Lewisham Local Health and Care Partners Strategic Board – Part I
Date: Thursday 27 March 2025, 14.00-16.00hrs (includes 5-minute break)
Venue: MS Teams (meeting to be held in public)
Chair: Fiona Derbyshire, CEO, Citizens Advice, Lewisham

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 30 January 2025 (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** *Note response from previous question(s) received from members of the public*	Appendix A		For Noting	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.	**Joint Forward Plan: Annual update**	Enc 4	Charles Malcolm-Smith	For Approval	14.15-14.30 15 mins
5.	**Community Development Projects and Funding**	Enc 5	Laura Jenner	For Discussion	14.30-14.45 15 mins
6.	**Neighbourhood health service** • **SEL Framework** • **Lewisham Integrated Neighbourhood Team Model of Care**	Enc 6	Laura Jenner	For Approval	14.45-15.05 20 mins
7.	**Primary Care Access Plan**	Enc 7	Ashley O' Shaughnessy	For Discussion	15.05-15:15 10 mins
	Break – 5 mins				

	Governance & Performance				
8.	**Take Home and Settle (THAS) & Homeless support discharge services update**	Verbal	Amanda Lloyd	For Noting	15.20-15.30 10 mins
9.	**Risk Register**	Enc 8	Ceri Jacob	For Discussion	15.30-15.40 10 mins
10.	**Finance update**	Enc 9	Michael Cunningham	For Discussion	15.40-15.50 10 mins
	Place Based Leadership				
11.	**Any Other Business**		All		15.50-16.00 10 mins
CLOSE					
12.	**Date of next meeting (to be held in public): Thursday 22 May 2025 at 14.00hrs via Teams**				
	Papers for information				
13.	**Minutes/Updates from:** • **Place Executive Group action log** • **Primary Care Group Chairs Report**	Enc 10			

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

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 30 January 2025 at 14.00 hrs.

via MS Teams

Present:

Vanessa Smith (VS) (Chair)	Chief Nurse, SLaM
Ceri Jacob (CJ)	Place Executive Lead (PEL) Lewisham, SEL ICS
Dr Neil Goulbourne (NG)	Chief Strategy & Transformation Officer & Deputy CEO LGT
Pinaki Ghoshal (PG)	Director of Children's Services, LBL
Anne Hooper (AH)	Community representative Lewisham
Dr Catherine Mbema (CMb)	Director of Public Health, LBL
Barbara Gray (BG)	VCSE representative, KINARAA
Michael Kerin (MK)	Healthwatch representative
Fiona Derbyshire (FD)	CEO, Citizens Advice Lewisham, Voluntary Sector Representative
Dr Helen Tattersfield (HT)	GP, Primary Care representative
Sabrina Dixon (SD)	VCSE representative, SIRG

In attendance:

Cordelia Hughes (CH) (Mins)	Borough Business Support Lead, SEL ICS
Dan Rattigan (DR)	Associate Director – Strategy, LGT
Laura Jenner (LJ)	Director of System Development, SEL ICS
Michael Cunningham (MC)	Associate Director of Finance, SEL ICS
Charles Malcolm-Smith (CMS)	Associate Director of System Development, SELICS

Kenny Gregory (KG)	Director, Adult Integrated Commissioning, SEL ICS
Ashley O'Shaughnessy (AOS)	Associate Director of Community Based Care & Primary Care, Lewisham, SEL ICS
Amanda Lloyd (AL)	Assistant Director Service Development & UEC, SEL ICS
Alise Cotton (AC)	Clinical and Care Professional Lead, LD&A
Ann Guindi (AG)	Clinical and Care Professional Lead, CYP
Erfan Kidia (EK)	Associate Director for Medicines Management, SEL ICS
Dr Tom Simpson (TRGS)	Clinical and Care Professional Lead, Chair
Georgina Fekete (GF)	Non-Executive Director, SEL ICB
Chima Olugh (CO)	Neighbourhood Development Manager SEL ICS
Dr Aaminah Verity (AV)	Heath Equity Fellow, Lewisham
Deborah Jenkins (DJ)	Public Health Consultant, Public Health
Kenneth Miller (KM)	Member of the public

Apologies for absence: Denise Radley, Dr Simon Parton, Dr Prad Velayuthan.

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 21 November 2024** Vanessa Smith (VS) (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. VS advised attendees of the housekeeping rules. Apologies for absence were noted as detailed above. Declaration of Interests – There were no new or amended declarations of interest. Minutes of the Lewisham LCP Strategic Board meeting held on 21 November 2024 – these were agreed as a correct record; however just a minor amendment to the initials for Pinaki Ghoshal (PG) which were noted as PK on the action log.	

	Action log – The following items listed on the action log are completed and are now closed. 1. PG to circulate SEND inspection link to members of the Board. 2. BG to invite KG to present on the PSR changes to procurement at a LBVN Network so they are aware of this. Matters Arising None **The LCP Board approved the Minutes of the meeting held on 21 November 2024.**	
2.	**Questions from members of the public** Ceri Jacob (CJ) read out the four questions that were raised via the Lewisham Questions inbox as follows. Questions need to be sent to the Lewisham Questions inbox, 7 days in advance of the Board meetings and a response would be provided within 14 days. To note the responses to the questions below will be appended to papers for the meeting in March 2025. **1)The Lewisham Autism service provision and the ongoing lack of any specific pre or post-diagnostic support for autistic adults as opposed to Children?** *CJ reported that the ICB and LA commissioned an All Age support service in April 24, which offers bespoke support and signposting to individual assessed needs. In addition, a new consultation on the Autism strategy has been extended to February 2025.* **2)The Neighbourhood Development Framework signals a fundamental shift in how the system works with residents and communities. Surely, for this shift to take place, effective engagement with unpaid carers needs to be embedded within the system. It is disappointing that the Lewisham presentation on system intentions makes no reference to unpaid carers?** *CJ reported that the ICB recognises the importance of unpaid carers and that this is embedded in the 10 Year plan. To date there has been recruitment of 12 residents to be part of the integrated neighbourhood*	

	design group and that planned engagement is in progress via the carers board. **3)What is the point of all these proposed improvements when you still can't get past your Dr's receptionist to see your Dr to be referred to all these improvements? You should concentrate on making your GP more accessible before anything else?** *CJ said a full response will be given but aware of the concerns around accessibility to get GP appointments. Also, to note that demand for GPs is quite high.* **4)What is your supporting strategy, and wider implementation programme, for the introduction of the GP surgery messaging services offered through the NHS App (IM1 PSF) for two-way communications between surgeries and patients? Is this service safe and secure? If not, in what other ways are you planning to improve patient communication to and with their GP surgery?** *CJ said that this question is similar to the previous question and reiterated that a formal response will be provided to the recipient.* VS thanked CJ for reading of the questions and thanked KM for his question and confirmed that a formal response would be provided. HT asked that in providing a response on GP appointments, to note that not all practices should be lumped together as some practices have improved in this area and if this could be considered in the response. In addition, patients have a choice regarding GP practice in which to register to.	
3.	**PEL (Place Executive Lead) report** CJ reported on the 25/26 priorities and operational **Planning Guidance** which is expected today, which sets out a number of national priorities for 2025/26 with an emphasis on improving access to timely care for patients, increasing productivity and living within allocated budgets, and driving reform. To support this, systems will have greater control and flexibility over how they use local funding to best meet the needs of their local population. **SEL Overarching Neighbourhood Development Framework.** The SEL development framework is across six Places and will focus on how we work, change and cultural shift as a system. This framework is being built up from local work across the six Places and will provide a	

	framework to guide ongoing development of neighbourhoods in South East London. This will ensure consistency where it is needed but with enough flexibility to accommodate local variation where that is needed. Further discussion around this will be included at a future Board seminar. **Action:** CH to add to the forward planner. CJ gave an update on the **Waldron Centre Soft Launch** and that funding had been received for Neighbourhood 1. A community event was held at the Waldron on Wednesday 22nd January, offering a programme of health and wellbeing advice which was delivered in partnership with the VCSE colleagues to promote proactive selfcare. The event was an opportunity to engage with the local community and find out more about the services people would like to see in the future. A formal event will be held in Spring 2025. LJ confirmed it has been a positive project. Michael Kerin (MK) asked about community diagnostics centres in Eltham, Queen Mary etc., and what were the plans for Lewisham in terms of access? NG replied that two CDC centres are due to open imminently in Greenwich commissioned by LGT and applicable across SEL. At present there has been discussion about having CDCs in each borough and if there is demand. MK mentioned the importance of planning for the future regarding these services, as well as raising awareness through publicity so that everyone is informed. **Action:** NG to present a briefing on the CDCs at a future meeting.CH to add to planner for month of May 2025. Barbara Gray (BG) asked what metrics are available and is there an opportunity to capture data. CJ confirmed that some of these points are in progress. LJ added activity is being monitored at the Waldron Centre and would be happy to provide a report at the next meeting. **Action:** LJ to provide a report on activity from the Waldron especially in relation to Black community. CH to add to forward planner for month of May 2025. **The Lewisham LCP Board noted the PEL report.**	**CH** **NG/CH** **LJ/CH**
4.	**System Intentions** Laura Jenner (LJ) reported on systems intentions: what has been achieved, how we will move forward and the expectations of SLaM and LGT in terms of a joint approach and delivery of systems intentions. • LTC will focus on hypertension and especially around wait lists.	

- Older People - transformation programme is implementing the frailty project.
- Community and urgent care aim is to provide a reduction in ED and an increase in Home first and same day urgent care.
- Mental health will focus on Autism and ADHD.
- Community based care will focus on access to primary care and medicine management but will also improve the interface between primary and secondary care.
- In progress is an improvement dashboard for wider system which is currently in progress.
- CYP will focus on ADHD and access to diagnostics and family hub.

MK thanked LJ for the presentation and asked about what public engagement had taken place, as there was no mention on the engagement with LA and voluntary sector. Also, how are we getting people out of hospital? Also, what are the timescales for the improvement dashboard. LJ confirmed that system intentions had programmes behind it and that people bringing the work forward would also ensure engagement. In addition, there had been involvement from People's Partnership to help improve engagement. Finally, the performance dashboard is in progress and in line with our objectives of this Board.

HT thanked LJ for good piece of work but added there is a lot of what we are going to do but not much of the how. Also, HT confirmed that usage of the 111 in Lewisham has seen a 10% reduction. Also, family hubs –there is a lack of funding, jobs etc so what are the future investment opportunities for family hubs. LJ will review the data regarding 111 service. PG added that children centres are now in-house and as a result, a redesign took place which is now completed. This means that there are new design arrangements for family hubs and additional funding was secured via DfE including a Staff For Life grant for 1 Year, which will extend the range of services for family hubs. The Pathfinder programme is funded externally and delivery going forward will be from family hubs.

The LCP Board approved the Systems Intentions updates.

5.	**Health Inequalities update** LJ said that the health inequalities programme has been running since 2022, and the programmes have been reviewed and that today is about proposed programmes to take forward. (LJ introduced presenters). Dan Rattigan (DR) reported on elective waiting list and confirmed there had been a £103k funding via Health Inequalities budget. Key points to raise are: Lewisham wait times are high and people are presenting with multiple conditions, and some are unfit for surgery. The aim is to reduce patient stay in a hospital setting and to reduce inequity in access. Using the integrated data system HealthinIntent; this helps to identify the patients unfit for surgery and manage preventable conditions. Results so far include (as of the first 12-months), 70% people are from the most deprived quintiles, approx. £350k were seen at a clinical panel with 65% cohort requiring some form of optimisation. Preventative assessment shows that most will pass for surgery; with 43 patients proceeding to surgery (relatively small) but they are staying less in hospital and/or cancelling on the day. **Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) update** Dr Catherine Mbema (CMb) gave a brief update on Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) and progress on this area of work. Key point relates to the ongoing 2-year relationship with community partner SIRG which will continue for the next 6 months. CJ referred to high prevalence of obesity and data in the BLACHIR report that refers to performance against the national average and indicators. CJ asked how is this sustained and measured? Deborah Jenkins (DJ) to discuss with CMb offline. **Health Equity Fellows update** HEF programme lead for Lewisham Dr Aaminah Verity (AV) gave an update on HEFs. AV confirmed that there are 6 HEF teams working with community GPs and Black led community organisations for co-design with primary care projects and to address health inequalities. Projects include from holistic health and wellbeing, health checks, to diabetes groups. Also, working with Health Innovation Network to give opportunities for Black-led organisations to contribute to NHS service	

	delivery and improving outcomes for residents. There are also 6 PCN leads to help with delivery and achieving outcomes. Project timelines are embedded into integrated neighbourhood team. Key recommendations: - • Improving access by bringing healthcare to the community • The growth of community champions • Gains for community-based organisations • **Pharmacy First Plus** Erfan Kidia (EK) reported on Pharmacy First Plus - the locally commissioned Minor Aliments Service (MAS). The service is freely available to all Lewisham residents who are registered with a Lewisham GP. The service comprises a consultation and medicines supply service without an appointment, provided by 88% of pharmacies across Lewisham (42 of 48 pharmacies) and 28 minor ailments. EK referred to the outcome's activity report. There had been 14k consultations, 12k the year before - so it is increase. Utilisation is uneven, access to the service is 83% and compared to the standard GP appointment cost, is less costly providing system savings that equate to £500k. The aim of Pharmacy First Plus is to reduce avoidable spend in the healthcare system, increase access to expensive over the counter treatments and improve access for those in the most deprived areas. MK asked about public engagement and access to services. EK confirmed there had been proactive engagement. AG asked regarding the patients with children and if they would still need to attend GP appointments or could been seen via health visitors, or prescribers in the community. EK confirmed that this is what Pharmacy First Plus is doing. **The LCP Board noted the above updates.**	
6.	**Hypertension VCSE award report** Ashey O Shaughnessy (AOS) presented on the hypertension business case on behalf of Jonathan McInerny. AOS reported on the Hypertension Business case on hypertension which is £100k over two years; £50k pa. Market engagement has been held, there were 3 bids received, and **Africa Advocacy Foundation** was the successful bidder and have been awarded the contract. Currently in the mobilisation phase and due to begin in the next couple of months.	

	The LCP Board noted Hypertension VCSE award report.	
7.	**Interpreting Service procurement update** YD gave an update on the update on procurement services which took place in Lambeth, Southwark and Lewisham. A 10-day standstill period has been completed, and mobilisation and implementation has commenced with a new contract start date of 1st April 2025 on a 3+ 2-year contract. The successful bidder for the service is Bidder 4, **DA Languages Ltd**. As DA Languages are an incumbent provider the service will continue with no disruption to patients, service delivery or service pathways. The contract value £496,890 p.a. as outlined in the Contract Award Recommendation Report (CARR) and is based on indicative activity reflecting 2023/24 activity but as is a variable contract and taking account of activity pressures and variation from activity levels modelled is likely to be a greater value. The current budget for this contract is £659,740 and an envelope of £700,000 had been allowed reflecting activity pressure equating to approximately £3.5 (£2.1m +£1.4m) based on a 3+2-year contract. YD is requesting approval from the Board. **The LCP Board noted the Interpreting Service procurement as detailed above.**	
VS advised there would be a 5-minute break. The meeting resumed at 15:17 hrs.		
8.	**Contract awards: Take Home and Settle & Homeless Patients Legal Advocacy Service** Amanda Lloyd (AL) presented on the **Take Home and Settle** (THAS), provided to date by Age UK (Bromley and Greenwich) which was commissioned in 2021 to sit alongside the existing LGT service offered at QEH. The service takes vulnerable patients' home from hospital, ensuring they are safe when arriving home, have food, heat and light, next of kin advised, and referrals to other helpful services made. **Homeless legal Advisory Service** – a law centre - provides legal service advise to patients stuck in hospital with no recourse to public funds such as immigrants. Under advice from our procurement advisors, both services needed to be re-procured under PSR regulations.	

	Take Home and Settle – contract 3+2 years, to be awarded to the highest-scoring bidder. Contract value p.a. £135,793 of which Greenwich funds £53,100 and Lewisham funds £82,693. Allocation of contract activity to reflect the allocation of contract funding. Homeless legal Advisory Service – contract 3+2 years, to be awarded to the highest-scoring bidder. Contract value p.a. £81,357 of which Greenwich funds £27,000 and Lewisham funds £54,357. Allocation of contract activity to reflect the allocation of contract funding. The request is for the Board to approve the procurements. **The LCP Board approved the Take Home and Settle & Homeless Patients Legal Advocacy Service procurements.**	
9.	**Lewisham Risk Register** CJ reported on the financial position, which is an improved position, but that there is still risk. The intermediate care beds risk has improved, everything else is the same. A new risk relates to the Adults safeguarding team, due to the designate safeguarding lead being on long term medical leave, although there is some acting up arrangements. Also, the risk regarding prescribing is expected to go up. Key themes relate to financial, statutory and workforce limitations. **The Board noted the Risk Register update.**	
10.	**Finance update** Michael Cunningham (MC) provided a M8 financial report under the headings of the ICB, Lewisham Council and the Wider ICS. **Lewisham Place** MC reported that for Lewisham against the delegated ICB budget at M8 there is an overspend of £224K; and even though it is an overspend, it is the third consecutive month of improvement. In M9 we will return to a surplus of £176k. Key areas of overspend continue to be prescribing and CHC, but both teams within those areas have done a good job in in trying to recover their positions during the year. Lewisham is forecasting an outturn of break even. Although forecasting to achieve a break even position this year, a lot of the mitigations in place to deliver are non-recurrent in nature.	

	ICB is £745k adverse to plan and due to costs associated with the Synnovis cyber-attack and forecast for the year will be a break-even position; this is across all six Places. **Lewisham Council** MC confirmed that the Adult Social Care services are forecasting an overspend of £4.4m this year, children are forecasting £14.2 million overspend. Key drivers in adults are unusually higher inflation request from providers, complexity of care requirements for discharge clients and the cost of children transitioning to adult hood. For children services key drivers are that more children are presenting with high level of need and higher care costs, even though the numbers are fairly consistent with the previous year. The **ICS** is forecasting break-even against plan. YTD deficit of £69m adverse to plan by £36m. Drivers are the Synnovis cyber-attack, also slippage in efficiency programmes. MC said that the planning guidance has been published and that the finance team will be preparing the budget proposals for 25/26. **The LCP Board noted the finance update.**	
11.	**Any Other Business** AH mentioned the Synnovis cyber-attack in Primary Care Chair's report, and for attention of the Board. There has been a significant impact across SE London Healthcare system with disruption to blood and a High Level 3 critical incident was declared by NHSE. VS asked Board members to note of the additional papers for information and thanked everyone for their contributions.	
12.	**Date of next meeting.** Thursday 27 March 2025 at 14:00hrs, MST	
13.	**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. **PEL Report (item 3) 30/01/25**	**SEL Overarching Neighbourhood Development Framework** to include at a future LCPSB seminar session. CH forward planner.	**CH**	Included on forward planner April 2025 seminar – Completed 26/02/25.
2. **PEL Report (item 3) 30/01/25**	NG to provide a briefing on **Community Diagnostic Centres** at a future LCPSB public meeting. CH to add to forward planner.	**NG/CH**	Included on forward planner for May 2025 – Completed 26/02/25.
3. **PEL Report (item 3) 30/01/25**	**Waldron Centre Soft Launch** LJ to provide a report on activity from the Waldron especially in relation to Black community. CH to add to forward planner.	**LJ/CH**	Included on forward planner for May 2025 – Completed 26/02/25.
Report SEND Inspection 21/11/24	PG to circulate SEND inspection link to members of the Board.	**PG**	Completed 30/01/25. Closed.
Intermediate Care Bed 21/11/24	Intermediate care bed strategy to be added to the forward planner.	**CH**	Completed 21/11/24. Closed.
LCP Assurance Report 21/11/24	JSNA summaries to be circulated to LCP Board members around vaccinations for a deep dive around data and recommendations.	**CMb**	

	Also, Older Peoples and flu vaccinations stats particularly around Black African and Black Caribbean populations; to be included as an agenda item for a future LCP Strategic Board, with emphasis on how we are doing in relation to the BLACHIR recommendations.CH to add to the forward planner.	**CMb/CH**	Completed 21/11/24. Add to a future LCP Board meeting. Closed.
PSR 21/11/24	BG to invite KG to present on the PSR/changes to procurement at a LBVN Network so they are aware of this.	**BG**	Closed.
Risk Register 19/09/24	**Primary Care Access** - SP commented on primary care access and that access work has been quite significant in the last year. CJ and LJ would meet and discuss further.	**CJ/LJ**	Closed
Finance update 19/09/24	**Prescribing.** SP noted for prescribing this had been historical and would require a cultural change. OTC (over the counter) medications for example were a challenging area, Pharmacy First Scheme etc. This needed promotion to patients. CJ said she would pick this up with AOS and Erfan Kidia (meds optimisation team). CJ noted **AF/Hypertension** work and work on obesity and diabetes prevention. LJ/CMb and CJ would consider the best way forward.	**CJ/EK/AOS** **LJ/CJ/CMb**	Closed
Lewisham Intermediate Care Bed Extension 19/09/24	**Lewisham Intermediate Care Bed Extension** BG commented on the taking time to involve people and queried if any black-led VCSE had been included at all. BG also noted BLACHIR and		Closed - as being discussed on 21/11/24

	community work. There is scope and opportunity to involve people with this. KG stated this was more for physical health rather than mental health. KG agreed to produce a summary for BG and would talk to colleagues about the right people to contribute to the development.	**KG**	
Improving Flu Uptake **19/09/24**	**Workforce vaccination.** SP noted there had been a delay last year in practices vaccinating their own staff. LJ agreed to look into workforce vaccination and take it as an action with AOS.	**LJ/AOS**	Closed
4&5 Health inequalities **19/09/24**	**Learning & Impact/Health Inequalities Funding** Evaluating the impact - evaluation of the work would be invaluable and would include qualitative feedback. CMb agreed to bring this item back to the LCP Board in the new year. CH to add to forward planner. BG said it would be helpful to see the questions being asked. CMb agreed to take this request back to the evaluation partner and would also pick this up offline with BG.	**CMb/CH**	Closed.
Welcome and previous actions. **19/09/24** **Reopened** **19/09/25**	**REOPENED** **Provider Selection Regime**. *Terms of reference for existing groups will be amended. Paper coming to SMT and will bring to LCP Board for noting in November.*	**KG/CJ**	Closed.

Community Integration – Fuller report. **25/07/24**	**Community Integration – Fuller report** The team is reviewing data to understand what is driving this type 3 increase. LJ suggested that it would be useful to come back to this meeting in the future with an update.	**CH**	To add to forward planner. Closed.
PEL (Place Executive Lead) report. **30/05/2024**	**Waldron** - *BG commented on contracts for organisations to deliver services access to space issue and booking rooms. Reception area and pop ups will be in the large ground floor space. Can space for black led VCSE organisations be accommodated. Also, space for 1:1's as well. CJ advised space is available for free for VCSE groups, CMS to take away the suggestion with LJ.*	**CMS/LJ**	Closed.

South East London Integrated Care System

NHS South East London

Appendix A

[redacted]

Sent by email:
[redacted]

19 Februaury 2025

Dear [redacted]

Re: The use of NHS App for two-way communications between surgeries and patients?

I am writing in response to your questions submitted on 29 January 2025. This response will be appended to the minutes of the Lewisham Local Care Partnership Strategic Board meeting held on Thursday 30th January 2025.

Improving patient access and experience in the borough is a key component of the local Five year forward view delivery plan for Primary Care in Lewisham (2023-2028). Key details can be found in the papers of the Lewisham Local Health and Care Partners Strategic Board held in public on 21st November 2024.

The Integrated Care Board has a range of initiatives in place to empower patients to manage their own health including the use of NHS App, self-referral pathways and through more services delivered in community pharmacies.

The NHS App messaging service provides a secure inbox that allows patients to receive messages from their GP practice via the NHS App, instead of SMS (text message) or letter and is available to anyone who has downloaded the App.

The two way communication function is also available as part of the NHS App, however it is for the practice to decide whether it is switched on.

The NHS England Delivery plan for recovering access to primary care outlines a new Modern General Practice model which will improve the way in which patients contact their practice. All Lewisham practices have transitioned to transition to this model.

The model helps align capacity with need and improve patient experience using a total triage approach by:

- Optimising contact channels into a practice
- Using structured information gathering to understand need, assess and prioritise need fairly and safely.
- Ensuring patients get access to the right healthcare professional or service, in the appropriate time frame, moving away from a 'first come first served' approach.
- This approach does also mean that patients will not always get a face-to-face appointment within 2 weeks.

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

Yours sincerely
Ceri Jacob
Place Executive Lead (Lewisham)

Appendix A

[redacted]

Sent by email:
[redacted]

19 Februaury 2025

Dear [redacted]

Re: The Neighbourhood Development Framework signals

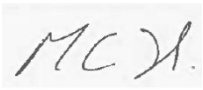
I am writing in response to your questions submitted to the Lewisham Local Care Partnership Strategic Board on 29 January 2025. This response will be appended to the minutes of the meeting held on Thursday 30th January 2025.

We recognise and support the comments regarding the importance of involving unpaid carers in this work. We have recruited 12 residents to be part of the design group that is developing our local work on neighbourhoods and Integrated Neighbourhood Teams and plan to engage with the Carers Board in the next month to ensure we understand the particular needs of unpaid carers and reflect these in our planning.

To note, the local authority has initiated the development of a Carers Action Plan for the borough from 25-28, building on the 2022-24 plan. Progression against its key milestones and actions will also be reported into the LCP.

I hope this addresses your question raised.

Yours sincerely



Ceri Jacob
Place Executive Lead (Lewisham)

South East London Integrated Care System

NHS South East London

Appendix A

[redacted]

Sent by email: [redacted]

19 Februaury 2025

Dear [redacted]

Re: General Practice Access

I am writing in response to your question submitted on 29 January 2025. This response will be appended to the minutes of the Lewisham Local Care Partnership Strategic Board meeting held on Thursday 30th January 2025.
.

I have outlined below the national direction for improving access to general practice, and our approach locally, which is contained in the Lewisham Primary Care Access Plan.

To improve access to general practice, NHS England has made a commitment to tackle the GP practice 8am rush and make it easier and quicker for patients to get the help they need from primary care.

The NHS England Delivery plan for recovering access to primary care outlines a new Modern General Practice model aimed at improving patient access and experience.

All Lewisham GP practices have transitioned to this new (total triage operating) model where every patient contacting their practice first provides some information on the reasons for contact and is triaged, based on medical urgency, before making an appointment.

The Modern General Practice model aligns capacity with need and helps to improve patient experience using a total triage approach. This includes:

- **Optimising contact channels into a practice**
- **Using structured information gathering to understand need, assess and prioritise need fairly and safely.**
- **Ensuring patients get access to the right healthcare professional or service, in the appropriate time frame, moving away from a 'first come first served' approach.**
- **This approach also means that patients will not always get a face-to-face appointment within 2 weeks, and an appointment might not be with a GP, depending on the presentation.**

I hope this addresses your question raised.

Yours sincerely

Ceri Jacob
Place Executive Lead (Lewisham)

South East London Integrated Care System

NHS South East London

Appendix A

[redacted]

Sent by email: [redacted]

19 February 2025

Dear [redacted]

Re: Lewisham autism service provisions and the ongoing lack of any specific pre or post-diagnostic support for autistic adults.

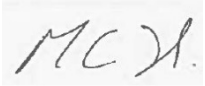
I am writing in response to your question submitted on 26 January to the Lewisham Health and Care Partnership Strategic Board (LCPSB). This response will be appended to the minutes of that meeting.

The ICB and Local Authority jointly commissioned an All-Age Autism Support Service in April 2024. This is delivered by Resources for Autism and offers bespoke support, advice or signposting, based on individually assessed needs. In addition to the individually tailored support provided, where multiple individuals may be interested in specific interventions, these will be offered on a broader scale within the service.

Please note that a new consultation on the Autism strategy started in October 24 and the deadline for contributions has been extended until February 25. The consultation is intended to determine whether or not there has been any significant progression against "I-statements" in the strategy however, it also provides the opportunity for community members feedback on any other issues they want to raise. The consultation is being promoted across our health and care partners and wider community forums. Responses will be analysed and to inform future plans.

I hope this answers your question and thank you for taking the time to contact the LCPSB on this matter.

Yours sincerely



Ceri Jacob
Place Executive Lead (Lewisham)

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 3
Enclosure 3

Title:	**PEL Report**
Meeting Date:	27 March 2025
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 Department of Health and Social Care (DHSC) recently announced a set of changes to the NHS. These include, the abolition of NHS England, a reduction of 50% in running costs for the DHSC and NHS England. ICBs are also required to reduce by 50%. This is in addition to the 30% that has been removed over the last 2 years. NHS providers are required to reduce by 50% the increase in corporate costs since 2019/20.

Current understanding is that these changes will need to be enacted by Quarter 3 of 2025 i.e. October 2023.

At time of writing this report, detailed guidance on the parameters ICBs and providers will need to work within to achieve the required reductions has not been received.

The ICB already has an employee support scheme established and will be increasing capacity in this scheme to support its staff through this process. LHCP partners will be kept updated as more detailed guidance is received.

Planning 2025/26
Work is continuing to finalise plans for 2025/26. All Local Care Partnerships have been required to identify 5% savings for the coming year. For Lewisham LHCP this equates to £8,975k. A plan has been agreed which achieves the requirement and has been submitted within deadlines. The focus will now move to implementation. A summary of these can be provided at a future meeting.

	SEL frameworks for LTC and Frailty Work has been undertaken collectively across the 6 SEL Places and SEL wide teams to develop overarching frameworks for multiple (3+) Long Term Conditions (LTCs) and frailty. These are to be delivered through neighbourhood working and Integrated Neighbourhood Teams (INTs). The LTC framework was previously agreed across the 6 Places. More recent work has focused on understanding gaps in the framework for each Place and how these may be addressed. This work also links to the SEL ICS work on System Sustainability. The 6 Places are now tasked with implementing the framework locally as far as possible within current budgets or repurposed budgets. Two workshops have been held across SEL ICS to agree an overarching framework for ageing well and frailty. A final workshop will be held on 21 March. There has been good representation from Lewisham in this work and the final outputs will be taken through the Lewisham Older People Board for implementation. **VCSE representation on the LHCP Strategic Board** March 2025 will be the final LHCP Strategic Board that Barbara Gray of KINAARA will attend. I would like to thank Barbara for her contributions to the work of the LHCP Strategic Board and for helping to strengthen the voice of our black led VCSE partners in the decisions of the board.				
Potential Conflicts of Interest	**None**				
Any impact on BLACHIR recommendations	Neighbourhood working and INTs are expected to impact positively on health inequalities and a number of the Opportunities for Action set out in the BLACHIR report. These will be set out within the EIA.				
Relevant to the following Boroughs	**Bexley**		**Bromley**		
	Greenwich		**Lambeth**		
	Lewisham	✓	**Southwark**		
	Equality Impact	An EIA will be carried out on both the SEL Neighbourhood and INT framework and the Lewisham articulation of the framework.			
	Financial Impact	Not relevant to this paper.			
Other Engagement	Public Engagement	Public engagement has been carried out in relation to the Lewisham neighbourhood development programme of work and representatives are being recruited to support ongoing engagement. An engagement plan is being developed to support this work at a SEL and Place level.			
	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:	**NHS South East London Integrated Care Board Joint Forward Plan 2025-26**
Meeting Date:	27th March 2025
Author:	Charles Malcolm-Smith, Associate Director for System Development (Lewisham),
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The Board is asked to: • Review and endorse the South East London Integrated Care Board's (SEL ICB) draft Joint Forward Plan as it pertains to Lewisham. • Provide feedback on any key areas requiring further development.	Update / Information	
		Discussion	x
		Decision	x
Summary of main points:	The SEL ICB draft Joint Forward Plan (JFP) outlines strategic priorities for health and care services across South East London, including specific initiatives for Lewisham. The ICB's first Joint Forward Plan was published in June 2023. This is a five year plan that is intended to be refreshed each year (see Executive Summary document at Appendix 1). The JFP for 2025/26 aims to support the two key priorities: • Improving population health and reducing health inequalities across the population • Ensuring the sustainability of health provision now and as demand continues to grow **Lewisham Priorities** The priorities for the Lewisham Health & Care Partnership (LHCP) were agreed in 2022. The JFP summary provides updated action areas and outcomes (see LHCP JFP document at Appendix 2). 1. To strengthen the integration of primary and community based care: • Establishing Integrated Neighbourhood Teams (INTs) to provide proactive and preventative care. • Enhancing multi-disciplinary meetings for complex patient cohorts. • Expanding virtual wards and urgent community response services. • Improving primary care access and digital integration. 2. To build stronger, healthier families and provide families with integrated, high quality, whole family support services:		

	• Expanding family hubs and integrating children's health services. • Increasing access to immunisations and weight management support. • Strengthening perinatal and infant mental health services. 3. To address inequalities throughout Lewisham's health and care system and tackle the impact on health and care outcomes : • Targeting poverty, housing, and education as social determinants of health. • Piloting debt and benefits advice within healthcare settings. • Enhancing cancer screening outreach and hypertension management. 4. To maximise our roles as 'anchor organisations' as employers: • Expanding local employment and training opportunities. • Enhancing collaboration across health and care workforce planning. • Developing joint recruitment initiatives. **South East London Care Pathway Plans** The South East London Care Pathway Plans outline a coordinated approach to improving health outcomes through integrated service delivery, focusing on prevention, early intervention, and equitable access across primary, community, and specialist care services. The pathways are: • Cancer • Children and Young People • Learning Disability and Autism (LDA) • Long-Term Conditions • Maternity and Neonatal • Medicines Optimisation • Mental Health • Palliative and End of Life Care • Planned Care • Prevention, Wellbeing, and Equity • Primary Care • Specialised Services • Urgent and Emergency Care • Women and Girls' Health
Potential Conflicts of Interest	None identified
Any impact on BLACHIR recommendations	Reducing health inequalities is one of two key priorities for the JFP for south east London and the impact on health inequalities is identified for each priority area. Addressing inequalities is also a specific priority within the Lewisham place plans and is supported by actions including investing in local VCSE groups to work with local communities and focus on wider determinants of health.

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

	Equality Impact	Initiatives and actions are identified that support population health and reduce inequalities and include targeted

		interventions such as the GP youth clinics, investment in VCSE groups to work with local populations to improve access and screening rates.
	Financial Impact	Financial sustainability is one of two priorities for the JFP for south east London and the impact on system sustainability is identified for each priority area.
Other Engagement	Public Engagement	Lewisham's approach to engagement is outlined in the place JFP including through the People's Partnership, family hubs and GP youth clinics, mental health community engagement sessions, and working with community groups.
	Other Committee Discussion/ Engagement	LCP Board seminar 27th February 2025, Health & Wellbeing Board 19th March 2025
Recommendation:	The Board is asked to comment on the SEL ICB draft JFP that sets out its medium-term objectives and plans.	

South East London Integrated Care System

NHS South East London

South East London 2025/26 Joint Forward Plan

Executive Summary

DRAFT V0.1

Contents page

South East London Integrated Care System

What is the Joint Forward Plan

NHS South East London

Our Integrated Care Board Joint Forward Plan sets out our **medium term objectives and plans**, at both a place level and from the perspective of our key care pathways and enablers at ICS system level, to ensure that we are developing a service offer to residents that:

- **Meets the needs of our population.**
- Demonstrates and makes tangible progress in **addressing the core purpose of our wider integrated care system** - **improving outcomes** in health and healthcare, **tackling inequalities** in outcomes, experience and access, **enhancing productivity and value for money** and helping the NHS support broader **social and economic development**.
- Delivers **national Long Term Plan and wider priorities**, all of which resonate from a SEL population health perspective.
- Meets the **statutory requirements** of our Integrated Care Board.

We published our first Joint Forward Plan in June 2023. This is a five year plan that is intended to be refreshed each year. For 2025/26 we want to ensure that the work we do supports the two key priorities we have as an Integrated Care Board:

- Improving population health and reducing health inequalities across the population we serve
- Ensuring the sustainability of health provision now and as demand continues to grow.

Our refreshed plan providers the following:

- A strategic overview of how our local care partnerships and care pathway programmes will **improve population health and inequalities and system sustainability**
- A high level summary of the **actions** that we will take this year, working with partners, to make progress; and
- The measures that we will use to **track the impact** of our actions on our population

How does it all fit together

Overall context of the SEL System plans

The SEL Joint Forward Plan sits within a suite of strategic and operational documents and plans developed by our Integrated Care Board and wider Integrated Carew Partnership. These have differing objectives but importantly are interlinked with a clear golden thread across them.

Integrated Care Strategy

- Integrated Care Partnership developed plan covering the NHS and Local Authorities.
- Work supported by significant engagement over summer 2022 and beyond.
- Medium term focussed - 3-5 year timeframe.
- Secures an agreed vision, mission and the identification of 5 key strategic priorities for the SEL integrated care system, with further detail around the 5 priorities now developed.
- Gives overarching consideration to key enablers and ways of working.

Published February 2023
2023/24 work to develop the detail around our five strategic priorities.

Joint Forward Plan

- Integrated Care Board medium term NHS focussed plan - 5 year timeframe.
- Is the ICB response to the integrated care strategy identified priorities
- Sets out how we will improve population health and reduce health inequalities whilst improving the sustainability of our health system
- Ensures what we do aligns to the delivery of national and local priority
- Sets out the key actions we will take and how we will measure our progress
- Refreshed every year with new actions and measures but no material changes to our objectives

First Joint Forward Plan published in June 2023. A refresh is published annually. The publication of the NHS Long Term Plan later in 2025 will require a full review of our Joint Forward Plan.

Operational Plan

- Integrated Care Board operational plan – an overarching ICB plan and underpinning plans for the ICB's five major NHS providers.
- Short term 2025/26 focussed plan, building on the plan from 2024/25 and encompassing:
  - Sets out how we will deliver national planning priorities and targets
  - Reflects key actions from our ICS Strategy and Joint Forward Plan
  - A financial plan for 2025/26, inclusive of the agreed application of the ICB's allocation.
  - Detailed activity and workforce planning and performance trajectories.

Draft plan due for submission end of March 2025, final submission expected May 2025

How we have built our Joint Forward Plan

Borough Plans

- **A plan for each of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark boroughs.**
- Driven by local health and wellbeing and local care partnership plans.
- Set out the key objectives and actions that will be taken forwards on a borough basis.
- Reflect needs of the population and a focus on reducing inequalities in access, experience and outcome.

Shared Delivery

Care Pathway/Service Plans

- **A plan for prevention, urgent and emergency care, mental health, children and young people, womens health, learning disability and autism, planned care, maternity, cancer, long term conditions, primary care and end of life.**
- Sets out the SEL vision, objectives, framework and approach for particular pathways and population groups.
- Key to driving forwards our commitment to reducing inequalities in service offer and experience, improving outcomes and value across our system

Enablers

- Set out how key enabler functions **workforce, estates, digital / data** are supporting the delivery of our plan plus our approaches to **population health management, sustainability, the green agenda, wider social and economic development and the development of our integrated care system.**
- Our **Medium Term Financial Strategy** that sets out our planned allocation of ICB funding over the next five years.

Our 2025/26 refresh focuses on **how our plan supports delivery of our two major overarching priorities of population health and inequalities and system sustainability**. We also want to make the plan **more concise and accessible** for our population and stakeholders.

Our 2025/26 plan consists of:

- An **executive summary document** that focuses on our context and our combined approach to population health and inequalities and system sustainability as our two major overarching priorities. This executive summary includes a plan on a page for each of our places and care pathway ywhich outlines how they will contribute to our shared objectives around population health and inequalities and system sustainability
- A set of appendices, which enable readers to delver more deeply into the plans of our places and care pathways with a focus on the actions we will take, the impact we will have and how this will be measured.

NHS Long Term Plan

This refresh of our Joint Forward Plan has been undertaken prior to the publication of the anticipated NHS 10 Year Health Plan which we anticipate will be published later in 2025. At that point a more extension revision of our Joint Forward Plan will be required aligned to wider reform of the nationally coordinated NHS planning processes.

Within our current refresh, we have taken into account the outputs of the Darzi Review and independent investigation of the NHS in England undertaken in 2024. We have also reflected on the three strategic shifts that we would expect to see within the NHS 10 Year Health Plan:

1. **moving care from hospitals to communities,** for example:
   - Delivering more services at places like GP clinics, pharmacies, other neighbourhoods based locations and in people's homes
   - Supporting people to lead healthier and more independent lives, reducing the likelihood of serious illness and long hospital stay

2. **making better use of technology,** for example
   - using shared electronic records to improve the patient experience and make it easier for staff
   - virtual appointments with healthcare professionals

3. **focussing on preventing sickness, not just treating it,** for example
   - increased screening services to identify and better manage disease earlier
   - more support for those wanting to live healthier lifestyles

South East London Integrated Care System

Overview of our people and communities

NHS South East London

- Southwark is ranked amongst the 15% most deprived local authority areas in the country
- Southwark has the third largest lesbian, gay and bisexual communities in the country
- 46% of Southwark's population are from a Black and Minority Ethnic background

- Lambeth is ranked amongst the 15% most deprived local authority areas in the country
- Lambeth has the second largest lesbian, gay and bisexual communities in the country
- 60% of Lambeth's population are from a Black and Minority Ethnic background

- Lewisham is ranked amongst the 15% most deprived local authority areas in the country
- 22.6% of children in Lewisham live in low-income families
- 47% of Lewisham's population are from a Black and Minority Ethnic background

- Greenwich is ranked amongst the 15% most deprived local authority areas in the country
- 21.8% of children in Greenwich live in low-income families
- 38% of Greenwich's population are from a Black and Minority Ethnic background

- 16% of Bexley's population are aged 65 and over
- 16.3% of children living in Bexley live in low-income families
- Life expectancy is 7.9 years lower for men and 6.7 years lower for women in the most deprived areas of Bexley, compared to the least deprived areas

- 18% of Bromley's population are aged 65 and over
- 13.2% of children living in Bromley live in low-income families
- Life expectancy is 8.1 years lower for men and 6.1 years lower for women in the most deprived areas of Bromley, compared to the least deprived areas

Overview of our integrated care system

About our Integrated Care System

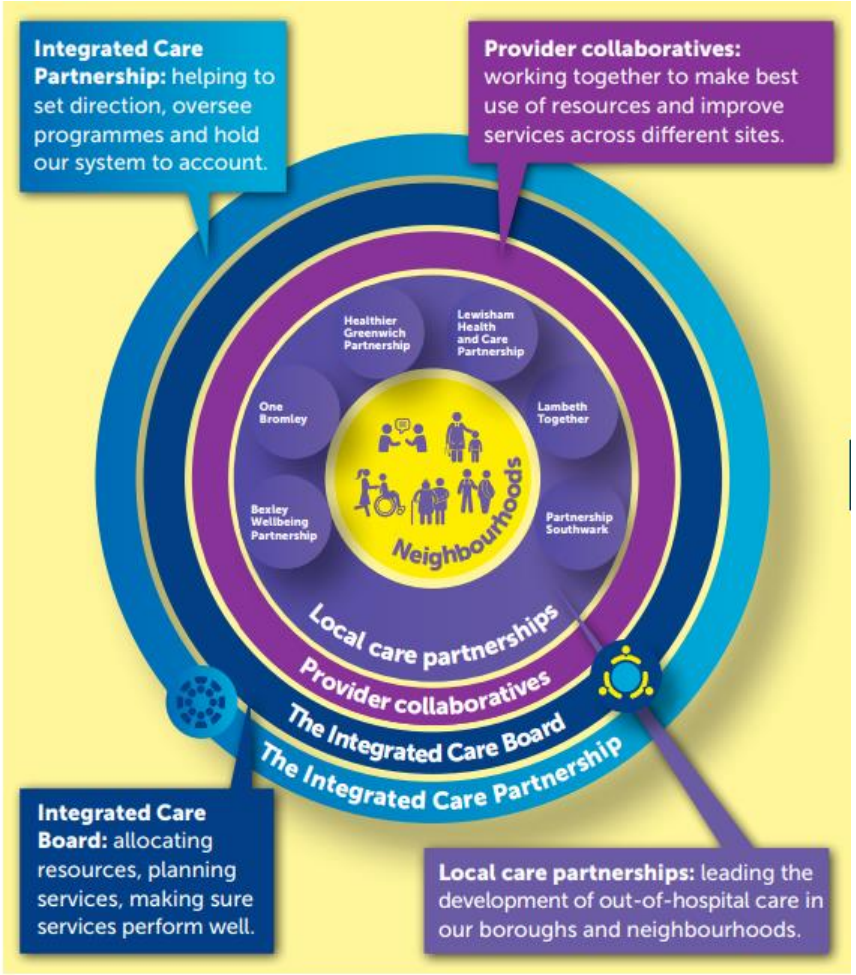
On 1 July 2022, we set up a new Integrated Care Board and a new Integrated Care Partnership, bringing together the leaders of health and care organisations across south east London to plan services and improve care for our population of almost two mission.

Our new board and partnership are responsible for supporting the many organisations delivering health and care services in south east London, which we call the South East London Integrated Care System (ICS). We have four overarching objectives.

1. Improving outcomes in population health and healthcare;
2. Tackling inequalities in outcomes, experience and access;
3. Enhancing productivity and value for money; and
4. Helping the NHS support broader social and economic development.

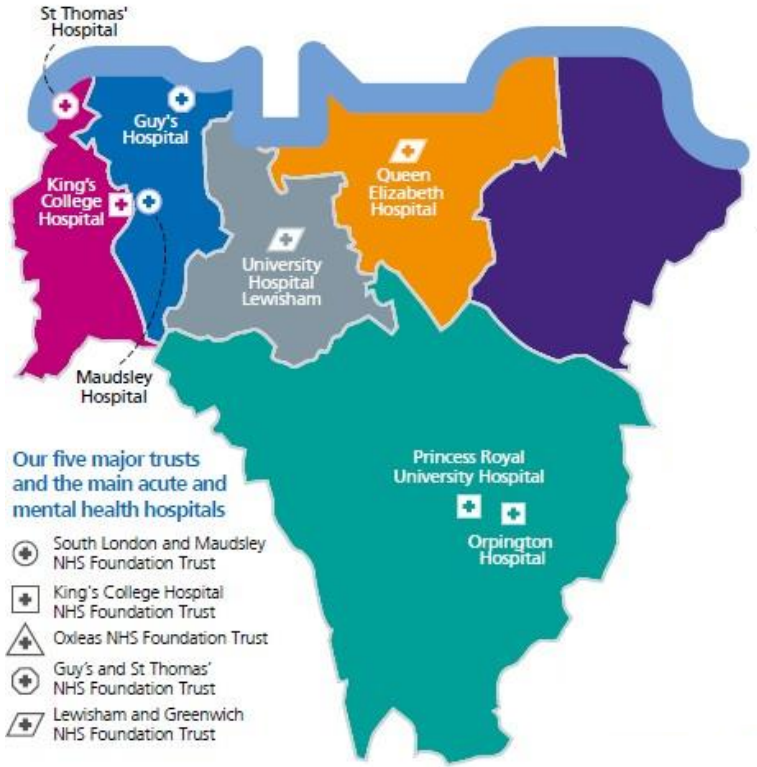
Our new arrangements are based on partnership working, bringing together the range of skills and resources in our public services and our communities, They are also based on the principles of trust, taking decisions at the right level in our system, giving partnerships and organisations within our system the power to lead and improve their services and working in partnership with our service users.

The diagrams on this slide give an overview of our partnership working within our system, and an overview of NHS provider provision within south east London.



Note: NHS England is expected to ask integrated care boards to commission some specialised services in the future

Our System of Systems



NHS provider landscape in South East London

Our approach to Neighbourhood Working

In response to the national drive to deliver a Neighbourhood Health Service, South East London (SEL) has committed to working in a more integrated way at the neighbourhood level, and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities.

The overarching aim of this work is to develop a shared approach to INT development across SEL, which will bring together services with communities through a population health management approach, at a scale which enables the delivery of genuinely preventative, holistic, locally tailored services.

