increased benefit payments. These outcomes are linked to a set of structural conditions operating across the UK economy:

1. Stagnating and declining wages.
2. Rising inequalities in wealth between regions.
3. Increasing poverty levels among those in work.
4. Persistently low levels of social mobility.

Health inequalities cost the UK billions each year

The Frontline Impact

A 2024 report by Schmuecker and Bestwick, primary school staff estimated that, on average, 48% of their pupils had experienced hardship since the start of the school year. Primary and community healthcare staff reported similar concerns, with 57% of their patients having faced poverty-related hardship and mental heath challenges within the past 12 months.

Anxiety and depression are increasingly linked to structural economic insecurity. Clark and Wenham (2022) state that the UK's cost-of-living crisis is increasingly a crisis of mental distress. Households already on the margins of poverty experience the highest levels of psychological harm yet remain the least able to access appropriate mental health support.

The trend of medicalising the consequences of poverty without addressing its root causes leads to inefficiency and burnout across public services, deepening mistrust and pushing families further from the systems meant to support them.

Structural inequality thus reproduces itself in new forms, affecting not just physical health outcomes but societal cohesion and intergenerational opportunity.

48% of primary school pupils experienced hardship since the start of the 2024 school year.

57% of primary and community healthcare patients faced hardship within the past 12 months.

What Collaboration Looked Like

The Advisory Board

The Advisory Board has been established to provide accountability for SIRG's role in the engagement process and to ensure that the priorities of the Health Equity Teams (HET) informed both operational decisions and wider strategic planning. The Board was made up of representatives from the six Black-led voluntary and community sector organisations that formed the first wave of HET. Meeting monthly online, it became a trusted space for teams to share updates, reflect on progress, and discuss challenges openly.

After the establishment of the Board, it became clear that there was a need for additional support and a "sounding board" function from a trusted, neutral source. In practice, this meant that SIRG took on a role supporting organisations with mobilisation within the community, troubleshooting conflicts between HET partners and their Health Equity Fellows (HEFs), and addressing confidential or sensitive issues. This extra layer of support strengthened relationships, enabled earlier resolution of problems, and increased the chances of delivering successful outcomes.

The Advisory Board also acted as a peer-learning and collaboration platform. HET members regularly shared insights from their community engagement, exchanged learnings on project delivery, and helped disseminate events and initiatives. This cross promotion and mutual attendance at activities increased visibility, strengthened community trust, and amplified the impact of individual projects.

Strategically, one of the Board's key contributions was the joint selection and prioritisation of six OFA from the BLACHIR report, which were then fed back to Lewisham's public health team. This ensured that the work on the ground directly shaped borough-wide health equity priorities and demonstrated the value of coordinated community-led input into public health strategy.

Health Equity Teams and Health Equity Fellows

As part of its community advisory role, SIRG invited the Health Equity Teams (HET) to provide advice and constructive challenge regarding their BLACHIR community engagement work. In practice, its role as a community advisory board evolved into a support space for members facing delivery and partnership challenges. The Community Advisory Group fulfilled a distinct developmental role by shaping the priorities of the Opportunities for Action (OFAs) through lived-experience and grassroots insight.

The HET are multi-agency partnerships between Lewisham's six Primary Care Networks (PCN), NHS clinicians, and Black-led voluntary and community sector organisations, including SIRG, Action for Community Development, Downham Dividend Society CLT/Social Life, Holistic Well Women, Red Ribbon Living Well, Therapy 4 Healing, 360° Lifestyle Support Network, and Mabadiliko. These teams coordinate resources, clinical expertise, and community engagement to deliver locally tailored health equity projects responding to the BLACHIR Opportunities for Action. HET activities include mobile health clinics, targeted screenings, culturally tailored health workshops, workforce training, multi-service health hubs, and outreach in trusted community spaces. This aims to improve access to primary care and preventative services, strengthen trust between the NHS and communities, and influence redesignes of care pathways to be more culturally competent.

The Health Equity Fellows (HEF) are clinicians embedded within each PCN, trained to lead on health equity and act as a bridge between primary care and community partners. These Fellows use population health data to identify local priorities, co-design targeted interventions with Black-led organisations, and deliver GP and workforce training shaped by community insight. Their work developed a cohort of clinical leaders skilled in population health, strengthened GP engagement with community initiatives, and drove service changes such as culturally sensitive hypertension protocols and community-led diabetes programmes.

Together, HET brought system resources and multi-agency coordination, while HEF brought clinical leadership and the ability to embed equity into primary care systems. Working in partnership with trusted, Black-led organisations, they co-created culturally relevant, evidence-based interventions that increased service uptake, reduced inequalities, and built lasting trust between communities and the health system.

The HET are multi-agency partnerships between Lewisham's six Primary Care Networks (PCN), NHS clinicians, and Black-led voluntary and community sector organisations, including SIRG, Action for Community Development, Downham Dividend Society CLT/Social Life, Holistic Well Women, Red Ribbon Living Well, Therapy 4 Healing, 360° Lifestyle Support Network, and Mabadiliko. These teams coordinate resources, clinical expertise, and community engagement to deliver locally tailored health equity projects responding to the BLACHIR Opportunities for Action. HET activities include mobile health clinics, targeted screenings, culturally tailored health workshops, workforce training, multi-service health hubs, and outreach in trusted community spaces. This aims to improve access to primary care and preventative services, strengthen trust between the NHS and communities, and influence redesignes of care pathways to be more culturally competent.

The Health Equity Fellows (HEF) are clinicians embedded within each PCN, trained to lead on health equity and act as a bridge between primary care and community partners. These Fellows use population health data to identify local priorities, co-design targeted interventions with Black-led organisations, and deliver GP and workforce training shaped by community insight. Their work developed a cohort of clinical leaders skilled in population health, strengthened GP engagement with community initiatives, and drove service changes such as culturally sensitive hypertension protocols and community-led diabetes programmes.

Together, HET brought system resources and multi-agency coordination, while HEF brought clinical leadership and the ability to embed equity into primary care systems. Working in partnership with trusted, Black-led organisations, they co-created culturally relevant, evidence-based interventions that increased service uptake, reduced inequalities, and built lasting trust between communities and the health system.

Scan the QR code to view the HET evaluation report

Community-Led Groups

Working alongside community organisations has brought genuine strengths to this report. These organisations, deeply rooted in their neighbourhoods, hold trusted relationships and understand both the culture and history that shape how people engaged. Their involvement created space for honest conversations and improved the quality of feedback. Their presence increased participation from local residents and surfaced valuable ideas for improving services.

SIRG provided coordination across this delivery model, linking community organisations, Health Equity Fellows, and statutory partners. This included supporting mobilisation within neighbourhoods, addressing partnership challenges, and managing sensitive issues that could not be handled through formal reporting structures. This enabled problems to be identified and handled at an early stage, reducing disruption to the engagement and maintaining confidence among participating groups.

Through its participation in statutory forums, including the Health Inequalities Workstream and the Lewisham Health and Care Partnership Board, SIRG created a route for community concerns to be raised within system-level discussions. At the same time, Lewisham Black Voluntary Network (LBVN) meetings enabled direct engagement between residents and statutory representatives, allowing specific issues to be discussed in person.

Feedback from community organisations and residents indicated that formal reporting processes did not always provide clear or accessible information about how decisions were being made or how community input was being used. This limited the ability of participants to track progress or respond to emerging priorities.

A more consistent and community-designed approach to sharing outcomes back to residents, including clear summaries and regular feedback sessions through LBVN, would support transparency, sustained engagement, and continued community involvement in health equity work.

This report demonstrates that working with community-led organisations adds important value, deeper understanding and greater local relevance in public health.

What We Heard

The forums and interviews captured broad experiences and priorities. In many cases, the podcast findings echoed what was heard in the forums. Where the podcasts differed, they added sharper critique, challenged the limits of the OFA, and highlighted system-level barriers. Taken together, the forums, interviews, and podcasts supported triangulation by showing what participants raised, how systems responded, and how accountability and change were understood across the programme.

Across the forums, residents spoke openly about the challenges they face from racism in public services to gaps in maternity care, mental health, education, and everyday wellbeing. Equally, they shared ideas for change. These were practical, actionable proposals: changes to policy, better training, improved access, and community-led solutions designed by and for the people they serve.

The findings are organised under the original eight BLACHIR themes and grouped under five headings: implementation, recommendations, research, training, and resources. The final three have been consolidated across themes to minimise repetition and support clarity.

1 Racism and discrimination

This theme evoked some of the most strongly held views from the community.

Across the forums, people highlighted how racism and discrimination are embedded in everyday experiences. These issues are underpinned in all other themes, evident in the language used by institutions and the way services are delivered. There was a shared understanding that racism is not a side issue, but a defining determinant of health, wellbeing, and opportunity.

Community members voiced concerns about how change is being implemented, who is responsible, and what anti-racism would look like in practice. For many, this theme was not simply about injustice, but about being made invisible by the very systems meant to protect and support them. They believed the system was not constructed to serve the needs of Black people but was intended to embed the Black community as workers and service providers.

OFA

1 Local Councils and Health and Wellbeing Board Partners

Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.

2 Local Councils and Children's Trusts

Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.

3 Local Councils and Health and Wellbeing Board Partners

Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.

4 Local Councils and Education Partners

Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

OFA implementation

One of the clearest concerns raised was the proposal to remove colour language from ethnic coding. Community members feared that this change, though presented as inclusive, would erase identity, undermine the ability to monitor racial disparities, and dilute efforts to tackle racism meaningfully. They questioned who made this decision, who is accountable, and how it would be evaluated.

Community members expressed concern that such a drastic shift, removing language in the name of equality, reflects a wider trend of depoliticising race without addressing the underlying determinants of inequality. There were also questions about transparency: people wanted to know how national public health bodies communicate their anti-racist stance and how that stance is made visible in both policy and practice.

> **Removing 'Black' from ethnic coding risks erasing a crucial aspect of identity and lived experience.**

> **This OFA risks undermining antiracist efforts by obscuring the specific challenges faced by Black individuals.**

Recommendations

There was a strong call to keep race visible in data and to ensure this data is actively used to inform service design based on real population needs. The community emphasised that race-based data must do more than reflect identity; it must drive accountability in commissioning and evaluating services. Without meaningful use, race data risks becoming performative rather than transformative. Public Health bodies and Local Authorities are urged to recognise the cultural and historical significance of the term “Black” and to protect it as both an identity marker and a tool for accountability.

The community stressed that any anti-racism approach must be co-designed with the community, with clear individuals and roles made responsible for delivering it. Participants called for urgent development of timelines, accountability structures, and consistent feedback loops with the community.

Regarding adverse childhood experiences (ACEs), racism must be recognised as a form of trauma, especially for children and adults with special educational needs and disabilities (SEND). The community warned that without swift, clear action, these vulnerable children remain exposed to unaddressed racial trauma with lifelong consequences.

There was also a call to place responsibility on the broader system. How will employees at every level be expected to contribute to eradicating racism? How will they be held accountable? Recommendations included embedding anti-racism policies in recruitment, procurement, and co-design processes. A systemic approach to these policies is essential to achieve measurable impact.

Short-term:

- Ensure race-based data collection is consistent and used to directly inform service commissioning and evaluation.
- Co-design anti-racism strategies with community involvement, clearly defining roles and accountability.
- Develop urgent timelines and feedback mechanisms that involve the community throughout implementation.
- Recognise racism as trauma in frameworks addressing adverse childhood experiences, with special focus on children and adults with SEND.
- Embed anti-racism principles across all public sector recruitment, procurement, and service design.
- Implement accountability measures that hold all public system employees responsible for contributing to anti-racism efforts.

Medium and long-term:

- South East London ICB and Public Health Lewisham should implement mandatory anti-racism and cultural competency training for frontline staff, with annual refresher requirements and accountability mechanisms.
- The Office for National Statistics and NHS Digital must reinstate ethnic coding across health and education datasets, with guidance and protections in place to prevent misuse.
- Develop local accountability frameworks (co-designed dashboards to track progress on OFA).
- Implement Black leadership pipelines (pathways into senior roles). This directly confronts institutional under-representation and embeds equity in leadership.

Podcast Findings

The first episode of the podcasts featured a long-standing community advocate (T.J.) who responded to the OFA on racism and discrimination, drawing on decades of professional practice in anti-racism work, statutory training, and grassroots organising.

T.J. acknowledged the value of the OFA but questioned whether they go far enough in addressing the underlying power structures that allow racism to persist. She challenged how institutions use the language of anti-racism without changing practice or demonstrating accountability. Language means little without a shift in power. Institutions are increasingly fluent in the rhetoric of anti-racism but resistant to redistributing power. She questioned the sincerity of inclusion efforts that centre optics over influence. Representation is not the same as participation, considering Black professionals are often placed in decision-making spaces with little authority to shape outcomes.

> **They bring you in as a Black face, but they have made up their minds. It is not about your input but it is about optics.**

> **If you remove 'Black' from the coding, you remove the ability to measure what is actually happening to Black people.**

A central concern in this theme was the disconnect between generations. T.J. reflected on how younger Black people are navigating more subtle, coded forms of racism, often without the language or support to name it. She described a growing emotional gap, where older people recognise institutional racism but feel exhausted to address it, while younger people feel it but struggle to articulate, recognise, and respond to discrimination. This, she argued, is why it is crucial to imbed anti-racist education early on in education and sustain its learnings throughout schools, youth services, and public institutions. Therefore, she strongly opposed the removal of racial categories in ethnic coding as suggested in OFA 1, calling it "a form of erasure". She also criticised terms like BAME as harmful, imposed, and institutionally convenient but not reflective of how people identify themselves.

While supportive of the OFA in principle, T.J. viewed them as a starting point rather than a complete response. She called for clearer mechanisms for accountability, ongoing community-led monitoring, and a stronger emphasis on redistributing power in reports and practice. For progress to be meaningful, control must shift to communities themselves. A successful implementation of OFA 3, for example, should therefore include investing in racial literacy training led by those with lived experience, rebuilding trust, and ensuring that communities lead not only in naming the problems, but in shaping the solutions.

> **The structures are still the same. You can change the words, you can change the staff, but if the community is not driving it, nothing is really changed.**

2

Maternity, parenthood and early years

This theme reflects the community's wish for (health)care that not only understands, but values the lived experiences of Black mothers, children, and families.

From pregnancy through to the early years of parenting, community members raised questions about how services are designed, who is consulted, and whether professionals are equipped to deliver care that is inclusive, informed, and sensitive to racialised trauma. A key message was that early years matter deeply, and the systems that serve mothers and children must be shaped by the communities they aim to support.

OFA

5 Local Councils and Health and Wellbeing Board Partners

Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.

6 Local Councils and Children's Trusts

Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.

7 Local Councils and Health and Wellbeing Board Partners

Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.

8 Local Councils and Education Partners

Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.

9 Local Councils and Education Partners

Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

OFA implementation

Community members expressed concerns about how much input they could have in shaping new tools and services meant for them and their children. Since these tools are meant to collect informtion, there was strong desire for more than just consultation. They called for genuine co-design, with their cultural knowledge and lived experiences forming the foundation of these online tools and maternity and early years interventions.

There were also questions about the diversity of needs within the Black community itself, especially in relation to migrants, refugees, and those with no access to public funds. The community members asked whether these groups are actively involved in shaping services that affect them, since their access to care could be limited and challenging.

> **How can Black parents contribute to the design of online tools that reflect our cultural practices around childbirth and parenting?**

> **What specific services are in place for Black women who are migrants, refugees, or asylum seekers, and how will their unique needs be addressed?**

Recommendations

Community members emphasised the urgent need for targeted interventions that are scalable and capable of delivering measurable improvements for Black communities, particularly in reducing disproportionate disadvantages and inequitable outcomes. These interventions must be rooted in real-life experiences and developed in partnership with those most affected.

A key priority is the creation of culturally tailored services for Black mothers, recognising systemic failings in maternity care. Special focus should be placed on women who face additional barriers, such as insecure immigration status or lack of familiarity with healthcare systems, ensuring that care is accessible, respectful, and responsive to their unique needs.

There is a need to develop culturally specific weaning guidance and support structures that celebrate and honour diverse traditions surrounding birth and early parenting. These include the use of holistic practices such as doulas, herbal remedies, and cultural approaches to wellness. While recognising that not all holistic interventions can be formally integrated into health services, the community asserts the importance of choice and agency in care that aligns with cultural identity.

Service providers are called upon to move beyond standardised models of care by embracing cultural flexibility, especially during key moments when mothers are accessing services. Policy and practice should be co-created with local families and shaped by genuine cultural understanding and flexibility. Community members strongly underscored that Black women experience pain just like anyone else, and that their voices and needs must no longer be ignored or minimised within healthcare settings.

Short-term:

- Design and scale up culturally responsive, targeted interventions for Black families, with particular attention to maternal health.
- Develop and disseminate weaning and early parenting guidance that is culturally relevant and honours community traditions.
- Support the integration of holistic practices, including the use of doulas and herbal support, allowing space for community-led approaches even if not all can be formally adopted.
- Transition service delivery from standardised care to culturally flexible models, ensuring programmes are co-created with, and for, local families.
- Train healthcare professionals to recognise and address biases and ensure that Black women's expressions of pain and need are heard, validated, and promptly addressed.

Medium and long-term:

- SEL must work with Black-led organisations to co-design specialised maternity and paediatric services responsive to the needs of Black families.
- Introduce annual cultural safety audits (reviewing anti-racism and accessibility). This will ensure that early-years and maternity care are culturally safe, inclusive, and responsive to Black mothers.

Podcast Findings

This episode featured two community-based experts: A.M., who leads the local Maternity Voices Partnership, and J.C., an early years educator with decades of frontline experience in Lewisham.

A.M. welcomed the emphasis on community engagement within maternity services and the articulation of clearer commitments. At the same time, she highlighted that previous consultation exercises have often failed to translate into sustained change, leaving many women uncertain about whether their experiences will lead to improved care. Concerns were raised about cultural safety and informed consent in maternity services, with Black women's pain and voices continuing to be undervalued in practice.

> **It is so important not to just hear this information and sit on it. It is about actually seeing what's been done with what you said.**

J.C. reflected on the growing focus on culturally responsive and preventative approaches within the early years sector. He supported the call in OFA 6 for earlier engagement and migrant-inclusive tools, noting that early years settings play a critical role in identity formation, emotional development, and long-term wellbeing. He also reported that early childhood provision continues to be framed primarily as childcare. This narrow framing reduces opportunities to embed trauma-informed and anti-racist approaches into the foundation of services.

Both speakers pointed to examples of community-rooted and co-designed services that are already producing change. However, they warned that this progress remains uneven and often under-resourced. They called for stronger accountability, particularly around how community feedback is taken forward and incorporated.

The absence of cultural continuity within education was raised, including the limited presence of Black male educators in early years settings. This could undermine children's sense of belonging and representation. J.C. spoke about the missed potential in not recruiting and retaining more Black men in early years roles, describing it as a major gap in both care and aspiration for youth. Black boys are frequently misread or adultified in early years settings, leading to disproportionate disciplinary responses and missed opportunities for support.

A.M. shared parallel concerns regarding maternity care, where Black women's voices are often dismissed and pain is under-recognised. She stressed that despite increased awareness; many women still experience care that lacks cultural safety or informed consent.

Both speakers were clear: these are not isolated incidents but systemic patterns that point to persistent gaps in racial literacy and trauma-informed practice.

In relation to OFA 7, both speakers supported the call for better recording and reporting of ethnicity but highlighted that existing categories are often reductive and alienating. For example the experience of being forced to tick “Other”, signals erasure and contributes to mistrust. Without more nuanced and inclusive data, services cannot adequately respond to the full range of Black communities’ needs and many residents will continue to disengage from research and feedback processes.

I keep ticking ‘Other’ — because none of the boxes fit me.”

A.M. and J.C. expressed cautious optimism. They acknowledged that the OFA capture the right principles of co-production, cultural competence, and accountability, and pointed to examples where this is already working well. An important aspect raised was that implementation must be consistent, resourced, and measured against the experiences of the community. Progress is possible only if communities are placed at the centre, not only in consultation, but in decision-making and delivery.

There are now more spaces opening up where women can speak. And they are being heard – not always, but more than before. In some of the MVP work, we have seen real change where feedback has gone into redesigning the antenatal pathway.”

3 Children and young people

Across the forums, community members shared concerns about how Black children and young people are being supported not only in school settings and health and care services, but in how they navigate the world.

Parents and caregivers raised questions about access to guidance, culturally sensitive care, and safe spaces where young people feel seen, protected, and able to thrive. There was a clear call for long-term support that reflects the everyday realities of Black families and for these services to be designed alongside the communities.

OFA

10 Education settings supported by the Regional Schools Commissioner and local Councils

Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.

11 Local ICS, Mental Health Trusts & Council commissioned Healthy Child Programme Providers

Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.

12 Education settings supported by the Regional Schools Commissioner and local Councils

Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.

13 Local Health and Wellbeing Boards and Integrated Care Systems

Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean ethnicity.

14 Local Directors of Children's Services and Strategic Children's Partnerships

Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.

15 Local Councils and climate change and air quality partners

Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.

OFA implementation

Many members asked how practical support like school transitions, youth provision, or access to healthcare will be implemented in ways that are culturally relevant, accessible, and sustainable, while some expressed concerns about visibility, follow-through, and inclusion.

> **How will you ensure that Black parents and children have access to information and support during the transition to secondary school and further education?**

Members also highlighted the importance of involving trusted local centres and Black-led organisations in the delivery of youth services, particularly when it comes to creating safe spaces and building trust through meaningful initiatives that engage young people. The youth are not hard to reach; they simply need to be met on terms that resonate with them.

16 Integrated Care Systems (ICS) and Health and Wellbeing Boards

Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Recommendations

Community members emphasised that the one-size-fits-all interventions do not work. This is reflected in disparities seen in education outcomes, overrepresentation of Black youth in exclusion statistics and criminal justice data, and disproportionality in health and care services.

The community called for services that are tailored to address the specific challenges faced by Black young people. Services should include focused interventions on mental health, sexual and reproductive health, and gender-based violence. There was a strong recommendation for partnerships with Black-owned businesses and grassroots organisations to keep initiatives grounded in lived experience and real outcomes. Forum discussions highlighted a deep sense of community responsibility, with families committed to building resilience and equipping the youth with tools to navigate economic hardship. This blend of institutional accountability and community ownership was viewed as critical for meaningful change.

There is growing concern about financial insecurity, especially among young people in families experiencing low wages and rising living costs. Economic hardship was linked to deteriorating wellbeing, prompting calls for poverty to be addressed as an integral part of youth support services. In response, families and communities have taken ownership by sharing budgeting skills, promoting financial literacy, and reviving traditional saving methods such as pardner to support each other through the economic crisis.

How are Black-led community organisations, leaders, and businesses being involved in providing safe spaces for Black youth?

Short-term:

- Develop targeted interventions addressing the unique challenges of Black youth, focusing on mental health, sexual and reproductive health, and gender-based violence.
- Foster partnerships with Black-owned businesses and grassroots groups to ensure initiatives reflect lived experience and achieve measurable outcomes.
- Support community-led resilience-building efforts by equipping young people with practical skills to manage economic challenges.
- Integrate poverty reduction strategies within broader youth support services to address financial insecurity and its impact on wellbeing.
- Promote financial literacy and the revival of community saving practices like pardner within Black families and communities.

Medium and long-term:

- To enhance the transition experience between secondary and further education, local education authorities should fund health literacy curricula in primary and secondary schools that incorporate practical skills such as navigating healthcare systems, booking GP appointments, and understanding mental health.
- Local Authority Commissioners should improve identification and referral pathways for youth carers in Black communities and offer tailored support options.
- Create intergenerational health hubs (community-owned wellbeing centres) that strengthen family and intergenerational wellbeing while fostering belonging for youth.

Podcast Findings

This episode brought together an intergenerational group of experts, including a safeguarding board member (S.R.) and Lewisham's Young Mayor (J.), who responded to the OFA with a mix of lived experience, professional insight, and local political engagement.

The OFA were recognised as addressing long-standing concerns, although questions were raised about their visibility and delivery more than two years after publication. While the priorities remain relevant, the experts stressed that delivery has been slow, inconsistent, or unclear.

> **Guys [are] stepping out in Nike and LV hats — but there's no bedsheet at home.**

Poverty and exclusion were described as both widespread and increasingly hidden. Both S.R. and J. spoke about the material realities that sit behind appearances, such as children's loneliness, food insecurity and overcrowded housing, and emphasised how economic hardship intersects with cultural pressure, shame, and invisibility.

S.R. challenged narratives that place responsibility solely on respective communities and called for greater recognition of structural drivers such as the lack of affordable housing, youth provision, and school reform. In relation to the commitments set out in the OFA, services were described as fragmented, disconnected, or tokenistic.

OFA 12, which calls for targeted educational approaches to improve academic outcomes for Black African and Black Caribbean children, was discussed in detail. While Lewisham introduced a borough-wide pledge and toolkit for embedding race and racial equality in schools, both experts stated that fewer than half of school leaders who signed the pledge are actively using it. They described the initiative as often reduced to a "tick-box exercise" with little accountability or follow-through. They stressed that many school heads continue to be uncomfortable with anti-racism work, particularly when it empowers students to question and challenge their own outcome narratives. The conversation called for stronger enforcement, including potential legal accountability.

> **In no other profession can you be well paid for bad outcomes. Yet that's exactly what's happening in schools.**

S.R and J. stressed the need for more equitable partnerships between local authorities and Black-led organisations, such as Youth First, with a shift from consultation to co-creation. In relation to OFA 15, they raised concerns about how engagement is often conditional, with Black-led groups invited to participate only on pre-defined terms, limiting their ability to lead or innovate.

Concerns were raised regarding the implementation of OFA 11, 13, and 14 when it comes to transparency and accountability in local authority spending. J. emphasised the need for residents to remain engaged in decision-making and to press for detailed, quantifiable reporting on how budgets are spent. Especially for public funds, allocated by councils, police, and service agencies to improve outcomes for Black communities.

They highlighted a lack of local employment opportunities for young people, warning that without clear equity in planning and procurement, communities will continue to be locked out of growth. Communities must stay at the table and “hold their hands to the fire” not just to demand better, but to insist on a return for the investment they already make through taxes, labour, and lived presence.

A clear call to action also emerged around addressing the persistent lack of cultural understanding across public systems. S.R. and J. expressed frustration that institutions often misinterpret or overlook the lived realities, values, and strengths of Black communities. They urged councils and service providers to work in culturally responsive ways, co-design solutions with community input, and invest in ongoing training to embed equity and cultural intelligence throughout policy and practice. Without this shift, even well-funded interventions risk missing the mark.

Both experts emphasised the importance of lived experience in shaping policy and practice. They called for impact measures that reflect whether interventions are improving outcomes for children and young people in ways that are meaningful to those directly affected.

Our situation’s not improving, so that money’s going somewhere.”

“I feel the BLACHIR report is a vital piece of research that highlights the previously hidden challenges faced by the Black community in the UK. Moving forward, it is important that we continue to hold those in charge accountable and ensure they are doing all they can to close the gap in inequality.”

Jentai Gen-One

Former Young Mayor of Lewisham 2023-2024

4

Ageing well

Elderly Black residents shared thoughtful and often personal reflections on how services perceive and respond to their needs.

Whether it is access to health checks, culturally sensitive care, or mental health support, the message was consistent: ageing should not mean being overlooked. The community stressed that services for elderly must be respectful, culturally grounded, and shaped by the realities of those they serve, particularly in communities where historical mistrust still shapes engagement with health systems.

OFA

17 Regional NHS England teams and Local Public Health Teams

Provide targeted and culturally appropriate screening services for Black African and Black Caribbean older adults.

18 Local Public Health Teams

Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

19 Integrated Care Systems

Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.

20 NHS England and Integrated Care Systems

Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.

21 Local Health and Wellbeing Boards and Integrated Care Systems

Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

OFA implementation

Members of the community questioned whether services were truly reaching elderly Black residents. Accessibility was raised repeatedly not just in terms of physical access, but whether services feel welcoming, respectful, and appropriate for their community.

There was concern that some campaigns and screening services, while well-intentioned, might not consider the full context of Black elders' experiences, including intergenerational trauma and the legacies of exclusion in healthcare systems.

> **How will you ensure that vaccination campaigns reach Black elders who may be hesitant due to historical mistrust of the healthcare system?**

Recommendations

Community members called for interventions that recognise the structural inequalities affecting older Black adults alongside the cultural values that shape their lives. Suggestions included campaigns promoting routine health checks, targeted vaccination programmes in high-deprivation areas, and support systems reflecting the real experiences of ageing within Black communities.

Trusted spaces such as the Hummingbird Club were described as central to how this work should happen. They expressed a desire to be co-drivers of initiatives rather than passive recipients, actively shaping solutions that reflect their lived realities and address their community's needs.

What specific campaigns are being developed to raise awareness among Black elders about the importance of routine health checks?

Forum participants emphasised the urgent need to tackle the system's lack of cultural understanding of older generations, especially migrants who have historically been excluded. Many older residents navigate a system unfamiliar to them, where values and service delivery remain misaligned with their needs.

Short-term:

- Design and deliver interventions that address both structural inequalities and cultural values influencing the wellbeing of older Black adults.
- Promote routine health checks and targeted vaccination efforts in high deprivation areas relevant to older Black communities.
- Build authentic partnerships with the community, leveraging trusted spaces like the Hummingbird Club for co-design and engagement.
- Ensure older residents are active co-creators in planning and monitoring services, valuing their lived experience as central to decision-making.
- Address cultural misunderstandings within systems serving older migrants and excluded groups by improving training and service adaptation.

Medium and long-term:

- Integrated Care Systems (ICS) and community health services should reinstate mobile health clinics in high-need areas such as Forest Hill, prioritising routine check-ups and preventative care to enhance accessibility and optimise public health messaging throughout communities where there are significant disparities in health needs.
- Pilot community health navigator roles (peer guides supporting access to services) that reduces isolation and improves access for elders through trusted, culturally informed support.

Podcast Findings

This episode featured B.G., a Lewisham resident with extensive expertise in public health and decades of community advocacy around health inequalities. In responding to the OFA, B.G. focused on how ageing is experienced in Black communities and how current systems engage with older residents.

B.G. supported the life course approach set out in OFA 5 and linked it to the need to address long-term patterns of exclusion affecting older Black Caribbean residents.

> **They don't know much, if anything, about Black Caribbean people in old age... That really made my stomach turn.**

However, she highlighted whether implementation would reach the structural depth required to undo what she called "decades of structural neglect". She pointed to the near-total absence of older Black Caribbean residents in health research and strategic planning, calling it a form of institutional erasure. The health inequalities she raised, namely high rates of diabetes, poor dementia care, and unmet needs at the end of life, are not new. She describes them as shaped by generations of racism, poverty, and systemic exclusion from preventative care.

OFA 17, 18, and 19 emphasise culturally appropriate services and mental health access, B.G. noted that awareness initiatives alone are unlikely to address entrenched inequalities and that targeted investment is required to reach those most affected. Public health providers must invest unequally for equal outcomes.

The conversation also tied OFA 20 to real-world distrust in health services, especially around vaccination. B.G. explained how current incentive models in GP practices often prioritise flu jabs over chronic condition management, therefore further undermining trust, especially after the COVID-19 pandemic.

> **If I would have had a stroke and I am lying in bed, you're going to come and offer me a flu vaccination? Come on. What are the priorities here?**

Digital exclusion and service design are additional barriers. New systems requiring patients to use GP apps or online booking services exclude many Black elderly. The focus of OFA 21 on interventions must therefore be grounded in real usage data and lived experience, not assumptions of access. B.G. reflected on how gentrification has pushed Black elders into deprived areas without adequate infrastructure. Due to the lack of services in their own area, Black elderly give up on GP services altogether, often leading to preventable deterioration in health. She described centres such as Calabash and Hummingbird as essential to physical and mental health, cultural connection, and intergenerational support. Yet, these spaces are "hanging on by a thread".

Importantly, B.G. pushed back against narratives of passivity in later life. She described how walking groups, intergenerational care, and healthier living are already being led by Black elders but are rarely acknowledged in formal systems.

Overall, B.G.'s analysis affirms the OFA but calls for sharper implementation, better data, and an improved redistribution of power. Without these, the risk is that older Black adults remain underserved.

> **They are still here. Still learning. Still leading. If we treat them like that, we might start seeing different outcomes.**

5

Mental health and wellbeing

Mental health emerged as a key area of concern across the forums, with community members calling for services that truly understand the weight of racial trauma and the ongoing impact of systemic discrimination.

The community stressed that mental health is not just an individual issue but is shaped by histories of exclusion, mistrust, and cultural disconnect. People called for trauma-informed, culturally rooted approaches that are developed with the community and delivered through trusted, safe spaces.

OFA

22 Local Public Health and Community Mental Health Trusts

Coproduce awareness campaigns for Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self referral in collaboration with carers, families, health services, community and faith centres.

23 Local NHS providers and Community Mental Health Trusts

Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.

24 NHS Mental Health Providers and Commissioners

Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.

25 Local Health and Wellbeing Boards and ICS Partnerships

Promote cultural competency training within healthcare services, the criminal justice system, and the police force.

26 Local Health and Wellbeing Boards and Integrated Care Systems

Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

OFA implementation

Across discussions, the design and delivery of mental health (awareness) work was closely linked to how far communities were involved in shaping it. Services were described as too often being designed for Black communities rather than with them, which was seen to limit relevance and trust. Community members

How are Black community leaders and organisations being involved in the development of mental health awareness campaigns in Lewisham?

emphasised that meaningful engagement begins with ownership, yet many campaigns were described as largely developed by statutory bodies and external providers. Mental health interventions often remained clinical or institutional in nature, failing to reflect the places and people Black communities turn to when they are struggling, such as faith groups, cultural spaces, and local advocates.

Recommendations

Strong support was expressed for mental health campaigns that are community-led and grounded in language that reflects lived experience and cultural identity.

Many said that using everyday language such as “wellbeing” makes it easier to start conversations than clinical terms that still carry stigma. What mattered most was feeling that these campaigns were shaped by the realities of their lives rather than imposed from outside.

> **How are you ensuring that mental health services use language that resonates with Black communities and reduces the stigma around seeking help?”**

Racism came up repeatedly as something that affects how people feel, cope, and seek help. It was described as part of what causes distress in the first place, such as housing, schooling, work, and how services treat people. This framing led to a call for racism to be addressed as a structural harm that requires system-wide intervention rather than isolated responses.

Because of this, participants felt that small changes to existing services are not enough. They talked about the need for mental health systems to be redesigned with communities, so that support reflects how people actually experience and manage stress, trauma, and care.

There was also a strong feeling that any changes made by the NHS need to be judged by whether they improve equity for Black communities, rather than by whether they simply roll out new programmes or structures.

Short-term:

- Develop mental health and wellbeing campaigns that are community-led and use culturally resonant language to reduce stigma.
- Implement practical approaches that recognise racism as a core driver of mental health inequalities and treat it as structural trauma.
- Co-lead a comprehensive audit and redesign of mental health services with voluntary sector partners and affected population groups.
- Ensure NHS mental health service reforms are rigorously evaluated for equity, preventing further widening of disparities in Black communities.
- Foster whole-system interventions to address structural racism within mental health care delivery.

Medium and long-term:

- PHL, in conjunction with SLAM/CAMHS, must consider commissioning grassroots organisations to optimise mobilisation of activity and deliverables. For example, the launch of Walk and Talk peer-support groups for young men in local parks and trusted community spaces.
- ICBs and Local Authorities should consider embedding a rolling grants programme to commission culturally grounded, non-clinical mental health spaces for young people, developed and led by Black community organisations.

Podcast Findings

This episode featured J.M., a Lewisham-based mental health practitioner and advocate with extensive experience in community-based care, public health, and Black-led service delivery. Her reflections focused on the gap between the intent of the OFA and the capacity of current systems to deliver them.

J.M. referred to the language of the OFA as aligned with community need, while describing the existing service infrastructure as limited in its ability to respond to what is being asked. The language is there, but "they are asking something from a system that cannot respond that way. It is not designed to." This reflects a wider trend in health planning, one where policy ambition is not matched by structural change.

The framing of Black communities as "hard to reach" was directly questioned. J.M. stated that services consistently failed to provide safe, accessible, and culturally and context-sensitive support. What appears to be low uptake is often the result of years of built-up mistrust and exclusion, rather than disinterest or disengagement.

> **We weren't hard to reach; there was just no in-reach.** ”

OFA 23, which calls for trauma-informed and culturally competent care was discussed in relation to practice. J.M. referred to Family Health ISIS, a Black-led organisation that offered advocacy, early intervention, and culturally safe care, as evidence of what works. Family Health ISIS addressed stigma, both internal and external, surrounding Black residents who needed mental health support. She connected fear of services and silence around suicide directly to the absence of trusted institutions such as this one. Its closure, despite its clear impact, showed how community-rooted responses are still de-prioritised and underfunded. Faith settings were identified as critical spaces, but also as places of spiritualisation of mental health. She emphasised that they are untapped spaces for culturally sensitive dialogue and support for the implementation of these OFA.

J.M. was critical of how the current system continues to criminalise distress, a reality that actively obstructs the successful implementation of the OFA. The over-use of Community Treatment Orders (CTOs), over-diagnosis of psychosis, and the quick escalation from unmet needs to involuntary detention are not incidental but structural patterns. These patterns are rooted in racism, not only as bias, but as an embedded practice within current services.

> **You say no to something, and suddenly you are non-compliant. You are not the expert in your own care anymore.**

OFA 26 includes a commitment to improve language in service delivery. J.M. welcomed this but stressed that meaningful change requires specificity, and that specificity depends on better mental health data. This presents a further challenge: “What data is being collected and how? And how precise are the questions, particularly around identity?”

> **You cannot measure wellbeing through the lens of illness alone, and yet that is still the standard.**

She highlighted that assessments still rely heavily on Eurocentric frameworks, and that wellbeing continues to be measured largely through a lens of illness. Without disaggregated data and a broader, community-informed understanding of mental health, accountability becomes impossible, and engagement from the community remains limited.

A shift in public mental health from deficit-based models to strength-based, prevention-led, community-rooted approaches could be a workable solution. There is a need for sustained investment in what the community has already built. This includes co-production, investment in Black-led services, trauma-informed practice, and system-wide racial literacy. Co-production should not remain rhetorical. Without the redistribution of power, the OFA risk becoming another well-meaning but unfulfilled promise of change.


IMAGO
Be Your Own
Success
Story

The BLACHIR Report is the most comprehensive review of health inequalities affecting African Caribbean communities, drawing on overlooked data and valuing communities as assets. It calls for community-led decision-making, influence over research design, and solution-focused interventions that improve quality of life rather than relying on deficit-based models. Investment in underserved Black communities, and aligning services to residents' needs are essential to delivering the national goal that "there is no health without mental health" for Black African and Caribbean people.

Juney Muhammad
Independent Mental Health Promotion Consultant

6 Healthier behaviours

This theme explores how health and wellbeing can be supported through everyday behaviours, trusted relationships, and accessible community education.

Health messages were described as most effective when delivered by familiar voices in familiar places. The need for services that understand how structural racism impacts both individual behaviour and community health outcomes was paramount. There was a strong push for local ownership, long-term investment, and an approach to health that values lived experience as much as clinical knowledge.

OFA

27 Local Directors of Public Health

Work with Black African and Black Caribbean communities and organisations to cocreate and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.

28 Health Education England

Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.

29 Local Councils and Integrated Care Systems

Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.

30 Local Directors of Public Health

Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.

31 Research funding bodies such as NIHR

Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in ‘action research’ to concurrently deliver and evaluate interventions.

32 Local Directors of Public Health and nationally OHID

Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

OFA implementation

The community asked how community organisations, particularly Black-led and faith-based groups, are being engaged in delivering health education and preventative care. The community made it clear that programmes should not be parachuted in through top-down initiatives but must be co-designed with those already embedded in local life, the real experts on their own communities.

> **How are you partnering with Black faith based organisations to promote healthier lifestyle choices in the community?**

There was also interest in how trauma-informed practices would be integrated into these health behaviour efforts not as an afterthought or an add-on, but as a foundational pillar from inception designed with Black communities and those with lived experience.

Recommendations

Calls were made for more meaningful engagement with local organisations, not just in delivering programmes, but at the design stage. Interventions that reflect Black residents' lived experiences and values, including faith, food, family, and social support are necessary to address (un)healthy behaviours.

Residents emphasised the importance of explicitly recognising racism and discrimination as direct contributors to poor health outcomes. They advocated for approaches that are explicitly anti-racist and that confront systemic barriers head-on. To achieve this, they stressed the need for robust, transparent commissioning and procurement processes. This would enable fair access to funding, ensure accountability in service delivery, and align with community priorities. The importance of upholding the Duty of Care under the Equalities Act was highlighted to strengthen these processes.

There was consensus that cultural competence training for all health employees should be an ongoing, embedded practice as this was considered a golden thread of best practice.

How are Black communities engaged in the design and delivery of health literacy programmes, and what role do local organisations play?

Short-term:

- Engage local Black organisations meaningfully in both the design and delivery of health programmes, ensuring interventions reflect community values around faith, food, family, and social support.
- Explicitly embed anti-racist approaches that address structural barriers within commissioning and procurement processes.
- Ensure transparency and fairness in funding allocation, holding providers accountable and aligning services with community priorities.
- Uphold the Duty of Care in service design, as mandated by the Equalities Act to protect community interests.
- Design services with and by Black communities to ensure needs are met authentically and effectively.
- Implement ongoing cultural competence training for all health employees as an essential element of best practice.

Medium and long-term:

- Local health authorities should support the creation of WhatsApp broadcast lists (opt-in) to share appointment reminders and public health updates with community members, to optimise the acceleration of health messaging.
- Develop a shared learning platform (hub for data, evaluation, and practice exchange) encouraging collaboration and learning around prevention, wellness, and lifestyle improvement.
- Introduce a long-term Equity Impact Fund (ring-fenced for Black-led innovation) that sustains preventative, community-led health and wellbeing initiatives.

Podcast Findings

This episode featured two community experts: Q.W., the founder of the Queen's Walking Group, and M.W., a lead member of the Men's Walking Group. Both responded to the OFA with insight grounded in lived experience and long-standing community health work.

Q.W. and M.W. welcomed the OFA' focus on promoting healthier behaviours but emphasised that change cannot happen without practical, community-based support. Q.W. spoke about how Black women in her network were ready to take charge of their health but often lacked accessible entry points. Education, health literacy and public health outreach were such entry points, but they require culturally sensitive, peer-led support and not generic campaigns.

Her walking group, which grew from a small WhatsApp group to nearly one hundred members in just six weeks, has become a consistent space for physical movement, mental wellbeing, and collective care. Besides exercise, this space rebuild healthy routines and accountability in everyday life.