Neighbourhood working will require a fundamentally different way of working and large cultural shift across the public sector, voluntary and community sector (VCSE), and our local populations; involving new means of collaboration, coordination, and, at times, integration. This reflects a significant transformation of how our system will operate together.

A key (but not the only) element of delivering neighbourhood working will be the establishment of INTs. This document is focussed on this element and presents an overarching framework for INT delivery which Places will be required to develop locally, tailoring to their local population needs and services. This framework will be subject to further socialisation and input before a final document is delivered early this year.

Moving forward, key enablers within the SEL system such as resourcing, workforce, and data analytics, will need to be configured to support the delivery of INTs and neighbourhood working.

What will Integrated Neighbourhood Teams do?

Our initial focus for INTs is to provide proactive care for higher and rising risk populations, and to work with communities on preventing ill health. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSE and social care, to meet the holistic needs of their local populations. These INTs will be able to easily draw upon specialist input as needed across all levels (from hyper-local to regional).

This is not about minor tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level in INTs will require a fundamental shift in how we work together as a system, with residents and within communities.

In SEL, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g., addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs,** through a combination of integrated working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities,** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders,** holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all SEL residents receive the same standards of care**, wherever they live and whatever their individual needs.

In 2025/26, the South East London Integrated Care System has chosen to prioritise the development of integrated neighbourhood teams for the following three population groups:

- Children and Young People with complex needs
- People living with three or more long term conditions
- People living with frailty

Population Health and Inequalities

Why is this one of our overarching priorities?

- High levels of health need, with a clear link across to the relatively high levels of deprivation and population diversity found in south east London.
- Life expectancy for south east Londoners is below the London average for all boroughs except Bromley.
- Differences in life expectancy are more marked for those born in the least and most deprived areas across south east London.
- These factors drive significant inequalities, with a variance across boroughs including higher levels of need, challenge and opportunity across our inner south east London boroughs, but with clear inequalities and an inequalities gap evident within each of our six boroughs.
- Known risk factors that drive poor health outcomes plus drive inequalities.
- Inequalities evident in terms of access, experience and outcomes.
- Cost of living crisis has further exacerbated inequalities

How will we make progress through our 25/26 plan?

- We will be building towards a Neighbourhood Health Service, with care provision organised around neighbourhoods and designed to mee the specific population health needs of their neighbourhoods
- We have been clearer and more specific on how our 25/26 borough based and care pathway plans will address population health and health inequalities
- We will be strengthening our Population Health Management capabilities across our system during 2025/26 to support the shift to neighbourhood care. This includes how we will start to plan care around specific population segments consistently across the ICS and how we will support front line teams to use shared data and insight.
- We will be building on progress made since 2023 on prevention and early intervention increasing access to both universal offers for the whole population and culturally tailored offers for communities experience the greatest inequalities.
- The themes of partnership and collaboration underline our plan, with the aim of strengthening trust and relationships between health, local authorities and our neighbourhoods to provide integrated and holistic care targeted to specific population need

System Sustainability

Why is this one of our overarching priorities?

- The south east London system faces significant financial challenges. We will end 24/25 with a system deficit of £359m; we currently spend more money than we receive
- In a “do-nothing” scenario, this financial deficit will rise incrementally each year over the next five years.
- As a system, we are committed to the delivery of a sustainable, recurrently balanced, financial position. This remains a key strategic objective and a clear national expectation; a financially sustainable system will enable us to continue providing high quality healthcare to our local population, and those from further afield who access our services
- There is significant work to do through our NHS organisations, and at a system level by working together collaboratively, to develop savings plans which achieve this goal
- In addition to our system’s financial position, we face significant operational challenges across urgent and emergency care, cancer, diagnostics, elective care, and access to primary care and mental health services. Transforming services to ensure they are operationally sustainable and meet nationally required targets, whilst maintaining quality and reducing inequalities, is also a key part of ensuring our system is sustainable
- In south east London, like other areas of London and across the country, there are significant opportunities to improve productivity and efficiency in our services. We need to make demonstrable progress in delivering these opportunities to enable us to meet demand and see and treat more patients, without needing to increase our cost base

How will we make progress through our 25/26 plan?

- We have been clearer and more specific on how our 25/26 borough based and care pathway plans will contribute to making our system more sustainable
- In late summer 2024, south east London established a System Sustainability Programme, to provide a framework for bringing organisations together to plan and deliver schemes which can only be delivered by working together
- We now have an agreed list of schemes we will progress through 25/26; some will be implemented during 25/26, while some more complex schemes are still in the planning stage
- The work of individual organisations and boroughs, alongside our system level schemes, will contribute to making our system more financially and operationally sustainable

How are we working with our communities and residents?

In 2024-25, the Integrated Care System (ICS) conducted various engagement activities, building on previous efforts. The now established South East London People's Panel and the Anchor Alliance listening campaign provided key insights into experiences and community challenges and have been augmented in 2024 by further insight collated by Mabadiliko CIC from predominantly Black African, Black Caribbean and South Asian communities. This insight is published at What we've heard from local people and communities - South East London ICS to share across programmes and projects.

We have also engaged with local people and communities on a range of other projects including the development of the women's and girls' health hub and NHS 111. Findings from these and other projects are published on our on-line engagement platform Let's Talk Health and Care South East London.

These insights have shaped this refresh of the **Joint Forward Plan.**

As part of our work to build trust with local communities we are partnering with the Voluntary, Community and Social Enterprise (VCSE) Strategic Alliance to work with five grassroot VCSE organisations over three years to co-create a prevention and health-creation collaborative. The aims are to build trust, foster equity and promote wellness within communities who experience the greatest health inequalities.

Over the next year we will build on this and the work of the Anchor Alliance and other initiatives to further develop our approach to engaging with people through working with the VCSE to build trust and develop solutions, as we develop our approach to integrated neighbourhood working.

Key themes from ICB engagement with our communities and residents

South East London Integrated Care System

Healthcare challenges: There are concerns about challenges in accessing services, long waiting times and institutional trust. People are often unaware of how to navigate the complex healthcare system and face barriers including language issues and systemic discrimination.

Use of health services: Many people self-care / go to pharmacies, use NHS 111 though some still use A&E unnecessarily with some communities not aware of NHS 111. People who use the NHS App find it helpful but note limitations, such as the inability to book GP appointments directly. Some concerns about digital exclusion.

Community and mental health: People want more joined-up, proactive services that focus on prevention and treat the "whole person." They also want services to be equitable and locally accessible. There is a call for better mental health support and recognition of the role of family carers.

Loneliness and wellbeing: Both young people and older adults report feelings of loneliness. Financial struggles, lack of employment, poor wages, poor housing and lack of support in areas like healthcare and mental health services are major concerns. People expressed the need for better community support and more accessible services.

Barriers to accessing services: Access to services is hindered by factors like language difficulties, lack of digital access and confidence, and confusion about service eligibility, especially for migrant communities. People also report poor experiences with mental health services and long-term conditions due to lack of coordination and personalised care.

Maternal health and support: Women, particularly from under-served communities, report inconsistent antenatal and postnatal care, with financial pressures and lack of family support affecting their wellbeing, as well as language and communication challenges.

Partnership and community engagement: There is a need for better collaboration between public services, local communities and the VCSE. This includes addressing health inequalities, especially in marginalised communities, and ensuring services are culturally sensitive and accessible.

Social determinants of health: Wider social issues like housing, safety, and employment are often overlooked but are critical to people's health and wellbeing.

Women and girls' health: people want improved and convenient access offering integrated care which is culturally appropriate, inclusive and incorporates outreach with a hybrid model of both digital and in-person.

Supporting Wider Social and Economic Development

South East London Integrated Care System

Our priorities are to enhance health and socioeconomic well-being in SEL by addressing key health determinants through targeted interventions, creating a system that prioritises prevention, and improves health equity in our disadvantaged communities through:

1. Reducing the magnitude of health disparities between different socio-economic groups, minimising risk factors and consequences of health conditions

Success Measures:

- Reduction in loneliness
- Reduction in infant mortality
- Improvement in life expectancy
- Reduction in premature mortality
- Improved accessibility of healthcare services
- Increase in use of preventative health care services

Black Maternal Health

- Support implementation of a community led intervention e.g. the provision of Doulas for Black women during pregnancy, childbirth and post-partum/fourth trimester (TBC)

Equity zones

- Implementation of health equity zones in collaboration with INT, co-created through local partnerships to tackle the social determinants of health and create more equitable neighbourhoods (TBC)

2. Empowering communities by fostering engagement, building trust and enhancing active participation

Success Measures:

- Increase the number of community leaders
- Participation rates in training
- Increase in residents in targeted communities participating in community initiatives
- Increase in the number of community led interventions
- Development of a community / VCSE organising model

Healthy Dialogue

- creating a model for community & system leaders to come together equitably & empower community voices to effectively shape services

Micro, By and For (capacity & sustainability)

- Capacity, skills and leadership building
- Build and sustain trusted relationship Small one-off grants to sustain and strengthen community-led delivery

VCSE Alliance & Leadership Roles

- Create streamlined access into diverse VCSE strategic leadership
- Support relationships and connections between the VCSE sector and system

Trust and Health Partnership

- Health prevention approach to codesign community /VCSE engagement model

Recognising Involvement

- Renumeration for local people that give their time at level 3 criteria

3. Improving housing conditions for low-income families by increasing access to safe and affordable housing

Success Measures:

- Reduce the number of individuals living in sub standard housing
- Number of new sites identified for affordable housing
- Number of new affordable housing units developed
- Increase in housing improvement initiatives

Housing Coalition

- NHS land identification for affordable homes
- Streamlining of processes and provision of support for housing needs
- Access to Wi-Fi and reducing digital exclusion

4. Enhancing mental health and well being services by increasing the availability of resources to underserved communities

Success Measures:

- Increase in community mental and HWB services
- Reduction in prevalence of mental health conditions
- Reduction in number of mental health related hospital admissions

Be Well

- Grow networks to ensure ongoing sustainability of HWB interventions
- Offer micro grants for community organisations

Mental Health Promotion

- Supporting VCSEs to deliver mental health promotion in culturally and ethnically diverse communities with an anti racism focus

Black Mental Health

- Scoping and delivery of interventions to address mental health in our black communities

Southbank CYP Creative Health Centre

- Creative interventions to support children on CAMHS waiting lists
- Implementation of creative health prevention programmes

5. Increasing access to education and job training, and reducing worker poverty through the London living wage and fair work policies for all

Success Measures:

- Increase in income levels
- Increase in employment rates
- Increase access to education and job training programmes in disadvantaged areas
- Increase number of organisations across SEL paying the LLW

Work and Wages

- Increase accreditation of London Living Wage organisations across SEL
- Widen access to quality work

6. Developing sustainable, healthy communities through promoting environmentally friendly practices, green spaces, and community-driven health initiatives

Success Measures:

- Reduction in smoking rates
- Reduction in alcohol consumption
- Increase in physical activity
- Number of organisations adopting environmentally friendly practices
- Reduction in pollution levels

Access to NHS estates for use by community organisations

- NHS buildings and spaces identified to support communities to deliver services
- Transformation of community-based spaces into community hubs

Procurement and contracting of local organisations

- Improve accessibility of procurement and contracting with small grassroot VCSE organisations
- To strengthen & diversify the partnership with the VCSE sector Reducing the environmental impact

Be Well

- Bring together community leaders and NHS/LA to act on issues creating most strain on mental health and wellbeing

The SEL Integrated Care Strategy – which is reflected in our JFP

Our Integrated Care Partnership has agreed its mission, vision and strategic priorities – set out in our January 2023 SEL Integrated Care System Strategy.

The strategy identified five key areas of priority - these areas have been selected on the basis of a number of criteria, including requiring cross system working to make demonstrable progress. Our Joint Forward Plan sets out the ICB's contribution to delivery of these priorities, and the slide reference below each priority sets out where this information can be found within our overall JFP.

These five strategic priorities are a sub-set of the work the ICB will be progressing within these pathway areas; for example the mental health (MH) section of our JFP covers work we will be progressing in addition to priorities around "ensuring quick access to effective support for common MH challenges in children and young people" and "making sure adults have quick access to early support". In addition, the ICB will be progressing work outside of these care pathways / population groups, in line our overall ICB responsibilities.

Bexley Wellbeing Partnership

South East London Integrated Care System

Our vision is:	Our vision is to improve the health and wellbeing of our population by creating a *Neighbourhood Health Service* that is better for everyone, supporting people to ***start well, live well and age well***.			
Our priority areas are:	Supporting **Children & Young People** *throughout life*	Supporting people living with **Mental Health** challenges	Supporting people to maintain a **Healthy Weight**	Supporting older people living with **Frailty**
In 2025/26, we will:	• Commission Integrated Child Health Model of care • Enhance CAMHS support through adoption of the THRIVE framework	• Implement Phase 2: Community Mental Health Transformation • Continue the 'bed recovery' programme	• Embed healthy lifestyles: • Provide tailored support for individuals	Development of Integrated Neighbourhood Teams with a focus on: Long-term conditions and Frailty
This will support population health and inequalities by:	Offering targeted proactive, personalised and preventative healthcare for our communities, targeting care and support to those who need it or will benefit from it the most to make the biggest impact on improving outcomes.	Addressing the close links between mental and physical health, particularly among vulnerable groups, and tackling the wider determinants of health and access to healthcare with the aim of creating a more equitable health and care system for everyone.	Targeting underserved communities including areas of deprivation, primary schools with higher levels of overweight children with the aim of improving individual physical and mental health and improve access to health-promoting resources across diverse populations.	Population health approach to target support, care, and services based on who needs it or will benefit = addressing variation, with a focus on prevention and health deterioration to make the biggest impact on improving outcomes.
This will support system sustainability by:	Focus on prevention, early intervention, targeted support and coordinated care ensuring healthier populations and a more sustainable healthcare system by improving efficiencies, reducing duplication and reducing costs associated with acute based care.	Integrating services to improve coordination, optimising resources and enhancing patient outcomes. Locally provided community care with faster access reduces demand for emergency services and reduce the need for hospitalisation.	Addressing obesity ensures the long-term viability of our healthcare system by avoiding increasing costs, improving resource allocation, and promoting healthier populations.	Risk stratifying our population to focus on our high risk and rising risk population, ensuring our interventions are targeted appropriately for a more sustainable healthcare system by reducing immediate costs associated with acute based care.
We will measure our impact by:	• Reduction in waiting times • Increase in community-based care • Reduction in hospital-based activity	• Reduction acute inpatient admissions • Reduction in waiting times • Increased number of patients with an SMI who receive an annual health check	• Increased referrals to support services • Increased number of resident participation and engagement in healthy initiatives • Improved recording of weight	• Reduction in frailty scores • Appropriate admissions and Emergency Departments attendances • Delaying admissions to long-term care

Bromley

South East London Integrated Care System

Our vision:	to help everyone in our population live longer, more independent lives with less variation in health outcomes across Bromley.			
Our priority areas are:	Establish joint working in integrated neighbourhood teams	Population health management tool to enable risk stratification to target interventions	Delivery of transformation of all age mental health and welling prevention and early intervention services	Continued delivery of universal and targeted service to meet the needs of CYP at the earliest stage
In 2025/26 we will:	• Building neighbourhood teams across primary, secondary, community, mental health, social care and VCSE. • Adult initial focus: prevention, proactive care and management of multiple long-term conditions and frailty, including through hospital discharge.	• Place agreement, including public & health social care, on population health management tool to utilise. Secure PHM tool and appropriate expertise. • Agree data sharing arrangements across Place partners	• Embed Bromley-Y/CAMHS partnership with focus on step down, prevention & transition to adult services. • Adult – further development of single point of access, recommissioning of talking therapies, improved mental health discharge processes.	• Develop local children's health team (B-CHIP) into CYP INTs to meet specific and challenged areas where we wish to improve outcomes. • Review long term condition pathways to have greater focus on prevention and hyper-localised working to target need.
This will support population health and inequalities by:	• INTs focus on local population need and work with communities. • Research identifies a connection between people with multiple long term conditions & health inequalities. • Improved services for frail & Core20 in target cohorts.	• Identification of individuals with highest and/or combinations of health and care needs associated with poorer outcomes, and those predicted to have those needs in the future: allowing targeted proactive intervention.	• All target group is Core20PLUS5. • Improved access in all age MH access will improve outcomes for key population groups. • Further targeted outreach and inequalities offers with focus on areas of relative deprivation.	• Targeted to areas where greatest improvement to CYP health and wellbeing could be made as identified through 2024/25 refreshed CYP and mental health joint strategic needs assessments.
This will support system sustainability by:	• Better manage biopsychosocial, medical and mental health factors. • Left shift in urgent acute and social care. • Earlier identification and management • Improved resident resilience, self and family management.	• Identification of individuals who may benefit from earlier intervention and proactive management, supporting left-shift away from acute and social care.	• Improved prevention offer to reduce hospital admission & CAMHS activity, shifting to third sector & support education outcomes. • Support people in employment and living independently in own homes.	• Supporting family resilience and reduced acuity of need. • Productivity and left-shift through B-CHIP with significant reduction in acute instances of care, making every contact count and increase community working.
We will measure our impact by:	• A&E attendances; rates not seen in primary care; social prescribing referrals • % over 65 receiving CFS at healthcare interaction; % over 65 with CFS 5+ receiving CGA, care admissions.	• PHM tool agreement in place. • Place partners to agree to share data to improve population health outcomes and reduce inequalities. • Utilisation of tool commences.	• CYP – reduced hospital admissions, CAMHS caseload, reduced referral to specialist services. • Adults - reduced hospital admissions, reduced referral to specialist services.	• B-CHIP: reduced post intervention primary & secondary care attendances; reduced waiting times & lists • LTC: Reduction LTC exacerbation.

Greenwich

South East London Integrated Care System

Our vision	To improve lifelong outcomes for Greenwich residents by reducing risks and strengthening protective factors, with a focus on neighbourhood-level delivery.				
Our priority areas are:	Start Well: Ensuring CYP get the best start in life and can reach their full potential.	Be Well: Everyone is more active and can access nutritious food.	Feel Well: Integrated neighbourhood community teams provide the right support when & where needed.	Stay Well : Fewer residents are affected by poor mental health (MH).	Age Well: Services support people and carers to live fulfilling & independent lives.
In 2025/26, we will:	• Review universal provision to meet evolving needs. • Improve access to the Family Information Directory and Local Offer. • Improve the core offer and build a cohesive system for ASD and ADHD.	• Update and deliver the Royal Greenwich Get Active Strategy, tackling activity inequalities with community-focused solutions. • Improve the local food environment across neighbourhoods, highs streets, and organisations through integrated commissioning.	• CYP: Establish a SPA for MH and well-being, improve school-based support, embed the Thrive approach, and Waiting Well initiatives. • Adults: Conduct a mental health and learning disability needs analysis, promote key services and equip staff with signposting resources. • Addiction: Integrate VBA into practice and strengthen communication.	• Expand Making Every Opportunity Count (MEOC) • Align neighbourhood development with existing service footprints. • Implement the new Social Prescribing and Live Well integrated model. • Strengthen End of Life and Frailty support pathways.	• Procure a trusted assessor service. • Test the neighbourhood working with integrated teams. • Expand the use of Assistive Technology. • Roll out the Home First communication strategy and staff training.
This will support population health and inequalities by:	• Improving access to information and support for families. • Enhancing service quality and timeliness.	• Ensuring equitable access to physical activity and nutritious food. • Building healthier environments.	• Improving MH service access for CYP. • Address care gaps through "Waiting Well" initiatives. • Providing tailored support for underserved groups.	• Integrating holistic, community-focused approaches. • Strengthening end-of-life and frailty pathways.	• Advancing preventive, proactive care. • Expanding Assistive Technology. • Implementing Home First.
This will support system sustainability by:	Strengthening early intervention, improve service access, and reduce long-term demand.	Promoting a healthier lifestyle Reducing future healthcare demand.	Developing efficient, coordinated mental health services across all age groups. Strengthening early intervention to reduce long-term service demand.	Promoting integrated, community-based care models to enhance efficiency and eliminate service duplication.	Prioritising prevention and early intervention to lower future care costs and service demand.
We will measure our impact by:	• Improving Childhood obesity and breastfeeding rates. • Reducing diagnosis waiting times.	• Increase activity levels. • Strengthening resident engagement in strategy development.	• Monitoring drug use and alcohol intake and increasing sign-ups for treatment. • Expanding community interventions • Reducing MH A&E attendances. • Shortening waiting times for CYP MH.	• Improving vaccination rates. • Increasing diagnoses of long-term conditions (LTCs). • Strengthening neighbourhood community services. • Reducing resident falls.	• Increasing reablement rates. • Monitoring high-intensity care pathway activity. • Tracking P3 admissions.

Lambeth Together Care Partnership

South East London Integrated Care System

Our vision is:	We are committed to improving health and social care outcomes for all communities, ensuring that everyone, regardless of background or lived experience, can reach their full potential, feel valued, and have access to safe, positive choices. We proudly celebrate our rich diversity and actively listen to our communities' voices, making sure they are heard and represented. Our focus remains on advancing equality, diversity, and inclusion to create a more equitable and supportive environment for all		
Our priority areas are:	People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible	Physical and mental health conditions are detected early, and people are supported and empowered to manage these conditions and avoid complications	People have access to and positive experiences of health and care services that they trust and meet their needs
In 2025/26, we will:	• Work with local communities, to ensure residents have access to advice and support in the community • Implement our Tobacco Control strategy • Develop our local health improvement services including weight management/obesity Diabetes, Substance Misuse Young Person services • Launch new Suicide Prevention Strategy • Deliver actions in our Childhood Vaccination Strategy	• Develop our Integrated Neighborhood Teams • Further develop the Child Health Integrated Learning and Delivery System (CHILDs) Framework. Further develop the Primary Care Alliance Network (PCAN) • Increase uptake of NHS Health Checks for those with highest risk • Explore options to scale up the Pain Equality of Care and Support in the Community (PEACS) programme • Expand urgent and emergency care initiatives	• Integration the Patient and Carer Race Equality Framework (PCREF) within mental health provision • Launch the Lambeth Offer to support General Practice to provide high quality, equitable services. • Enable expansion of Hospital @Home services • Improve uptake of the Pharmacy First scheme • Scale up the Children and Young Person's Alliance (CYPA) wellbeing & mental health pilot partnership • Deliver Carers & Age Friendly initiatives Strategies
This will support population health inequalities	Prioritising those at greater risk, including people from Black, Asian, multi-ethnic backgrounds. Address wider health determinants e.g supporting employment, skills development, food security/cost-of-living initiatives.	Enabling earlier detection of physical and mental health conditions in high-risk groups, helping to improve outcomes. E.g. the PEACS programme supporting people with chronic pain, particularly Black individuals, who face greater health inequalities	Improving access, experience, and outcomes for underserved groups. For example, the PCREF on mental health for Black and Multi-Ethnic communities
This will support system sustainability by:	Prioritising early interventions that address inequality in outcomes and reduce costs. E.g the National Institute for Health and Care Excellence (NICE) advises tobacco control measures generate a return on investment and Lambeth is investing an additional £400,000 in support.	Enabling early detection, timely care, reduced costs empowering patients to enable self-care. Our PCAN and Staying Well Service reduce pressure on community mental health services. while the CHILDs Framework provides early intervention to prevent acute care	Working in partnership across our local system to optimise resources shift from hospital-based care closer to home. Our Hospital@Home Service helps enables more patients to receive support at home, reducing costly hospital stays
We will measure our impact by:	Smoking prevalence reduction / Substance Misuse successful treatment / NHS Health Checks uptake / Childhood Immunisations / Mental health support Services / STI diagnosis and testing	Cancer screening programmes / Pre-Exposure Prophylaxis (PrEP) activity / Diabetes 8 Care Processes / Long Term Condition programmee / Structured Medication Reviews / Improving Access	Access to General Practice / Pharmacy First / Hospital@Home activity / Reablement and carer assessments/ Infant and maternal mortality / Maternity patient experience / Learning Disabilities discharges from Inpatient units / Individual Placement Services

Lewisham Health & Care Partners

South East London Integrated Care System

Our vision is:	Lewisham Health and Care Partnership aims to achieve a sustainable and accessible health and care system, to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high-quality care, when they need it. **Our commitment is to make Community Based Care that is proactive and preventative, accessible and co-ordinated.** https://www.selondonics.org/in-your-area/lewisham/			
Our priority areas are:	To strengthen the integration of primary and community based care	To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	To address inequalities throughout Lewisham's health and care system and tackle impact on health & care outcomes	To maximise our roles as 'anchor organisations' as employers
In 2025/26, we will:	Establish or develop key services and approaches in: • Integrated Neighbourhood Teams (INTs) • Admissions Avoidance and Home First • Proactive Ageing Well Service • Mental health services early intervention and support and community model	• Review the GP Youth Clinic model • Establish key elements of the Start for Life Perinatal and Infant Mental Health programme • Bring wider Children and Young People (CYP) community health services and primary care into the Family Hub	• Focus on wider determinants areas in line with new Health and Wellbeing Strategy • Pilot debt/benefits advice based in health and social care settings • Work closely and invest in VCSE groups • Work with partners to prevent ill health	• Establish entry level roles in the community workforce and INTs • Co-ordinate joint recruitment initiatives • Joint training to improve joint working and making every contact count
This will support population health and inequalities by:	Supporting patients to manage their long-term conditions (LTCs); identifying people who do not regularly access health and social care services to help prevent ill-health and improve well-being.	• Community based activity closer to families and CYP can help remove barriers to access • GP Youth Clinic model shows positive uptake by Black and Mixed heritage young people	• Reduces the gap between the worst and best off in the borough • Populations will feel more able to self-manage their LTCs, living longer with less time in poor health	• Increased entry level employment opportunities for local populations • Roles that contribute to health needs at a neighbourhood level, connecting with local populations
This will support system sustainability by:	Taking a preventative approach to prevent, delay, stabilise frailty; reduce hospital admissions, demand for mental health beds, Emergency Department attendance and admission to residential care	Family Hubs and GP youth clinics help by redirecting activity away from more intensive and costly interventions and support	• The use of services for acute reasons should decrease as people live healthier, longer lives • Offering people safe and trusted spaces to discuss early signs and symptoms	• Better use of apprenticeships and ARRS funding opportunities and training opportunities across the partnership
We will measure our impact by:	• Reduction in unplanned admissions, and improved management of LTCs • Improved referrals, appointments and waiting times	• Uptake of childhood immunisations • Children with excess weight at Reception and Year 6 • Range of locality-based and digital wellbeing offers	• Cancer screening rates • Reduction in smoking rates • Use of non-health related data	• Numbers of local people starting entry level roles

Partnership Southwark

South East London Integrated Care System

Our vision is:	Our vision is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years.				
Our priority areas are:	Children and young people's mental health	Adult mental health	Frailty	Integrated neighbourhood teams	Prevention and health inequalities
In 2025/26, we will:	Reduce waiting times for children and young people who need help with their mental health. The support will be easy to access and coordinated around their needs.	Reduce waiting times for adults who need help with their mental health. The support will be easy to access and co-ordinated around their needs.	Pilot an integrated neighbourhood team for the frailty pathway in the Walworth Triangle. Use the learning from the pilot to inform spread and scaling to other neighbourhoods.	Launch a new model of care for Integrated Neighbourhood Teams (INTs) in Southwark.	Work in partnership so that Core20Plus5 communities will be more easily able to access tailored support for the five leading causes of poor health (the Vital 5).
This will support population health and inequalities by:	Enabling earlier access to mental health support and interventions and reduce escalation to crises and more costly acute health and social care intervention, with a focus on harder-to-reach young people.	Bringing together existing services and increasing the-involvement of the VCSE to streamline and increase capacity, providing a more holistic and accessible service for all residents.	Utilising outreach to identify vulnerable and hidden cohorts prone to health inequalities, alongside a population health based targeted approach to mild, moderate and severe frailty.	Providing proactive joined up health and care services focused on local inequalities, improving outcomes by providing services at an earlier stage before deterioration leads to hospital admission.	Tackling the leading cause of death; and driving a focus on residents most at risk of poor health outcomes in our local communities.
This will support system sustainability by:	Reducing demand on acute services, modernising pathways, improving system navigation, and improving the use of resources (staffing, training and estates).	Adults who need help with mental health will not have to wait as long. The support will be easy to access and co-ordinated around their needs.	Promoting independent health and wellbeing for mild frailty to focus on prevention and providing coordinated care closer to home.	Shifting the balance of care from acute to community and from treatment to prevention through efficient integrated neighbourhood care.	By early identification of high-risk residents and preventing crisis stage, it will reduce demand on high-cost acute sector services.
We will measure our impact by:	Increase in % achievement of a system wide 4 week wait standard.	Increase in % achievement of a system wide 4 week wait standard. Reduction in number of patients waiting 72 hours in ED..	Improved proactive care reducing need for Emergency Care. Patient outcomes – Experience and Quality of Life. Improved proactive care meeting unmet needs	Metrics to be confirmed but will focus on reducing the rate of avoidable hospital and care home admissions.	Increase in uptake of Vital 5 checks by people from Core20Plus5 communities and increase in uptake of interventions.

Cancer

South East London Integrated Care System

Our vision is:	To deliver high quality cancer services across community, primary, and secondary care to ensure that: Fewer people get cancer; patients receiving timely diagnosis; More people survive cancer; More people have a positive experience in their pathway; everyone receives the same high-quality services, no matter who they are or where they live; more people are supported to live as well as possible post treatment.			
Our priority areas are:	Reducing waiting times to treatment	Improving Cancer Screening Rates to Support Earlier Diagnosis	Embed and Improve Personalised Cancer Care and access to support	Deliver Sustainable Cancer Pathways –Focus on Breast
In 2025/26, we will:	• Improve pathways & process to support faster diagnosis. • Embed Inter-Trust Transfer policy • Mitigate challenges on highest volume or most complex clinical pathway inc. Lung, LGI and Skin • Continue to work with SEL providers to identify barriers to timely treatment	• Deliver communications campaigns, targeting non responders & communities with low engagement. • Support implementation of new technologies & age extension. • Develop a SEL HPV & Cervical Screening implementation plan.	• Evaluate remote follow up (PSFU) and support further roll out • Widen access to psychosocial care and physical activity • Develop improvement plan for prehabilitation • Improve support for people on endocrine treatment	• Evaluate current service configuration. • Work across hospital teams and system partners to agree the "problem statement" for Breast. • Identify opportunities to improve patient experience, and financial and physical pathway delivery.
This will support population health and inequalities by:	• Reduce variation in waiting times and outcomes across our population • Reducing inequity of access by ensuring consistent pathways across all sites • Supporting attendance and reducing (DNA) rates.	• Reducing variation in access and early diagnosis of cancer. • Increased screening uptake Prevention/secondary prevention through bowel and cervical cancer screening and smoking cessation opportunities in lung.	• Increased take up, with benefit to other long-term conditions • Reducing unnecessary hospital appointments • Enabling patients to be better prepared and fitter for their treatment • Impact cancer incidence/recurrence	• Reduce variation for Breast pathway waits to Treatment • Improve access to specialised care • Improve outcomes for patients by improving waits for treatment.
This will support system sustainability by:	• More efficient use of resources. • Reduce additional costs • Optimising non-recurrent funding. • Reduce time to treatment & better health outcomes	• Diagnose cancers earlier, which reduces time in hospital, improves quality of life and increases the number of people back in work.	• release clinic capacity • service usage optimisation • reduce on the day cancellations, length of stay, complications • positive impact on other LTCs	• Reduce additional cost Improved resilience of workforce • Reduce administrative burden to support patients through their care pathways.
We will measure our impact by:	• Best Practice Timed Pathways and Inter Trust Transfer dashboards. • Constraints and inequalities dashboard	• Screening uptake and coverage, including by demographic. • HPV vaccination uptake.	• PSFU evaluation • National Quality of Life survey and local patient experience work • Cancer Patient Experience survey	• Cancer Patient Experience Survey • Cancer waiting times. • Cancer outcomes

Children and Young People

South East London Integrated Care System

Our vision is:	**To deliver an integrated, informed and proactive model of care for children and young people (CYP) with expert community and primary care services that enable CYP to stay well in their local communities, supported by timely access to high quality specialist services**			
Our priority areas are:	**Improve waiting times** for CYP into health services across acute services (*Reforming elective care for patients)*, community-based care and mental health care	Develop pathways and services that support safe, effective and appropriate CYP **access to Urgent and Emergency Care (UEC)** (ref. UEC programme)	Develop and embed **population health management** approaches including models of care which are proactive, support self management and the prevention agenda	Ensure we provide the best start in life for CYP by focusing on the impact of health in **early years subsequent life course events**

In 2025/26, we will:	• Review of CYP waiting times in acute, mental health and community services
	• Develop and implement a measurable plan and trajectories for reducing waiting times in key areas
	• Develop a plan to reduce waiting times over next 5 years
		• Prioritise work on
		  • Same Day Emergency Care (SDEC) services
		  • Front door triage / streaming for CYP
		  • Out of hospital care pathways
		  • Implement the 'Healthier Together' website
		• Implement the RCPCH guidance on CYP with complex medical needs
			• Prioritise work on
			  • SEL wide uptake of CYP integrated care models
			  • Asthma and Epilepsy bundles of care and the Diabetes Hybrid Closed Loop (HCL) system
			  • Teen health checks
			• Develop a CYP health inequalities dashboard to support delivery of core20+5
				• Prioritise work on
				  • the health of parents pre-conception and the health of the infant
				  • Reducing risk factors for infant mortality, specifically maternal obesity
				  • Develop and test models for a teen health check programme (ref. vital 5 programme)

This will support population health and inequalities by:	• Improving access into services allowing CYP to be treated in a timely manner • Ensure CYP needing care can be seen in the right place first time	• Improving access and flow into UEC services • Provision of single CYP platform for information for CYP / Families and health professionals	• Population health management approach to care, with focus on the core 20 and Send populations	• Ensuring equity of access to preconception healthy weight support • Preventing future health inequalities by intervening earlier
This will support system sustainability by:	• Ensuring CYP are seen by the right service first time, reducing inappropriate referrals into acute systems , improving process to ensure sustainable services	• Ensure CYP are seen in right place first time, • Reduce pressures / improve flow and increase access to information	• Moving care from acute to community settings • Providing a proactive care model to target core populations for early intervention	• Early years interventions to impact on later life outcomes • Reducing the number of pregnant women who are obese/overweight with weight related complications
We will measure our impact by:	• Monitoring waiting times for acute OPA, elective care and community services against a trajectory plan	• Monitoring waiting times • Monitoring access to HT website	• Monitor the impact of integrated clinics on referrals into acute services	• Proxy indicators for maternal and infant health • Reduction in infant mortality figures

Learning Disability, Autism and SEND

South East London Integrated Care System

Our vision is:	People with a learning disability, Autistic people and all children and young people with Special Educational Needs and Disability (SEND) achieve equality of life chances, live as independently as possible as they transition to adulthood and have the right support from health and care services, through early identification of needs, improved coordinated multi-agency working, information sharing and support to access the right care at the right time.			
Our priority areas are:	Strategic response to Autism and Neurodiversity	Develop the SEL Care and Support offer in the community with ICS partners and development of workforce	Reduce inpatient care by reducing reliance on inpatient beds by admission prevention and improving quality of life by delivering co-ordinated care.	Development of the SEL SEND Network to support implementation of SEND priority actions at Place as described in the SEND ICS Work Plan.
In 2025/26, we will:	• Continue implementation of Adult Autism pathway by reducing variation and improve equity for assessments across all six (6) boroughs. • Work with each borough to ensure provision of community services meets the needs of the Autistic population and can be evaluated.	• Build on the analysis of inpatient and community provision costs. • With ICS partners – local authorities, ICB and provider collaborative implement community housing and accommodation • Delivery of Oliver Mc Gowan Mandatory Training (OMT) to SEL workforce. • Implement Care Education Treatment Reviews (CETRs) and Dynamic Support Registers (DSR) across SEL	• Ensure business as usual for DSRs, place based steering groups, inpatient surgery reviews and undertake reviews of admissions and discharges. • Fully embed good quality effective AHCs in primary care networks (PCNs). • Implement learning from LeDeR reviews across SEL • Undertake quality oversight of inpatient hospital.	• Strengthen ICB Governance and relationships with Place for SEND and support risk escalation. • Share learning to support improvement of health outcomes • Strategically commission with Place. • Improve workforce capability and capacity. • Data and intelligence and a SEL SEND Dashboard
This will support population health and inequalities by:	Ensuring autistic people have access to timely assessments, interventions and support to meet needs in local communities.	Ensuring population can be repatriated by to South London as close to home as possible and in the least restrictive setting.	Preventing admissions to hospital and by supporting discharge from hospital and reducing the length of stays in hospital.	Ensuring reduced variation in and improved access to SEND Local Offers and delivery of good quality, education, health and care pathways.
This will support system sustainability by:	Reducing the reliance on non-contracted activity with Right to Choose providers.	Care and Support on discharge from hospital are high cost and of variable quality across SEL. Understanding the market leads to better management and delivery of quality services	Specialist learning disability and autism inpatient bed costs are high. By reducing the number of people in inpatient settings, this will release funds to the system to enable improved community offers.	Creating opportunities to commission differently across the ICS to secure value for money and quality outcomes.
We will measure our impact by:	Autism Dashboards Reported waiting times for all boroughs.	Affordable community placements and accommodation and value for money. Reduction/No readmissions to hospital	NHSE Assuring Transformation (AT) data NHS Digital AHC reporting	SEND Inspection Outcomes

Long-term Conditions (LTCs)

South East London Integrated Care System

Our vision is:	We want holistic, personalised, proactive care for people living with one or more LTCs in SE London, that improves outcomes and reduces inequalities		
Our priority areas are:	**Spreading & Scaling holistic, personalized, proactive multiple LTC care**	**Reducing health inequalities and unwarranted variation in LTC care**	**Identifying support and enablers needed for Integrated Neighbourhood Team working with a focus on multiple LTCs**
In 2025/26, we will:	• Support our boroughs to implement integrated neighbourhood working for people with 3 or more LTCs, through consistent Implementation • Develop a new primary care/ community-based offer for weight management, including some access to new obesity drugs, incorporating the principles of integrated neighbourhood working • Further Cardiovascular disease prevention work, improving Blood Pressure control	• Replicate proven approaches to reducing unwarranted variation • Ensure that the developing community-based offer for obesity prioritises groups at risk of experiencing Health Inequalities • Tailored approaches across LTC services that specifically address the needs of communities at risk of suffering Health inequalities	• Support all 6 SEL boroughs to spread and scale integrated neighbourhood working, with a focus on LTCs, by: • Producing Toolkits and other support resources (podcast tutorials, Primary Care training, video resources) • Supporting expanded Point of Care testing for people with LTCs,
This will support population health and inequalities by:	• Implement approaches that transform current care models, such as Point of Care Testing and systematic risk stratification and optimising patients' medicines • Targeted approach to areas of Health Inequalties	• Ensure better use of data that allows a clear approach to risk stratification of people most at risk of health inequalities • Improving data collection for areas where Health inequalities exist, but where known data is not robust (e.g. obesity in primary care)	Ensure better use of data in agreed integrated neighbourhood working priority populations, that allows a targeted approach to risk stratification that reduces health inequalities
This will support system sustainability by:	• Consistent integrated neighbourhood working approach to 3+LTCs will release savings in acute and community services in the medium/ longer term	• By focussing on reducing unwarranted variation in agreed population cohorts, we will drive better ‘ageing well’ and reduce use of healthcare, including acute services.	• Consistent integrated neighbourhood working approach to 3+LTCs will release savings in acute and community services in the medium/ longer term
We will measure our impact by:	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)

Local Maternity and Neonatal System (LMNS)

South East London Integrated Care System

Our vision is:	That all women and birthing people receive high quality care, individualised to their needs that supports them to have the best outcome and experience			
Our priority areas are:	Reducing avoidable harm	Reducing inequalities and increasing equity	Improving personalised care including access to information	Supporting development of the service user voice
In 2025/26, we will:	• Collaborate with providers and business intelligence to gather the best data for improving outcomes. • Co-produce improvements with women and birthing people	• Continue collaborating with women, birthing people, and community organisations through the LMNS Equality and equity action plan	• Work closely with key stakeholders to improve information for women and birthing people enabling access to services informed decision making.	• Evolve from Maternity Voices Partnerships to Maternity and Neonatal Voices Partnerships
This will support population health and inequalities by:	• Identifying those in south east London with the poorest maternal and neonatal outcomes, allowing targeted projects to reduce variation and improve care	• Ensuring focus on reducing inequalities and supporting women's health • Supporting key support initiatives for underrepresented women and birthing people	• Providing individualised/woman centred and informed care • Supporting stronger relationships between women and birthing people and their care givers	• Ensuring that all voices are heard across maternity and neonatal services and support for co-production on improvement implementation
This will support system sustainability by:	• Understanding the needs of women and birthing people and their babies across SEL • Sharing best practice that will support improvements and reduce poor outcomes and therefore reduce the number of incidents and complaints	• Through the reduction of inequitable and avoidable harm and outcomes • Provision of equitable care for all enabling a more efficient and responsive service. • Reduction in unknown complexity which impacts resource and provision of care	• Enabling women and birthing people to be key stakeholders in their own care and support them with decision making • Ensuring that women and birthing people consider the importance of the choices across the life course	• Clear pathways and processes to support the engagement of service users at both a local and system level • Meaningful co-production across all maternity and neonatal services
We will measure our impact by:	• Key metrics that will track improvements but also facilitate focused intervention as required • Monitoring of service user and staff feedback	• Mortality and morbidity data • Service user feedback • Reduction in complaints and incidents	• The uptake of Personalised Care and Support Plans • Improved service user feedback	• Implementation of the MNVP guidance and localised SEL plans • Feedback from all SEL communities

Medicines Optimisation

South East London Integrated Care System

Our vision is:	For all SEL residents to have access to medicines which are appropriate and effective for their specific health conditions, maximising the benefits of their medicines while minimising any potential risks or harm. Target £850million annual medicines investment to areas of greatest need, improving outcomes and reducing inefficiencies.			
Our priority areas are:	Developing **"one pharmacy workforce"**, adoption of **digital** technology, the **neighbourhood NHS**	**Community Pharmacy** integration, moving **care closer to home**, **primary prevention**.	**Medicines Value, Medicines Safety and Antimicrobial stewardship (AMS)**	**Long Term Conditions (secondary, tertiary prevention), genomics, overprescribing, sustainability.**
In 2025/26, we will:	• Implement "one pharmacy workforce" to drive collaboration, enhance development and retention • Explore safe and convenient ways of supplying hospital medicines. • Support Integrated Neighbourhood teams. • Increase use of digital support	• increasing access to community pharmacy clinical services. • Increase access to prevention services in community pharmacy. • Test community pharmacy independent prescribing,. • Foster collaboration between general practice and community pharmacy	• Deliver high priority medicines optimisation and value opportunities. • Prevent severe harm from medicines and reduce the impact of medicines shortages • Implement the 5-year-action-plan-for-AMR	• Increase access to structured medicines reviews and reduce polypharmacy. • Reduce the environmental impact of medicines and medicines wastage • Enhance early diagnosis, prevention, and management of long-term conditions • Foster personalised medicine approaches tailored to genetic profiles.
This will support population health and inequalities by:	• Leveraging technology to improve efficiency, access, and care quality. • Developing flexible, multidisciplinary teams that work across organisational boundaries focusing on the person. • Delivering care closer to people's homes.	• Community pharmacies offering convenient access to health services, especially in underserved communities. • Ensure services are accessible to all, particularly underserved and disadvantaged communities.	• Enhancing medicines safety strengthens public confidence. • Minimising the risk of untreatable infections spreading, reducing the likelihood of global health crises. • Improving access to high value medicines.	• Shift focus from reactive care to prevention and long-term condition management. • Empower individuals to take responsibility for their health • Reduce inequalities in access, experience and outcome.
This will support system sustainability by:	• Reducing avoidable acute demand • Building a robust, diverse, and well supported workforce with the right skills and capacity.	• Reducing avoidable acute service demand • Ensuring rapid access to high quality services when people need them	• Prioritising interventions that deliver the highest value for investment. • Preventing errors to reduce the financial burden of treating complications or hospital stays.	• Ensure services are accessible to all, particularly underserved and disadvantaged communities. • Commitment to achieving net-zero carbon emissions by 2040.
We will measure our impact by:	Regularly assessing the impact through a workforce dashboard. Use data to refine strategies and adapt to emerging challenges.	Community Pharmacy Clinical Services dashboard. Use data to refine strategies and adapt to emerging challenges. Audit and evaluation of new services.	Establishing systems to detect, report, and learn from medication-related incidents. Medicines Value, Medicines Safety and AMS dashboard and metrics.	Long Term Conditions optimisation and overprescribing dashboards Engaging with the public and the voluntary and community sector on medicines use.

Mental Health (All Ages)

South East London Integrated Care System

Our vision is:	**Ensure residents receive mental health and emotional wellbeing support across their life course - timely, culturally appropriate, anti-discriminatory, trauma-informed, co-ordinated and holistic - and enables the development of resilient communities to live longer, healthier and more independently in the community.**			
Our priority areas are:	Community based support offers for AMH, including those who require assertive and intensive outreach care.	Integrated, holistic and consistent mental health care for children and young people (0-25).	Improve quality of care and timeliness of care for inpatient services across all ages to improve patient outcomes.	Working across the sector with partners, sustainably improving care for people who are neuro-divergent.
In 2025/26, we will:	• Delivering value and impact from our community transformation programme, including piloting a new model of care in Lewisham. • Move towards the new 28-day standard for community waits. • Explore opportunities to provide stepdown care via primary care.	• Continue to transform community CAMHS to further reduce waiting times and move towards the new 28-day standard. • Develop a clear/consistent offer for CYP crisis care across the sector. • Deliver co-produced and targeted interventions for children in primary schools.	• Improving access and flow through inpatient services. • Ensuring inpatient services offer effective, holistic and therapeutic care.	• Open a new ADHD Singe Point of Access for Adults and develop the assessment and treatment pathway. • Test and pilot a new integrated offer for CYP neurodiversity assessments. • Reducing waiting times
This will support population health and inequalities by:	• Ensuring residents have access to timely mental health care in the community, providing earlier intervention and support.	• Delivering improved access to community CAMHS (as per the CYP CORE20PLUS5 framework). • Early mental health care and intervention to CYP.	• Enable care in the least restrictive environment. • Ensure care as close as possible to home. • Offer patient-centred and culturally appropriate care.	• Ensuring all patients have equal access to timely assessment and treatment to then enable access to other support services.
This will support system sustainability by:	• Providing pro-active community-based care. • Reducing dependency on inpatient mental health services.	• Intervening earlier in the life course of an individual preventing escalation as adults. • Appropriate and adequate use of secondary care resources.	• Reduction of spend on private bed usage through better flow, including improved length of stay.	• Ensuring appropriate use of secondary care services. • Reducing spend on non-contracted activity for ADHD.
We will measure our impact by:	• DIALOG score for patient outcomes • Community caseloads and contacts • Reducing inpatient admissions for patients known to CMHTS. • Delivery of 28-day community waiting times standard.	• Delivery of the 28-day community waiting times standard and other waiting times standards. • DIALOG score for patient outcomes, and other feedback direct from CYP/parents/schools.	• Out of Area Placements • Length of stay • Waiting times for inpatient admission • DIALOG score for patient outcomes	• Waiting times from referral to assessment and treatment. • Local patient experience and satisfaction surveys.