M.W. echoed the importance of belonging and consistency, especially for older Black men managing diabetes, hypertension, prostate cancer, and social isolation. His group, formed in a local park, offers a space where men can "walk and talk" away from clinical settings that often feel alienating.

> **Health isn't just about steps. It is about who is walking beside you."**

Both experts raised concerns about how health initiatives are delivered. While they acknowledged the efforts made under OFA 27 and 29, they felt programmes, like Up Up, were difficult to access and too often reliant on GP referrals that do not reflect community realities. OFA 29, the provision of long-term investments for Black-led grassroots organisations, is a welcome and much-needed commitment, but in practice often feels unimplementable. Q.W. described how she now carries flyers for local initiatives in her bag because "you have to meet people where they are, not where you wish they'd be."

Cost-of-living pressures were named as a critical barrier to healthier behaviours and successful implementation of the OFA. M.W. described how food prices have reshaped men's diets, making it harder to choose what is healthy over what is affordable. Q.W. added that nutrition advice often does not account for the cultural and economic context of the people it is aimed at.

They are always going to go for whatever they can get because no one is helping them stretch a pound.

Both experts agreed that lasting change requires information and communication that speaks the language of the people and understand where they are economically and culturally.

The experts also warned against framing health behaviours through a deficit lens. M.W. challenged assumptions that Black men lack discipline or interest in wellbeing, pointing instead to inherited trauma, systemic neglect, and a lack of culturally safe services. Both experts called for OFA 28 and 30 to be implemented with care, especially in faith spaces, which can either reinforce silence or serve as hubs for prevention, depending on who is leading.

Ultimately, both Q.W. and M.W. described behaviour change not as a matter of individual willpower, but as something shaped by design, access, and trust. Their experiences highlight what is possible when community-led initiatives are supported and when health is made part of everyday realities.

You don't need a field to grow food. You just need someone to show you where to start.

What Works

The Walking Men's Group of Lewisham (WMG) began with support from the Better Mental Health Fund, created in response to mental health challenges after the COVID-19 pandemic. Inspired by the positive effect of social connection on wellbeing, SIRG helped launch WMG with 360° Lifestyle Support Network. Starting with just 20 Black men for a six-week pilot, the group has grown to nearly 100 members in three years.

WMG uses walking and peer support as simple but powerful tools to improve mental and physical health. Walking promotes exercise, reduces loneliness, and opens space for honest conversation. The group builds community and encourages self-care, reducing mental health crises and providing ongoing support.

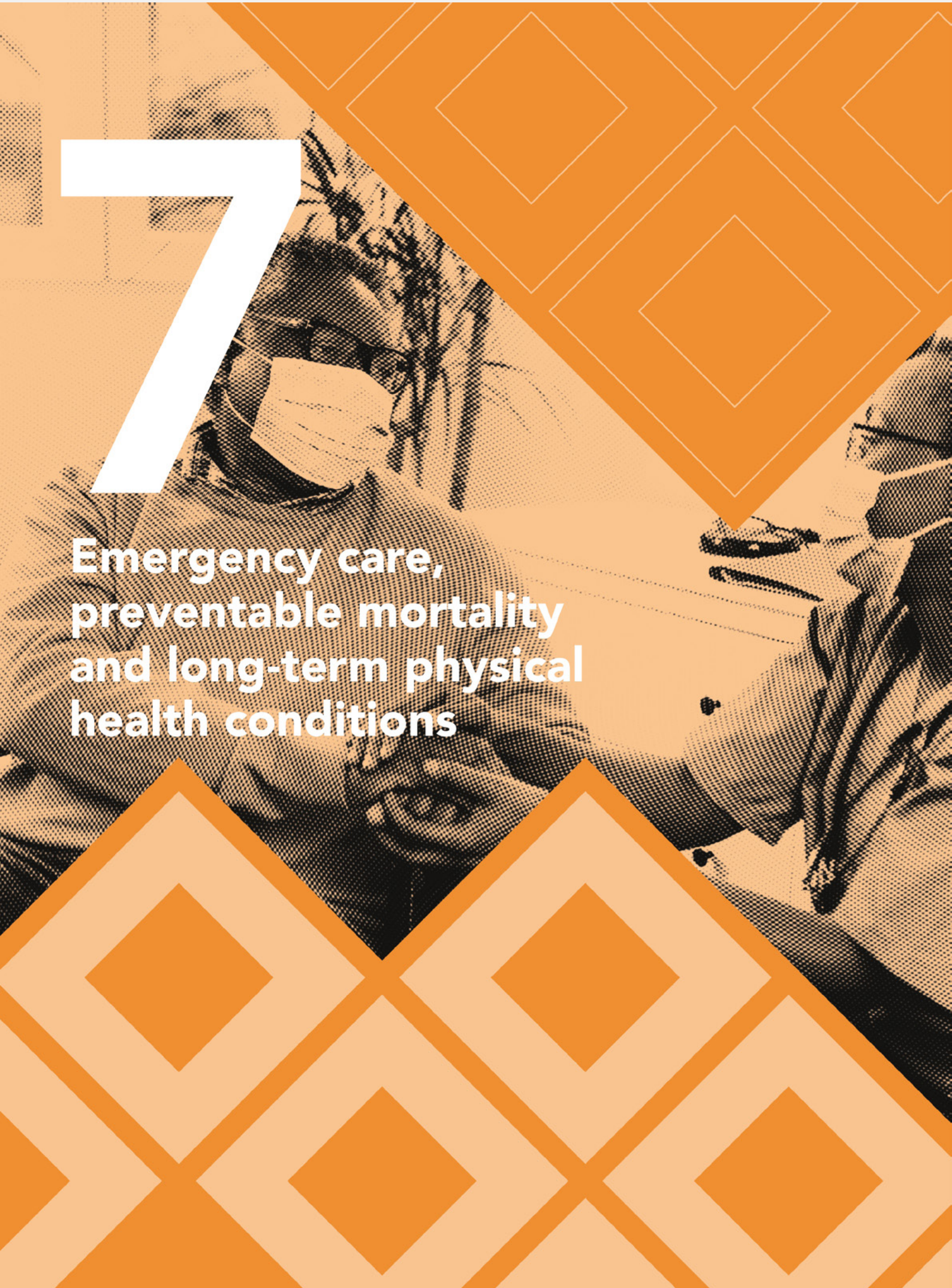
Over three years, WMG has hosted events such as expos, trips, and participated in large mental health campaigns. It now receives independent funding from Walking & Cycling Grants London, showing strong sustainability.

This group highlights how grassroots, community-led initiatives can leverage public funding to deliver culturally relevant, effective support, especially to communities often seen as hard to reach.

I love going on walks in the fresh air in a beautiful South London Park. The discussions we have on various topics help me learn more about life and to become the man I want to be.

I enjoy connecting with a group of men who are improving their lives and also helping the younger generation. We debate a diverse range of subjects and focus on making positive changes.

The group brings something out of me that helps me to move on in my life. It gives us men a chance to talk and discuss things and not sit behind closed doors.



7

Emergency care, preventable mortality and long-term physical health conditions

This theme generated some of the most detailed and consistent feedback from the community.

Long-standing challenges in accessing care for chronic conditions and during health emergencies were raised repeatedly, attributed to poor access, under-diagnosis, unsafe interactions, and a lack of culturally sensitive support. The discussion went beyond clinical concerns and pointed to a system where trust has been eroded and where adequate action is overdue. Experiences during the COVID-19 pandemic were highlighted as part of this context.

Fears about being overlooked or misdiagnosed, frustrations with medication systems and appointment access, and the toll of navigating services that do not reflect their lived experiences were discussed. Community members called for visibility, accountability, and equity, and made clear that any response must centre the realities of both younger and older generations.

OFA

33 NHS England, Integrated Care Systems and Local Councils

Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations.

34 Local Health and Wellbeing Boards and ICS Partnerships

Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments.

35 Local Directors of Public Health and NHS Prevention Leads

Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy.

OFA implementation

A major shared concern was the invisibility of action. Community members expressed that they often do not see the presence of Public Health or emergency services in their communities, in a way that feels familiar, respectful or reliable. They called for tangible engagement: outreach that is consistent, spaces that are safe, and services that meet people where they are, whether in barbershops, churches, or community centres. Accessibility and proximity are crucial; services must be in places people readily go to and trust.

> **Our community has no safe space outside their homes... this matter has to meet us where we are.**

The community also stressed the need for multi-generational responses. Older adults raised concerns about delayed care and overlooked conditions, while younger people and their parents spoke about the ongoing mistrust in healthcare systems and the desire for better prevention and education early in life.

> **What are we doing to change this thinking for the younger generation? It's not just the older generation, it is the same for the younger people.**

Recommendations

The forums generated a set of specific and urgent proposals. These included stronger support around stroke prevention and cardiovascular health, with clearer guidance and education for clinicians on prescribing and care delivery.

Particular concern was raised about the way uterine fibroids are addressed in Black women. Community members described fibroids as having a significant impact on fertility, quality of life, and emotional wellbeing, while often being treated as low-priority within health services. Despite the evidence showing that Black women are disproportionately affected by fibroids, the condition is frequently underdiagnosed or dismissed, contributing to mistrust and inadequate care. Black women feel that healthcare professionals do not take them seriously. Raising awareness among both healthcare providers and Black women about the prevalence and seriousness of fibroids is critical.

> **Fibroids in Black women is a huge issue which is underplayed. I would love to see this highlighted.”**

> **My daughter asks me to go with her and she’s 30. She feels she is not listened to.”**

The community also expressed a strong desire for the creation of a Black-led digital health platform, such as a “Black UK Medic,” to provide culturally relevant health education, facilitate provider access, and strengthen community connections.

Short-term:

- Increase support and public health campaigns focused on stroke prevention and cardiovascular health tailored specifically for Black communities.
- Develop and deliver targeted clinician education programmes to improve understanding and management of conditions like fibroids, emphasising their impact on Black women's health and wellbeing.
- Promote awareness campaigns within Black communities about uterine fibroids to encourage early detection and timely care.
- Establish a Black-led digital health platform offering culturally relevant health information, provider access, and community networking opportunities to empower health literacy and engagement.
- Ensure that health services incorporate culturally competent approaches in managing conditions prevalent in Black populations, prioritising patient trust and effective communication.

Medium and long-term:

- ICB must reinstate phone-based GP appointment bookings and provide clear alternatives for patients unable to use online systems.
- Lewisham Council, in partnership with youth organisations, must fund and coordinate technical support buddy schemes, enabling young people to support older residents with NHS app usage and digital form navigation.
- South East London ICB and Healthwatch must consider commissioning co-designed multimedia materials (e.g., short videos, audio messages), explaining how to access NHS services, produced in African and Caribbean languages.
- Integrated Neighbourhood Teams (INTs) must embed trained community health advocates within surgeries to assist with navigating forms, booking appointments, and understanding diagnoses.

Podcast Findings

This episode featured J.J., a community development worker embedded in North Lewisham's Health Inequalities programme, who responded to the OFA drawing on frontline delivery and long-standing experience working in communities that statutory services have historically struggled to reach.

She described how North Lewisham pioneered a health equity model in response to COVID-19 to implement early intervention and prevention services for the local population. The introduction of Health Equity Fellows included the organisation of free, walk-in MOT-style health checks, covering BMI, blood pressure, diabetes, cholesterol, prostate cancer, and HIV, delivered in everyday places like churches, mosques and community centres.

> **We brought them in and gave them a full MOT… and through that, we were able to detect people that had pre-diabetes or were having diabetes. We could then direct them to where they had to go.**

OFA 35, focuses on fair and appropriate prevention services, was welcomed. J.J. noted that the challenge lies in sustaining and replicating what is already working. She noted that North Lewisham had been the pilot site for this work and that its success helped shape a borough-wide strategy. Still, she questioned why similar levels of resourcing and ambition were not visible across all localities. In her view, the expertise and access already exist within communities. The barrier is that systems continue to operate at a distance.

> **As soon as they start, you have got to be looking for the next lot of money… they always do that to us.**

On OFA 33, which calls for culturally appropriate data collection, J.J. highlighted that the current approach still lumps diverse communities into one category and treats Black communities as one homogenous group. She stressed the need for data that captures real cultural and national variation, particularly when it comes to understanding long-term conditions. "If you are Nigerian, it should say you are Nigerian," she argued, noting that meaningful service planning cannot happen without better data.

> **We were the pilot of the health inequalities programme... and because we did such a good job, that is now why you have got HEFs in all the other PCNs.**

In reference to OFA 34, which focuses on meaningful engagement, was also discussed. J.J. supported the proposals in principle but warned that unless they are matched by resourced, long-term planning, they risk becoming another short-lived cycle of outreach.

Throughout the conversation, J.J. challenged the idea that Black communities are disengaged from care. What appears to be low participation was often a sign that services are not going where people are, or they are designed without community input.

Whether in places of faith or Domino's, J.J. emphasised that trusted spaces already exist. The real test is whether services are willing to meet people there, actively listen to what is needed, and follow through on implementation. The OFA offer a strong and detailed blueprint, but their effectiveness depends on services being willing to operate in these spaces, invest in existing community infrastructure, and maintain consistent delivery over time.

8 Wider determinants of health

Although this theme did not receive dedicated responses in the forums, it remains a crucial structural lens through which to understand health inequalities.

Community members recognised that health outcomes cannot be separated from the social and economic systems that shape people's lives.

Health was placed at risk by housing insecurity, poor air quality, employment and income disparities, and experiences of discrimination in schools and public services. For Black communities, these risks intertwine and compound, resulting in systemic barriers that influence physical and mental health outcomes. The intersection of race with these wider determinants of health highlights how structural racism and marginalisation operate across these domains. creating an unequal access to resources and opportunities.

Addressing health inequalities requires a comprehensive approach that tackles these underlying social and economic conditions.

OFA

36 Local Health and Wellbeing Boards and Integrated Care Partnership Boards

Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black Mixed ethnic minority groups.

37 Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations

Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.

38 Local Health and Wellbeing Boards

Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.

39 Local Health and Wellbeing Boards and Integrated Care Partnership Boards

Take action to address employment inequalities and issues around racism and discrimination in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high risk occupations.

Short-term:

- Develop cross-sector policies that address housing quality, employment opportunities, and environmental justice as central components of health equity strategies.
- Increase investment in community-led initiatives to improve living conditions and reduce environmental hazards disproportionately affecting Black communities.
- Implement anti-discrimination measures in education and public services to dismantle systemic barriers that impact health outcomes.
- Collect and use disaggregated data to better understand and respond to the complex ways social determinants affect health in Black populations.
- Foster collaboration between healthcare, housing, employment, education, and environmental sectors to create integrated solutions that address the root causes of health disparities.

Medium and long-term:

- ICS must pilot travel subsidies for patients with SEND and complex needs facing long commutes to access GP or hospital care.
- Create equitable funding pathways (micro-grants for grassroots projects), addressing structural inequity in funding and supports community economic resilience.
- Establish a Black Health Equity Institute (community-academic policy hub) to tackle systemic inequity through long-term research, policy, and cross-sector influence.
- Integrate health equity KPIs into local authority performance frameworks. Makes racial health equity a measurable requirement in council accountability.

Podcast Findings

This episode featured J., a youth worker and community organiser in Lewisham, who reflected on the OFA through the lens of lived experience and local action. His response focused on how the priorities set out in the OFA translate into power and decision-making on the ground.

J. supported the OFA' emphasis on representation and on addressing racism and discrimination in public systems, while questioning whether representation alone leads to change. The presence of Black service members alone is not enough. He pointed to the lack of adequate representation of Black voices on local NHS Boards and reflected on his own public appointment to the Youth Justice Board, describing it as rare. What matters is not just having a seat at the table, but being able to use that position to instigate necessary change and create meaningful impact.

> **For us to be in those spaces [police, NHS] and do well, the culture has to shift. Because the culture isn't set up for us to thrive or to be ourselves. You get in there, and before you know it, you are conforming.**

If systems want to understand culture, they need to trust those who live it. J. challenged the common pattern of consultation (only speaking with the community to “pick their brain”) without power. He called for a shift from surface-level engagement to genuine power sharing, where communities help set the agenda instead of only responding to it. For the OFA to be succesful, knowing what hurts is not enough; systems must also be clear and practical about what healing looks like. “We know what’s hurting us, but what is needed now is clarity around solutions, long-term planning, and the tools to make those solutions real.”

So, when they are creating these jobs for us in terms of cultural competency or whatever, we are the only ones who can feel it. Because we are the only ones who know how to build solutions.”

Mental health for Black men was raised as a wider determinant that is often left unspoken. Shame, silence, and pressure to perform strength often prevent men from seeking care until it is too late. He proposed reframing mental health through the lens of hygiene, a universal construct. This shift could create space for earlier conversations and more culturally grounded support.

Across the conversation, J. emphasised that communities are not waiting to be fixed. They are already doing the work, building spaces of support, care, and resistance despite the current systems, not because of them.

Think of mental health like hygiene, you know if you haven’t bathed, just like you know when you are not okay.”

Community Needs

Across All Themes

Throughout all eight themes, three topics have been identified as the groundwork needed to consolidate all efforts in the OFA:

1 **Research**

2 **Training**

3 **Resources**

What people brought into the room was shaped by years, sometimes decades, of experience with systems that listen but do not act and speak the language of equity but fail to resource it. These were not abstract issues. They were about trust, visibility, and being taken seriously.

Together, these conversations show not only what needs to change, but how current systems are experienced on the ground and where people feel unheard.

Research

Across all themes, community members raised deep concerns about how research is conducted, what is being measured, and whether it ever leads to meaningful change. While there was broad recognition of the value of data, many expressed scepticism about how it is gathered, who it serves, and what is done with it.

The community expressed clear discomfort with research-led approaches that fail to produce visible change. Many spoke of the exhaustion that comes from sharing their experiences repeatedly, only to see them disappear into reports without feedback, follow-up, or real acknowledgement. As one resident put it, “What other metrics are being used for those who may not fill out the questionnaire?”

Many questioned whether current research methods truly capture the complexity of their lives. There were calls for:

- Disaggregated data that reflects ethnic, national, cultural, and migration-based differences within Black communities.
- A shift away from broad ethnic categories that flatten identity and obscure systemic inequalities.
- Stronger community-led or action-oriented research models that are designed with and for the people of the community.

There were also questions on how research success is measured. Counting the number of programmes is not enough, as communities want to know whether those programmes work, how they are being evaluated, and who sets the standards for success. This was particularly relevant in areas such as mental health, maternity care, early years, ageing, and education, where poor evaluation can result in culturally inappropriate services being repeated or even expanded.

Crucially, there were repeated questions about why some issues remain under-researched. Why is there so little evidence around the experiences of Somali, Eritrean, or Ethiopian communities in Lewisham? Why is there limited understanding of why Black men delay or avoid GP visits? And how are we addressing the longstanding lack of research on SEND families and racial trauma?

Despite being willing to share, many participants expressed low trust in research, as their contributions have rarely led to meaningful change. They emphasised the need for greater transparency in how findings are used and clearer communication about what follows.

Above all, the message was clear:

Research should not just document inequality, it should help dismantle it.

Training

Training was described as a test of whether systems are serious about change. Community members were clear that box-ticking exercises do little to challenge harmful behaviours or shift practice on the ground. They spoke of professionals continuing to arrive unprepared, despite the availability of information, because little effort is made to apply it meaningfully within real-world contexts.

The concerns went beyond whether training takes place. People questioned what is being taught, who is delivering it, and whether it leads to any tangible difference. Across health, education, mental health, and public services, there was a strong call to move away from detached, generic approaches and towards training grounded in lived experience.

Key messages included:

- **Anti-racism and trauma-informed training**
  The community repeatedly called for training that directly addresses systemic racism and its impacts — including race-based trauma, intergenerational stress, and discrimination in care. This applies across the life course, from early years to elder support, and must be embedded in prevention, education, and emergency response.
- **Training led by those with lived experience**
  People were clear that training must be co-designed and delivered by those who understand what it means to navigate racism and exclusion within systems, not with consultants without connection to the communities affected. Participants called for more visibility of Black professionals in training, leadership, and service delivery.
- **Sector-wide, not one-off**
  The community raised concerns about inconsistencies in how training is delivered across settings, particularly between police, schools, health services, and local authorities. They called for a joined-up approach that recognises racism as a cross-sector issue, not something to be handled in isolation. Training must be consistent, repeated, and accountable.

There were also specific calls:

Early years staff should be equipped to recognise racism as trauma.

Mental health teams must be trained to “listen before they label”.

Maternity professionals need deeper understanding of how discrimination affects Black women’s experiences and outcomes.

Clinicians should understand how structural inequality shapes physical health, including the impact of poverty, vitamin D deficiency, and psychosomatic stress on Black residents.

The community highlighted that training is not only about transferring knowledge. It is about how people show up in practice, and whether that results in different choices, better care, and improved outcomes.

Resources

Behind nearly every concern was a shared truth: without long-term, meaningful investment, even the strongest ideas from communities or government will fail to become sustainable.

Community members described systems that rely heavily on community-led care, yet offer little back in terms of stability, recognition, or funding. They spoke about safe spaces being lost, outreach teams being understaffed, and programmes disappearing just as trust begins to build. The community is already doing the work, but they are doing it without the tools, support, or certainty to sustain it.

Key messages included:

- **Sustainable funding, not pilot projects**
  Across youth provision, maternity care, mental health, chronic conditions, and ageing, residents called for an end to short-term funding cycles. They want investment that supports long-term change, not one-off trials or awareness weeks.
- **Support for Black-led and grassroots organisations**
  These organisations are often closest to the community, most trusted by residents, and best placed to respond to local needs; yet they remain underfunded and over-relied upon. Residents stressed that praise is not enough. They need financial support, workforce development, along with a seat at the table that is not merely ceremonial, but one with teeth, capable of driving necessary change.

- **Investment in safe, familiar spaces**
  From community halls to faith centres and local networks, people want care to be available in places they already trust. These are the spaces where early intervention happens, where stigma is reduced, and where cultural context is understood without needing explanation.

- **Infrastructure to support participation**
  Co-design, cultural competency, training, advocacy, none of which can happen without resources. Residents want to see investment not just in services, but in the processes that bring them to life. That includes funding for translators, community advocates, and staff who can build long-term relationships across difference.

- **Staffing that reflects community need**
  People raised concerns about staffing levels. Effects are felt from delays in getting medications to the absence of outreach workers. They want more staff who are not only present but prepared, trained, representative, and able to walk alongside those navigating complex systems.

At its core, this is not a call for charity. It is a call for fairness. Communities cannot be expected to carry the weight of broken systems without being resourced to do so. As one participant said:

> **We don't need new strategies. We need support for what's already working.**

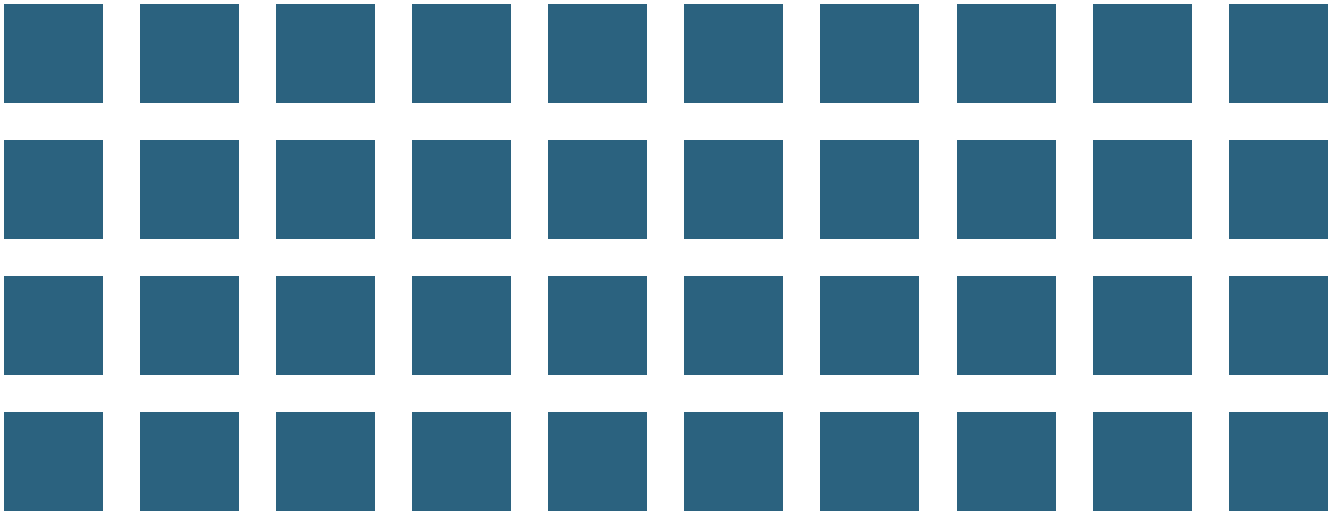
The Voice of Generations

Across 160 community interviews conducted for this engagement report, a clear thread emerged:

Health inequality remains a daily reality.

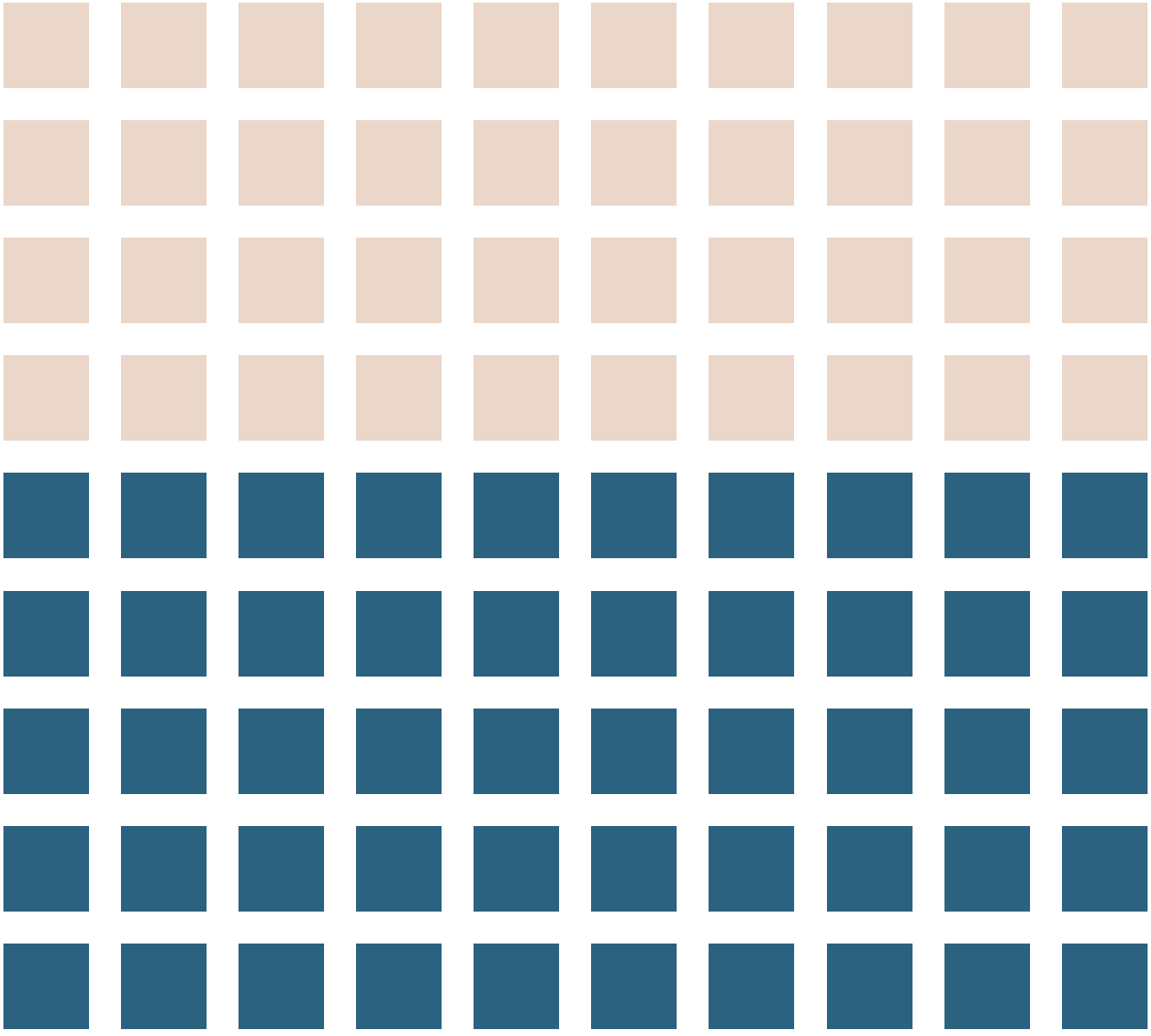
70 elders

90 young people



This chapter brings together reflections from 90 young people and 70 elders, offering a generational perspective on how unequal access to care is experienced, understood, and remembered.

These insights do not stand apart from the themes explored in the main engagement but rather they reinforce them, bringing the OFA into sharper focus through everyday lived realities.



Shared Realities

Both young and older participants spoke about unequal access to healthcare. Although they were at different life stages, the barriers they described were similar. Elders often recalled years of navigating services that were neither accessible nor responsive, facing delays, postcode restrictions, and the burden of self-advocacy. One woman explained she delayed care because her GP was too far and public transport too difficult: “It doesn’t feel like we’re meant to be seen quickly or seen at all.” Others noted the shift to digital systems had made things worse: “My GP stopped phone bookings, now it’s all online. I have to get my daughter to help, otherwise I just do not go.”

Younger participants, though newer to the system, had already observed and internalised similar patterns. Some had never visited a GP or had a routine check-up. One 16-year-old male living in temporary accommodation said: “Care feels like it’s for clean people, people with jobs and suits.” Others described watching their parents being misunderstood or treated as a risk. These early experiences shaped their expectations of care as something inaccessible, or even hostile.

> **Care feels like it’s for clean people, people with jobs and suits.”**
>
> **Male, 16, Sydenham**

Inequality was not only spoken about in terms of delayed care, but it was also seen in its consequences. Elders shared stories of peers who missed out on treatment or received diagnoses too late. Young people reiterated these concerns, pointing to the difficulty of finding mental health support that felt accessible or culturally appropriate. One explained: “They write things down, ask how I am, then bounce. Same thing every time.”

All generations understood health goes beyond the medical aspects. Poor housing, financial pressure, racism, and stress were all identified as health issues. Young people, in particular, described how these wider determinants affected their ability to sleep, eat well, or feel safe. Elders recognised the same patterns, tracing them over decades of living with inadequate housing and inconsistent care.

> **Sometimes it’s crisps and fizzy drinks for dinner. That’s all I can afford.”**
>
> **Male, 20, Deptford**

Connected Voices

Despite frustrations, the interviews reflected a sense of shared strength and purpose. Elders expressed confidence in the younger generation: “They have got a voice now. They speak up in ways we couldn’t.” Young people, in turn, acknowledged the persistence of their elders and were already stepping in to support them, helping with forms, translating at appointments, or sharing information with peers. “We could run tech buddy schemes to help our elders use the systems that are meant to help them.”

The solidarity was not symbolic; it was practical. One young woman shared, “I see what my mum went through, and I do not want that for my daughter.” Rather than seeing this resilience as something from the past, many saw it as something to carry forward. Together, these voices pointed to hardship, but also to a collective willingness to act.

This intergenerational perspective reinforces what has been heard throughout: communities are already identifying what needs to change and where efforts should be focused. While their experiences differ, young people and elders share a clear understanding of what gets in the way of good health and what could make a difference. The OFA set a useful frame, but these narratives add depth, pointing to approaches that are both practical and rooted in daily life.

The next section outlines the solutions that community members described, reflecting on the priorities, ideas, and contributions of those living with the consequences of inequality.

Bridging The Gap

Older participants repeatedly stressed the need for real, lasting investment instead of short-term fixes. The frustration was not just about poor access, but about being treated as if digital solutions alone could solve structural neglect. Online booking systems, automated referrals, and impersonal consultations left many feeling locked out of care.

Their proposals were simple, grounded, and actionable:

- Bring back mobile health clinics in areas like Forest Hill.
- Introduce walk-in Wednesdays at GP surgeries, with staff who know the community.
- Provide travel funds for patients registered far from home.
- Position trusted patient advocates inside practices to help navigate forms, bookings, and appointments; especially for elders who feel talked down to or overlooked.

These are ideas for smart innovation and easy implementation.

We don’t want another pilot.
We want someone to actually stay.”

Younger participants shared a clear-eyed view of the barriers their families face and proposed tech-smart, culturally grounded, and community-led responses to structural exclusion. In several case studies, they suggested:

- Creating WhatsApp groups to share appointment reminders.
- Setting up digital drop-in clinics at libraries, churches and youth centres.
- Producing explainer videos in African and Caribbean languages, helping families understand NHS systems.
- Running tech buddy schemes, where young people support older relatives in navigating health apps and online forms.

Making Space For Mental Health

Mental health was a priority across generations, but especially among young men. Their suggestions were informal but action-driven:

- Launching “Walk and Talk” groups in local parks.
- Producing community podcasts to open conversation.
- Creating safe spaces — informal, peer-led environments where young people could speak honestly without fear of judgement.

These reflections pointed to a gap in care but also to existing resilience. Many were already holding that space for each other, without professional support. One young woman shared:

> **There should be a number to call when life feels heavy, someone who sounds like your auntie giving real talk and care, not scripts.”**

Meeting People Where They Are

Whether young or old, participants wanted services to show up in the places that already hold trust such as faith centres, barbershops, community kitchens. Health messaging in these spaces was not just practical; it was about restoring dignity and respect.

One participant said:

> **You do not need to rebuild trust if you go where trust already lives.”**

Beyond Representation

There was shared concern about the lack of Black leadership in NHS structures. But participants went further than representation: they wanted roles with accountability. As one young man put it:

> **If you're creating cultural competency jobs, why not trust the people who live the culture to lead them?**

This was not about visibility alone. It was about decision-making power and whether those shaping services had lived knowledge of the communities they serve.

A Call To Action

Across generations, there was no shortage of insight or answers. What the community asked for was not more consultation, but commitment. To fund what has worked and what is working. To follow the lead of those already doing the work. To stop starting over. The task now is not to extract more stories, but to act on them.

Conclusion

This engagement report did not simply revisit the Opportunities for Action set out in the original BLACHIR report. It created space to test them against the realities people are living with now. By returning to Black African and Black Caribbean residents in Lewisham, the process brought lived experience back to the centre of how health inequality is understood and addressed.

Across interviews, forums, and podcast discussions, people described the same obstacles in different ways: difficulty accessing care, services that do not understand their lives, and limited influence over the decisions that affect them. These were patterns that shape how health, care, and trust are experienced day to day. These shared priorities give weight to the revised OFA.

Community members were clear that meaningful change depends on work that is long-term, locally rooted, and shaped by the conditions people face. In engaging with the OFA, they did more than endorse them. They pushed them further, drawing attention to digital exclusion, intergenerational care, and the mental health of young men as areas that require stronger focus. These concerns are not new and reflect a deeper understanding and continued relevance of how health inequalities operate across systems and life stages.

Finally, this report reaffirms that community insight is not supplementary; it is essential. The recommendations set out here come directly from lived experience and from people who know how services work in practice. They set a clear direction for what must take place next. With these insights in hand, the focus now turns to action and implementation, with accountability mechanisms in place to ensure that community priorities remain central.


LOVE

With Gratitude To:

Project Leadership & Content

Sabrina Dixon
Project Lead & Chief Executive, SIRG CIC

Assia Nait Kassi & Sabrina Dixon
Authors

Tania Tarraf
Communication Specialist

Podcast Contributors & Community Experts

Thank you to the powerful voices who shared their truth on the *"Same Place, Worlds Apart"* podcast series:

Callum Reddish
Podcast Co-Host

Akilah Muhammad, Barbara Gray, Donovan Grant, Dr Catherine Memba, Jacob Sakil, Jamal Robinson, Jentai Gen-One, Joyce Jacca, Juney Muhammad, Queen Joan, Susan Rowe, Tracey Jarrett
Guests

Your reflections brought clarity, courage, and deep community insight to this engagement report.

Community Venues & Hospitality

Calabash Centre
Venue

Lewisham Local
Community Venue

Cumming Up
Hospitality

Creative, Design & Media

Natalia Tkaczyk
Creative Design and Communications Manager

Community Advisory Support

We are especially thankful to the individuals and organisations who guided and strengthened our Community Advisory Board:

Betty Efemini
Holistic Well Women

Francine Daley & Leon Thompson
360 Lifestyle & Support Network

Hillna Fontaine
Mabadaliko

Husaina Hamza
Red Ribbon Living Well

Joseph Oladosu
Action for Community Development

Joyce Jacca
Health Inequalities Community Link Worker

Naomi Louise
Therapy 4 Healing

Tim Oshodi
Downham CLT

To Our Communities

To the hundreds of residents, who joined conversations, forums, and interviews: thank you for your trust and your courage.
To the youth mentors, outreach leads, and community builders who ensured no voice was left behind: thank you for holding space with care.
To the organisations who collaborated with integrity and purpose, thank you for showing what partnership truly looks like.

This report reflects your brilliance, your pain, your power, and your enduring belief in the possibility of a fairer, more just world.

To the Team at SIRG

Thank you for your bold vision, care-led practice, and deep-rooted belief in community-powered change. Your leadership has helped create not just an document, but a movement.

Together, we honour the past, act in the present, and shape a more equitable future.

Dr Catherine Memba, Callum Reddish, Sabrina Dixon

Jamal Robinson, Akilah Muhammad, Barbara Gray, Queen Joan, Donovan Grant, Jacob Sakil, Tracey Jarrett, Jentai Gen-One, Susan Rowe, Juney Muhammad, Joyce Jacca

References

Azpitarte, F., & Holt, L. (2023). *Failing children with special educational needs and disabilities in England: New evidence of poor outcomes and a postcode lottery at the Local Authority level at Key Stage 1*. British Educational Research Journal, 50(1), 414–437. Portico. https://doi.org/10.1002/berj.3930

Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR). (2022). Birmingham City Council/Lewisham Council - March 2022 - 107.4

CarersUK. (2023). *State of caring 2023. The impact of caring on health*. soc23-health-report_web.pdf

Clark, T. & Wenham, A. (2022). *Anxiety nation? Economic insecurity and mental distress in 2020s Britain*. Joseph Rowntree Foundation.

Health and Social Care Committee, House of Commons. (2025). *Health inequalities and their cost to the NHS and society.* Health inequalities in health protection report 2025 - GOV.UK.

Joseph Rowntree Foundation. (2025). *UK Poverty 2025. The essential guide to understanding poverty in the UK*. Joseph Rowntree Foundation.

Marmot, M. (2020). *Health equity in England: the Marmot review 10 years on*. BMJ, m693. https://doi.org/10.1136/bmj.m693

Schmuecker, K & Bestwick, M. (2024). *The impact of hardship on primary schools and primary and community healthcare*. Joseph Rowntree Foundation.


HIGHER RATES OF DEMENTIA

Appendix 1

Recommendations

For the purposes of this report, Local Commissioners refers to Lewisham Council and the relevant commissioning functions of the South East London Integrated Care Board (SEL ICB).

While some recommendations require national action, this report prioritises actions within the direct influence of Lewisham Council and the South East London Integrated Care Board (SEL ICB). National recommendations are included to ensure structural alignment and long-term equity.

Theme 1

- Ensure race-based data collection is consistent and used to directly inform service commissioning and evaluation.
- Co-design anti-racism strategies with community involvement, clearly defining roles and accountability.
- Develop urgent timelines and feedback mechanisms that involve the community throughout implementation.
- Recognise racism as trauma in frameworks addressing adverse childhood experiences, with special focus on children and adults with SEND.
- Embed anti-racism principles across all public sector recruitment, procurement, and service design.
- Implement accountability measures that hold all public system employees responsible for contributing to anti-racism efforts.
- South East London ICB and Public Health Lewisham should implement mandatory anti-racism and cultural competency training for frontline staff, with annual refresher requirements and accountability mechanisms.
- The Office for National Statistics and NHS Digital must reinstate ethnic coding across health and education datasets, with guidance and protections in place to prevent misuse.
- Develop local accountability frameworks (co-designed dashboards to track progress on OFA).
- Implement Black leadership pipelines (pathways into senior roles). This directly confronts institutional under-representation and embeds equity in leadership.

Theme 2

- Design and scale up culturally responsive, targeted interventions for Black families, with particular attention to maternal health.
- Develop and disseminate weaning and early parenting guidance that is culturally relevant and honours community traditions.
- Support the integration of holistic practices, including the use of doulas and herbal support, allowing space for community-led approaches even if not all can be formally adopted.
- Transition service delivery from standardised care to culturally flexible models, ensuring programmes are co-created with, and for, local families.
- Train healthcare professionals to recognise and address biases and ensure that Black women's expressions of pain and need are heard, validated, and promptly addressed.
- SEL must work with Black-led organisations to co-design specialised maternity and paediatric services responsive to the needs of Black families.
- Introduce annual cultural safety audits (reviewing anti-racism and accessibility). This will ensure that early-years and maternity care are culturally safe, inclusive, and responsive to Black mothers.

Theme 3

- Develop targeted interventions addressing the unique challenges of Black youth, focusing on mental health, sexual and reproductive health, and gender-based violence.
- Foster partnerships with Black-owned businesses and grassroots groups to ensure initiatives reflect lived experience and achieve measurable outcomes.
- Support community-led resilience-building efforts by equipping young people with practical skills to manage economic challenges.
- Integrate poverty reduction strategies within broader youth support services to address financial insecurity and its impact on wellbeing.
- Promote financial literacy and the revival of community saving practices like pardner within Black families and communities.
- To enhance the transition experience between secondary and further education, local education authorities should fund health literacy curricula in primary and secondary schools that incorporate practical skills such as navigating healthcare systems, booking GP appointments, and understanding mental health.
- Local Authority Commissioners should improve identification and referral pathways for youth carers in Black communities and offer tailored support options.
- Create intergenerational health hubs (community-owned wellbeing centres) that strengthen family and intergenerational wellbeing while fostering belonging for youth.

Theme 4

- Design and deliver interventions that address both structural inequalities and cultural values influencing the wellbeing of older Black adults.
- Promote routine health checks and targeted vaccination efforts in high deprivation areas relevant to older Black communities.
- Build authentic partnerships with the community, leveraging trusted spaces like the Hummingbird Club for co-design and engagement.
- Ensure older residents are active co-creators in planning and monitoring services, valuing their lived experience as central to decision-making.
- Address cultural misunderstandings within systems serving older migrants and excluded groups by improving training and service adaptation.
- ICS and community health services should reinstate mobile health clinics in high-need areas such as Forest Hill, prioritising routine check-ups and preventative care to enhance accessibility and optimise public health messaging throughout communities where there are significant disparities in health needs.
- Pilot community health navigator roles (peer guides supporting access to services) that reduces isolation and improves access for elders through trusted, culturally informed support.

Theme 5

- Develop mental health and wellbeing campaigns that are community-led and use culturally resonant language to reduce stigma.
- Implement practical approaches that recognise racism as a core driver of mental health inequalities and treat it as structural trauma.
- Co-lead a comprehensive audit and redesign of mental health services with voluntary sector partners and affected population groups.
- Ensure NHS mental health service reforms are rigorously evaluated for equity, preventing further widening of disparities in Black communities.
- Foster whole-system interventions to address structural racism within mental health care delivery.
- PHL, in conjunction with SLAM/CAMHS, must consider commissioning grassroots organisations to optimise mobilisation of activity and deliverables. For example, the launch of Walk and Talk peer-support groups for young men in local parks and trusted community spaces.
- ICB and Local Authorities should consider embedding a rolling grants programme to commission culturally grounded, non-clinical mental health spaces for young people, developed and led by Black community organisations.

Theme 6

- Engage local Black organisations meaningfully in both the design and delivery of health programmes, ensuring interventions reflect community values around faith, food, family, and social support.
- Explicitly embed anti-racist approaches that address structural barriers within commissioning and procurement processes.
- Ensure transparency and fairness in funding allocation, holding providers accountable and aligning services with community priorities.
- Uphold the Duty of Care in service design, as mandated by the Equalities Act to protect community interests.
- Design services with and by Black communities to ensure needs are met authentically and effectively.
- Implement ongoing cultural competence training for all health employees as an essential element of best practice.
- Local health authorities should support the creation of WhatsApp broadcast lists (opt-in) to share appointment reminders and public health updates with community members, to optimise the acceleration of health messaging.
- Develop a shared learning platform (hub for data, evaluation, and practice exchange) encouraging collaboration and learning around prevention, wellness, and lifestyle improvement.
- Introduce a long-term Equity Impact Fund (ring-fenced for Black-led innovation) that sustains preventative, community-led health and wellbeing initiatives.

Theme 7

- Increase support and public health campaigns focused on stroke prevention and cardiovascular health tailored specifically for Black communities.
- Develop and deliver targeted clinician education programmes to improve understanding and management of conditions like fibroids, emphasising their impact on Black women's health and wellbeing.
- Promote awareness campaigns within Black communities about uterine fibroids to encourage early detection and timely care.
- Establish a Black-led digital health platform offering culturally relevant health information, provider access, and community networking opportunities to empower health literacy and engagement.
- Ensure that health services incorporate culturally competent approaches in managing conditions prevalent in Black populations, prioritising patient trust and effective communication.
- ICB must reinstate phone-based GP appointment bookings and provide clear alternatives for patients unable to use online systems.
- Lewisham Council, in partnership with youth organisations, must fund and coordinate technical support buddy schemes, enabling young people to support older residents with NHS app usage and digital form navigation.
- South East London ICB and Healthwatch must consider commissioning co-designed multimedia materials (e.g., short videos, audio messages), explaining how to access NHS services, produced in African and Caribbean languages.
- Integrated Neighbourhood Teams (INT) must embed trained community health advocates within surgeries to assist with navigating forms, booking appointments, and understanding diagnoses.

Theme 8

- Develop cross-sector policies that address housing quality, employment opportunities, and environmental justice as central components of health equity strategies.
- Increase investment in community-led initiatives to improve living conditions and reduce environmental hazards disproportionately affecting Black communities.
- Implement anti-discrimination measures in education and public services to dismantle systemic barriers that impact health outcomes.
- Collect and use disaggregated data to better understand and respond to the complex ways social determinants affect health in Black populations.
- Foster collaboration between healthcare, housing, employment, education, and environmental sectors to create integrated solutions that address the root causes of health disparities.
- ICS must pilot travel subsidies for patients with SEND and complex needs facing long commutes to access GP or hospital care.
- Create equitable funding pathways (micro-grants for grassroots projects), addressing structural inequity in funding and supports community economic resilience.
- Establish a Black Health Equity Institute (community-academic policy hub) to tackle systemic inequity through long-term research, policy, and cross-sector influence.
- Integrate health equity KPIs into local authority performance frameworks. Makes racial health equity a measurable requirement in council accountability.

Appendix 2

Glossary

Adverse Childhood Experience (ACE)

A potentially traumatic event or experience during childhood, including exposure to racism, which contributes to long-term health and psychosocial consequences.

Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

A comprehensive review conducted in 2022 exploring persistent health inequalities faced by Black African and Black Caribbean populations in Birmingham and Lewisham. It identifies root causes and outlines 39 Opportunities for Action (OFA) to address these disparities.

Black-led Organisation

Community or voluntary organisation primarily run and governed by Black individuals, delivering culturally relevant services informed by lived experience.

Child and Adolescent Mental Health Service (CAMHS)

The NHS services that provide assessment and treatment for children and young people, usually up to 18, experiencing emotional, behavioural or mental health difficulties.

Community Treatment Order (CTO)

A legal mechanism under the Mental Health Act allowing supervised community treatment.

Culturally Competent Care / Service

Healthcare and social service delivered with awareness, knowledge, and responsiveness to cultural practices, values, and needs of specific communities to reduce disparities and improve engagement.

Cultural Responsiveness

Adaptation and tailoring of services and interventions to reflect and respect the cultural identities and lived experiences of the communities served.

Disaggregated Data

Detailed population data separated by specific ethnic, national, or cultural groups rather than broad categories, enabling nuanced understanding and targeted service design.

Digital Exclusion

Barriers preventing individuals, particularly elders or those without digital literacy or access, from effectively using digital platforms for healthcare access and communication.

Established Community Partnership

A long-term collaboration between statutory health bodies and community organisations involving co-production, shared decision-making, and mutual accountability.

Health and Wellbeing

A holistic concept that includes physical, mental, emotional, and social health aspects, as understood and experienced within communities.

Health Equity

The absence of avoidable or unfair health differences across populations; achieving equitable health outcomes by addressing social determinants and systemic barriers.

Health Equity Fellow (HEF)

A clinician embedded within Primary Care Networks trained to lead and embed health equity initiatives, acting as a bridge between community organisations and healthcare providers.

Health Equity Team (HET)

Multi-agency partnership formed between Primary Care Networks, clinicians, and Black-led organisations to design and deliver targeted health equity interventions locally.

Integrated Care Board (ICB)

The NHS statutory body responsible for planning, commissioning, and funding health services across a local area, ensuring services meet population health needs and reduce inequalities.

Integrated Care Partnership (ICP)

A statutory collaboration between the NHS, local authorities, and other partners within an ICS that sets the shared strategic direction for health and care through an integrated care strategy.

Integrated Care System (ICS)

A partnership of NHS organisations, local authorities, and voluntary and community sector partners working together to improve population health, deliver joined-up care, and reduce health inequalities.

Integrated Neighbourhood Team (INT)

A multidisciplinary local team supporting coordinated community-based care.

Lewisham Black Voluntary Network (LBVN)

A network supporting Black-led voluntary and community organisations in Lewisham.

Life Course Approach

An approach to health interventions and policy recognising that health outcomes are shaped by factors and experiences throughout a person's life, including early childhood and ageing.

Lived Experience

Knowledge and insights gained through personal, first-hand experience of societal issues, such as racism or health inequalities.

Maternity Voices Partnership (MVP)

A local NHS-led group ensuring service user voice informs maternity care design.

Mental Health Wellbeing Campaigns

Initiatives aimed at improving mental health awareness, access, and support, particularly emphasising culturally appropriate and trauma-informed methods.

National Institute for Health and Care Research (NIHR)

The UK's major funder of health and care research.

Office for Health Improvement and Disparities (OHID)

UK government body responsible for public health improvement and reducing health inequalities.

Opportunities for Action (OFA)

Thirty-nine specific, actionable recommendations identified in the BLACHIR report to address health inequalities across eight thematic areas.

Peer-led Support / Peer Approaches

Interventions delivered or facilitated by individuals from the same community who share similar lived experiences, enhancing trust and engagement.

Physical Health Equity

Ensuring equal opportunity for all individuals to attain their highest level of physical health, by tackling social and systemic determinants.

Primary Care Network (PCN)

Group of general practices that collaborate with local health providers and communities to deliver integrated healthcare services.

Public Health Lewisham (PHL)

A team that focuses on improving population health, reducing inequalities, and preventing illness.

Racism as Trauma

Recognition of racism as a form of psychological trauma with significant effects on mental and physical health across generations.

Racialised Community

Group of people identified or treated differently due to their racial or ethnic backgrounds, often experiencing systemic marginalisation.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 6
Enclosure 6

Title:	**ICB/VCS Infrastructure Support Impact Summary**
Meeting Date:	**26th March 2026**
Author:	Gulen Petty, CEO Lewisham Local and Mottie Omideyi, Managing Director Joined Up Thinking/LBVN
Executive Lead:	

Purpose of paper:	To provide the board with an update on ICB/VCS Infrastructure Support Impact Summary.	Update / Information	*x*
		Discussion	*x*
		Decision	

Summary of main points:

The Board are asked to note the following key aspects:

The LBVN brings together Black-led community organisations working across Lewisham to support residents facing health, social and economic inequalities.

<u>Mission</u>
To strengthen, empower, and amplify the voices of Black-led voluntary and community organisations in Lewisham by building a unified, well-resourced, and strategically connected network.
The network provides:

- Peer support between organisations
- Shared learning and collaboration
- Representation of Black community voices
- A platform for community organisations to engage with public services

The network helps ensure that communities most affected by inequality are not only heard, but able to deliver solutions.

However, many face structural barriers that limit their ability to grow.
Barriers include:

- Limited organisational infrastructure
- Lack of administrative capacity
- Small volunteer-led teams
- Limited access to funding systems

Potential Conflicts of Interest	Funding, delivery and advocacy overlap. Also, risk that strategic priorities may be shaped by those receiving funding rather than through wider, independent community engagement.			
Any impact on BLACHIR recommendations	The BLACHIR recommendations require both Birmingham and Lewisham to embed action on Black African and Black Caribbean health inequalities into commissioning, partnership working and system wide approach rather than treating this as standalone work. In Lewisham, this is reflected in a stronger emphasis on strengthening Black-led organisations to move from informal activity to governed, sustainable organisations, improving access to funding, leadership development, and system readiness for groups historically excluded from funding systems. However, if community infrastructure bodies are heavily reliant on ICB funding, their ability to challenge system decisions robustly may be questioned.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Positive equality impact by prioritising neighbourhood-based delivery and directly supporting BLACHIR aims to reduce health inequalities for Black African and Black Caribbean communities.		
	Financial Impact	No immediate additional financial pressure identified.		
Other Engagement	Public Engagement	Strengthen public and community engagement through co-production, neighbourhood hubs, and direct involvement of VCSE and faith groups, ensuring lived experience informs design and delivery and improving trust, access and uptake of services. As part of commissioning new services, there will be a strong emphasis on co-production with residents and individuals possessing lived experience.		
	Other Committee Discussion/ Engagement	N/a		
Recommendation:	To provide the board with an update on ICB/VCS Infrastructure Support Impact Summary.			

LBVN LEWISHAM BLACK VCS NETWORK

ICB/VCS Infrastructure Support Impact Summary

LBVN & Lewisham Local

The Lewisham Black VCS Network (LBVN)

The LBVN brings together Black-led community organisations working across Lewisham to support residents facing health, social and economic inequalities.

Mission

To strengthen, empower, and amplify the voices of Black-led voluntary and community organisations in Lewisham by building a unified, well-resourced, and strategically connected network.

The network provides:

- Peer support between organisations
- Shared learning and collaboration
- Representation of Black community voices
- A platform for community organisations to engage with public services

The network helps ensure that communities most affected by inequality are not only heard, but able to deliver solutions.

The Reality Facing Many LBVN Organisations

Many LBVN members are small grassroots organisations providing vital community support. However, many face structural barriers that limit their ability to grow.

Barriers include:

- Limited organisational infrastructure
- Lack of administrative capacity
- Small volunteer-led teams
- Limited access to funding systems

Many groups are delivering real impact but operating without the infrastructure required by funders.

The Biggest Barrier: Access to Funding

For many LBVN organisations the main challenge is not just sustainable funding but access to funding. Most grant programmes require organisations to have:

- A formal constitution or legal structure
- A governing board
- Bank account - organisational
- Financial management systems
- Policies – particularly safeguarding and governance
- Digital infrastructure such as email and websites.

A lack of these foundations prevent many grassroots groups from accessing funding opportunities.

The Role of the ICB Infrastructure Funding

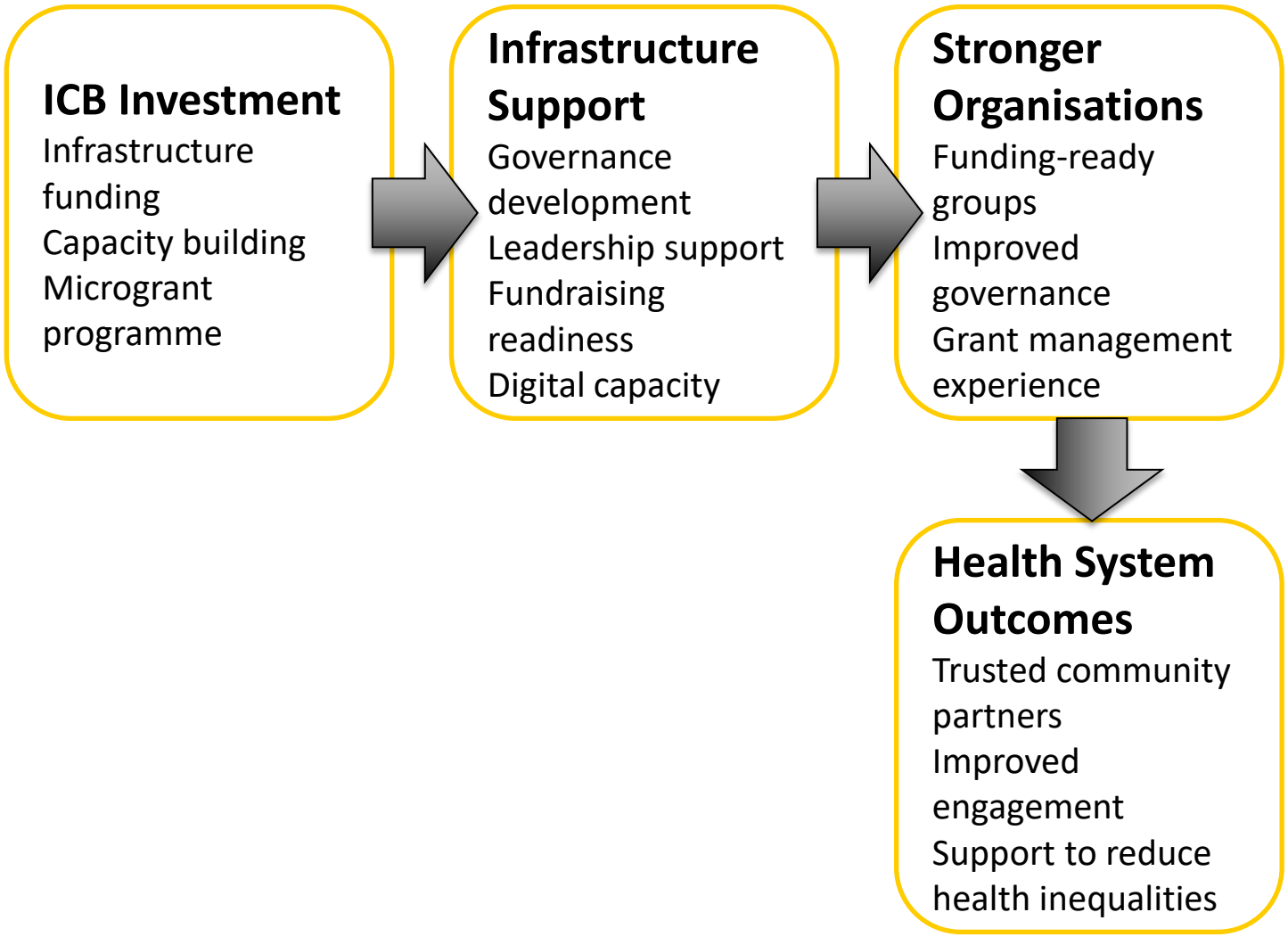
The ICB investment has enabled the Lewisham Local and LBVN partnership to provide targeted capacity building support to at least 10 LBVN organisations.

This support focuses on:

- Organisational development
- Governance support
- Leadership development
- Fundraising readiness
- Digital capability

Our aim has been to ensure that LBVN organisations are equipped to deliver and sustain health-related work.

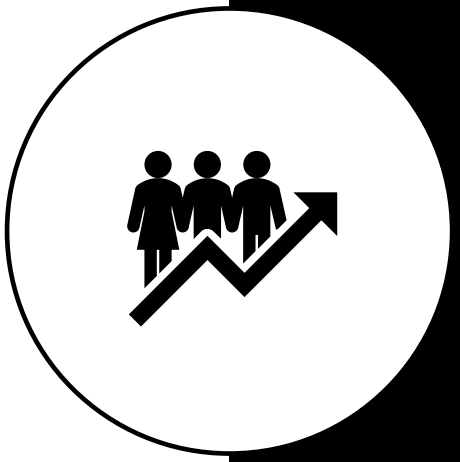
ICB Programme Logic Model



ICB Investment

The investment has provided LBVN organisations with capacity building support which includes:

- Helping incorporating organisations & supporting establishing governing boards
- Development of key governance policies
- Supporting the development of financial systems
- Financial growth
- Development of leadership skills
- Improving strategic planning
- Helping community capacity to be more sustainable and reduce health inequalities
- Enhancing the ability of LBVN members to contribute to INT's and prevention work



Strengthening Skills and Leadership

Training and mentoring have also helped strengthen organisational leadership.

Support has included:

- governance training
- leadership development
- volunteer management support
- organisational planning and goal setting

These activities help organisations move from informal community groups to sustainable organisations.

Case Study

360 Lifestyle Support Network CIC – A Black-led organisation that addresses health inequality in the Black community in Lewisham.

Issue

- 360 struggled to adequately function and receive suitable funding prior to receiving support. Strategic and governance issues caused by having 2 directors resigning within a short period of time.
- CEO needed structure and clarity on how the organisation should operate.
- CEO was sole worker and needed support in putting systems in place to get people to support.

Support

- Role description was created. 2 new directors recruited – one with lived experience, the other with professional experience was sourced through networks. 360 now meets funding criteria.
- Working through a creative workplan and projected organisational growth plan.
- “Fabian is a sounding board to support with unexpected issues.” “Support has been so beneficial to organisation and personally – working smarter as a CEO.”

Micro Grants: Creating an Entry Point to Funding

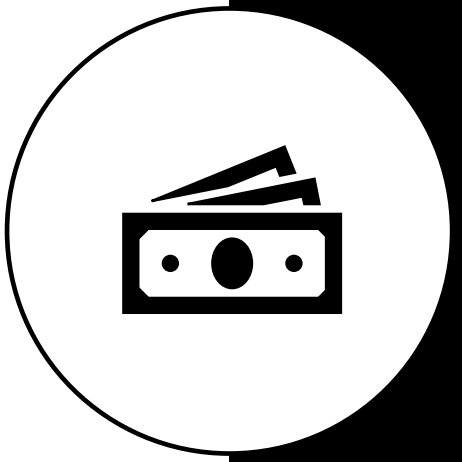
The LBVN micro-grant programme has provided small grants to grassroots organisations.

This has enabled organisations to:

- test ideas and projects
- gain experience managing grants
- build confidence working with funders
- generate evidence of impact.

Microgrant Programme – Outcomes

- 14 applications reviewed
- 10 grants awarded
- 87 hours 10 minutes community assessment
- Grant panel - 6 LBVN members
- £2,179.15 invested in LBVN-led decision-making
- Grant amount: £3,000



Our Network

Membership Growth	95+ members
Funders	South East London ICB, Lewisham Council
Partnerships	Lewisham Local, AfCD, Mabadiliko, SEL ICB, Lewisham Council, KINARAA

Our Funding Supported Work

Advocacy Engagement & Networking	Consultation responses - public health, community issues/concerns Collaboration, consortiums, partnership working
Micro-grants / Capacity building Delivery	20 organisations supported, 6 organisations receiving supplementary support, 4 capacity building group sessions
Capacity Building	Dedicated Capacity Building Lead providing targeted 1:1 support. Also providing capacity building workshops, training access, funding information, peer support
Fundraising	LBVN Fundraiser, dedicated to raising funds to support the LBVN infrastructure. Working on collaborative bids as well as
Communication	Increased Network information via WhatsApp group, email distribution, Newsletter

The Difference the ICB Investment Is Making

Infrastructure support is helping organisations move from:

- Informal community activity → Structured organisations
- Volunteer-only initiatives → Governed organisations
- Invisible community work → Recognised partners in the system

This creates stronger organisations that can contribute to reducing health inequalities in Lewisham.

Why Another Year of Investment Matters

Organisational development takes time.

Another year of infrastructure funding would allow LBVN to:

- support more grassroots organisations to become funding-ready
- strengthen organisations that have begun their development journey
- build leadership capacity within the network
- strengthen collaboration between community organisations and the health system
- provide targeted support to groups serving underserved neighbourhoods and priority populations

This will create a larger and stronger community delivery network.

Future Plans

- Funding - dedicated fundraiser to continue supporting the LBVN - raising larger grants and multi-year funding to further develop LBVN's infrastructure and grow.
- Deliver further capacity building support - including training, mentoring, and peer-learning programmes to strengthen the capacity and resilience of member organisations.
- Support organisations to secure funding and commissioned work - becoming sustainable.
- Establish regular forums and engagement with statutory and sector partners to champion the collective voice of Black VCS and impact local policy and strategy.
- Develop shared knowledge, peer support and an online resource hub for LBVN members and wider Black VCSEs.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 7

Title:	**New Lewisham VCS Neighbourhood Contract**
Meeting Date:	**26th March 2026**
Author:	Abbi Greene, Director Age UK Lewisham
Executive Lead:	

Purpose of paper:	To provide the board with an update on progress with delivery of the New Lewisham VCS Neighbourhood and the requirements for future plans at place.	Update / Information	*x*
		Discussion	*x*
		Decision	
Summary of main points:	The Board are asked to note the following key aspects to the main grants programme. 1. Neighbourhood Investment 2. Focus of Funding 3. Borough-Wide Infrastructure 4. Strategic Alignment 5. Expected Outcomes As collective partners we come together to work with community groups and organisations and residents to improve the wellbeing of people living in the North / East / South / West Neighbourhoods of Lewisham.		
Potential Conflicts of Interest	Organisations involved in designing or presenting the neighbourhood model may also be current or prospective recipients of VCS funding, creating a perceived interest. Strong alignment to BLACHIR and neighbourhood priorities could be perceived as advocacy for a preferred model, rather than a neutral options appraisal. Organisations involved in early model development may later bid creating a potential forward-looking conflict.		
Any impact on BLACHIR recommendations	The BLACHIR recommendations require both Birmingham and Lewisham to embed action on Black African and Black Caribbean health inequalities into commissioning, partnership working and system wide approach rather than treating this as standalone work. In Lewisham, this is reflected in a stronger emphasis on neighbourhood-based delivery, Black-led VCSE approach and community hubs and front-door access to health and wellbeing support. Overall, BLACHIR strengthens		

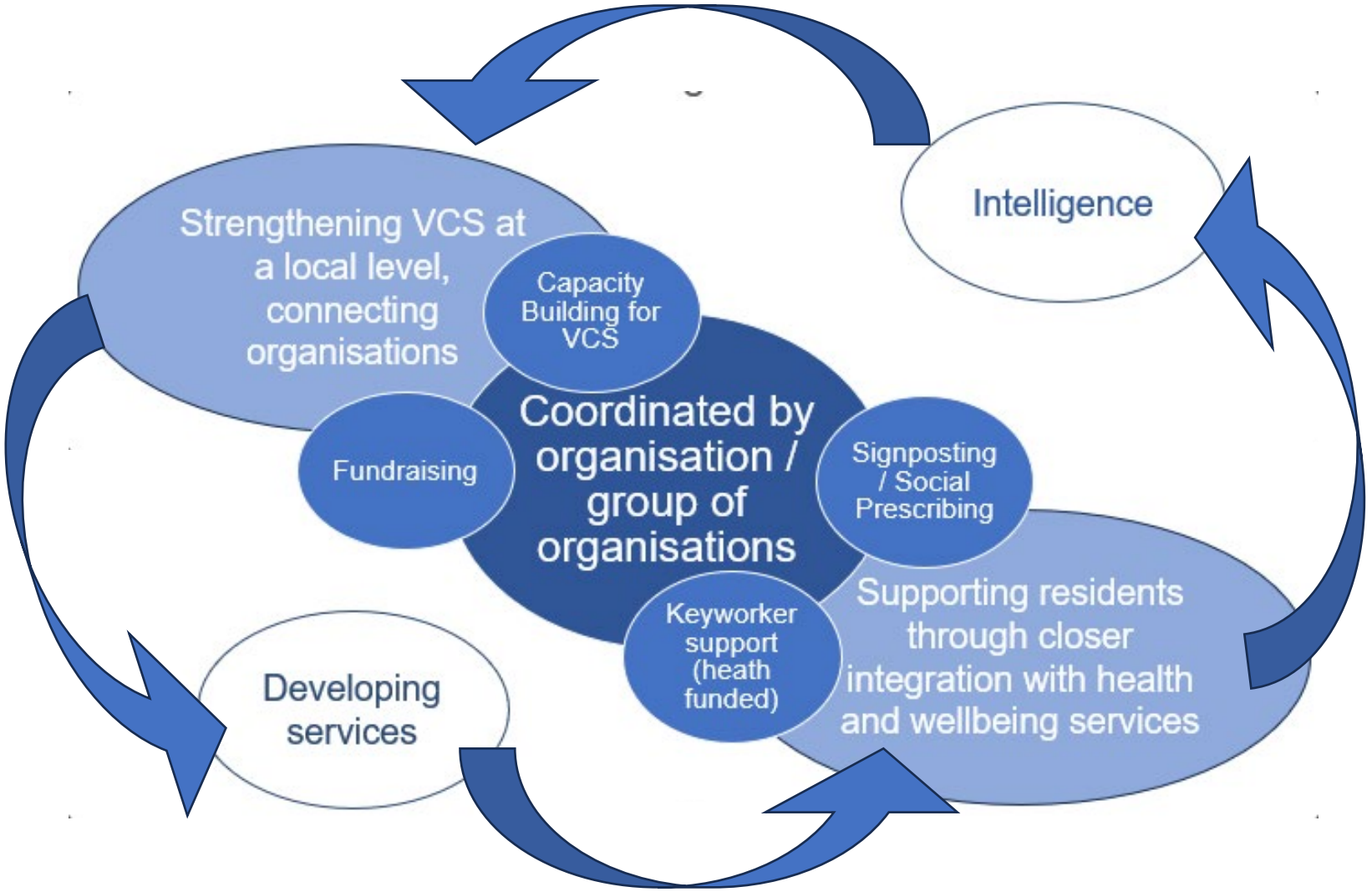
	the case for sustained, place-based and culturally competent approaches, tailored to local context.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Positive equality impact by prioritising neighbourhood-based delivery and directly supporting BLACHIR aims to reduce health inequalities for Black African and Black Caribbean communities.		
	Financial Impact	No immediate additional financial pressure identified.		
Other Engagement	Public Engagement	Strengthen public and community engagement through co-production, neighbourhood hubs, and direct involvement of VCSE and faith groups, ensuring lived experience informs design and delivery and improving trust, access and uptake of services. As part of commissioning new services, there will be a strong emphasis on co-production with residents and individuals possessing lived experience.		
	Other Committee Discussion/ Engagement	N/a		
Recommendation:	To provide the Board with an update on progress with delivery of the New Lewisham VCS Neighbourhood service and the requirements for future plans at place.			

New Lewisham VCS Neighbourhood Contract

Background to Main Grants Programme

	Existing Programme (2022-2026)	New Programme (2026 – 2029)
Neighbourhood Investment	Not a dominant focus; some services operated borough-wide or thematically.	Focus divided across four neighbourhoods; based on the local need. North & South expected to need more investment
Focus of Funding	Mixture of service delivery and sector support, including social prescribing, mental health, advice, digital skills, BAME-led infrastructure, arts)	Infrastructure & capacity building, including organisational development, fundraising, networking, governance, digital capability. New Transition Grants for frontline orgs (only existing (2022–26) grant recipients) to adapt to new model
Borough-Wide Infrastructure	Included BAME infrastructure, volunteer brokerage, community directory, digital inclusion.	Black-led VCS; digital inclusion; LGBTQ+ support; adults with learning disabilities; sanctuary seekers; sports; plus arts infrastructure
Strategic Alignment	Linked to COVID recovery and general council priorities.	Explicit alignment with: Cultural Strategy (2022–28), Physical Activity Strategy, Disabled People's Commission, Borough of Sanctuary Strategy, Integrated Neighbourhood Teams
Expected Outcomes	Direct resident support; increased access to advice; wellbeing; increased volunteering; support for community organisations. Improved partnerships	Stronger local ecosystems; resilient community groups; increased fundraising capacity; reduced duplication; coordinated neighbourhood delivery; integrated VCS-health-council systems; more equal access

How this will work



New Lewisham VCS Neighbourhood Contract

As collective partners we come together to work with community groups and organisations and residents to improve the wellbeing of people living in the North / East / South / West Neighbourhoods of Lewisham

Lewisham Irish Community Centre

Growing Hope – Accessibility Award – Bronze

St Lukes Downham

bear

Community Connections Lewisham

Lewisham & Southwark age UK

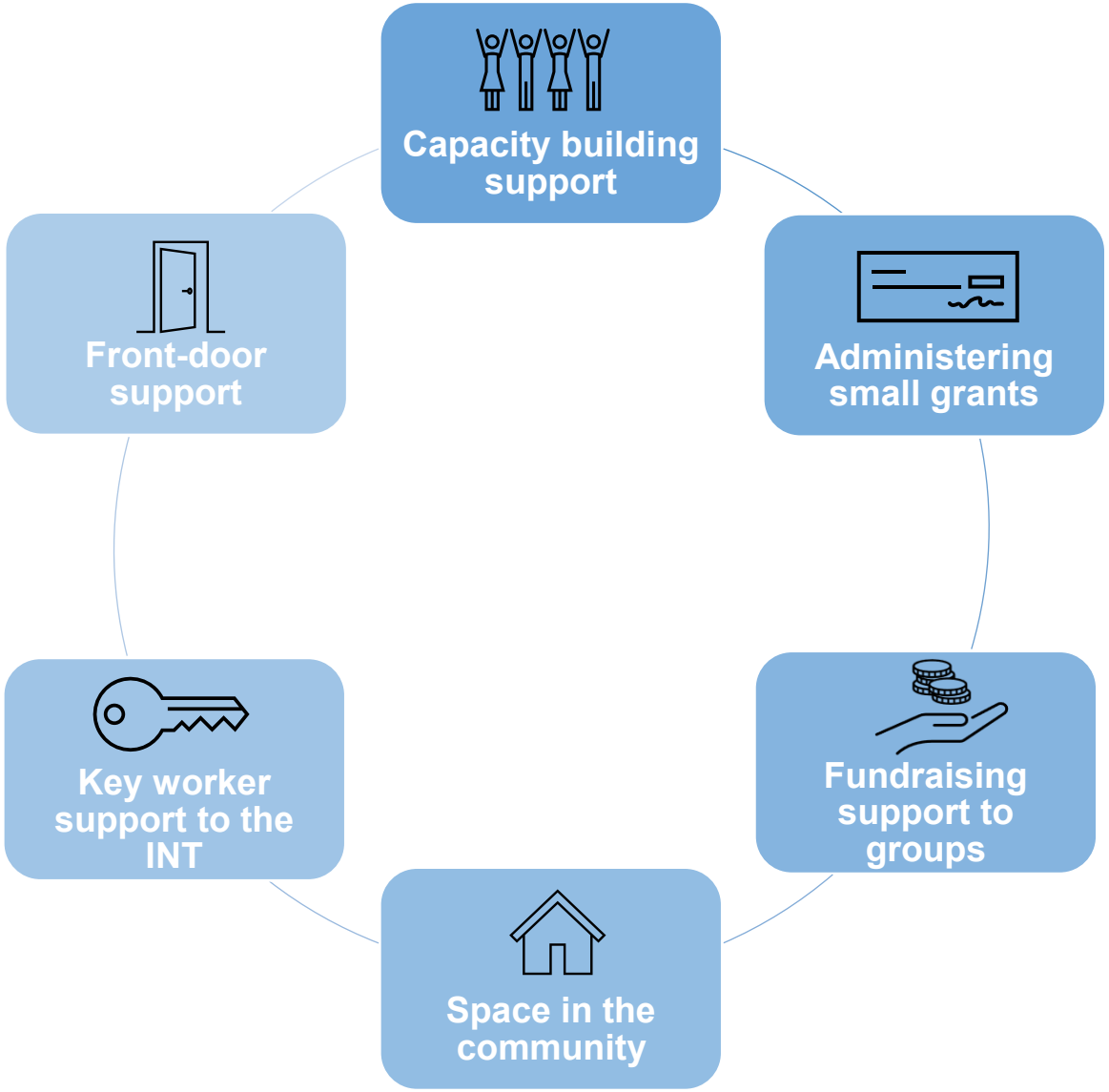
Ignition Brewery Lewisham

Lewisham Local

New Lewisham VCS Neighbourhood Contract

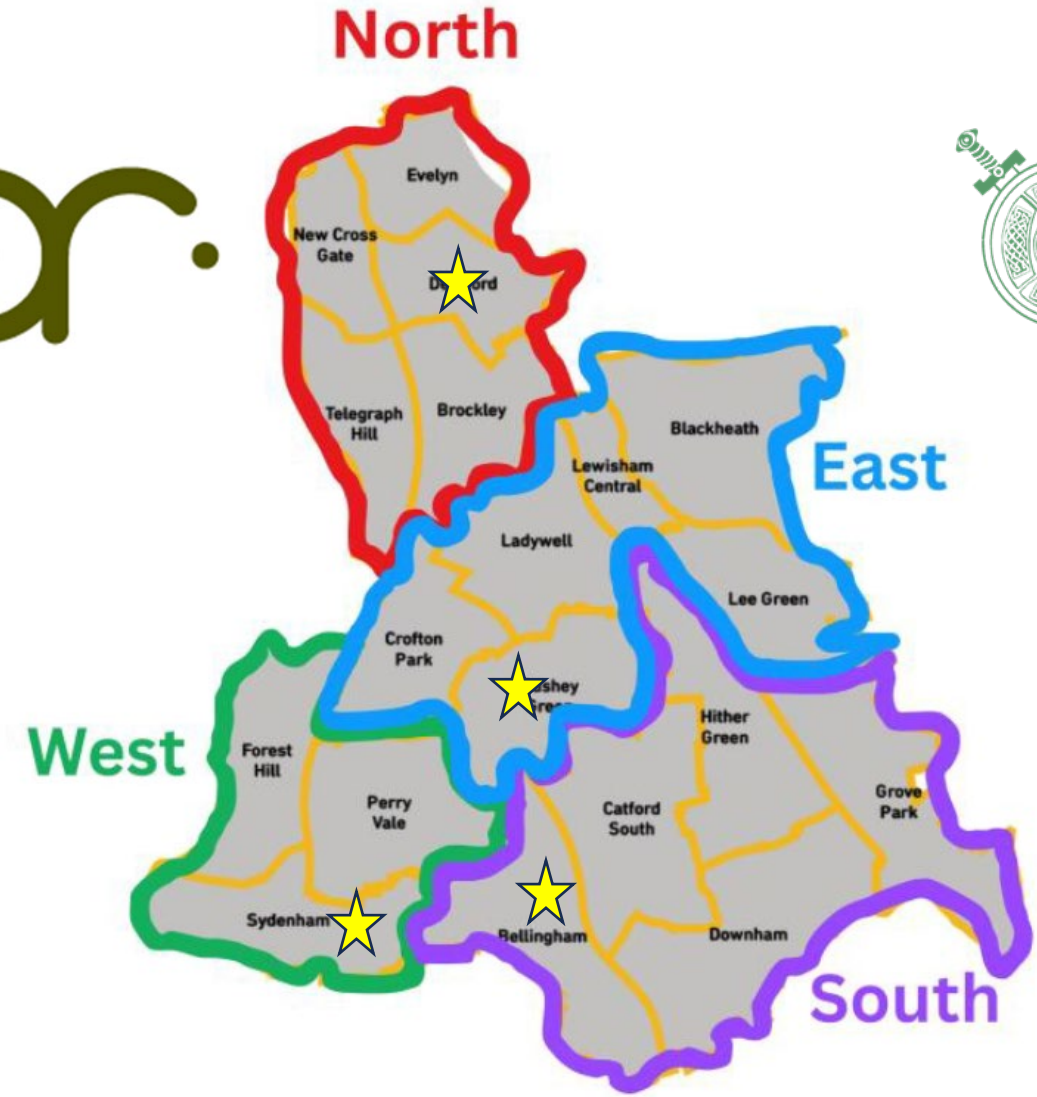
Lewisham & Southwark age UK

Community Connections Lewisham



LEWISHAM LOCAL©

Neighbourhood Community Hubs



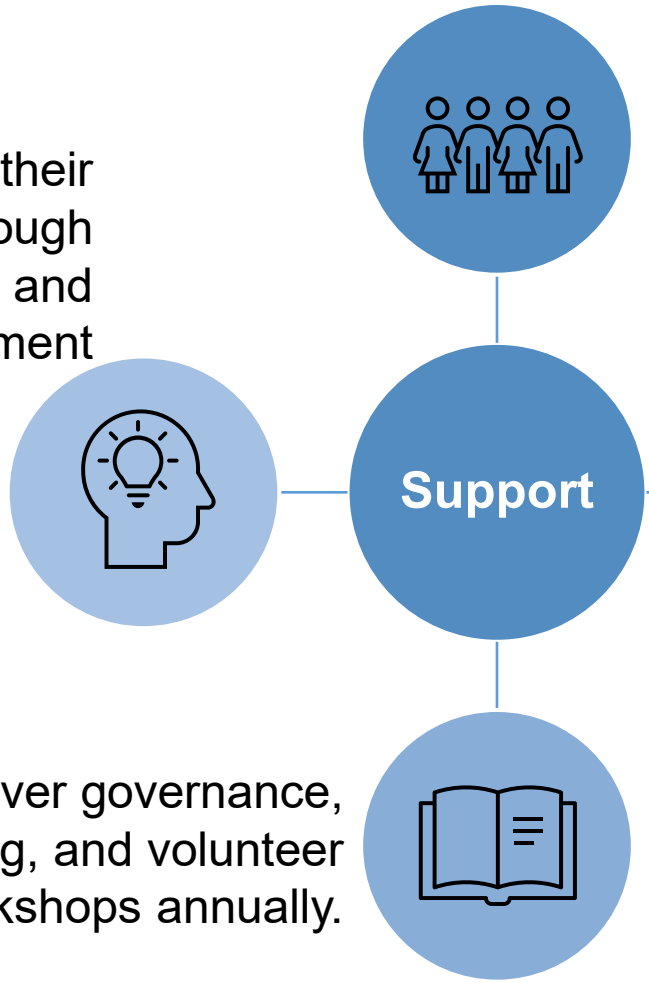
Lewisham Irish Community Centre

IGNITION BREWERY LEWISHAM

ACCESSIBILITY AWARD Growing HOPE BRONZE

St Lukes Downham

What Will Capacity Building Do



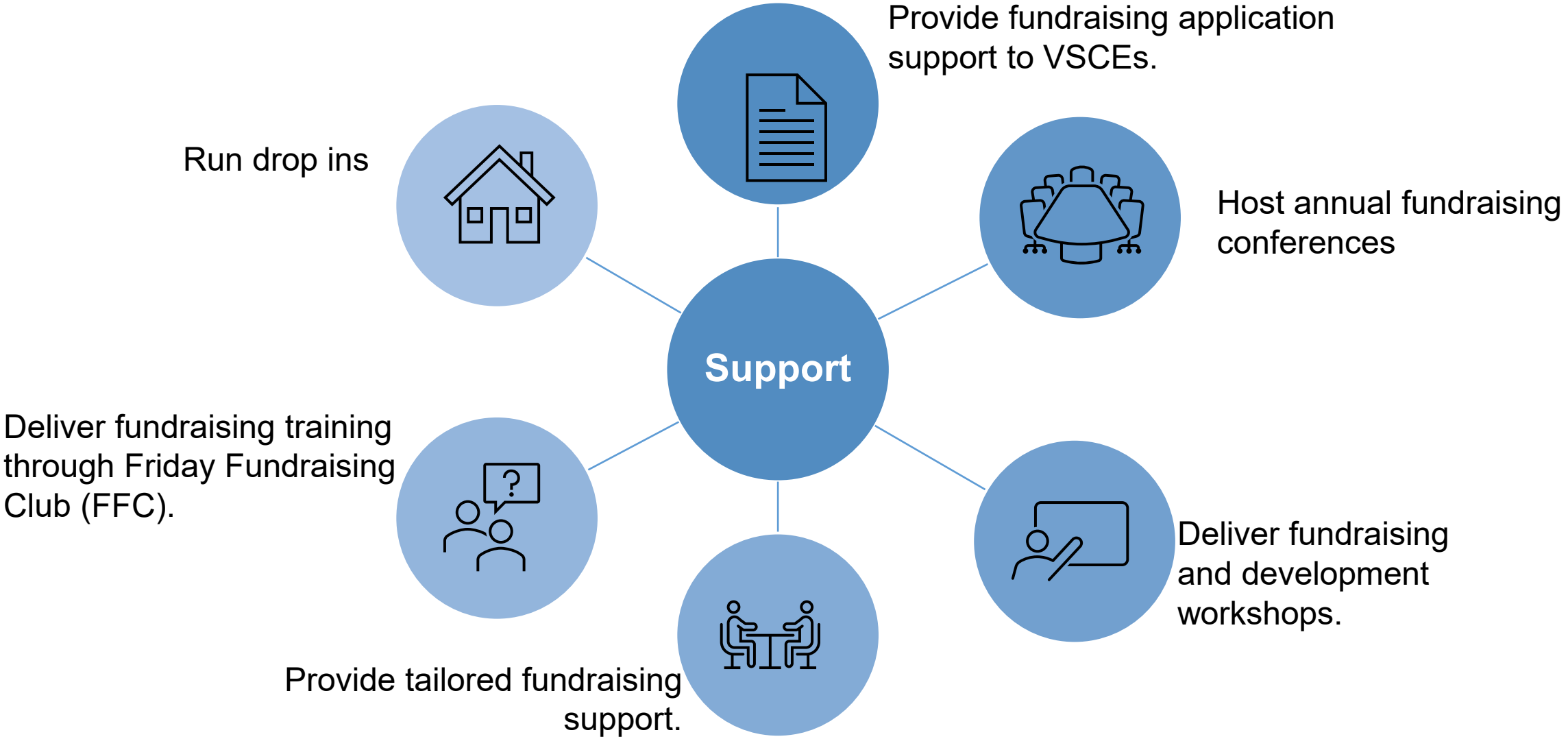
Information sharing with VSCE and faith groups connecting them with each other and statutory work/funders.