*N.B: Although we are generally talking about 'last year of life' there will be some people where a palliative care approach may be earlier. For others, they may be identified in the very last weeks, days or hours

Palliative and End of Life Care

South East London Integrated Care System

Our vision is:	**To ensure people of all ages at the end of their lives* are identified early so they can be supported to make informed choices, receive 24/7 care in the place of their choice and receive the best quality, personalised care, with people close to them supported by people who are empowered, skilled, confident and timely**			
Our priority areas are:	**1. Proactive and Personalised Care:** We will improve early identification of people approaching end of life and ensure proactive, personalised care and support planning	**2. Improve our service offer:** We will ensure evidence-based improvements are identified and recommended to make Palliative and End of Life Care services more accessible 24/7 for patients, carers and professionals	**3. Improve access:** We will identify groups who are marginalised and improve access for these groups	**4. Improve palliative care awareness:** We will improve awareness of palliative care support with patients / carers, the community and the wider workforce, including harder to reach populations
In 2025/26, we will:	Deliver place-based projects to increase the use of the Universal Care Plan across South East London, alongside other activity to promote the use of the Universal Care Plan	Undertake a review of existing services that provide support to people at end of life in the Out of Hours period, alongside exploring recommendations and new models support, including provision of information advice and guidance	Deliver a range of events and awareness raising activities to improve workforce awareness of marginalised groups and their needs, alongside sharing learning around ethnically marginalised communities	Deliver training and awareness raising activity to the wider clinical workforce to improve confidence in identifying, and having associated discussions with, those nearing end of life, alongside delivering improved online information, advice and guidance
This will support population health and inequalities by:	Targeting specific groups facing inequality with Advance Care Planning resources / improving take up of Universal Care Plan within marginalised groups	Improving consistency of service provision and access to information regardless of geography or demographic background	Improving awareness of the palliative needs and considerations for marginalised groups - leading to improved access and support, plus more culturally competent practitioners	Ensuring all care settings can access relevant training, and information advice and guidance
This will support system sustainability by:	Reducing unwarranted demand on emergency hospital departments and hospital admissions	Moving more care into the community, reducing unwarranted demand on emergency hospital departments and hospital admissions	Reducing unwarranted demand on emergency hospital departments and hospital admissions, also increasing community empowerment	Reducing unwarranted demand on hospital departments and primary care, also increasing community empowerment
We will measure our impact by:	An increase in the proportion of South East London's registered population that have an End of Life Universal Care Plan	A reduction in the proportion of hospital deaths in South East London	An increase in the proportion of South East London's registered population that have an End of Life Universal Care plan	Improvement of understanding within the renal workforce around hospice and palliative care through post-training feedback

Planned Care

Our vision is:	**For elective services to be equitable, deliver high quality care and be responsive to the needs of our population. Our aim is to work collectively as a system to ensure that patients have better access to appropriate care when they need it, reduce the number of times patients need to come to hospital and ensure care is offered quickly and, whenever appropriate, close to where patients live.**			
Our priority areas are:	Creating **improved pathways** for patients accessing specialist care.	Maximising the **value of secondary care** clinical activity.	**Minimising waiting times** and **improving treatment capacity** for admitted pathways.	**SEL Community Diagnostic Centre (CDC) rollout** programme to create additional diagnostic capacity.
In 2025/26, we will:	• Expand the specialist advice offer in SEL and identify variations in utilisation of specialist advice. • Develop the provision of community-based alternatives to planned care.	Develop robust clinical and administrative processes, review and transform pathways, enable patient choice, increase provision of PIFU, reduce DNA rates and better support patients with prevention and self-management.	Increase treatment hub capacity, modify Orpington orthopaedic operating model and increase use of independent sector where financially possible.	Develop business cases for additional CDC capacity, embed Soliton Share+, increase referrals to CDCs, utilise SEL data to improve communications with primary care and review demand and capacity management.
This will support population health and inequalities by:	Ensuring equitable access to specialist advice to support timelier access to care and the management of patients in the most appropriate care setting.	Patients receiving faster care, reducing the risk of worsening health outcomes whilst waiting. Targeting DNA interventions to underserved groups.	Reducing health risks associated with long waits for treatment and the variation in waiting times across Trusts, supporting equitable access and waits across the population.	Supporting equitable and timely access to diagnostic procedures across all population groups and delivering a faster pathway to treatment and management.
This will support system sustainability by:	Efficient use of resources across all tiers of care by ensuring patients are seen in the most appropriate care setting .	Ensuring outpatient and other secondary care capacity is used efficiently, appropriately and with maximum value for our patients.	More efficient use of resources across the whole system and improving resilience to manage increases in demand or other pressures.	Expanding CDC capacity helps improve performance, makes more efficient use of system resources and reduces financial burden of long waits.
We will measure our impact by:	Improved utilisation, provision and turnaround time of specialist advice services (eRS and Consultant Connect).	Analysing the proportion of patients moved to PIFU, DNA rates, waiting times for first appointments.	Monitoring number of patients waiting > 52 weeks, receiving treatment within 18 weeks and number of treatments delivered.	Analysing trends in patients waiting <6 weeks and >13 weeks, vacancy and turnover rates.

Prevention, Wellbeing and Equity

South East London Integrated Care System

Our vision is:	Equitable access to prevention and wellbeing support for all SEL residents through systematic, community-partnered approaches			
Our priority areas are:	**PREVENTION FRAMEWORK**: System-wide approach to embed evidence-based prevention across SEL and enable better resource alignment and collaborative delivery across key prevention priorities	**BUILDING TRUST AND CONFIDENCE WITH OUR COMMUNITIES:** Improving partnerships with residents and community groups to meet diverse population needs	**VACCINATIONS & IMMUNISATIONS:** Working collaboratively to improve vaccination coverage and protect population health	**VITAL 5**: Systematic approach to identify and support residents with Vital 5 risk factors through health promotion, early identification, self-management, and proactive management
In 2025/26, we will:	• Embed systematic approach make every prevention contact count Define core prevention offer with prioritised populations, clear metrics and evidence-based delivery Use data, evidence and insights to shape system-wide prevention priorities through operational planning	• Facilitate partnership development with community-based organisations Create equitable cross-sector partnership for community-led approaches Develop indicative community-led outcome measures	• Map provision, coverage and evidence of action Develop communications and culturally appropriate promotion Make an integrated offer the default for vaccination catch-up Maintain skilled workforce	• Strengthen health promotion and awareness of the Vital 5 in communities Improve detection of risk factors and early intervention with focus on Core20Plus5 Embed Vital 5 in SEL care pathway programmes (incl. Vital metrics for CYP)
This will support population health and inequalities by:	• Improve resource allocation to areas of greatest need and inequality Evidence-based prevention interventions aligned to population need	• Trust building in underserved communities Transform partnerships with local voluntary sector organisations	• Reducing vaccination inequalities Ensuring convenient access, with bespoke offers for under-served communities	• Earlier identification of modifiable risk factors Improved access to and more targeted preventative services
This will support system sustainability by:	• More efficient use of prevention resources Prevention embedded in system planning in more coordinated and focused way Sustainable prevention delivery models Reduced acute-care based healthcare utilisation	• Efficient prevention resource use and return on investment Community-led solutions aligned to evidence base of improving sustainability	• More efficient use of prevention resources through V&I Ensuring rapid access to high quality services when needed Improving care for disadvantaged groups	• Reducing acute service demand Cost-effective early intervention Improving workforce capabilities Better integration of prevention into routine care and SEL care pathways
We will measure our impact by:	• Agreed outcome measures and baseline data for priority areas through a framework for outcomes and benefits tracking	• Co-developed impact measures Digital outcome tracking capabilities	• Regular qualitative insights from on vaccination uptake	• Number and demographics of V5 checks across different settings • Prevalence of V5 in different communities

Primary Care

South East London Integrated Care System

Our vision is:	All residents of have access to high quality, personalised, integrated primary and community care services when they need it, delivered in a sustainable way.			
Our priority areas are to:	**Deliver high quality, equitable primary care that** minimizes unwarranted variation in outcomes for all	**Improve Access** by understanding the drivers of poor access for population groups and co-develop approaches that tackle the issue.	**Improve the sustainability of Primary Care a**s part of the neighbourhood health service	**Make the shift to neighbourhoods,** working with communities, health & care providers, voluntary organisations to improve the health and wellbeing of a local community
In 2025/26, we will:	• Define consistent standards of care • Measure delivery of the standards by improvement in patient, staff and system outcomes • Better target our resources into areas where outcomes are poorest	• Work with practices, PCNs and patients to understand the core components of access for different populations • Implement plans to tackle issues including making an appointment, waiting times, risk stratification, types of appointments, workforce planning and collaborative working	• Improve recruitment and retention of staff in priority areas • Develop change leadership within primary care • Provide evidence on most effective use of ARRS staff to improve patient, staff and system outcomes. • Develop a framework to improve the sustainability of primary care	• Agree a common population health segmentation approach • Establish neighbourhood teams starting with those living with multiple LTCs, frailty and children and young people • Implement common framework and models of care for priority populations • Establish an outcomes framework and monitoring approach
This will support population health and inequalities by:	Lifting standards of care for the whole population, whilst reducing variation in outcome between popualtions	Taking a more targeted approach to ensuring that those in greatest need have responsive access and proactive care and support.	Ensuring we are targeting our sustainability support for primary care into the services and areas where this is most needed.	Identifing residents within target populations and connecting them into health, wellbeing and br6ader services that support being to stay well for longer.
This will support system sustainability by:	Optimising prevention, treatment and proactive care across primary care to reduce growth in ill-health over the longer term..	Tackling complex issues impacting on access in general practice, to ensure that people at greatest risk will not need to navigate alternatives and will receive a holistic service.	Tackling the issues within our control affecting the stability of primary care, so that services are able to meet the growing needs of our population for both episodic and proactive care.	Reducing hospital admissions and outpatient appointments by shifting the care from an expensive hospital reactive environment to a more cost effective community model.
We will measure our impact by:	Reducing variation in key treatment and clinical care outcomes across our population (such as blood pressure control, diabetes control, care planning etc)	• Triangulating outcomes from FFT, the GP patient and Health Insights survey • Increasing the number of appointments delivered within 2 weeks	• Increasing and reducing variation in the the number of whole time equivalent roles per 100,000 of our population • Setting out a core offer to primary care by the end of 2025/26	• Tracking the number of patients being supported through new neighbourhood models • Tracking patient and staff experience of new neighbourhood models

Specialised Services

South East London Integrated Care System

Our vision is:	To provide integrated, high-quality, and equitable specialised services that meet population health needs, reduce inequalities, and ensure system sustainability through collaboration and innovation.		
Our priority areas are:	Delivery of a Specialised Sustainability Review	Sickle cell disease (SCD)	Blood borne virus ED testing and HIV re-engagement / South London HIV network
In 2025/26, we will:	• Create a Compendium of Opportunities, drawing together possible transformation projects. • Undertake a holistic data review, to assess variation and inequalities across all specialised services. • Create an executive summary of opportunities for efficiency, effectiveness, and improved outcomes to feed into ICS financial sustainability plans	• Evaluate and embed learning from existing pilots into wider care pathway planning • Promote the new community service, including via engage with patients, local media and attending Learning Time events for GP practices to raise awareness of enhanced service / CNS coverage. • Ongoing consistent delivery of MDT clinics across the three community providers. • Full implementation and collection of EQ-5D patient outcomes survey across all ages	• Expand opportunities of opt-out testing (e.g. at GP practices) • Building stronger partnerships with primary care across SEL through the GP Champions • Work to improve our linkage to care rates • Continue to build clinical expertise and excellence through our SL HIV Network • Continue to work closely with the hep C network to deliver high quality hep C care • Further close working with primary care to provide holistic care for people living with HIV
This will support population health and inequalities by:	• Ensuring inequalities analysis is at the heart of the holistic data review process, to uncover variation and inequalities • Scoring and prioritising known opportunities with a significant focus on preventing health inequalities.	• Reduction in health inequalities relating to SCD • Improved patient experience of engaging with sickle cell services • Increased awareness of SCD • Increased quality of life for sickle cell patients, their families and carers	• Opt out BBV testing is an effective way of reducing health inequalities – there is evidence that the majority of new diagnoses have not been tested in other venues • Our re-engagement work has effectively reached our Core20PLUS population
This will support system sustainability by:	• Maximising the opportunities provided by delegation to understand where services can be delivered more efficiently. Once identified, it will propose the key projects needed to do this.	• Reduced pressure on acute providers • More sustainable working habits and demands for healthcare services	• Proactive identification of people living with HIV not in care and diagnosing to keep them well to reduce inpatient admissions • Proactive identification of people living with hep B and C to treat them and to reduce costly liver transplants
We will measure our impact by:	• Projects and opportunities will be scored against a set criteria to determine priority. • Those undertaken will be comprehensively evaluated to understand their impact.	• EQ5D-L • Activity data • Emergency care usage	• Activity data • Inpatient admissions (number and LoS) • Viral hepatitis related liver transplant and liver cancer rates

Urgent and Emergency Care

South East London Integrated Care System

Our vision is:	To deliver an integrated safe and responsive Urgent and Emergency Care model that meets population needs and enables people to access the care they need, in the least intensive setting, when they need it and minimising the time spent in hospital through a resilient and sustainable service offer.		
Our priority areas are:	Front Door – ensuring high quality care, improving the timeliness of UEC responses and sustainability of UEC performance standards (all ages, ref CYP Programme; ref Mental Health Programme).	Discharge – ensuring nobody spends more time in hospital than is necessary with supportive transfers of care and delivery of discharge standards (mental and physical health for adults).	Contributing to the SEL System sustainability plan across UEC pathways by implementing the National Criteria to Admit (CTA) tool for all specialities prior to admission from the ED.
In 2025/26, we will:	Work with partners to support site-based audits, improvements and evaluation to deliver enhancements in performance. Continue to focus on improvements in provision, trusted assessor referrals to SDECs and to improve front door streaming to the most appropriate setting, exploring and optimising digital functionality improvements.	Work with acute partners to improve flow models to reduce discharge delays for those who do not meet criteria to reside, focusing work on patients on pathway zero. Work with local authority partners to improve discharge for patients on pathways 1-3 and meet SEL discharge standards. Support our mental health trusts to embed the 10 principles of mental health discharge	Work with acute partners to carry out clinically-led CTA audits focusing on high-volume specialities initially using the National CTA audit guidance. Implement the CTA tool in ED departments. Evaluate impact.
This will support population health and inequalities by:	Consistency in streaming models across SEL to support the delivery of parity of access to urgent and emergency care. Where required, pilots and pathways supporting those from Core20+ groups to improve access and experience.	Consistency in meeting the SEL discharge standards for both mental and physical health discharges helps us work towards parity for all patients who require supported discharge and transfer of care.	Consistency in the admission threshold/criteria for all specialities prior to admission from ED; reduces variation of practice between individual clinicians. Reduction in LoS in EDs improving the patient experience.
This will support system sustainability by:	Streaming patients to the most clinically appropriate destination will reduce the pressure on EDs and improve system performance against UEC performance standards.	Reducing the number of patients who are clinically ready for discharge but continue to reside in hospital, providing an opportunity to reduce costs around escalation beds, boarding and agency staff if (NB although this may also require investment in some alternative service provision)	Reduction in admissions and reducing bed costs; patients seen in a more appropriate setting; utilisation of alternative pathways.
We will measure our impact by:	• Improvement in performance against 4 hour target • Improvement in performance of ambulance handover times • Improvement in outcomes from missed opportunities audits	• Improvement on the number of admitted patients not meeting criteria to reside • Improvement on number of patients discharged by 1pm • Reduction in SEL costs of escalation beds open/boarding	• Improvement in conversion rate (% admitted from ED) • Reduction in patients admitted in over 12 hours from the time of arrival (%) • Mean time in department - admitted patients

Women's and Girls' Health

South East London Integrated Care System

Our vision is:	To improve access to health care for women and girls across the life course, enhancing experience, empowerment, and improving health equity and outcomes - with a focus on increasing services and support available closer to where women and girls live, work and are educated in the community.			
Our priority areas are:	Reducing health inequities and improve access to timely care for women and girls in the community	Co-commission pilot women's and girls' health hub models in Greenwich/Bexley and Lambeth to guide future commissioning arrangements and scaling	Upskill the ICS workforce in women's and girls' health through multidisciplinary teams, supporting satisfaction and retention	Improve health education for women and girls with culturally tailored approaches, empowering individuals to make informed choices
In 2025/26, we will:	• Embed population health management approaches within pilot hub models • Work with voluntary sector organisations to deliver in/outreach • Continue to gather resident insights through our Let's Talk About Women and Girls' Health survey, focus groups and outreach	• Launch two pilot hub and spoke models • Embed continuous improvement and evaluation within pilot hubs to inform business case to reinvest from acute-care into community hub models. • Use the Women and Girls' Health Network to share best practice and address challenges	• Create a centralised repository for healthcare providers with current, evidence-based guidelines on the eight core health services for women and girls. • Offer specialised training on these services in partnership with training hubs, Trusts and the Acute Provider Collaborative SEL Gynaecology Network	• Create a centralised repository with trustworthy, easy-to-understand information, advice and guidance available for residents across SEL • Work with schools and voluntary/community sector organisations to develop and disseminate culturally tailored health resources
This will support population health and inequalities by:	Improved access for underserved groups with tailored and culturally competent health care interventions	Improved access to integrated, quality care through pilot hub models, leveraging evaluation and shared best practices to reduce disparities women's health care services across the hub scope of service	Reduce variation of services across south east London so that women and girls don't experience disadvantages in the healthcare they receive based on where they live or which service they access	Improving access to reliable, culturally relevant health information empowering underserved communities to make informed decisions and manage their well-being throughout life
This will support system sustainability by:	Reducing health inequities, improving resource efficiency, and shifting care towards prevention and early health intervention services and treatment.	Sharing in real-time any benefits realised through the pilots and opportunities to commission services in a more joined-up way	Shifting service delivery out of acute settings and into the community where appropriate and upskilling the workforce with specialist women's and girls' health input	Reducing demand for healthcare services through improved health literacy, empowering residents to engage in preventative care, self-management, and early intervention
We will measure our impact by:	Track the number of people accessing pilot hubs and outreach services, capturing ethnicity, age and deprivation data to see improvements in health equity	Tracking demographic data on access, experience and outcomes within hubs against and assessing the feasibility of the hub model through formal evaluation	Uptake of and feedback on training and education	• Resident access and feedback on usability • Number of culturally tailored health resources developed

South East London Integrated Care System

Enabling delivery of the plan

Digital

Key themes within the Joint Forward Plan	Empower people through digital and data	Digital solutions for connected care	Deliver data driven insights	Ensure system resilience, data integrity and cyber security	Drive continuous improvement and innovation	Undertake workforce planning to support our digital, data and analytics activities
In 2025/26, we will take the following actions to make progress in these areas	• Increase uptake and usage of the NHS App and increase functionality available in the App • Continue initiatives to improve patient experience in accessing general practice • Support digital inclusion by expanding the laptop donation scheme and continue to support the ICS Digital Inclusion Lead to ensure	• Digital enablement of integrated neighbourhood teams • Progress electronic patient record projects for LGT and SLAM • Convergence of pathology GP ordering onto the radiology GP ordering platform • Supporting integration between general practices and pharmacy • Continue support for the London Care Record and on expansion of the Universal Care Plan	• Launch the first release of the London Secure Data Environment • Facilitate the transition to a consistent population health management data source and tools for SEL • Expand access to the integrated data held to support proactive care and population health in alignment with information governance and data sharing provisions • Define the plan for utilisation of the Federated Data Platform	• Finalise and implement the ICS Cyber Security and System Resilience Strategy • Improve timeliness of data sharing and information governance requests • Review of technical and support infrastructure to identify opportunities to improve efficiency and cyber security and resilience	• Implement the AI Framework in South East London and progress opportunities to increase the use of AI and automation • Pilot the use of ambient voice technology for GPs • Host a second innovation day and digital showcases. • Continue to drive improvements to digital maturity across PC and ASC	• Work with London region to progress development of workforce plans for the Digital, Data and Analytics workforce • Plan for the implementation of the NHS Staff Passport • Identify and promote opportunities to develop digital and data skills in our workforce
We will measure our impact by:	• NHS App registration Number of GPs offering appointment booking and management in the NHS App • Number of laptops repurposed to community partners • ONS Health Insights Survey re GP access	• Evaluation of digital enablement of integrated neighbourhood teams • Business cases approved including benefits defined for LGT and SLAM EPRs • Views of the London Care Record	• Feedback from population health management teams on access to data • Increase in utlisation of the FDP across South East London	• DSPT compliance • Decrease in Windows Defender Score • Time taken to process a data sharing request or data protection impact assessment	• Number of AI projects taken from demand to proof of concept or pilot • Review of pilot results of ambient voice technology • Digital maturity assessment score	• Number of staff on data and AI apprenticeships across SEL • Improvement in digital maturity assessment score for supporting people

ESTATES

The key supporting themes highlighted in our Joint Forward Plan are:	**Maximising the Use of Public Estate, including by:** • **Exploring co-location opportunities.** • **Supporting service transformation through efficient estate planning**	**Supporting Integrated Neighbourhood Care including by:** • **Ensuring estates facilitate collaboration between primary, secondary, and social care services.** • **Prioritising solutions that enhance service delivery closer to home**	**Focussing on Long-Term strategic planning, including by:** • **Investing in long-term estate solutions that support community health needs** • **Ensuring estates infrastructure aligns with future population health demands.** • **Leveraging digital and data solutions to optimise space utilisation**	**Improving sustainability by:** • **Implementing carbon reduction initiatives within the healthcare estate.** • **Exploring energy-efficient building solutions to support NHS sustainability goals.**
In 2025/26, we will take the following actions to make progress in these areas	Use the Estates Board for South East London to explore opportunities to plan for joint estate development where possible. Create a financial sustainability plan to save money, generate savings and create additional revenue	Working with place teams to identify current and future neighbourhood hub needs and locations we will: - • prioritise initiatives to enable better colocation of primary care and community services and delivery of primary care at scale • prioritise opportunities to enable delivery of primary care estate that is fit for purpose, supports care models, and is energy efficient to reduce costs and contribute to sustainability targets • Develop a system tool to better understand how clinical spaces are being used in General Practice that could be used	Develop our 10 year Capita10-yearthat is aligns with the drivers for change that were identified within The South East London Estates and Infrastructure Strategy: • Decompressing acute sites • Development of proximal ambulatory hubs • Delivery of Community Diagnostic Centres • Community properties: using the existing stock of buildings, and developing new facilities, to enable routine care (e.g. outpatients) to be shifted closer to patients Enhanced collaborative working across South East London; acute and community providers, and local authorities working together to make better use of resources (system wide optimisation) Borough priorities - Provider, Local Care Partnership, Borough, and VCSE	Prioritise the use more green energy; consumption of green energy appears to be low across the ICS. Signing up to the national CCS framework for energy. Identify opportunities to reduce flood occurrences across our estate as these pose an increased risk to business as usual Disposal of waste is less cost efficient than our peers, particularly the disposal costs for GSTT and KCH (compared to peers); we must prioritise identification of opportunities to reduce waste disposal costs. Opportunities should be identified to reduce carbon emissions from clinical waste, which are significantly above peer values for GSTT, KCH, and above peer values for LGT
We will measure our impact by:	List of sites in delivery	Formalising our neighbourhood plan	Speaking to our patients and staff and acting on feedback.	Reduced energy bills Reduced property costs Amalgamate contracts to ensure economies of scale

Green Plan delivery/Net Zero

South East London Integrated Care System

The key areas where we can support the Joint Forward Plan are:	Delivery of the ICS Green Plan and achievement of the NHS net zero targets supports – either directly or indirectly (in partnership or via co-dependencies with other ICS workstreams): • **Prevention and wellbeing** – creating a clean and healthy environment to support maintenance of good health • **Mental health** – reducing the impact of climate and environmental change on mental health • **Primary care and people with long-term conditions** – working with primary care through existing structures, and within medicines workstreams, especially around respiratory care, inhaler usage and recycling • **Reduction of health inequalities** – a healthy environment reduces exacerbations of health conditions that may drive health inequality • **Partnership with our staff and communities** – cross-organisation working and inviting our people to learn and act alongside us • **Protecting our finances and the environment** – reducing waste, and therefore cost, from our system • **Contributing to system sustainability** – including moves from hospital to neighbourhood-based care • **Sustainable digital transformation** – realising the environmental benefits of home and self care for patients, and remote working for staff
In 2025/26, we will take the following actions to make progress in these areas	• Refresh the ICS Green Plan (as per NHS England guidance) for 2025-2028, and deliver objectives to drive reductions in waste, energy use, water use, single use consumables, unnecessary treatment and – ultimately - carbon emissions, and to increase climate resilience, circularity and quality of care. • Develop the partnership between the ICS Sustainability Programme and System Sustainability workstreams • Increase engagement with research and innovation activities • Increase the focus on sustainable models of care and/or lean pathways; seeking more clinical leadership to enable this • Identify and follow-up on funding opportunities to improve capacity and expertise to deliver our plans • Find opportunities for pan-London working alongside other London ICBs and Greener NHS, to deliver benefits at scale, where relevant and possible • Foster our relationships with other ICS-led workstreams, to align objectives and strategies • Continue strengthening our governance and networks; using the leadership provided by the (board/exec-led) Sustainability Oversight Board to further drive collaboration across system partners
We will measure our impact by:	• Utilising our networks to follow progress against objectives, upwards reporting to our Sustainability Oversight Board and onwards assurance reporting to Greener NHS • Quantitative assessment of progress against defined targets - reporting metrics as per quarterly Greener NHS dashboard submissions and Estates Return Information Collections • Calculating reductions in carbon emissions against pre-plan carbon baselines • Internal and external air quality measuring • Identification and mitigation of programme and climate risks • Contract monitoring our trusts and our suppliers • Tracking social value measures included in procurement exercises and contract awards • Number of heat and flood occurrences triggering risk assessments

People Programme

South East London Integrated Care System

Key supporting themes for the Joint Forward Plan	Support the development of integrated community-based workforce models, including: • Flexible employment and reducing turnover. • Apprenticeships and shared employment across heath, social care and VCSFE	Improving recruitment and retention, through workforce development, including: • Attracting and retain healthcare staff. • Developing shared career pathways and promoting careers in health and care.	Reducing inequalities & supporting inclusion including: • Addressing disparities in career progression and training access, particularly for staff from diverse backgrounds. • Anti-racist and culturally competent healthcare initiatives
In 2025/26, we will take the following actions to make progress in these areas	• Work through the ICB governance, People Committee and partnerships formed to actively support community based workforce models • Promote system-wide learning and leadership development through informal networks e.g. OD/leadership collaborative • Build on existing work delivered against the SEL People Strategy and work to support the development of Neighbourhood Care Teams. • Define a model of expanded social care workforce support to aid retention • Expand sharing of educational resources and information across partners through the SEL website and the Hub Online • Utilise the London staff movement agreement (and NHS Digital Staff Passport) • Promote and increase apprenticeship uptake and support smaller providers via apprenticeship levy	• Support delivery of the NHS operating plan by improving productivity system-wide. • Improve and expand the processes of workforce planning and utilisation of workforce intelligence to drive evidence- based decision making. • Targeted action for risks to workforce supply • Retention programme to support flexible working, legacy mentoring, career conversations and reasonable adjustments; further sharing of good practice from retention exemplar programmes. • Delivery of staff Health and Well-being (HWB) strategy, with a focus on Primary and Social Care. • Expand and extend the activity of the Health and Care Jobs Hub. GLA funding and delivery plan confirmed until Sept 2025. • Delivery of the “Volunteering without Barriers” programme led by KCH; with potential to link to Get Britain Working white paper	• Equality, Diversity and Inclusion plan delivered with the EDI committee, sharing good practice from EDI awards, sexual safety plans and anti-racism policy. • Continue expansion and engagement of EDI events and activities and supporting design of London EDI training programmes to ensure return on investment. • Expand and extend the activity of the Health and Care Jobs Hub to deliver the priorities of Anchor Alliance, South London Listens and “Get Britain Working”. • Working with partners in DWP, NHS, LA and VCSE to streamline access to employability & skills support for people with disability/long term conditions and ill health to get into and stay in work. • Develop bids for work well and connect to work funds. • Promotion of leadership academy coaching and mentoring platform and local offers across SEL. • Supporting Care Leavers into work and improving understanding of complex needs to plan future support
We will measure our impact by:	• Co-designing and agreeing a delivery plan for supporting community-based workforce models • Quantify uptake of educational resources • Monitor the utilisation of staff passporting and develop case studies showcasing best practice • Monitor and track apprenticeship uptake and spend, subject to upcoming National changes	• Key workforce data including staff vacancies Utilisation of data to support workforce planning, including use of new roles & workforce models. • Tracking staff turnover and retention • Employers engaged, education delivered and job outcomes through the jobs Hub • Staff satisfaction and uptake of wellbeing initiatives	• Participation at EDI events • Use of online resource monitored through hits, surveys and feedback • Get Britain working programme established with governance and delivery plan set • Number of local people supported into education and employment, including demographic detail

Population Health

The key supporting themes highlighted in our Joint Forward Plan are:	Developing a robust population health management approach, including: • Using data and analytics to understand population health needs. • Supporting early intervention and prevention strategies with data-driven insights	Enhancing Data and Information Governance, including: • Effective data-sharing to enable effective population health interventions. • Establishing infrastructure to support data monitoring and evaluation.	Enabling continuous improvement including: • Sharing insights and case studies to improve learning across the healthcare system. • Regularly reviewing outcomes and adapting strategies to optimize health service delivery	Utilising population health data for health promotion and intervention including: • Using predictive analytics and real-time dashboards to track health trends and service efficiency. • Supporting clinicians with data-driven insights for better decision-making at the point of care
In 2025/26, we will take the following actions to make progress in these areas	• Bring together experts within our system from across data, analytics, digital, clinical leadership and cross-system programmes to define an SEL approach to PHM. • Develop, within the shared approach, a centralised 'enabling arm' for PHM activity.	• Explicitly confirm the use of a single data source (a 'single version of the truth'). • Define our infrastructure to continue supporting PHM across SEL, starting with a clear statement to standardise where practical. • Continue to consider impacts and opportunities from the London Health Data Strategy and subsequent availability of at scale data and analytics capabilities for London.	• Continue developing Community of Practice and use it to provide training, disseminate information on useful tools, and collaborate on resolving some of the system-wide PHM issues	• Continue to work with priority programmes, starting with four strategic priorities (Children and Young People, Frailty, Multiple Long Term Conditions and the SEL Prevention Programme), to understand and meet their needs, particularly through the implementation of Integrated Neighbourhood Teams.
We will measure our impact by:	• Agreement of a single option for each 'consideration' (or component) of the SEL approach to PHM. • The creation and dissemination of a clear process map for clinicians and care professionals to access and use PHM in support of their work.	• Agreement of a single option for each data and information governance related 'consideration' (or component) of the SEL approach to PHM.	• The continuation of the Community of Practice with an explicit focus on the sharing of best practice.	• The use of PHM within the four stated strategic priority programmes (*this will be monitored within the relevant programmes*).

Quality and Safety

South East London Integrated Care System

The key supporting themes highlighted in our Joint Forward Plan are:	Reducing avoidable harm, including: • Learning from suboptimal care events to improve outcomes. • Identifying and scaling best practice across the system	Strengthening Oversight and Governance, including: • Ensuring clear structures for quality, safety and safeguarding across health services. • Enhancing multi-agency collaboration to protect vulnerable populations.	Improving intelligence on quality, safety and safeguarding, including: • Enhancing data monitoring to improve insight to identify emerging patient safety themes • Using data monitoring to identify safeguarding risks early. • Using analytics to inform interventions and track safeguarding outcomes.	Addressing Inequalities in quality, safety and safeguarding, including by • Improving recognition of the impact of poverty, domestic abuse, and exploitation on safeguarding. • Implementing culturally sensitive approaches to safeguarding interventions. • Providing additional support for groups at higher risk
In 2025/26, we will take the following actions to make progress in these areas	• Implementation and embedding of the national Patient Safety Strategy • Continue to develop the After Action Reviews (AAR) led by the quality team • Lead on cross-system Patient Safety Incident Investigations • Collaborating with partners across the system to share learning from patient safety events	• Working with NHSE and partners to embed the principles of the Oversight Framework • Collaboration with Providers across the system to establish consistent patient safety reporting • Integrate Specialist Commissioning quality oversight into the ICB quality governance framework	• Collaborate with providers and business intelligence to gather the best data for improving oversight and outcomes	• Raise awareness and embed the use of the new Quality Impact Assessment policy • Ensuring focus on reducing inequalities during patient safety learning responses
We will measure our impact by:	• Key metrics that will track safety insight and facilitate focused intervention as required • Monitoring of data inputted via the Learning from Patient Safety Events (LfPSE) platform	• Ensuring oversight is establishing in line with the ICB Quality Governance Framework	• Establishing a system quality and patient safety dashboard • Creating a SEL.net page for ICS colleagues to utilise	• Mortality and morbidity data

Safeguarding

The key supporting themes highlighted in our Joint Forward Plan are:	Reducing avoidable harm, including: • Learning from suboptimal care events to improve outcomes. • Identifying and scaling best practice across the system	Strengthening Oversight and Governance, including: • Ensuring clear structures for quality, safety and safeguarding across health services. • Enhancing multi-agency collaboration to protect vulnerable populations.	Improving intelligence on quality, safety and safeguarding, including: • Enhancing data monitoring to identify safeguarding risks early. • Using analytics to inform interventions and track safeguarding outcomes.	Addressing Inequalities in quality, safety and safeguarding, including by • Improving recognition of the impact of poverty, domestic abuse, and exploitation on safeguarding. • Implementing culturally sensitive approaches to safeguarding interventions. • Providing additional support for groups at higher risk
In 2025/26, we will take the following actions to make progress in these areas	• Improve inputs to the Safeguarding Case Review Tracker (S-CRT), including updates and recommendations. • Ensure that all ICB staff are compliant with mandatory safeguarding training at a level commensurate with their role and grade. This will involve delivering a L3 training programme.	• Strengthen our governance and inputs towards ICB involvement in Domestic Abuse Related Death Reviews (DARDR). • Develop the function and outputs of the newly formed ICB System Safeguarding Group (SSG).	• Develop, implement and share an ICB dataset recording information based on the Information Sharing to Tackle Violence dataset. This will enhance the ICB response to the Serious Violence Duty. • Develop a standardised safeguarding dataset for health organisations across SEL, aiding consistency and reducing variation.	• Further develop the ICB Care Leavers Covenant, ensuring health related employment opportunities for this group of vulnerable children. • Deliver a local pilot project on the Child Protection – Information Sharing system (CP-IS), further developing the uptake and use of the system in south east London.
We will measure our impact by:	• A quarterly audit of inputs to the S-CRT will be undertaken, and learning from the audit shared with the borough based ICB safeguarding teams. • A quarterly audit, benchmarking role against the safeguarding competency framework, and monitoring training compliance.	• Agree a governance framework for ICB involvement in DARDRs. Audit timeliness and quality of inputs to DARD's by ICB employed staff. • In early 2026, conduct a short survey of SSG members to ensure that the group is meeting their needs and expectations.	• The ICB dataset will be complete, updated quarterly and shared on a regular basis with Community Safety Partnerships. • The safeguarding dataset will be completed and agreed upon and used as widely as possible within the health system.	• Audit the numbers of care leavers who have found employment through the Care Leavers Covenant initiative. • The pilot project will be completed and a 'next steps' plan formulated.

System Sustainability

Addressing the need to develop long term savings on top of existing provider CIP programmes

- The South East London NHS system is under significant financial pressure. There are programmes of work in place to address this challenge in both the short and longer term.
- The current provider Cost Improvement Programmes aim to deliver c £250m per annum. Even if these programmes deliver in full, there is still a recurrent financial gap that needs to be filled. This recurrent gap is expected to be c £300m and will need to be mitigated in a 3-5 year time horizon.
- A System Sustainability Programme of work has been established by the ICB and system partners. The overarching objective of this programme is to develop plans that will enable the ICB and its providers to move from a position of financial deficit to one of financial balance.

The below summary details some of the main opportunities and approaches to deliver long-term financial savings in the South East London system.

- **Preventative Healthcare** → *Reduce demand on services, absorb unmitigated growth in demand*
- **Release** underutilised resources → *Reduce old estate and collaborate for economies of scale.*
- **Innovation** and technology → *Drive productivity, absorb demand for greater staffing resource*.
- **Simplify** → *Consolidate services and modernise pathways.*

- There is clear understanding and agreement that maintaining safety of services is of paramount importance. There will be clinical input into all opportunities that are identified to ensure that patient safety is preserved.

Voluntary and Community Sector Development

South East London Integrated Care System

The key supporting themes in our Joint Forward Plan	Partnership Working with VCSE Organisations: • Collaborating with local community groups to enhance service delivery. • Integrating VCSE organisations into healthcare planning and neighbourhood models.	Supporting Community-Led Health Initiatives: • Leveraging VCSE expertise in addressing health inequalities. • Expanding access to mental health and social prescribing services.	Enhancing Public and Patient Engagement: • Co-producing services with local VCSE organisations. • Ensuring diverse communities have a voice in shaping healthcare.
In 2025/26, we will take the following actions to make progress in these areas	• Continue to support Place implementation of agreed plans for utilisation of ICB funded capacity and skills building support for micro 'By and For' VCSEs • Support Place implementation of agreed plans for utilisation of ICB enhanced grant funding programme for micro 'By and For' VCSEs • Launch a SEL 'reflect & learn' space bringing together Place leads delivering ICB funded By and For capacity building work • Co-develop impact measurement indicators for By and For capacity building offer • Work with 5 SEL NHS Trusts to recruit and onboard VCSE leadership roles to be embedded within Trust's strategy teams • Co-develop with Trusts & VCSE Alliance leads impact measurements for embedded VCSE leadership roles • Expansion of estates access pilot across SEL enabling free access to NHS estates for By and For VCSEs who provide services to local communities.	• Launch SEL Trust & Health Creation Partnership (T&HCP) bringing together By and For VCSEs, and ICB & LA V5 & vaccination and immunisations leads • T&HCP to co-develop 'Trust & Health Creation Model' for SEL • Launch pilot testing of SEL co-developed Creative health framework- enabling better access to creative health • Insight sessions with SEL VCSE Strategic Alliance for further development of VCSE sector role in INT • Development of a staff-facing digital directory of SEL wide VCSE provision • Create a cross-system procurement and contracting working group to make ICB funding & procurement processes more accessible and equitable	• T&HCP to start the process of co-creating & testing community-led prevention and health creation approaches which are embedded within VCSE holistic 'life' provision (for communities which experience the greatest inequalities). • T&HCP to co-develop approaches and plans for transformation of traditional health-led prevention services to incorporate community-led health creation approaches • Embed diverse VCSE representation across system sustainability programme task & finish groups • Launch SEL community pharmacy & VCSE overprescribing pilot project • Co-develop VCSE & community pharmacy led approaches to increasing community knowledge of overprescribing and access to Structure Medication Review.
We will measure our impact by:	• More By and For VCSEs access tailored support which strengthen their provision • By and For VCSEs report their provision is more sustainable (serving inclusion communities) • More VCSEs and underserved communities have safe & accessible spaces to deliver & receive services in • Trust & VCSE leaders report having better working relationships • We have more community-led approaches embedded in Trusts and broader system provision	• SEL ICB has a first version of Trust & Health Creation framework setting SEL's approach to trust building with communities. • We have an agreed co-created Trust-building metrics • We have developed an accessible digital way for By and For VCSEs to capture trust-building insight and impact • We have a clearer vision and articulation of the role of VCSEs within SEL INT model • We have in place a SEL-wide directory of VCSE provision for use by healthcare staff	• We have co-created and tested approaches for embedding prevention & health creation approaches into existing By and For VCSE provision • We have an agreed approach trust-building with communities • System sustainability programme incorporate VCSE insight into the development of programmes • More local people impacted by overprescribing have more agency over their medication use and more local people feel informed and access SMRs

South East London
2025/26 Joint Forward Plan
Refresh – Lewisham Health & Care Partners

January 2025

draft

Lewisham Health & Care Partners PLAN ON A PAGE

South East London Integrated Care System

Our vision is:	Lewisham Health and Care Partnership aims to achieve a sustainable and accessible health and care system, to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high-quality care, when they need it. **Our commitment is to make Community Based Care that is proactive and preventative, accessible and co-ordinated.** https://www.selondonics.org/in-your-area/lewisham/			
Our priority areas are:	To strengthen the integration of primary and community based care	To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	To address inequalities throughout Lewisham's health and care system and tackle the impact on health and care outcomes	To maximise our roles as 'anchor organisations' as employers
In 2025/26, we will:	Establish or develop key services and approaches in: • Integrated Neighbourhood Teams (INTs) • Admissions Avoidance and Home First • Proactive Ageing Well Service • Mental health services early intervention and support and community model	• Review the GP Youth Clinic model • Establish key elements of the Start for Life Perinatal and Infant Mental Health programme • Bring wider Children and Young People (CYP) community health services and primary care into the Family Hub	• Focus on wider determinants areas in line with new Health and Wellbeing Strategy • Pilot debt/benefits advice based in health and social care settings • Work closely and invest in local VCSE groups • Work with partners to prevent ill health	• Establish entry level roles in the community workforce and INTs • Co-ordinate joint recruitment initiatives • Joint training to improve joint working and making every contact count
This will support population health and inequalities by:	Supporting patients to manage their long-term conditions (LTCs); identifying people who do not regularly access health and social care services to help prevent ill-health and improve well-being.	• Community based activity closer to families and CYP can help remove barriers to access • GP Youth Clinic model shows positive uptake by Black and Mixed heritage young people	• Reduces the gap between the worst and best off in the borough • Populations will feel more able to self-manage their LTCs, living longer with less time in poor health	• Increased entry level employment opportunities for local populations • Roles that contribute to health needs at a neighbourhood level, connecting with local populations
This will support system sustainability by:	Taking a preventative approach to prevent, delay, stabilise frailty; reduce hospital admissions, demand for mental health beds, Emergency Department attendance and admission to residential care	Family Hubs and GP youth clinics help by redirecting activity away from more intensive and costly interventions and support	• The use of services for acute reasons should decrease as people live healthier, longer lives • Offering people safe and trusted spaces to discuss early signs and symptoms	• Better use of apprenticeships and ARRS funding opportunities and training opportunities across the partnership
We will measure our impact by:	• Reduction in unplanned admissions, and improved management of LTCs • Improved referrals, appointments and waiting times	• Uptake of childhood immunisations • Children with excess weight at Reception and Year 6 • Range of locality-based and digital wellbeing offers	• Cancer screening rates • Reduction in smoking rates • Use of non-health related data	• Numbers of local people starting entry level roles

draft

Lewisham Health & Care Partners

South East London Integrated Care System

Vision

Lewisham Health and Care Partnership aims to achieve a sustainable and accessible health and care system, to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high-quality care, when they need it. Our commitment is to make Community Based Care that is **proactive and preventative, accessible and co-ordinated.** https://www.selondonics.org/in-your-area/lewisham/

Deliverables / Improvements since 2023/24

- Waldron Community Hub refurbishment with free space for community
- Delivered and evaluated neighbourhood Hypertension community training
- Review of practice based Multidisciplinary Meeting to improve anticipatory case finding
- Second GP youth clinic opened the south of Lewisham
- Opened fourth Family Hub
- Embedding the Virtual Ward service, a single point of contact with the Urgent Community Response team, and ability to treat patients at home rather than hospital
- Launch of a Lewisham Community Anticoagulation services
- Atrial fibrillation detection for undiagnosed patients provided through Community Pharmacy
- The Same Day Emergency Care unit at Lewisham Hospital expanded
- Creation of a housing protocol for health and care reducing delayed discharges
- Continuation of the Primary Care Network (PCN) Health Equity Fellow programme for local health inequalities initiatives
- Increased access to personalised creative wellbeing activities, working with ICS SEL Creative Health Lead
- Black Therapists Hub set up, referral through local black-led community organisations and IAPT
- Enhanced the delivery of the Start for Life programme to increase reach
- 'Should I really be here' project: to increase mental health/wellbeing literacy within black Caribbean and black African communities, for young males ages 16-25 yrs
- Extension of the Joy Social Prescribing Platform
- Initiated Hypertension service and Atrial fibrillation identification service across primary care and the Voluntary, Community and Social Enterprise Sector (VCSE)
- Initiated Proactive Wellness Service for Older People
- Expansion of Primary Care Mental health team capacity
- All-age Autism Hub launch and operational

Key Challenges / Opportunities Remaining

- The continuing development of integrated working between primary care and community services, and between primary care and mental health services can transform the delivery of our services to impact on outcomes and patient experience.
- Working within a neighbourhood footprint that is not coterminous with PCNs can present challenges, there is a need to flex across these boundaries. Also, recognition that within the 'neighbourhood' there are also hyper local communities
- The Neighbourhood model relies on data sharing and digital systems for coordinating care between multiple service providers
- Expanding our Population Health Management data to include housing and benefit support information will help us to respond to the wider determinants of health
- Implementing the Neighbourhood model requires a well-trained and adequately resourced workforce. If staff are not trained in integrated care models, multi-disciplinary work, or using new technologies, they may not be able to deliver the program as designed
- Access to equitable estates across the borough to support a consistent neighbourhood offer
- Improve the uptake of immunisations using the family hub model and improve links with primary care for all ages
- Expand GP youth clinics model to cover the whole borough
- Maintaining the Start for Life offer (Perinatal and Infant Mental Health)
- Opportunity to use the partnership arrangements bridge work between the family hubs, mental health services, Integrated neighbourhood Teams (INTs), adult learning, employment, housing
- Optimising the use of financial resources and ensure delivery of services which meet the needs of the local population and are sustainable in the long term
- Sharing of information to underpin activity and financial planning, and to better inform timely decision making around deployment of resources

draft

Lewisham Health & Care Partners

South East London Integrated Care System

	What are our priority areas for 2025/26 (Max 4)	Why has this been identified as a priority areas?
1	**To strengthen the integration of primary and community based care** Through our Integrated Neighbourhood Network Programme, building on existing work across the partnership to improve the delivery and integration of community-based care at a neighbourhood level and will establish the model, infrastructure and framework required to deliver integrated neighbourhood working across health and social care, while ensuring there is alignment with family hubs and programmes for children and young people	Local, integrated services can make service provision less confusing for residents and for people working in the system. They will lead to better outcomes through more holistic support, addressing health inequalities and the links between some of the wider determinants of health, social care and health needs and improved outcomes. Integrated services that are designed and targeted based on population health needs data will also support system sustainability and reduce the duplication of resources. More targeted support will support people manage their long term condition and reduce the need for further acute services.
2	**To build stronger, healthier families and provide families with integrated, high quality, whole family support services.** Establishing the integrated model for family hubs across Lewisham and to identify the integrated pathways that can be delivered through family hubs.	Need to address poor outcome areas for children through increasing access to support in the community, including immunisations and healthy weight, development of prevention and early help interventions in relation to emotional wellbeing and mental health for children, young people and parents
3	**To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes** Reducing the inequalities experienced by those who are most disadvantaged in Lewisham, reducing the gap in poor health between the best and the worst off through dedicated programmes and by ensuring a health inequalities approach is incorporated into everything that we do, building on the progress achieved in the 2022-24 Health Inequalities & Health Equity Programme	Inequalities in life expectancy continue to rise in Lewisham (Marmot,2024). The main causes of death in Lewisham are cancer, circulatory disease and respiratory problems. Lewisham's under 75 mortality rate from Ischemic heart disease (IHD) is higher than the rate for England. There is around 26% of the population with long term conditions, and nearly 10% with more than one long term condition. The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) gathered insights on health inequalities experienced by Black African and Caribbean communities to inform our health inequalities programmes.
4	**To maximise our roles as 'anchor organisations', be compassionate employers and build a happier, healthier workforce.** Working together we will establish joint initiatives to attract and retain staff; provide opportunities for shared career pathways; promote health and care careers; and address workforce inequalities	There are opportunities to create more entry level roles by leveraging each individual organisation's anchor institution status. Increasing employability for the community, resolving workforce challenges and contributes to wider local economic development in Lewisham. Working together on joint learning for frontline staff enhances partnership working.

draft

Lewisham Health & Care Partners

South East London Integrated Care System

Priority Area:

Strengthening the integration of primary and community based care

What are the actions we will deliver in 2025/26

- Establish the new Integrated Neighbourhood Model and Teams (INTs): targeted proactive support and identification of preventative needs for people with 3+ LTC.
- Improve Multi-disciplinary Meetings for most complex patient cohort working and management of discharges of significantly complex patients
- Developing new Community Hubs, building on the model established in the Waldron Centre
- Continuing primary care access improvement plans
- Admission Avoidance: averting crisis attendances at Emergency Department, developing Urgent Community Response, Assistive Tech pilot to reduce fallers in the community/care homes
- Discharge/ 'home first': Virtual Ward and reducing the barriers to discharges direct into care homes
- 111 re-procurement and delivery of a same day urgent care shadow running from autumn 2025
- Primary, community and secondary care working jointly to improve referral pathways
- Proactive Ageing Well Service to identify frail people who will benefit from a geriatric assessment
- For mental health, implementing the VCS co-operative project, the 24/7 Community Model in Neighbourhood 2, and developing alternative opportunities for early intervention and support

Population Health and Inequalities Impact

- Our approach is driven by population health data to help us understand the unique needs and challenges faced by our patients. We will focus on factors that put patients at rising risk if not managing their Long-term Condition and potentially becoming complex and frail and to identify people who do not regularly access health and social care services.
- A key focus of Urgent and Emergency Care work is supporting over 65's to remain more safely at home and to return home after an unexpected event leading to a hospital stay

System Sustainability Impact

- Increase proportion of resources used to support people to stay well for longer, by reducing unnecessary hospital attendances, outpatient referrals, hospital admissions and reduced demand on mental health beds, long term residential and nursing placements and care packages
- Create capacity, reinvested to scale the model sustainably and improve cost effectiveness.
- By taking approach to prevent, delay and/or stabilise frailty, we are expecting a reduction in hospital admissions, Emergency Department attendances and admissions to Residential Care.