Work with residents to develop their ideas into practical delivery through governance, safeguarding and volunteer management

Promote networking and peer learning between organisations in the borough.

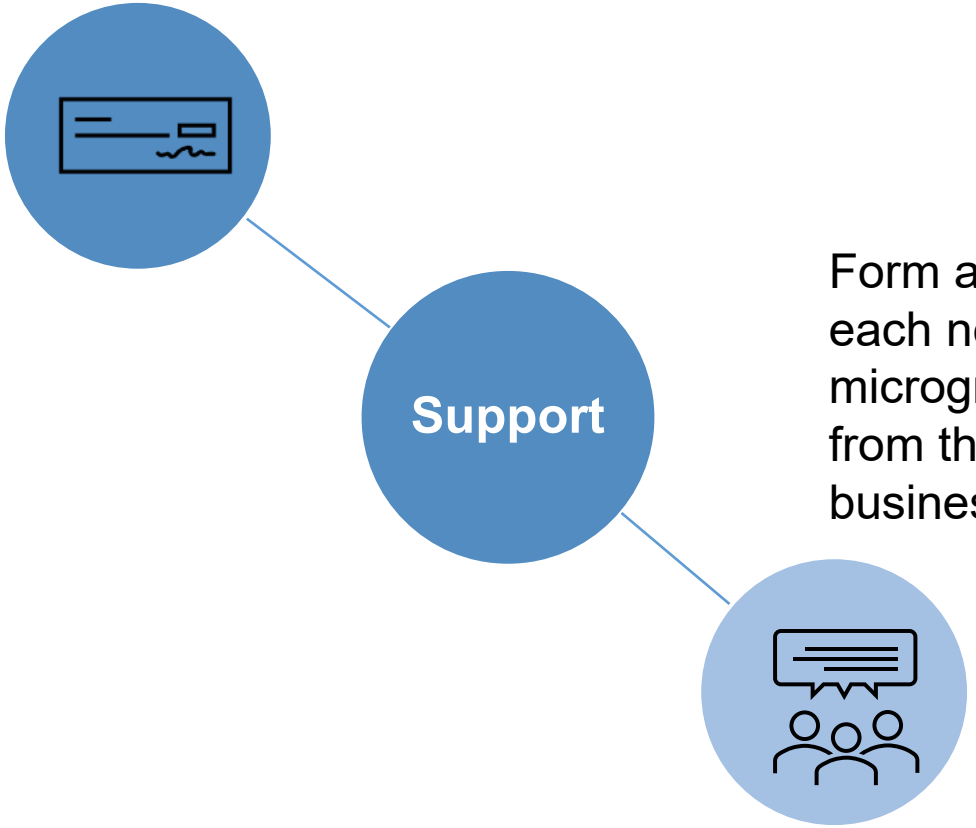
Deliver governance, safeguarding, and volunteer management workshops annually.

What Will Fundraising Development Do



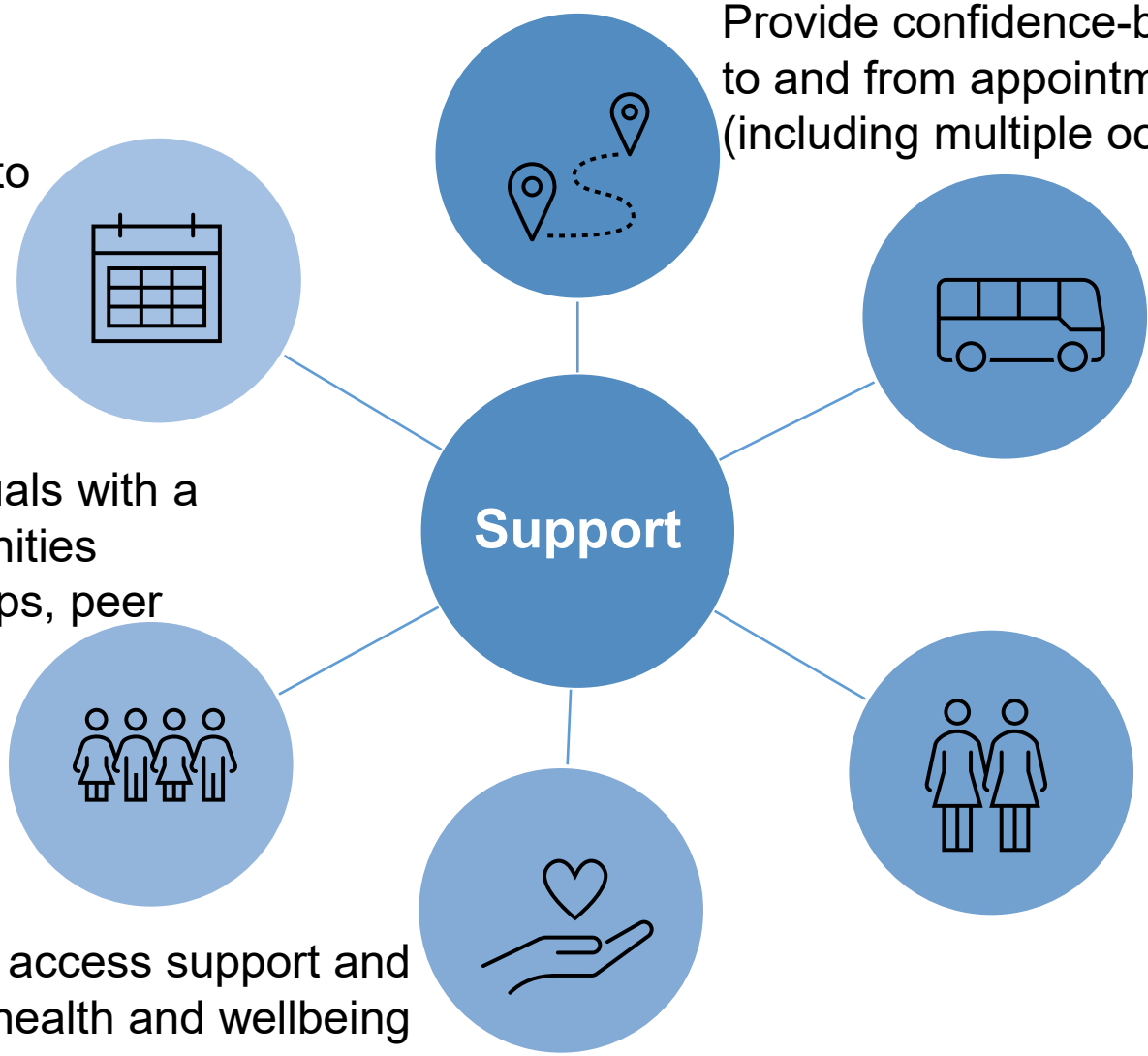
What Will Grant Administration Do

Where more funds are raised, distribute these



Form and work with steering groups in each neighbourhood to administer microgrants to VSCE and Faith groups from the Main Grants fund, businesses/funders.

What Will the INT *"Key Worker Role"* Do



Provide confidence-building support with travelling to and from appointments, activities, and groups (including multiple occasions if required).

Provide support for up to 12 weeks

Support individuals to identify suitable transport options and assist with relevant applications

Explore and connect individuals with a range of community opportunities including health related groups, peer support, social activities

Help individuals overcome barriers to accessing health cervices, with a focus on building confidence and independence

Help individuals access support and services that improve health and wellbeing

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 8
Enclosure 8

Title:	**Lewisham LCP Performance Report**
Meeting Date:	**26 March 2026**
Author:	Mervlyn Clarke, Community Based Care Development Manager
Executive Lead:	Catherine Mbema (flu) Ceri Jacob (general)

Purpose of paper:	To update the Lewisham LCP Board on progress against performance targets to be delivered at Place.	Update / Information	*x*
		Discussion	
		Decision	
Summary of main points:	There are a range of national targets and SEL ICB Corporate Objectives that are delivered at a Place level. The attached report sets out Lewisham performance, benchmarked against other SEL ICB Places. Many of the targets remain challenged over a long time period, despite significant work at a local and SEL wide level. These include for example, immunisations and screening targets. Whilst these have improved over time and benchmark well against other SEL boroughs, the national target has still not been achieved. Flu uptake among people aged 65 and over in Lewisham has been challenging since the COVID-19 peak. Whilst Lewisham's overall pattern of uptake broadly mirrors that seen across London and England, performance remains consistently below the England average. Although uptake among the 65+ cohort increased week on week during the season, this improvement was insufficient to meet the locally set 61% target, and final uptake continues to lag behind national performance, highlighting a persistent and unresolved gap. Uptake in under-65 at-risk groups increased gradually but remained relatively low overall, ending the season in the mid-30% range. Lewisham has the highest number vaccinated in SEL for Pregnancy and second highest for 2-3yr olds.		
Potential Conflicts of Interest	None		

Any impact on BLACHIR recommendations	Uptake remains lower among under-65 at-risk groups, Black African and Black Caribbean communities, and some deprived geographies, despite extensive outreach and communications. However, VCSE engagement such as community-led has demonstrated improved confidence, awareness and intention to vaccinate.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Not applicable to this report, noting that all performance targets will impact on health inequalities		
	Financial Impact	Not applicable to this report		
Other Engagement	Public Engagement	Not applicable to this report		
	Other Committee Discussion/ Engagement	Lewisham LCP SMT		
Recommendation:	To note Lewisham LCP's achievement against national targets and SEL ICB Corporate Objectives.			

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partnership
LCP performance data report

February 2026

Contents

Overview of report

Summary:

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

Contents and structure of report:

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

Structure

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

Definitions:

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

South East London Integrated Care System

Lewisham performance overview

NHS South East London

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	Jan-26	National standard	67%	72%
IAPT discharge	↑	Dec-25	Operating plan	377	430
IAPT reliable improvement	↑	Dec-25	Operating plan	67%	66%
IAPT reliable recovery	↑	Dec-25	National standard	48%	45%
SMI Healthchecks*	↑	Q3	Local trajectory	62%	55%
PHBs	↑	Q3 - 25/26	LTP indicative trajectory	611	265
NHS CHC assessments in acute	↔	Q3 - 25/26	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↓	Q3 - 25/26	National standard	80%	60%
CHC - Incomplete referrals over 12 weeks	↑	Q3 - 25/26	National standard	0	4
Children receiving MMR1 at 24 months	↑	Q2 - 25/26	PH efficiency standard	90%	84%
Children receiving MMR1 at 5 years	↑	Q2 - 25/26	PH efficiency standard	90%	89%
Children receiving MMR2 at 5 years	↓	Q2 - 25/26	PH efficiency standard	90%	74%
Children receiving DTaP/IPV/Hib % at 12 months	↓	Q2 - 25/26	PH efficiency standard	90%	88%
Children receiving DTaP/IPV/Hib % at 24 months	↑	Q2 - 25/26	PH efficiency standard	90%	89%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↑	Q2 - 25/26	PH efficiency standard	90%	70%
Children receiving DTaP/IPV/Hib % at 5 years	↑	Q2 - 25/26	PH efficiency standard	90%	89%
LD and Autism - Annual health checks*	↑	Dec-25	Local trajectory	981	1143
Bowel Cancer Coverage (60-74)	↓	Apr-25	Corporate Objective	65%	64%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	68%	67%
Breast Cancer Coverage (50-70)	↑	Apr-25	Corporate Objective	60%	60%
Percentage of patients with hypertension treated to NICE guidance	↑	Q2 - 25/26	Corporate Objective	75%	62%
Flu vaccination rate over 65s	↑	Jan-26	Corporate Objective	61%	53%
Flu vaccination rate under 65s at risk	↑	Jan-26	Corporate Objective	34%	31%
Flu vaccination rate – children aged 2 and 3	↑	Jan-26	-	-	42%
Appointments seen within two weeks*	↓	Dec-25	-	-	87%
Appointments in general practice and primary care networks*	↓	Dec-25	Operating plan	-	110320
Appointments per 1,000 population*	↓	Dec-25	-	-	323

*Reported Lewisham performance for SMI health checks, LD health checks and GP practice appointments includes data covering the south east London Special Allocation Service GP practice. This practice is associated with Lewisham but serves patients who have been removed from practice lists across south east London.

South East London Integrated Care System

NHS South East London

Performance data

Dementia Diagnosis Rate

SEL context and description of performance

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

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

Talking Therapies

SEL context and description of performance

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

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

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

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

SMI Physical Health Checks

SEL context and description of performance

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

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

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

Personal Health Budgets

SEL context and description of performance

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

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

NHS Continuing Health Care

SEL context and description of performance

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

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

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

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

Childhood immunisations (1 of 2)

Description of metric and SEL context

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

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

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

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

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

Childhood immunisations (2 of 2)

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

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

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

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

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

Learning disabilities and autism – annual health checks

SEL context and description of performance

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

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

Cancer screening

SEL context and description of performance

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

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

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

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

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

Management of hypertension to NICE guidance

SEL context and description of performance

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

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

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

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

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

Adult flu immunisation (1 of 2)

SEL context and description of performance

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

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

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

Adult flu immunisation (2 of 2)

Published January 2026 Performance

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

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

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

Primary care access

SEL context and description of performance

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

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

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

NHS
South East London

Lewisham

Influenza Vaccination in Lewisham

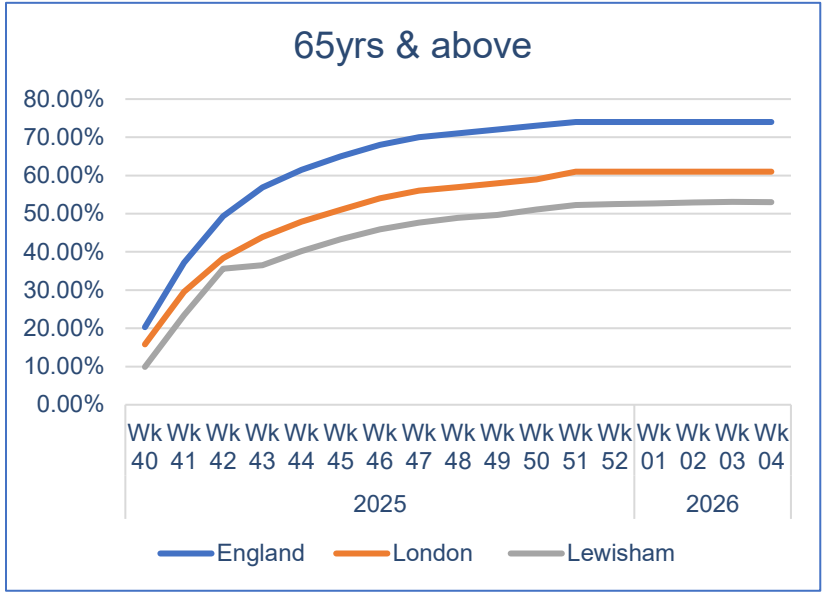
2025-26

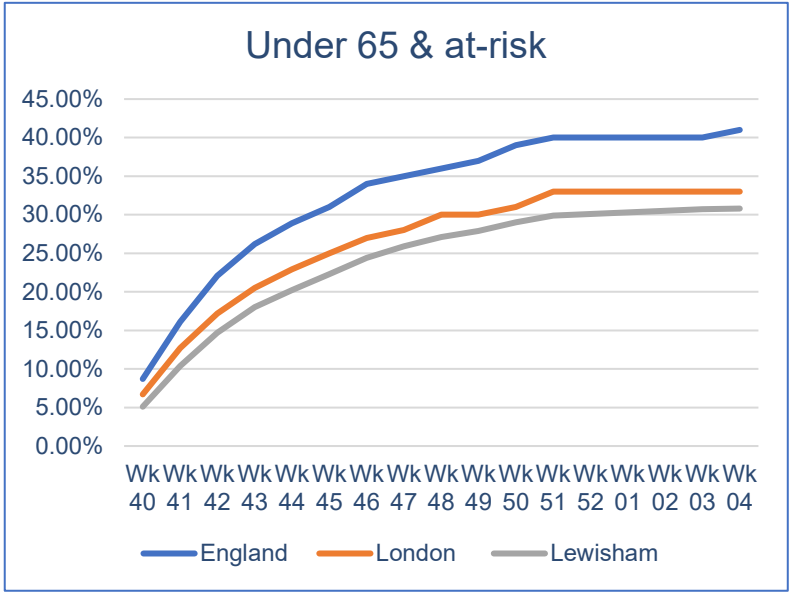
Slide pack contents

This slide pack includes:

- Percentage uptake of flu vaccination in different population groups, 2025-26
- Annual trend in flu vaccination uptake in 65 years and above
- Outreach flu vaccination clinics
- Communication and messaging to increase influenza vaccine uptake for 2025/26
- Reports by the voluntary and community organisations

Percentage uptake of flu vaccines in 65y & over and under 65 at risk groups over time in 2025/26

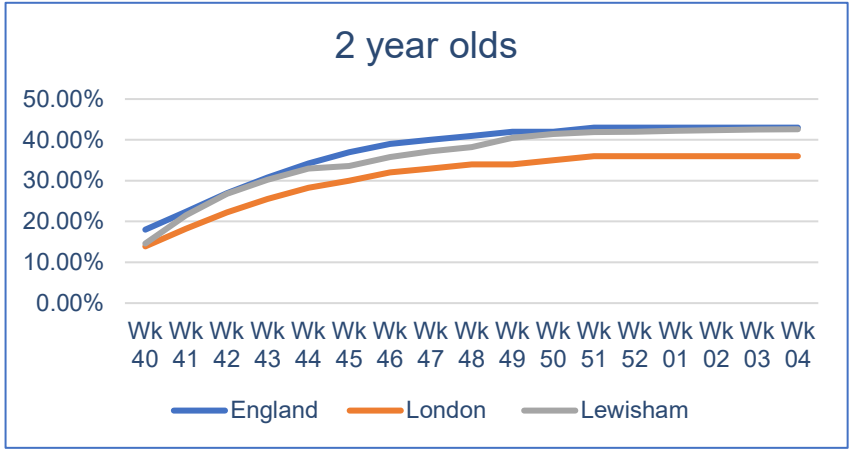


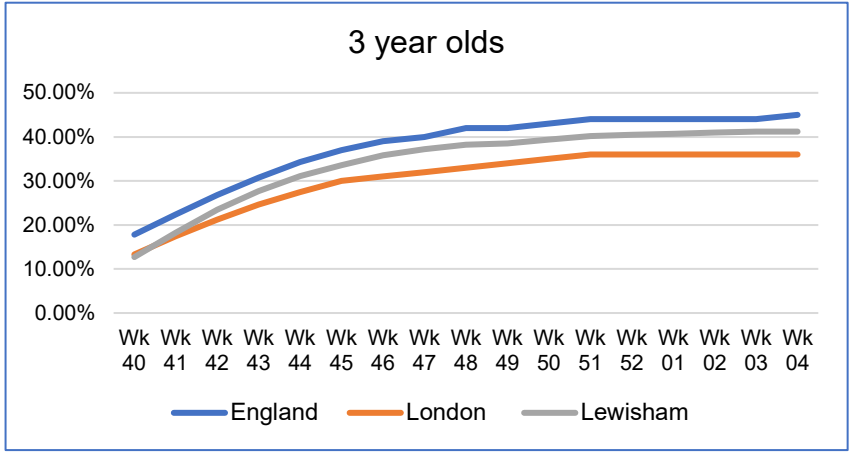


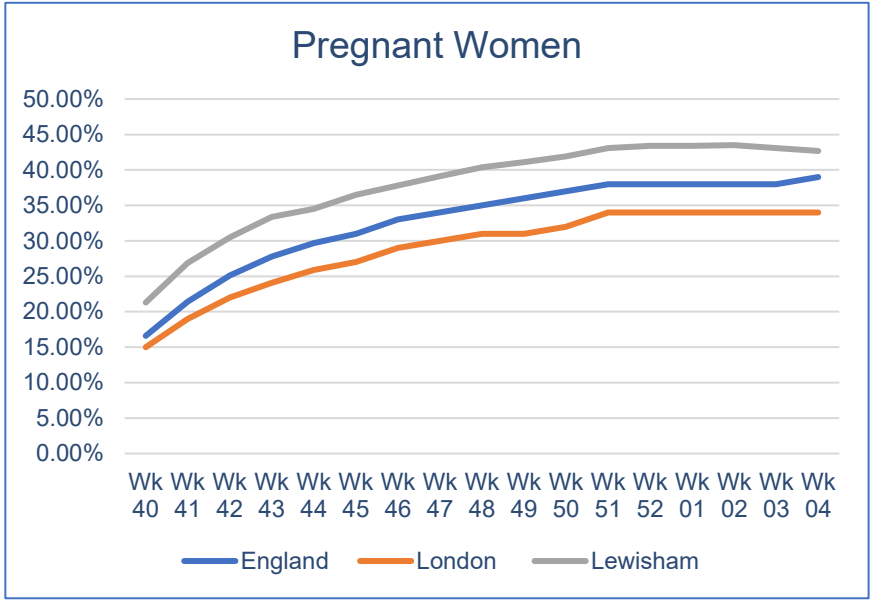
Lewisham Council's Corporate KPIs include:
Uptake of flu vaccines in persons over 65-year-olds: 61%
This 61% target is based on local performance from the previous years.

Data source: Imm Form

Percentage uptake of flu vaccines in 2y & 3y olds and pregnant women over time in 2025/26

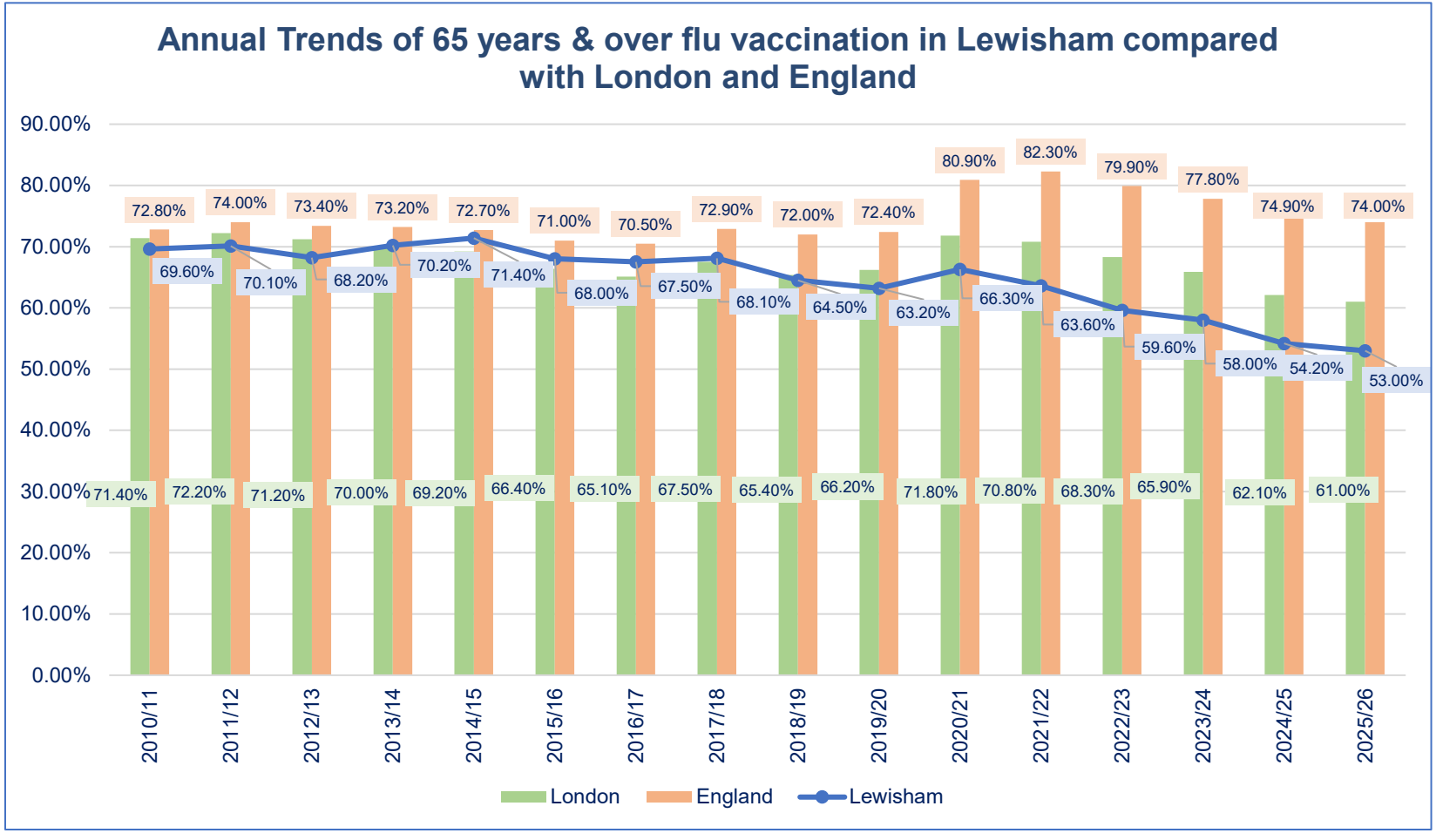






Data source: Imm Form

Note – influenza vaccines are also delivered to school-aged children and young people, data not currently available publicly



Data source: Finger Tips, UKHSA

Flu uptake by cohort, gender and ethnicity (Boroughs)

AW24 Cohorts (Flu)	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
01: CH Res	70%	72%	61%	59%	56%	72%
02: 65+	69%	73%	61%	52%	52%	53%
03: HCW (ESR)	37%	46%	34%	41%	36%	38%
05: At-Risk	40%	44%	40%	34%	34%	36%
06: Immunosuppressed	42%	45%	39%	38%	37%	38%
07: HC Immunosuppressed	14%	17%	11%	7%	10%	7%
08: Pregnant	40%	41%	42%	46%	49%	44%
09: Secondary	39%	47%	34%	24%	29%	23%
10: Primary	50%	56%	43%	34%	41%	32%
11: 2-3	35%	47%	37%	38%	41%	38%

AW24 Cohorts (Flu)	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Female	50%	57%	43%	36%	38%	36%
Male	49%	55%	43%	34%	37%	34%
Not known	63%	50%	0%	25%	0%	0%
Not specified	20%	0%	13%	17%	17%	40%

Ethnic group	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
A: White - British	56%	62%	53%	54%	54%	51%
B: White - Irish	57%	63%	58%	50%	51%	51%
C: White - Any other white background	39%	46%	38%	35%	35%	36%
D: Mixed - White and Black Caribbean	29%	32%	26%	21%	24%	19%
E: Mixed - White and Black African	36%	38%	32%	25%	31%	26%
F: Mixed - White and Asian	54%	61%	49%	52%	55%	49%
G: Mixed - Any other mixed background	42%	45%	36%	29%	34%	30%
H: Asian or Asian British - Indian	55%	59%	50%	46%	46%	40%
J: Asian or Asian British - Pakistani	41%	45%	32%	29%	26%	29%
K: Asian or Asian British - Bangladeshi	47%	46%	43%	32%	37%	31%
L: Asian or Asian British - Any other Asian background	54%	54%	52%	41%	44%	38%
M: Black or Black British - Caribbean	29%	25%	25%	18%	20%	21%
N: Black or Black British - African	35%	32%	33%	24%	26%	26%
P: Black or Black British - Any other Black background	33%	28%	32%	18%	21%	22%
R: Other ethnic groups - Chinese	59%	65%	55%	45%	49%	43%
S: Other ethnic groups - Any other ethnic group	40%	41%	35%	28%	32%	29%
X:Unknown	37%	47%	29%	22%	26%	21%

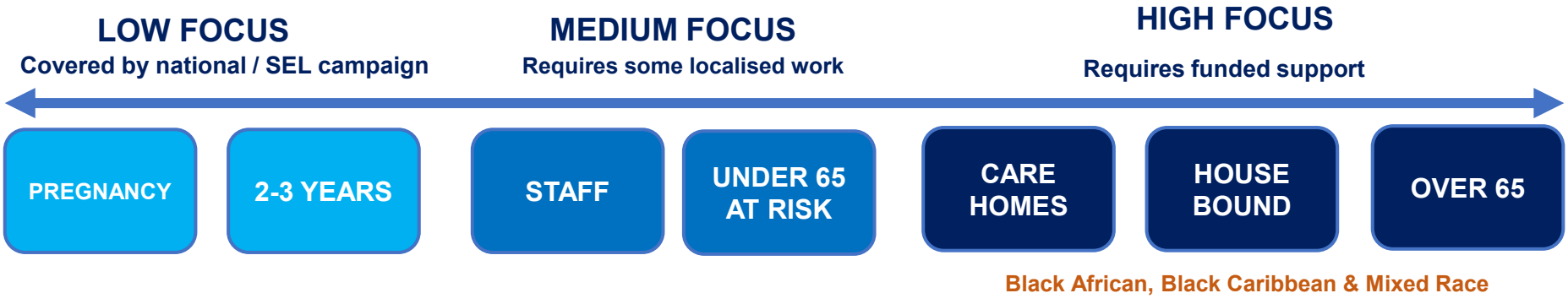
Source: FDP (09/02/2026)

Outreach Flu Vaccination Clinics

- In addition to the regular flu vaccination clinics in the GP Surgeries, Community Pharmacies and in Primary and Secondary Schools in the borough, flu vaccination outreach clinics were organised in various parts of the borough to bring service near the communities.
- Following outreach flu vaccination sessions were organised:
  - Lewisham Shopping Centre – 4 sessions were organised – Pharmacist led. Estimated 20 covid vaccines, 20 flu vaccines, 10 blood pressure measurements
  - Orchard Garden Community Centre – 1 session was organised with no flu vaccination, but 4 residents got their BP measured – Pharmacist led.
  - Millwall Football Club – 3 sessions on match days but no flu vax.
  - CYPCIS organised flu vaccination outreach clinics for school aged children who missed vaccination in schools. The outreach session were organised in the Evelyn family hub and Bellingham family hub on weekends as well as after school.

Cohorts and messaging 2025/26

Priority of cohorts:



What messages were given to residents?

SELF CARE

- Winter health tips
- How to treat winter ailments
- Community support/ cafes

VACCINATIONS

- What is flu
- Why vax is important
- Who is eligible
- Where to go to get vax

DIRECTIONS

- What to do when unwell
- Pharmacy First
- Navigating primary care
- When to visit UTC/ED

Flu Planning Outcomes 2025/26

Additional ideas and rationale:

HIGH FOCUS

CARE HOMES

OVER 65

OVER 65

- Consider working with POSAC and Aging Well Forum
- Consider further focusing in on geography to target areas with lowest uptake (Sevenfields / North Lewisham?)

MEDIUM FOCUS

STAFF

UNDER 65

- Working with partners to encourage staff vaccinations is required, how do we make uptake easier?
- How do we make staff our champions in the community?

LOW FOCUS

PREGNANCY

2-3 YEARS

- These cohorts were well covered in terms of communications and engagement last year by SEL campaigns and we expect that activity to continue for 2025/26

Engagement focus – co-design

FLU OUTREACH CODESIGN SESSION

- A session was organised involving LBL, Public Health, ICB, LCHP, VCSE, Healthwatch, Lewisham Local, HEF and other trusted community figures to codesign flu outreach activity
- Focusing on what we should do differently (and together) to overcome the barriers to vaccination
- Two voluntary and community organisations were commissioned to work for 2025/26

IDEAS TESTED

- Door knocking by wellbeing coaches
- Health & wellbeing coaches delivering vaccines alongside other checks (healthy living advice as primary focus)
- Roaming vaccinations teams
- Possibility of combining the trusted conversations with vaccines available straight away (i.e., faith settings)
- Focusing in on specific housing estates to target residents
- Care Homes family day outreach

Collaborative Delivery Lewisham Housebound Patients

LGT District Nursing team were utilised to deliver covid and Flu vaccinations to housebound patients.

- 6 out of 7 PCNs signed up to have DNT vaccinate their patients
- The model used the newly appointed INT roles
- INT staff obtained consented lists and sent to DN team
- The DN team organised visits and vaccinations
- INT staff recorded all vaccines given
- 31% Vaccinations given by DNT team

Communications activity

ONLINE ADS (SEL)

Paid for online advertising featuring Pharmacy Forst across SEL

WEBSITE (LCHP/SEL)

Refreshing winter pages including - flu and covid vaccinations information and adding all digital materials

SOCIALS (LHCP & LBL)

- Why we get vaccinated
- Maternity vaccinations
- Sickle Cell video
- Diabetes and flu vax
- CYPCIS clinics
- Where to get your vaccine at the pharmacy
- Who is eligible
- Stop the spread (Get Winter Strong)
- Real voices videos: range of topics and community figures

PRINT ADS

POSAC: full page winter wellness

Lewisham Life: full page ad in development (Nov print)

WEBSITE (LBL)

Ensuring info on flu pages is up-to-date. Sign posting to NHS services

Communications activity

ICB SCREENS

Winter wellness and vaccinations

JCD BOARDS

Flu season is nearly here. Start thinking about vax.

LHCP BULLETINS

Winter preparedness

Vaccine eligibility and where to get vaccinated

Winter wellness guide

LBL NEWSLETTERS

Resident newsletter: flu season is coming.

School newsletter: winter wellness booklet, reminder of catch-up clinics

LBL STAFF COMMS

Staff flu vax clinics: 235 staff vaccinated with 75 Boots flu vouchers

Chief Executive's email

Photo/video of Mayor / Chief Executive / DPH/ Executive Director getting vaccinated

Posters around LH/Wearside

Photos/video of first clinic to promote others

Communications activity - Oct

PRINTED MATERIALS

Winter wellness booklet: x10,000 physical copies circulated to GPs, pharmacies, community centres, libraries, family hubs and other spaces

Pharmacy map: x1,000 physical copies available for circulation

COMMUNITY OUTREACH

Worked with Citizens Advice Lewisham and Diversity Health and Wellbeing on a range of culturally appropriate messaging and communications materials to support the community outreach

STAFF CAMPAIGN

Are you a social care worker in Lewisham?

NHS

Protect yourself, your family, and the people you care for by getting your flu vaccine.

When you use the NHS complementary scheme you may need to present proof of your employment at your local GP or pharmacy. Some of the things you could use are:

- a letter from your employer
- an ID badge
- a payslip

For people in at-risk groups, such as older people or those with an underlying health condition, flu can be a serious disease and can cause death. As someone delivering social care or as a carer, you will be caring for many people in these at-risk groups.

Getting the vaccine will mean you are much less likely to spread flu to them and will help to protect those you are caring for this winter.

For further information, scan the QR code or check the intranet

Scan Me

LONDON'S

WINTER HEALTH BUS

FREE WINTER HEALTH CHECK ONBOARD

NHS
South East London

Come on board to get health information and support.

Take control of your health with a free Vital 5 check. The free check will measure your blood pressure, weight, and look at your mental health. It will also check how much alcohol you're drinking, and can give information and support on how to quit smoking.

We'll also be offering free flu and Covid-19 vaccinations to those eligible.

Come see us at:

Princess Royal University Hospital	Fri 28 November
Kingswood Estate	Mon 1 December
Guy's Hospital KCL Square	Tues 2 December
Giffin Street (off Deptford High St)	Weds 3 December
Albion Way (opposite Lewisham Shopping Centre)	Fri 5 December

Summary of reports from the Voluntary & Community Organisations

Diversity Health & Well-being CiC: Community-Led Flu Vaccination Engagement for Lewisham Winter Wellness Programme

- A total of 168 older residents participated in structured conversations and completed surveys, with the majority identifying as Black Caribbean (104) and Black African (34) — communities disproportionately affected by health inequalities.
- The outreach successfully increased awareness, confidence, and intention to vaccinate.
- 113 residents reported feeling more confident about the flu jab after the conversation, and 106 planned to get vaccinated this winter. The programme also identified clear barriers to access, including GP appointment availability, safety concerns, and mistrust rooted in historical and cultural experiences.
- The findings demonstrate that culturally sensitive, community-based engagement is a highly effective strategy for improving vaccine confidence and reducing health inequalities.

Summary of reports from the Voluntary & Community Organisations

Learnings from the project:

- **Trust-building is essential for effective engagement:** Sustained, visible presence within communities and delivery through trusted individuals significantly improves openness and participation.
- **Culturally competent approaches enhance impact:** Tailoring messages to reflect cultural and social contexts increases relevance and understanding.
- **Personalised engagement is more effective than generic messaging:** One-to-one and group conversations that respond to health concerns and circumstances are more successful in addressing hesitancy.
- **Integrated well-being messaging supports engagement:** Linking flu vaccination to wider Winter Wellness themes enables more holistic and meaningful conversations.
- **Early and coordinated planning improves delivery:** Alignment with partners and early scheduling of outreach sessions strengthen reach and operational efficiency.

Summary of reports from the Voluntary & Community Organisations

Recommendations by Diversity Health & Well-being CiC : Based on delivery experience and community feedback, the following recommendations are proposed to strengthen future outreach initiatives:

- **Adopt a longer-term, relationship-based engagement model:** Sustained community presence is more effective than short-term interventions in building trust and improving vaccine confidence.
- **Embed vaccination messaging within wider well-being initiatives:** Integrating flu vaccination into broader Winter Wellness, cost-of-living, and mental well-being conversations increases relevance and participation.
- **Strengthen Community Champion models:** Continued investment in training and supporting trusted local representatives enhance reach within priority populations.
- **Improve coordination with primary care and pharmacy services:** Clear referral pathways and timely access to vaccination appointments would improve conversion from engagement to uptake.
- **Expand culturally appropriate materials:** Increased availability of translated, easy-read, and accessible formats is essential to support inclusion.

Summary of reports from the Voluntary & Community Organisations

Citizens Advice Lewisham: Community-Led Flu Vaccination Engagement Report

- The project focused on Black African and African Caribbean adults aged 65+, alongside adults living with long-term health conditions groups known to experience lower flu vaccination uptake and poorer flu-related health outcomes.
- Using established satellite outreach locations across the borough, high-volume enquiry line, and trusted partnerships with primary care, foodbanks, and faith organisations, we engaged **563 residents** in meaningful conversations about flu vaccination.
- While immediate changes in vaccination decisions were limited, the project succeeded in building trust, increasing awareness, and opening sustained dialogue in communities where mistrust of health systems and vaccination is deeply rooted.
- The evidence from this programme demonstrates that short-term engagement can shift understanding and confidence for some residents, but that entrenched hesitancy requires longer-term, repeated engagement supported by trusted clinical voices.

Summary of reports from the Voluntary & Community Organisations

Outcomes and Impact from Citizens Advice Lewisham's project

- The project increased awareness of flu vaccination eligibility and access routes strengthened trust between residents and frontline services, and reinforced partnerships with health and community organisations. Importantly, it created safe spaces for open, non-judgemental discussion of concerns that residents often do not feel able to raise elsewhere.
- At the same time, the findings confirm that short-term engagement alone is insufficient to shift entrenched vaccine hesitancy, particularly where mistrust of statutory health services is longstanding and reinforced by previous negative experiences or perceived side effects.
- Trust-building is cumulative and requires sustained presence.
- The evidence from this programme demonstrates that Citizens Advice Lewisham is effective at initiating conversations, building rapport, and improving confidence, but that deeper change requires time and reinforcement.

Summary of reports from the Voluntary & Community Organisations

Recommendations by Citizens Advice Lewisham

- Repeat funding would allow for continued engagement with the same communities, enabling trust to develop over multiple touchpoints and winter seasons.
- It would also support co-delivery with NHS clinicians in trusted community settings, combining the credibility of clinical expertise with the relational trust of advice services.
- This model offers the greatest potential for translating increased confidence into measurable improvements in flu vaccination uptake and reducing winter health inequalities.
- Citizens Advice Lewisham is uniquely placed to bridge the gap between communities and health services.
- Through trusted advice delivery, we are able to reach residents experiencing multiple disadvantages and engage them in conversations that are critical to prevention and wellbeing.
- Continued investment in this approach will enable long-term behaviour change, contribute to reduced health inequalities, and support improved winter health outcomes for Lewisham residents.

Breakdown of costs 25/26

• 2 x VCSE Groups	£30,000
• Keeping your family Winter Well Booklet	£8,322
• Paid social media Advertising	£2,500
• Why we get vaccinated Campaign	£3,040
• Outreach events –vaccinations offered	£1,926
• Housebound Delivery Support	£20,000
• LBL Staff Vaccinations	£3,855
Total	**£69,643**

2026/27 Planning

- Build on the work with the VCSE groups to continue community in-reach and also see if there are targeted opportunities for increasing access.
- Use VCSE survey (25/26) findings as a foundation for shaping new approaches to delivery. The feedback gathered reflects the community's preferences and experiences, so integrating these insights will help us develop strategies that are both targeted and effective
- Amplifying the communications presence within the borough messaging to start pre- campaign.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 9
Enclosure 9

Title:	**Lewisham Risk Register**
Meeting Date:	**Thursday 26 March 2026**
Author:	Cordelia Hughes, Borough Business Support Lead
Executive Lead:	Ceri Jacob Place Executive Lead, Lewisham

Purpose of paper:	The purpose of the paper is to provide an update to the Lewisham Health and Care Partnership Strategic Board regarding the Lewisham Risk Register.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

1.Current Status, Direction of Risk and current Risk Appetite Levels

Risk Type	Risk Description	Direction of Risk	*Risk Appetite Levels
Financial	**592. Achievement of Recurrent Financial Balance 2025/26.** Lewisham borough anticipates achieving financial balance in 2025/26 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material one being an ability to fund mental health investment driven by the demand for and costs of ADHD assessments carried out in the independent sector. In addition, there are business as usual risks relating to activity pressures within continuing care and prescribing.	⟷	Open (10-12)
Financial	**593. Achievement of Efficiency Savings 2025/26.** Lewisham borough has a mandated efficiency savings target of £8.975m (5% on all budget lines). A material element £4.228m is dependent on delivery of efficiency programmes to manage activity within continuing care and prescribing. The programme is on track to deliver in full at month 6. However, given the nature of these activity driven costs, there remains a reduced residual risk of under achievement of the efficiency programme.	⟷	Open (10-12)
Financial	**496. Prescribing Budget Overspend**. Risk that the prescribing budget 2025/26 may overspend.	⟷	Open (10-12)
Strategic	**528. Access to Primary Care** There is a risk that patients may experience an inequality (and inequity) in access to primary care services.	⟷	Cautious (7–9)
Strategic	**529. Increase in vaccine** preventable diseases due to not reaching herd immunity coverage across the population. ***Childhood Immunisations***	⟷	Cautious (7–9)
Strategic	**561. Increase in vaccine** preventable diseases due to not reaching herd immunity coverage across the population. ***Seasonal Vaccinations***	↓	Cautious (7–9)

Strategic	**648. Uncontrolled mental health cost pressures restricting delivery of early-intervention, prevention and transformation programmes in Lewisham.** There is a risk that uncontrolled and rising mental health cost pressures in Lewisham - including ADHD Right to Choose activity, Section 117 placement costs and wider cost-per-case pressures - will significantly reduce the financial headroom and capacity required to deliver the Place-based mental health transformation programme.	⟷	Open (10-12)
Financial	**506. The CHC outturn for Adults will not deliver in line with budget** Activity and Acuity - the number of complex transition cases at high cost appears to have decreased during 2024/25, but this is still a risk due to high long term care costs associated with these cases. Uplifts - alongside this is the pressure caused generally by costs of existing packages being driven up by inflation and increases in both NLW and LLW and the hourly rate for homecare included within the MWAH framework. Recovery Work - we have made good progress in decreasing the number of delayed reviews. Staff vacancies and sickness in the CHC Team which were impacting on timely reviews and completion of Decision Support Tools have largely been addressed by the use of agency staff and overtime	⟷	Open (10-12)
Strategic	**644. Adults and CYP neurodevelopmental diagnostic pathways (Autism and ADHD).** There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	⟷	Open (10-12)
Operational	**611. INT Digital** The Neighbourhood model may not operate optimally if there are issues with IT infrastructure and data interoperability	↑	Eager (13-15)
Data and Information Management	**612. System Platform.** Funding for the population health management (PHM) platform is due to end in March 2026. It is unlikely that current local arrangements can sustain the platform beyond this date. The contract itself continues until March 2027, a strategic decision has been provisionally agreed to use GSTT's Snowflake as our replacement platform and we have obtained permission through the Data Usage Committee to add our data to GSTT's platform for this purpose.	⟷	Open (10-12)

Key - Direction of Risk ***refer to risk appetite statement 24/25 for level descriptions.**

↓ Risk has become worse.

⟷ Risk has stayed the same.

↑ Risk is improving.

2.Process

Risks are discussed monthly with risk owners and reported at the now quarterly Risk Forum chaired by the Chief of Staff. Key areas for discussion relate to themes around workforce, nationally and regionally identified risks, potential risks, funding and delivery of service. In addition, what mitigations have been implemented in the interim.

3. Risk Appetite Statement and Levels

	The ICB's stated appetite for risk provides a framework within which decisions can be made in a way that balances risks and rewards, costs and benefits. The ICB risk appetite framework is designed to allow NHS SEL ICB to tolerate more risk in some areas than others as it seeks to deliver its responsibilities and achieve the ambitious aims for the local health and care system. Risk appetite is not about the extent to which the ICB will seek to make changes or maintain the status quo. It is about the extent to which the organisation is willing to take risks in the process of securing the change we know is needed. ***Appendix 1 – Risk Appetite Statement***. **4.Local Care Partnership Risks - Comparative Review** A comparative risk review takes place quarterly to ensure a proactive review across all 6 risk registers and their respective scores. The aim is to identify potential risks that should be considered for inclusion in LCP risk registers, comparable analysis of risks with suggestive similarities and/or contrasts. A new comparative review is attached, please refer to ***Appendix 2 – LCP Risks Comparative Review*** **– January 2026** **5.New/Closed Risks/Matrix Scores** There is a total of **11 risks** on the Lewisham risk register. **New, closed or reduced risks are detailed below:** **New risks** **0** **Closed risks** **334** **Matrix Scores** • **592 - Achievement of Recurrent Balance.** Residual score reduced to 3x2=6 • **529 - Increase in vaccine preventable diseases – Childhood Imms.** Residual score increased to 3x4=12 • **649 - Uncontrolled mental health cost pressures.** Risk has been closed (344) and updated. • **611 – INT Digital.** Residual score changed to 3x3=9 and target 2x2=4 • **612 – Population Health Platform.** Risk reviewed in line with transition to new platform All risks will be reviewed in the new financial year 26/27. There is an issues log which monitors previous risks considered BAU and/or in development. Service areas have their own local risks to monitor. **6.Key Themes:** The key themes from the risk register relate to finance, budgetary and statutory impacts, workforce limitations, and quality of care around delivery of services.
Potential Conflicts of Interest	**N/a**
Any impact on BLACHIR recommendations	BLACHIR has coproduced recommendations for the Black African and Black Caribbean communities with the aim of reducing health inequalities. Under the risk-related main headings: finance/budgetary impact, workforce limitations and quality of care around delivery of services. If the residual risk score increased (high-level red

	risks), mitigations not met and funding/budgetary constraints escalate; limitations on health improvements/health inequalities as per the BLACHIR recommendations would be impacted.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Yes		
	Financial Impact	Yes		
Other Engagement	Public Engagement	Public Engagement, where required, takes place as part of the mitigating actions set out in the Risk Register.		
	Other Committee Discussion/ Engagement	Not in relation to this paper but some actions may require engagement and will be picked up via individual teams and initiatives. Risks are allocated each month for a deep dive at a weekly Senior Management Team and is a standardised agenda item at the Lewisham Health & Care Partners Strategic Board. Regular monthly meeting regarding all risks with the Place Executive Lead.		
Recommendation:	The Lewisham Health & Care Partners Strategic Board are asked to note the upcoming changes to the risk process across SEL. The ICB Board will be taking more of an interest in the risk process as mentioned above for corporate and borough risks going forward and have asked for all high-level red risks to be reviewed at the Planning and Finance Committee along with the BAF. At local level risk owners with risks that are high-level (red) will meet with the Place Executive Lead and Borough Business Support Lead with their delivery plan to conduct a deep dive into risks and mitigations.			

	Ref	Risk Type	Risk Title	Risk	Inherent Risk (L x I)	Residual Risk (L x I)	Target Risk (L x I)	Risk Appetite Level	Direction of Travel	Risk sponsor	Risk owner	Ongoing controls	Assurances	Impact of ongoing controls	Control gaps
Finance															
1	592	Financial	**Achievement of Recurrent Financial Balance 2025/26**	Lewisham borough anticipates achieving financial balance in 2025/26 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material one being an ability to fund mental health investment driven by the demand for and costs of ADHD assessments carried out in the independent sector. In addition there are business as usual risks relating to activity pressures within continuing care and prescribing.	3x3=9	3x2=6	3x2=6	Open (10–12)	⟺	Cate Jacobs	Mosunmi Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 5. Review at LCP meetings with members on a bi-monthly basis. 6.System approach is being followed with LCP partners to align savings opportunities. 7. The ICB is implementing an ADHD referrals triage system from November 2025.	1.Monthly budget meetings. 2.Monthly financial closedown process. 3.Monthly financial reports for ICS and external reporting. 4.Review financial position at CHC Recovery meeting. 5.Lewisham Senior Management Team Review.	1.The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed. 2.Regular borough financial focus group meetings with CFO and Director of Planning.	There are no currently identified control gaps.
2	593	Financial	**Achievement of Efficiency Savings 2025/26**	Lewisham borough has a mandated efficiency savings target of £8.975m (5% on all budget lines). A material element £4.228m is dependent on delivery of efficiency programmes to manage activity within continuing care and prescribing. The programme is on track to deliver in full at month 6. However, given the nature of these activity driven costs, there remains a reduced residual risk of under achievement of the efficiency programme.	3x3=9	3x2=6	3x2=6	Open (10–12)	⟺	Cate Jacobs	Mosunmi Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 5. Review at LCP meetings with members on a bi-monthly basis. 6. System approach is being followed with LCP partners to align savings opportunities.	1.Monthly budget meetings. 2.Monthly financial closedown process. 3.Monthly financial reports for ICS and external reporting. 4.Review financial position at CHC Recovery meeting. 5.Lewisham Senior Management Team Review.	1.The impacts of controls will be assessed during the financial year. 2. Regular borough financial focus group meetings with CFO and Director of Planning.	There are no currently identified control gaps.
Medicines Optimisation															
3	496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2025/26 may overspend due to: 1. Medicine supplies and cost increases -NCSO/price concessions and Category M. 2. Reduced capacity to implement in year QIPP schemes by borough medicines optimisation teams following NHS reform. 3. Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 5. Changes to disease pathways and guidance, recommending novel treatments earlier in the patient disease course, creating cost pressures 4. Increased patient demand for prescriptions including self-care items, LTC. 5. Prescribing budget although uplifted for 25/26, a gap remains with regards to forecast outturn and budget. 6. Priority shifts towards qualitative outcomes such as patient safety issues in Meds Management and supporting prevention, hospital avoidance or discharge. 7. Shift in prescribing from acute to community setting which places a pressure on primary care prescribing.	3x4=12	3x4=12	3x3=9	Open (10–12)	⟺	Laura Jenner	Erfan Kidia	1. Monthly monitoring of spend (ePACT, PrescQIPP), inclusive of Cat M and NCSO spend. 2. Monthly budget finance meetings with finance colleagues reviewing PPA budgets to date. 3. Monthly savings meeting with SMT at Place to review prescribing spend and development of mitigations. 4. Bi-monthly MG/Finance SEL meetings tracking prescribing spend. 5. Borough QIPP plans, and incentive schemes developed, with following ongoing: - QIPP and Incentive scheme monitoring dashboards - Practice level budget deep dives with RAG and action plans - Face to face practice visits with targeted spend analysis and feedback. - Forum meetings providing information on QIPP status and recommending actions to optimise prescribing (i.e. Practice Managers forum, PLT, etc.)	1.Any actions with regard to the prescribing budget are completed by Erfan Kidia, to dates agreed with the Place Executive, Associate Director of Finance.	1. Cost and budget pressure.	No gaps in control identified.
Primary Care / Community Based Care															
4	528	Strategic	**Access to Primary Care Services**	There is a risk that patients may experience an inequality (and inequity) in access to primary care services. The inequality in access may be caused by 1.Patients not understanding the various routes to access primary care services and the appropriate alternatives that are available 2.GP Practices operating different access and triage models 3.Digital exclusion 4.Workforce challenges 5.Increasing demand It could lead to: Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls	4x4=16	3x3=9	4x2=8	Cautious (7 – 9)	⟺	Cate Jacobs	Ashley O'Shaughnessy	The current controls in place are: Several priorities for 25/26: 1. All practices have now received the full Transformation and Transition funding based on evidence submitted and self-declaration of transition to the Modern General Practice Access model. The ICB will continue to fully embed Cloud Based Telephony and Online Consultation tools and develop and share good practice in respect of their utilisation. 2. A public communications and engagement campaign to raise awareness with the public about how best to access primary care and other options e.g. Pharmacy First via community pharmacy, self-management resources, self-referral pathways, NHS APP. The Primary Care Access Campaign is due to go live before the end of August 2025. It includes information on the NHS App, Access & Triage, Pharmacy First and the wider GP Practice teams. 3.Continue to review themes emerging from the SLF practice visits and develop and implement action plans to take forward. 4. Some of our larger practices are taking part in the Practice Level Support Group Based Learning Sessions which is designed to implement modern general practice and to assist practices to improve their efficiency, productivity and overall patient experience with a particular focus on patient access. 5. Build on the progress made with local discussions to take forward improvements in the primary / secondary care interface and expand this work to wider system interfaces i.e. mental health, local authority. 6. Consider opportunities to work with dental and community optometry providers/services to support improved access across all primary care services. 7. Continue support for GP practice estates developments planned through the London Improvement Grant and the NHSE Primary Care Utilisation Fund, to increase clinical space for appointments. 8. Continue support for PCNs to maximise use of the increased flexibility within ARRS budgets.	1.Assurances going forward are outlined in the controls section. Furthermore: Primary care access is reviewed on a monthly basis at the Primary Care Group and discussions with the Primary Care Leaders at PCLF, PM forum and PLTs about the models of access and delivery.	Highlight of progress made in 25/26: - In the months April to June 2025, Lewisham GP Practices delivered 337,000 appointments. Ongoing work programme with all practices to review and refine their websites to make them easier to navigate for patients including ensuring they are up to date, consistent and cover all key areas. Good progress has been made across all practices in Lewisham in implementing the MGP model. All practices now using Cloud Based Telephony systems with features such as a queue position and call back functionality as well as real time data monitoring to support evidence-based service decisions. All practices have an Online consultation system available for patients to use to submit requests. Quarterly reporting in place for PCN Enhanced Access delivery with all PCNs meeting their contracted required number of additional hours. In 2024/25, approximately 20,244 hours were delivered offering a total of 60,497 appointments: 73% of these appointments were face to face 36% of these appointments were with a nurse 48% of these appointments were with a GP 26% of these appointments were by telephone 17% average DNA rate across Lewisham. 17 practices have undertaken the Support Level Framework programme delivered by the SEL Primary Care Workforce Academy who have been commissioned to lead this work. The programme will continue into 25/26 with the aim of all practices participating. Some selected practices have now started the 2025/26 Practice Level Support. All PCNs utilised their total ARRS budgets for 24/25. Good progress is being made on the interface with Primary Care and Secondary Care including the sharing of clear contact points, creation of a dedicated WhatsApp group and the implementation of a formal letter to highlight and redirect inappropriate requests that are sent to General Practice from the local acute provider. In addition, a community pharmacy representative added to the Primary Care Group membership. Approximately 50% (165,000) of Lewisham patients have downloaded the NHS App - July 2025. Several significant estates developments have been completed through the London Improvement Grant programme which has resulted in increased clinical space for face to face appointments - a total of 8 new clinical rooms. There has been continued promotion and use of Pharmacy First for urgent emergency prescriptions and medicines requests. Between February 2024 and May 2025 34,461 patients were seen under the Pharmacy First scheme.	A robust and accurate access dashboard which triangulates and reflects data and intelligence from a range of sources across the system.
5	561	Strategic	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations**	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x4=12	3x4=12	3x3=9	Cautious (7 – 9)	⬇	Ashley O'Shaughnessy	Marilyn Clarke	The current controls in place are: 1.Practice level vaccination delivery remains in place across all GP practices, with co administration of eligible seasonal vaccinations offered as standard where clinically appropriate and operationally feasible. 2.Robust patient call/recall systems are operational across practices, ensuring timely invitations and follow up for eligible cohorts. 3.Dedicated Lewisham Flu and Immunisations Coordinator provides ongoing operational support to Primary Care, including data monitoring, troubleshooting, and quality improvement activity and liaison with practices and public health. 4.Continue to work jointly with Public Health to plan and deliver targeted outreach vaccination services for underserved communities, addressing wider health inequalities. 5.Convenient local vaccination sites and mobile/outreach models are maintained to widen access, particularly for groups with historically lower uptake a few outreach sites were mobilised as well as the Millwall Bus and 'big week' national Vaccination Bus, which piloted in Sept or no activity. 6.A universal, consistent core vaccination offer is delivered in recognisable, stable settings to strengthen public understanding of where to attend for vaccinations. 7.Opportunistic vaccination remains embedded across relevant services, ensuring vulnerable cohorts (e.g., asylum seekers, refugees, rough sleepers) are offered protection at every contact. 8.Lewisham Immunisation Partnership Group provides strategic oversight, supported by targeted task and finish groups for specific programmes. 9.Regular communications plan and engagement activity built around existing winter wellness theme. This included targeted social media activity, messaging through Lewisham Life and JCD Decaux digital boards and information leaflets distributed at vaccination clinics across the community. 10.Lewisham Immunisation Strategy refresh is underway, led by Public Health. 11.Voluntary and Community Sector (VCS) organisations are commissioned to support community engagement around flu/winter wellness and promote vaccination uptake. Worked particularly well with insight reports submitted and will use as the basis for updated plans in future campaigns. 12.Vaccine confidence behavioural science training was provided to family hubs and VCS partners to support effective vaccine-confidence conversations. 13.A vaccination chatbot/helpline pilot has been commissioned and is final stages of sign off. in place to answer patient questions and reduce misinformation barriers. 14. Collaboration with Southwark Health Bus continues, including vaccination provision at Millwall match days to access harder to reach groups. No vaccinations were given supporters were more engaged with BP checks and Vital 5 checks. As with The big week vaccination Bus based in central Lewisham and Deptford yielded most of it's engagement n vital 5 checks. 15.District Nursing Services were commissioned to deliver housebound vaccinations, ensuring equitable access for immobile and clinically vulnerable patients. The delivery program worked in collaboration with LGT and the newly appointed INT staff. Some challenges were met operationally but all involved worked hard to get through them. Questionnaire gone out to all involved to support debrief report.	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Future increased numbers in seasonal Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Future decrease in A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is vaccine hesitancy, fatigue and reluctance following covid 19 pandemic. Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 2.LHCP approach to 'making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity.
6	529	Strategic	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Childhood Immunisation Programme**	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x4=12	3x4=12	3x3=9	Cautious (7 – 9)	⟺	Ashley O'Shaughnessy	Marilyn Clarke	The current controls in place are: 1.Robust practice level call and recall systems are in place across all GP practices to ensure timely invitation and follow up for all eligible children. 2.National failsafe mechanisms continue to identify unvaccinated children and flag them to their registered GP practice for follow-up. 3.Dedicated Lewisham Flu & Immunisations Coordinator provides ongoing support to practices, with targeted focus on those with the lowest uptake and identified inequalities. 4.The ICB works jointly with Lewisham Public Health to design and deliver targeted outreach models for underserved and high risk population groups, addressing wider inequalities in immunisation uptake. 5.Local vaccination delivery points remain available at convenient community locations, with an increase in sites, by pharmacy being able to administer MMR. 6.A universal, age specific core vaccination offer is delivered in consistent, well communicated settings, improving public awareness of where to attend and at what age vaccines are due. 7.Opportunistic vaccination pathways continue across key services, ensuring children from vulnerable groups—such as asylum seekers, refugees, and those experiencing homelessness—are offered protection at every contact point. 8.Strategic oversight is provided through the Lewisham Immunisation Partnership Group, with programme specific task and finish groups (e.g., MMR/polio) coordinating focused improvement actions. 9.A co produced, system wide Childhood Immunisation Strategy—developed with parents, residents, system partners, and community organisations—is now in place. The strategy is outcomes based, aligned with the Lewisham Health & Wellbeing Strategy and SEL Immunisation Board's priorities. 10.Engagement support from the African Advocacy Group is in place from May 2025, strengthening culturally informed outreach and trusted community messaging. 11.Behavioural science training has been rolled out to family hubs, with planned engagement of nursery managers to expand confidence building conversations with parents. 12.The nationally revised childhood vaccination schedule launched July 2025 is being actively communicated across Lewisham to raise awareness among parents and professionals and support improved understanding and uptake. The MMRV vaccine, introduced in January 2026, has been accompanied by targeted communications to raise awareness of its impact on the childhood vaccination schedule and ensure parents and professionals understand the updated requirements. 13. Working with CHS Nurse Immunisation coordinators to improve immunisation recording at practice level. 14. SEL/place based focus on measles outbreaks. Comms sent to primary care awaiting system wide approach	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Increased numbers in childhood Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Decreased A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is also a clear lack of knowledge of the importance and effectiveness of vaccinations amongst young parents. 2.Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 3.LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity. 4.Limited influence over commissioning of vaccination programmes including routine childhood immunisations and school age vaccinations. These are commissioned regionally by NHSE&I. 5.Following a review of the immunisations survey that was shared with all practices, we are now taking steps to act on the suggestions received.
Commissioning															
7	648	Strategic	**Uncontrolled mental health cost pressures restricting delivery of early intervention, prevention and transformation programmes in Lewisham**	There is a risk that uncontrolled and rising mental health cost pressures in Lewisham - including ADHD Right to Choose activity, Section 117 placement costs and wider cost per case pressures — will significantly reduce the financial headroom and capacity required to deliver the Place based mental health transformation programme. Lewisham may be unable to sustain or expand early intervention and prevention offers, particularly those delivered through the VCSE sector, and programme management time may be diverted towards cost containment over wider system development and transformation objectives.	4x4=16	4x3=12	2x3=6	Open (10–12)	⟺	Kenny Gbogoriy	Ellen McCrate	1. Enhanced financial monitoring of ADHD Right to Choose activity & setting of Indicative Activity Plans 2. Improved processes regarding S117 care package costs and strategic commissioning of blocks etc 3. Alliance oversight of cost drivers and mitigations, with regular reporting through the Mental Health Alliance Finance Working Group 4. Prioritisation of transformation workstreams within available financial envelope, including oversight of VCSE grants and funded Prevention & Early Help projects	Monthly ICB finance reports and activity monitoring. Mental Health Alliance finance and performance oversight. Section 117 joint review panels and QA processes. Finance & Contracting meetings reviewing actuals, forecasts and mitigation plans.	1. The strengthened financial oversight and joint review mechanisms provide earlier visibility of cost growth and enable targeted mitigation of high cost areas such as placements and ADHD Right to Choose activity. This supports improved forecasting and helps protect, where possible, priority elements of the transformation programme.	1. Structural inability to influence national cost drivers, including ADHD Right to Choose activity and mandated Section 117 responsibilities. 2. Insufficient financial flexibility to protect or expand early intervention and VCSE delivered prevention services during periods of rising spend and tightening national efficiency targets. 3. Impact of the NHS 5% efficiency requirement on provider uplift negotiations, potentially reducing baseline sustainability and exacerbating pressures across the local MH pathway. 4. Programme management capacity increasingly consumed by cost containment, reducing bandwidth for longer term transformation. 5. Data gaps and forecasting limitations, especially regarding demand growth, complex care activity and future pathway flows.
8	506	Financial	**The CHC outturn for Adults will not deliver in line with budget**	Pressure in adult spend is being driven by a number of variables: Activity and Acuity The number of complex transition cases at high cost appears to have decreased during 2024/25, but this is still a risk due to high long term care costs associated with these cases. CHC continues to see an increase in patient acuity in the 24/25 year particularly in terms of PoC at home for patients requiring tracheotomy care and other health related tasks needing specialist care worker input. There has been an increase in Home Care Packages in 2024/25. The numbers that required tracheotomy care increased by 3. Numbers of newly eligible for CHC appear to have decreased in 2024/2025 for all Care Categories. Uplifts Alongside this is the pressure caused generally by costs of existing packages being driven up by inflation and increases in both NLW and LLW and the hourly rate for homecare included within the MWAH framework. There was a 5.1% increase in the AQP rate (2025/26). New rate is £1,247 per week. 1.5% uplift has been offered to Fairfax Group. Local Authority are recommending 5% uplift for Direct Payment rate. SEL ICB have been alerted to the Stoke Judgement and may need to change their approach to Uplift Offers to social care providers. Recovery Work We have made good progress in decreasing the number of delayed reviews, especially during the second half of 2024/25. However, opportunities for savings are still being delayed whilst we await Social Care input to the DST. Workforce Staff vacancies and sickness in the CHC Team which were impacting on timely reviews and completion of Decision Support Tools have largely been addressed by the use of agency staff and overtime. However, many of these solutions are short term and likely to be impacted by the ongoing MCR/ICB Change process.	5x4=20	4x3=12	3x3=9	Open (10–12)	⟺	Kenny Gbogoriy	Cynthia Mcsorley	1. Interim Nurse Assessor concentrating on high-cost packages to deliver savings. Prioritisation of reviews of long-term fast track packages. 2. Attendance at quarterly Transition panels to support better understanding of demand and potential cost, supports improvement of <18 assessment in line with the Framework, increases possibility of deflecting unnecessarily high costs/ SEND decisions. 3.Quarterly review of joint funding funded packages to divert risk. 4.Cost avoidance of the increase in the existing ICB contract with Fairlie/ Highfield Consideration through identification of more cost-effective packages with other providers (e.g. RVND and PoCs at home. 5. Monthly budget review meetings. 6. Weekly review of CHC eligibility decisions and related cost of packages. 7. Monthly review of neuro specialist patients to manage associated trim point costs and escalating earlier where there are blockages to discharge not in the control of the ICB.	1.Prioritising review of all new LD packages transferring from LBL to look for savings opportunities. 2.Prioritise outstanding reviews and ensure that annual reviews revert to BAU for CHC Nurse Assessors. 3.Participating in wider SEL ICB CHC savings programme.	1.Pressure from other CHC priorities (particularly appeals/ LRMs/ IRPs) continue to take significant management time and attention. 2.Allocation of Social Worker by LBL may still delay timely completion of DST.	1.Potential patient safety issues through the reduction in packages – all reductions are reviewed in dialogue with both patient and service provider. 2. Reputation of the ICB with Council/other partners – LBL regularly updated on progress against assessment, though there are several long term outstanding disputes. 3. Increase in complaints because of reduction in packages, or decision to remove CHC eligibility. 4. Assessing nurse to be clear about the rationale for the reduction in package or no longer eligible and this explanation to be put in writing at time decrease/change from CHC eligible is being enacted.
Children and Young People															
9	644	Strategic	**Neurodevelopmental diagnostic pathways (Autism and ADHD) - Adults and CYP**	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	4x4=16	4x4=16	4x3=12	Open (10–12)	⟺	Simon Wiltcock	Paul Cowen	**ICB and system level controls** 1.SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. 2.New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. 3. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. 4.Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis 5.Place Executive Group meeting has oversight via SDIP with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. 6. Opportunity to join arrangements with other boroughs	Oversight through the Place Executive Board via SDIP with Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYP MH Delivery Group and borough governance.	1. Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. 2.Limited ability to influence activity and quality within private 'Right to Choose' pathways. 3. Data completeness and standardisation across providers and places not yet consistent. 4. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments.	1. Inconsistent and incomplete SEL BI reporting across places. However, this is not applicable via CYP Joint Commissioning due to local monitoring. 2. ADHA Limited independent verification of data accuracy and trajectory modelling.
Enablers															
10	611	Operational	**INT Digital**	The Neighbourhood model may not operate optimally if there are issues with IT infrastructure and data interoperability. It is caused by: •Reliance on data sharing using digital systems for coordinating care and between multiple service providers It could lead to: •Duplication and lack of truly integrated approach	3x3=9	3x3=9	2x2=4	Eager (13-15)	⬆	Charles Malcolm-Smith	Laura Jenner	1. System Development Manager has developed digital pathway for INT service, reviewed by INT programme team and shared with ICB and LGT digital leads to ensure understanding of digital requirements. 2. Regular meetings with ICB digital leads and completed INT digital needs assessment. 3. Demonstrations and discussions on potential platforms to integrate systems including Blink PACO, Patienteer and Accurx.	1.Continuing development of digital requirements with partner IT/Digital Teams and IG Leads; potential to procure digital platform to help integrate patient data from multiple providers. 2. Access to interoperable Primary Care EMIS systems secured for all core members of INT teams and INT teams are now operational in all PCNs and Neighbourhoods. 3.INT teams are now operational with all core team members able to use EMIS to record data and share with practices and PCNs.	1.Lack of clarity of optimal solution. 2.Lack of identified funding to procure optimal digital solution.	1.Quality of service will be affected if data cannot be shared between service providers. 2.Single integrated data platform for all health and social care data in the borough still has not been sourced.
11	612	Data and Information Management	**Population Health Platform**	Funding for the population health management (PHM) platform is due to end in March 2026. It is unlikely that current local arrangements can sustain the platform beyond this date. The contract itself continues until March 2027, a strategic decision has been provisionally agreed to use GSTT's Snowflake as our replacement platform and we have obtained permission through the Data Usage Committee to add our data to GSTT's platform for this purpose. However, risks pertain to transition to Snowflake, meeting platform requirements, planning and the quality of case finding to support MDMs and INTs will be compromised.	4x3=12	3x3=9	4x2=8	Cautious (7 – 9)	⟺	Rachael Smith	Laura Jenner	1. We have obtained permission through the Data Usage Committee to add our data to GSTT's platform for this purpose. 2. We will enter a discovery phase in February 2026 to develop detailed technical plans with all participating organisations (the PHM Team, LGT, GSTT, the AI Centre, NTT and Accenture) for completion of the work. 3. We are requesting quotes to include all possible options with GP and Acute data as a minimum but also potentially Community data from Rio. 4. We have developed plans for interim solutions for INTs Case Finding and MDMs, which will be built by Ardens. These will be based on GP data only. 5. We are developing interim dashboard internally to replace Elective Recovery, and confirming that there will not need to be full replacements for other work (PAWS and other less regular requests) until we are operational at GSTT. Elective Recovery interim cover may not have access to data from all GPs. 6. For our internal interim work, we are working to ensure we have access to data from as many GP Practices as possible, by ensuring they sign up.	1. This period will be used to determine resource and timelines for the work to migrate to the new platform and to prepare interim cover for all delivery arms until that is achieved.	1. Plans will be developed for full migration and are being finalised for interim cover.	In the interim, the quality of case finding to support MDMs and INTs will be compromised, as it will be based solely on GP data, and will use a different emergency admissions risk model (which drives prioritisation of patients for both). The quality of case finding to support Elective Recovery and other delivery arms will also be compromised if we are unable to access data for all GPs via EMIS Web, if not all sign up, continue or replicate the work currently being undertaken to generate and maintain cohort lists.

1	**Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.**	Initial Health Assessment (IHA) – By law, Children Looked After require an IHA to be undertaken by a medical professional within 20 working days of the child entering care. The Lewisham CLA Health Team is able to see all CLA within 20 working days of notification. To give context, in 2023, 50% of IHA were completed outside the timescale (with a monthly range of 0-90%). Children not seen for their IHA may not have their health needs addressed in a timely manner and their carers are not enabled to promote their health appropriately.	*Medium Impact Issue*	*Medium*	Open (10-12)	Open	30/05/2025	Margaret Mansfield	Improvements in place, so agreed to move to issues log as a BAU.
2	**Shortage of commissioned nursing capacity in the CLA Health Team**	Risk related to Lewisham Children Looked After (CLA) Health Team commissioned by SEL ICB (provided by Lewisham and Greenwich NHS Trust) The risk relates to a shortage of commissioned nursing capacity in the CLA Health Team. With 1.8 FTE nursing staff, Lewisham's CLA Health Team has the lowest staffing levels in London, at 2.5 FTE fewer than the London average based on CLA population size. The Team is below average capacity for all of the four staff groups (Band 8a Named Nurse, Band 7 Specialist Nurse, Band 6 Nurse, and Admin staff), but most significantly for Band 7 Specialist Nursing. In addition, the team is operating with a nursing workforce significantly below that of the recommendations of the RCN and RCPCH Intercollegiate Guidance. The Impact is: 1. Statutory health assessments will not be completed within timescale, resulting in failure to comply with statutory responsibility. 2. Timely completion and distribution of health reports and care plans could be delayed. 3.Attendance at strategy meetings where health is a core agency is restricted which means that the most vulnerable CYP being discussed will not have a health advocate to contribute to action plans which often require health input. 4. Ability to reduce the breach list is limited which means the vulnerable CLA remain on the list with limited capacity to offer further appts. 5. Delivery of other key elements of the CLA service is restricted such as training and development and drop-in/consultation sessions which means that early intervention and health promotion opportunities are missed. The consequences of this are that the health needs of CLA may not be met. That access for CLA to other services may be delayed and/or compromised. There is a potential for staff burnout, ill health. May increase number of complaints and reputational damage to the ICB/Trust.	*Medium Impact Issue*	*Medium*	Eager (13-15)	Open	11/11/2025	Emily Sewell	Improvements in place, so agreed to move to issues log as a BAU.

Key

Inherent risk	is current risk level given the existing set of controls rather than the hypothetical notion of an absence of any controls.
Residual risk	would then be whatever risk level remain after additional controls are applied.
Target risk	the desired optimal level of risk.
What is a risk	Risk is the likelihood and consequences of a potential negative outcome. Risk involves uncertainty about the effects/implications of an activity often focusing on undesirable consequences.

Key - Direction of Risk

Risk has become worse.

Risk has stayed the same

Risk is improving

Risk Scoring Matrix

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

showing direction of travel. Green arrow up (improving risk), yellow arrow sideways (risk has stayed the same) and red arrow down (risk has become worse).

Likelihood Matrix

Likelihood (Probability) Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency Time-frame	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency Will it happen or not?	<0.1%	0.1 to 1%	1 to 10%	10 to 50%	>50%

Severity Matrix

Severity (Impact) Score	1	2	3	4	5
Descriptor	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

South East London Integrated Care System

NHS South East London

NHS SEL ICB
Risk Appetite Statement 2023/24

SEL ICB Risk Appetite Statement 2023/24

The statement

1. *Risk management is about finding the right balance between risks and opportunities in order that the Integrated Care Board – as a key partner in the South East London Integrated Care System – might act in the best interests of patients, residents, and our staff.*

2. *The ICB's stated appetite for risk provides a framework within which decisions can be made in a way that balances risks and rewards; costs and benefits.*

3. *The ICB risk appetite framework is designed to allow NHS SEL ICB to tolerate more risk in some areas than others as it seeks to deliver its responsibilities and achieve the ambitious aims for the local health and care system. Risk appetite is not about the extent to which the ICB will seek to make change or maintain the status quo. It is about the extent to which the organisation is willing to take risks in the process of securing the change we know is needed.*

4. *This risk statement is issued by the ICB and relates to the risk management processes in place to support the organisation's Board to manage risks faced by the organisation. However, as an integral part of the SEL Integrated Care System – working to shared operational and strategic objectives – a significant proportion of ICB risks will also affect ICS partner organisations, and vice versa. The ICB's risk approach aims to respect individual institutional responsibilities and processes, whilst seeking a better coordinated response to risks that exist across the partnership. This approach is a particular priority given that risks exist at provider interfaces and as part of patients' interactions across system partners.*

5. *The ICB has a dual role. It functions as a highly regulated organisation with responsibilities for ensuring statutory compliance, overseeing provision and ensuring financial sustainability. It additionally functions as an engine of change, with responsibilities to promote joined-up care, innovation, and to deliver improved population health outcomes.*

6. *To achieve our ambitious objectives for the health and care system in south east London, the ICB, as a leading voice in the wider ICS partnership, will need to be an increasingly innovative and change-driven organisation. The ICB has consequently adopted an **OPEN** or **EAGER** appetite in most areas of risk. However, the ICB will in pursuit of its wider objectives, operate with a **CAUTIOUS** posture to risks relating to the quality and safety of clinical care and to data and information management*

7. *Where a risk related to the ICB's activities is recorded with a residual risk score in excess of the defined risk tolerance level for the stated category of risk, that risk will be escalated within the SEL governance structure and ultimately be included in the Board Assurance Framework (BAF) for consideration by the ICB Board.*

South East London Integrated Care System

NHS South East London

ICB risk appetite level descriptions by type of risk

Proposed risk appetite levels by risk category (1 of 3)

Risk appetite level description (and residual risk score)					
Risk Category	**Averse (1 – 3)**	**Minimal (4 – 6)**	**Cautious (7 – 9)**	**Open (10 – 12)**	**Eager (13 – 15)**
Financial	Avoidance of any financial impact or loss is the key objective.	Only prepared to accept the possibility of very limited financial impact if essential to delivery.	Seek safe delivery options with little residual financial loss only if it could yield upside opportunities	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Prepared to invest for best possible benefit and accept possibility of financial loss (controls must be in place).
Clinical, Quality and Safety	Prioritise minimising the likelihood of negative outcomes or harm to patients. Strong focus on securing compliance with existing protocols, processes and care standards for the current range of treatments.	Prioritise patient safety and seeks to minimise the likelihood of patient harm. Is focussed on securing compliance with existing protocols, but is open to taking some calculated risks on new treatments / approaches where projected benefits to patients are very likely to outweigh new risks.	Is led by the evidence base and research, but in addition to a commitment to prioritising patient safety, is open to taking calculated risks on new treatments / approaches where projected benefits to patients are likely to outweigh new risks.	Strong willingness to support and enable the adoption of new treatments / processes / procedures in order to achieve better outcomes for patients where this is supported by research / evidence. Willing to take on some uncertainty on the basis of learning from doing.	Prioritises the adoption of cutting edge treatments / processes / procedures in order to achieve better outcomes for patients where this is supported by research / evidence. Willing to take on reasonable but significant uncertainty on the basis of learning from doing.
Operations	Defensive approach to operational delivery – aim to maintain/protect current operational activities. A focus on tight management controls and oversight with limited devolved authority.	Largely follow existing ways-of-working, with decision-making authority largely held by senior management team.	Will seek to develop working practices but with decision-making authority generally held by senior management. Use of leading indicators to support change processes.	Willingness for continuous improvement of operational processes and procedures. Responsibility for non-critical decisions may be devolved.	Desire to “break the mould” and challenge current working practices. High levels of devolved authority – management by trust / use of lagging indicators rather than close control.

Selected ICB risk appetite level

Proposed risk appetite levels by risk category (2 of 3)

Risk appetite level description (and residual risk score)					
Risk Category	**Averse (1 – 3)**	**Minimal (4 – 6)**	**Cautious (7 – 9)**	**Open (10 – 12)**	**Eager (13 – 15)**
Governance	Avoid actions with associated risk. No decisions are taken outside of processes and oversight / monitoring arrangements. Organisational controls minimise risk with significant levels of resource focussed on detection and prevention.	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximised through robust controls and sanctions.	Willing to consider actions where benefits outweigh risks. Processes, and oversight / monitoring arrangements enable cautious risk taking.	Receptive to taking difficult decisions when benefits outweigh risks. Processes and oversight / monitoring arrangements enable considered risk taking.	Ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking.
Strategic	Guiding principles or rules in place that largely maintain the status quo and seek to limit risk in organisational actions and the pursuit of priorities. Organisational strategy is rarely refreshed.	Guiding principles or rules in place that typically minimise risk in organisational actions and the pursuit of priorities..	Guiding principles or rules in place that allow considered risk taking in organisational actions and the pursuit of priorities.	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities.	Guiding principles or rules in place that welcome considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is reviewed and refreshed dynamically.

Selected ICB risk appetite level

Proposed risk appetite levels by risk category (3 of 3)

Risk appetite level description (and residual risk score)					
Risk Category	**Averse (1 – 3)**	**Minimal (4 – 6)**	**Cautious (7 – 9)**	**Open (10 – 12)**	**Eager (13 – 15)**
Data and Information Management	Lock down data & information. Access tightly controlled, high levels of monitoring.	Minimise level of risk due to potential damage from disclosure.	Accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Accept need for operational effectiveness in distribution and information sharing.	Level of controls minimised with data and information openly shared.
Workforce	Priority to maintain close management control and oversight. Limited devolved authority. Limited flexibility in relation to working practices. Development investment in standard practices only.	Decision making authority held by senior management. Development investment generally in standard practices.	Seek safe and standard people policy. Decision making authority generally held by senior management.	Prepared to invest in our people to create innovative mix of skills environment. Responsibility for non-critical decisions may be devolved.	Innovation pursued desire to “break the mould” and do things differently. High levels of devolved authority and a strong willingness for workforce to act with autonomy to improve its impact.
Reputational	Zero appetite for any decisions with high chance of repercussion for organisations’ reputation.	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Appetite for risk taking limited to those events where there is little chance of any significant repercussion for the organisation	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Appetit to take decisions which are likely to bring additional Governmental / organisational scrutiny only where potential benefits outweigh risks.

Selected ICB risk appetite level

South East London Integrated Care System

NHS South East London

Summary of SEL LCP risks

Prepared for the place executive leads (PELs)

January 2026

Purpose

1. The ICB risk and assurance team have a role to support LCP SMTs with identifying potential risks that should be considered for inclusion in LCP risk registers. Possible areas of risk might be identified following the emergence of risks on related programmes of work, near misses / incidents, nationally and regionally identified risks, reviewing risks recorded by other organisations, pro-active horizon scanning of likely areas of risk not recorded, looking at risks identified in other reports (e.g. performance, quality, PMO reports), looking at the wider applicability of risks have been recorded by other parts of the organisation. The role of the risk and assurance team is to work with LCP governance leads and SMTs to assess the applicability of these risks to their boroughs.

2. LCP risks are scheduled for PEL review on a quarterly basis. This pack provides an updated set of LCP risks, as of **26 January 2026.**

3. LCP risks on slides 5 - 11 have been assigned* to one of two categories as below:

    - **Primarily ICB risks** – those that have the potential to impact on the legal and statutory obligations of the ICB and / or primarily relate mainly to the operational running of the organisation. Controls for these risks are primarily within the ICB's scope to be able to resolve. The risk summaries have been highlighted in **green**.

    - **Primarily system risks** – those that relate to the successful delivery of the aims and objectives of the ICS as are defined in the ICB's strategic, operational, financial plans, corporate objectives and which impact on and are impacted by multiple partners in the integrated care system. Controls for these risks require a contribution from both the ICB and other ICS system partners to be able to resolve. The risk summaries have been highlighted in **blue**.

***important note:** this categorisation is indicative and PELs should highlight any areas of risk which they think belong in the alternative category.