Priority Area:

Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services

What are the actions we will deliver in 2025/26

- Review of the GP Youth Clinic model and integration with wider adolescent health services, with the longer-term aim of creating an integrated Adolescent Health and Wellbeing offer.
- Establishing key elements of the Start for Life Perinatal and Infant Mental Health programme as a core offer in Lewisham.
- Bringing wider Children and Young People (CYP) community health services and primary care into the Family Hub model to replicate the Adult Integrated Neighbourhood model.

Population Health and Inequalities Impact

- Community based activity closer to families and CYP can help remove barriers to access, especially for those who may be put off attending other health centric centres. Integrated services providing a single-point of access with reduced handover points between services, increase efficiency in access.
- Early evaluation of the GP Youth Clinic model shows positive uptake by Black and Mixed heritage young people compared to specialist mental health support.

System Sustainability Impact

- Family Hubs and GP youth clinics contribute to the improvement of community based services for children and young people. these provide a joined-up, early intervention approach across a number of services, helping redirecting activity away from more intensive and costly interventions and support.

draft

Lewisham Health & Care Partners

South East London Integrated Care System

Priority Area:

Addressing inequalities throughout Lewisham health and care system through taking partnership action

Reducing the inequalities experienced by those who are most disadvantaged in Lewisham, reducing the gap in poor health between the best and the worst off by taking focussed action on the wider determinants of health

What are the actions we will deliver in 2025/26

- Actions focusing on specific wider determinants areas in line with new Health and Wellbeing Strategy – poverty, housing and education e.g. testing poverty proofing approaches for 2-3 key clinical pathways in Lewisham.
- Through work across neighbourhood areas piloting debt/benefits advice based in health and social care settings i.e. in selected GP practices within target PCNs.
- Working closely and investing in local VCSE groups to bridge gaps between statutory services and communities, for instance to improve cancer screening rates
- Working with partners to identify opportunities to intervene earlier and prevent ill health, better recording of risk factors and management of CVD related LTCs in primary care
- Tackling risk factors of preventable causes of death and ill health in the borough such as smoking and rolling out new services to improve management of hypertension and atrial fibrillation

Population Health and Inequalities Impact

- Gap in health outcomes between the worst and best off in the borough should stabilise and begin to reduce (slope index of inequality)
- Populations will feel more able to self-manage their long term conditions, living longer with less time in poor health (health life expectancy)
- People from different community groups that do not currently access primary care supported to engage in proactive and preventative measures to improve their health outcomes (ethnicity data for cancer screening & NHS Health Checks, deprivation data for services)

System Sustainability Impact

- Over the next five years reduced acute admissions for CVD and smoking related conditions
- Decrease in the number of emergency attendances and admissions at ED for ambulatory care conditions

Priority Area:

Working together we will establish joint initiatives to attract and retain staff; provide opportunities for shared career pathways; promote health and care careers; address workforce inequalities

What are the actions we will deliver in 2025/26

- Community workforce and integrated neighbourhood teams
  - To look at entry level roles – strong preference for the AHP type of support worker role with also a suggestion about health and well-being coaches
  - Areas for consideration: development pathway through rotations, employment and transfer between organisations; access to apprenticeships
- Co-ordinated and joint recruitment initiatives: shared calendar of recruitment events to co-ordinate planning; establishing links between recruitment teams and council's "Lewisham Works" team for joint advertising of roles and joint recruitment events
- Joint training and OD approach to improve joint working and making every contact count

Population Health and Inequalities Impact

- Increased entry level employment opportunities for local populations
- Roles that contribute to health needs at a neighbourhood level, connecting with local populations

System Sustainability Impact

- Flexible workforce to reduce vacancy and turnover rates
- Better use of apprenticeships and ARRS funding opportunities
- Better use of training opportunities across the partnership

draft

Lewisham Health & Care Partners

South East London Integrated Care System

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
To strengthen the integration of primary and community based care	• Delivery of services and management of care for people with long-term conditions (LTCs) that are proactive, holistic, preventive and patient-centred, with collaborative personalised care planning • An established model of care for older people with Proactive Care, Admission Avoidance, Integrated Discharge and Intermediate Care for this cohort • Improve access to primary care and community therapy waiting time	• Reduction in non-elective admissions for LTC conditions • Reduction in unplanned admissions and attendances for Older People • Reduced variation for GP appointments per 1000 patients, in line with the SEL average • Reduction in waiting time for community therapy
To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	• An increase in uptake and completion of immunisations. • A reduction in the number of children with excess weight at Reception and Year 6, to show a reduction of 2% from 2023/24 to 2025/26 • CYP using range of locality-based and digital wellbeing offers as alternative to CAMHS and other specialist social care services metrics for treatment waiting times.	• % uptake of childhood immunisations • % of children with excess weight at Reception and Year 6 • A reduction in waiting times for specialist mental health services (CAMHS).
To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes	• Increased cancer screening rates by population demographic • Reduction in smoking rates by population demographic • Improved recording of risk factors and ongoing management of LTCs in primary care • Longer healthier life expectancy	• Cancer screening rates for breast, bowel and cervical (medium term) • Reduction in smoking rates (short term) • Use of non-health related data in identifying those at risk of decline, i.e. housing/frailty and reducing risks of falls
To maximise our roles as 'anchor organisations' as employers	• Enhances local employment opportunities, make full utilisation for organisations of their apprenticeship levy, and help to overcome workforce challenges in specific areas with high vacancy rates such as community and AHPs	• Numbers of local people starting entry level roles

draft

Lewisham Health & Care Partners

South East London Integrated Care System

What do we need from enablers and partners to deliver?

- Workforce: a programme around workforce and employment is a key priority for Lewisham. We want to enable further collaboration and integration of workforce plans and aim to improve succession planning, increase the use of joint appointments, adopt joint recruitment approaches and have the flexibility to rotate roles across the local and SEL system.
- Digital: shared data and patient records are fundamental to joint working, while ensuring digital inclusion and patient and stakeholder engagement in developing new assistive technology, digital tools and platforms
- Estates: as partners we want our estate to support service transformation and collaboration and integration across the health and care system, to enable us to work smarter and more effectively in delivering community based
- Communications & Engagement: provide an overarching plan to support our priorities, particularly on integration, ensure that stakeholders and partners are appropriately engaged

How will we work in collaboration with our system?

- Our LCP board provides the strategic direction and oversight of the partnership priorities and delivery. The board is supported by a number of other forums within our local governance structures. All of our key groups have full representation from across the partnership, and the LCP board has increased its representation from the VCSE sector to improve representation from our black communities in particular.
- Our clinical and care professional leadership group plays a key role in all of our transformation programmes and includes secondary and primary care clinicians, and from medicine, nursing and allied health professions.
- Where engagement and leadership with primary care is needed we work the Primary Care Leadership Forum which connects with GPs, community pharmacy and the Local Dental Committee.

How will we engage with our population?

- The Lewisham People's Partnership sits alongside and feeds into the broader structures of the LHCP bringing patient and citizen voices and lived experience into the work of the LCP. It is developing a more strategic focus, a hub and spoke approach and an outcomes framework to demonstrate how the views and lived experiences of people and communities influence LHCP decision making and are utilised in future planning and commissioning. Its work is particularly focused on co-production and engagement work in neighbourhood development, long-term conditions and hypertension, and with primary care improvement.
- Family hubs and GP youth clinics will provide continual engagement of young people and parents in the design of the offer as it expands across the borough.
- Through the All-age Mental Health Alliance, share learning from existing transformation and pilot projects via Mental Health specific community engagement sessions
- For neighbourhoods, we have developed a framework for building inclusive citizen and community engagement in Lewisham. This is about ensuring local people are at the heart of our plans for improving health and wellbeing.
- Work with the Lewisham Black Voluntary Network to shape and develop a tailored co-design approach with Black Led Community Groups.

How will we monitor and share progress?

- The LCP board monitors progress against our priorities while the Place Executive Group monitors programme delivery through programme boards including urgent and emergency care, integrated neighbourhood network alliance, all-age mental health alliance, and the population health management board.
- We use our existing and established communication channels to provide regular progress reports on our programmes through stakeholder bulletins.
- Our various community and citizen engagement arrangements also provide opportunities for progress review with partners in the statutory and voluntary sectors.
- Partners in the Family hubs and GP youth clinics provide dashboards which feed back to the Integrated governance boards for CYP to provide updates and monitoring for delivery of the programmes.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 5
Enclosure 5

Title:	**Service Development and Improvement Plan allocation. (SDIP)**
Meeting Date:	**27th March 2025**
Author:	Laura Jenner Director of System Development Tom Hastings Deputy Chief Operating Officer
Executive Lead:	Ceri Jacob Lewisham Place Executive Lead Dr Neil Goulbourne Chief Strategy and Transformation Officer & Deputy CEO

Purpose of paper:	**The paper is to endorse proposals for the Service Development and Improvement Plan allocation. (SDIP)**	Update / Information	***Yes***
		Discussion	
		Decision	

Summary of main points:

Introduction

Lewisham and Greenwich NHS Trust receive growth funding as part of its contract, with a portion allocated to the development and delivery of community services. This investment is aligned with a broader Service Development and Improvement Plan (SDIP), which is overseen by the Lewisham Place team in collaboration with partners across South East London (SEL).

Over the past six months, discussions have taken place with finance, operational, and executive colleagues to assess the available funding for investment in 2025/26, including recurrent vs non-recurrent funding.

For 2025/26, £1.7 million is available for recurrent investment, comprising:

- £1.2 million carried over from 2024/25
- Additional growth funding for 2025/26

While acknowledging the financial challenges facing both LGT and the wider system in 2025/26, SEL commissioners, aligned with national policy have issued a directive to ringfence community resources to strengthen and develop community services.

In addition, a commissioning priority is to ensure prioritisation of resources for children and young people, recognising a disproportionately lower level of investment over the previous years and a growing agenda.

It is important to note that final contractual agreement discussions are still taking place between the ICB and LGT and therefore, the final funding envelop for 2025/26 is not yet finalised.

SDIP – Approach for 2025/26

The investment priorities for 2025/26 were reviewed by the respective clinical divisions within LGT to ensure that all relevant initiatives were considered. This process took into account service changes, risk factors, and the latest demand and capacity pressures.

In parallel, the Lewisham commissioning team, in discussion with Lewisham partners, updated the proposed system intentions for 2025/26, building on progress made in 2024/25. These updates set system-wide priorities, which have shaped the overall investment approach.

To guide decision-making, LGT established a dedicated working group that fed into the **Community Services Board**, ensuring a structured review of priorities and the proposed allocation of funds.

Bid summaries were prepared and presented to a panel on **26 January 2025**, comprising representatives from LGT and system partners, including commissioning, clinical and operational leadership, and finance teams.

For the Supported Discharge Pathway and Children and Young People's (CYP) Neurodevelopmental Services, both a 'Gold' and 'Bronze' option were submitted, reflecting different levels of funding to accommodate resource availability.

In total, request for investment, assuming gold option schemes, where presented, totalled £3.1m FYE against a funding envelope.

The below table outlines the funding agreed.

SDIP 25/26 – Indicative plan

NHS Lewisham and Greenwich NHS Trust

Community Therapies lead	45	• Partial funding for community therapy lead role to support professional leadership of multiple community therapy professions and aid integration with wider district nursing teams and neighbourhood development work. • This post has been in planning since 2023/24 and agreed to partially fund through 2025/26 SDIP pot. Post-holder offered and due to start in summer 2025.
Supported discharge pathway (Gold option)	606	• Uplift of supported discharge team by 5.5 WTE band 6 therapists and 3 WTE therapy assistant practitioners (band 4) to be able to provide earlier commencement of community therapy and rehabilitation in the enablement period (up to 6 week period) and more intensive rehabilitation. • HomeFirst work identified significant demand/capacity mismatch in order to provide support at optimal time period; this investment addresses this demand/capacity mismatch. • Some of this resource/investment has been provided non-recurrently through the discharge incentive programme for Q4 24/25.
Community CYP Neurodevelopmental – Reducing Waiting (Gold option)	291	• This scheme supports recurrent investment to enhance the community paediatric medical team neurodevelopmental pathway, by expanding the workforce with Allied Health Professionals (AHPs) Clinical Nurse Specialists (CNS) and Health Support Assistants (HSA) to support the implementation of the ASD core offer and reduce waiting times for Initial Assessment (IAs).
Enhancing bladder, bowel and pelvic health	89.5	• This scheme supports increase staffing for the Bladder, Bowel, and Pelvic Health Team (BBPH) to address critical challenges in service delivery and waiting times whilst shifting to a more preventative focus to better match capacity/demand within the service.
Integrated Neighbourhood Team – Clinical prescriber roles	318	• To support the delivery of the Integrated Neighbourhood Team Model, 4 x Clinical Prescriber roles are proposed to be embedded within the structure. This aims to provide additional clinical capacity, to improve patient outcomes and support seamless service integration across the INT. The Clinical Prescriber will focus on providing clinical support, optimising prescribing practices and contribute to multi-disciplinary teams. The role hold will play a key role in addressing complex patient needs, conducting holistic assessment and optimising patient care. The aim is to reduce the need for secondary care outpatients appointments and support DN with complex cases. The post will also support the bridge between primary and community and improve the coordination of patients.
Community CYP - Medical contribution to Statutory Assessment	93	• This scheme requests recurrent investment of £77K to recruit a Clinical Nurse Specialist (CNS) to support the Community Paediatric Medical team in completing Educational Health Care Needs Assessments (EHCNA). The goal is to reduce waiting times for these assessment and improve compliance with statutory submission of assessment within six weeks of request from 12.56% to 25% and test the proof of concept for this CNS role. • This scheme will enable LGT to comply with the recommendation from the Area SEND inspection of the Lewisham Local Area Partnership Sept 2024, to improve the "quality and timeliness of input into plans from health.

- Indicative values from the above schemes total **£1.45m** and are at Full Year Effect and including overheads – assuming all costs are spent from 1 April 2025.
- Remainder of funding – up to £1.7m – to be allocated to support a number of cost/budgetary pressures for LGT community services including community/lone working support system, community property rental increases plus some allocation to district nursing establishment to give headroom within budget – currently set at zero.

To be exceptional

Following the allocation of the funding a monitoring and performance framework will be put in place and will report into the Community Board.

Potential Conflicts of Interest	**N/A**
Any impact on BLACHIR recommendations	Services funded from this budget have the opportunity to address several of the recommendations in BLACHIR report partially covers the following **27** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions. **25**. Promote cultural competency training within healthcare services, the criminal justice system, and the police force. **17** Provide targeted and culturally appropriate screening services for Black African and Black Caribbean older adults.

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

Equality Impact	Each service will carry out an EIA under Trust arrangements.
Financial Impact	For 2025/26, £1.7 million is available for recurrent investment, comprising:

		• £1.2 million carried over from 2024/25 • Additional growth funding for 2025/26
Other Engagement	Public Engagement	As part of the funding allocation criteria a question on co-design was asked and considering when making the allocation. Lewisham and Greenwich NHS Trust (LGT) employ the NHS Friends and Family Test (FFT) to gather patient feedback on their experiences with the Trust's services. This initiative formed part of the understanding of areas that require improvement
	Other Committee Discussion/ Engagement	LGT Community Board Lewisham LHCP Place Executive Group (PEG) Lewisham LHCP SMT meeting
Recommendation:	Recommendation: The Board is asked to agree to take forward the allocation to the community services to support improvement in service delivery and implement the SDIP plan.	

SDIP 25/26 – Indicative plan

Lewisham and Greenwich NHS Trust

Community Therapies lead	45	• Partial funding for community therapy lead role to support professional leadership of multiple community therapy professions and aid integration with wider district nursing teams and neighbourhood development work. • This post has been in planning since 2023/24 and agreed to partially fund through 2025/26 SDIP pot. Post-holder offered and due to start in summer 2025.
Supported discharge pathway (Gold option)	606	• Uplift of supported discharge team by 5.5 WTE band 6 therapists and 3 WTE therapy assistant practitioners (band 4) to be able to provide earlier commencement of community therapy and rehabilitation in the enablement period (up to 6 week period) and more intensive rehabilitation. • HomeFirst work identified significant demand/capacity mismatch in order to provide support at optimal time period; this investment addresses this demand/capacity mismatch. • Some of this resource/investment has been provided non-recurrently through the discharge incentive programme for Q4 24/25.
Community CYP Neurodevelopmental – Reducing Waiting (Gold option)	291	• This scheme supports recurrent investment to enhance the community paediatric medical team neurodevelopmental pathway, by expanding the workforce with Allied Health Professionals (AHPs) Clinical Nurse Specialists (CNS) and Health Support Assistants (HSA) to support the implementation of the ASD core offer and reduce waiting times for Initial Assessment (IAs).
Enhancing bladder, bowel and pelvic health	89.5	• This scheme supports increase staffing for the Bladder, Bowel, and Pelvic Health Team (BBPH) to address critical challenges in service delivery and waiting times whilst shifting to a more preventative focus to better match capacity/demand within the service.
Integrated Neighbourhood Team – Clinical prescriber roles	318	• To support the delivery of the Integrated Neighbourhood Team Model, 4 x Clinical Prescriber roles are proposed to be embedded within the structure. This aims to provide additional clinical capacity, to improve patient outcomes and support seamless service integration across the INT. The Clinical Prescriber/Nurse will focus on providing clinical support, optimising prescribing practices and contribute to multi-disciplinary teams. The role hold will play a key role in addressing complex patient needs, conducting holistic assessment and optimising patient care. The aim is to reduce the need for secondary care outpatients appointments and support DN with complex cases. The post will also support the bridge between primary and community and improve the coordination of patients.
Community CYP - Medical contribution to Statutory Assessment	93	• This scheme requests recurrent investment of £77K to recruit a Clinical Nurse Specialist (CNS) to support the Community Paediatric Medical team in completing Educational Health Care Needs Assessments (EHCNA). The goal is to reduce waiting times for these assessment and improve compliance with statutory submission of assessment within six weeks of request from 12.56% to 25% and test the proof of concept for this CNS role. • This scheme will enable LGT to comply with the recommendation from the Area SEND inspection of the Lewisham Local Area Partnership Sept 2024, to improve the “quality and timeliness of input into plans from health.

- Indicative values from the above schemes total **£1.45m** and are at Full Year Effect and including overheads – assuming all costs are spent from 1 April 2025.
- Remainder of funding – up to £1.7m – to be allocated to support a number of cost/budgetary pressures for LGT community services including community/lone working support system, community property rental increases plus some allocation to district nursing establishment to give headroom within budget – currently set at zero.

Lewisham Local Care Partners Strategic Board

Item 6
Enclosure 6

Title:	**SEL Neighbourhood and Integrated Neighbourhood Team (INT) Framework**
Meeting Date:	**27 March 2025**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

Purpose of paper:	To approve with Lewisham partners the outputs of the SEL wide work on an Integrated Neighbourhood Team (INT) Framework.	Update / Information	
		Discussion	x
		Decision	x
Summary of main points:	The Fuller Report of 2022 and national planning guidance has made clear the expectation that all ICBs will put in place a neighbourhood-based care model, including the use of Integrated Neighbourhood Teams (INTs). Whilst work has been underway in Lewisham on increasing integration and neighbourhoods for some time, this new focus nationally has accelerated that work. Neighbourhood working is not about tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level in INTs will require a fundamental shift in how we work together as a system, with residents and within communities, building out from what has already been achieved. In SEL, INTs will: • Tackle health inequalities • Eliminate the need for referrals and hand-offs • Work closely with residents and within communities • Provide holistic, person-centred care, closer to home • Ensure that all SEL residents receive the same standards of care. The six Place Executive Leads (PELs) and their leads worked together and with their local partners to develop a SEL neighbourhood and Integrated Neighbourhood Team (INT) framework. This framework has been built up from local work across the six Places and provides a framework to guide ongoing development of neighbourhoods in southeast London. This will ensure consistency where it is needed but with enough flexibility to accommodate local variation where that is needed.		

	The following paper sets out the SEL framework and shows how the existing Lewisham work on neighbourhoods relates to this.			
Potential Conflicts of Interest	None			
Any impact on BLACHIR recommendations	Neighbourhood working and INTs are expected to impact positively on health inequalities and a number of the Opportunities for Action set out in the BLACHIR report. These will be set out within the EIA.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	An EIA has been completed for the Lewisham neighbourhood and INT work.		
	Financial Impact	Not relevant to this paper.		
Other Engagement	Public Engagement	Public engagement has been carried out in relation to the Lewisham neighbourhood development programme, including recruitment of people with lived experience to be a part of the design work. At a SEL level, an engagement plan is being developed to support this work over a longer timeframe. This will be delivered at SEL and Place level.		
	Other Committee Discussion/ Engagement	This has been discussed and supported at the SEL Neighbourhood Based Care Board and at the ICB Board.		
Recommendation:	The Board is asked to approve the SEL ICS Neighbourhood and INT Framework.			

South East London Integrated Care System

Developing our shared approach to Neighbourhood development

Board Papers

January 2025

This document

This document outlines how neighbourhood working, and integrated neighbourhood teams within that, will be realised in South East London. This documents responds to and will sit alongside emergent national and regional guidance and related London-wide work on Healthier Communities, ensuring neighbourhood working in SEL both reflects and models wider policy aspirations to:

- **Establish a clear and shared vision for the Neighbourhood Health Service,** so we can communicate what it means for professionals, patients and service users, and communities across SEL.
- **Balance a need for consistency**, building from where we are, and being flexible to local needs
- **Be clear on what good looks like** and the role of national bodies, systems, providers, places and neighbourhoods in delivering this
- **Set out the roadmap** in the short, medium and longer term

This document sets out key definitions, and a delivery framework and roadmap aligned to and building on implementation work already underway across our six Places and their local partnerships; scaling and spreading key existing initiatives such as the 3+ Long Term Conditions (LTCs) focussed work ongoing in at least one Primary Care Network (PCN) per borough.

Places will be responsible for realising this framework at a local level and working through local challenges and delivery nuances – SEL must support and facilitate Places in this endeavour, and in ensuring we are all moving toward the same end point.

This work has been produced in partnership with PPL, a social enterprise based in Southwark, which is working to improve health and care outcomes across the UK.

Context

- **In response to the national drive to deliver a Neighbourhood Health Service, South East London (SEL) previously committed to working in a more integrated way at the neighbourhood level,** and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities.
- **Without this shift in focus, any improvements in delivery of individual services across health, local government and wider partners will continue to be overwhelmed** by growth in activity and demand and will become unaffordable too.
- **Neighbourhood working is a continuation of local, regional and national initiatives** across successive governments that have aimed to bring Primary and Community Care closer together, including the development of integrated care and a more place-based approach to how services are organised, to address the drivers for change:

Social

- Many services are working in isolation, and there is a need for more joined-up, proactive care, which is flexible and able to respond to local needs.
- A consistent approach, clear understanding of what self care and proactive support is available and a strong message that service delivery in partnership with communities is required.
- Recognition that statutory services alone cannot provide all the support people need, particularly with regards to addressing inequalities and reaching underserved communities.

Political

- Government priority to transform the NHS into a 'Neighbourhood Health Service' and shift from hospital to community and sickness to prevention.
- Access issues in primary, community and mental health care, and delays in Emergency Departments and diagnostics.
- Increasing wider social determinants and underinvestment in public health has led to the deterioration of the overall health of the nation.

Economic

- There are significant costs associated with the failure to prevent ill health, to detect and intervene and to mitigate complications.
- Strong and shared economic case especially for the working age adult population – to prevent people becoming economically inactive and to support people back to work.
- Long term sickness is contributory factor to economic inactivity.

Technological

- One of the shifts planned for health and care services nationally – analogue to digital.
- Investment is required to build and maintain effective infrastructure outside of hospitals.
- Finding effective and practical solutions to co-ordinate and share data for planning, delivery and evaluation purposes.
- Utilising technology at scale to improve efficiency and effectiveness.

Neighbourhood working and INTs in SEL

South East London Integrated Care System

The overarching aim of this work is to develop a shared approach to INT development across SEL, which will bring together services with communities through a population health management approach, at a scale which enables the delivery of genuinely preventative, holistic, locally tailored services.

Neighbourhood working will require a fundamentally different way of working and large cultural shift across the public sector, voluntary and community sector (VCSE), and our local populations; involving new means of collaboration, coordination, and, at times, integration. This reflects a significant transformation of how our system will operate together.

A key (but not the only) element of delivering neighbourhood working will be the establishment of INTs. This document is focussed on this element and presents an overarching framework for INT delivery which Places will be required to develop locally, tailoring to their local population needs and services. This framework will be subject to further socialisation and input before a final document is delivered early this year.

Moving forward, key enablers within the SEL system such as resourcing, workforce, and data analytics, will need to be configured to support the delivery of INTs and neighbourhood working.

What we mean by neighbourhood working

Developing INTs will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health, social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area. INTs will not replace existing, effective multi-disciplinary teams.

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than INTs and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual or group. Collaboration tends to occur at key points, such as meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Representatives from different disciplines (e.g., health, social care, voluntary sector) working as a single team to deliver coordinated and person-centered care to individuals within a defined neighbourhood or locality. They will manage and deliver integrated clinical and operational services, provide continuity of care and work together to shared outcomes. There is an emphasis on continuous collaboration around prevention and pro-active care to improve outcomes, reduce duplication and address complex needs more efficiently. They will reach in and out of the other tiers for specialist input and care planning.

(see p.5 for further detail)

What a SEL INT looks like

Note: The detail required to operationalise each function and how they relate to each other will need to be established at a Place-level.

South East London Integrated Care System

INTs provide the structure for multidisciplinary collaboration through the development of "teams of teams": integrating services across health, social care, public services, and the VCSE sector to design and deliver holistic, person-centred care.

- **Our model enables local variation tailored to local needs while maintaining a consistent foundation across all neighbourhoods in SEL.** Investment levels will vary depending on each neighbourhood's starting position and specific needs.
- **Our INTs will be organised using a tiered system**, acknowledging that different functions and services are delivered to residents across a range of different scales.
- **Our INTs will leverage population health data** to proactively identify individuals and populations who would benefit from support earlier and prioritising populations experiencing greatest levels of health inequalities.

Aligned Functions

- The INTs will be augmented by additional specialist input, generalist roles (e.g., geriatricians) and resources tailored to local needs.
- While they may not sit directly in the INTs (e.g., because it doesn't make sense to dedicate their time to a specific INT all the time), clear communication lines and clarity on how they input will need to be established.
- They will reach in and out of the other tiers to provide specialist input and care planning.

Tailored Functions

- This will vary between each INT depending on what is available and what helps the INT to meet the needs of the population that it is serving and achieve its specific aims and benefits (e.g., specialists).
- They will have consistent presence, dedicated resource and a role specific to the neighbourhood (e.g., integration hubs or specific VCFSE providers).

Consistent Functions

- There will be consistent membership from INT to INT, bringing together primary care, social care, community and mental health services, acute clinicians/specialties, key VCFSE organisations and population health dedicated / allocated to each INT (e.g., district nurses)
- They will manage and deliver integrated clinical and operational services, and provide continuity of care and work together to shared outcomes
- They will reach in and out of the other tiers for specialist input and care planning.

Hyper-Local Functions

- Services (e.g., community pharmacy, general practices, VCFSEs) that often serve as the first point of contact for residents need to be reached into by / strongly linked with INTs.
- They hold deep community knowledge and connection, and play a proactive role in population health management, identifying needs early and escalating complex cases.
- Clear shared care protocols will enable seamless coordination with INTs.

Resident

- The resident is at the centre of all neighbourhood working.
- INTs need to be strengths-based building on local knowledge, community assets and local needs.

How to enable integration

Why is this important? We recognise that Place will be the key enabling layer for developing neighbourhood working and INTs which will sit at their core. Each Place will be responsible for identifying an "integrator" to host integration "functions" required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level. Acting as a bridge, these integrators will help INTs function cohesively while maintaining flexibility to respond to local needs and adapt as neighbourhoods transition from development to delivery.

This role cannot operate in isolation or replace individual responsibility and accountability from partnering local organisations.

Thoughts on Key Integrator Functions Consistent Across Places

- **Support operational coordination** between sectors and partners across the borough and between INTs, bridging the gap across the current reality of fragmented pathways and services by addressing the practicalities of collaboration (e.g., building interfaces and relationships, supporting workforce planning, and business intelligence).
- **Facilitate population health management** (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes.
- **Address interface issues and share learning** through coordinating discussions at Place level (e.g., sharing resources and managing care transitions) and escalating issues affecting multiple neighbourhoods to ensure system-wide alignment.
- **Drive equity in access and outcomes** using PHM data and working closely with partners (including VCSFEs) to identify and address disparities in access and care delivery, supporting INTs to meet local needs and reduce inequalities.
- **Provide essential infrastructure** supporting people, finance, governance and risk management for INTs in a way which is consistent and cost-effective so that neighbourhood delivery becomes business-as-usual, harnessing existing local assets and resources.

What we want our INTs to do

Our initial focus for INTs is to provide proactive care for higher and rising risk populations, and to work with communities on preventing ill health. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSE and social care, to meet the holistic needs of their local populations. These INTs will be able to easily draw upon specialist input as needed across all levels (from hyper-local to regional).

This is not about minor tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level in INTs will require a fundamental shift in how we work together as a system, with residents and within communities.

In SEL, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g. addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs,** through a combination of integrated working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities,** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders,** holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all SEL residents receive the same standards of care**, wherever they live and whatever their individual needs.

South East London Integrated Care System

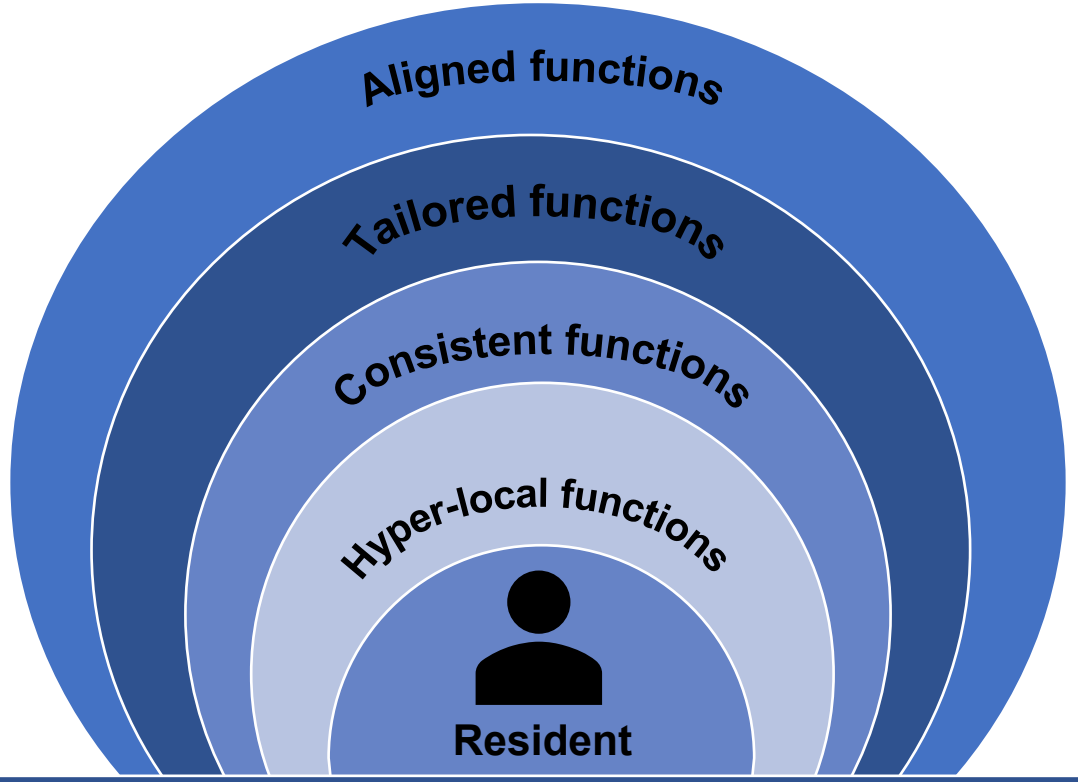
NHS South East London

INT delivery framework

Components of our SEL INT Framework

South East London Integrated Care System

Our SEL INT Framework outlines a shared approach to INT development across Places, and a way in which SEL can increase the proportion of resources used to support people to stay well for longer, and release capacity which is reinvested to scale the model sustainably.



SEL INTs will be underpinned by a number of key ingredients, including a population health management approach and the recognition that we will have to 'test and learn' our approach as INTs develop to ensure they meet population health needs effectively.

Underpinned by key ingredients:

- Organisational development to enable culture shift for system-wide way of working
- Population health management approach
- Shared, clear metrics
- Test and learn approach
- Robust leadership and shared governance
- Interprofessional training infrastructure
- Overarching quality management system
- Alignment with partner and system priorities
- Interoperable digital tools and knowledge
- Contractual mechanisms and human resources (HR) infrastructure to allow joint working
- Geography principles to ensure organised around population needs

What this framework is (and what it is not)

The framework set out is…

- **An overarching structure for INTs across SEL**, providing 'enough' structure to ensure we deliver consistently and in alignment, without being prescriptive, and recognising that local nuances will mean INTs look different in each Place.
- **A commitment from each of our Places** to work ambitiously and intentionally, through a 'test and learn' approach, toward a shared vision for neighbourhood working.
- **Providing a way to build upon, not undo, existing integration successes** recognising that there has been significant progress in recent years and any re-structure takes capacity, time and energy. We do not want to overhaul what is working well, rather we want to develop an adaptable strengths-based way of working.

It is **not**…

- **Static**: this framework will evolve over the coming years as neighbourhood working builds across the SEL system and will be updated to integrate new and effective approaches that have been developed and tested, bringing in learning from previous integration efforts.
- **Exhaustive**: each Place and INT will need to work through local challenges and delivery questions to ensure their INTs work effectively within their local system and are tailored to the needs of their local populations.
- **About just the 'top of the pyramid':** this framework describes a whole system, whole-population approach which strives to improve the lives of all people of all ages across SEL.

Key ingredients

Drawing on learning from other INTs, as well as the conversations we have had to date with stakeholders, key commonalities across models and suggestions for effective neighbourhood working include:

- **Be organised around population health needs** and avoid unwarranted variation. This will involve using population health data to obtain a deep understanding of local communities and use this to proactively identify people who would benefit from support earlier.
- **Be a system-wide way of working and a model of care, and not a programme of discrete projects.** This will include joint workforce and estates planning to enable sharing of assets to best use system resources and promote integration.
- **Eliminate siloed working practices** through equal access to information and flexible models of working. Supporting frontline staff to work in an integrated way—where every connection counts—ensures that teams are equipped to collaborate seamlessly across boundaries. This approach minimises gaps in care and encourage cohesive service delivery, so residents are unaware of how they are being moved through the system to meet their needs.
- **Embed a robust interprofessional training infrastructure.** System leadership training should be a core component of the INT model, with health professionals trained together to strengthen collaboration, build cohesive teams, and foster interprofessional relationships. Training must include data analysis and interpretation to enable INTs to effectively use Population Health Management (PHM) tools for proactive decision-making. This will support succession planning and sustainable leadership within and beyond INTs
- **Have an overarching quality management system** – ideally linked with the quality improvement method – so teams can work in psychological safety, confident in what they are delivering and how they do works and be assured of the impact of the INT way of working.
- **Align to partner and system priorities** to ensure one direction of travel.
- **Shared, clear metrics** expected for INTs will help ensure local decisions are data-driven and ultimately achieve the expected outcomes, even if *what* they do is different to achieve these dependent on local populations and assets. Consistent processes for reviewing outcomes will ensure those which do not see progress over time are understood, addressed, and relevant learning is shared.
- **Release capacity which is reinvested to scale the model sustainably.** This will require routinely measuring impact to understand and embed what works and build a body of evidence.
- **Increase the proportion of resources used to support people to stay well for longer.** This will include offering joined up accessible preventative care, making full use of the knowledge and skills of the team, as well as ensuring the contractual mechanism and human resources (HR) infrastructure is in place to enable this. Commissioners /partners should be able to readily draw on this in relation to job planning/recruitment.
- **Be underpinned by interoperable digital tools and knowledge** that support population data analysis and enable person-based care.
- **Have robust leadership and shared governance arrangements** enabling services to be arranged at neighbourhood level to maximise their ability to engage with local communities and shift investment towards prevention. This includes effective clinical governance that allows genuinely shared care between organisations and professions that make up an INT.

We recognise there will be a level of local variation to ensure each neighbourhood can serve the local population needs. However, the broad approach to integrated neighbourhood working should remain consistent across all population groups and all areas within SEL.

Taking a population health approach

The success of INTs will rest on our ability to develop a deep understanding of our local populations. INTs will be organised around data insights drawn from **Population Health Management (PHM) analyses** - providing the evidence base to tailor services to local need and shift the dial to prevention.

To understand local needs, we will need to define a way to effectively **segmenting our population** (including those who are not registered in SEL general practices) and capturing key priority cohorts. Our segmentation model must:

- **Cohort across all life stages (children to older people) and need status (low- to high-)**, ensuring no one slips through the net
- **Reflect the different factors** that influence a person's needs (e.g., health conditions, psychosocial attributes, wider determinants)

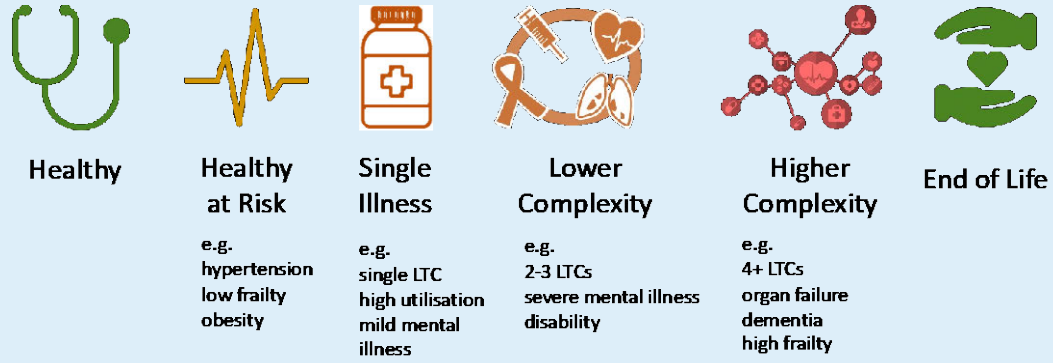
PHM will be used to build up a richer picture of local populations over time, recognising that **data availability may be limited during the mobilisation of INTs** and **processes for continuous learning and adaptation to PHM insights** will ensure INTs remain responsive to changing population health needs.

The voice of residents will be a key input into PHM, essential for completing the picture implied by the data.

How do we get there?

- Agree a common language to describe our population segments to facilitate integrated planning and support collaborative working.
- Agree key metrics to enable a degree of comparability between Places.
- Invest in organisational development to implement new tools, and ensure staff have the ability to effectively use them and integrate insights into delivery and improvement.

A number of our Places in SEL and INTs elsewhere in London are adopting the **Bridges to Health** approach to segmentation. The approach can be tailored to different INT priorities (e.g., around CORE 20 plus 5 and to include social determinants of health). Examples of key areas identified using the Bridges to Health approach in SEL:

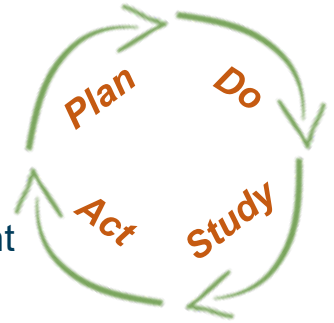


Adopting a test and learn approach

We recognise that INTs are a radical change to existing ways of working and will therefore require experimentation through the early implementation phases to understand what is and is not working and explore ways of overcoming challenges.

Over time, our INTs across SEL will also evolve to respond to local population needs. This flexibility will be essential to address local inequalities and deliver services which are genuinely holistic and preventative.

To ensure INTs are delivering impact in the right places, we will adopt a "test and learn" approach to quality improvement which creates space for failure and ensures we understand our impact with each new iteration of the INT model, enabled by:



- **Quality Improvement (QI) metrics aligned to and embedded within the local and SEL-wide vision for INTs.** Metrics must develop our understanding of our impact in key INT priority areas including inequalities and prevention, recognising that preventative interventions demonstrate impact over the long-term, often in diffuse ways.
- **Being expansive and innovative when sourcing data and evidence,** drawing in and learning from ongoing QI insights, while making best use of existing evidence and information collected in the community, regionally, and nationally.
- **A culture of evidence gathering and rigorous and rapid evaluation** to inform future planning, design, and delivery. By building a robust evidence base, our INTs will be able to learn from each other, develop sustainably and target improvement efforts toward what we know works, and demonstrate impact which can secure funding into the future. Evidence gathering should be coordinated at system-level to coordinate efforts and ensure all Places benefit from key learning.
- **Ensuring a degree of comparability between QI metrics for our INTs and Places** so we can understand the drivers of impact across SEL, action system inequalities, and ensure every resident in SEL experiences good quality neighbourhood services.
- **Concise reporting requirements** which are focussed on impact and proportionate to the monitoring capacity of each INT partner.
- **A standard approach to applying PDSA-style (Plan, Do, Study, Act) improvement cycles between INTs**, and embedding learning, evaluation, and improvement.

Geography principles

Designing the geographical footprint for INTs needs to balance local population needs, existing healthcare boundaries, local assets, and operational efficiency. Key components for SEL to ensure boundaries enable effective INT functionality include:

Centre around populations and natural communities. While INTs are expected to naturally coalesce around registered populations linked to GP lists, it is crucial to address challenges such as PCNs engaging in multiple neighbourhoods where INT boundaries do not align and recognise that SEL maintains responsibility for those not registered but living in SEL too. This requires clear differentiation between integrated neighbourhood working and INTs, ensuring alignment without disrupting care continuity.

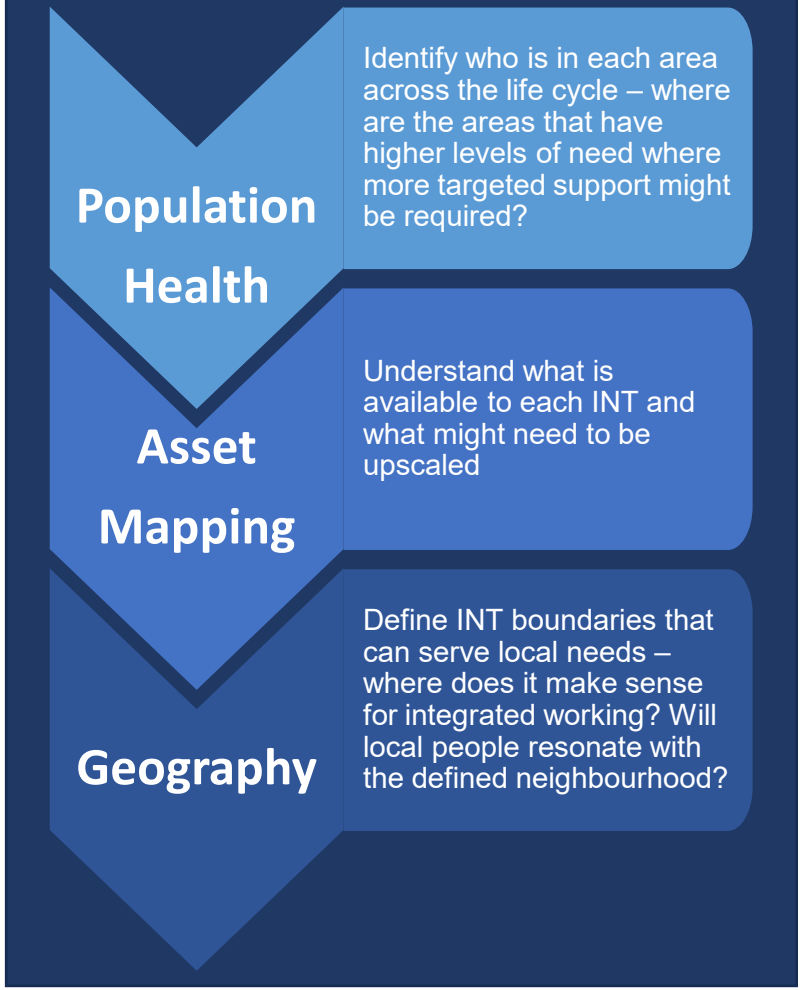
Build on existing networks and local assets. Enhancing integration without requiring new infrastructure where possible is essential to ensure equitable service delivery while maximising existing resources. This will require better use of primary care estates (e.g., community pharmacy consultation rooms) and addressing challenges in engaging community pharmacies with PCNs (particularly those arising from PCN contractual frameworks).

Include population sizes roughly between 50k-100k. Where the population size exceeds 100k, there needs to be consideration of the additional resource required for this area to ensure the size is 'manageable'.

Enable not hinder joint working. The number of INTs must be of a minimum viable scale for team co-ordination; able to be effectively in-reached to by borough-wide services and have appropriate travel times for staff to patients' homes and residents to services.

Adapt footprints based on specific challenges. Areas where there are higher levels of deprivation or inequality require additional, smaller INTs – or at least 'mini-hubs'– for targeted support while larger geographical area could allow for fewer but geographically broader INTs focused on e.g., long-term conditions and frailty. INTs should still pro-actively maintain a degree of demographic and needs variation within INT footprints.

All Places have broadly followed a three-step process to model INTs:



Where there needs to be consistency

Taking a strengths-based approach means there will be local differences. But, beyond working to the same objectives regarding improving health outcomes and addressing inequalities, SEL would expect all to have:

Access to core services: INTs should enable increased service access, and ensure residents have equitable access to essential health and care services within the 'consistent functions' of the INT model (see slide 5) regardless of where they live, proactively identifying and acting on access inequalities.

Proactive care for those with both rising risk and high risk of acute intervention and prevention, beginning with 3+ LTCs, moving along the frailty continuum. This supports overall better outcomes, improved sustainability, and a population well enough to improve access/ address inequalities (e.g., by spotting if there are patterns in service access issues at a level where it can be addressed).