Contents

LCP risks summary as of 18 December 2025

Bexley

Extreme	High	Moderate	Low	Total
0	9	3	2	14

Bromley

Extreme	High	Moderate	Low	Total
(1) 1	10	0	0	11

Greenwich

Extreme	High	Moderate	Low	Total
(1) 1	13	1	2	17

Lambeth

Extreme	High	Moderate	Low	Total
(1) 1	5	3	0	9

Lewisham

Extreme	High	Moderate	Low	Total
(1) 1	9	1	0	11

Southwark

Extreme	High	Moderate	Low	Total
(1) 1	8	1	0	10

(1) *Risk to be shown on ICB BAF*

South East London Integrated Care System

Finance related risks

NHS South East London

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Achievement of financial balance in the borough	6	12	12	9	9	9
Identify and achieve efficiency savings within the borough	6				6	12
Overspend against the prescribing budget	12	12	12		12	Inc. as part of overall financial balance risk
Overspend against the borough's delegated CHC budget	4	12	Inc as part of overall financial balance risk		12	
Unbudgeted costs due to transfer of high-cost LD clients / MH placements		12	Inc as part of overall financial balance risk	9	Inc as part of overall financial balance risk	12
Delegated Primary Care productivity & efficiency requirement				9	Inc as part of overall financial balance risk	
Financial / performance/ poor delivery risk relating to the community equipment services provider		9	6	4 ↓		9
HealtheIntent (HI) Platform and Funding Position					9	
Delays or challenge within community MSK Procurement			12 ○			

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased* (↑)
- *Score decreased* (↓)
- *Primarily ICB risk*
- *Primarily System risk*

LCP performance related risks

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Dementia diagnosis			8			
IAPT		10				
SMI Physical health checks	12	12	9			
Childhood immunisations	12		9	12	9	9
Flu vaccination rates	12	12	6 ↓	9	12	
Learning disability and autism annual health checks			2 ↓			
Hypertension treatment to NICE guidance	12		12			
Primary care access			4 ↓		9	
Cancer screening targets			9			

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased* (↑)
- *Score decreased* (↓)
- *Primarily ICB risk*
- *Primarily System risk*

Joint Forward Plan related risks

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Delivery of Joint Forward Plan commitments	8				12	
The Neighbourhood model may not operate optimally if there are issues with IT infrastructure and data interoperability					12	
INTs not delivered as planned						6

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased*
- *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Service transformation / improvement related risks

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Delivery of community-based MH programmes / CAMHs waiting times not achieved				6		9
Patient flow and discharge improvements not made	9		12			9
Risk to delivery of MH LTP trajectories					Inc. as part of JFP delivery risk	
Virtual wards will not be developed / optimised			9			
Risk to development of iThrive and preventative system approach to children's MH and wellbeing			12			

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased* (↑)
- *Score decreased* (↓)
- *Primarily ICB risk*
- *Primarily System risk*

Other performance related risks

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Diagnostic waiting times for autism and ADHD targets not being met (*CYP only, **CYP and adults)	12*	16** ●	16** ●	16* ●	16** ●	16** ●
Expected SEND standards	6					9

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since last update*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Workforce related risks affecting targets

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Limited capacity in CHC team		12				
Recruitment challenges within safeguarding teams	3			6		

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased*
- *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Estates related risks

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Primary care premises lost / insecure lease agreements / other estates issues	9 ↓	12	12			

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased* (↑)
- *Score decreased* (↓)
- *Primarily ICB risk*
- *Primarily System risk*

Key questions for consideration

1. As we are in the final quarter of the financial year 2025/26, **are the scores for the finance related risks a suitable reflection of forecast year** end positions (note, there is some discrepancy in borough scoring here – see slide 5)?

2. Greenwich have added a risk relating to community MSK procurement:
    - *"There is a risk that delays or challenge within the Community MSK procurement process (including representations, legal challenge, or mobilisation slippage) could result in service disruption, reduced continuity of care, and adverse impact on patient access, waiting times, and outcomes. This may also create financial, reputational, and operational risks for the ICB if interim arrangements are required or if the procurement timetable cannot be delivered as planned."*
    - **Is this a risk for other boroughs?**

3. The January 2026 Neighbourhood Based Bare Board papers, highlighted several risks across place and workstreams:
    a. uneven pace of delivery across places
    b. workforce and leadership capacity constraints
    c. digital interoperability and data limitations
    d. estates and neighbourhood hub feasibility
    e. risk of over-ambition relative to capacity and time
    f. sustainability of interim arrangements

    - **Should we further consider any of the above areas of risk for inclusion in place risk registers?** See slide 7, and note discrepancy in risk framing.

4. Lewisham specific question:
    - Greenwich have closed the risk related to HealtheIntent platform and funding position, because "LGT will exit the current platform and contract on 31 March, and a new platform provider has been agreed. Interim arrangements are also in place to ensure case finding can continue during the transition period to the new platform. A new risk will be logged covering both the interim arrangements and the new platform".
    - **Should this risk be closed for Lewisham now too?**

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 10
Enclosure10

Title:	**Lewisham Health and Care Partnership Board – Quality Summary Q3**
Meeting Date:	**26th March 2026**
Author:	Annette Fogarty, Associate Director of Quality and Patient Safety Caroline Walker, Senior Quality Manager
Executive Lead:	Dinae Jones, Chief Nursing Officer

Purpose of paper:	To provide an overview of quality for Quarter 3	Update / Information	*X*
		Discussion	
		Decision	

Summary of main points:	The report includes: • Current position on progress with Quality Impact Assessments • Q3 quality summary highlighting the themes of quality alerts and patient safety incident investigations (PSII) reported during that time. • SEL position on the national paediatric audiology improvement programme • Various updates from the Learning from Deaths group including medication safety and progress with the Medical Examiner process • Providers report progress embedding the Patient Safety Incident Response Framework (PSIRF) 2 years on. • The PSIRF pilot within General Practice also continues with support from the Health Innovation Network (HiN) • Public Health deep dive into termination of pregnancies within a SEL borough
Potential Conflicts of Interest	**Nil known**
Any impact on BLACHIR recommendations	**Data is presented to highlight potential inequalities in the quality of care provided**

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	

	Lewisham	✓	**Southwark**	
	Equality Impact	Data is presented to highlight potential inequalities in the quality of care provided		
	Financial Impact	N/A		
Other Engagement	Public Engagement	Patient Safety Partner engagement		
	Other Committee Discussion/ Engagement	Data and information discussed at Learning from Deaths Group, Themes and Concerns Group and the System Quality Group.		
Recommendation:	The Board are asked to note the content of the report			

South East London Integrated Care System

NHS South East London

Lewisham Health and Care Partnership Board Quality & Patient Safety Report 2025/26 Q3

Annette Fogarty Associated Director for Quality and Patient Safety SEL ICB

March 26th 2026

Lewisham Q3 System Quality Oct 2025 – Dec 2025 *cont.*

Lewisham Borough QIA's

Service Area		Quarter	QIA Status	QIA Outcome
Proactive remote monitoring service	Jack Howell	Q4 2025/26	Ful DTAC processed followed by commissioners- evidence provided.	Closed
LTC Annual Review	Yvonne Joy (nee Davies)	Q1 2025/26	Nil changes to service spec - direct award C to the incumbent provider	Closed
Kooth Children & Young People's Online Counselling Service	Sam Sayha	Q3 2025/26	SEL Wide procurement led by Lewisham	Closed
Lewisham Winter Plan	Jack Howell	Q2 2025/26	*Superseded by the SEL Winter Plan*	Closed
Lewisham Dermatology (CHEC)	Mervlyn Clarke	Q1 2025/26	ICP reviewing policy/ A/W Safeguarding Policies	Open
Lewisham Integrated Neighbourhood Team	Yvonne Joy (nee Davies)	Q1 2025/26	Fully approved: with the Commissioning team A/W final version	Closed
Lewisham Intermediate Care Beds	Lorraine Smedmor	Q4 2024/25	A/W approval of Safeguarding Polices	Closed
LSL Interpreting Services (Lambeth, Lewisham and Southwark)	Yvonne Joy (nee Davies)	Q4 2024/25	A/W approval of Safeguarding Polices	Closed
Lewisham QIPP & MOP QIA	Helen-Magnusen Baker	Q4 2024/25	*Superseded by the SEL QIPP/MOP Plan*	Closed
Lewisham Homeless People Legal Advice Service	Phill Hall/Amanda Lloyd	Q3 2024/25	Fully approved: with the Commissioning team A/W final version	Closed
Lewisham Take Home and Settle Service (THAS)	Phill Hall/Amanda Lloyd	Q3 2024/25	Fully approved: with the Commissioning team A/W final version	Closed

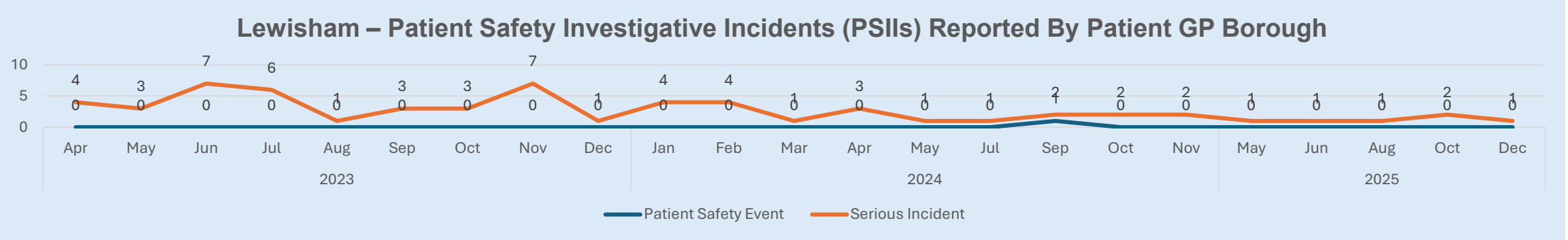
South East London Integrated Care System

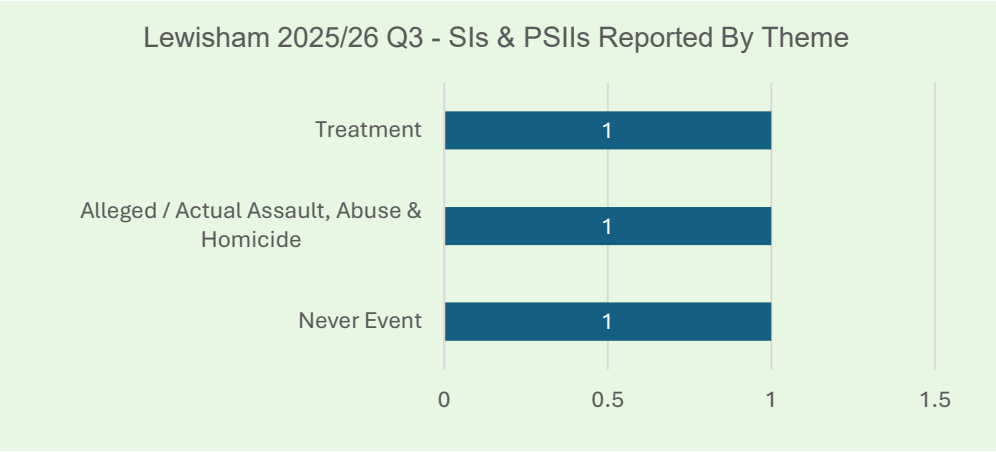
NHS South East London

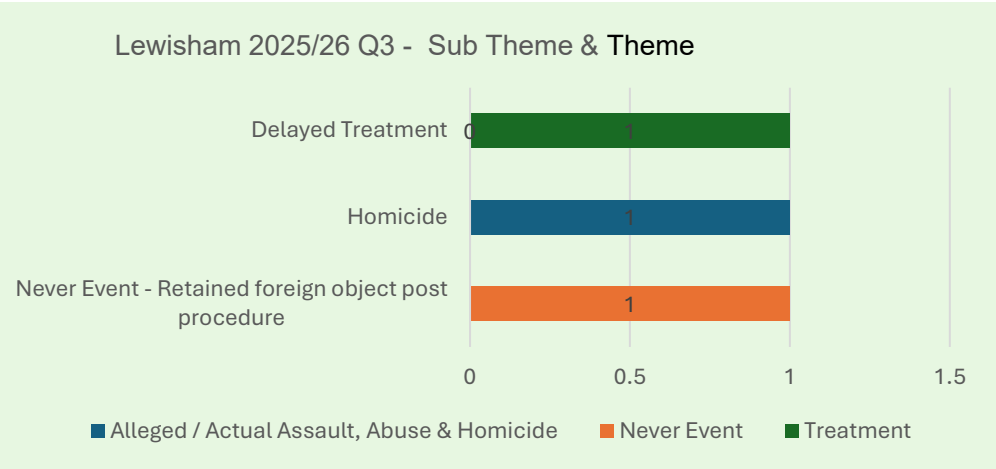
Lewisham Q3 SIs/PSIIs

(Oct 2025 – Dec 2025)

Lewisham Q3 PSIIs







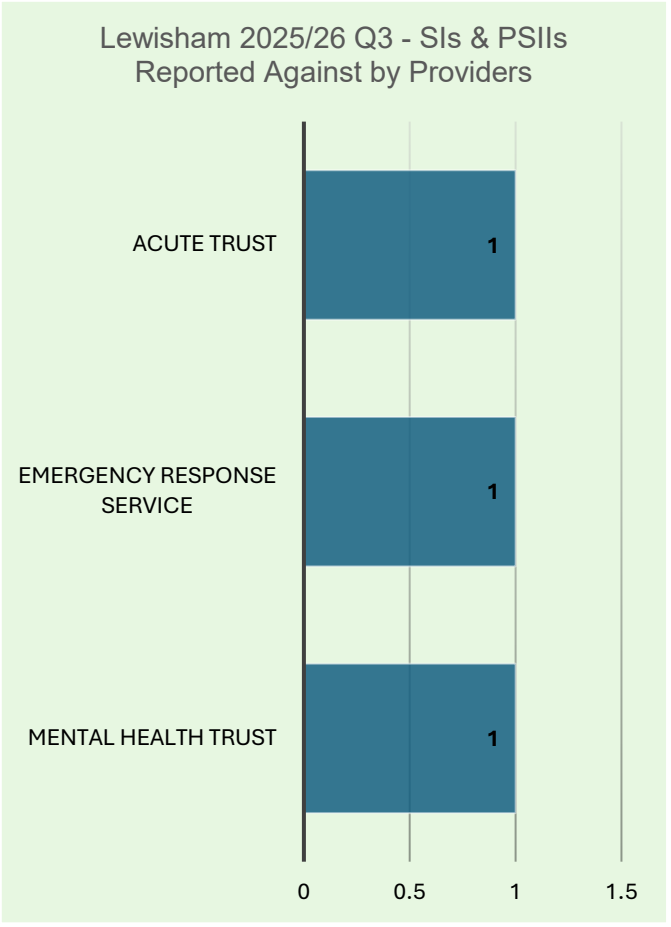
This summary provides an overview of Patient Safety Incident Investigations (PSIIs) reported during Quarter 3 of 2025/26.

A total of **three PSIIs** were reported relating to Lewisham residents.

Three separate providers each reported **one PSII**.

One PSII has been **completed**, with a thorough investigation and actions agreed through the closure process.

The remaining **two PSIIs** are **ongoing** and currently under review.



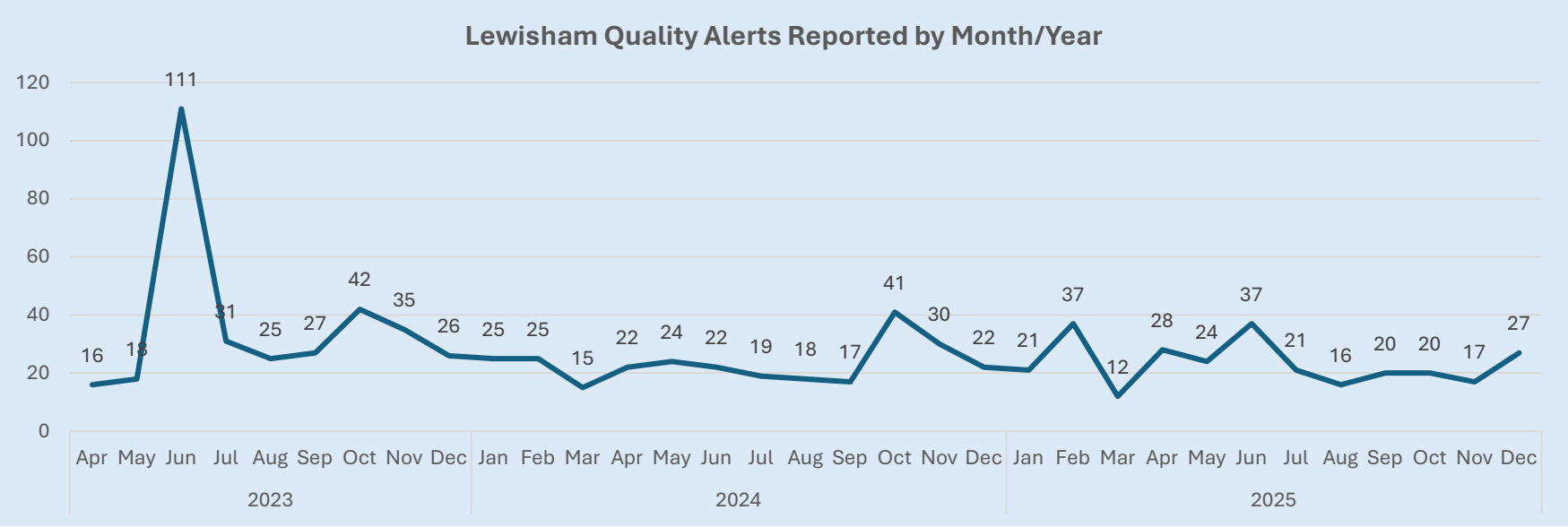
South East London Integrated Care System

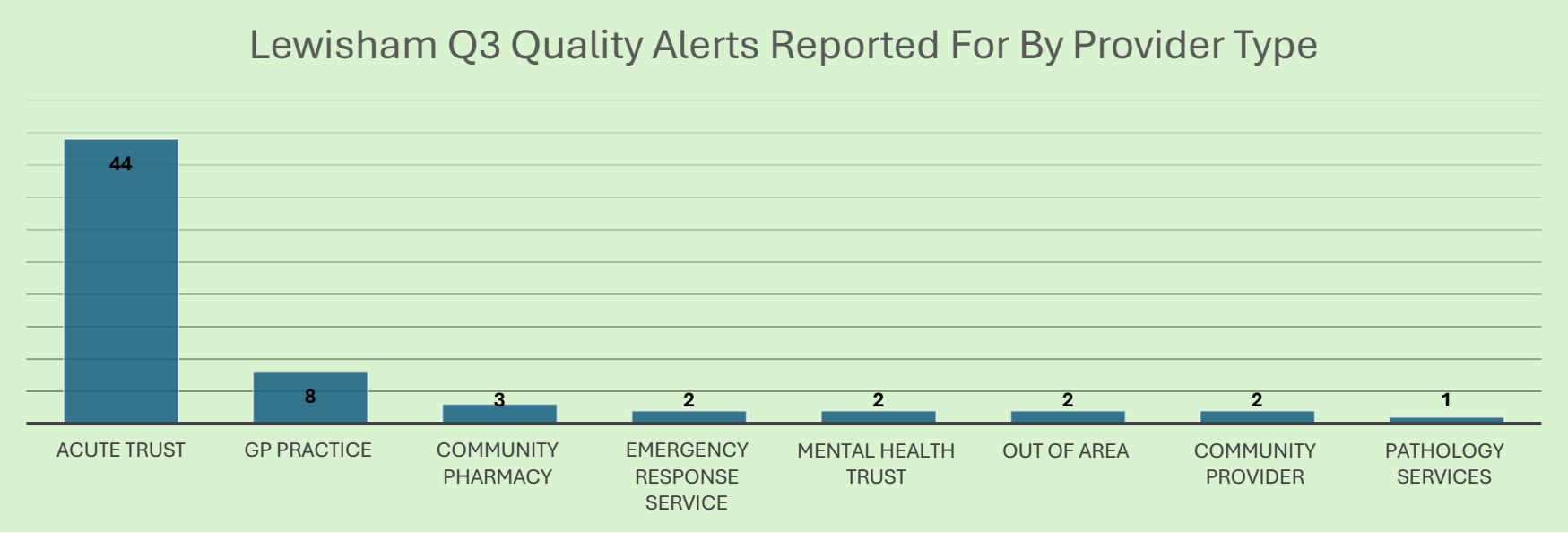
NHS South East London

Lewisham Q3 Quality Alerts

(Oct 2025 – Dec 2025)

Lewisham Q3 Quality Alert Reporting Trends Oct 2025 – Dec 2025





This summary report provides an overview of the key themes and trends identified from Quality Alerts submitted during Q3 2025/26, covering the period October to December 2025.

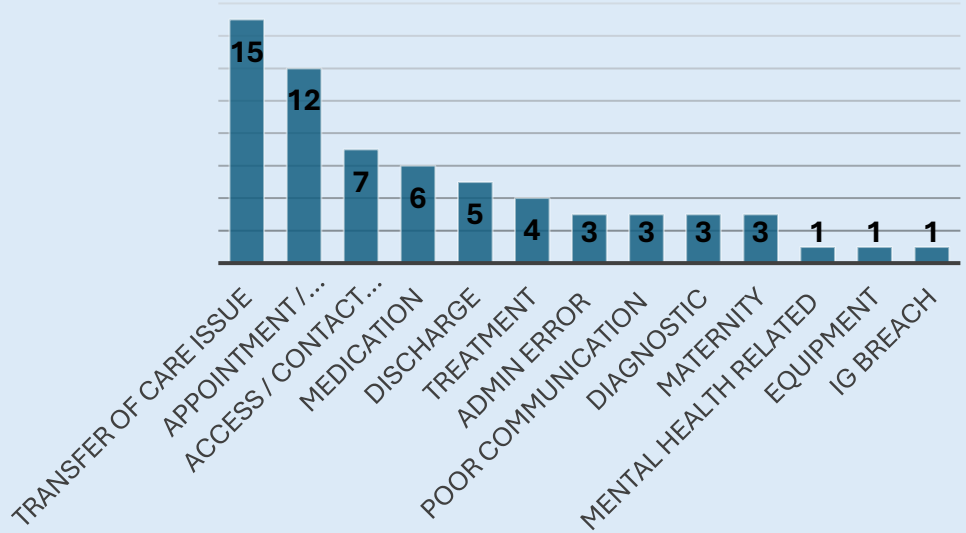
Reporting Trends
A total of **64 Quality Alerts** were submitted during the quarter, representing a **13% increase** compared with Quarter 2 (**57**).

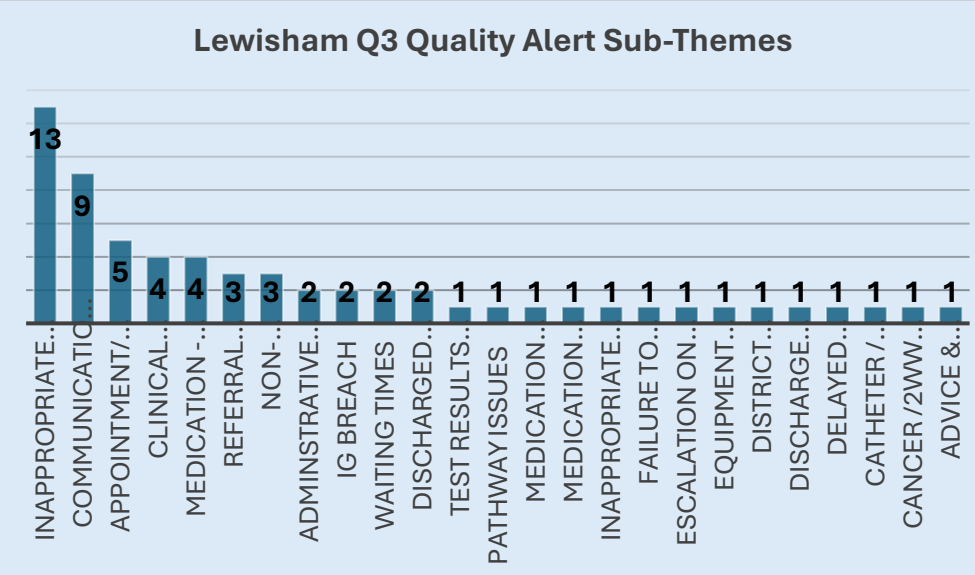
Four Quality Alerts were escalated for formal investigation under the **Patient Safety Incident Response Framework**, and these reviews remain in progress.

The **majority of Quality Alerts** were raised about the **Acute Trusts'**, with most submissions originating from **primary care settings**.

A smaller proportion were raised by **urgent care and community-based services**. In contrast, **primary care providers** themselves accounted for **12%** of all alerts received.

Lewisham Q3 Quality Alert Themes and Sub-Themes Oct 2025 – Dec 2025





Top 3 themes
Transfer of Care issues (15) , Appointment / Referral Issues (12), and Access / Contact issues (7).

Top 3 Sub-Themes
Inappropriate request to primary care (13), Communication between teams / external stakeholders (9), and Appointment / Referral issue (5).

The **most prominent themes** centred on **Transfer of Care issues**, including delays, incomplete handovers, or gaps in discharge arrangements.

Appointment and Referral issues, particularly incorrect or inappropriate referrals, rejected referrals, and difficulties securing timely appointments.

Medication-related concerns, including prescribing, dispensing, or omission errors.

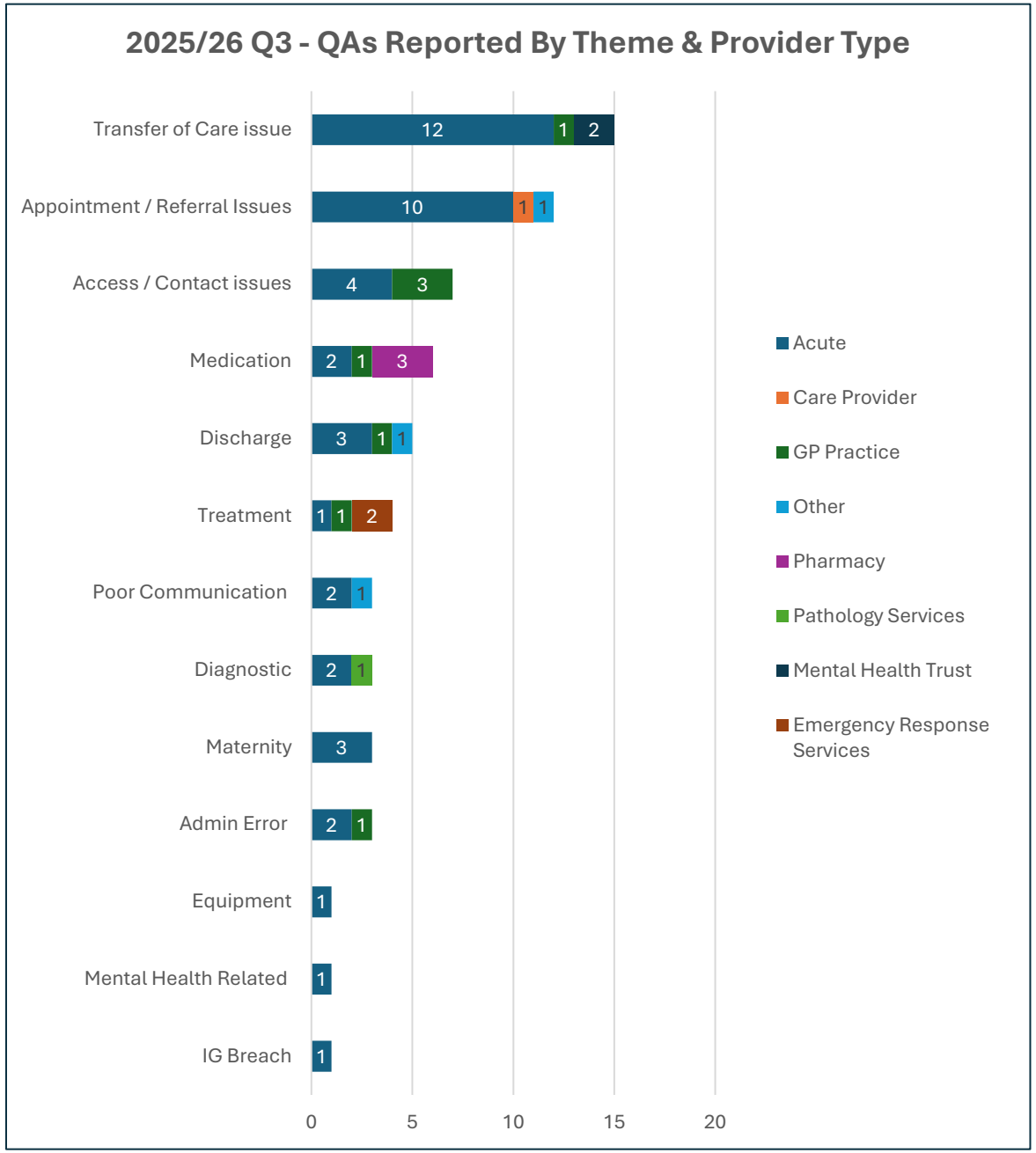
Communication challenges between hospital teams, primary care, and other external stakeholders.

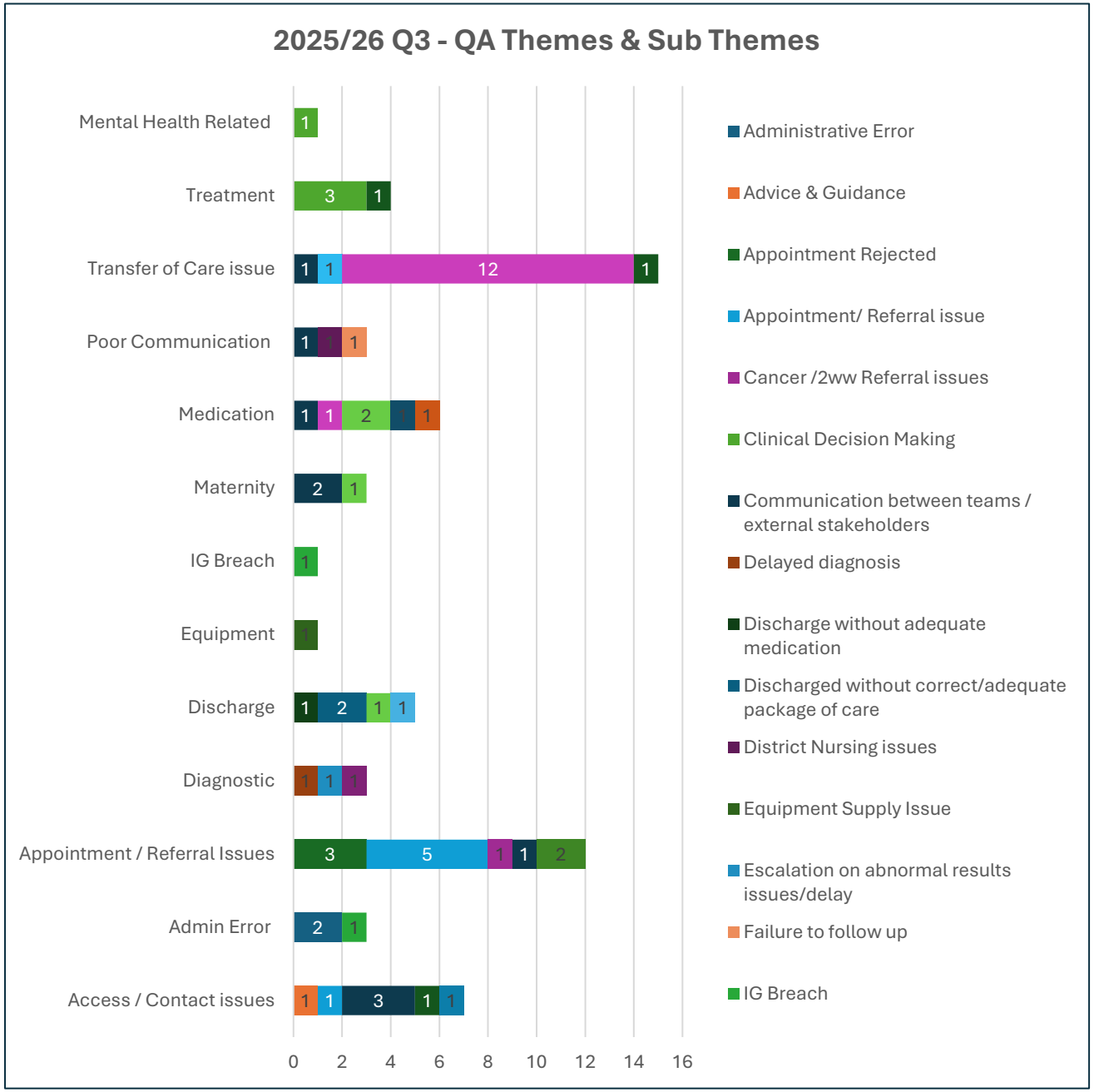
Inappropriate requests to primary care, where hospital teams redirected tasks without completing required clinical steps.

Quality Alerts were spread across a wide range of hospital specialties. Several acute specialties received clusters of alerts, typically **2–3 per service**, while many departments recorded **isolated single incidents**, indicating that issues were system-wide rather than concentrated in a small number of services.

70% of all Quality Alerts raised during Q3 remain **under review (45)**, while **17** have received a response (**27%**). **Two** Quality Alerts remain in holding areas awaiting clarification.

Lewisham Q3 Quality Alert Themes and Sub-Themes Oct 2025 – Dec 2025 *cont.*





South East London Integrated Care System

NHS South East London

SEL 2025/26 Q3 System Quality Summary Report

Prepared for the SEL Quality and Safeguarding Committee

Learning from Deaths

Shared Learning from other London ICBs

A five-year review in another London Mental Health Trust identified a significantly higher risk of fatal choking among mental health inpatients, particularly those with schizophrenia and schizoaffective disorders.

Key Findings:

- Key risk factors include disordered eating behaviors, medication side effects, poor dentition, and cognitive impairment. Most incidents occurred during mealtimes, with bread and toast being the most common foods involved.
- Service improvements implemented include hiring a dedicated speech and language therapist, introducing a standardised choking risk screening tool for all new admissions, and enhancing staff training and supervision at mealtimes.
- The initiative has led to increased staff confidence, improved documentation, and no further significant choking incidents since implementation
- The review highlighted the need for better access to allied health professionals in mental health settings and raised the question of whether similar risks and mitigations are being addressed in acute and community settings
- SEL Providers were asked to take the learning back and review current processes.

Medication Safety

Three medication-related deaths were reviewed, each highlighting systemic learning: time critical medication for cliff-edge conditions, duplicate prescribing of paracetamol leading to overdose, and dispensing errors resulting in incorrect medication delivery.

Key Findings:

- Key themes identified include the need for real-time risk identification, improved electronic prescribing safeguards, consistent discharge and transfer processes, and regular reassessment of patients using multi-compartment aids.
- Actions taken include sharing learning regionally, escalating issues to the national patient safety team, and forming a medication safety working group to address system improvements and information sharing across the local system.
- Due to the rise in multi-compartment aid incidents seen, the medication optimisation group are currently reviewing whether this should be a key priority for 2026/27

Medical Examiner Report

The Medical Examiner report gave an overview of Q2 progress across SEL

What's Going Well:

- Near 100% success rate for urgent scrutiny of deaths when requested by families, reducing delays in death registration and supporting faith burial needs.
- Introduction of a text message service to notify families promptly, reducing anxiety and premature registration attempts.
- Overall, there has been a reduction in the number of cases referred to the coroner since ME system implementation, streamlining the process and improving efficiency.
- Positive feedback from next of kin and clinicians regarding the ME service, with ongoing development of standard operating procedures.

Areas for Improvement:

- Q2 has seen a higher-than-average percentage of deaths referred to the coroner in South East London, reflecting patient complexity and inter-hospital transfers.
- Occasional delays due to missing critical data in referrals (e.g., time/place of death, next of kin contact), and administrative bottlenecks.
- Confusion around coronial processes, especially when paramedics and police refer expected palliative deaths to the coroner, causing unnecessary delays.
- Need for improved coordination and information sharing between ME offices, GPs, and other stakeholders to address broader system learning and avoid duplication.

Themes and Concerns Group

Paediatric Audiology

In 2024/25, the ICB stood up the paediatric audiology improvement programme specifically for Tier 2 services following the development of the nation hearing improvement screening programme.

Following the national review of paediatric audiology services, clinical risks have been identified locally with providers across SEL due to estate constraints, pathway inconsistencies and significant patient tracking list (PTL) backlogs, requiring a lookback and recall process.

Immediate mitigations are in place, including paused unsafe testing, mutual aid, shared estates, risk stratification supported by national experts.

To address unwarranted variation, capacity constraints and governance weaknesses, the ICB intends to move to a single system-wide hub-and-spoke model to improve safety, oversight, resilience and equity of access for children and families.

A key action for SEL ICB was the establishment of a harms review panel to review outcomes from the paediatric audiology lookback and patient tracking list reviews, using nationally defined NHS England harm definitions. The panel is overseeing confirmation of outcomes, including a small number of moderate and low harms identified to date, with further clinical appointments arranged where required to finalise assessments.

In quarter 2, the panel working with providers has identified 2 patients with moderate harm from the lookback review and 1 moderate and 1 low harm patients due to delays in the PTL.

Patient Experience

Presentations were received from both SEL ICB complaints team and Healthwatch. Reports highlighted both positive and negative feedback from service users across the system.

Key Findings:

Positive Feedback:

- Staff are frequently described as caring, respectful, and professional, especially in hospitals and care homes.
- Most patients' rate treatment quality as good or very good, noting strong teamwork and clinical skill.
- Many facilities are clean, calm, and make patients feel safe and comfortable.
- Patients appreciate joined-up support, where different teams work together and everyone is aware of their case.
- Some care homes and hospital wards demonstrate understanding of residents' backgrounds and traditions through personalised activities and flexible services.

Negative Feedback:

- Some patients feel staff are rushed, affecting dignity and comfort; phone consultations can feel impersonal.
- Carers sometimes feel left out of care planning and not kept informed about treatment.
- Lost test results, unclear updates, and lack of proactive information, especially between hospitals and GPs, are recurring problems.
- Difficulty booking GP appointments, long waits for hospital treatments, specialist services and mental health support are common concerns.
- Delays and poor coordination between services negatively impact patient experience, especially for vulnerable groups.
- Some patients, particularly black men with severe mental illness, report feeling misunderstood or over-medicated
- Translation and interpretation services are not always promoted or accessible.
- Formal complaints have increased especially about primary care and continuing healthcare. The team have also seen an increase in persistent contacts, and these can have an impact on staff resilience.

System Quality Group

Patient Safety Incident Response Framework (PSIRF)

Providers updated on their progress with PSIRF two years on. Providers discussed successes and challenges with their progress to date:

Key Findings:

Successes:
- Greater flexibility and proportionate responses to incidents
- Improved focus of improvement plans/groups for better impact
- Strong embedding of PSIRF principles and processes across several providers
- Development of formal patient safety response plans and integration of equality impact assessments
- Innovative reflective models for incident response in complex settings, e.g., prisons
- Increased staff engagement in After Action Reviews and learning events
- Collaboration across organizations and participation in pan-London PSIRF initiatives

Challenges:
- Persistent culture of blame and difficulty shifting fully to systems thinking
- Logistical difficulties in arranging multidisciplinary learning responses and AARs
- Limited QI capacity and challenges in sustaining and evidencing improvement actions
- Central patient safety teams are stretched; need for broader organisational engagement
- Reporting burdens and system integration issues (e.g., LFPSE/Datix) discourage low-level incident reporting
- Difficulty triangulating learning from multiple sources
- Training quality, especially with external contractors, remains a concern

PSIRF Pilot in General Practice

- The ICB is supporting phase two of the PSIRF rollout in primary care which started in July, with five providers involved: two PCNs, one federation, one practice, and one hospice
- The pilot focuses on operationalising PSIRF for general practice, recognising differences from larger providers particularly around resource
- Emphasis is on making PSIRF business as usual and not onerous, with the pilot focusing on accurate and consistent recording of incidents
- A focus being on linking it to CQC preparedness.
- This then focuses on embedding the principle of compassionate involvement and psychological safety in reporting, with efforts to embed these culturally.

Termination of Pregnancy

Public Health has conducted a deep dive into termination of pregnancies following concerns raised by the Quality Team about the decrease in the use of contraception and corresponding increase in termination and repeated terminations.

Key Findings:
- There has been a decrease in oral and long-acting reversible contraception and an increase in emergency contraception dispensing.
- Black and Black & White women are over-represented, particularly those in the 20 – 24 age group at a rate of 39.0 per 1000 head of population compared to a total termination rate of 20.7 per 1000.
- By ethnicity, the termination rate is highest for Black Caribbean women (75.7 per 1000) and White & Black Caribbean women (56.7 per 1000) compared to total termination rate of 20.7 per 1000. The termination rate for White women is 13.3 per 1000.
- Women identifying as Black make-up the highest percentage of women who have had a subsequent abortion (43%) compared to White women who have had a subsequent abortion (33%).
- Women aged between 25 – 29 make up the highest percentage of women who have had a subsequent termination (27%).

Key Considerations include:

Distrust of the health system, cost of living, access to contraception/advise, inequality in service delivery

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 11
Enclosure 11

Title:	**Month 10 Finance Report 2025/26**
Meeting Date:	**26th March 2026**
Author:	Michael Cunningham
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board on the ICB - Lewisham Place financial position at month 10 2025/26. A month 10 position is also included for the wider ICB/ICS and Lewisham Council.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

Month 10 2025/26 – SEL ICB – Lewisham Place

At month 10, the borough is reporting breakeven in line with plan. There are material overspends for Mental Health Services, Continuing Care and Prescribing offset by favourable variances (against budget) mainly in Community where delivery of cumulative efficiencies across the borough are reported. At month 10 the forecast outturn for the year overall is breakeven.

Further details of the financial position are included in this report.

Month 10 2025/26 – Lewisham Council

At month 10 Adult Social Care is forecasting an adverse variance to budget of £2.5m. Children and Young People is forecasting an adverse variance to budget of £6.1m. Further details are included in this report.

Month 10 2025/26 – SEL ICB

As at month 10, the ICB is reporting a year to date (YTD) and forecast out-turn (FOT) break-even position against its revenue resource limit (RRL) and financial plan.

Further details of the ICB position are shown within Appendix A to this report.

	Month 10 2025/26 – SEL ICS At month 10, the ICS is reporting a YTD deficit of (£16.2m), £5.8m ahead of plan. This reflects a £2.9m improvement compared to month 9. The main improvement is largely driven by the net impact of NHSE industrial action (IA) funding (£0.7m) and improved contractual performance (£1.8m). As at month 10, all organisations are forecasting a break-even year-end position in line with the overall ICS financial plan submitted on 30 April. Further details of the ICS position are shown at Appendix B to this report.			
Potential Conflicts of Interest	Not applicable			
Any impact on BLACHIR recommendations	Not applicable			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Not applicable		
	Financial Impact	The paper sets out the financial position at month 10 2025/26.		
Other Engagement	Public Engagement	Not applicable		
	Other Committee Discussion/ Engagement	The ICB Finance Report Appendix A is a standing item at the ICB Planning and Finance Committee.		
Recommendation:	The Lewisham Health & Care Partners Strategic Board is asked to **note** the month 10 financial position for 2025/26.			