Access to and use of population data: an enabler to the above, population health management (PMH) analysis will drive the composition and priorities of INTs. Each INT will need to identify their baseline position to measure change in outcomes and ability to re-identify patients, as well as a consistent approach and sufficient capabilities to interpret and draw insight from population data.

Data sharing and digital platforms: there needs to be a concentrated effort to ensure INTs are underpinned by interoperable systems and common digital infrastructure to enable co-ordinated care.

Governance and accountability: consistent governance structures across INTs will support clarity in roles, decision-making and accountability. There will need to be clear reporting mechanisms, such as the existing ICB Executive Groups and Local Care Partnerships, and standardised metrics* to report against to share learning, establish effective two-way communication channels, and iterate priorities.

A test and learn approach: recognising that neighbourhood working will take time and will require iteration. INTs should adopt a consistent approach to applying PDSA improvement cycles and embedding learning, evaluation, and improvement.

Coproduction and engagement with communities: communities should experience, understand, and have the opportunity to input into INTs in the same way no matter which INT their locality is served by. Messaging to the public should be consistent to prevent confusion and support proactive engagement and uptake of services.

Common interface with larger / cross-Place providers: e.g., with acute trusts. This will help avoid providers managing an impractical number of different systems.

**Note different Places will want to maintain or develop some specific outcomes measures which speak to major issues on their own patch too.*

Where there will be local variation

Fundamental to our INT model is the need to balance consistency with local variation and taking a strengths-based approach. This means that INTs can effectively meet the differences in local population needs. Emerging thoughts on where there will need to be local variation in INT models include:

Partnering with the voluntary sector: each neighbourhood will have its unique network of voluntary and community sector organisations; leveraging local strengths can amplify the impact of INTs. Consistency in the manner of partnering and engagement, however, should be upheld through common partnering principles.

Interfaces with local authorities: local authorities will have different structures feeding into INT delivery - INTs will need to variously respond and integrate with these to ensure local authority voices are centred in delivery.

Composition of specialist input and resources feeding into each INT: while the core INT will remain consistent from INT to INT, based on local population needs, specialist services should be positioned to flexibly respond to changes in local demand and ensure staff operate on the right spatial level with respect to capacity and demand. Where there is more limited workforce capacity or services, these resources may need to be shared across INTs.

Community engagement: a critical element of the INT model will involve co-designing services with communities and residents to ensure solutions are shaped by lived experiences and local priorities. Tailored public engagement strategies in particularly diverse areas will ensure that INTs meet the needs of all their residents, especially those historically underserved.

Local health system economics: INT priorities will be informed by and respond to local variance in demand for services and supply– for instance, where there may be high, avoidable utilisation of high-cost placements such as residential care.

Physical infrastructure: like workforce, effective INTs should be built on what is already working well within communities which will necessarily look different in each neighbourhood depending on how residents want to and can engage with health and care and wider public services. This might mean developing integration hubs that e.g., leverage hospitals as in Bexley, build on existing community hubs or form ‘mini-hubs’ as in Lewisham.

Key areas of work to deliver Neighbourhoods

South East London Integrated Care System

SEL recognises INTs require a big shift in ways of working, and some requirements will take time to fully implement. However, this should not prevent Places from progressing INT implementation. The following describes key areas of work that will be included in the INT implementation plans at Place and SEL levels, that will need to be driven from a local level upwards with support from SEL to ensure that INTs meet local population needs.

Delivery of INTs	Enabling functions delivered once across SEL, building from Place upwards	Enabling functions delivered at Place and across SEL concurrently
• Confirm neighbourhood footprints and align service delivery • Establish Integrated Neighbourhood Teams (INT) • Implement 3+ LTC scheme* • Implement Frailty scheme* • Implement CYP scheme* • Agree and implement integrator function • Utilisation of population health management (PHM) to address health inequalities through neighbourhood working	• Single PHM function for the ICS • Ongoing evaluation of impact • Outcomes framework, using shared metrics • Digital enablement of neighbourhood working including single health and care record	• Flexible workforce models and associated culture change • Comms and engagement • Delivery and implementation of a common QI process to support test and learn approach • Agree governance to understand implications and secure good governance of neighbourhoods • Identify and implement neighbourhood hubs, linking to broader estates planning and community diagnostic centres (CDC) development • Create business cases, linked to SEL sustainability

*To common spec collaboratively developed by the 6 Places and with support from SEL.

INT initial areas of focus

South East London Integrated Care System

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.
- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

1

3+ Long-Term Conditions

There are currently pilots in each place, and there is a current cost of £18m, £16 Non-Elective (NEL) admissions per year, £3-6m outpatient opportunities for diabetes alone.

2

Frailty and those approaching end of life

There are examples of best practice already and a current cost of £244m* per year on NEL admissions. This also aligns with how many Places are prioritising Ageing well as a strategic goal over the next six years. This might mean pivoting virtual wards and other admission avoidance initiatives into maximising independence outside of the hospital.

3

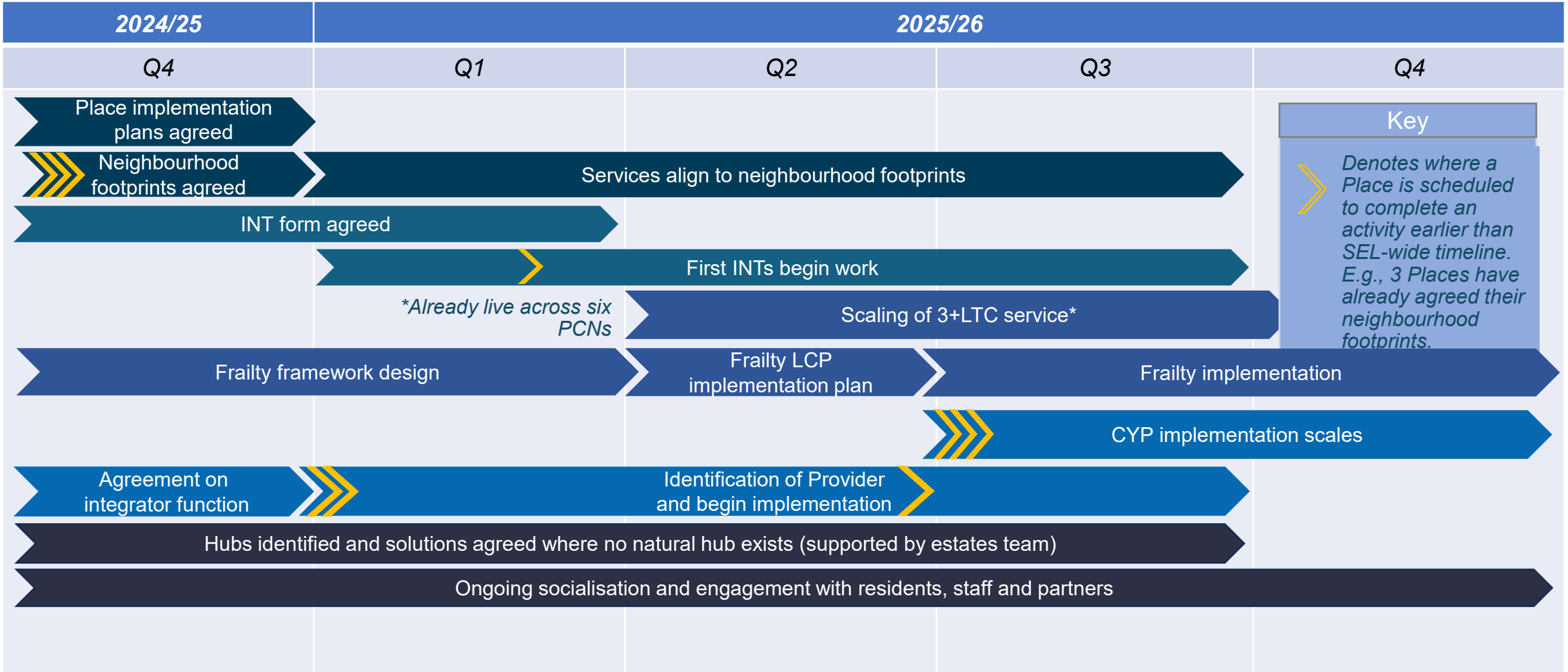
Children and Complex Needs

There is an existing model which has demonstrated reductions in GP and outpatient appointments, Accident and Emergency (A&E) attendances and NEL admissions.

- Initial INT rollouts and pilots within each Place will focus on these areas. However, there is an expectation that as INTs develop, they may identify additional specific priorities based on their local population needs.

Next steps: testing, learning and scaling

Each Place is making significant progress towards establishing and embedding their respective INT models. The following timeline sets out when all Places will have delivered an area of work, reflecting the different starting points and assets in each Place.



Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 6
Enclosure 6

Title:	**Lewisham Integrated Neighbourhood Model of Care**
Meeting Date:	27th March 2025
Author:	Laura Jenner Director of System Development
Executive Lead:	Ceri Jacob Place Executive Lewisham

Purpose of paper:	**Review Lewisham Neighbourhood model of care** **Endorse the further work to implement the Integrated Neighbourhood model for Lewisham**	Update / Information	***Yes***
		Discussion	
		Decision	
Summary of main points:	**Introduction** The Lewisham Integrated Neighbourhood Model of Care is all about bringing health and care services closer to the community. It's a collaborative approach, bringing together the NHS, local council, voluntary groups, and community organisations to ensure people get the right support when and where they need it. The slides attached sets out the vision for the model, how it works, and the benefits it brings. Better coordination of care, earlier intervention, and tackling health inequalities. By focusing on neighbourhoods, we can build stronger local networks and make services more accessible and effective for residents. The Board is invited to review the model and discuss, feeding back any comments.		
Potential Conflicts of Interest	**N/A**		
Any impact on BLACHIR recommendations	The Lewisham Integrated Neighbourhood Model of Care has the potential to make a real impact in reducing health inequalities for the Black community by focusing on: • Ensuring services are designed with input from Black residents to reflect their needs and experiences. • Addressing conditions that disproportionately affect the Black community, such as hypertension, diabetes, and maternal health disparities.		

	• Increasing access to preventative care, early screening, and health education. • Recruiting and training more staff from diverse backgrounds to better understand and support the Black community. • Delivering cultural competency training to ensure care is inclusive and sensitive to racial and ethnic health differences • Working with faith groups, local leaders, and grassroots organisations to improve communication and trust in services.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	EQIA completed the changes with have a positive impact on the following Carers and Families People from Lower Socioeconomic Backgrounds Ethnic Minority Communities People with Disabilities Older Adults		
	Financial Impact	A full Business case is currently being developed which will include the full return on investment for the Lewisham Health and Care system. By supporting the health and wellbeing of Lewisham residents with multiple long-term conditions at rising risk of becoming acutely unwell, the INT model aims to save money through fewer ED visits, secondary care admissions, and ad-hoc GP appointments as a result of poorly managed health conditions.		
Other Engagement	Public Engagement	The programme reporting into the Board are being is being co-designed, and community-led, via several avenues: The People Partnership The Partnership Boards The Health Inequalities programme Carers- small group being arranged to review and refine the model The development of INTs in Lewisham has been informed by a co-design initiative with 16 patients and residents with lived experience of health and care services, including those with a range of ages, religion, ethnicity, disabilities, and carer responsibilities.		

	Other Committee Discussion/ Engagement	LGT community Board ASC- DMT, ELT Stronger communities Health and Wellbeing Board Council Scrutiny committee SlaM
Recommendation:	Recommendation: The Board is asked to agree to take forward the Lewisham Integrated Neighbourhood Model of Care as set out in this paper.	

South East London Integrated Care System

Overview of Integrated Neighbourhood Teams Programme

Laura Jenner

Director of System Development, Lewisham

Dr Camille Hirons

GP and Clinical and Care Professional Lead (CCPL) for community-based care in Lewisham

Dr Kathryn Griffiths

Kidney Doctor and Inequalities Fellow in Lewisham Population Health and Care team

National Context

South East London Integrated Care System

Professor Claire Fuller
GP and Chief Exec, Surrey ICS

- *"providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs*
- *helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention"*

- Fuller Stocktake, May 2022

Lord Ara Darzi
Surgeon in House of Lords

- *"People are struggling to see their GP*
- *Waiting lists for community services and mental health have surged*
- *A&E is in an awful state*
- *Waiting times for hospital procedures have ballooned;*
- *Cancer care still lags behind other countries*
- *Care for cardiovascular conditions is going in the wrong direction"*

- Darzi Review, November 2024

Wes Streeting
Health Secretary

"The 3 big shifts that will underpin our 10-year plan for health:

- *from hospital to community*
- *from analogue to digital*
- *from sickness to prevention"*

- Parliamentary speech, November 2024

South East London Context

South East London Integrated Care System

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.

- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

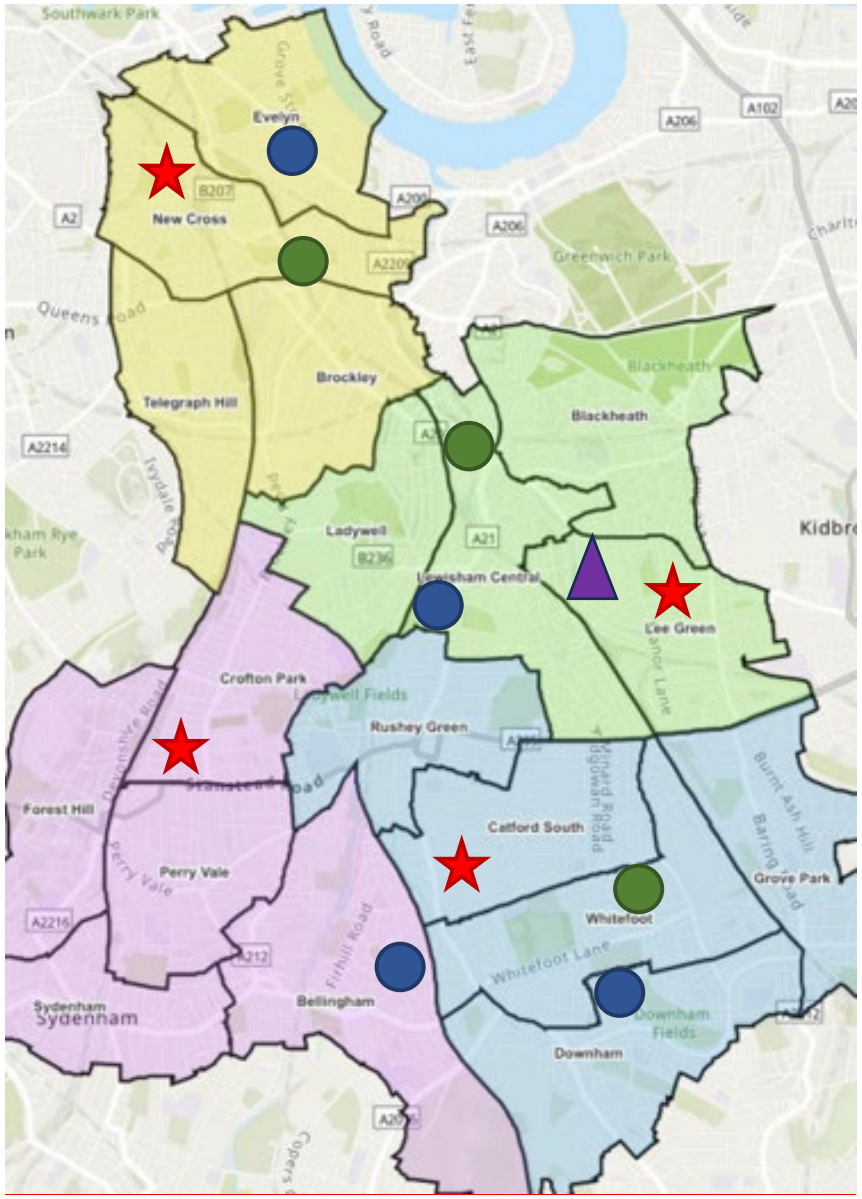
1. **3+ Long-Term Conditions**
2. **Frailty and those approaching end of life**
3. **Children and Complex Needs**

Lewisham Neighbourhoods

South East London Integrated Care System

Neighbourhood 1

- INT for Health & Care Support **(location TBC)**
- Waldron Health Centre *(inc. Community Wellbeing Space)*
- Deptford Family Hub



Neighbourhood 2

- INT for Health & Care Support **(location TBC)**
- Lewisham Shopping Centre CommUNITY Space
- Lewisham Centre for Children and Young People (Kaleidoscope)
- Mental health pilot

Neighbourhood 4

- INT for Health & Care Support **(location TBC)**
- Bellingham Family Hub

Neighbourhood 3

- INT for Health & Care Support **(location TBC)**
- Goldsmiths Community Centre *(inc. Appletree Community Café)*
- Downham Family Hub

Lewisham Context

South East London Integrated Care System

Integrated Neighbourhood Programme

Integrated Neighbourhood Teams (INTs)

INT Model designed to meet the holistic needs of the local population. By using our local population health data patients with 'rising risk' will be proactively identify and supported by the INT team.

Health Equity Teams (HETs)

HEFs work within a PCN, with their local community, GP practices and other partners to identify at risk population, identify local priority workstreams and work with the community to codesign initiatives to make an impact on health outcomes for Lewisham residents.

CESEL

PHM

Multi-Disciplinary Teams (MDMs)

A group of professionals from primary care (and other health and social sectors) discuss individual patients at practice level, to coordinate ongoing support for the most complex patients.

Community Hubs

Waldron Community Centre
Goldsmiths Centre Appletree Cafe
Lewisham Shopping Centre

Creating local care hubs that provides coordinated services all in one location.

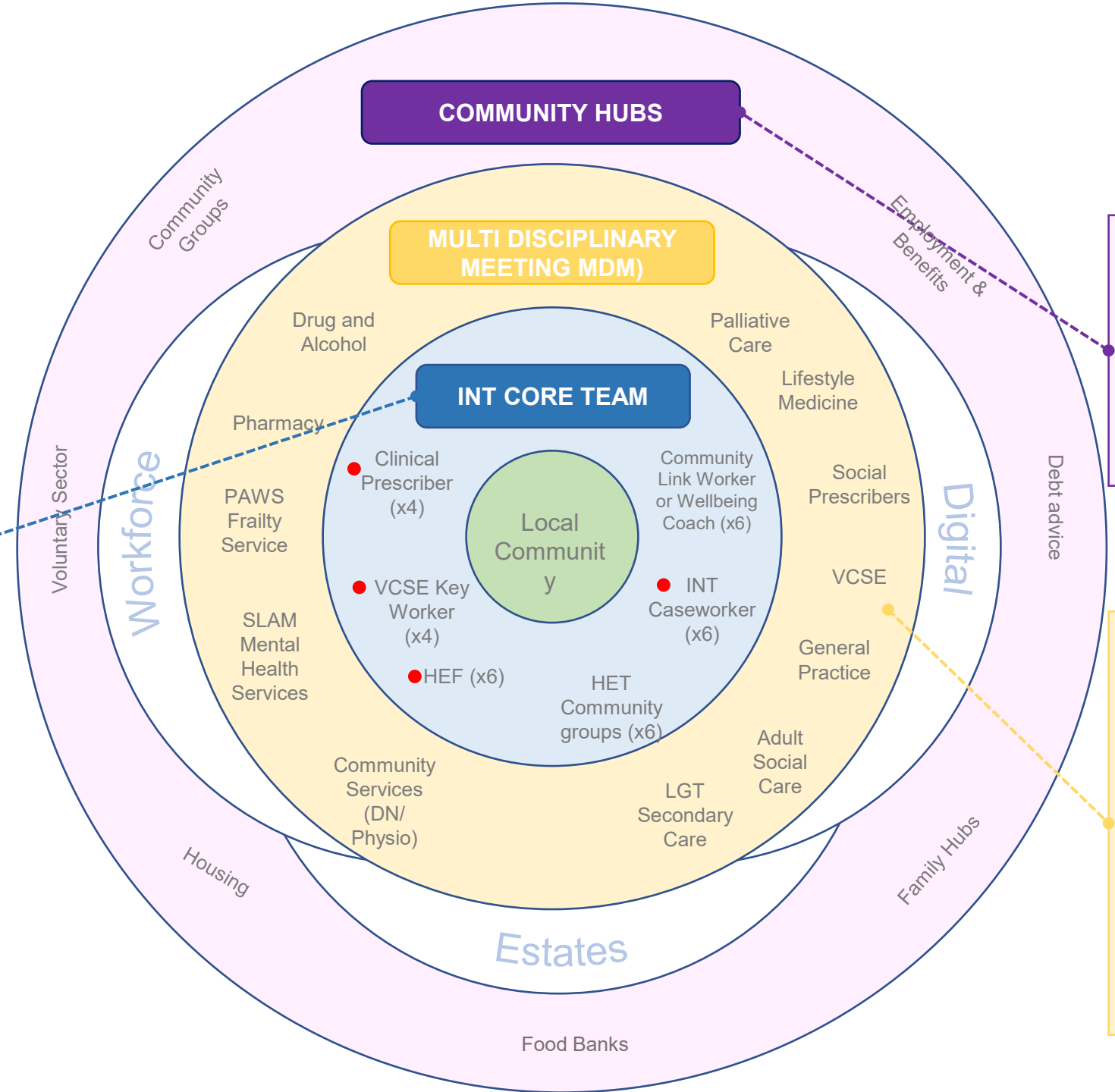
Integrated Neighbourhood Programme Comms and Engagement Plan

Key ● New Role Enablers

South East London Integrated Care System

INT Core Team:
The core team includes a variety of professionals working in integrated roles, such as Clinical Prescribers, and Community Link Workers, PCN Coordinators and lifestyle support

The team also includes a GP and community group that work together to design community-based support with residents



Wider Support Services:
This includes community groups, debt advice, adult education, employment support – all contributing to a holistic approach to patient care.

Multi-Disciplinary Meetings (MDM):
Through the **MDM**, the core team will also be able to **support vulnerable populations** who may not fit into specific LTC cohorts but need comprehensive care due to a variety of health and social factors.

Lewisham INTs – Initial Focus

South East London Integrated Care System

Lewisham are starting the model focussing on 4 prevalent and overlapping cardiovascular and metabolic diseases. Of the 27 long term conditions, we will initially focus on:

- *Atrial Fibrillation*
- *Chronic Kidney Disease*
- *Diabetes*
- *Hypertension*

We have chosen to focus on these 4 conditions because:

- *This is a national and local priority*
- *Implementation needs to start and be tested in a focussed way and scale up*
- *There is overlap in these diseases within the population as well as overlap in the holistic management of these diseases*
- *There are CESEL guides to support the clinical care in each of these disease*

Proactive management of these conditions reduces: strokes, heart attacks, vascular dementia, heart failure, peripheral vascular disease, amputation, and dialysis

South East London Integrated Care System

Population Segmentation

Delivery Vehicle

A. Patients that need complex care

1. 0.5% of those most likely to be admitted as an emergency
2. Vulnerable people presenting at practice referred in by HCPs (not a data search)

****Does not include Palliative Care or Care home patients as they are separated out for another MDM****

Approx ~1300

A. Practice MDMs

Defined as:
- aiming to prevent admission for those patients that are the most complex
- Management of patients that are vulnerable and falling through the cracks between services.

total

B. Patients with 3+ LTCs from the 4 CVD conditions

- Currently focussing on the 4x CVD conditions for undiagnosed (uncoded) and diagnosed and unoptimised)
- TBC at risk HEFs only

Future LTCs can also be grouped together for easier management and care delivery e.g. Respiratory or Neuro.

C. Segment for rising risk to prevent them becoming more complex

- They fall into the Core20PLUS (deprived/ ethnicity/ vulnerable)
- They have had more than 3 ED attends in the last 12 months, and they have had 2 or more admissions in the last 18 months
- They have Pain and / or Depression
- They have not been in contact with their GP (no primary care related encounters) in last 18 months and/or 'building block' for those that find access difficult e.g. are/have a carer, reading / writing difficulties
- Frail (EFI of severe and 8+ meds U65 years)
- Dementia / LD / SMI

3485 with any risk factor

C. INT

1. Those that are unoptimized and undiagnosed to have a multi morbidity assessment to optimise disease state **(CORE INT)**
2. **They will receive a tailored up to 12-week intervention including medicine, lifestyle management and enabling support addressing their social issues . One-one support and group consultation**
3. Patients not in contact with their GP to have a community designed intervention to respond to the patient need and bring patients back to GP services and deliver better outcomes than GP "business as usual". Testing for at risk and undiagnosed tbc. **(HEFs)**
4. A focus on LD and SMI and dementia for a separate intervention **TBC**
5. A focus on frail **(PAWS)**

3.0 Project Updates

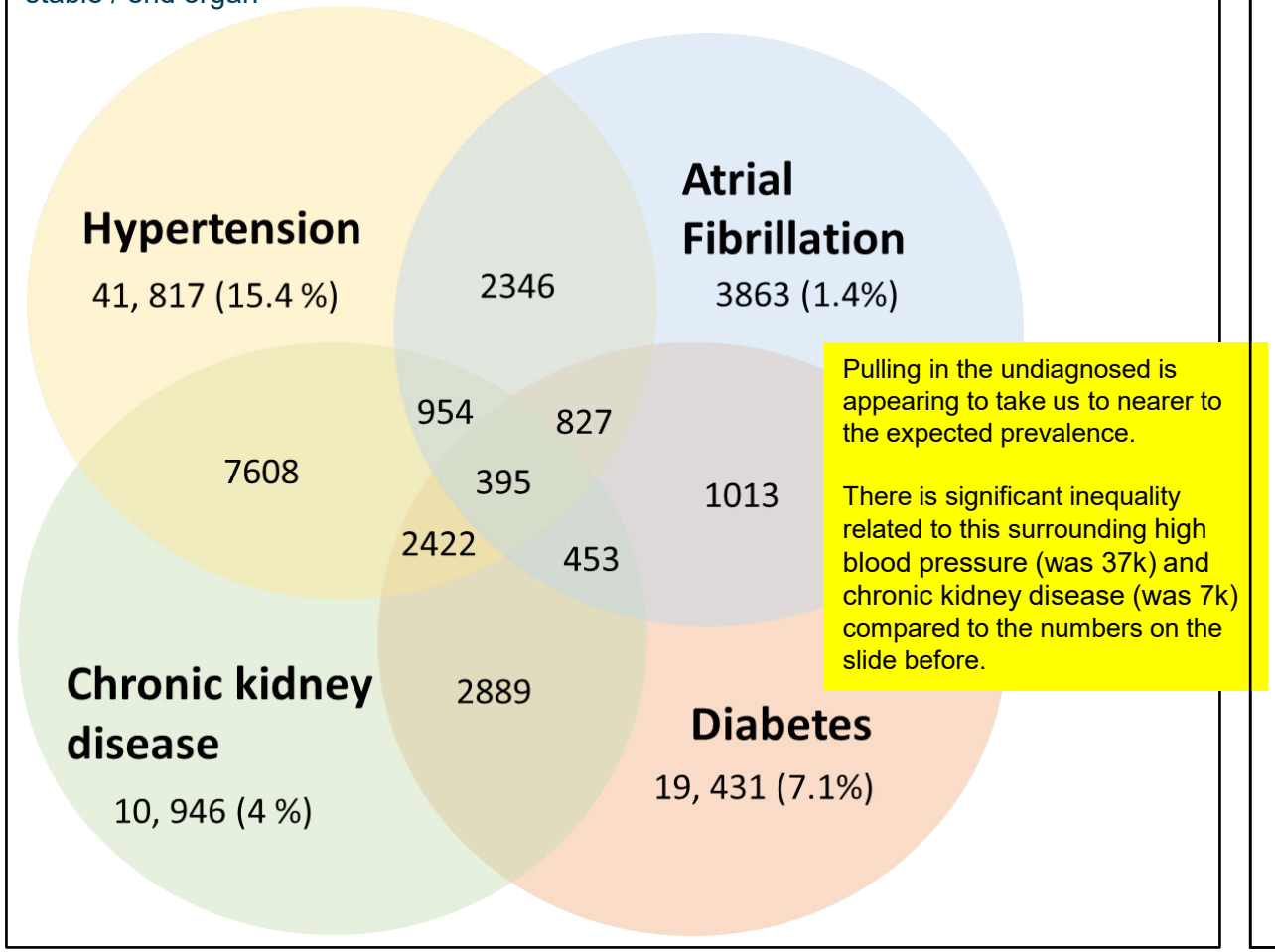
The PHM team recommend we expand the 4 CVD conditions, to see if we can accurately increase our coded numbers by testing the undiagnosed and at risk of having the disease.

South East London Integrated Care System

2. Venn diagram of overlaps in those undiagnosed and diagnosed with the 4 x CVD conditions

Conditions: AF / CKD / DM / HT

Workstreams 2, 3, 4: undiagnosed and not on a register (with diagnostics) / unoptimised / stable / end organ



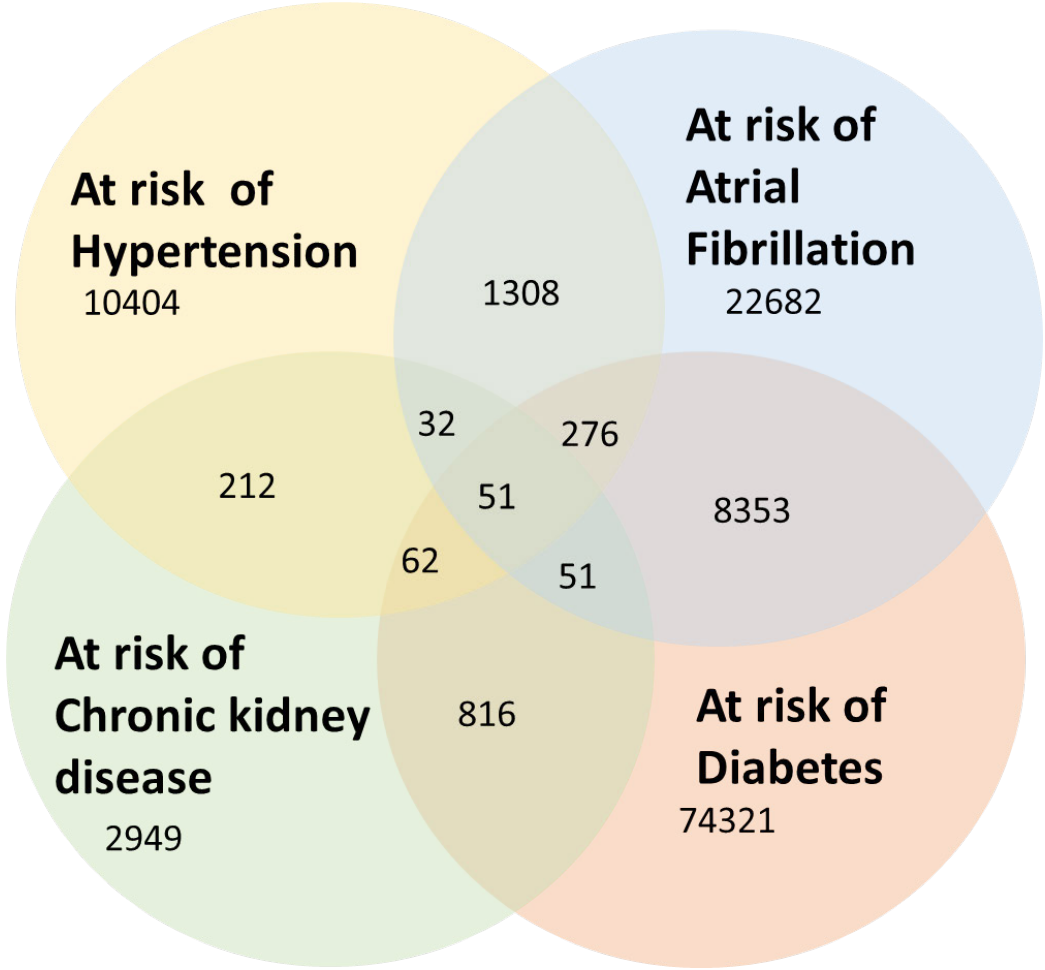
Pulling in the undiagnosed is appearing to take us to nearer to the expected prevalence.

There is significant inequality related to this surrounding high blood pressure (was 37k) and chronic kidney disease (was 7k) compared to the numbers on the slide before.

3. Venn diagram of overlaps in those at risk of having the 4 x CVD conditions

Conditions: AF / CKD / DM / HT

Workstreams 1: High risk without diagnostic test



Multi-Discplinary Meetings (MDMs) Membership

South East London Integrated Care System

The core members of the practice based multi-disciplinary meeting are:

- GP(s)
- The Practice Manager
- Social care representative(s)
- District nurse representative(s)
- **Neighbourhood Co-Ordinator**

Role of the Four Neighbourhood coordinator (Adult Social Care Role)

Central to the success of the MDMs, established good relationships across organisations.

Their role is to:
Coordinate the meeting and support the MDM to connect to wider health and care services.
Act as a conduit for queries or referrals, supporting professionals to better co-ordinate care and support.
Holding complex cases

Wider membership: Depending on the cases to be discussed, it may be appropriate to invite relevant specialist health and care professionals such as:

- Mental health specialist(s)
- Home care agency / care worker
- LIMOS
- Clinical psychologist(s)
- Specialist services such as housing, drug and alcohol support services
- Speech and Language Therapy (SALT) team
- Specialist nurses e.g. respiratory, diabetes, dementia
- Pharmacists
- Housing Provider(s) e.g. Sheltered Scheme Manager
- Enablement team
- Voluntary sector representatives e.g. Community Connections.

MDM Review 2023/4 and Areas for Action

South East London Integrated Care System

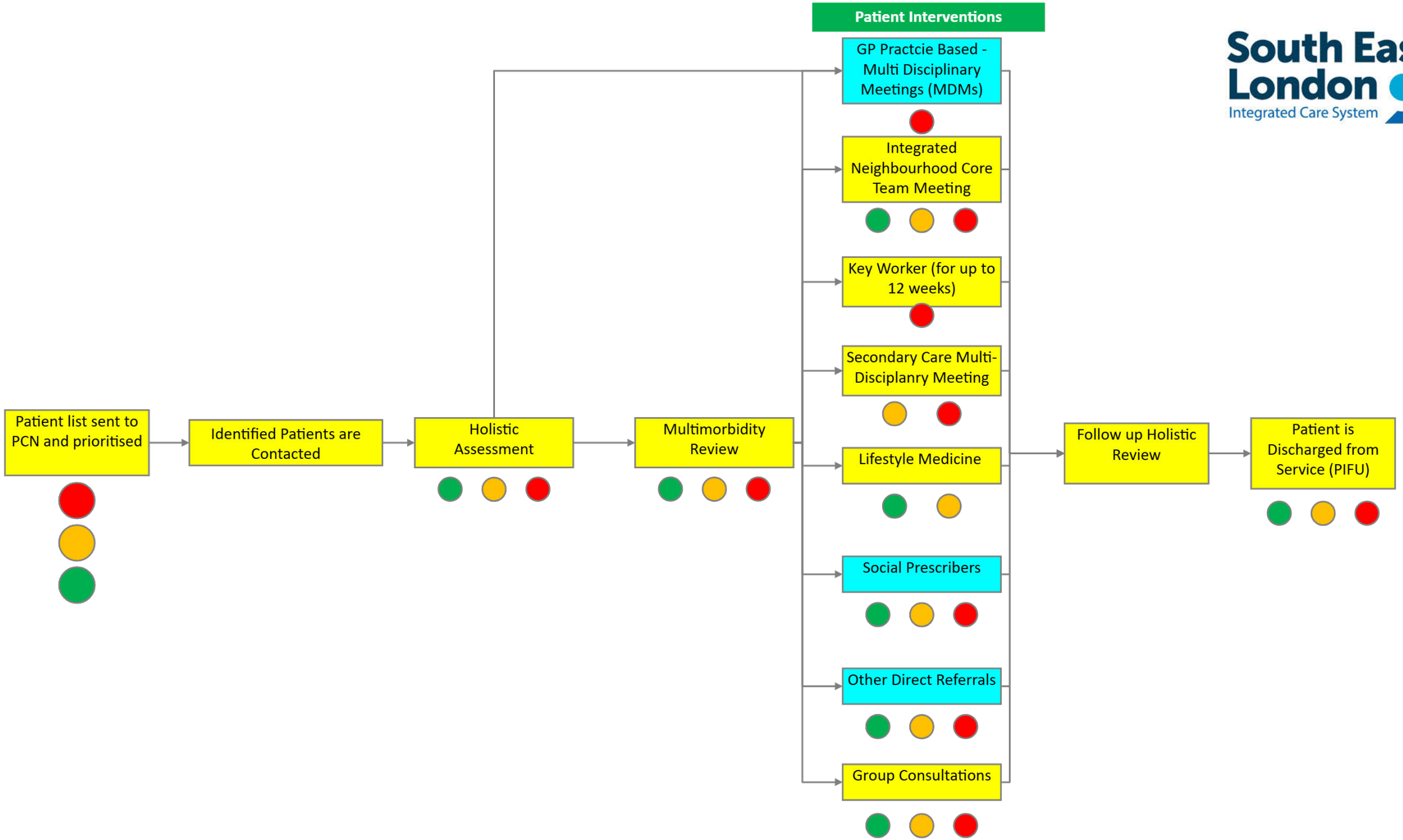
Area	MDM leads	Membership	Case Finding & Referrals	Processes	Patient Outcomes	General
						
	• Most of the MDM register is made of up patients with complex mental health needs and elderly frail patients. • Identified gaps in CYP MDM.	• There are consistent gaps in membership across the MDMs.	• Agencies may be interested in a case finding tool to identify patients for discussion. • Efficiencies could be made by reducing 'inappropriate' referrals or cases e.g., could be resolved outside of the meeting. • There is potential to move to a more anticipatory approach for MDMs.	• There is a wide variation in the processes surrounding MDMs which may impact consistency in quality. • IT access is a barrier to effective MDM working.	• Patient outcomes are well documented and there is agreement for those being added and removed from the patient list. • There is variation across the borough in the level of patient and/or carer involvement in the MDMs.	• There are a vast range of MDTs and there is likely to be overlap of patients being discussed.

Roles and Interventions within INT

South East London Integrated Care System

- Clinical Prescriber (Pharmacist)
- INT Caseworker
- Voluntary Sector Key Worker
- Health Equity Team
- Lifestyle Medicine Service
- Community Link Worker
- Secondary Care MDT
- Neighbourhood Coordinators

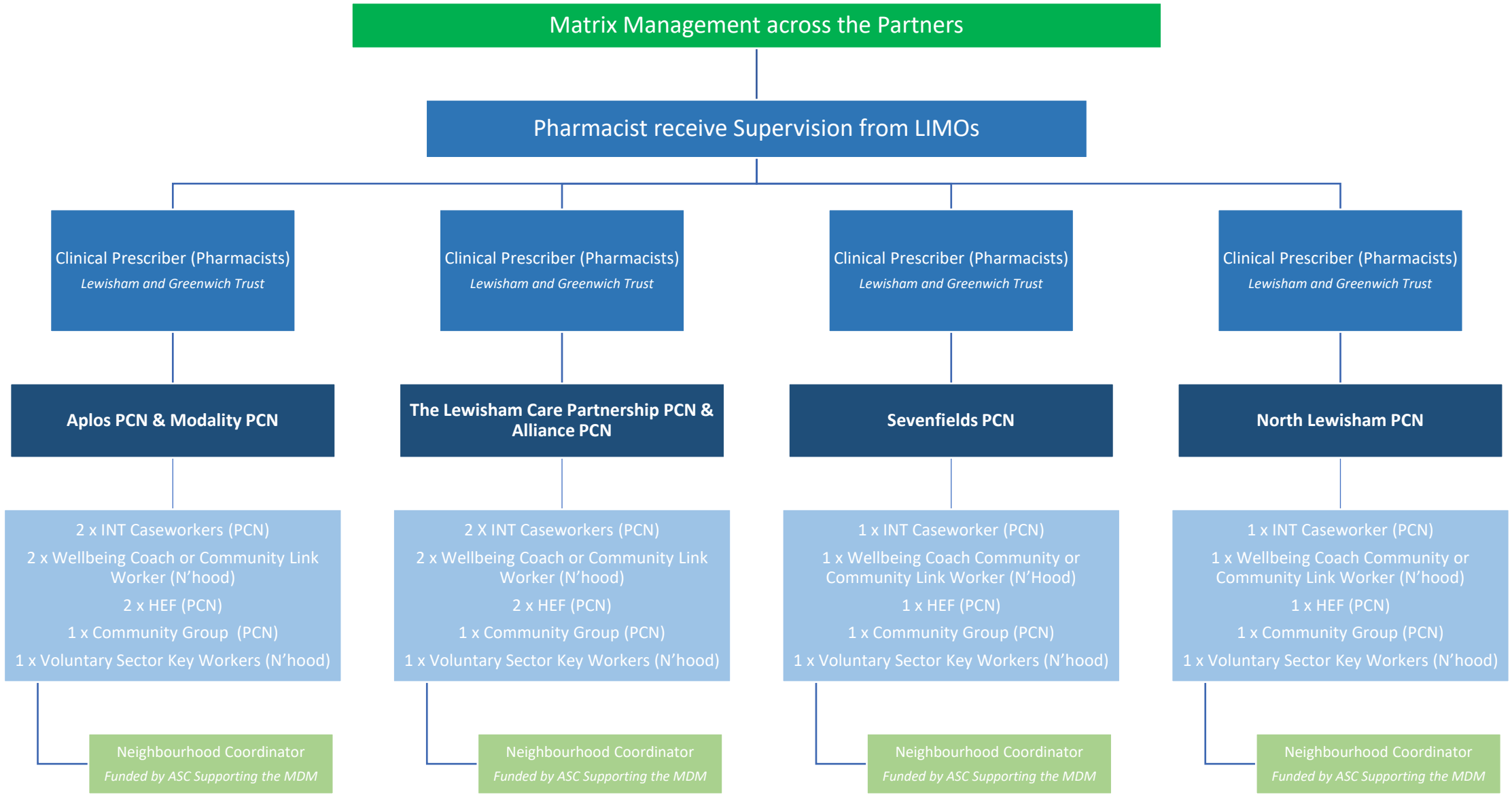
4 x Neighbourhood Coordinators funded from Adult Social Care continue to support the practice-based MDMs



South East London Integrated Care System

Integrated Neighbourhood Team (INT) Structure
as it relates to prescribing

South East London Integrated Care System



Comms and Engagement Timeline

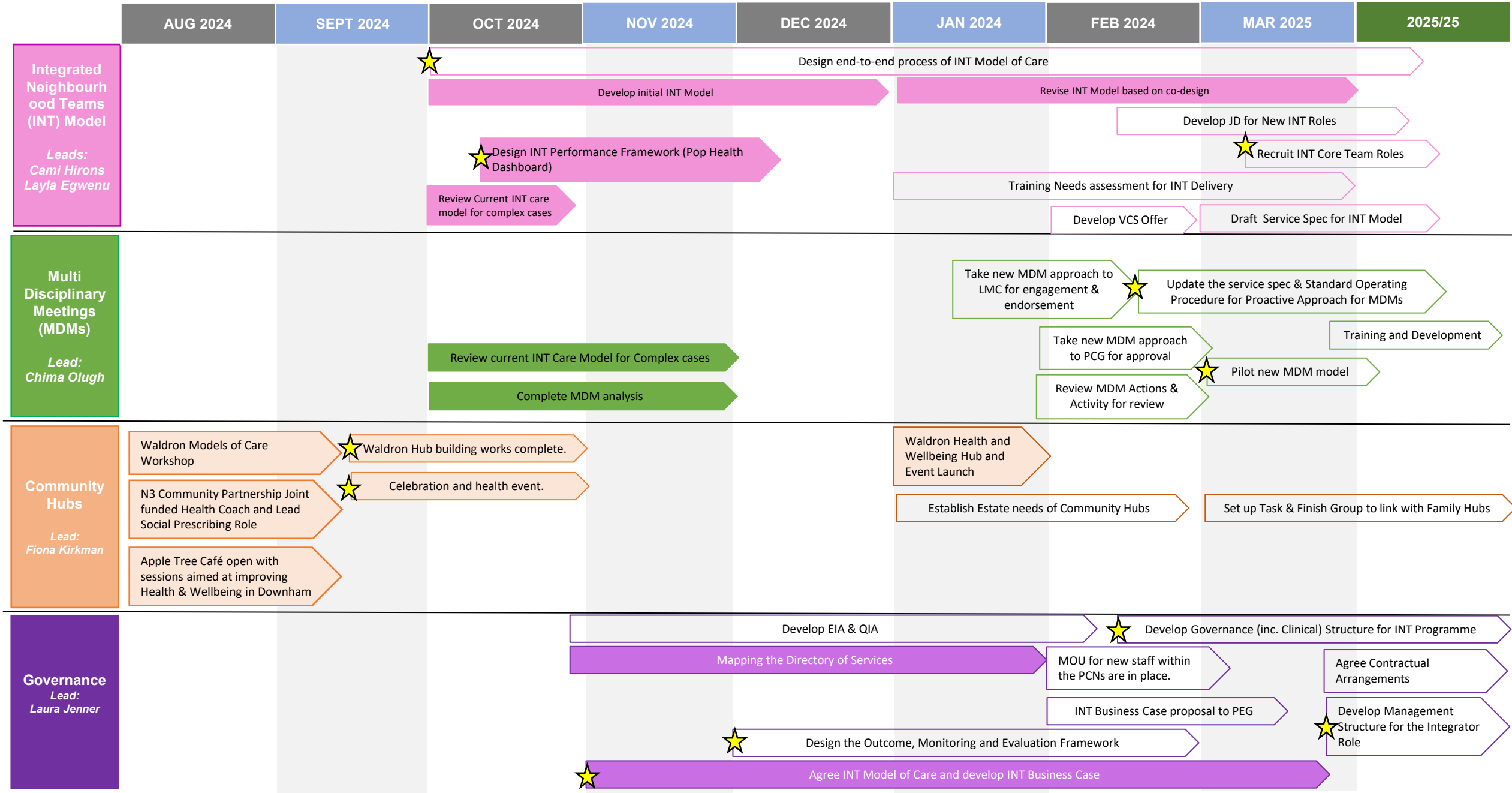
Engagement to Date

South East London Integrated Care System

	AUG 2024	SEPT 2024	OCT 2024	NOV 2024	DEC 2024	JAN 2024	FEB 2024	MAR 2025	2025/25
Comms & Engagement ***Leads: Fiona Kirkman Layla Egwenu***		Develop Comms and Engagement Plan							
		INT Market Place Engagement Event		Start Engagement with Voluntary Organisations					
		INT Design group Established	INT Design Group Workshop – 23rd October		INT Roadshow with each of the 6 Primary Care Networks				
	Waldron Models of Care Workshop				Workshops with system partner organisations (SROs, MH, CYP)				
	N'Hood 3 Partnership				Recruit People With Lived Experience for Co-Design	People With Lived Experience for Co-Design			

Integrated Neighbourhood Programme Timeline and Milestones

Key: ★ Milestone; Filled Box = Task Completed; Unfilled Box = Task Not Completed



Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 7

Title:	**Primary Care Access Plan**
Meeting Date:	27th March 2025
Author:	Ashley O'Shaughnessy, Associate Director of Primary Care and Community Based Care (Lewisham)
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The purpose of this paper is to share the Lewisham Primary Care Access Plan for 24/25 and progress made to date and also to highlight areas for specific consideration across the whole Local Care Partnership (LCP)	Update / Information	
		Discussion	X
		Decision	
Summary of main points:	NHSE published the Delivery plan for recovering access to primary care in May 2023 Primary Care access is also a key component of the local Five year forward view delivery plan for Primary Care in Lewisham (2023-2028) Much work is already underway to support improved access and this high level summary plan seeks to consolidate these activities into one place The plan is structured in line with headings of the national Delivery plan for recovering access to primary care, namely: • Empower patients • Implement 'Modern General Practice Access' • Build capacity • Cut bureaucracy The governance that is overseeing delivery of the plan and metrics to track progress are included as well as example reporting dashboards that are currently available Particular areas that impact across the LCP have also been highlighted for consideration as follows: • Communications and Engagement • Additional Roles Reimbursement Scheme (ARRS) • Closer work with pharmacy, dental, ophthalmic providers/services		

	• Integrated neighbouhood teams (INTs) and multi-disciplinary meetings (MDMs) • Interface The latest highlight report of progress against the plan (February 2025) has also been appended for information			
Potential Conflicts of Interest	None identified			
Any impact on BLACHIR recommendations	No specific impacts identified			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Delivery of the plan should support a reduction in health inequalities with patients having equal access whether they contact their practice face to face, via the phone or online.		
	Financial Impact	Financial considerations are included within the plan and are a mixture of national and local contracts, incentives and programmes		
Other Engagement	Public Engagement	There has been extensive engagement with the Lewisham Peoples Partnership and one of the key elements of the plan is a comprehensive public communications and engagement campaign		
	Other Committee Discussion/ Engagement	▪ Lewisham Primary Care Group ▪ Lewisham People's Partnership ▪ Lewisham Place Executive Group ▪ LCP Board Seminar		
Recommendation:	The Lewisham Local Care Partnership Strategic Board is asked to note the Primary Care Access Plan for 24/25 and the latest highlight report of progress and consider the areas highlighted for broader LCP focus			

NHS
South East London

Lewisham Primary Care Access Summary Plan 24/25

Ashley O'Shaughnessy, Associate Director CBC and Primary Care (Lewisham)

Version 2.0

Lewisham LCP Board

14th March 2025

Introduction

NHS South East London

NHSE published the Delivery plan for recovering access to primary care in May 2023

Primary Care access is also a key component of the local Five year forward view delivery plan for Primary Care in Lewisham (2023-2028)

Much work is already underway to support improved access and this high level summary plan seeks to consolidate these activities into one place

The plan is structured in line with headings of the national Delivery plan for recovering access to primary care

The governance that is overseeing delivery of the plan and metrics to track progress are included as well as example reporting dashboards that are currently available

Empower patients

NHS South East London

Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.

Initiative	Detail	Lead	Timescales	Incentives	Considerations / gaps
NHS APP	Maximise registrations and usage of the NHS APP for repeat prescriptions, viewing medical records, booking appointments and receiving messages	Digital change manager	Quarterly deep dive review of data to assess progress and update detailed plan as needed	None	Current focus is on maxmising registrations but also need to track and push actual usage of the NHS APP
Practice websites	Ongoing work with all practices to review and refine their websites to make them easier to navigate including ensuring they are up to date, consistent and cover all key areas	Digital change manager	Quarterly review of progress	None	Need to confirm this is still a priority with the SEL digital team who may be looking to divert the change manager focus away from this
Self referral	Promoting self referral into appropriate pathways	Planned care leads	Quarterly review of progress	None	What are the ICB and partners (SEL and place) directly doing to promote self referral pathways
Pharmacy First	Promoting use of the pharmacy first pathway	Medicines team	Quarterly review of progress	Incentives for community pharmacy	Need to consider the role of the community pharmacy neighbourhood leads
Pharmacy oral contraception (OC) and blood pressure (BP) services	Promoting use of the OC and BP pathways	Medicines team	Quarterly review of progress with specific focus in Q4 24/25 to coincide with decommissioning of practice based ABPM service	Incentives for community pharmacy	Need to consider the role of the community pharmacy neighbourhood leads
Public comms and engagement campaign	Campaign to clearly articulate key aspects of the access programme particularly to include new ARRS roles and triage models	Comms and engagement team	Ideally would have plan agreed by Q4 24/25	None	Consider how we work with the Peoples Partnership to do this - conversations have already started

Implement 'Modern General Practice Access'

NHS South East London

Implement Modern General Practice Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

Initiative	Detail	Lead	Timescales	Incentives	Considerations / gaps
Cloud based telephony (CBT)	Ensuing all practices are using fit for purpose CBT to support patients who wish to contact via the phone	Digital change manager	All practices already transitioned to CBT including call back functionality but some practices scheduled to move to more optimal systems	Funding already provided to support adoption of fit for purpose CBT Part of CAIP and T&T	Need to consider what resource/support is available to enable practices to maximise the benefits of CBT i.e. training
Online consultation (OC) offer	Ensuing all practices are using fit for purpose OC tools to support patients who wish to contact online	Digital change manager	All practices already using OC tools to some degree	Part of CAIP and T&T	Need to consider what resource/support is available to enable practices to maximise the benefits of OC i.e. training
Capacity and Access Improvement Payment (CAIP)	PCN incentive for 24/25 which focuses on better digital telephony, simpler online requests and faster care navigation, assessment, and response.	Lewisham place CBC team	Local guidance for 24/25 already circulated to practices with PCNs to confirm compliance across all constituent practices by 31 March 2025	National CAIP funding – compliance with the 3 elements can be submitted individually or collectively at any point up until 31 March 2025	National scheme with no flexibility. PCN CDs to self declare compliance but guidance circulated to help provide assurance and option of post payment verification (PPV) available
Transition and Transformation (T&T) funding	Specific funding for practices to support transition to the modern general practice model.	Lewisham place CBC team	Funding available until 31 March 2025	Non-recurrent national transition and transformation funding – an average of £13,500 available per practice.	All practices have now received full funding based on evidence submitted and self declaration of transition to the Modern General Practice Access model
Support Level Framework (SLF) programme	Programme commissioned from the SELWDH to undertake a structured diagnostic with practices to assess strengths/weaknesses and develop corresponding action plans	SEL Workforce Development Hub (SELWDH)	All practices to undertake SLF assessment by March 2025 SLF+ programme also now being offered as a follow up	Funding for practices already allocated to support engagement in the SLF programme	Need to consider what resource/support is available to follow up on actions/themes emerging from the SLF/SLF+ programme

Build capacity

NHS South East London

Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed

Initiative	Detail	Lead	Timescales	Incentives	Considerations / gaps
Additional Roles Reimbursement Scheme (ARRS)	Supporting additional roles in primary care including first contact physiotherapists, pharmacists, social prescribing link workers, health and wellbeing coaches, care coordinators, physician associates and mental health and wellbeing practitioners	System Development team	Rolling programme for 24/25 Awaiting final clarity on arrangements for 25/26	National funding for roles provided	Whilst we need to support PCNs to fully utilize their available budgets, we also need to consider how we work with PCNs to integrate and embed these roles into the wider system, taking a more strategic approach
Enhanced Access	Additional capacity on weekday evenings (6.30-8pm) and on Saturdays (9-5pm). Delivered at a PCN level	Lewisham place CBC team	Quarterly review process already in place	Part of the PCN Network DES requirements and funded as such	Annual review of 23/24 delivery undertaken – as part of this, PCNs were required to submit action plans to address any areas of challenge i.e. appointment mix, consistency of information on practice websites
Closer work with pharmacy, dental, optom providers/services	Programme to be developed to explore opportunities to work with local pharmacy, dental, optom providers/services to support improved access across all primary care services	Lewisham place CBC team	Q3-4, 24/25	TBC based on national contractual agreements	Good progress already in train with community pharmacy. Need to consider what resource might be available to support this work
Integrated neighbouhood teams (INTs) and multi-disciplinary meetings (MDMs)	Continued development of INTs and MDMs to take a more proactive approach to the management of the more complex patients, streamlining both their access and also for all others	System Development team	Separate detailed plan in place for this workstream	Population Health Framework Primary Care Service Development Funding (SDF) PMS premium	Need to consider how we make the link between this work and improved access

Cut bureaucracy

NHS South East London

Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

Initiative	Detail	Lead	Timescales	Incentives	Considerations / gaps
Primary / secondary care Interface	Improving the interface between general practice and secondary care services to include discharge letters, onward referrals, test requests, clear communication channels	System Development team	Interface group to be set up by Q3 24/25	None	Need to formalize our local programme work plan and also consider how we link to the SEL work in this area
District Nursing interface	Improving the interface between general practice and district nursing services	System Development team	Workshop held in July 2024 Short term actions identified and being progressed	None	Approach to longer term, more strategic/contractual actions to be agreed

Governance

NHS
South East London

Access is a standing agenda item at the Lewisham Primary Care Group which reports through to the LCP strategic board via a chairs report

There is also a SEL Primary Care Recovering Access Transformation Programme meeting which covers common issues across all 6 SEL boroughs

As appropriate, access is also discussed at the Lewisham Primary Care Leadership Forum especially in regard to the primary/secondary care interface (LGT are regular attenders) and pharmacy matters (LPC are members of the group).

Individual metrics to track progress have been identified (see next slide) but more work is needed to try and combine these to highlight practices/PCNs where good progress is being made and also where more focus is needed

‘Ambitions’ against agreed baselines should be set where appropriate to help track progress over time

Metrics to track progress

NHS South East London

Metric	Data source	Suggested Frequency	Specific considerations
GP Appointment Data (GPAD)	https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice	Quarterly	• Number of appointments per 1000 patients • Appointments within 2 weeks
Pharmacy First/OC and BP services	SEL BI dashboard (in development)	Quarterly	• Uptake
NHS APP	SEL BI dashboard	Quarterly	• % of patients who have registered for the APP
PCN Enhanced Access	PCN reporting	Quarterly	• Delivery against contractual requirements including 60 mins per 1000 patients
ARRS	SEL BI dashboard	Quarterly	• Spend against budget
GP Patient Survey (GPPS)	https://gp-patient.co.uk/	Annual	• Getting through on the phone • Overall experience of contacting practice
Friends and Family Test (FFT)	https://www.england.nhs.uk/fft/friends-and-family-test-data/	Quarterly	• % good / very good
111 utilisation	SEL BI dashboard	Quarterly	• Calls per 1000 patients

Focus areas for the LCP

NHS South East London

Focus areas	Considerations
Communications and Engagement	How do we best work across the partnership to communicate a consistent message to the public about how best to utilise primary care services i.e. NHS APP, Pharmacy First, expanding primary care team, Modern General Practice model
Additional Roles Reimbursement Scheme (ARRS)	Can we take a more strategic approach to ARRS to fully integrate and embed this workforce into the local system i.e. recruitment & retention, training, supervision, rotational roles, shared posts
Closer work with pharmacy, dental, ophthalmic providers/services	When exploring closer working with community pharmacy, dental and ophthalmic providers/services, are there broader connections that can be made i.e. health promotion, social prescribing, mental health support
Integrated neighbouhood teams (INTs) and multi-disciplinary meetings (MDMs)	How do we collectively prioritise our work on INTs and MDMs to support our complex patients and make best use of available resources
Interface	Building on the work already started focusing on the primary/secondary interface and the interface with district nursing services, can we go further and faster in these areas and what are the opportunities to expand this work to other system interfaces i.e. mental health, local authority, VCSE

NHS
South East London

Example reporting dashboards

National GP Appointment Data

NHS South East London

Table 4: Practice level summary of appointments by Appointment Mode, England, January 2025

Notes:

1 - Practices using the Cegedim and Informatica GP systems are unable to supply appointment mode data.

2 - This table only includes appointments recorded in GP practice appointment books systems. Where PCN activity is recorded within GP practice appointment systems those appointments will be included.

Month	GP Code	GP Name	PCN Name	Face to Face	Home Visit	Telephone	Video / Online	Unknown	Total appointments	List Size	Appointments per 1,000 patients
Jan-2025	G85004	MODALITY LEWISHAM (ML)	MODALITY LEWISHAM PCN	7746	159	3885	96	3	11889	35823	331.88
Jan-2025	G85015	THE QRP SURGERY	NORTH LEWISHAM PCN	1809	0	828	824	0	3461	9204	376.03
Jan-2025	G85020	KINGFISHER MEDICAL CENTRE	NORTH LEWISHAM PCN	3431	26	782	0	0	4239	16232	261.15
Jan-2025	G85023	LEWISHAM MEDICAL CENTRE	LEWISHAM ALLIANCE PCN	3527	0	829	0	0	4356	14778	294.76
Jan-2025	G85024	SYDENHAM GREEN GROUP PRACTICE	APLOS HEALTH PCN	2758	18	1214	0	43	4033	15147	266.26
Jan-2025	G85026	CLIFTON RISE FAMILY PRACTICE	NORTH LEWISHAM PCN	378	0	1124	0	29	1531	4402	347.80
Jan-2025	G85032	TORRIDON ROAD MEDICAL PRACTICE	SEVENFIELDS PCN	3112	12	1773	0	0	4897	11865	412.73
Jan-2025	G85038	THE LEWISHAM CARE PARTNERSHIP	LEWISHAM CARE PARTNERSHIP PCN	10035	78	10595	924	108	21740	52810	411.66
Jan-2025	G85046	LEE ROAD SURGERY	LEWISHAM ALLIANCE PCN	3274	9	21	0	0	3304	12465	265.06
Jan-2025	G85057	ASHDOWN MEDICAL GROUP	SEVENFIELDS PCN	3171	20	2442	0	25	5658	12985	435.73
Jan-2025	G85061	WOOLSTONE MEDICAL CENTRE	APLOS HEALTH PCN	2408	12	704	357	0	3481	9474	367.43
Jan-2025	G85076	NEW CROSS CENTRE (HURLEY GROUP)	NORTH LEWISHAM PCN	1806	24	1919	0	0	3749	9877	379.57
Jan-2025	G85085	GROVE MEDICAL CENTRE	NORTH LEWISHAM PCN	1493	5	315	323	13	2149	12882	166.82
Jan-2025	G85104	ICO HEALTH GROUP	SEVENFIELDS PCN	2305	8	770	0	0	3083	10055	306.61
Jan-2025	G85105	VESTA ROAD SURGERY	NORTH LEWISHAM PCN	1215	2	299	78	0	1594	6618	240.86
Jan-2025	G85114	WELLS PARK PRACTICE	APLOS HEALTH PCN	9618	1	1060	389	0	11068	12921	856.59
Jan-2025	G85120	TRIANGLE GROUP PRACTICE	LEWISHAM ALLIANCE PCN	1092	0	1297	605	0	2994	6638	451.04
Jan-2025	G85121	PARKVIEW SURGERY	SEVENFIELDS PCN	2803	181	562	0	0	3546	9785	362.39
Jan-2025	G85633	NOVUM HEALTH PARTNERSHIP	SEVENFIELDS PCN	3897	3	1501	0	19	5420	21233	255.26
Jan-2025	G85696	VALE MEDICAL CENTRE	APLOS HEALTH PCN	3819	2	761	0	441	5023	16541	303.67
Jan-2025	G85698	AMERSHAM VALE TRAINING PRACTICE	NORTH LEWISHAM PCN	2198	0	2057	103	2	4360	15798	275.98
Jan-2025	G85711	DEPTFORD SURGERY	NORTH LEWISHAM PCN	2213	0	561	0	0	2774	12087	229.50
Jan-2025	G85716	OAKVIEW FAMILY PRACTICE	SEVENFIELDS PCN	1332	0	655	43	2	2032	6332	320.91
Jan-2025	G85722	WOODLANDS HEALTH CENTRE	LEWISHAM ALLIANCE PCN	2818	14	2612	0	0	5444	10702	508.69
Jan-2025	G85727	NIGHTINGALE SURGERY	LEWISHAM ALLIANCE PCN	1731	0	400	0	0	2131	6814	312.74
Jan-2025	G85736	DEPTFORD MEDICAL CENTRE	NORTH LEWISHAM PCN	1333	0	435	0	0	1768	4322	409.07
			TOTALS	81322	574	39401	3742	685	125724	357790	
			AVERAGES	3127.77	22.08	1515.42	143.92	26.35			351.93
			% SPLITS	64.68%	0.46%	31.34%	2.98%	0.54%	100.00%		

NHS App Utilisation - Summary

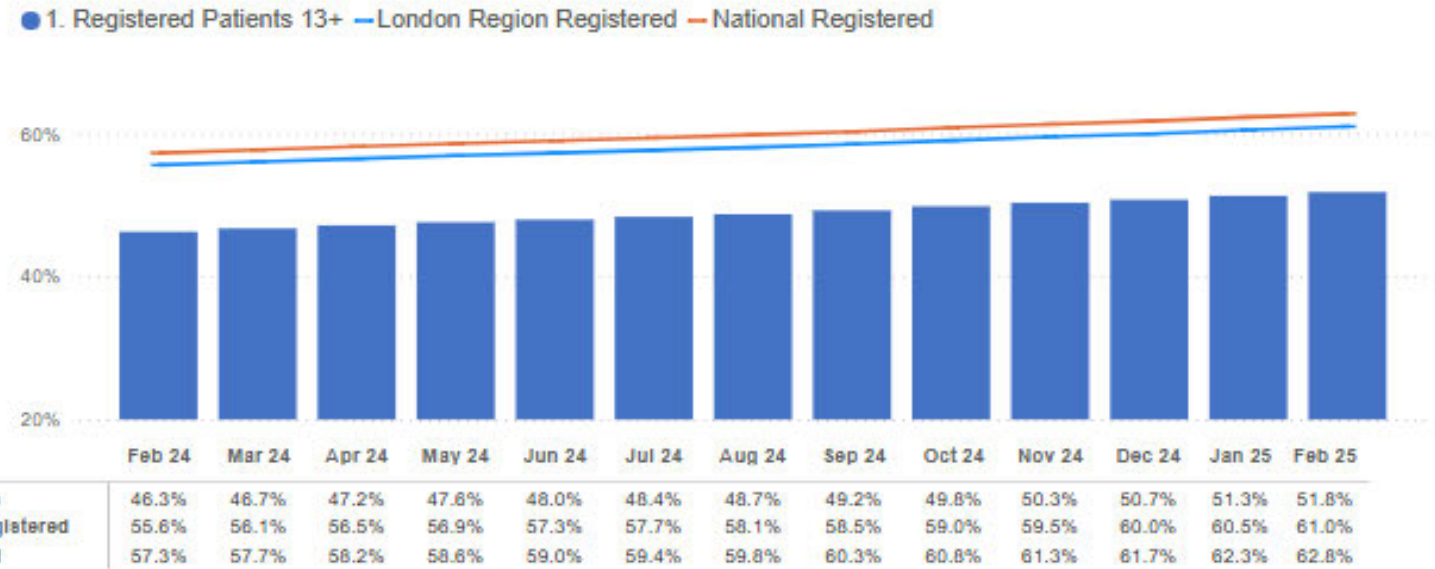
South East London Integrated Care System

NHS South East London

Borough, PCN Name, Practice Name

Lewisham

SEL ICB Registered Patients 13+ benchmarked against London Region and National



	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
Registered Patients	46.3%	46.7%	47.2%	47.6%	48.0%	48.4%	48.7%	49.2%	49.8%	50.3%	50.7%	51.3%	51.8%
London Region Registered	55.6%	56.1%	56.5%	56.9%	57.3%	57.7%	58.1%	58.5%	59.0%	59.5%	60.0%	60.5%	61.0%
National Registered	57.3%	57.7%	58.2%	58.6%	59.0%	59.4%	59.8%	60.3%	60.8%	61.3%	61.7%	62.3%	62.8%

Current Month : Feb 25

51.8%

NHS App Registrations	GP Registered patients 13+
160,428	309,712

60%

Target

Key Performance Indicator	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
Total registrations	143,271	144,719	146,049	147,384	148,555	149,747	150,877	152,493	154,297	155,855	157,172	158,838	160,428
1a. Push Notifications turned on	62,262	66,642	71,208	75,652	78,803	81,517	81,517	88,647	90,437	94,662	97,777	100,461	103,194
2. No. of logins	121,323	145,357	125,194	130,280	123,832	136,706	139,066	169,820	207,753	190,180	166,888	217,374	205,646
3. Appointments booked	746	820	1,000	1,014	1,009	899	900	1,025	1,121	941	799	1,308	1,063
4. Appointments cancelled	436	452	496	475	528	622	511	749	1,099	726	622	915	956
5. Repeat Prescriptions	9,697	11,141	11,644	12,363	12,260	13,209	12,997	13,828	14,940	14,385	15,269	16,462	15,442
6. Record Views	51,341	59,202	59,323	70,918	73,874	96,885	122,301	66,934	75,790	74,021	65,917	85,389	83,145

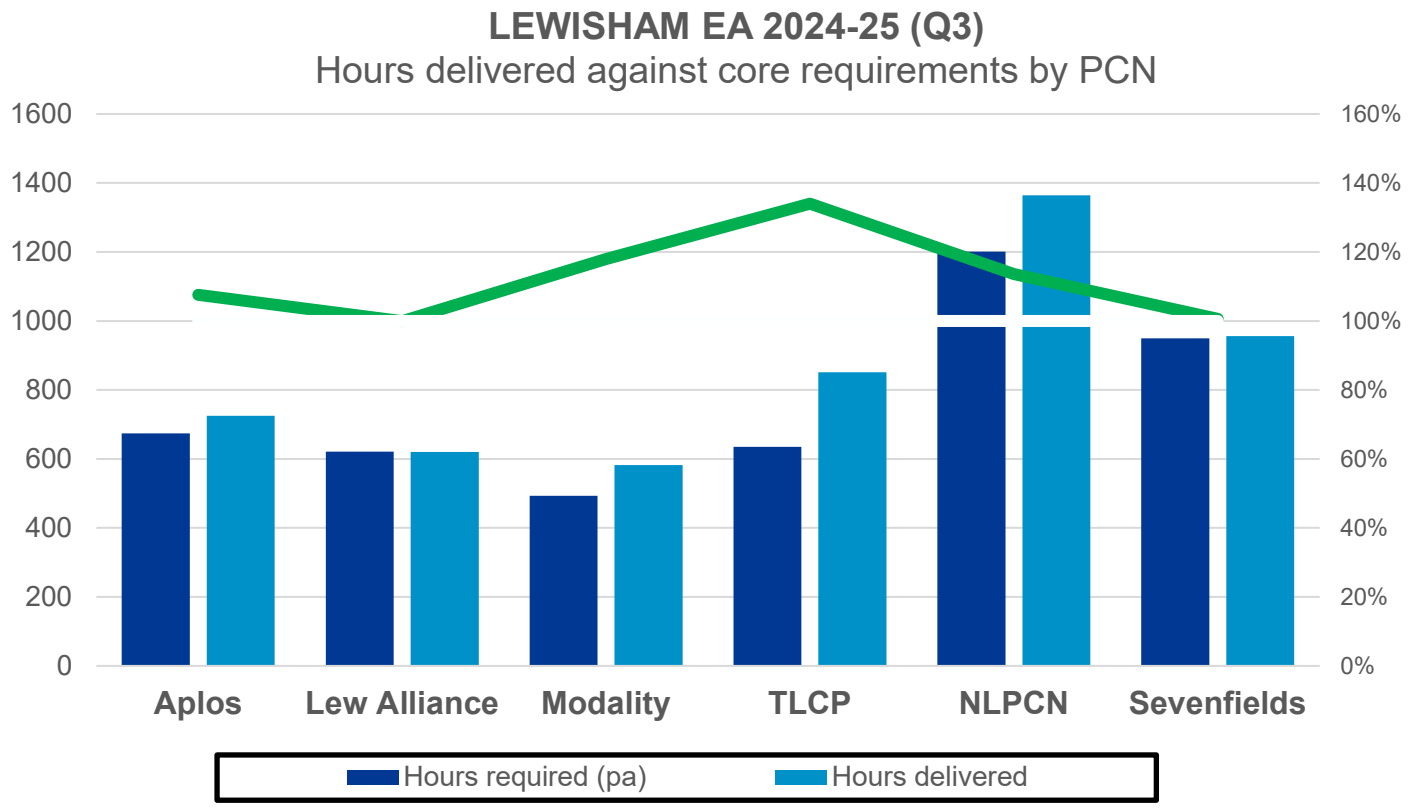
Key Performance Indicator	Latest change
Total registrations	↑ 1.0%
1a. Push Notifications turned on	↑ 2.7%
2. No. of logins	↓ 5.4%
3. Appointments booked	↓ 18.7%
4. Appointments cancelled	↑ 4.5%
5. Repeat Prescriptions	↓ 6.2%
6. Record Views	↓ 2.6%

Enhanced Access Offer

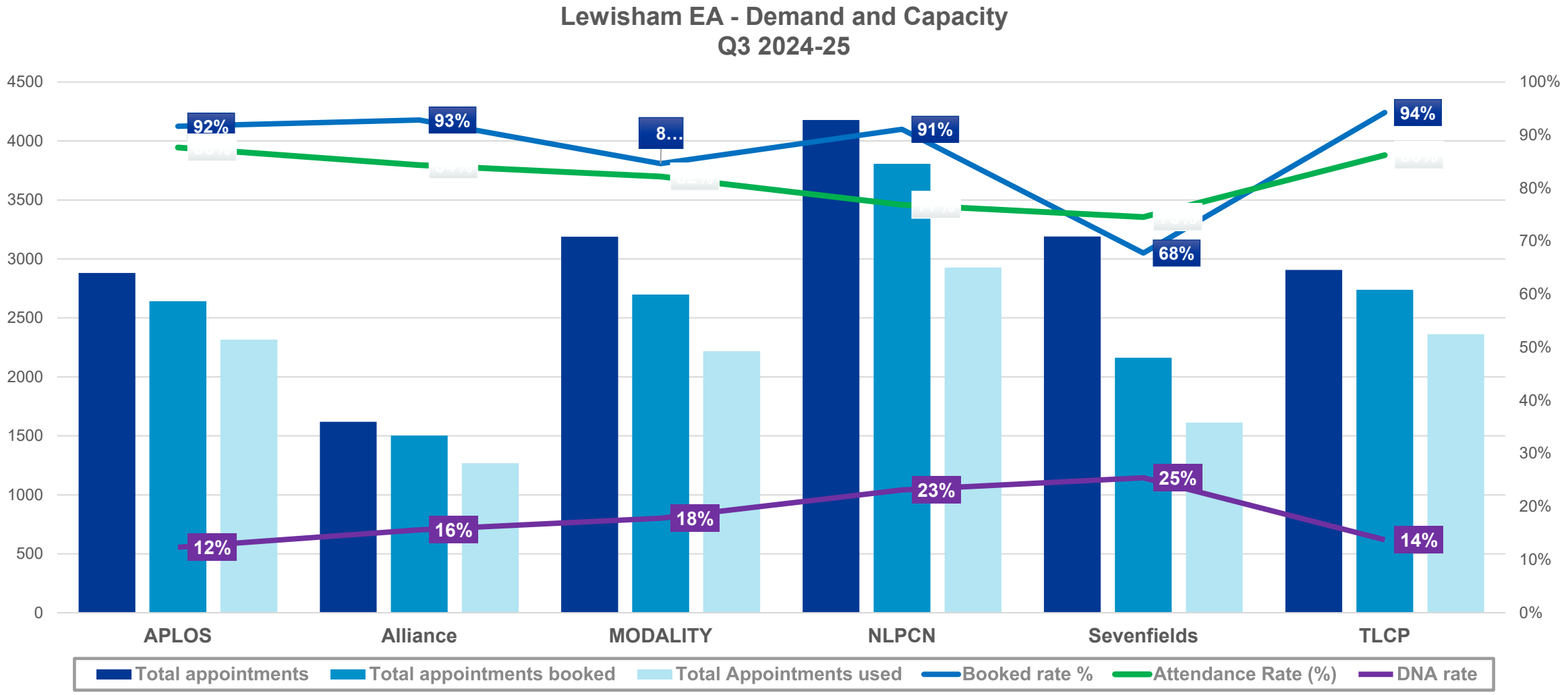
South East London Integrated Care System

- Lewisham delivered approximately **5305.5** hours from the required 4573.9hours **(+16% variance).**

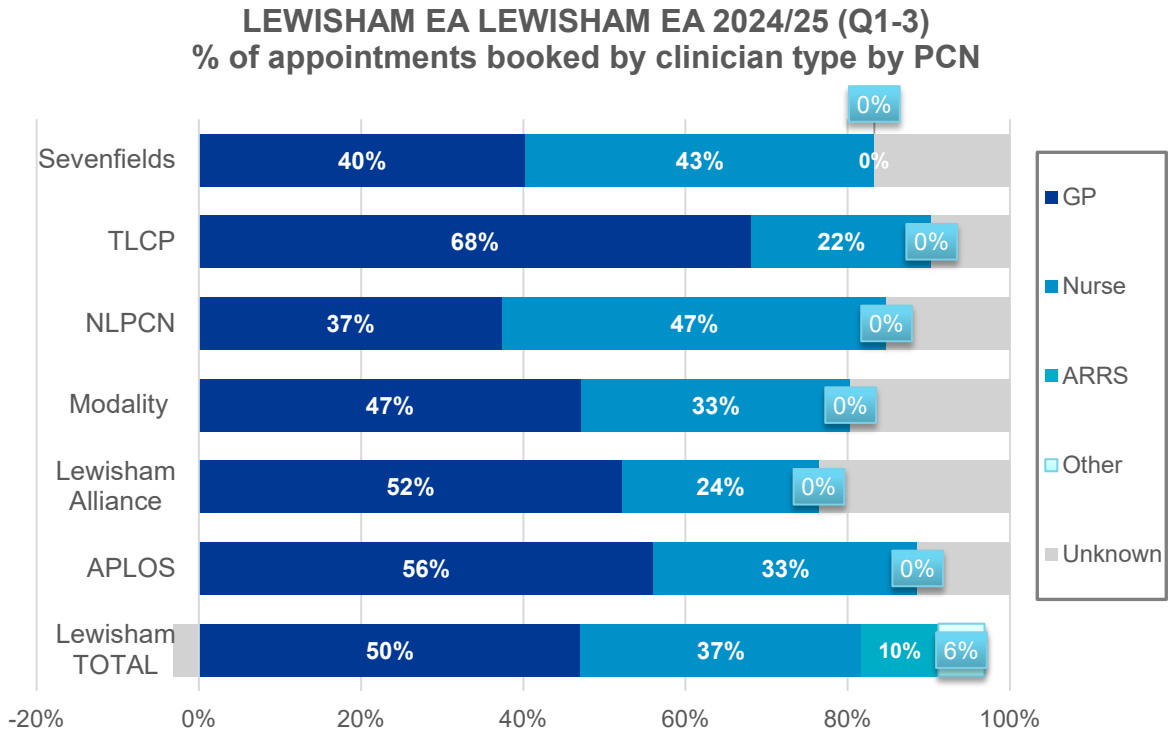
	Additional hours to be delivered per quarter	Delivered	Variance (hrs)	% variance
Aplos	674.1	806	131.9	20%
Modality	620.8	790.8	169.9	27%
Lew Alliance	493.3	560	66.7	14%
TLCP	635.4	664.8	29.3	5%
NLPCN	1200.5	1239	38.5	3%
Sevenfields	949.6	1245	295.3	31%
Total Year	**4573.9**	**5305.5**	**731.6**	**16%**

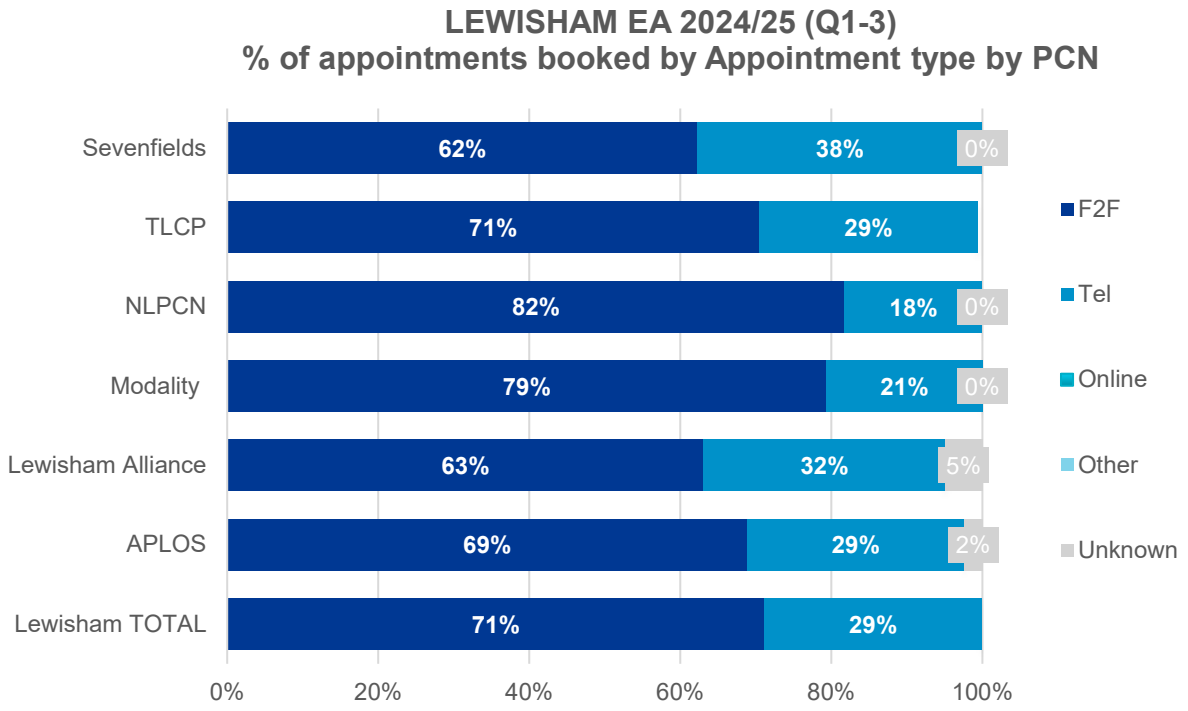


Demand and capacity



EA Activity – by clinician & appointment type





- **50%** of appointments offered are for GPs compared to 37% nurses, 10% ARRs and 6% other HCPs.
- **51% of** DNA rate relate to Nurse appts, GPs (28%), ARRs (8%), Other (13%)

- F2F appointments was the most utilised across all 6 PCNs.
- **71%** of appointments were for face-to-face appointments followed by Telephone (29%)
- **22%** DNA rate for F2F bookings and Telephone 3%
- **97%** attendance rate for Telephone compared to F2F (78%)

Please note comparisons are made against each service type and total activity

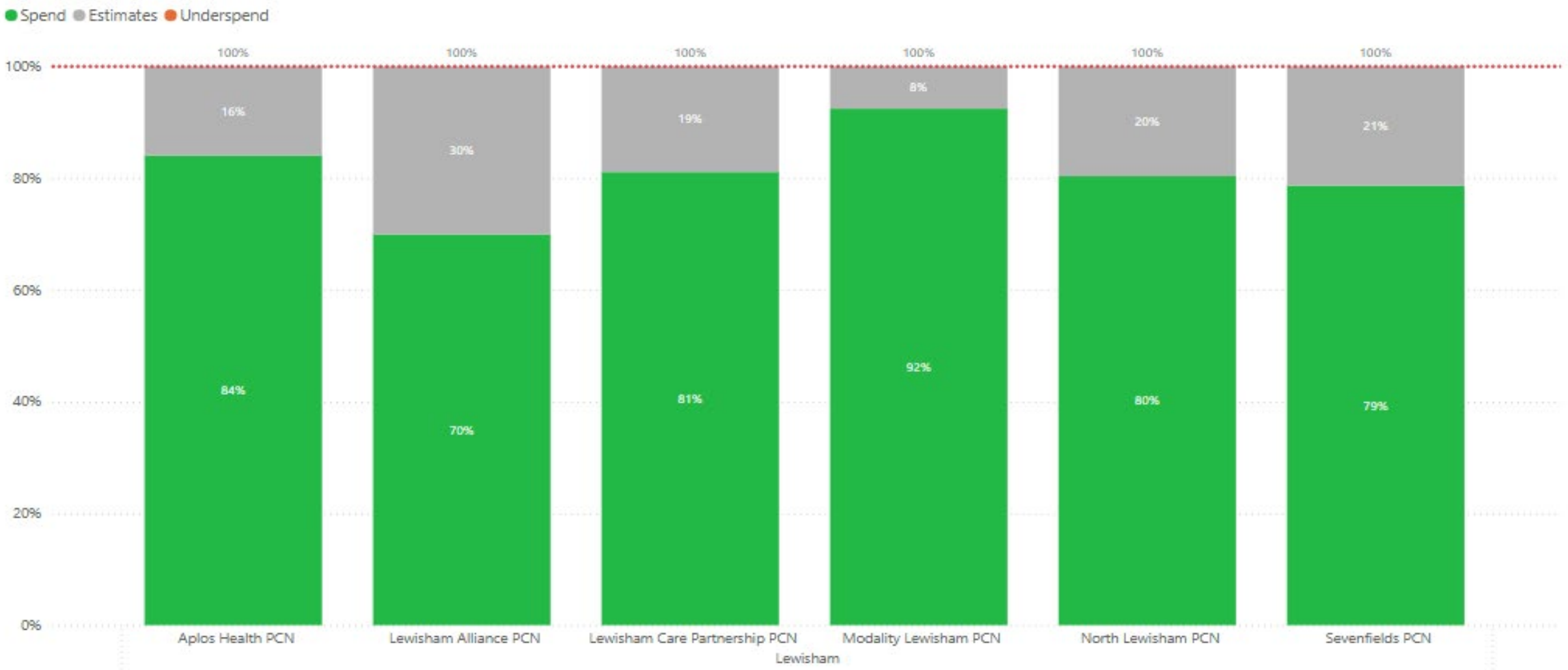
ARRS Sum Utilisation

Lewisham

South East London Integrated Care System

Data source

Important information



PCN Workforce

Lewisham

South East London
Integrated Care System

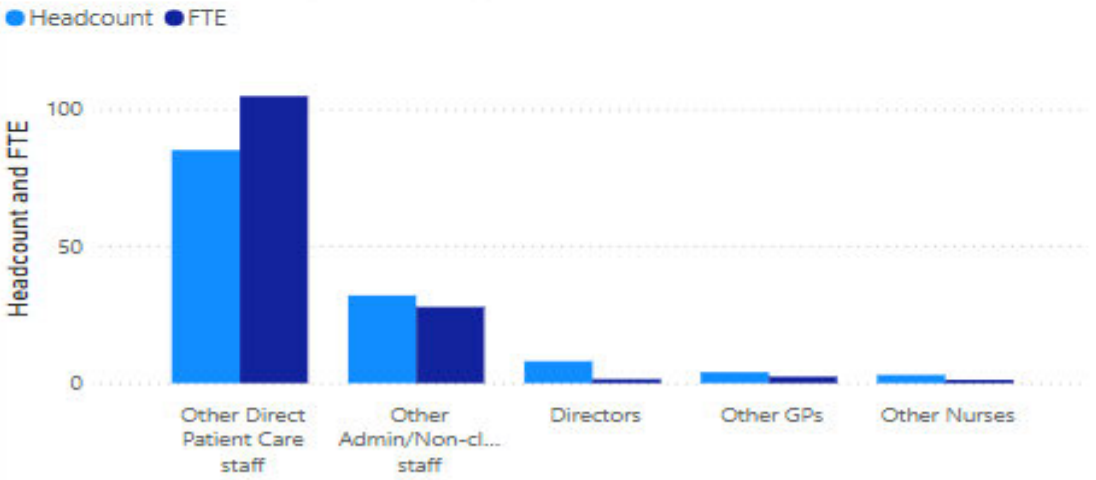
Data source

Important information

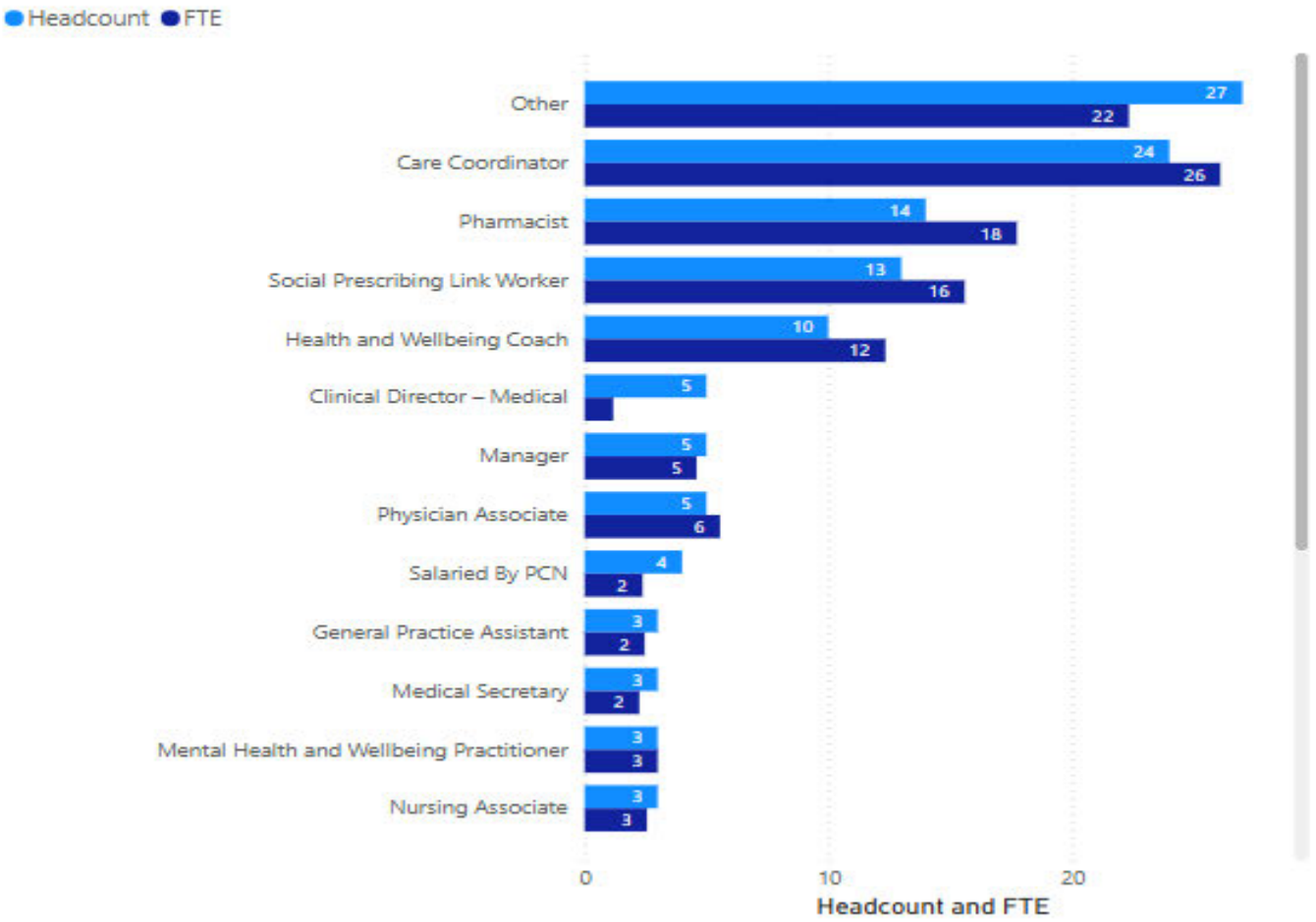
132
Headcount

138
FTE

Headcount and FTE by Staff Group



Headcount and FTE by Job Role



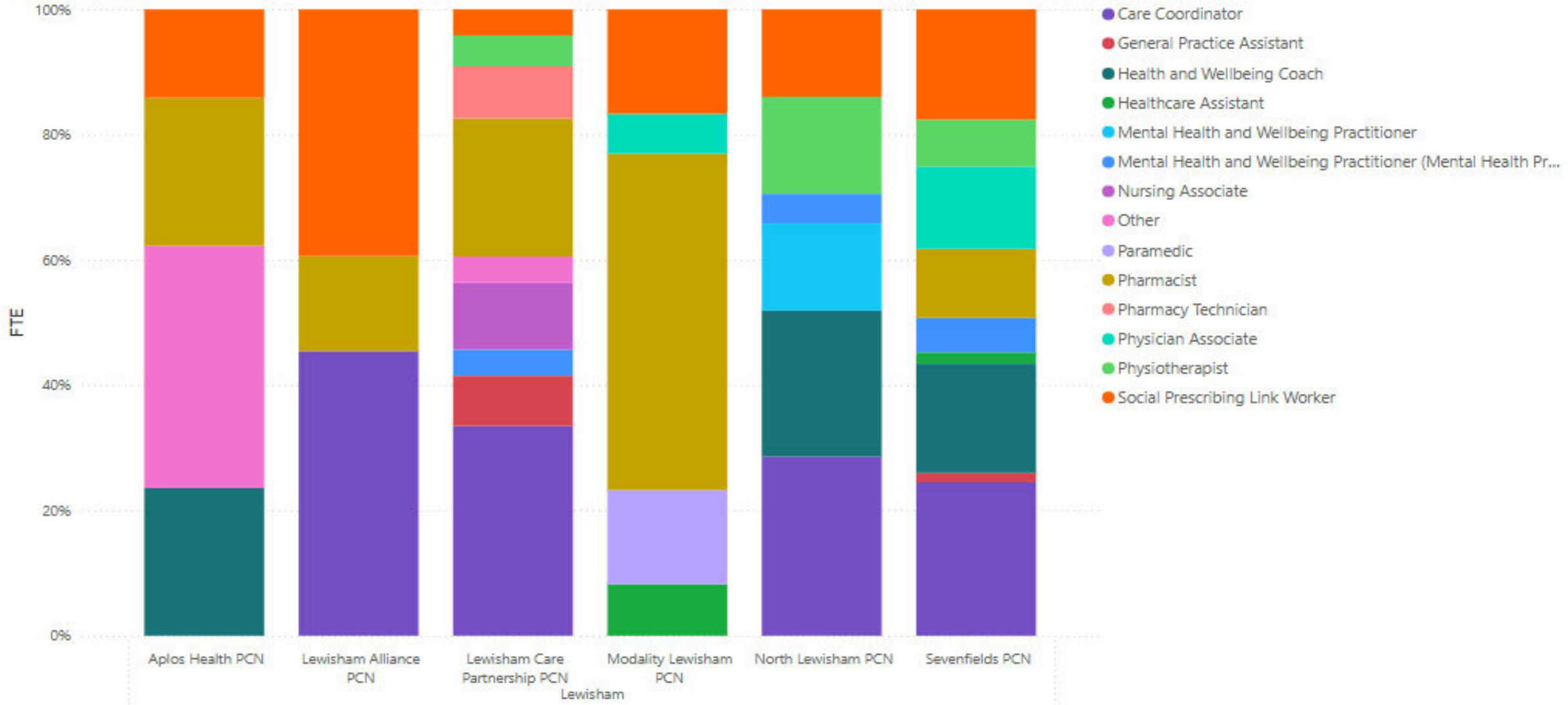
Primary Care Network Workforce

PCN Workforce Breakdown by Role

Show Filters

South East London Integrated Care System

Data source



GP Patient survey

South East London Integrated Care System

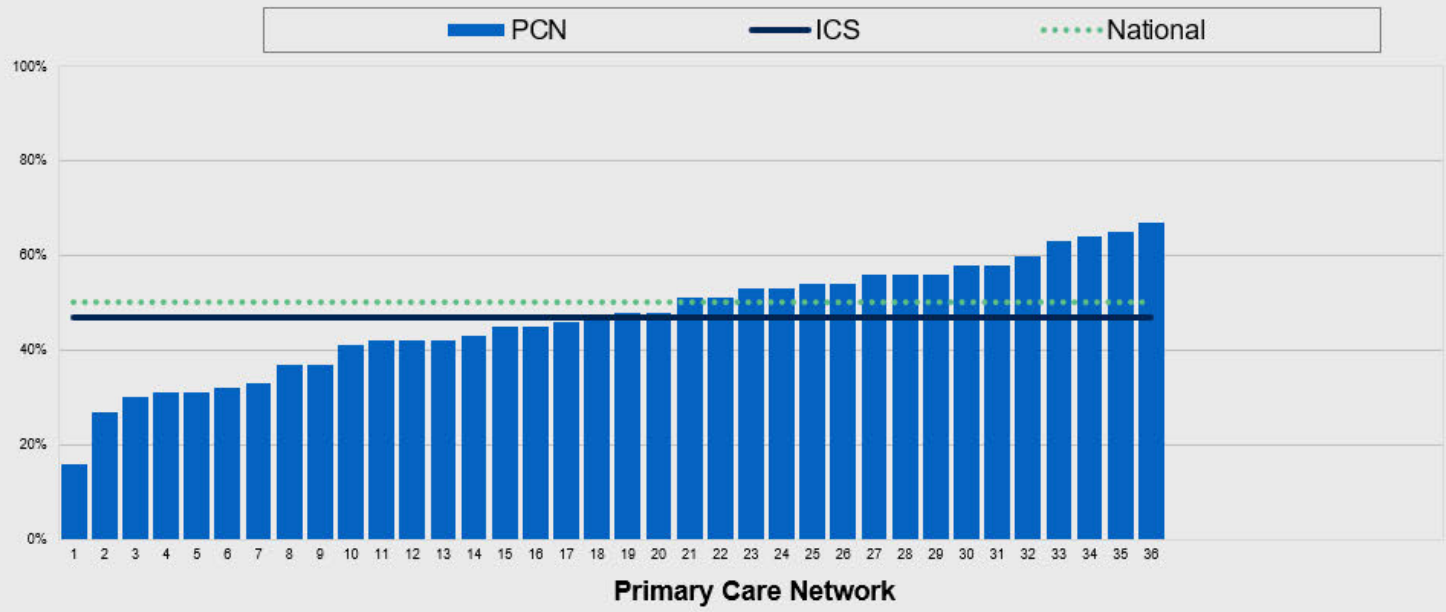
Ease of contacting GP practice on the phone: how the results vary by PCN within the ICS

GP PATIENT SURVEY

SOUTH EAST LONDON INTEGRATED CARE SYSTEM

Q1. Generally, how easy or difficult is it to contact your GP practice on the phone?