NHS
South East London

Lewisham LCP Finance Report

Month 10 – 2025/26

Month 10 2025/26 - ICB (Lewisham)

NHS South East London

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	735	761	(26)	882	913	(31)
Community Health Services	23,502	24,701	(1,199)	28,203	28,447	(245)
Community Health Services - *(cumulative efficiencies)* **	6,031	1,086	4,945	7,237	2,345	4,892
Mental Health Services	6,641	7,561	(921)	7,969	8,956	(987)
Continuing Care Services	21,182	22,860	(1,678)	25,418	27,417	(1,998)
Prescribing	36,718	38,725	(2,007)	43,920	46,584	(2,664)
Prescribing Reserves	0	(610)	610	0	(712)	712
Other Primary Care Services	1,784	1,577	207	2,140	1,892	248
Other Programme Services	21	22	(0)	26	26	0
Delegated Primary Care Services	60,530	60,283	246	72,635	72,340	295
Corporate Budgets	2,771	2,702	69	3,325	3,251	74
Total	**159,914**	**159,668**	**246**	**191,755**	**191,459**	**296**
Delegated Primary Care - not available balances across ICB			**(246)**			**(296)**
Total FOT			**0**			**(0)**

** - place cumulative efficiencies reported within community

- At month 10, the borough is reporting breakeven year to date (YTD) and on a forecast outturn (FOT) basis. Mental health, continuing care services (CHC) and prescribing all show material overspends.
- These overspends are offset by a favourable position in community services. As referenced at previous meetings, the position includes mandated cumulative efficiencies generated within Lewisham place and reported within the community budget line. For transparency, these efficiencies have been shown as a separate line in the table. Excluding these, the community budget is forecast to spend broadly consistent with agreed in year plans showing an adverse variance of £245k.
- CHC shows a material overspend YTD of £1,678k and FOT overspend of £1,998k. The run rate on CHC has improved on the closing position from 2024/25, reflecting actions taken through the Lewisham recovery meetings which are now held monthly. This position is a significant improvement on the overspend reported in the same period in the prior year 2024/25 (Month 10 YTD £2,956k and actual outturn £4,028k). The borough is continuing to make good progress on reviews and strengthening further financial controls and database integrity. Whilst the overspends remain high, the benefit of this work is reflected in over achievement of the 5% savings target. The forecast over delivery of £792k in Lewisham reflects the focused work outlined above and partially accounts for the improved position to budget in 2025/26 compared to the prior year.
- The mental health position is driven mainly by costs incurred with independent providers for ADHD which are reflecting a significant increase in demand for these services impacting all places across SEL. The forecast outturn on these costs shows an overspend of £2,356k. The ICB has implemented a referrals triage system which commenced in November. It is hoped this system will start to slow down the growth in these costs. The pressure is currently being mitigated from other budget lines within mental health and the wider delegated budget.
- Prescribing activity data to month 8 is available. This is reflected in the month 10 YTD position and the forecast outturn. The key cost drivers include appliances e.g. freestyle libre sensors, endocrine products and stoma appliances. The borough has identified further mitigations of £806k above the 5% efficiency target and these are being delivered to try to reduce these costs closer to budget.
- Delegated primary care is forecast to underspend by £296k. However, since the ICB receives funding for delegated primary care as a ring- fenced allocation, the underspend cannot be utilised to offset other pressures. Therefore, this has been adjusted out of the position to ensure the ICB overall breaks even on delegated primary care.
- The borough 5% efficiency target is £8,975k, is fully identified, and is forecast to over-achieve for the year reflecting the CHC position referenced above.

Month 10 2025-26 – Lewisham Council

NHS South East London

2025/26 Efficiencies	Year-to-date Month 10 2025/26				Full-Year Forecast 2025/26		
	Plan	Forecast	Variance		Plan	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	3.1	3.1	0.0		3.7	3.7	0.0
Children and Young People	0.3	0.3	0.0		0.3	0.3	0.0
Total	**3.3**	**3.3**	**0.0**		**4.0**	**4.0**	**0.0**

2025/26 LBL Managed Budgets	Year-to-date Month 10 2025/26				Full-Year Forecast 2025/26		
	Budget	Forecast	Variance		Budget	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	77.3	79.3	(2.1)		92.7	95.2	(2.5)
Children and Young People	94.4	99.5	(5.1)		113.3	119.4	(6.1)
Total	**171.7**	**178.8**	**(7.2)**		**206.0**	**214.6**	**(8.6)**

Adult Social Care & Commissioning: We have seen a continual increase in the packages and placements commitment over the course of the year. The total increase in packages and placements commitment between Period 2 and Period 10 this year is £7.8m, significantly greater than the total increase between Period 2 and Period 12 in 2024/25 (£5.34m). This pressure on statutory Adult Social Care services provided under the Care Act 2014 is being seen across London boroughs and nationwide.

Children and Young People: the reported position at Period 10 of £6.1m overspend which is a worsening of the position by £2.4m since Period 8. There are forecast variances within Family Help and Care (£6.5m overspend) and Education Services (£0.4m underspend):

- Family Help and Care: an overspend of £6.5m is now forecast at Period 10, an increase of £2.4m since Period 6. There has also been a net growth of 15 children entering the service this financial year, but also within the younger age group which is more costly, than care leavers who are leaving the service. The Directorate has also seen an increased number accessing the service under Section17. The service all also negotitating with providers to ensure that packages are rightsized to reflect the care required. This is leading to anticipated cost reduction in future months.
- Education Services: An underspend of £0.4m is reported at Period 10, unchanged from Period 8. This is early delivery of 2026/27 savings and the balanced position on the rest of the service is reflective of the £3.9m additional funding added to the transport budget as part of budget setting to address the budget shortfall in 2024/25 and current year growth.

NHS
South East London

Appendix A

SEL ICB Finance Report

Month 10 2025/26

Contents

NHS South East London

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 10, the ICB is reporting a year to date (YTD) and forecast out-turn (FOT) **break-even position** against its revenue resource limit (RRL) and financial plan. Within this reporting, the ICB has delivered **£50,700k** of savings YTD compared to the plan value of £49,600k.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year-end after the "equalisation" (implementation of the risk-share) of the delegated primary care budgets and for 2 boroughs non-recurrent support in respect of the new ICES contracts.**
- The ICB is showing a YTD underspend of **£6,999k** and forecast out-turn position of underspend of **£7,164k** against the **running cost allowance (RCA)** due to the full allocation received from NHSE in respect of redundancy costs **(£12,486k)** being badged as RCA whereas some costs will be programme costs. The full anticipated impact of the ICB change programme on redundancy costs has been included in the month 10 accounts as either a provision or an accrual as per accounting rules.
- All financial duties have been delivered for the year to month 10 period.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	4,905,320	4,905,320	5,887,195	5,887,195	
Operating Under Resource Revenue Limit	4,905,320	4,905,320	5,887,195	5,887,195	
Not to exceed Running Cost Allowance	40,210	33,211	47,184	40,020	
Month End Cash Position (expected to be below target)	5,663	341			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	99.9%			
95% of non-NHS creditor payments within 30 days	95.0%	98.7%			
Mental Health Investment Standard (Annual)			537,494	549,722	

2. Executive Summary

NHS South East London

- This report sets out the month 10 financial position of the ICB. The financial reporting is based upon the final plan submission. This included a **planned break-even position** for the ICB. The ICB's financial allocation as at month 10 is **£5,887,195k**. In month, the ICB has received an additional **£66,001k** of allocations. These are as detailed on the following slide. **As at month 10, the ICB is reporting a year to date (YTD) break-even position.**
- Due to the routine time lag, the ICB has received eight months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,734k overspend YTD across PPA and non PPA** budgets. The overspend continues to be variable across the Places.
- The continuing care financial position is **£259k overspent** at month 10, which is a deterioration on last month. The boroughs which are most impacted with overspends are Lewisham, Bromley and Greenwich which is a continuation of the trend from last year. The YTD position for **Mental Health services** is an overall **overspend of £8,698k** which is a deterioration on last month. This is generated by pressures on cost per case services with all boroughs impacted. **ADHD and ASD assessments** are also a significant financial pressure, with both activity and costs increased significantly in this financial year. The new referral centre arrangements for these assessments went live at the beginning of November but the impact is not yet known.
- Places are also being impacted by the current contractual difficulties in the **community home equipment contract**, led by the London consortium. A full year cost pressure of **circa £1,500k** has been included in financial positions. Contractual changes were implemented from August.
- The ICB is continuing to incur pay costs for the remaining displaced staff following the original MCR process. All associated costs are charged to the balance sheet provision which was set up for this purpose. Some staff left the ICB in June, which leaves a small number of impacted staff who remain at the ICB.
- One place is reporting a material overspend YTD at month 10 – **Bromley (£369k – driven by MH and CHC overspends), with a break-even or better position being forecast by all.** All places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans. More detail regarding the individual place financial positions is provided later in this report.
- In reporting this month 10 position, the ICB has delivered the following financial duties:
    - Underspend of **£6,999k YTD** against its management costs allocation, due to the allocation in respect of redundancy all being badged as running costs (RCA) whereas some costs will be programme costs. The full anticipated impact of the redundancy programme has been included as provisions and accruals this month, as the allocation has now been received.
    - Delivering all targets under the **Better Practice Payments code**;
    - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance.
- As at month 10 the ICB is reporting an overall **forecast break-even position** against its financial plan. More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

3. Revenue Resource Limit (RRL)

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	**161,660**	**273,947**	**194,703**	**237,803**	**189,711**	**187,894**	**4,395,891**	**5,641,609**
M2 internal adjustments	-	-	-	-	47		(47)	-
M2 Allocations	-	-	-	-	-	-	51,058	**51,058**
M2 Budget	**161,660**	**273,947**	**194,703**	**237,803**	**189,758**	**187,894**	**4,446,902**	**5,692,667**
M3 Internal Adjustments	261	396	300	599	136	149	(1,840)	**0**
M3 Allocations	-						26,788	**26,788**
M3 Budget	**161,921**	**274,343**	**195,003**	**238,402**	**189,894**	**188,043**	**4,471,850**	**5,719,455**
M4 Internal Adjustments	478	668	628	857	678	705	(4,013)	**(0)**
M4 Allocations	112	131					47,083	**47,326**
M4 Budget	**162,510**	**275,142**	**195,631**	**239,259**	**190,571**	**188,748**	**4,514,920**	**5,766,781**
M5 Internal Adjustments	72	114	51	111	93	124	(565)	**(0)**
M5 Allocations							5,044	**5,044**
M5 Budget	**162,582**	**275,257**	**195,682**	**239,371**	**190,664**	**188,871**	**4,519,399**	**5,771,825**
M6 Internal Adjustments	603	811	701	885	784	850	(4,634)	-
M6 Allocations	-	-	-	-	-	-	21,961	**21,961**
M6 Budget	**163,185**	**276,068**	**196,383**	**240,256**	**191,448**	**189,721**	**4,536,726**	**5,793,786**
M7 Internal Adjustments	-	(25)	-	-	-	-	25	-
M7 Allocations	-	-	-	-	-	-	-	-
M7 Budget	**163,185**	**276,043**	**196,383**	**240,256**	**191,448**	**189,721**	**4,536,751**	**5,793,786**
M8 Internal Adjustments	314	1,023	223	345	98	346	(2,348)	**0**
M8 Allocations							1,091	**1,091**
M8 Budget	**163,498**	**277,066**	**196,605**	**240,600**	**191,546**	**190,068**	**4,535,494**	**5,794,877**
M9 Internal Adjustments								-
M9 Allocations							26,317	**26,317**
M9 Budget	**163,498**	**277,066**	**196,605**	**240,600**	**191,546**	**190,068**	**4,561,811**	**5,821,194**
M10 Internal Adjustments								
Planning Adjustments to boroughs	260	130	70	472	209	61	-1,203	-
M10 Allocations								
Winter Surge Funding							29,160	**29,160**
Redundancy Funding							12,486	**12,486**
Industrial Action Provider Funding (5 Intra system providers)							11,812	**11,812**
Pension Costs 9.4%							3,952	**3,952**
Month 10 depreciation adjustments							2,754	**2,754**
Primary Care Transformation final 2025/26 funding							2,556	**2,556**
Elective Sprint - 52 Week Wait/Outpatient							2,171	**2,171**
Frontline Digitisation 25/26 Commercial Q2-4 LPP Funding							513	**513**
Cancer performance improvement- National Cancer Programme							285	**285**
Various minor allocations under £100K		63					249	**312**
M10 Budget	**163,759**	**277,259**	**196,675**	**241,072**	**191,755**	**190,129**	**4,626,546**	**5,887,195**

- The table sets out the Revenue Resource Limit (RRL) at month 10.
- The start allocation of **£5,641,609k** is consistent with the Operating Plan submissions.
- In month, the ICB has received an additional **£66,001k** of allocations, giving a total allocation of **£5,887,195k** at month 10**.**
- Included as part of the additional allocations was Redundancy Funding of **£12,486k.**
- Other additional allocations received in month 10 included Winter Surge funding of **£29,160k,** Industrial Action Provider Funding totalling **£11,812k,** Employer pension funding of **£3,952k**, a Depreciation adjustment of **£2,754k,** the Primary Care Transformation final 25/26 adjustment of **£2,556k,** Elective Sprint funding **£2,171k,** Frontline Digitisation funding of **£513k** and other smaller adjustments totalling **£597k.** Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

4. Budget Overview

NHS South East London

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

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

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

- As at month 10, the ICB is reporting a YTD **break-even position**, albeit with **pressures in specific budgets.** Key areas of financial pressure are in **mental health services, CHC for some Places and prescribing.**
- Due to the routine time lag, the ICB has received eight months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,734k overspend YTD** across PPA and non PPA budgets. The overspend continues to be variable across the Places.
- The CHC financial position is **£259k overspent** at month 10, which is a deterioration on last month's reported numbers. The boroughs which are most impacted are Lewisham, Bromley and Greenwich which is a continuation of the trend from last year.
- The YTD position for Mental Health services is an overall **overspend of £8,698k** which is a deterioration on last month. This is generated by pressures on **cost per case services** with all boroughs impacted. **ADHD and ASD assessments** are also a significant financial pressure, with both activity and costs increased significantly in this financial year. The new referral centre arrangements for these assessments went live at the beginning of November but the impact of this is not yet known.
- The ICB is continuing to incur pay costs for the remaining displaced staff following the original MCR process. All associated costs are charged to the balance sheet provision which was set up for this purpose. Some staff left the ICB in June, which still leaves a small number of impacted staff who remain at the ICB.
- One place is reporting a material overspend YTD at month 10 – Bromley (£369k), **with a break-even or better position being forecast by all.** Places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans. More detail regarding the individual place financial positions is provided later in this report.

5. Prescribing

- The table below presents the month 10 PPA Prescribing position and shows a YTD overspend of **£4,116k** and FOT overspend of **£4,902k**. The YTD position is calculated on 8 months of actual PPA data and 2 months of accruals which are estimated based upon a rolling average of data from previous months, multiplied by the number of dispensing days.
- The non-PPA prescribing budgets are underspent by **£382k YTD** – generating an overall prescribing position of an overspend of **£3,734k YTD** at month 10.

M10 Prescribing	Total PMD (Excluding Cat M & NCSO) £	Central Drugs £	Flu Income £	Q4 24/25 Flu (Benefit)/Cost pressure £	Public Health Drug Recharge £	IPP Pharmacy First £	Total 25/26 PPA Spend £	M10 YTD Budget £	YTD Variance - (over)/under £	Annual Budget £	Forecast Outturn £	FOT Variance - (over)/under £
BEXLEY	32,530,084	1,073,493	(307,737)	(28,749)	(78,333)		33,188,758	32,465,856	(722,902)	38,831,403	39,465,566	(634,163)
BROMLEY	42,245,324	1,394,096	(443,173)	(3,940)	(48,953)		43,143,353	43,760,704	617,350	52,341,042	51,307,428	1,033,614
GREENWICH	32,749,415	1,080,731	(258,479)	(86,423)			33,485,243	31,907,457	(1,577,787)	38,163,821	40,017,509	(1,853,688)
LAMBETH	36,378,748	1,200,499	(292,352)	(60,319)			37,226,575	36,719,822	(506,752)	43,919,787	44,648,705	(728,917)
LEWISHAM	37,304,870	1,231,061	(216,957)	(49,435)	(375,465)		37,894,073	35,886,925	(2,007,147)	42,922,530	45,586,175	(2,663,645)
SOUTHWARK	30,806,857	1,016,626	(176,336)	(30,609)			31,616,538	30,057,577	(1,558,961)	35,951,219	37,950,267	(1,999,048)
SOUTH EAST LONDON						262,831	262,831	1,902,885	1,640,054	2,776,000	832,697	1,943,303
Grand Total	**212,015,297**	**6,996,505**	**(1,695,035)**	**(259,476)**	**(502,752)**	**262,831**	**216,817,370**	**212,701,226**	**(4,116,144)**	**254,905,802**	**259,808,347**	**(4,902,545)**

Prescribing
Comparison of April to November 2025 v April to November 2024

	2024/25 April to November	2025/26 April to November	Change £	Change %
South East London ICB:				
Expenditure (£'000)	163,556	170,029	6,472	**4.0%**
Number of Items ('000)	17,756	18,294	537	**3.0%**
£/Item	9.21	9.29	0.08	**0.9%**
London ICBs:				
Expenditure (£'000)	836,864	872,330	35,466	**4.2%**
Number of Items ('000)	101,445	105,189	3,744	**3.7%**
£/Item	8.25	8.29	0.04	**0.5%**
All England ICBs:				
Expenditure (£'000)	6,859,524	7,040,663	181,138	**2.6%**
Number of Items ('000)	829,762	845,012	15,250	**1.8%**
£/Item	8.27	8.33	0.07	**0.8%**

- Key areas of current pressures in the prescribing budget include endocrine systems, appliances and respiratory – reflecting the ICB's investment in the management of long-term conditions.
- The table to the left compares April to November prescribing data for 2024/25 and 2025/26. The headlines are that the trend in expenditure in the ICB is higher than nationally (**an increase of 4.0%**) but lower than the London average (**an increase of 4.2%**). This is driven primarily by a lower increase in the number of items **(3.0%)** – compared to an **increase of 3.7%** across London ICBs.

6. Dental, Optometry and Community Pharmacy

NHS South East London

- In April 2023, ophthalmic, community pharmacy and dental services were delegated to ICBs from NHS England. The table below sets out the financial position of these budgets on both a month 9 YTD and forecast basis.

Service	YTD Budget £'000s	YTD Actual £'000s	YTD Variance - (over)/under £'000s	Annual Budget £'000s	Forecast £'000s	FOT Variance - (over)/under £'000s
Delegated Primary Dental	92,072	92,072	(0)	110,486	110,486	0
Delegated Community Dental	7,229	7,229	(0)	8,675	8,675	0
Delegated Secondary Dental	45,332	45,332	(0)	54,398	54,398	0
Total Dental	**144,633**	**144,633**	**(0)**	**173,560**	**173,560**	**0**
Dental Ring Fence	144,596	144,596	0	173,515	173,515	0
Dental Non Ring Fence	38	38	(0)	45	45	0
Total Dental	**144,633**	**144,633**	**(0)**	**173,560**	**173,560**	**0**
Delegated Ophthalmic	14,692	14,692	0	17,630	17,630	0
Delegated Pharmacy	35,292	33,254	2,037	44,289	41,844	2,445
Delegated Property Costs	619	619	0	742	742	0
Total Delegated DOPs	**195,235**	**193,198**	**2,037**	**236,221**	**233,776**	**2,445**

a) Delegated Dental

- The ICB has reported a break-even position for the year-to-date and the full year. There is an underlying full year underspend of circa £2,000k which is an unintended consequence of commissioning more activity as patient charge revenue has also increased. **The dental ringfence of £173,515k is expected to be delivered**. As per last year, the monthly accrual is based on the dental report downloaded from the national e-Den system. The delegated property costs relate to where the primary care dentists are working either in NHS PS or CHP sites, and rent is charged.

b) Delegated Ophthalmic

- ICB has reported a break-even position for the year-to-date and the full year, with arrears on the annual price uplift due to be paid in February. The majority of the spend relates to Optician Sight Tests and Vouchers submitted by opticians within the SEL geography regardless of where the patient resides – claims are based upon location of provider not client/patient. The claims are as per a national framework arrangement, under which the ICB has a requirement to pay.

c) Delegated Community Pharmacy

- ICB has reported a **favourable £2,037k** variance for the **year-to-date** and **£2,445k** the **full year.** Information is generally received 2 months in arrears with an accrual then based upon the months average using the number of Prescribing days. Pharmacy First will be fully funded by non-recurrent allocations from NHS England which are received in arrears.

7. NHS Continuing Healthcare

NHS South East London

- As of Month 10, the Continuing Healthcare (CHC) budget reflects an overall an **overspend of £259k YTD**, although cost pressures continue to vary across boroughs. **Lewisham and Bromley** are currently reporting material overspends.
- **Lewisham** remains the largest contributor to the overall overspend, reporting a variance YTD of **£1,678k above budget and a forecast outturn of £1,998k**. This is primarily driven by high costs associated with **palliative care clients, PHB Clients** and includes a **£428k full year provision** for anticipated increases in provider prices. This position is significant improvement on the overspend reported in the same period in the prior year 2024/25 (Month 10 YTD £2,956k and actual outturn £3,553k). The borough is continuing to hold twice monthly financial recovery meetings with the CHC team ensuring good progress on reviews and strengthening further financial controls and database integrity. Whilst the overspends remain high, the benefit of this work is reflected in over achievement of the 5% savings target. **Bromley** is reporting an **overspend of £1,157k**, mainly due to Funded Nursing Care and palliative care costs, alongside a **£795k provision** for upcoming provider price uplifts.
- To support a consistent management of provider price uplifts, an ICB-wide panel has been established to review all requests exceeding 1.5%. Most providers have now agreed to the proposed uplift, with only a small number still to be finalised. As a result, the uplift panel, which initially met weekly, now convenes monthly. Lambeth and Lewisham have maintained a 4.0% contingency to manage inflationary pressures where uplifts have not yet been formally agreed, while Greenwich, Bromley, Southwark, and Bexley have reduced their contingency to 2.83% in line with current inflationary agreements.
- In terms of **savings delivery**, all boroughs have identified and are actively progressing against their CHC savings plans. **Bexley,** and most materially **Lewisham** are forecasting to exceed their targets. The **forecast over delivery of £792k** in Lewisham reflects the focussed work outlined above and partially accounts for the improved position in 2025/26 compared to the prior year. In contrast, **Greenwich** is reporting an **under-delivery of £110k**. Despite this progress on savings, rising activity levels and the growing number of **high-cost clients** continue to place upward pressure on the CHC budget.
- In summary, the ICB's CHC financial position has deteriorated in-month **(circa £400k overall),** driven primarily by rising client numbers and package costs in **Lewisham, Greenwich, and Bromley**, which remain the key areas of concern due to persistent **overspending and demand-led financial pressures**. **Positively**, **however, average client numbers** increased year-on-year by **40** between October 2022 and October 2024 but have subsequently **decreased by 24 this year**. This reduction demonstrates the boroughs' ongoing efforts to review and optimise clients' care packages to contain CHC expenditure within budget.

8. Provider Position

NHS South East London

Overview:

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

- In year, the ICB is forecasting to spend circa **£4,352,786k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£1,114,123k**
    - Kings College Hospital **£1,184,837k**
    - Lewisham and Greenwich **£759,816k**
    - South London and the Maudsley **£370,690k**
    - Oxleas **£330,442k**

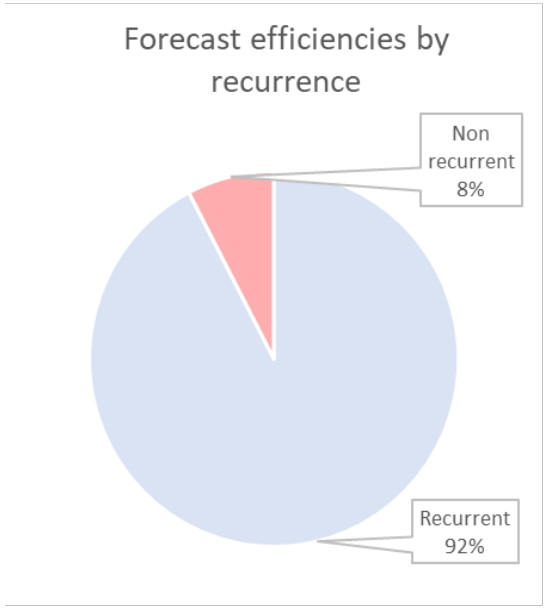
- In month, the ICB position is showing a break-even position on these NHS services, and a break-even position has also been reflected as the forecast year-end position.

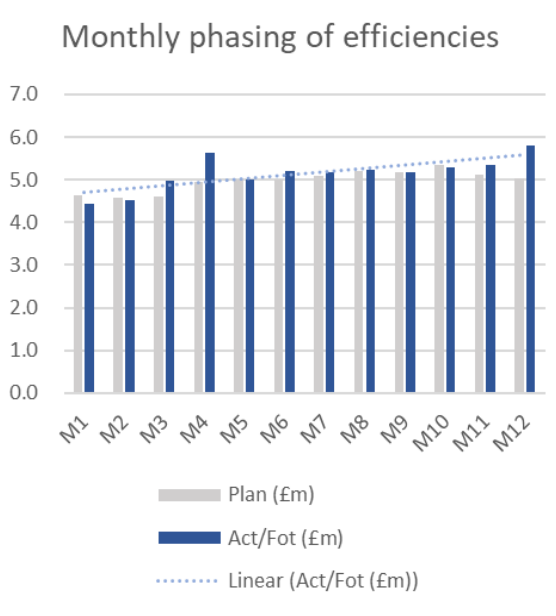
9. ICB Efficiency Schemes at as Month 10

NHS South East London

	Year-to-Date			Forecast			Forecast (Risk)			Forecast (Recurrance)		Forecast (cash releasing)		Forecast
	Plan	Actual	Variance	Plan	Forecast	Variance	Low	Medium	High	Recurrent	Non-recurrent	Cash Releasing	Non-cash Releasing	FYE
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	6.4	6.6	0.2	7.7	7.9	0.2	7.9	0.0	0.0	7.9	0.0	4.8	3.1	7.9
Bromley	10.9	10.9	(0.0)	13.1	13.1	0.0	8.6	3.9	0.6	11.6	1.5	12.5	0.6	11.6
Greenwich	7.0	7.9	0.9	8.4	9.6	1.1	7.4	1.2	1.0	7.7	1.9	2.3	7.3	7.7
Lambeth	10.5	9.8	(0.7)	12.6	12.5	(0.0)	0.9	9.2	2.4	11.5	1.1	4.7	7.8	11.5
Lewisham	7.5	8.2	0.8	9.0	9.8	0.8	3.0	6.7	0.0	9.8	0.0	9.8	0.0	9.8
Southwark	7.2	7.2	(0.0)	8.9	8.9	0.0	8.0	0.6	0.2	8.6	0.2	8.6	0.3	8.6
SEL ICB Total	**49.6**	**50.7**	**1.1**	**59.7**	**61.8**	**2.1**	**35.9**	**21.7**	**4.2**	**57.1**	**4.7**	**42.7**	**19.1**	**57.1**

- The 6 places within the ICB have a total savings plan for 2025/26 of **£59,700k.** In common with the previous financial year, the key elements of the savings plans are in Primary Care, continuing healthcare and Community Healthcare.
- The table above sets out the YTD and forecast status of the ICB's efficiency scheme as at month 10.
- **As at month 10, the ICB is reporting actual delivery of £50,700k which is ahead of plan (£1,100k).** The forecast is to deliver annual savings of **£61,800k** and exceed the efficiency plan by **£2.1m.**
- The current risk rating of the efficiency plan is also reported. At this stage in the year, **£4.2m** of the forecast outturn of has been assessed by the places as **high risk.**
- Most of the savings **(92%)** are forecast to be delivered on a recurrent basis.





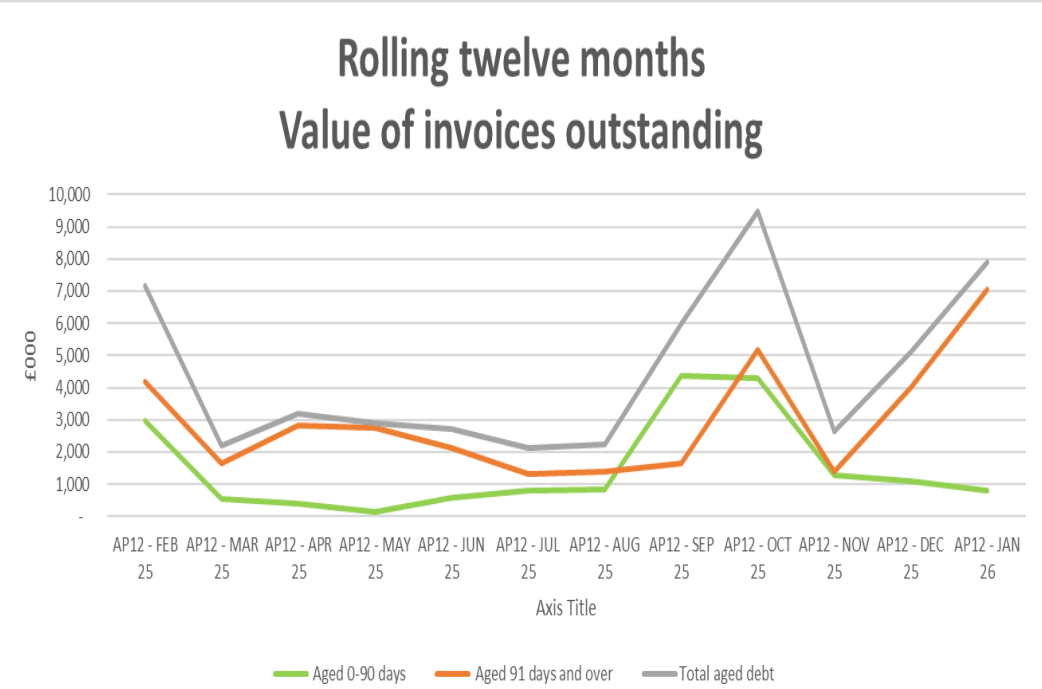
10. Corporate Costs – Programme and Running Costs

NHS South East London

	Annual Budget	Year to Date		
		Budget	Actual	Variance
Boroughs	£			
Bexley	3,028,897	2,524,079	2,303,079	221,000
Bromley	3,785,075	3,105,025	2,890,025	215,000
Greenwich	3,522,109	2,935,089	2,753,090	182,000
Lambeth	4,666,340	3,888,617	3,864,617	24,000
Lewisham	3,325,012	2,770,841	2,701,841	69,000
Southwark	4,139,792	3,449,827	3,233,826	216,000
Subtotal	22,467,225	18,673,479	17,746,478	927,001
Central				
CESEL	483,829	403,192	344,333	58,860
Chief of Staff	3,376,578	2,813,814	2,651,831	161,983
Comms & Engagement	1,755,377	1,462,813	1,483,044	(20,231)
Digital	1,751,562	1,459,635	1,079,881	379,755
Digital - IM&T	3,362,066	2,801,723	2,684,002	117,721
Estates	698,304	581,920	740,406	(158,486)
Executive Team/GB	2,617,895	2,181,580	2,039,505	142,075
Finance	2,940,949	2,450,790	2,151,845	298,946
General Reserves	0	0	0	0
London ICS Network	0	0	0	0
Medical Director - CCPL	1,651,050	1,375,876	1,226,068	149,807
Medical Director - ICS	288,359	240,299	175,958	64,341
Medicines Optimisation	4,723,418	3,936,182	3,341,948	594,233
Planning & Commissioning	8,929,703	7,441,419	6,545,908	895,511
Quality & Nursing	2,058,615	1,715,514	1,635,604	79,910
SEL Other	0	0	32,802	(32,802)
Other Corporate Budgets inc Non Pay	4,349,984	3,624,987	3,791,147	(166,160)
Subtotal	38,987,689	32,489,744	29,924,281	2,565,462
Grand Total	61,454,914	51,163,222	47,670,759	3,492,463

- The table shows the YTD month 10 position on programme and running cost corporate budgets.
- **Overall, the ICB is reporting an overall YTD underspend on its corporate costs of circa £3,492k. This is largely a result of vacant posts.** Recruitment to vacant posts is being considered on a case-by-case basis. Overall, the estates budget is in balance with offsetting pay and non-pay over and underspends.
- As highlighted in earlier slides, the ICB is **underspending £6,999k YTD and £7,164 FOT** against its management (running) costs allocation of £47,184k. The allocation having increased in-month for redundancy costs, and pension contribution funding.
- The ICB is continuing to incur the pay costs for some staff at risk from the original MCR process. These costs are excluded from the table opposite, as expenditure is being charged to the provision made for the final pay and redundancy costs for these staff.
- The process of issuing notices to at risk staff has largely been completed with most of redundancy payments now having been made. Some staff left the ICB in June, which leaves just a small number of people who remain but have been displaced through this process.
- Work is ongoing to comply with latest request to restructure the ICB as per the NHSE blueprint document. Consultation is expected to begin in early March. The outcome of the blind voluntary redundancy scheme is now known and an accrual made. The month 10 accounts included the total estimated provision for redundancy costs and notice periods.

11. Debtors Position



Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	591	78	0	0	0	144	813
Non-NHS	6,366	683	20	0	0	1	7,070
Unallocated	0	0	0	0	0	0	0
Total	**6,957**	**761**	**20**	**0**	**0**	**145**	**7,883**

- The ICB has an overall debt position of **£7,883k** at month 10. This is circa **£2,483k higher** than last month and is a result of the planned raising of invoices for quarters 3 and 4 to ensure where possible cash is received in year. Overall, the age profile of debtors has improved from last month with circa **£145k** over 90 days.
- **The largest debtor values are with partner organisations and the ICB does not envisage any risk associated with settlement of these items.**
- The ICB has implemented a BAU approach to debt management, focusing on ensuring recovery of its larger debts, and in minimising debts over 3 months old. Regular meetings with SBS are assisting in the collection of debt, with a focus on debt over 90 days.
- The top 10 aged debtors are provided in the table below:

Number	Supplier Name	Total Value £000	Aged 0-90 days Value £000	Aged 91 days and over Value £000
1	LONDON BOROUGH OF BROMLEY	3,161	3,161	-
2	LAMBETH LONDON BOROUGH COUNCIL	2,608	2,608	-
3	NHS SOUTH WEST LONDON ICB	545	445	100
4	CHIESI LTD	508	508	-
5	SOUTHWARK LONDON BOROUGH COUNCIL	478	478	-
6	LEWISHAM LONDON BOROUGH COUNCIL	284	284	-
7	LEWISHAM AND GREENWICH NHS TRUST	146	146	-
8	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	78	34	44
9	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FT	44	44	-
10	ETHYPHARM UK LTD	22	22	-

12. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at month 10 was **£5,886,361k**. The MCD available as at month 10, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing, community pharmacy and primary care dental expenditure) was **£1,052,723k**.
- As at month 10 the ICB had drawn-down 82.1% of the available cash compared to the budget cash figure of 83.3%. In month 10, the ICB did not need to request a supplementary cash drawdown, nor has it in February. A supplementary cash drawdown was requested for April 2025, to clear old year creditors.
- The cash key performance indicator (KPI) has been achieved in all months so far this year, showing continued successful management of the cash position by the ICB's Finance team. The actual cash balance at the end of Month 10 was **£341k**, well within the target set by NHSE **(£5,663k). The ICB expects to utilise its cash limit in full by the year end.**
- ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. To date the ICB has met the BPPC targets each month, and it is expected that these targets will be met in full both each month and cumulatively at the end of the financial year.

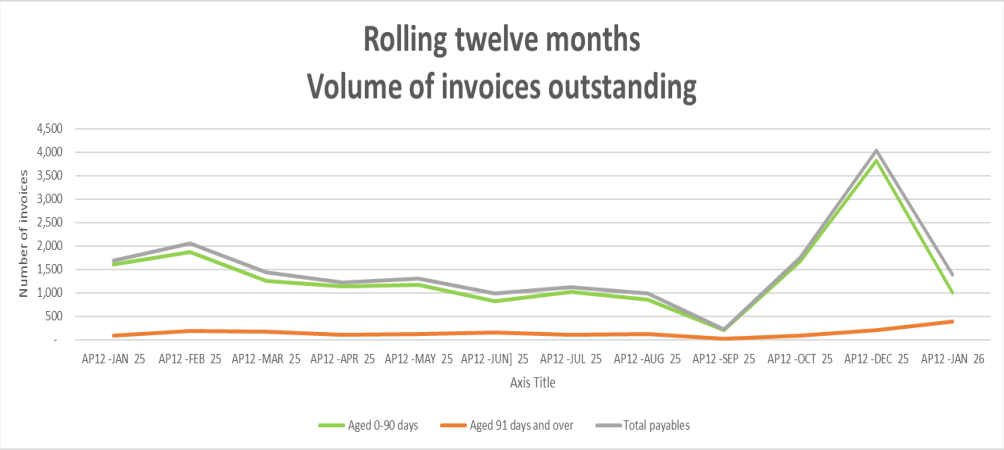
ICB Annual Cash Drawdown Requirement for	2025/26 AP10 - JAN 26	2025/26 AP9 - DEC 25	2025/26 Month on month movement
	£000s	£000s	£000s
ICB ACDR	5,886,361	5,820,360	66,001
Capital allocation	0	0	0
Less:			
Cash drawn down	(4,489,000)	(4,036,000)	(453,000)
Dental	(85,275)	(75,832)	(9,443)
HOT	(1,782)	(1,670)	(112)
Prescription Pricing	(253,631)	(225,086)	(28,545)
Pay Award charges			0
PCSE POD charges			0
Pension Uplift	(3,952)		(3,952)
Remaining Cash limit	**1,052,723**	**1,481,773**	**(429,050)**

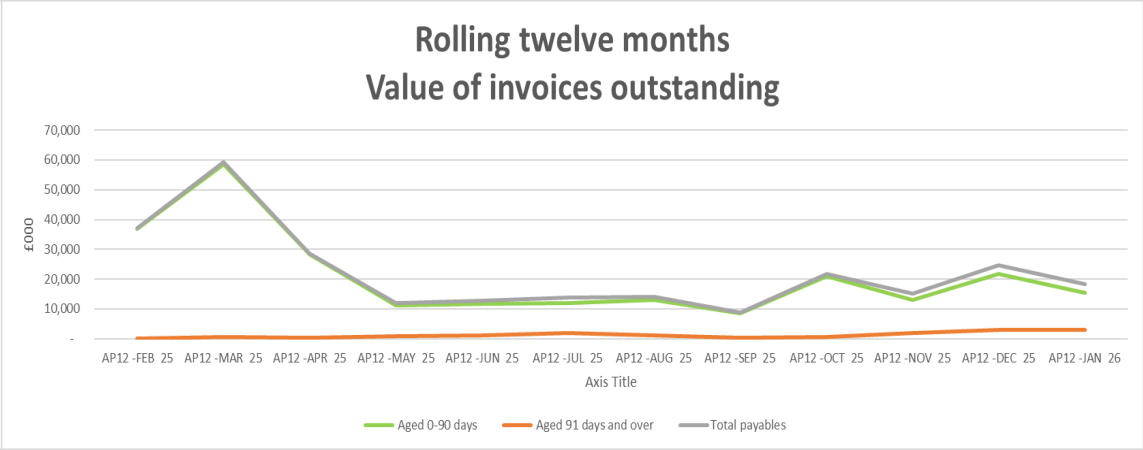
Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR cummulative %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-25	435,000	20,000	455,000	8.70%	5,438	50	0.01%
May-25	455,000	0	910,000	17.10%	5,688	2,164	0.48%
Jun-25	440,000	0	1,350,000	25.70%	5,500	2,178	0.49%
Jul-25	445,000	0	1,795,000	33.39%	5,563	1,665	0.37%
Aug-25	458,000	0	2,253,000	41.90%	5,725	1,317	0.29%
Sep-25	460,000	0	2,713,000	50.30%	5,750	577	0.13%
Oct-25	435,000	0	3,148,000	58.37%	5,438	5,135	1.18%
Nov-25	448,000	0	3,596,000	66.70%	5,600	2,958	0.66%
Dec-25	440,000	0	4,036,000	74.54%	5,500	3,285	0.75%
Jan-26	453,000	0	4,489,000	82.12%	5,663	341	0.08%
Feb-26	470,000	0	4,959,000		5,875		
Mar-26							
4,939,000	**20,000**						

13. Aged Creditors

- The new ledger (ISFE2) was implemented on 1st October 2025 and the ICB only had circa 200 invoices on the system. During the transition, invoices were not scanned onto the system and so at go live there was a backlog of invoices to be processed onto the system. At the end of January as the graph below shows, the ICB had circa 1,386 outstanding invoices which is less than the previous month which is encouraging. The table below shows that there are £3,015k of invoices outstanding which are over 90 days, most of which are non-NHS. This represents an increase of £25k from last month. These items will be reviewed as a matter of urgency as we continue our focus on clearing old invoices in the new ledger. The overall value of creditors (£18,438k) has decreased by circa £6,281k from last month which again is very positive. The Finance team continues to actively support budget holders to resolve queries with suppliers as they start to use the new ledger with the aim of reducing the number and value of outstanding invoices by year end as colleagues become more familiar with the system and it becomes BAU.
- As part of routine monthly reporting, high value invoices are being reviewed on a regular basis to establish if they can be settled quickly, and budget holders are being reminded on a constant basis to review their workflows.

Customer Group	Aged 0-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121-180 days £000	Aged 181+ days £000	Total £000
NHS	1,520	361	382	127	134	179	2,703
Non-NHS	10,493	1,963	704	725	1,069	781	15,735
Total	**12,013**	**2,324**	**1,086**	**852**	**1,203**	**960**	**18,438**





14. Mental Health Investment Standard (MHIS) – 2025/26

South East London

Mental Health Investment Standard (excluding LD and Dementia) and delegated Specialised Commissioning Mental Health Investment Standard:		2_1Achieve01	2_1PLAN%01	2_1AuditedPY	2_1TARGET01	2_1ACT02	2_1VAR%01	2_1VAR02	2_1Achieve02	2_1POP01	2_1Achieve03	2_1SCMHISAuditedPY	2_1TARGET02	2_1ACT03	2_1SCMHISVAR%01
		MHIS Achieved per plans submitted 09/05/2025	2025/26 allocation growth	2024/25 Outturn	Target MHIS spend 2025/26	FOT 2025/26	Excess/Shortfall in 2025/26 MHIS Delivery %	Excess/Shortfall in 2025/26 MHIS Delivery	MHIS Achieved in 2025/26?	Projected Population 2025/26	SCMHIS Achieved per plans submitted 09/05/2025	2024/25 SCMHIS Outturn	Target SCMHIS spend 2025/26	SCMHIS FOT 2025/26	Excess/Shortfall in 2025/26 SCMHIS Delivery %
		Desc	Plan	Actual	Target	Forecast	Actual	Actual	Desc	YTD	Desc	Actual	Target	Forecast	Actual
		31/03/2026	31/03/2026	31/03/2025	31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2025	31/03/2026	31/03/2026	31/03/2026
	Expected Sign	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending
		TEXT	%	£'000	£'000	£'000	%	£'000	TEXT	Number	TEXT	£'000	£'000	£'000	%
MHIS Achievement	+/-	Yes	4.93%	471,495	537,494	549,722	2.27%	12,228	Yes	2,755,228	Yes		89,920	91,032	1.24%

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2024/25 outturn by a **minimum of the growth uplift of 4.93%, a target of £537,494k. These figures were updated in month 4 to allow for the current year pay awards.** This spend is subject to the usual annual independent review.