Percentage of patients saying it is 'easy' to contact GP practice on the phone



Base: Asked of all patients. Patients who selected 'I haven't tried' have been excluded. National (661,424); ICS 2024 (19,981); PCN bases range from 100 to 1,869

PCN	Name
1	LEWISHAM CARE PARTNERSHIP PCN
2	MODALITY LEWISHAM PCN
3	AT MEDICS STREATHAM PCN
4	FROGNAL PCN
5	NORTH BEXLEY PCN
6	MOTTINGHAM, DOWNHAM & CHISLEHURST PCN
7	UNITY (GREENWICH) PCN
8	RIVERVIEW HEALTH PCN
9	FIVE ELMS PCN
10	GREENWICH WEST PCN
11	APLOS HEALTH PCN
12	BROMLEY CONNECT PCN
13	ORPINGTON PCN
14	CLOCKTOWER PCN
15	NORTH SOUTHWARK PCN
16	THE CRAYS COLLABORATIVE PCN
17	HERITAGE PCN
18	BLACKHEATH AND CHARLTON PCN
19	ELTHAM PCN
20	HAYES WICK PCN
21	BECKENHAM PCN
22	SEVENFIELDS PCN
23	SOUTH SOUTHWARK PCN
24	STREATHAM PCN
25	LEWISHAM ALLIANCE PCN
26	VALENTINE HEALTH PCN
27	APL BEXLEY PCN
28	NORTH LAMBETH PCN
29	PENGE PCN
30	HILLS, BROOKS & DALES GROUP PCN
31	NORTH LEWISHAM PCN
32	BRIXTON AND CLAPHAM PARK PCN
33	CROXTED PCN
34	FIVEWAYS PCN
35	CLAPHAM PCN
36	STOCKWELLBEING PCN

Comparisons are indicative only: differences may not be statistically significant

%Easy = %Very easy + %Fairly easy

Ipsos

GP Patient survey

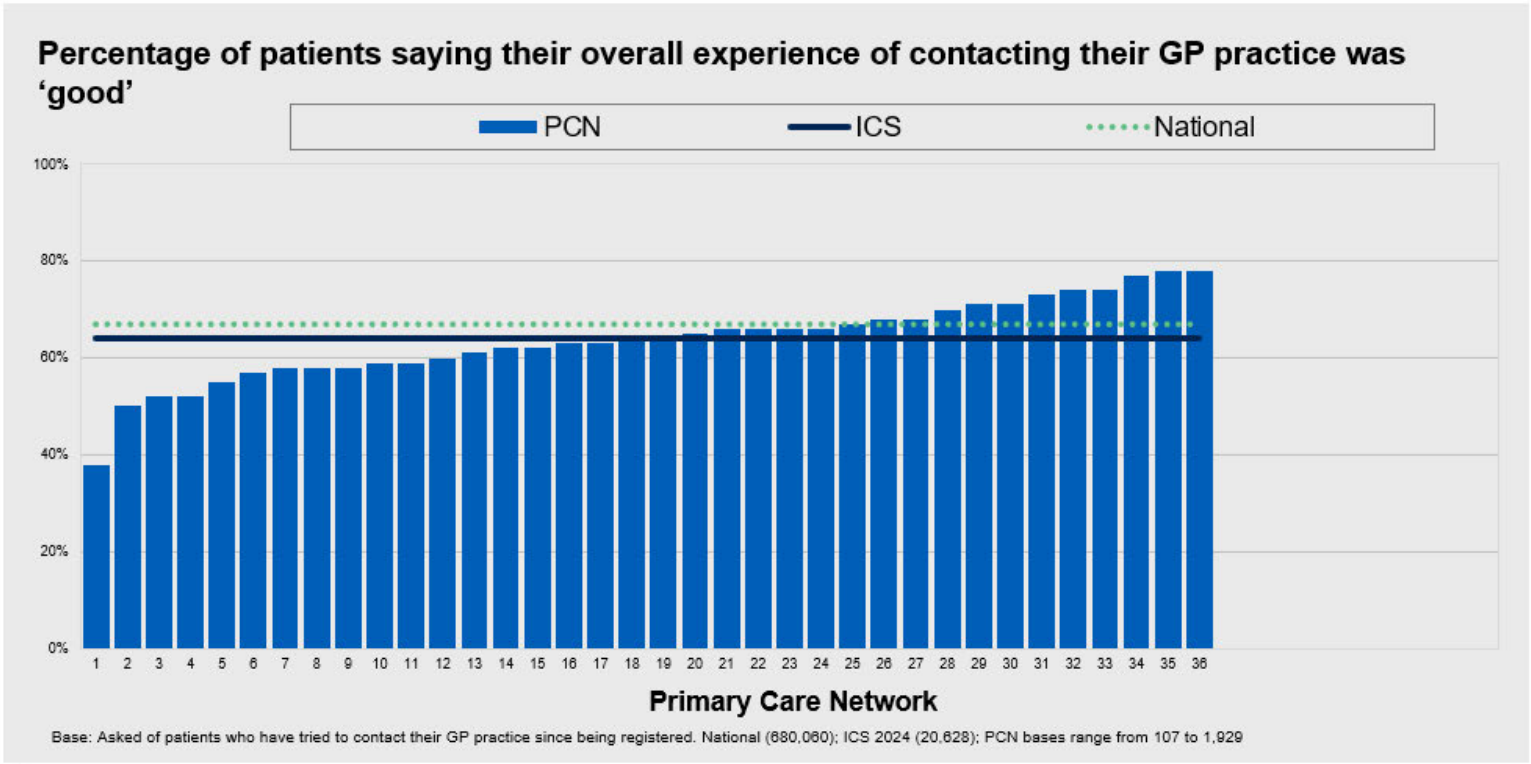
South East London Integrated Care System

Overall experience of contacting GP practice: how the results vary by PCN within the ICS

GP PATIENT SURVEY

SOUTH EAST LONDON INTEGRATED CARE SYSTEM

Q16. Overall, how would you describe your experience of contacting your GP practice on this occasion?



Base: Asked of patients who have tried to contact their GP practice since being registered. National (680,060); ICS 2024 (20,628); PCN bases range from 107 to 1,929

PCN	Name
1	LEWISHAM CARE PARTNERSHIP PCN
2	MODALITY LEWISHAM PCN
3	AT MEDICS STREATHAM PCN
4	UNITY (GREENWICH) PCN
5	NORTH BEXLEY PCN
6	RIVERVIEW HEALTH PCN
7	BROMLEY CONNECT PCN
8	ORPINGTON PCN
9	CLOCKTOWER PCN
10	GREENWICH WEST PCN
11	FIVE ELMS PCN
12	APLOS HEALTH PCN
13	THE CRAYS COLLABORATIVE PCN
14	MOTTINGHAM, DOWNHAM & CHISLEHURST PCN
15	NORTH SOUTHWARK PCN
16	FROGNAL PCN
17	NORTH LEWISHAM PCN
18	BLACKHEATH AND CHARLTON PCN
19	LEWISHAM ALLIANCE PCN
20	NORTH LAMBETH PCN
21	HERITAGE PCN
22	ELTHAM PCN
23	SEVENFIELDS PCN
24	HAYES WICK PCN
25	SOUTH SOUTHWARK PCN
26	BECKENHAM PCN
27	PENGE PCN
28	STREATHAM PCN
29	APL BEXLEY PCN
30	STOCKWELLBEING PCN
31	HILLS, BROOKS & DALES GROUP PCN
32	BRIXTON AND CLAPHAM PARK PCN
33	CROXTED PCN
34	FIVEWAYS PCN
35	CLAPHAM PCN
36	VALENTINE HEALTH PCN

Comparisons are indicative only: differences may not be statistically significant

%Good = %Very good + %Fairly good

Ipsos

111 Activity

PCD

Age	Call Received Date	Working Day	Weekday	Hour	In Hours	Presenting Symptom	Skill Set Required	Disposition (Initial)	Disposition (Outcome)	Borough/PCN/GP of Caller
All	All	All	All	All	All	All	All	All	All	Lewisham

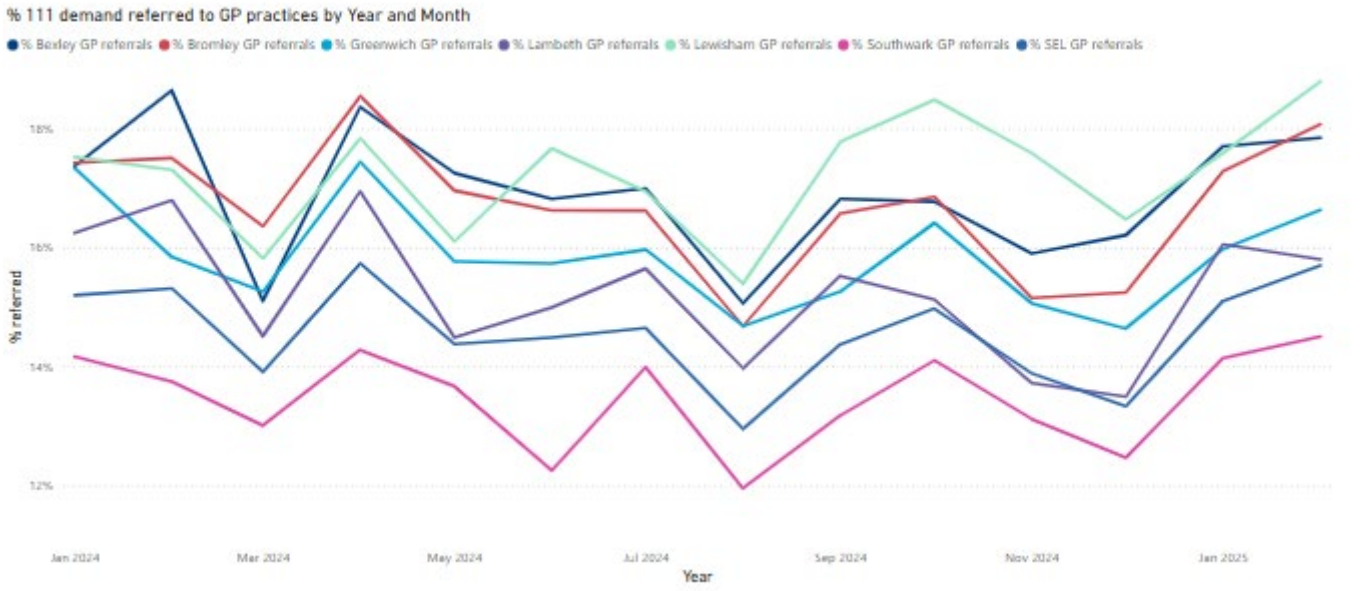
PCN Caveat

South East London Integrated Care System

Primary Care Demand

GP Practice Name	PCN	Borough	111 calls per 1,000 Weighted List	Activity Total	GP Practice Referrals Without Bookings	GP Practice Booked Appointments	Total GP Practice Referrals	%111 Demand Referred to GP Practice	UTC Referrals
The Qrp Surgery	North Lewisham	Lewisham	1438.0	13,552	1,538	555	2,093	15%	2,353
Vale Medical Centre	Aplos Health	Lewisham	1429.1	19,045	1,430	1,191	2,621	14%	3,212
Wells Park Practice	Aplos Health	Lewisham	1422.7	16,356	868	1,844	2,712	17%	2,769
Vesta Road Surgery	North Lewisham	Lewisham	1389.2	9,286	941	168	1,109	12%	1,743
Triangle Group Practice	Lewisham Alliance	Lewisham	1364.4	9,619	655	868	1,523	16%	1,530
Sydenham Green Group Practice	Aplos Health	Lewisham	1347.3	21,339	1,121	2,927	4,048	19%	2,996
Torridon Road Medical Practice	Sevenfields	Lewisham	1314.2	14,630	958	1,287	2,245	15%	2,401
Novum Health Partnership	Sevenfields	Lewisham	1259.4	26,236	1,617	2,485	4,102	16%	4,343
Lewisham Medical Centre	Lewisham Alliance	Lewisham	1256.5	15,774	1,022	1,522	2,544	16%	2,976
Deptford Surgery	North Lewisham	Lewisham	1254.4	11,227	706	1,122	1,828	16%	2,071
Oakview Family Practice	Sevenfields	Lewisham	1183.8	6,260	451	275	726	12%	1,273
Parkview Surgery	Sevenfields	Lewisham	1183.7	8,488	654	323	977	12%	1,540
Ashdown Medical Group	Sevenfields	Lewisham	1172.0	8,401	534	623	1,157	14%	1,476
New Cross Centre (Hurley Group)	North Lewisham	Lewisham	1163.3	12,166	1,173	741	1,914	16%	2,163
Amersham Vale Training Practice	North Lewisham	Lewisham	1157.0	16,086	842	2,329	3,171	20%	2,679
Woodlands Health Centre	Lewisham Alliance	Lewisham	1116.4	10,263	734	668	1,402	14%	1,878
Nightingale Surgery	Lewisham Alliance	Lewisham	1086.7	6,438	414	561	975	15%	1,159
Total				**357,043**	**23,397**	**33,440**	**56,837**	**16%**	**59,164**

Please note: SEL Special Allocation Practice sits under the PCN of Sevenfields despite residing within the Borough of Bromley (unlike all other practices of Sevenfields that reside under the Borough of Lewisham)



South East London Integrated Care System

Highlight report – Reporting period: February 2025

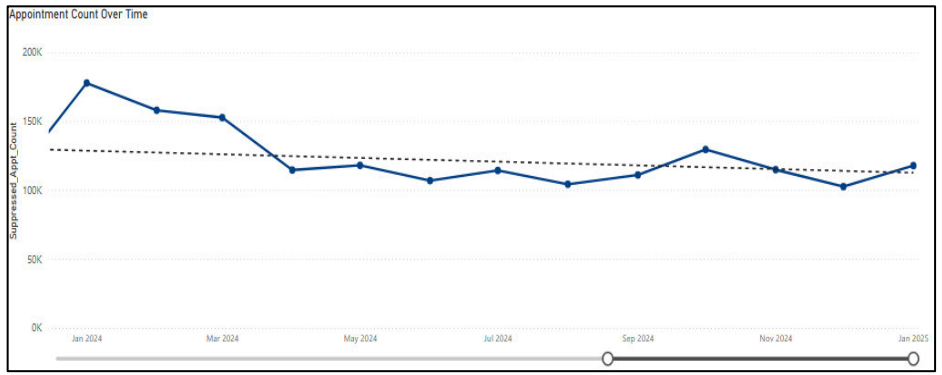
Programme	Lead	Sponsor	Exec
Primary Care Access	Ashley O'Shaughnessy	Laura Jenner	Ceri Jacob

Programme Vision

Implementation of the NHSE Delivery plan for recovering access to primary care published in May 2023. The plan has two central ambitions:

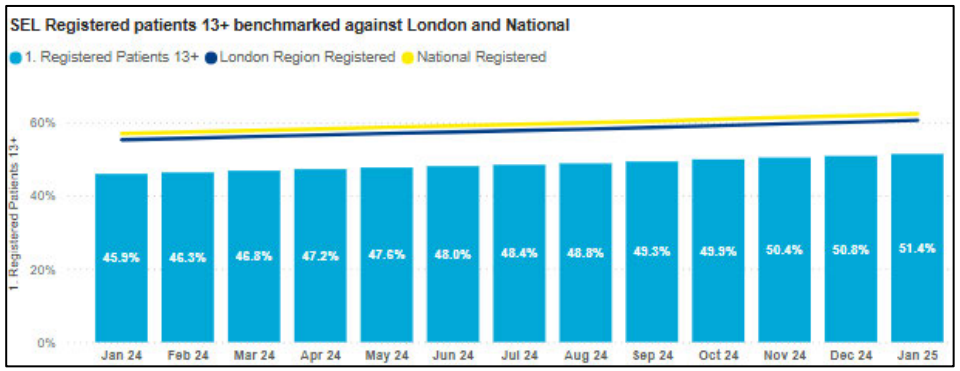
1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.
2. For patients to know on the day they contact their practice how their request will be managed.

Indicator: General Practice Appointments



Time period
Jan 2024 to Jan 2025
Latest performance
117,730 (Jan 25)
Target achievement
Target TBC
Data source
Discovery data service

Indicator: NHS APP registrations



Time period
Jan 2024 to Jan 2025
Latest performance
51.4% (Jan 25)
Target achievement
60%
Data source
NHSE NHS APP dashboard

Top contributors

- Full utilization of ARRS budgets forecast across all PCNs for 2024/25
- All Lewisham practices now on cloud based telephony
- All Lewisham practices now live with an online consultation offer
- Following practice self declarations, 100% of the Transition and Transformation funding has been released to practices to support the implementation of the Modern General Practice Access model
- Regular monitoring of PCN Enhanced Access continues to ensure contractual requirements are met i.e. number of appointments to be offered
- Primary/secondary care interface group now formed and meeting regularly with subgroup also meeting to improve the interface with district nursing services

Actions Taken

- NHS APP registration implementation plan developed
- Practice website reviews continue to support access to consistent information for patients
- Support Level Framework (SLF) visits led by the SEL Primary Care Workforce Academy continue
- PCNs followed up on their plans to utilise the available GP ARRS budget – currently 3/6 PCNs have taken these roles forward
- Continued focus on promoting Pharmacy First (and oral contraceptive/BP services) available through community pharmacy to release capacity in General Practice

Planned Activity

- Final assessment against the 24/25 Capacity and Access Improvement Payments which incentivises implementation of the Modern General Practice Access model at a PCN level
- Implementation of the NHS APP registration plan
- Public comms and engagement campaign to be developed and implemented – attending Peoples Partnership on the 5/3/25 to discuss further
- Attendance at the LCP board seminar (27/2/25) and PEG (3/3/25) to share the overarching plan and highlight areas of focus and support across the partnership
- Deep dive review of General Practice Appointment Data to be undertaken to validate accuracy, particular in terms of inclusion of online consultation activity – intending to engage through the LSE masters student programme to support this work
- Await further detail from the 25/26 operating plan and the national GP/PCN contractual arrangements for 25/26 to help inform our plans going into 25/26

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 9
Enclosure 8

Title:	**Lewisham Risk Register**
Meeting Date:	Thursday 27 March 2025
Author:	Cordelia Hughes
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 & Care Partners 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	**498.** *Achievement of Recurrent Financial Balance 2024/25.* Cost pressures are on an upward trend and expected to continue into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m). There is a material risk that the borough will not be able to achieve recurrent financial balance in 2024/25.	⟺	Open (10-12)
Financial	**549.** *Achievement of Non-Recurrent Financial Balance 2024/25.* Cost pressures are on an upward trend and are continuing into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m). There is a risk that the borough will not be able to achieve non-recurrent financial balance in 2024/25.	⟺	Open (10-12)
Financial	**496.** *Prescribing Budget Overspend.* Risk that the prescribing budget 2024/25 may overspend.	⟺	Open (10-12)
Clinical, Quality and Safety	**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)
Clinical, Quality and Safety	**529.** *Increase in vaccine preventable diseases* due to not reaching herd immunity coverage across the population. *Childhood Immunisations*	⟺	Cautious (7–9)
Clinical, Quality and Safety	**561.** *Increase in vaccine preventable diseases* due to not *reaching herd immunity coverage across the population - Seasonal Vaccinations*	⟺	Cautious (7–9)
Clinical, Quality and Safety	**562.** *GP Collective Action. There is a risk that the BMA recommendation for GP Collective Action results in reduction in primary care access and provision, and pressure on acute sector through some of the actions.*	⟺	Cautious (7–9)

Strategic	**334.** Inability to deliver revised *Mental Health Long Term* Plan trajectories.	⟺	Open (10-12)
Financial	**335.** Financial and staff resource risk in 2023/24 of *high-cost packages* through transition.	⟺	Open (10-12)
Financial	**506.** The CHC outturn for adults will not deliver in line with budget.	⟺	Open (10-12)
Clinical, Quality and Safety	**527.** Intermediate Care Bed Provision. There is a risk that Lewisham will not have Intermediate Care Bed provision within the Borough.	↑	Cautious (7–9)
Governance	**347.** Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.	↑	Open (10-12)
Clinical, Quality and Safety	**571 –** Limited capacity in Adults Safeguarding team due to designate safeguarding lead going on long term medical leave.	⟺	Cautious (7–9)
Governance	**359.** Failure to deliver on statutory timescales for completion of *EHCP health assessments*.	⟺	Open (10-12)
Governance	**360.** Failure to deliver on statutory timescales for completion of *ASD health assessments*.	⟺	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 – February 2025.***

5.New/Closed Risks/Matrix Scores

There are a total of 15 risks on the Lewisham risk register, no increase/decrease from last month. To note, the following risks have reduced scores:

	498. Achievement of Recurrent Financial Balance 2024/25. This risk has been reduced to 9 (3x3) and will be reviewed in the new financial year. **562**. GP Collective Action. Following a Place Executive Leads meeting and agreement with risk review, this risk has been reduced to 6 (3x2). There is an issue's log to monitor previous risks considered BAU and/or in development. New/closed risk(s) are detailed below: 0 **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.		
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 Risk	Risk sponsor	Risk owner	Ongoing controls	Assurances	Impact of ongoing controls	Control gaps
Finance														
498	Financial	**Achievement of Recurrent Financial Balance 2024/25**	During 2023/24 Lewisham delivered efficiencies in excess of the targeted 4.5% (c.£4.2m) of the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and expected to continue into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m), it is unlikely these will be sufficient and available non recurrent measures are limited. There is therefore a material risk the borough will not be able to achieve recurrent financial balance in 2024/25.	5x3=15	3x3=9	2x2=4	Open (10–12)	⟺	Ceri Jacob	Michael 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. This includes for 2024/25 development of business cases to identify opportunities for system wide efficiencies and meetings with system partners have been arranged to discuss these proposals. 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.	Monthly budget meetings. Monthly financial closedown process. Monthly financial reports for ICS and external reporting. Review financial position at CHC Executive meeting. Lewisham Senior Management Team Review.	The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed in new financial year. Regular borough financial focus group meetings with CFO and director of planning.	1. There are no currently identified control gaps.
549	Financial	**Achievement of Non Recurrent Financial Balance 2024/25**	During 2023/24 Lewisham delivered efficiencies in excess of the targeted 4.5% (c.£4.2m) of the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and are continuing into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m), it is unlikely these will be sufficient and available non recurrent measures are limited. There is therefore a risk the borough will not be able to achieve non recurrent financial balance in 2024/25.	3x3=9	3x2=6	3x2=6	Open (10–12)	⟺	Ceri Jacob	Michael 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. This includes for 2024/25 development of business cases to identify opportunities for system wide efficiencies and meetings with system partners have been arranged to discuss these proposals. 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.	Monthly budget meetings. Monthly financial closedown process. Monthly financial reports for ICS and external reporting. Review financial position at CHC Executive meeting. Lewisham Senior Management Team Review.	The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed in new financial year. Regular borough financial focus group meetings with CFO and director of planning.	1. There are no currently identified control gaps.
Medicines Optimisation														
496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2024/25 may overspend due to: 1- Medicines supplies and cost increases -NCSO/price concessions and Category M. 2- Lack of capacity to implement in year QIPP schemes by borough medicines optimisation teams following post MCR staffing changes may effect implementation of the QIPP scheme. 3- Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 4- Increased patient demand for prescriptions including self-care items, LTC. 5- Prescribing budget although uplifted for 24/25 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 hospital avoidance or discharge. 7-Income protection for MOP scheme 24/25 (practices are de-incentivised to reach targets).	3x4=12	3x4=12	3x3=9	Open (10–12)	⟺	Laura Jenner	Erfan Kidia	1. Monthly monitoring of spend (ePACT and PrescQIPP), and also Cat M and NCSO spend 2. Monthly meetings with finance colleagues reviewing PPA budgets to date 3. 2 weekly Place finance meetings 4. Monthly savings meeting with SMT at Place to review prescribing spend and development mitigations. 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) 5. SEL rebate schemes continue to be reviewed, evaluated and processed	Any actions with regard to the prescribing budget are completed by Erfan Kidia, to dates agreed with the Place Executive, Associate Director of Finance.	Cost and budget pressure	1. No gaps in control identified
Primary Care / Community Based Care														
528	Clinical, Quality and Safety	**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	4x3=12	4x2=8	Cautious (7 – 9)	⟺	Ceri Jacob	Ashley O'Shaughnessy	The current controls in place are: 1.Local implementation of the national "Delivery plan for recovering access to primary care" 2.The Modern General Practice model is being implemented across practices supported through the national transition and transformation funding. 3.All practices have telephone and digital access options in place to support and maximise patient access. 4.Work with PCNs to implement the Capacity and Access Improvement Payment metrics for 24/25 which focus on better digital telephony, simpler online requests and faster care navigation, assessment, and response. 5.The PCN Additional Roles Recruitment Scheme is fully operational to support use of a diverse skill mix and provide additional workforce capacity. 6.The PCN Enhanced Access service is operational to provide additional capacity between 6.30pm and 8pm, Monday – Friday, and 9am – 5pm on Saturday. 7.Implementation of the national Pharmacy First scheme to support the management of minor ailments and supply of prescription only medicines for specific conditions. 8.Community self-referral pathways have been developed to empower patients to manage their own health. 9.Continued promotion of the NHS APP so patients can directly book appointments, request repeat prescriptions and access their own medical record. 10.Ongoing review of practice websites to ensure up to date and consistent to support patient navigation 11.Continued support for PCN digital inclusion hubs to support patients who are willing and able to maximise use of digital tools 12.Focused work on the primary/secondary care interface to free up capacity in General Practice 13. Oversight through the Lewisham Primary Care Group	As outlined in controls.	Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls	Need an effective public-facing communications and engagement plan to educate and inform the public on the new ways of working in general practice and wider primary care to improve understanding of services and manage expectations. Ongoing industrial action may have an impact on patient access.
561	Clinical, Quality and Safety	**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	Mervyn Clarke	The current controls in place are: 1. All practices administer vaccinations and where clinically appropriate and operationally feasible, make co-administration of seasonal vaccinations the default model. 2. Practices have robust patient call and recall systems in place. 3.Lewisham has a dedicated flu and immunisations coordinator who supports general practice. 4.The ICB works with the local authority (Public Health) to take responsibility for planning outreach services that meet the needs of underserved populations and address wider health inequalities. 5.There is vaccination delivery in convenient local places, with targeted outreach to support uptake in underserved populations. 6.Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes i.e. MMR/Covid/polio. 7.Vulnerable populations, such as asylum seekers, refugees, and rough sleepers, are opportunistically offered vaccinations in different settings to ensure they are given the best chance of protection. 8.Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes i.e. MMR/polio. 9. Collaborative working with Population Health team to target smaller cohorts for flu vaccinations. 10. Seasonal vaccinations for 24/25 - have not been met. 11. Spring Booster campaign (Covid-19) - currently not in a contract to deliver and PCNs can opt out. Only 4 out 6 - currently contracting the Spring Booster. Housebound and Care home patients at risk.	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	Severe and harmful disease outbreaks. Increased pressure on Primary Care. Increased A&E attendances and emergency admissions. Poor patient outcomes, including disability and mortality.	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. LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity
529	Clinical, Quality and Safety	**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.	3x3=9	3x3=9	3x2=6	Cautious (7 – 9)	⟺	Ashley O'Shaughnessy	Mervyn Clarke	The current controls in place are: 1. Practices have robust patient call and recall systems in place. 2. A national failsafe should ensure that unvaccinated individuals are flagged with registered practices. 3.Lewisham has a dedicated flu and immunisations coordinator who supports general practice. 4.The ICB works with the local authority (Public Health) to take responsibility for planning outreach services that meet the needs of underserved populations and address wider health inequalities. 5.There is vaccination delivery in convenient local places, with targeted outreach to support uptake in underserved populations. 6.A universal, core offer in a consistent location/setting to increase efficiency and capitalise on public understanding of 'where to go' and at 'what age' for vaccinations. 7.Vulnerable populations, such as asylum seekers, refugees, and rough sleepers, are opportunistically offered vaccinations in different settings to ensure they are given the best chance of protection. 8.Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes i.e. MMR/polio.	As outlined in controls.	Severe and harmful disease outbreaks. Increased pressure on Primary Care. Increased A&E attendances and emergency admissions. Poor patient outcomes, including disability and mortality.	There is also a clear lack of knowledge of the importance and effectiveness of vaccinations amongst young parents Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity Limited influence over commissioning of vaccination programmes including routine childhood immunisations and school age vaccinations. These are commissioned regionally by NHSE&I.
562	Clinical, Quality and Safety	**GP Collective Action**	There is a risk that the BMA recommendation for GP Collective Action results in reduction in primary care access and provision, and pressure on acute sector through some of the actions.	4x4=16	3x2=6	2x3=6	Cautious (7 – 9)	⟺	Ceri Jacob	Ashley O'Shaughnessy	National Sitrep in place and daily local monitoring of impact based on situation . Use local information and understanding of key pressure points to monitor the situation. Continue to engage / contact local practices. PCNs and LMC regularly to maintain communications and provide local support as necessary to minimise patient impact	National Sitrep in place and daily local monitoring of impact based on situation . Use local information and understanding of key pressure points to monitor the situation. Continue to engage / contact local practices. PCNs and LMC regularly to maintain communications and provide local support as necessary to minimise patient impact	See controls	Negotiations at a national level will be required to resolve issue. System plans with Trusts. Workarounds may be required to minimise patient impact.
Commissioning														
334	Strategic	**Inability to deliver revised Mental Health Long Term Plan trajectories**	There is a risk that Mental Health Long Term Plan trajectories cannot be met as a result of activity and financial pressures that are currently affecting SLAM. This is caused by increased demand, limited bed availability, insufficient workforce and insufficient digital solutions to meet a proportion of local demand. This will impact on the ICB's ability to meet statutory requirements and reduce health inequalities.	5x5=15	2x5=10	3x2=6	Open (10–12)	⟺	Kenny Gregory	Natalie Sutherland	1.Outcomes framework measure for Community Mental Health Transformation (CMHS) being produced across SEL ICB. 2.Place based assurance framework being updated to reflect new interventions and monitored through all-age MH Alliance Leadership Board. 3.Understand the needs of people not being admitted after attending A&E to understand what interventions could be accessed instead of A&E and gaps in the system. 4.Continue to implement the CMHS transformation plan and local priorities. 5.Quality Impact Assessments undertaken on all of the priority investments that have been proposed as result of mitigating financial pressures in SLaM and the ICS.	Alliance data/performance review process to be established to provide local oversight and improvement actions. SLaM Stocktake of CMHS through Quality Centre to understand impact of CMHS transformation.	Improvement against KPIs and better collaboration and integration across services (in line with provider alliance ambition).	1.Mitigation plans formulated for Red rated measures i.e. Physical Health Checks for SMI. 2.Additional in-patient 16 bed mate ward in Lewisham (trust wide resource) to help with bed capacity, as well as Bed management pilot in Lewisham to manage bed supply locally and not Trust wide. 3. SLaM Stocktake of CMHS to review effectiveness has taken place. Reviews of services and initiatives taking place. Culturally appropriate programme review taken place. Annual review of Bridge Cafe to take place Q3/4. 4. Mobilisation 24/7 Community mental health Centre in N2 in progress. 5. Project to increase capacity within Primary Care taking place by working with the resource currently in place. 6. Reiestablish alliance sub-groups for improved oversight and ownership i.e. Crisis Collaborative, Adult Transformation and assurance and outcomes forum to review system dashboard and other key system assurance processes.
335	Financial	**Financial and staff resource risk of high cost packages through transition. This is a recurring annual risk.**	The financial risk identified in 2023/24 of new high cost LD packages through transition remains. There are a small number identified but at very high cost. These are young people with significant health needs requiring double handed and overnight waking care or with behaviour which is significant challenging in children's services. There is a potential impact of eligible patients leaving day schools in 24/25 which will represent (a) additional day time care costs previously met by education, or (b) 'hotel and support' costs additional to the costs of education if the person is placed in a residential college or (c) costs relating to full time residential care. This risk is SEL wide. These risks are reflected both in financial terms with cost of care potentially being in the hundreds of thousands of pounds a year. The complexity of health need also represents an increase in nurse time on complex case management.	4x4=16	4x3=12	4x3=12	Open (10–12)	⟺	Kenny Gregory	Tom Bird (interim)	1. Head of CHC is attending quarterly Transition panels from a CHC perspective 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. Also to flag early warning signs for joint funding requests. Regular comms (1) from the CYP DSR meeting to the adult DSR meeting and (2) from the CYP CHC lead re children already joint funded and where likely demand for joint funding in adulthood is predictable. Quarterly flagging of transition you people not alerted through either process and a RCA of why those young people were not flagged to the adult CHC Team. 2. Quarterly review of ongoing requirement for joint funding funding of packages. 3. Adult Social Care are working with SENs to engage with them whenever they are considering a placement in a residential school or college.	Prioritising review of all new LD packages transferring from LBL to look for savings opportunities. Compliance with the Joint Funding Protocol. Weekly reporting through Funding & Governance Standing agenda item CHC Executive.	Mitigation of financial risk to Lewisham ICS/ ICB. Strengthened projection of future financial risk. Improved robustness and visibility of transitioning plans.	1. Quarterly projection of when younger SEN adults will leave day education and the potential impact on CHC budget to CHC Exec. (High cost) Joint Funded packages to be included as a standing agenda item at monthly Integrated Commissioning Budget Monitoring. Also to review at CHC Executive.
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: •Growth in the number of LD complex transition cases at a high cost appears to have stabilised but this is still a risk due to high long term care costs associated with these cases. •Alongside this is the pressure caused generally by costs of existing packages being driven up both by inflation and increases in both NLW and LLW and the hourly rate for homecare included within the MMAH framework. There was a 4.5% increase in the AQP rate (2024/25) and the ICB's contract with Fairlie/ Highfield increased by 2.4%. •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. •Numbers of newly eligible for CHC appear to have increased compared to 2023/24 with number of patients fast track or eligible due to physical disability increasing, however LD eligibility appears to have plateaued. •There continues to be a large number of delayed reviews which might have offered opportunities for savings through reduction or eligibility decisions. •Staff vacancies and sickness, across CHC Team and Social Work Team have impacted on timely referral to assessment activity which has meant backdating of costs, which show as large stepped changes in spend, making budget projection and management problematic. •Significantly delayed discharge from RHND and BBIU for 2 people that the ICB has struggled to influence (housing issues)	5x4=20	4x3=12	4x3=12	Open (10–12)	⟺	Kenny Gregory	Corinne Moocarme	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. Regular comms from CYP and Adult DSR meetings to clarify risk of Joint Funding Requests from the LDA hospital admission diversion imperative and to clarify S117 pathways 4.Quarterly review of joint funding funded packages to divert risk 5.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. RHND and PoCs at home. 6. Monthly budget review meetings 7. Weekly review of CHC eligibility decisions and related cost of packages 8. 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	Prioritising review of all new LD packages transferring from LBL to look for savings opportunities Allocating SEL ICB review resource to prioritise remaining outstanding reviews Participating in wider SEL ICB CHC savings programme	Absence of Head of CHC and Team Leader has meant that attendance at Transition Panels has not been robust Pressure from other CHC priorities (particularly appeals/ LRMs/ RPs) have taken significant management time and attention Review of outstanding eligibility assessments and presentation scheduling for CHC Eligibility Panel	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 Councilother partners – LBL regularly updated on progress against assessment, though there is one long term outstanding dispute 3. Increase in complaints because of reduction in packages – Assessing nurse to be clear about the rationale for the reduction in package and this explanation to be put in writing at time decrease is being enacted.
527	Clinical, Quality and Safety	**Intermediate Care Bed Provision in Lewisham**	There is a risk that Lewisham will not have Intermediate Care Bed provision within the Borough. It is caused by: •The current provider not meeting contractual obligations and the contract is being terminated. •However, provider is currently performing against contractual conditions. •The current provider has submitted evidence to address areas of concern - to be reviewed by subject matter experts. •In the meantime, the current providers have been extended (by 6 months) to September 2025. Leading to: •No intermediate care bed provision in Lewisham. •Cohort of patients not being able to receive bed based rehabilitation locally. •Delay in patients being discharged from an acute bed when medically fit.	4x3=12	3x3=9	4x2=8	Cautious (7 – 9)	⇧	Kenny Gregory	Lorraine Smoothy	1.Quarterly contract monitoring in place. 2. Monthly meetings to address areas of concern identified as part of procurement. 3. Signed NHS Standard contract in place (01/04/24 – 31/03/25 with the option to extend by 6 months) which includes both organisations giving adequate notice if contract to be terminated. 4. Current provider has held a contract for 10 years+ and there have never been any major concerns / safeguarding issues / incidents to cause commissioners a significant cause of concern.	Service continuity for longer term absence. Reporting and escalation process for incidents and where governance sits within the organisation. How learning will be disseminated from incidents and complaints.	No intermediate care bed provision in Lewisham. Cohort of patients not being able to receive bed based rehabilitation locally. Delay in patients being discharged from an acute bed when medically fit.	Monthly meetings to be arranged with relevant SME's. Uncertainly of next steps following contract expiry, especially given the most recent 2 failed procurements.
Safeguarding														

347	Governance	**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.	4x3=12	2x3=6	2x3=6	Open (10–12)	⇧	Ceri Jacob	Christiane Nkinchi/Rachel Lardukan	1.KPIs and provider data set in place. Provider data set includes IHAs undertaken outside of statutory timescales and IHAs on children placed in Lewisham by other local authorities. 2.The Designated Doctor, Medical Adviser and medical colleagues undertake IHAs. The Designated Doctor for Children Looked After who is involved in completion of Initial Health Assessment (IHA) and normally covers 12 IHA clinic sessions . However a Medical Advisor has been appointed. 3.The Named Nurse supports CLA Admin with IHA data collection (although IHA are not a nursing remit) . There is no Named Doctor in place to focus on this issue (The Designated Doctor does not have any time ringfenced for operational issues but uses some of the allocated DD time to support the Named Nurse). 4. Both Named and Specialist Nurse for CLA have regular discussions with Social Workers preparing forms for IHAs (at a drop-in). 5.Local Authority business support is expected to help with the timely preparation of IHA forms (completing demographic and contact details), provide a reminder to Social Workers regarding the completion of consent forms within 5 days of a child becoming looked after and sent those forms to the CLA health team. 6.Designated and Named Professionals are part of the Partnership CLA Steering Group for service improvement. 7.The quarterly Health and Social Care CLA Steering Group looks has a standing item looking at the issues affecting the timely completion of initial health assessments (includes children placed out of borough and those placed in Lewisham by other local authorities). 8.Health and CSC have developed a SOP for IHAs. 9.LAC health team plans to provide powerpoint slides - this is under review. Reiterating good practices around IHA paperwork and consent. Slides will be included in new Social Worker starter pack. 10.Head of service (LA) to highlight importance of paperwork being completed in a timely manner from social worker. 11. A monthly meeting with LA - Children's social care.	Statutory guidance in place. Integrated Care Pathway with SOP for Social Workers (and Doctors) in place. IHAs are being completed but assessments are delayed as required forms (consent and demographic/contact details) are not being completed by Social Workers in a timely manner. Designated Doctor, Medical Adviser and other doctors continue completing IHAs as soon as consent is available. Health and Social Care CLA steering group continues monitoring.	IHAs are being completed but assessments are delayed as required forms (consent and demographic/contact details) are not being completed by Social Workers in a timely manner. Designated Doctor, Medical Adviser and other doctors continue completing IHAs as soon as consent is available. Health and Social Care CLA steering group continues monitoring.	1. Any gaps in service provision escalated to Lewisham Place Executive Director.
571	Clinical Quality and Safety	**Limited capacity in Adults Safeguarding team due to Designate Safeguarding Lead going on long term medical leave.**	The Named GP for safeguarding is covering the role of Designated Adult Safeguarding Lead due to the latter's long-term medical leave. However, they are only available to provide support for 6 sessions, which raises concerns about limited workforce and capacity. This situation may impact the ability to effectively manage safeguarding responsibilities and respond to cases in a timely manner.	3x3=8	3x3=9	2x3=6	Cautious (7 – 9)	⇔	Ceri Jacob	Fiona Mitchell	1. Workload will be shared and distributed amongst children's safeguarding lead, designate LAC and HoN at SEL. 2. Engage external safeguarding experts or organisations to assist with cases if needed. 3. Focus on high-risk cases and ensure that urgent safeguarding concerns are addressed promptly. 4. Collaboration with partners: Work closely with local safeguarding boards and agencies to ensure effective information sharing and support.	See ongoing controls	Provide assurance in safeguarding team	Gap in cover - raised with Place Executive Lead in Lewisham.
		Children and Young People												
359	Governance	**Failure to deliver on statutory timescales for completion of EHCP health assessments**	Failure to deliver on statutory timescales for completion of Education Health Care Plan health assessments (EHCP). This is being driven by challenges in recruitment and capacity of community paediatricians and therapists. Significant increase in families requesting Special Educational Needs Assessment (SENA) Lewisham has one of the highest numbers for requests for Special Educational Needs Assessment. This will impact on the ICB's ability to meet statutory timescales for completion of EHCP assessments as it does not have the capacity to carry them out within the 22 weeks deadline.	4x4=16	3x4=12	2x3=6	Open (10 – 12)	⇧	Sara Rahmani	Paul Creech	1.GPs are being rotated from Primary Care into community paediatrics to support some activity and free time for statutory CMPS work. There has been limited uptake from GPs so no further scope to expand. 2. Paediatric Nurse in place to support medical work which does not require a Paediatrician. 3. Trust are using American recruitment agent to recruit internationally. So far response has been limited but LGT are reviewing the applications. 4.Therapists continue to work weekends to clear the back-log of reviews. 5. Monthly Recovery meetings held with Head of Integrated SEN & LGT Manager to review EHCNA numbers. Detailed performance data identifies delays for assessments by teams to help determine areas to improve. 6.The DCO reviewing the joint working arrangements between health and SEND to streamline the process. EHCNA requests are triaged to reduce the number of new assessments necessary. 7. Recruitment has improved, demand still higher than capacity. 8. A working group is in place to update on the implementation of the pilot to change the pathway for ECHNAs and activity that have been identified as part of the improvement plan.	Monitoring ongoing to gauge impacts of controls. New Head of Integrated SEND is now in place and attending monitoring meetings.	Increase in EHCPs health assessments being completed on time.	1. Families not attending appointments., 2. Appointments changed. 3. Delayed paperwork (service user end). 4. Brexit has led to loss of staffing (therapists). 5. COVID has also had an impact on staffing levels. 6. Increase in EHCP requests.
360	Governance	**Failure to deliver on statutory timescales for completion of ASD health assessments.**	Failure to deliver on statutory timescales for completion of Autism Spectrum Disorder health assessments. There is an 18 month waiting list. This is being driven by challenges in recruitment of community paediatricians. Impact on ICB - referral to treatment timescale, reputational risk, financial risk - ICB to pay for private assessments.	4x3=12	3x3=9	2x3=6	Open (10 – 12)	⇔	Sara Rahmani	Paul Creech	1.Quarterly review of ASD assessments with LCG, includes audit of initial assessments. 2.DCO commissioning reviewing existing autism support pathway to provide pre-diagnostic support. There is the all aged autism service which provides advise and info without the need for a diagnosis. 3.GPs are being rotated from Primary Care into community paediatrics to free up capacity for ADOS assessments. Paediatric Nurse in place to support medical work. 4.International recruitment ongoing (x2 Paediatricians recruited). New adverts in place to attract more application being carefully considered to inspire applicants. No further recruitment - 1.2 vacancies at present and another round of recruitment due. In terms of capacity, clinical staff assessing ECHP will prioritise where possible ASD assessments too to assist with work demands. 5. Outsourced some assessment capacity for CYP waiting the longest to reduce the backlog (outsourced 200 assessments - in progress). 6. SDIP in progress to increase capacity. 7. A working group is in place to update on implementation of the pilot to change the pathway for ASDs and activity that have been identified as part of the improvement plan.	Monitoring ongoing to gauge impacts of controls via Quarterly monitoring meetings.	Reduction in waiting times for assessments.	1. Availability of partners to undertake joint ASD assessments. COVID has increased childhood anxiety in some kids.

Key - Direction of Risk

⇓ Risk has become worse.