- There are two changes in the MHIS target for 2025/26:
  - the MHIS target now includes £42,754k of Service Development Funding (SDF) transferred into the ICB baseline.
  - there is now a separate MHIS target for Delegated Specialised Commissioning of £89,325k where responsibility has been transferred to the ICB from NHSE for services delivered through contracts managed by the South London Partnership (the Mental Health Provider Collaborative).

- MHIS excludes:
  - spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements.
  - spend on SDF and other non-recurrent allocations, noting that the majority of SDF funding has been transferred into the ICB baseline.

- The 2025/26 planned spend exceeds the MHIS target as result of funding to support financial recovery and further investment in areas formerly funded through SDF and forming part of ICB core allocations.

- **As at Month 10 we are forecasting MHIS delivery of £549,722k, exceeding the target by £12,228k (2.27%). This is consistent with the planned over-delivery as described above. This is summarised in the above table.**

14. Mental Health Investment Standard (MHIS) – 2025/26

NHS South East London

Risks and Mitigations

- We continue to see growth in mental health cost per case spend, in terms of client numbers, cost and complexity, for example on S117 placements. Mitigating actions include ensuring that timely client reviews are undertaken, reviewing and strengthening joint funding panel arrangements and developing new services and pathways. For Lambeth, Southwark and Lewisham (LSL) clients in particular, work is being undertaken collaboratively with SLaM and SLP to review the complex care client cohort.

- Learning disability placements costs continue to grow in some boroughs, with an increase in the complexity of some care packages being seen. Mitigating actions include reviewing LD cost per case activity across health and social care to understand care package costs, planning for future patient discharges to agree funding approaches, developing new services to prevent admissions and seeking to implement risk share agreements.

- ADHD is outside the MHIS definition and is therefore excluded from this reported position. There is, however, significant and increasing independent sector spend on both ADHD and ASD services, with expenditure exceeding £4,500k across a growing number of independent sector providers for Right to Choose referrals.

  The following actions are being taken:
  - increasing local provider capacity to reduce waiting times.
  - working with local providers across adult and CYP ADHD services to review and transform care pathways to create sustainable services.
  - undertaking an accreditation process to ensure the quality and VFM of independent sector providers.
  - working to agree contracts with high value independent sector providers to attempt to mitigate financial risk and ensure quality.

SEL ICB Finance Report

Updates from Boroughs

Month 10

Appendix 1 – Bexley

NHS South East London

Overall Position

	Year to date Budget	Year to date Actual	Year to date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	4,413	4,344	69	5,295	5,212	83
Community Health Services	21,753	21,527	226	26,104	25,861	243
Mental Health Services	9,221	9,975	(754)	11,065	12,009	(944)
Continuing Care Services	22,258	21,663	595	26,709	25,985	724
Prescribing	32,718	33,550	(832)	39,134	40,006	(872)
Other Primary Care Services	1,278	1,308	(30)	1,534	1,570	(36)
Other Programme Services	1,021	500	521	1,225	600	625
Delegated Primary Care Services	41,386	41,386	0	49,664	49,663	0
Corporate Budgets	2,524	2,303	221	3,029	2,775	254
Total	**136,572**	**136,557**	**15**	**163,759**	**163,682**	**77**

- As at Month 10 (January 2026) Bexley place is reporting an underspend of £15k year to date and £77k full year forecast.
- Mental Health Services is reporting an overspend of £754k year to date and £944k full year forecast. The overspend is driven by an increase in spend relating to section 117 mental health and learning disabilities cost per case placements. The position also includes a material overspend on the right to choose ADHD and ASD assessments conducted by private providers. This activity has been increasing significantly overtime and creating a cost pressure which is impacting all boroughs in the ICB. Work is being undertaken across all boroughs to identify options to mitigate the cost pressure going into the next financial year.
- Continuing Care is reporting an underspend of £595k year to date and £724k full year forecast. Continuing Care has seen a reduction in costs this financial year and this is due to the number of care packages reducing as well as savings achieved following Continuing Care reviews conducted by the team.
- Prescribing is reporting an overspend of £832k year to date and £872k full year forecast. Prescribing data is provided two months in arrears; therefore, the financial position includes an estimate for this period. The main drivers for the current position are increased costs relating to endocrine (especially diabetes and GLP-1s such as tirzepatide), flash glucose monitoring and appliances such as catheters. Work is ongoing by the medicines management team to deliver efficiencies to improve the financial position. The forecast spend includes a run-rate improvement due to the favourable financial impact of the drug Dapagliflozin coming off patent during the year.
- Delegated primary care is a ring-fenced allocation across the ICB, therefore any variances at individual places have been equalised to reflect a breakeven position. Without equalisation of budgets across the ICB, Bexley place is forecasted to underspend by £249k for the year based on the latest list size data.
- Other Programme services budget is reporting a forecast full year underspend of £625k. This is following the release of uncommitted growth funding to mitigate the cost pressures being seen in the overall Bexley place budgets.
- Corporate budgets are reporting an underspend of £221k year to date and £254k full year forecast. The underspend is a result of vacant posts which cannot be recruited to due to the recruitment freeze as per the current ongoing ICB change programme.
- Acute and Community Services is reporting small underspends against several services.
- Bexley place has an annual efficiency plan of £7,750k which is forecasted to deliver in full by year end.

Appendix 2 – Bromley

NHS South East London

Overall Position

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	ICB Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	6,953	6,540	413	8,344	7,875	468
Community Health Services	79,971	79,075	896	95,904	94,944	961
Mental Health Services	12,739	13,894	(1,155)	15,287	16,538	(1,251)
Continuing Care Services	23,447	24,604	(1,157)	28,137	29,575	(1,438)
Prescribing	44,011	43,759	252	52,642	52,046	595
Other Primary Care Services	1,691	1,524	167	2,029	1,829	200
Delegated Primary Care Services	59,277	58,426	851	71,132	70,111	1,021
Corporate Budgets	3,104	2,888	215	3,785	3,560	225
Total	**231,193**	**230,711**	**482**	**277,259**	**276,478**	**782**
Adjustments						
Delegated Primary Care - Equalisation			(851)			(1,021)
Non recurrent ICES support						240
Total FOT			**(369)**			**0**

- The borough is forecasting a breakeven position at year end.
- The Acute Services position is forecasting a £468k underspend due the release of un-committed budget and savings expected from non-Bromley UTC contracts.
- The Community budget is forecasting an £961k underspend. This position includes the release of un-committed budgets and non-recurrent savings.
- The Mental Health budget is forecasting a £1,251k overspend due to pressures on diagnostic assessments and cost per case budgets. The former is forecasting a £794k overspend due to the significant year on year growth in expenditure. The actual forecast spend for the year is £1m, two years ago (2023/24) it was less than £200k.
- The Continuing Healthcare budget is £1,157k overspent year to date and the forecast is £1,438k overspent. This is due to a continuation of the increase in adult CHC and FNC client numbers in recent years due to additional capacity within the borough, combined with price increases above budgeted levels.
- The Prescribing budget is forecasting an £595k underspend. This is an estimated position based upon eight months of PPA data. Based upon previous years trends the overspend may reduce in the final few months of the year.
- The Delegated Primary Care Services forecast is breakeven will be reviewed each month and be adjusted for quarterly list size changes. Variances in this area are not available to boroughs as this is currently a ringfenced allocation that is managed across the ICB.
- The 2025/26 borough savings requirement is £13,130k. At month 10 the borough is reporting an under delivery of £21k against plan and the year end forecast is breakeven.

Appendix 3 – Greenwich

NHS South East London

Overall Position

Description	Annual Budget £'000s	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	7,091	5,909	5,923	(14)	7,108	(16)
Community Health Services	41,144	34,286	34,194	92	41,033	111
Mental Health Services	8,879	7,399	9,389	(1,990)	11,528	(2,649)
Continuing Care Services	30,307	25,256	25,322	(66)	30,111	196
Prescribing	38,454	32,149	33,359	(1,210)	40,027	(1,573)
Other Primary Care Services	1,929	1,608	1,470	137	1,764	165
Other (Neighbourhood) Programme	1,795	1,496	0	1,496	0	1,795
Programme Wide Projects	0	0	(1,333)	1,333	(1,600)	1,600
Delegated Primary Care Services	63,555	52,962	53,379	(416)	64,054	(499)
Corporate Budgets	3,522	2,935	2,753	182	3,274	248
Sub-Total	**196,675**	**164,000**	**164,456**	**(456)**	**197,299**	**(624)**
Greenwich - Control Total				**(416)**		**(624)**
Variance to Control Total				**(40)**		**0**

- The overall Greenwich financial position is £40k adverse to the year-to-date (control total) plan, with a forecast breakeven.
- The Prescribing position is reporting £1,210k adverse year to date and is attributable to price inflationary pressures. There is mitigation with the drug Dapagliflozin coming off-patent in conjunction with targeted deep dives on identified Practices through local financial recovery board meetings.
- Mental Health is £1,990k overspent to date and is attributable to additional joint funded (S117) clients alongside continuing pressure through the 'right to choose' patient pathway for ASD/ADHD assessments. Mitigations are being explored through repatriation of placements to other boroughs (incl. non-SEL) alongside assessment capacity discussions with Oxleas.
- The £1,333k favourable variance on programme services (neighbourhood investment) reflects no spend incurred to date and is in mitigation for pressures elsewhere. The opportunity cost in balancing in-year pressures is the prospective on MTFS delivery noting this is predicated on OOH activity shift through neighbourhood investment
- Delegated Primary Care is reported £416k overspent to date, attributable to core contractual payments informed by registered GP list size.
- Community services is £92k favourable to plan and reflects the delivery of planned savings in line with plan and in support of the overall financial position.

Appendix 4 – Lambeth

NHS South East London

Overall Position

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	539	539	0	646	573	73
Community Health Services	25,576	25,638	(61)	30,692	30,765	(73)
Mental Health Services	20,597	21,907	(1,310)	24,717	26,462	(1,746)
Continuing Care Services	29,925	28,464	1,461	35,911	33,928	1,982
Prescribing	36,785	37,272	(487)	43,998	44,703	(705)
Other Primary Care Services	3,324	2,726	598	3,989	3,271	718
Delegated Primary Care Services	80,379	80,573	(194)	96,454	96,687	(233)
Corporate Budgets	3,889	3,865	24	4,666	4,664	2
Total	201,014	200,983	31	241,072	241,054	18
Equalisation of Ring Fence Delegated Primary Care			194			233
Revised Full Year Forecast Variance			**225**			**251**

- The borough is reporting an overall £225k year to date underspend position and a forecast £251k underspend position at Month 10 (January 2026) after the "equalisation" of the ring fenced delegated primary care budgets. The reported forecast position includes £1,746k overspend on Mental Health Services and £705k overspend on Prescribing offset by underspend on Continuing Health Care (CHC) Services and Primary Care Services.

- The key risks within the 2025-26 Lambeth's finance position are exponential growth in referrals to independent sector providers for ADHD & ASD assessments and Mental Health Cost Per Case. Further risks remain associated with demand driven budgets (Mental Health and Learning Disability Services, Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Prescribing and Continuing Health Care Services).

- Mental Health budget year to date and forecast overspend is mainly driven by increased ADHD and ASD assessments under the Right to Choose process (the forecast expenditure at M10 for this specific budget is £2.7m overspend) and Mental Health placements expenditure mitigated by constraining investments. Borough Commissioners leading on efficiency and productivity schemes including right sizing projects with providers to enable service users to live more independently through either stepping down restrictive levels of care or moving to more independent settings.

- Delegated Primary Care Services is reporting a forecasted breakeven position after the "equalisation" of the ring fenced delegated primary care budgets at month 10, noting previous year (2024-25) overspend position was driven by locum reimbursements, retainer scheme and list size growth.

- The Continuing Healthcare budget is forecasting £1,982k underspend as the CHC team continues to deliver on reviewing high-cost packages and out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M10 is 532.

- Prescribing actual data is available two months in arrears and the borough is reporting a £705k forecast overspend position against in year budget at month 10 based on eight months actual data.

- The borough 2025-26 minimum (5%) efficiency and productivity target is £11.3m and has a savings plan of £12.6m. In addition to the embedded efficiency (£5.6m) as part of the budget setting process, the borough has saving plans for Continuing Healthcare (£1.9m), Prescribing (£1.1m) and Mental Health Services Learning Disability Services (1.2m). The borough efficiency and productivity target is forecasting an adverse variance of £32k.

Appendix 5 - Lewisham

NHS South East London

Overall Position

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	735	761	(26)	882	913	(31)
Community Health Services	29,533	25,787	3,746	35,440	30,792	4,647
Mental Health Services	6,641	7,561	(921)	7,969	8,956	(987)
Continuing Care Services	21,182	22,860	(1,678)	25,418	27,417	(1,998)
Prescribing	36,718	38,725	(2,007)	43,920	46,584	(2,664)
Prescribing Reserves	0	(610)	610	0	(712)	712
Other Primary Care Services	1,784	1,577	207	2,140	1,892	248
Other Programme Services	21	22	(0)	26	26	0
Delegated Primary Care Services	60,530	60,283	246	72,635	72,340	295
Corporate Budgets	2,771	2,702	69	3,325	3,251	74
Total	**159,914**	**159,668**	**246**	**191,755**	**191,459**	**296**
Delegated Primary Care - not available balances across ICB			**(246)**			**(296)**
Total FOT			**0**			**(0)**

- At month 10, the borough is reporting breakeven year to date (YTD) and on a forecast outturn (FOT) basis. Mental health, continuing care services (CHC) and prescribing all show material overspends with a smaller overspend on acute services. These are offset by favourable positions on other budget lines, mainly community services reflecting cumulative savings achieved.

- CHC shows a material overspend YTD of £1,678k and FOT overspend of £1,998k. The run rate on CHC has improved on the closing position from 2024/25, reflecting actions taken through the Lewisham recovery meetings which are now held monthly. This position is a significant improvement on the overspend reported in the same period in the prior year 2024/25 (Month 10 YTD £2,956k and actual outturn £4,028k). The borough is continuing to make good progress on reviews and strengthening further financial controls and database integrity. Whilst the overspends remain high, the benefit of this work is reflected in over achievement of the 5% savings target. The forecast over delivery of £792k in Lewisham reflects the focused work outlined above and partially accounts for the improved position to budget in 2025/26 compared to the prior year.

- The mental health position is driven mainly by costs incurred with independent providers for ADHD which are reflecting a significant increase in demand for these services impacting all places across SEL. The forecast outturn on these costs shows an overspend of £2,356k. The ICB has implemented a referrals triage system which commenced in November. It is hoped this system will start to slow down the growth in these costs. The pressure is currently being mitigated from other budget lines within mental health and the wider delegated budget.

- Prescribing activity data to month 8 is available. This is reflected in the month 10 YTD position and the forecast outturn. The key cost drivers include appliances e.g. freestyle libre sensors, endocrine products and stoma appliances. The borough has identified further mitigations of £806k above the 5% efficiency target and these are being delivered to try to reduce these costs closer to budget.

- Delegated primary care is forecast to underspend by £296k. However, since the ICB receives funding for delegated primary care as a ring- fenced allocation, the underspend cannot be utilised to offset other pressures. Therefore, this has been adjusted out of the position to ensure the ICB overall breaks even on delegated primary care.

- The borough 5% efficiency target is £8,975k, is fully identified, and is forecast to over-achieve for the year reflecting the CHC position referenced above.

Appendix 6 – Southwark

NHS South East London

Overall Position

Service Area	YTD Budget	YTD Actual	YTD Variance	FOT Budget	FOT Actual	FOT Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	201	236	(35)	242	283	(42)
Community Health Services	32,063	29,608	2,455	38,476	35,227	3,249
Mental Health Services	9,084	11,237	(2,154)	10,900	13,696	(2,795)
Continuing Care Services	17,098	16,512	585	20,517	19,838	680
Prescribing	30,272	31,972	(1,700)	36,208	38,376	(2,168)
Prescribing Reserves (Non PPA)	-	-	-	-	-	-
Other Primary Care Services	789	764	25	947	916	30
Other Programme Services	727	-	727	872	-	872
Programme Wide Projects	216	216	-	259	259	-
Delegated Primary Care Services	64,641	64,596	45	77,569	77,515	54
Corporate Budgets	3,450	3,234	216	4,140	3,899	241
Total	**158,539**	**158,374**	**165**	**190,129**	**190,009**	**120**
Delegated P/Care Equalisation			**(45)**			**(54)**
Revised Total			**120**			**66**

- As at month 10 the borough is reporting a year-to-date underspend of £120k and forecast outturn underspend of £66k. Material overspends continue to be reported in mental health and prescribing with smaller overspend in acute services. These are offset by underspends in continuing healthcare, corporate budgets, other programme and other community services.

- The boroughs most significant risk continues to be in Mental Health and Prescribing. For Mental Health we are reporting a year to date overspend of £2,154k and a forecast overspend of £2,795k. The forecast position has deteriorated from previous month. This is driven mainly by overspends in two areas:

- Right to Choose adult ADHD/Autism pathways. Increased expenditure with independent providers on mainly adult ADHD/ASD. Our forecast overspend in mental health includes an overspend of circa £2,500k on Right to Choose adult ADHD/ASD. This pressure is being mitigated from other budget lines particularly community services. The ICB has implemented a triage referral system, which it is hoped will reduce the rate of increase in expenditure for ADHD/ASD. Commissioning leads are considering commissioning and contracting options as part of our planning process for 2026/27.

- Placements costs for Learning disability continues to be a cost pressures. Increase in children's placements and additional enhanced support results in significant costs. Savings plans in mental health have delivered some savings which are supporting the overall position.

- Prescribing actual data is provided two months in arrears and the borough is reporting a forecast overspend of £2,168k as at month 10. This forecast position is as a small increase from previous month. Prescribing continues to be impacted by increase in expenditure relating to long term conditions drug prescribing, case finding and active health programmes identifying patients eligible for treatment in each borough. There are also some national price increases due to shortages for some specific drugs.

- Continuing care forecast position is an underspend of £680k and this reflects the savings delivered in high-cost packages and other planned savings. However, continuing healthcare is a volatile area with ongoing retrospective reviews and appeals.

- The Borough's 5% efficiency savings amounts to circa £8,800k and has been identified in full. As at month 10 (January) we are forecasting full delivery of savings. To mitigate the cost pressures in Southwark, reserves, and uncommitted budgets have been released and growth in community services has been restricted to manage the overall position.

NHS
South East London

Appendix B

SEL ICS Financial Highlights

Month 10 2025/26

South East London Integrated Care System

NHS South East London

Executive Summary

- This appendix sets out the month 10 financial position of the ICS.
- At month 10, the ICS is reporting a YTD deficit of (£16.2m), £5.8m ahead of plan. This reflects a £2.9m improvement compared to month 9. The main improvement is largely driven by the net impact of NHSE industrial action (IA) funding (£0.7m) and improved contractual performance (£1.8m).
- As at month 10, all organisations are forecasting a break-even year-end position in line with the overall ICS financial plan submitted on 30 April.
- The forecast underlying position included in the 2025/26 planning submission was £255.0m. As at month 10, the forecast is an underlying deficit of £284.2m, an adverse movement of £29.1m against plan. This reflects non delivery of CIP plans (£17.5m) and cost pressures within pay and non-pay run rates (£15.5m), at one of the providers.
- The following slide shows a bridge from YTD plan to actual.

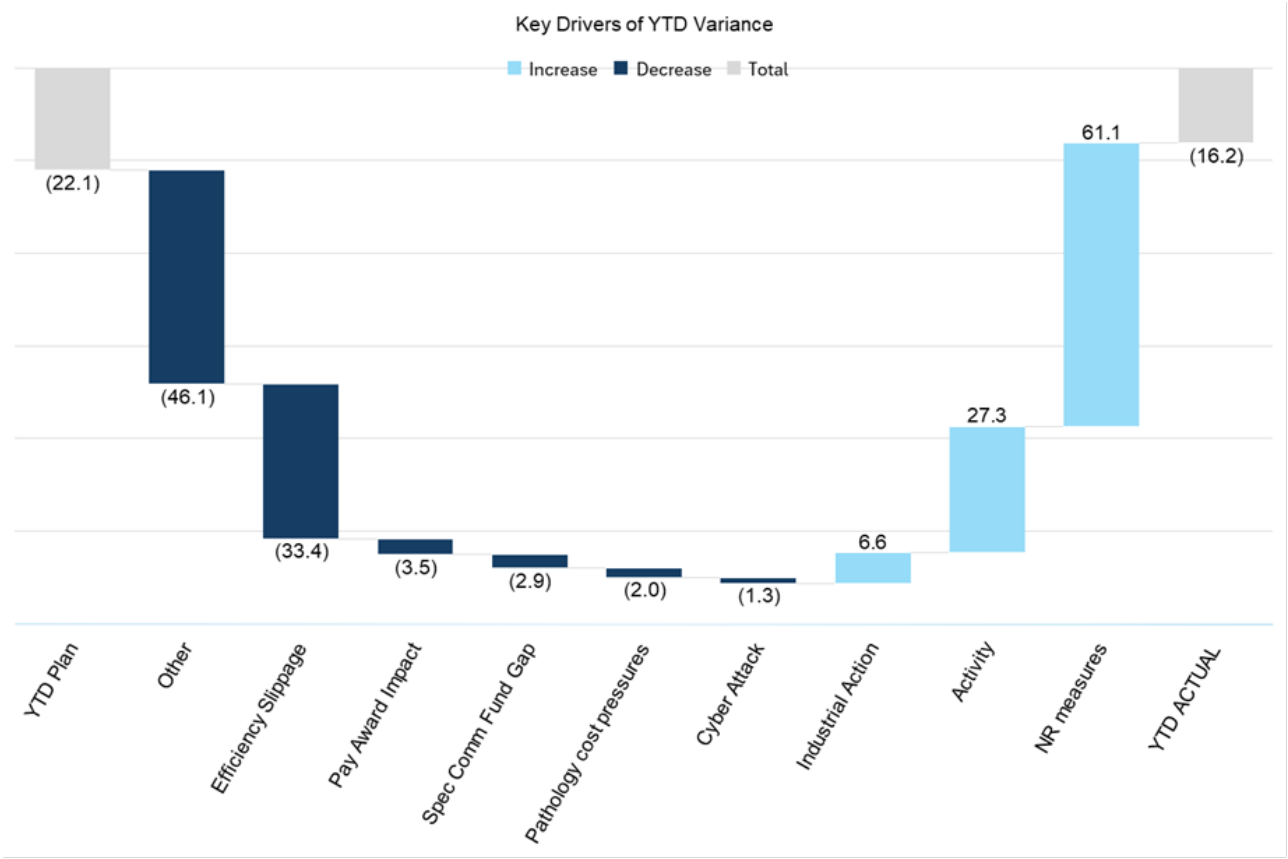
Analysis of month 10 YTD Position

South East London Integrated Care System

NHS South East London

At Month 10, SEL ICS is reporting a **year-to-date deficit of (£16.2m), £5.8m ahead of plan. This represents a £2.9m improvement compared to month 9.** The position is driven by the following factors:

- Efficiency slippage across providers: £33.4m
- Other impacts: £46.1m
  - Includes £29.4 on clinical supplies overspends driven by inflationary and activity pressures.
  - £17.5m balance sheet flex timing.
  - Offset by net £0.8m non-recurrent mitigations across providers.
- Cost pressures: £9.7m
  - £3.5m – Pay award impact.
  - £2.9m – Specialised commissioning funding gap.
  - £2.0m – Pathology year-to-date pressures due to delayed price reductions.
  - £1.3m – Legal costs related to prior-year cyber attack.
- Offsetting Benefits
  - £61.1m non-recurrent mitigations.
  - £27.3m increased activity income against plan.
  - £6.6m upside across providers for NHSE IA funding (Nov & Dec).



Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 14
Enclosure 12

Title:	**Primary Care Group Chairs Report**
Meeting Date:	26 March 2026
Author:	Chima Olugh, Neighbourhood Development Manager
Executive Lead:	Ceri Jacob, Place Executive Lead

Purpose of paper:	The purpose of this report is to provide the Lewisham Local Care Partnership with an update on key primary care priorities discussed the Primary Care Group.	Update / Information	✓
		Discussion	
		Decision	
Summary of main points:	The following items were discussed at the January, February and March 2026 Primary Care Group meetings: 1. Lewisham Digital Flexible Staffing Pool Considerations 26/27 2. 2025/26 PCN Capacity and Access Improvement Payment 3. Triangle Group Practice Contract Novation 4. 2026/27 Local Incentive Schemes a) Primary Care Diabetes Injectables Initiation Scheme b) Practice-based Phlebotomy Service c) South East London Medicines Optimisation Plan All items listed are contractual in nature.		
Potential Conflicts of Interest	There are no conflicts of Interest as the paper is solely for information purposes.		
Any impact on BLACHIR recommendations	**NA**		

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

	Equality Impact	NA
	Financial Impact	NA
Other Engagement	Public Engagement	NA

	Other Committee Discussion/ Engagement	None
Recommendation:	The Lewisham Local Care Partners Strategic Board is asked to note the report.	

1. Lewisham Digital Flexible Staffing Pool Considerations 26/27

The Primary Care Group was asked to consider and approve a commissioning option for the South East London (SEL) Digital Flexible Staffing Pool for 2026/27

The SEL Digital Flexible Staffing Pool was established in 2022 and was designed to mitigate local workforce pressures by providing a coordinated and flexible pool of GPs who could be deployed to practices experiencing staffing gaps. It was also designed to increase capacity, lower costs and reduce administrative burden for staff.

As part of the service, practices have access to over 300 GPs and other staff types (including practice nurses, advanced nurse practitioners and healthcare assistants) in the area who can work across the boroughs to support practices to fill their locum shifts.

The service is currently funded across five SEL boroughs (£20k per borough), however the contract with the provider, Lantum, expires at the end of March 2026.

To inform Lewisham's commissioning decision for 2026/27, practices were invited to complete a questionnaire to provide feedback and suggestions on future service options, with responses received from 23 of 27 practices.

Feedback from 23 practices highlighted strong user satisfaction, with 90% rating the service essential or extremely important, alongside clear operational benefits and reliance for short-notice cover, though awareness gaps remain among non-users.

See Appendix A for the full questionnaire, Appendix B for a detailed questionnaire response analysis and Appendix C for a breakdown of service usage by practice (January 2025 – January 2026).

Three commissioning options (see table 1 below) were assessed, with the preferred option being a 12-month ICB-funded extension to maintain stability while long-term solutions are explored.

The preferred option aligns with local workforce resilience and financial efficiency priorities and supports the delivery of significant clinical hours and cost savings to Lewisham practices.

The Group approved the recommended option to extend the Digital Flexible Staffing Pool contract for a further 12 months, while longer-term solutions are developed and considered.

Table 1

Option 1 (Do Nothing)	Option 2	Option 3 (Preferred Option)
Decommission the service: The service would be decommissioned, with individual practices taking responsibility for sourcing and funding locum cover independently.	**Practice contribution to ongoing service:** The ICB would request that practices make a financial contribution in order to enable the continuation of the service.	**ICB continue funding for 12 months:** **The ICB would continue to fund the service for a further 12-month period, during which time alternative longer-term solutions would be explored**.
Pros ▪ Removes ongoing financial commitment for the ICB. ▪ Reduces central administrative oversight.	**Pros** ▪ Shares financial responsibility between the ICB and practices. ▪ Allows the service to continue in the short term.	**Pros** ▪ Maintains service continuity and workforce stability. ▪ Provides time to develop and agree a sustainable long-term model. ▪ Minimises immediate operational and financial disruption to practices. ▪ Supports equity and consistency across practices.
Cons ▪ Increased financial and operational burden on practices. ▪ Removes access to a staff pool of over 300 and risks inequitable access to locum cover. ▪ Potential impact on service continuity and workforce resilience.	**Cons** ▪ Variable ability of practices to contribute may lead to inequity. ▪ Risk of reduced participation and partial uptake. ▪ Additional administrative complexity in managing contributions.	**Cons** ▪ Ongoing short-term financial commitment for the ICB. ▪ Does not resolve the long-term funding position.
Risks ▪ Destabilisation of practices with limited capacity to source locums. ▪ Increased risk to service delivery and patient access. ▪ Potential reputational risk to the ICB.	**Risks** ▪ Fragmentation of the service model. ▪ Potential disengagement from practices. ▪ Risk that the service becomes financially unsustainable.	**Risks** ▪ Risk of delay in identifying and implementing a sustainable solution. ▪ Risk of perceived extension without clear exit strategy. **Mitigations:** ▪ Clear timelines and milestones for development of long-term options. ▪ Regular review and reporting during the 12-month period.

2. 2025/26 PCN Capacity and Access Improvement Payment

The Primary Care Group was recommended to approve the release of the full Capacity and Access Improvement Payment of £482,387.00 to PCNs.

In 2025/26, NHS England continued its commitment to improving access and capacity in general practice through two key funding streams available to Primary Care Networks (PCNs). The funding streams are the national Capacity and Access Support Payment (CASP) and the local Capacity and Access Improvement Payment (CAIP), through the PCN DES.

The purpose of the CASP and CAIP is to support achievement of the Delivery Plan for Recovering Access to Primary Care.

As was the case in 2024/25, 70% of funding is paid unconditionally to PCNs through the CASP with no reporting requirements. PCNs are expected to use the funding to support a wide range of network-level initiatives, as outlined in Section 11.2 of the Network Contract DES 2025/26.

The remaining 30% of funding is available to PCNs via the CAIP but has changed from three domains down to two.
The two domains are:

- A focus on supporting the adoption of the Modern General Practice access model (similar to 2024/25).

- PCNs to use intelligence gained from population health risk stratification tools to stratify their patients, including to identify those that would benefit most from continuity of care.

As part of the 2025/26 CAIP funding, SEL ICB was allocated £2,819,989 in total, of which £482,387.00 is allocated to Lewisham. The PCN allocation breakdown is shown in table 2.

Payments will be based on the PCN Clinical Director's (CDs) confirmation that all practices within the PCN have implemented both domains and met the assessment criteria that relates to the improvements prior to 31 March 2026.

Assessment Approach
The 6 South East London boroughs agreed on a consistent assessment approach and to support the process, the ICB developed an a**ssurance form** to help guide PCN CDs discussions with member practices and ensure they are compliant with both domains.

PCN CDs are responsible for confirming practice compliance in the two domains and are required to do so by completing and submitting the **CAIP Criteria and PCN claim form** to the ICB before the 31 March 2026.

To support practices in delivering the risk stratification domain, SEL agreed that practices should use two segmentation tools in combination via Ardens Manager. The two tools are

a) Bridges to Health segmentation, focusing on three priority groups: people with long-term conditions, people living with frailty, and children and young people with complex needs; and

b) A RAG-rating tool, to support practices prioritise patients and manage workload effectively.

Assurance Statement

In Lewisham, assurance is already in place, and practices are already delivering the requirements of this domain, through work led by the Population Health team.

The team has developed a predictive algorithm which supports clinical risk stratification as part of the local GP PMS Premium contract for Multidisciplinary Team Meetings (MDMs), and supplies practices with a proactive list of the top 0.5% of patients at highest risk of hospital admission for action.

The predictive algorithm is also used within the Lewisham Integrated Neighbourhood Teams programme to identify, segment, and risk stratify patients with three or more long-term cardiovascular conditions (e.g. atrial fibrillation, hypertension, chronic kidney disease, and diabetes), particularly those who are unoptimised or potentially undiagnosed, to support proactive care and intervention.

The ICB has completed its assessment and, based on the information submitted by PCN Clinical Directors, is assured that all PCNs have fully implemented both key domains and met the required criteria.

The Group approved the release of the full Capacity and Access Improvement Payment of £482,387.00 to PCNs.

Table 2: PCN allocation breakdown

Funding stream	Aplos Health PCN	Lewisham Alliance PCN	Lewisham Care Partnership PCN	Modality Lewisham PCN	North Lewisham PCN	Sevenfields PCN
Maximum Capacity and Access Improvement Payment	£73,531	£67,163	£66,852	£50,529	£123,912	£100,400

3. Triangle Group Practice Incorporation

The Group was recommended to approve the novation of an existing General Medical Services (GMS) contract held by Triangle Group Practice (a partnership) to Triangle Group Practice Ltd, a new company limited by shares.

The practice requested that the novation take effect from 1 April 2026, subject to completion of all conditions and regulatory requirements.

This was not a request for a new contract award or service reconfiguration, and it does not affect the scope, value, or delivery. There are no proposed changes to the services provided, registered patient population, practice premises, boundary or workforce composition, PCN membership, or contractual obligations under the GMS Regulations.
The existing partners will become the directors and shareholders of the incorporated entity, ensuring continuity of clinical leadership, accountability, and operational control.

The request was assessed in accordance with the NHS Act 2006, GMS Regulations, and Sections 8.10 – 8.10.38 of the Primary Medical Services Policy and Guidance Manual.

The request was also reviewed against the Provider Selection Regime (PSR) and met the criteria for a permitted modification under Regulation 13, as it represented a change in legal entity only, with no material change to services, patient population, or contract scope and therefore, no procurement was required.

Given that this was one of the first incorporation requests to be progressed end-to-end locally, and to ensure robust governance, external legal advice was sought in January 2026.

An incorporation assessment was completed using the PGM Annex 44 framework. Initial areas for clarification were identified and subsequently addressed following legal advice and receipt of supplementary information from the practice.

The commissioner requested supplementary information from the practice to address an area identified in the assessment framework which was a risk related primarily to procedural completion rather than service delivery.

These areas will be addressed prior to the proposed effective date of 1 April 2026.

The proposal was considered a low-risk organisational change by SEL ICB Contracting Officers and the associated legal advice.

ICB officers are satisfied that the assurance requirements for approval have been met and that the proposal represents a low-risk organisational change with no detriment to patients.

The Group approved the novation of the GMS contract held by Triangle Group Practice to Triangle Group Practice Ltd, a new company limited by shares.

The approval was subject to some conditions including:

- completion of CQC registration for the incorporated entity
- confirmation of insurance cover in the company name; and
- execution of the deed of novation.

4. 2026/27 Local Incentive Schemes

a) Primary Care Diabetes Injectables Initiation Scheme

The Group was asked to approve the proposal to continue the existing Primary Care Diabetes Injectables Initiation local Incentive Scheme into 26/27.

The rationale to continue the scheme rather than stop it are as follows:

- The impact on patient care through delayed initiation of the scheme.
- The impact on the Lewisham and Greenwich Trust community diabetes service that would need to absorb the primary care activity
- The risk to practices/PCNs who have employed dedicated resource to deliver this work based on the funding available through the scheme
- The movement of work out of primary care which contradicts the strategy to do exactly the opposite
- Not fully utilising trained staff in primary care and deskilling these staff.

A budget of £130,000.00 has been confirmed by the ICB for the 2026/27 scheme.

The landscape for GLP-1 analogue based medicines is predicted to change significantly over the coming years with anticipated further increases and so the cost and volume structure of the current scheme is unlikely to remain viable in the longer term. The ICB will continue to link to the South East London work in this area to inform our approach and consider any impacts on the local LIS.

The Group approved the proposal to continue the scheme into 2026/27.

b) Practice-based Phlebotomy Service

The Group was asked to approve the proposal to continue the practice-based Phlebotomy Local Incentive Scheme into 2026/27.

The scheme provides a convenient and accessible service for Lewisham patients, enabling access to urgent and routine phlebotomy services at or near their GP practice.

Practices receive £2.00 per bleed for providing the service to Lewisham patients.

The Group approved the proposal to continue the practice-based Phlebotomy Local Incentive Scheme.

c) South East London Medicines Optimisation Plan 2026/27

The Group was asked to approve the proposal to continue the 2026/27 South East London Medicines Optimisation Plan.

Prescribing schemes across SEL have evolved over time with indicators expanding beyond cost reduction to include quality improvement and the delivery of patient outcomes. The 2026/27 Medicines Optimisation Plan (MOP) builds on previous achievements to ensure strategic alignment, improved efficiency, and enhanced patient care, while also reducing unwarranted variation across practices.

Participation in the scheme remains voluntary for practices who may choose to collaborate on workstreams within their PCN or at Place however monitoring and awards will be assessed at individual practice level.

The 2026/27 MOP consists of 3 sections:

- Section A: RPS Toolkit Implementation (30%)
- Section B: Prescribing Indicators (55%)
- Section C: Quality Indicators (15%).

These sections are broadly the same as per the 25/26 MOP.

The Group approved the proposal to continue the 2026/27 South East London Medicines Optimisation Plan unchanged.

Date of Meeting	Agenda Item	Presenter
6th April	TOCH Hub Update	Sue Robinson
1st June		
3rd August		
5th October		
7th December		

Place Executive Lead Action Tracker
Commenced - 2nd February 2026

Date of Meeting	Agenda Item	Description	Responsible	Deadline	Update
02/02/2026	OD Provider for neighbourhoods	Charles Malcolm-Smith to share final spec for the OD programme.	Charles Malcolm-Smith	8th Februaury 2026	Closed - Reference to email from Charles dated 3rd February 2026
	UEC Improvement Programme	Rochelle Scott to share slides	Rochelle Scott	6th April 2026	
		Rochelle Scott, Ashley O'Shaughnessy and Laura Jenner to touch base offline to understand the pilot and view of how to engage with primary care	Rochelle Scott, Ashley O'Shaughnessy and Laura Jenner	6th April 2026	
	Frailty	Deeta Henry-Smith and Rochelle Scott to touch base offline in terms of Governance	Deeta Henry-Smith and Rochelle Scott	6th April 2026	
	Projects feeding into PEG	Agreement to add Malik Wagas (OHL)Rochelle Scott (LGT UEC) and Maryland Kansi (SLAM) to the PEG membership - Lauren Woolhead to update the membership	Lauren Woolhead	6th April 2026	
		Lauren Woolhead add onto the forward planner, Improving Comms & Visibility in promting UEC Radar more widely	Lauren Woolhead	6th April 2026	
		Laura Jenner, Tom Hastings and Beckie Burn to develop a 6–12 month forward plan	Laura Jenner, Tom Hastings and Beckie Burn	6th April 2026	

Date of Meeting	Agenda Item	Description	Responsible	Deadline	Update
01/12/2025	TOCH Hub Update	Sue Robinson agreed to provide updates to PEG for system oversight	LW to work with LJ/BB for suitable timeframe for SR updates	2nd February 2026	on the agenda for April
		Following reference that THOC has with Safeguarding Adult Reviews and JH comment around shared learning it was agreed for LJ/BB to touch point with the Safeguarding Leads	BB/LJ	2nd February 2026	on the agenda for April
	System Intentions / Mapping Transformation Project across the system	Laura Jenner/Joan Hutton to review transformation project that links to the Care Act stragary reasonability's	LJ/JH	2nd February 2026	Laura Jenner to check outstanding items with Joan Hutton re: Adult Social Care Transformation (keep open).

Date of Meeting	Agenda Item	Description	Responsible	Deadline	Update
07/07/2025	Updates on each partner	KG to add onto the risk register in terms of accommodation for the Pilot Project and the Pophealth Platform.	KG	6th October 2025	Lauren Woolhead to check with Kenny Gregory whether risks on Pop Health Platform and accommodation pilot have been added to risk register

ACTION LOG - Open

Month	Action and updates	Lead	Deadline	Status	Notes
12 September 2025	**Homelessness & Rough Sleepers mapping excercise** A discussion was held about what more could be done to support this cohort, particularly those with mental health needs. Consideration was given to what action may be required at a system wide level and whether a pan borough approach would be beneficial. It was agreed that CW would raise this with the SEL Quality and Commissioning teams to explore what could be done for this cohort and/or to raise it as an area of concern.	CW	08/05/2026		
	Drug & Alcohol Related Deaths This was noted to sit within the broader prevention agenda and the Integrated Neighbourhood Team (INT) approach. It was suggested that, through holistic assessments and the use of case workers, key information such as accommodation needs-could be captured to help identify and support this cohort. This approach has potential but would require further development and consideration, including whether a more structured programme could be established. It was agreed to return to this meeting in May 2026 with a more detailed outline.	FK/KL/CW	08/05/2026		
13 March 2025	**CHC Performance Deep Dive:** Invite the CHC team (Corinne or Peter) to a future meeting to provide a summary and update on CHC performance and challenges in relation to compliant performance.	CW	08/05/2026		
	Flu Vaccination Campaign Review: Bring a summary presentation on the flu vaccination campaign, including what worked and what did not, to a future meeting for review and discussion from a quality perspective.	AOS	08/05/2026		
	Flu Vaccination Planning for 26-27: Schedule a session in July to discuss preparation and planning for the 26-27 flu vaccination campaign, incorporating learning from the current year.	AOS/MC/CMb	08/05/2026		
	LAS 111 Quality Alerts: Share the recent report on LAS 111 quality alerts with Ashley and discuss how to communicate findings and improvement actions to practices to reduce inappropriate referrals.	AOS/CW	08/05/2026		

LIQ&A Group. Agenda sign off - Louise Crosby/Ceri Jacob				
Sep-26	**Jul-26**	**May-26**	**Mar-26**	**Jan-26**
Standing Items				
		Lewisham Performance dataset SEL Performance summary	Lewisham Performance dataset SEL Performance summary	Deferred to March 2026
		SEL ICB Quarter 4 Quality Report	SEL ICB Quarter 3 Quality Report	
Deep dives				
	Older People/Dementia	Update on LA CQC Inspection	Adult Mental Health	
	Maximising Wellbeing Programme	Update on SLaM CQC Inspection	Children's Mental Health	
			Peri-Natel Mental Health	
			MH SMI checks update	
	Unregulated providers	Primary and Secondary Care Interface - Quality Alerts (Cal)		