⇔ Risk has stayed the same

⇧ Risk is improving

Lewisham Risk Register Issue Log (last updated 10/09/24)

	Item	Risk description	Issue	Severity	Risk Appetite	Status	Date Logged	Owner	Action Plan/Status
1	**CAMHS waiting times**	There is a risk of CYP in Lewisham not receiving the mental health support they need within the expected timeframes of the service. This has been caused by continued increased demand. This impacts on the ICB's ability to ensure waiting times are met and could affect the ICB's reputation.	*Medium Impact Issue*	*Medium*	Eager (13-15)	Open	10/09/2024	Paul Creech/ John Dunning	Moved from Risk Register to Issue Log at the request of Ceri Jacob
2	**Diagnostic waiting times for children and young people**	There is a risk that waiting time targets for children and young people waiting for and ADHD assessment is unacceptably long. There is no ADHA pathway which is needed - need a neurodiversity pathway with links to both Autism and ADHA and other neurodevelopmental conditions. This impacts on the ICB's ability to ensure waiting time targets are met and could affect the organisations reputation. This could also have an adverse affect on CYP who are waiting for a diagnosis.	*Medium Impact Issue*	*Medium*	Eager (13-15)	Open	10/09/2024	Paul Creech/ John Dunning	Moved from Risk Register to Issue Log at the request of Ceri Jacob
3	**A large number of families (up to 200) have been relocated from Tower Hamlets to emergency temporary accommodation at Pentland House.**	There is a potential risk of failure to protect and safeguard the residents (adults and children) placed at Pentland House (temporary/emergency accommodation) due to a lack of health information available to form accurate assessments and provide appropriate support. Since Oct/Nov 2023, families were transferred to Pentland House accommodation. To date, information shared regarding families that have been placed in the accommodation has been limited and LBL CYP Joint Commissioning and LBL Housing are liaising with Tower Hamlets Housing Services to try to resolve this. Section 208 notice – housing legal requirements from Tower Hamlets to Lewisham is to provide data on all individuals including health. Emergency accommodation for Pentland House should only be for 56 days - this has now been breached. Families are also registered with Tower Hamlets (through choice) but the impact and risk is: pregnant females travelling across London for obstetric care, those fleeing domestic abuse, lack of advocacy generally within the location, those re-housed due to domestic / familial abuse and honour based violence abuse, nutritional concerns and limitations with security at Pentland House.	*Low Impact Issue*	*Low*	Cautious (7-9)	Open	10/09/2024	Margaret Mansfield/ Fiona Mitchell	Moved from Risk Register to Issue Log at the request of Ceri Jacob
4	**NHS@Home / Virtual Ward**	The NHS@Home Service is now significantly busier than it was earlier in the year. However, the outstanding risk remains that while patients are actively discharged from hospital, there is no agreement on the criteria which would define these patients as an early discharge. SEL Testing approaches are in place to measure patient acuity levels and Lewisham will adopt one of the measures in due course.	*Medium Impact Issue*	*Medium*	Eager (13 - 15)	Open	28/10/2024	Jack Howell/Amanda Lloyd	Moved from Risk Register to Issue Log at the request of Jack Howell and Amanda Lloyd. Developments in progress.
5	**GDPR: A number of staff in an Older People's Care Home are not compliant with GDPR regulations as using personal NHS Mail addresses.**	Recent cessation of IT assistance for the last few Care Homes in 'setting up' NHS email addresses in x 3 Older People's Care Homes in Lewisham. Risk impact : Could lead to a risk of breaching of GDPR guidelines. Breach of confidentiality Reduce confidence in exchange of residents' personal data, alongside consideration of recent cyber-attacks.	*Medium Impact Issue*	*Medium*	Cautious (7 - 9)	Open	14/10/2024	Shirley Spencer / Fiona Mitchell	Moved from Risk Register to Issue Log at the request of Shirley Spencer. Developments in progress
6	**All Initial accommodation centres such as Lewisham Stay City apartments Deptford Bridge have high levels of vulnerable Adults & Children and Young People asylum seekers residents.**	Initial Accommodation Centres:- Stay City apartments Deptford Bridge has high levels of vulnerable adults, children and young people (asylum seekers) and to date no safeguarding adult referrals into MASH, ATHENA or PREVENT. Impact: data raises concerns that referral pathways are not being followed and nonconcordance with Lewisham local safeguarding referral pathway for adults. Risk is; large volume of adults, children young people deemed to be at risk. NOTE: Pentland House closed on 11th September 2023 - the rationale has not been shared.	*low Impact Issue*	*Medium*	Cautious (7 - 9)	Open	29/10/2024	Shirley Spencer / Fiona Mitchell	Moved from Risk Register to Issue Log at the request of Fiona Mitchell. Developments in progress

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

Summary of SEL LCP risks

Prepared for the place executive leads (PELs)

Version 1

Purpose

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. Following review of the LCP risks by the PELs in November 2023, it was agreed to continue review of comparative LCP risks on a quarterly basis. This pack provides an updated set of LCP risks, as of **28 January 2025.**

3. LCP risks on slides 4 - 7 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

1. **Slides 4 - 5:** provide a summary of the risks which have been identified and recorded on more than one LCP risk register, with their residual risk score rating. These should be used by LCP SMTs to review whether any potential risks are missing from their registers.

2. **Slides 6 - 7:** provide a summary of all risks identified and recorded on a single LCP risk register. The list of risks is varied and may be specific to a particular LCP, however these risk make a useful list of risk that in some cases **may also be applicable to other LCPs.** They should therefore be reviewed and considered for inclusion in local risks registers.

3. **Slide 8:** provides areas of risk for consideration by PELs, with their SMTs.

Risks recorded on more than one LCP risk register (1 of 2)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Achievement of financial balance in the borough	6 ↓	12	9 ↓	6 ↓	15 ●	9
Unable to identify and achieve efficiency savings within the borough	4 ↓			6 ↓	6	9 ↓
Overspend against the prescribing budget	12	9 ↓	12	12	12	12
Overspend against the borough's delegated CHC budget	12	12		9	12	
Unbudgeted costs due to transfer of high-cost LD clients / MH placements		9		6	12	12
Delivery of community-based MH programmes / CAMHs waiting times not achieved		6		6		9 ↓
Recruitment and retention: lack of capacity within various teams in the LCPs, community teams, across the ICS…		4 and 4*	6	10	12 and 9*	
Financial risk (legal challenge / poor performance) relating to the community equipment services provider	Considered by PELs – risk not relevant to LCP	9 ↓	Recently closed	4 ↓	Considered by PELs – risk not relevant to LCP	8
Performance / poor delivery risk associated with community equipment services provider						8
Patients fit for discharge unable to leave hospital due to pressures in community and social care services / loss of funding	12		12			Recently closed

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since July 2024*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

*Note: * there are 2 risks recorded on these LCP risk registers in relation to recruitment and retention and scores for both have been shown.*

Risks recorded on more than one LCP risk register (2 of 2)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Virtual wards will not be developed / optimised			9		4	
CYP diagnostic waiting times for autism and ADHD targets not being met	To be added	6 ↓		9	Overlaps with ASD target risk	9 ↓
Population vaccination targets not met				12 and 9 ○	9 and 12 ● ○	
Primary care collective action	9 ○	9 ○	↓ 6 ○	9 ○	9 ○	9 ○
Primary care premises lost / insecure lease agreements / other estates issues	12	↓ 12 ○		Recently closed		
Safeguarding risk (due to pressures across partners / vulnerable adults, children in initial accommodation centres…)				6 and 8 ↓	9	
Potential Community Pharmacy collective action	12					

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since July 2024*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Risks recorded on one LCP risk register only (1 of 2)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
SEND improvement plan (partners failing to deliver areas from SEND inspection)	↑ 12 ○					
Primary care – delegated budget list growth cost pressure	↓ 8 ○					
CHC packages leading to deprivation of liberty		2 ↓				
Lack of engagement with local communities			6			
Risk to development of iThrive and preventative system approach to children's MH and wellbeing			9 ↓			
Risk to the rollout of Family Hubs programme			2 ↓			
Risk to ensuring food and nutrition is included as part of all diet-rated disease care pathways			Recently closed			
Risk to implementation of Get Active physical activity and sports strategy			Recently closed			
Risk to delivery of performance targets delegated to place (these include IAPT access, SMI health checks, children immunisation and cancer screening)			12			
Interpreting services overspend and procurement				8 and 3 ○		

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since July 2024*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Risks recorded on one LCP risk register only (2 of 2)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Initial Health Assessments (IHAs) not completed for children Looked After within 20 days					6 ↓	
Risk to delivery of MH LTP trajectories					10	
Families relocated to emergency temporary accommodation at Pentland House					Recently closed	
Intermediate care bed provision					9	
Access to primary care services					12 ●	
Breach of GDPR					9 ○	
Initial accommodation centres putting pressures on the local health system						Recently closed
Cost pressures due to rapid increase in patients seeking ADHD and Autism diagnostic services from independent sector providers						6
Service disruption due to delays opening of a health centre						Recently closed
MCR transition and implementation affecting BAU						Recently closed

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since July 2024*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Areas for PELs to consider with their SMTs

Areas for consideration and discussion by the PELs and their SMTs:

1. Greenwich have reduced their primary care collective action risk score down to 6. Is this a score change that should be mirrored on the other LCP risk registers?

2. Bexley have added a risk around collective action relating to community pharmacies. Is this a risk that should be recorded by the other LCPs too?

3. Lambeth have added a risk around interpreting services and procurement. Is this an area of risk affecting other LCPs?

4. Lewisham's risk relating to achievement of financial balance is highly rated in comparison to the other LCPs, and appears on the BAF. Does this position remain accurate at this time of the financial year?

5. At the January 2025 Risk and Audit Committee meeting, there was a discussion about whether all relevant primary care risks have been included on the registers. Are you satisfied that all primary care risks have been included or do you have any initial thoughts on areas that might be missing?

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.*

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

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 10
Enclosure 9

Title:	**Month 10 Finance Report 2024/25**
Meeting Date:	27th March 2025
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 2024/25. A month 10 position is also included for the wider ICB/ICS and LA, reflecting reporting timescales.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

Month 10 2024/25 – SEL ICB – Lewisham Place

At month 10, the borough is reporting an underspend year to date (YTD) of £86k (Month 9 £176k) but is retaining a forecast outturn (FOT) of breakeven. All budget areas individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing.

Further details of the financial position are included in this report.

Month 10 2024/25 – Lewisham Council

At month 10 Adult Social Care Services is forecasting an overspend of £5.1m and Children's Social Care Services is forecasting an overspend of £14.2m. Further details are provided in this report.

Month 10 2024/25 – SEL ICB

As at month 10, the ICB is reporting a year to date (YTD) surplus of £5,085k against the RRL, which is £5,164k adverse to plan. The overspend comprises £765k relating to non-recurrent costs incurred by the ICB resulting from the Synnovis cyber-attack, specifically to review discarded tests and additional SMS messaging. The balance reflects a planned movement in provider financial positions £4,399k for which previously the ICB was showing the surplus (net neutral to the ICS). Aside from this additional Synnovis expenditure, the ICB delivered in full the YTD element (£4,142k) of its additional savings requirement.

	As at month 10, and noting the risks outlined in this report, the ICB is forecasting that it will deliver a year-end position of break-even. The detail of the ICB position is also shown within Appendix A to this report. **Month 10 2024/25 – SEL ICS** Appendix B shows the financial highlights for the ICS at month 10. The key elements are as follows: • At M10 the system is forecasting to deliver breakeven against plan. • At M10 SEL ICS is reporting a YTD deficit of (£59.3m), £31.3m adverse to plan. The main drivers to the adverse variance are the impact of the Synnovis cyber-attack (£33.8m), and slippage in efficiency programmes (£29.4m).
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 YTD financial position and forecast for 2024/25.
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 YTD financial position and forecast for 2024/25.	

NHS
South East London

Lewisham LCP Finance Report

Month 10 – 2024/25

ICB – Lewisham Delegated Budget – Month 10 2024-25

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	1,102	672	430	1,322	783	540
Community Health Services	24,453	23,127	1,326	29,343	27,712	1,631
Mental Health Services	6,413	6,412	1	7,696	7,629	66
Continuing Care Services	19,213	22,170	(2,956)	23,056	26,609	(3,553)
Prescribing	35,629	36,908	(1,279)	42,591	44,323	(1,733)
Prescribing Reserves	0	0	0	0	0	0
Other Primary Care Services	1,981	1,426	555	2,377	1,711	666
Other Programme Services	2,795	1,031	1,764	3,354	1,239	2,115
Delegated Primary Care Services	49,194	49,034	160	65,419	65,227	192
Corporate Budgets	2,624	2,538	86	3,146	3,072	74
Total	**143,404**	**143,318**	**86**	**178,305**	**178,305**	**(0)**

- At month 10, the borough is reporting an underspend year to date (YTD) of £86k (Month 9 underspend £176k) but is retaining a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing.
- CHC shows a material overspend YTD of £2,956k and FOT of £3,553k (Month 9 £3,572k) (outturn 2023/24 £3,638k). The position is driven predominantly by the full year effect of activity pressures seen in the second half of last year, a significant element relating to LD clients.
- The material improvement in forecast outturn for CHC reflects the financial recovery work undertaken in Lewisham including weekly recovery meetings of the Lewisham CHC team to try to mitigate the financial position, focussing on conducting client reviews and price negotiation.
- Prescribing shows an overspend YTD of £1,279k and FOT £1,733k (Month 9 £1,860k). This compares to a risk assessed forecast overspend of £2,737k set out by the Lewisham Borough at the start of the current financial year.
- The overspend is mainly caused by increased costs relating to appliances, central nervous system and Endocrine system prescribing costs. The improved position at month 10 reflects the outcomes of management actions taken as set out in previous reports.
- The Lewisham Borough is taking every measure possible to reduce the forecast overspends on CHC and prescribing and has also identified other non-recurrent mitigations to help ensure a breakeven position is achieved at the year end. At month 10 the YTD position continues to show an underspend.
- The borough 4% efficiency target is £3,576k, is fully identified and forecast to deliver in full, but has been insufficient on its own to mitigate the scale of financial pressures faced by the borough, and material additional mitigations have been implemented.

Month 10 2024/25 – Lewisham Council

NHS South East London

Overall Position

2024/25 Efficiencies	Year-to-date Month 10 2024/25				Full-Year Forecast 2024/25		
	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
Childrens Care Services	0.8	0.6	(0.2)		0.9	0.7	(0.2)
Total	**3.9**	**3.7**	**(0.2)**		**4.6**	**4.4**	**(0.2)**

2024/25 LBL Managed Budgets	Year-to-date Month 10 2024/25				Full-Year Forecast 2024/25		
	Budget	Forecast	Variance		Budget	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	64.3	68.5	(4.3)		77.1	82.2	(5.1)
Childrens Care Services	54.3	66.2	(11.9)		65.2	79.4	(14.2)
Total	**118.6**	**134.7**	**(16.2)**		**142.3**	**161.6**	**(19.3)**

Adults Commentary:
The Adult Social Care & Health Directorate is forecasting a £5.1m overspend for 2024/25. This is 0.7m adverse movement from previous report. The movement relates to increasing demand in packages of care. Specifically, LD and MH residential and supported living as well as 18-64 Physical support Residential and Nursing placements.

The key cause of the overall overspend, is the unusually high inflation requests from providers, largely due to the increase in London Living Wage, which is estimated to be £4m (which is £2.5m higher than budget). This pressure is further exacerbated by the complexity of care requirements for discharged clients. Additionally, there is a steady increase in both the number of and cost of children transitioning to adulthood. Work is ongoing to ensure early intervention and planning so that their care costs can be better managed.

There is an ongoing challenge around collecting service user care costs where they are liable to pay for all or part of the care provided. There has been a concerted effort around Debt management which is yielding results, and it remains a corporate priority with a dedicated project group in place to ensure that these processes are continually improved.

Children's Social Care Commentary:

The projected overspend for Children's Social care in 2024/25 is £14.2m. The overall number of children looked after (CLA's) has remained consistent during 2024/25. There continues to be more children with a high level of need and care costs as was the case during 2023/24.

NHS
South East London

Appendix A

SEL ICB Finance Report

Month 10 2024/25

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) surplus of **£5,085k** against the revenue resource limit (RRL), which is **£5,164k** adverse to plan. The overspend relates to non-recurrent costs incurred by the ICB resulting from the Synnovis cyber-attack, specifically to review discarded tests and additional SMS messaging **(£765k)**, together with a planned change in financial positions with GSTT **(£4,399k),** net neutral to the ICS overall. The full year value of this change is **£13,198k**. Aside from the additional Synnovis expenditure, the ICB delivered in full the YTD element **(£4,142k)** of its additional savings requirement. **All boroughs are reporting that they will deliver a minimum of financial balance at the year end.**
- ICB is showing a YTD underspend of **£1,724k** against the running cost budget, which is largely due to vacancies within the ICB's staff establishment. These are in the process of being recruited to. The stranded costs (of staff at risk) following the MCR process to deliver 30% savings on administrative costs as per the NHSE directive, are being charged to programme costs in line with the definitions given for running costs versus programme costs.
- All other financial duties have been delivered for the year to month 10 period.
- As at month 10, and noting the risks outlined in this report, **the ICB is forecasting that it will deliver a year-end position of break-even, whilst noting the surplus of £33,321k included in the ICB plan on behalf of ICS partners.** More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	3,978,866	3,984,030	4,775,506	4,775,506	
Operating Under Resource Revenue Limit	4,012,053	4,006,968	4,814,464	4,814,464	
Not to exceed Running Cost Allowance	30,570	28,846	35,938	35,938	
Month End Cash Position (expected to be below target)	4,750	3,036			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	100.0%			
95% of non-NHS creditor payments within 30 days	95.0%	99.0%			
Mental Health Investment Standard (Annual)			469,778	470,753	

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 June plan submission. This included a **planned surplus of £40,769k** for the ICB which has now been adjusted due to the impact of the deficit support funding by £1,800k, to give a revised surplus of **£38,969k.**
- The ICB's financial allocation as at month 10 is **£4,814,464k.** In month, the ICB has received an additional **£35,967k** of allocations. These are as detailed on the following slide.
- As at month 10, the ICB is reporting a year to date (YTD) overspend of **£5,164k** against the planned surplus of **£10,249k**. The overspend relates to non-recurrent costs incurred by the ICB resulting from the Synnovis cyber-attack, specifically to review discarded tests and additional SMS messaging **(£765k)** together with a planned change in financial positions with GSTT **(£4,399k),** net neutral to the ICS overall. Aside from the additional Synnovis expenditure, the ICB has delivered in full the YTD element **(£4,142k)** of its savings requirement.
- Due to the usual time lag in receiving current year information from the PPA, the ICB has received eight months of prescribing data, with an estimate made for the last two months. The ICB is reporting an overspend YTD of **£3,084k** at month 10. Details of the drivers and actions are set out later in the report.
- The current expenditure run-rate for continuing healthcare (CHC) services is above budget **(£2,540k YTD),** a small improvement from last month. Lewisham **(£2,956k),** Bromley **(£534k)** and Greenwich **(£154k)** boroughs are particularly impacted, with the other boroughs reporting small underspends.
- The ICB continues to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and so the ICB has started the process of issuing notice to affected staff. This delay has generated additional costs for the ICB of **circa £4,624k YTD.** The first redundancy payments were made in December 2024, with the majority paid in January 2025.
- Only one place is reporting an overspend position YTD at month 9 **(Bromley, £255k),** which is a similar position to that reported last month. However, **a break-even position is being forecasted**. Financial focus meetings were held with all places and the CFO/Deputy CEO in December.
- In reporting this month 10 position, the ICB has delivered the following financial duties:
    - Underspending **(£1,724k YTD)** against its management costs allocation, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions;
    - Delivering all targets under the **Better Practice Payments code**;
    - 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 a forecast break-even position against its plan for a **£38,969k** surplus, whilst noting the surplus of **£33,321k** included in the ICB plan on behalf of ICS partners. 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	**147,630**	**249,631**	**177,025**	**214,455**	**170,943**	**167,786**	**3,333,394**	**4,460,864**
M2 Internal Adjustments	1,049	3,464	2,037	2,146	901	2,431	(12,028)	-
M2 Allocations							11,975	**11,975**
M2 Budget	**148,679**	**253,095**	**179,062**	**216,601**	**171,844**	**170,217**	**3,333,341**	**4,472,839**
M3 Internal Adjustments	1,286	1,666	812	1,770	1,512	1,541	(8,587)	-
M3 Allocations				128			7,831	**7,959**
M3 Budget	**149,965**	**254,761**	**179,874**	**218,499**	**173,356**	**171,758**	**3,332,585**	**4,480,798**
M4 Internal Adjustments	33	33	125	128	120	128	(567)	-
M4 Allocations	106	177			75		17,952	**18,310**
M4 Budget	**150,104**	**254,971**	**180,000**	**218,627**	**173,551**	**171,886**	**3,349,969**	**4,499,108**
M5 Internal Adjustments	127	296	165	230	184	189	(1,191)	-
M5 Allocations						20	2,685	**2,705**
M5 Budget	**150,231**	**255,267**	**180,165**	**218,858**	**173,734**	**172,095**	**3,351,463**	**4,501,813**
M6 Internal Adjustments	578	290	804	1,021	660	891	(4,244)	-
M6 Allocations	1,137	1,635	1,489	2,124	1,694	1,756	110,442	**120,277**
M6 Budget	**151,946**	**257,191**	**182,459**	**222,003**	**176,088**	**174,741**	**3,457,662**	**4,622,090**
M7 Internal Adjustments	277	425	372	442	325	414	(2,256)	-
M7 Allocations	1,346	3,400	1,913	1,883	1,557	1,588	109,347	**121,034**
M7 Budget	**153,569**	**261,017**	**184,744**	**224,328**	**177,971**	**176,743**	**3,564,753**	**4,743,124**
M8 Internal Adjustments	243	158	240	531	149	425	(1,746)	-
M8 Allocations	110	114					31,516	**31,739**
M8 Budget	**153,922**	**261,288**	**184,983**	**224,860**	**178,120**	**177,168**	**3,594,523**	**4,774,864**
M9 Internal Adjustments	52	234	107	148	38	107	(687)	**0**
M9 Allocations							3,635	**3,634**
M9 Budgets	**153,973**	**261,521**	**185,090**	**225,009**	**178,158**	**177,275**	**3,597,471**	**4,778,497**
M10 Internal Adjustments								
Delegated Primary Care	70	97	91	125	98	102	(583)	-
Other minor movements	-	136	(2)	(21)	49	3	(165)	-
M10 Allocations								
ERF ICB overperformance M6&7	-	-	-	-	-	-	11,735	**11,735**
ERF ICB Programme holdback released M6&7	-	-	-	-	-	-	8,943	**8,943**
ERF ICB Delegated DOP holdback released M6&7	-	-	-	-	-	-	356	**356**
Month 10 depreciation adjustment	-	-	-	-	-	-	5,259	**5,259**
DDRB Uplift	-	-	-	-	-	-	3,711	**3,711**
Pension costs 9.4%	-	-	-	-	-	-	3,731	**3,731**
Pharmacy First	-	-	-	-	-	-	777	**777**
Various minor allocations	-	-	-	-	-	-	1,455	**1,455**
	-	-	-	-	-	-		-
M10 Budget	**154,043**	**261,754**	**185,179**	**225,113**	**178,305**	**177,380**	**3,632,690**	**4,814,464**

- The table sets out the Revenue Resource Limit (RRL) at month 10.
- The start allocation of **£4,460,864k** is consistent with the Operating Plan submissions.
- During month 10, internal adjustments were actioned to ensure allocations were aligned to the correct agreed budgets. These had no overall impact on the overall allocation. The main adjustments related to delegated primary care and the allocation of a residual balance and other smaller allocations, which were added to borough delegated budgets.
- In month, the ICB has received an additional **£35,967k** of allocations, giving the ICB a total allocation of **£4,814,464k** at month 10**.** The additional allocations received in month were in respect of ERF monies totalling **£21,034k**, depreciation funding for providers **£5,259k**, DDRB uplift **£3,711k**, pensions costs at 9.4% **£3,731k,** Pharmacy First **£777k** plus some smaller value allocations.
- 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	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	4,170	6,591	6,017	990	1,102	71	2,078,728	**2,097,668**
Community Health Services	18,806	75,834	32,604	23,525	24,453	30,228	219,527	**424,978**
Mental Health Services	8,883	12,385	7,160	19,305	6,413	8,547	449,363	**512,057**
Continuing Care Services	21,782	22,607	24,350	28,847	19,213	16,467	-	**133,266**
Prescribing	31,328	42,705	31,196	35,694	35,629	29,374	487	**206,413**
Other Primary Care Services	2,814	1,917	1,903	3,351	1,981	1,130	16,197	**29,294**
Other Programme Services	999	-	833	-	2,774	664	51,523	**56,793**
Programme Wide Projects	-	-	-	-	21	216	(10,053)	**(9,816)**
Delegated Primary Care Services	33,452	48,118	42,606	65,971	49,194	52,854	(2,633)	**289,562**
Delegated Primary Care Services DPO	-	-	-	-	-	-	181,909	**181,909**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	2,527	2,906	2,927	3,264	2,624	2,838	39,654	**56,741**
Total Year to Date Budget	**124,763**	**213,063**	**149,597**	**180,948**	**143,404**	**142,389**	**3,024,701**	**3,978,866**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	4,150	6,432	6,058	729	672	74	2,077,089	**2,095,205**
Community Health Services	18,548	75,568	31,853	23,597	23,127	29,410	221,169	**423,271**
Mental Health Services	8,829	13,100	7,881	19,704	6,412	9,647	449,246	**514,820**
Continuing Care Services	21,631	23,141	24,504	28,499	22,170	15,861	-	**135,806**
Prescribing	31,910	42,534	32,062	35,392	36,908	30,118	573	**209,497**
Other Primary Care Services	2,814	1,917	1,894	3,011	1,426	1,146	16,297	**28,506**
Other Programme Services	999	-	-	-	0	-	41,018	**42,018**
Programme Wide Projects	-	-	-	-	1,031	215	4,118	**5,364**
Delegated Primary Care Services	33,452	48,118	42,615	66,560	49,034	52,996	(2,633)	**290,142**
Delegated Primary Care Services DPO	-	-	-	-	-	-	182,525	**182,525**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	4,624	**4,624**
Corporate Budgets	2,319	2,508	2,706	2,941	2,538	2,632	36,608	**52,252**
Total Year to Date Actual	**124,652**	**213,318**	**149,573**	**180,434**	**143,318**	**142,100**	**3,030,634**	**3,984,030**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	20	159	(42)	261	430	(3)	1,639	**2,464**
Community Health Services	259	266	752	(72)	1,326	819	(1,641)	**1,707**
Mental Health Services	54	(715)	(721)	(399)	1	(1,100)	117	**(2,763)**
Continuing Care Services	151	(534)	(154)	348	(2,956)	606	-	**(2,540)**
Prescribing	(582)	171	(866)	303	(1,279)	(744)	(86)	**(3,084)**
Other Primary Care Services	(0)	0	8	340	555	(16)	(100)	**788**
Other Programme Services	0	-	833	-	2,774	664	10,504	**14,775**
Programme Wide Projects	-	-	-	-	(1,010)	0	(14,171)	**(15,180)**
Delegated Primary Care Services	-	-	(8)	(589)	160	(143)	-	**(580)**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(616)	**(616)**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	(4,624)	**(4,624)**
Corporate Budgets	209	398	221	323	86	207	3,046	**4,489**
Total Year to Date Variance	**111**	**(255)**	**24**	**513**	**86**	**289**	**(5,932)**	**(5,164)**

- **As at month 10, the ICB is reporting a year to date (YTD) surplus of £5,085k, which is £5,164k adverse to plan.** The explanation for this overspend against plan is as set out in the earlier slides. Aside from this additional Synnovis expenditure, the ICB has delivered in full the YTD element **(£4,142k)** of its savings requirement.
- Due to the usual time lag, the ICB has received eight months of prescribing data. Using an estimate for December and January based on prescribing days, the ICB is reporting an overall YTD overspend of **£3,084k**, although it should be noted that the position is differential across places. This is clearly a significant financial risk area as in previous years.
- The continuing care (CHC) financial position is **£2,540k** overspent which is a small improvement on last month. Lewisham continues to have the largest overspend **(£2,956)** which is predominantly driven by the full year effect of activity pressures seen in the second half of last year. **However, the run-rate in Lewisham has improved in-month**. Further details are included in this report.
- As described previously, the ICB is continuing to incur pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and the ICB has issued notice and has now made most of the redundancy payments. The additional cost YTD is **£4,624k.**
- The MH/LD cost per case (CPC) budgets across the ICB are highlighting a cost pressure, with MH budgets reporting an overall overspend of **£2,763k,** a deterioration from last month. The CPC issue is differential across boroughs with Bromley, Greenwich, Lambeth and Southwark being the most impacted. ADHD and ASD assessments are a pressure in all boroughs.
- Only one place is overspending YTD at month 9 – **Bromley (£255k**), which is comparable with last month. **However, a break-even is forecast.** More detail regarding the individual place financial positions is provided later in this report.

5. Prescribing – Overview as at Month 10

NHS South East London

- The table below shows the month 10 prescribing position. Due to the usual lag in receiving information from the PPA, the ICB has received eight months of 2024/25 prescribing data. Based upon a prescribing days methodology to estimate spend for December and January, the ICB is reporting an overall YTD overspend on **PPA prescribing of £3,405k.**

M10 Prescribing	Total PMD (Excluding Cat M & NCSO)	Cat M & NCSO	Central Drugs	Flu Income	PY Flu (Benefit)/Cost Pressure	Adj and Cat M Clawback	Total 24/25 PPA Spend	M10 YTD Budget	YTD Variance - (over)/under	Annual Budget
	£	£	£	£	£	£	£	£	£	£
BEXLEY	30,838,954	213,608	1,030,553	(330,294)	3,336		31,756,158	31,125,767	(630,391)	37,205,018
BROMLEY	41,222,916	348,397	1,376,273	(517,895)	(31,432)		42,398,259	42,503,180	104,921	50,804,582
GREENWICH	30,848,882	261,747	1,031,294	(268,769)	(1,687)		31,871,466	30,954,249	(917,217)	37,000,001
LAMBETH	34,199,426	376,237	1,143,755	(304,058)	(23,696)		35,391,664	35,629,328	237,663	42,588,181
LEWISHAM	34,978,180	479,009	1,177,122	(219,804)	(6,642)		36,407,864	35,064,707	(1,343,157)	41,913,282
SOUTHWARK	28,825,984	351,140	968,673	(246,098)	(45,179)		29,854,519	29,073,631	(780,888)	34,752,075
SOUTH EAST LONDON						176,464	176,464	100,000.00	(76,464)	120,000
Grand Total	**200,914,342**	**2,030,137**	**6,727,669**	**(1,886,917)**	**(105,300)**	**176,464**	**207,856,395**	**204,450,861**	**(3,405,534)**	**244,383,139**

- This position is variable across the boroughs, with significant overspends in Lewisham, Greenwich and Southwark. Key drivers of the overspend continue to be Cat M and NCO price impacts, plus significant activity growth in medicines to support the management of long-term conditions. Other drivers of increased expenditure include increased prescribing of central nervous system drugs (especially ADHD drugs and migraine drugs), female sex hormones and nutrition and blood products. All these items are showing a higher % increase than is being seen nationally. The boroughs continue to reviewing how each of these issues has impacted them specifically.
- Lewisham place is seeing the largest cost pressure **(£1,343k YTD).** Actions being undertaken taken to address the position include the review of additional savings opportunities including the patent expiry on key drugs such as Rivaroxaban, and additionally drugs and other items which are recommended not to be prescribed in primary care are being reviewed to ensure they are not prescribed by practices. An audit has been undertaken of patients being managed under the Monitored Dosage System (MDS) and Medication Administration Records (MARS). This sets out a basis for ensuring that patients are reassessed as required on an annual basis and has been committed to by the Local Pharmaceutical Committee (LPC) and the Lewisham Medical Committee (LMC). Through ensuring an annual review of patient needs, recurrent savings against the annual budget of circa £626k are planned.
- Non PPA budgets are underspent by **£331k** giving an overall YTD overspend of **£3,084k,** a favourable movement of **£121k** in-month.

5. Prescribing – Comparison of 2425 v 2324

NHS South East London

- The table below compares April to November prescribing data for 2023 and 2024. The headlines are that expenditure in the ICB is increasing marginally faster **(2.3%)** than nationally **(2.0%)** and slower than the London average **(3.0%).** This is driven by a combination of the cost per item falling more slowly **(1.8%)**, together with a rise in activity **(4.2%)** albeit at a significantly slower rate than across London **(6.0%)**.

Prescribing
Comparison of April to November 2024 v 2023

	2023 April to November	2024 April to November	Change £	Change %
South East London ICB:				
Expenditure (£'000)	159,931	163,556	3,625	2.3%
Number of Items ('000)	17,042	17,756	714	4.2%
£/Item	9.38	9.21	-0.17	-1.8%
London ICBs:				
Expenditure (£'000)	812,568	836,864	24,296	3.0%
Number of Items ('000)	95,684	101,445	5,762	6.0%
£/Item	8.49	8.25	-0.24	-2.9%
All England ICBs:				
Expenditure (£'000)	6,722,381	6,859,524	137,143	2.0%
Number of Items ('000)	795,251	829,762	34,511	4.3%
£/Item	8.45	8.27	-0.19	-2.2%

- It is unrepresentative to base judgements solely on eight months of information, but the key factors explaining the SEL position include:
  - Increase in drugs activity and expenditure to support patients with long term conditions;
  - Increased prescribing of central nervous system drugs (especially ADHD drugs and migraine drugs), female sex hormones and nutrition and blood products. All these items continue to show a higher % increase than is being seen nationally;
  - Impact of NCSO remains a factor.

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 10 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	89,125	86,511	2,614	106,950	103,813	3,137
Delegated Community Dental	6,413	6,413	(0)	7,696	7,696	0
Delegated Secondary Dental	46,581	46,581	(0)	55,553	55,553	(0)
Total Dental	**142,119**	**139,505**	**2,614**	**170,199**	**167,062**	**3,137**
Dental Ring Fence	138,935	138,935	0	166,722	166,722	0
Dental Non Ring Fence	3,184	570	2,614	3,477	340	3,137
Total Dental	**142,119**	**139,505**	**2,614**	**170,199**	**167,062**	**3,137**
Delegated Ophthalmic	12,920	14,877	(1,957)	15,504	17,941	(2,437)
Delegated Pharmacy	26,268	27,542	(1,274)	31,271	32,799	(1,528)
Delegated Property Costs	602	602	0	722	722	0
Total Delegated DOPs	**181,909**	**182,525**	**(616)**	**217,696**	**218,525**	**(828)**

a) Delegated Dental

- Overall, Dental is showing a YTD underspend against budget of £2,614k, and a forecast of £3,137k for the full year. The underspend is forecast to partially mitigate the overspends within Ophthalmic and Community Pharmacy. **The dental ringfence of £166,722k is expected to be delivered in 24/25, with full year expenditure forecast to be £167,062k.** Due to the volatility of dental activity the 2425 budget was set greater than the ringfenced value. The month 10 accrual is based December's dental report downloaded from the national e-Den system. The year-to-date level of dental activity is 73.3% and the forecast is 90.9%, with activity levels expected to pick up as the year progresses. 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

- The YTD position is an **overspend of £1,957k**. The spend largely relates to Optician Sight Tests and Vouchers submitted by high street 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

- The YTD position is an **overspend of £1,274k**, noting that information is received 2 months in arrears with an accrual then based upon the 8 months average using the number of Prescribing days. The overspend is driven by the costs associated with professional fees and advanced services. 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

Financial Position (Month 10): The overall Continuing Healthcare (CHC) financial position reflects a **£2,540k** overspend, showing a slight improvement of £130k from the previous month. Cost pressures vary across boroughs, with Lewisham, Bromley, and Greenwich reporting overspends, while the remaining three boroughs collectively underspending by approximately £1,104k.

Key Drivers of Overspend:

- **Lewisham:** the largest contributor to the overspend **(£2,956k),** primarily driven by the full-year impact of activity pressures from late last year (approximately £1,445k), particularly among Learning Disability (LD) clients. Actions taken to address this include:
    - Weekly meetings led by the Place Executive Lead to implement and monitor savings plans.
    - An ongoing review and cleansing of the client database, which has resulted in an improvement in the monthly run rate as of Month 10.
- **Bromley:** the overspend **(£534k)** is due to increased activity from expanded bed capacity, higher staff costs from new contracting arrangements, and settlements for retrospective cases. A review of these cases is ongoing to understand why Bromley appears to be an outlier, compared to other SEL boroughs.
- **Greenwich:** the overspend **(£154k)** can be attributed to an increase in activity in Funded Nursing Care and Joint Funded clients.
- **Other Boroughs:** are reporting improvements to financial positions, primarily due to ongoing service and client database reviews.

Provider Price Reviews: an ICB panel was established to review provider price increase requests exceeding 1.8%. The panel meets weekly to ensure consistency across SE London and mitigate significant cost increases. Boroughs initially budgeted for a 4% inflationary uplift. In Month 7, reserves were released where agreements were below budget, and this process will be repeated in Q4.

Savings Initiatives: all boroughs report progress on CHC savings plans, with three boroughs exceeding their targets. However, rising activity levels and higher-cost patients continue to exert financial pressures on the CHC 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 **£3,354,944k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£765,680k**
    - Kings College Hospital **£873,911k**
    - Lewisham and Greenwich **£688,344k**
    - South London and the Maudsley **£330,249k**
    - Oxleas **£255,436k**

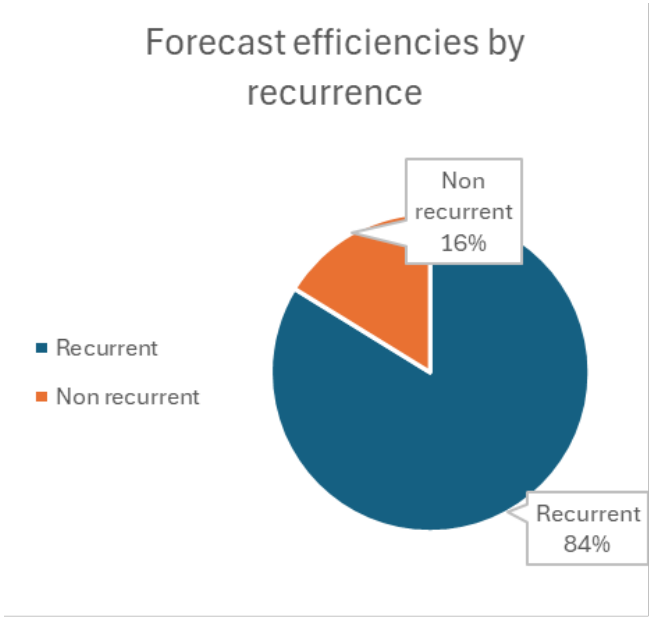
- In month, the ICB position is showing a break-even position on these NHS services and a break-even position has also been reflected as the forecast year-end position.

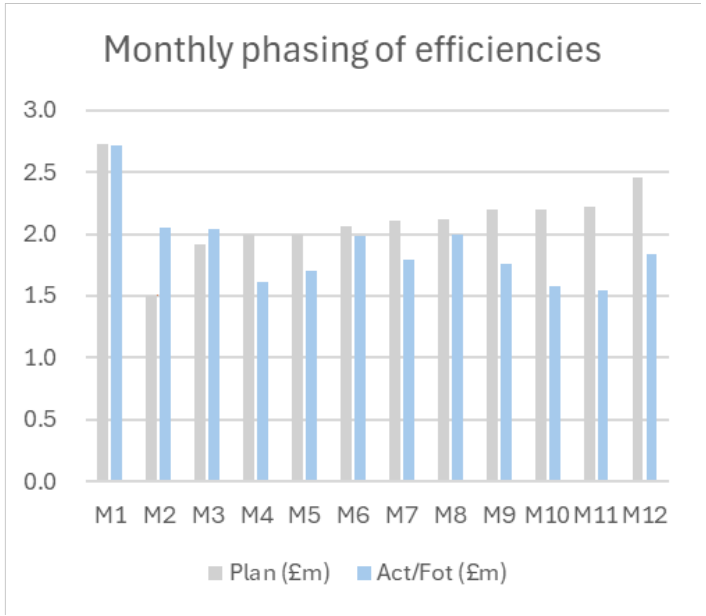
9. ICB Efficiency Schemes at as Month 10

NHS South East London

- The 6 places within the ICB have a total savings plan for 2024/25 of **£25.5m.** In common with the previous financial year, the key elements of the savings plans are in continuing healthcare (CHC) and prescribing.
- The table to the right sets out the YTD and forecast status of the ICB's efficiency scheme as at month 10.
- **As at month 10, overall, the ICB is reporting actual delivery of £24.4m, which is £5.8m ahead of plan.** At this stage in the financial year, the annual forecast is to exceed the efficiency plan **(by £3.6m),** although this will need ongoing close monitoring.
- The current risk rating of the efficiency plan is also reported. At this stage in the year, none of the forecast outturn of **£29.1m** has been assessed by the places as **high risk.**
- Most of the savings **(84%)** are forecast to be delivered on a recurrent basis.

	M9 year-to-date			Full-year 2024/25			Full Year - Identified			Full Year Forecast - Scheme Risk		
	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	FOT	Change	Low	Medium	High
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	2.8	3.6	0.8	3.5	4.4	0.9	3.5	4.4	0.9	4.4	0.0	0.0
Bromley	4.4	5.1	0.7	6.3	6.4	0.1	6.3	6.4	0.1	4.2	2.2	0.0
Greenwich	2.5	3.8	1.2	3.5	4.6	1.1	3.5	4.6	1.1	2.6	2.0	0.0
Lambeth	3.8	5.6	1.8	5.2	6.1	0.9	5.2	6.1	0.9	2.2	3.9	0.0
Lewisham	2.4	3.0	0.6	3.2	3.6	0.4	3.2	3.6	0.4	2.9	0.7	0.0
Southwark	2.7	3.4	0.7	3.8	4.0	0.2	3.8	4.0	0.2	3.9	0.1	0.0
SEL ICB Total	18.6	24.4	5.8	25.5	29.1	3.6	25.5	29.1	3.6	20.2	8.9	0.0



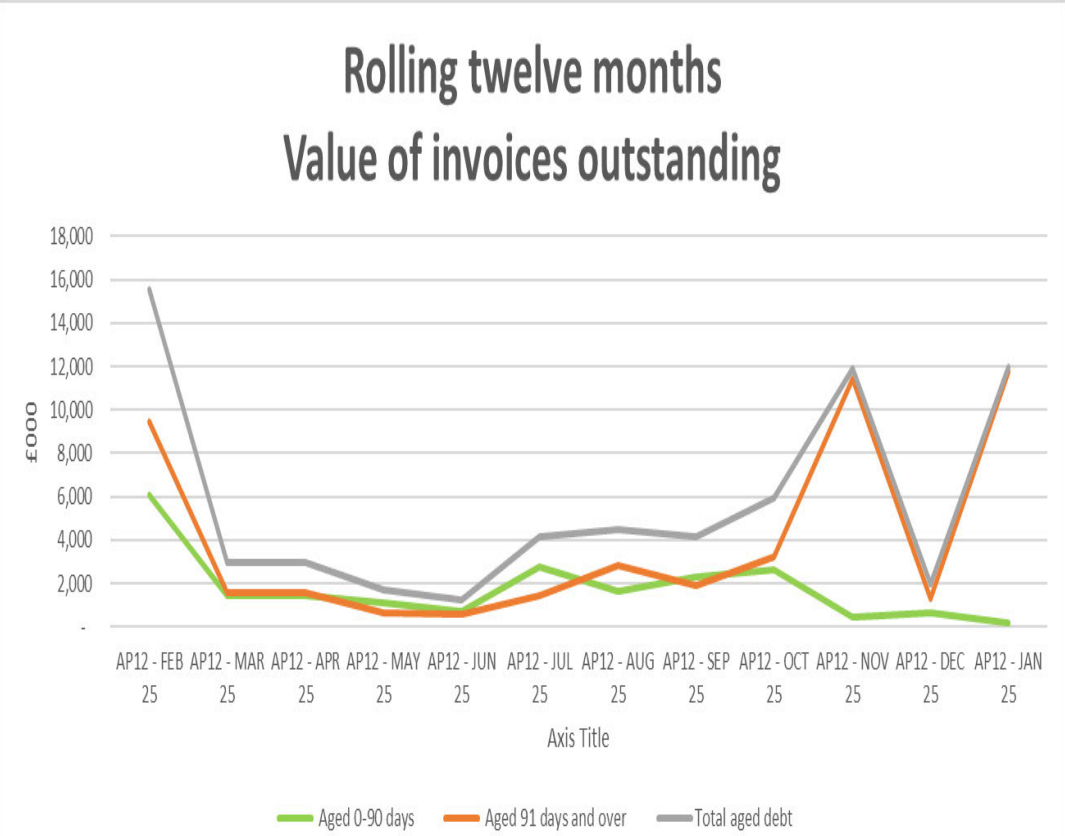


10. Corporate Costs – Programme and Running Costs

Area		Year to Date		
	Annual Budget	Budget	Actual	Variance
	£	£	£	£
Boroughs				
Bexley	2,629,810	1,967,360	1,775,033	192,327
Bromley	3,314,269	2,494,952	2,038,414	456,539
Greenwich	3,221,499	2,428,123	2,250,499	177,624
Lambeth	3,737,440	2,704,196	2,417,766	286,430
Lewisham	2,930,436	2,200,827	2,120,486	80,341
Southwark	3,320,399	2,418,490	2,239,085	179,405
Subtotal	19,153,853	14,213,949	12,841,283	1,372,666
Central				
CESEL	461,544	384,619	234,997	149,622
Chief of Staff	3,141,259	2,617,717	2,384,632	233,085
Comms & Engagement	1,677,650	1,398,041	1,153,774	244,267
Digital	1,688,342	1,406,951	987,050	419,902
Digital - IM&T	3,163,430	2,636,190	2,527,261	108,930
Estates	649,177	540,980	620,899	(79,919)
Executive Team/GB	2,387,601	1,989,668	1,914,847	74,821
Finance	6,830,563	2,582,969	2,348,076	234,893
Staff at Risk Costs	0	-	4,621,944	(4,621,944)
London ICS Network	(1)	0	-	0
Medical Director - CCPL	1,604,413	1,335,511	1,063,678	271,833
Medical Director - ICS	271,387	226,155	192,039	34,116
Medicines Optimisation	4,353,888	3,628,238	2,974,690	653,548
Planning & Commissioning	8,402,233	7,001,858	6,264,658	737,200
Quality & Nursing	1,937,472	1,614,557	1,482,561	131,995
SEL Other	0	-	(258)	258
South East London	0	-	181,769	(181,769)
Subtotal	36,568,958	27,363,456	28,952,617	(1,589,161)
Grand Total	55,722,811	41,577,405	41,793,900	(216,495)

- The table shows the YTD month 10 position on programme and running cost corporate budgets.
- As described earlier in the report, the ICB is continuing to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs.
- The process of issuing notices to at risk staff has largely been completed with most of redundancy payments now having been made. The delay has generated additional costs for the ICB both in respect of the ongoing cost **(circa £4,622k YTD)** together with the impact upon the final redundancy payments, given longer employment periods etc. The monthly costs should now see a significant reduction going forward. The actual redundancy costs are not included in this table as they have been charged against the provision made at the end of the last financial year.
- **Overall, the ICB is reporting an overall YTD underspend on its corporate costs of circa £216k,** a deterioration in-month, which is a result of vacant posts being recruited into.
- As highlighted in earlier slides, the ICB is **underspending (£1,724k YTD)** against its **management (running) costs** allocation.

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	132	72	(16)	6	9	0	203
Non-NHS	11,064	628	32	13	0	1	11,738
Unallocated	0	0	0	0	0	0	0
Total	**11,196**	**700**	**16**	**19**	**9**	**1**	**11,941**

- The ICB has an overall debt position of **£11,941k** at month 10. This is circa **£10,000k higher** when compared to last month; this is mainly due to large value invoices relating to quarter 4 being raised to ensure cash is received before year-end. **The age profile of debtors is very similar to last month.** Of the current debt, there is only **£10k** of debt over 3 months old. **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. This will be especially important as we move to a new ISFE2 ledger, likely at some point during 2025/26. 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	LAMBETH LONDON BOROUGH COUNCIL	7,558	7,558	-
2	LONDON BOROUGH OF BROMLEY	3,305	3,305	-
3	SOUTHWARK LONDON BOROUGH COUNCIL	299	299	-
4	ROYAL BOROUGH OF GREENWICH	209	209	-
5	LEWISHAM LONDON BOROUGH COUNCIL	158	158	-
6	BEXLEY LONDON BOROUGH	143	143	-
7	ROYAL FREE LONDON NHS FOUNDATION TRUST	76	76	-
8	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	70	70	-
9	BROMLEY HEALTHCARE LIMITED	30	30	-
10	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FT	22	13	9

12. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at month 10 was **£4,773,507k**. 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 **£819,568k**.
- As at month 10 the ICB had drawn-down 82.8% 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. No supplementary cash drawdown has been requested for February 2025 either.
- 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 **£3,036k**, well within the target set by NHSE **(£4,750k). 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	2024/25 AP10 - JAN 25	2024/25 AP9 - DEC 24	2024/25 Month on month movement
	£000s	£000s	£000s
ICB ACDR	4,773,507	4,737,540	35,967
Capital allocation	0	0	0
Less:			
Cash drawn down	(3,638,000)	(3,258,000)	(380,000)
Prescription Pricing	(233,712)	(210,218)	(23,494)
HOT	(1,894)	(1,709)	(185)
POD	(76,645)	(69,137)	(7,508)
Pay Award charges			0
PCSE POD	43	43	0
Pension Uplift	(3,731)		(3,731)
Remaining Cash limi	**819,568**	**1,198,519**	**(378,952)**

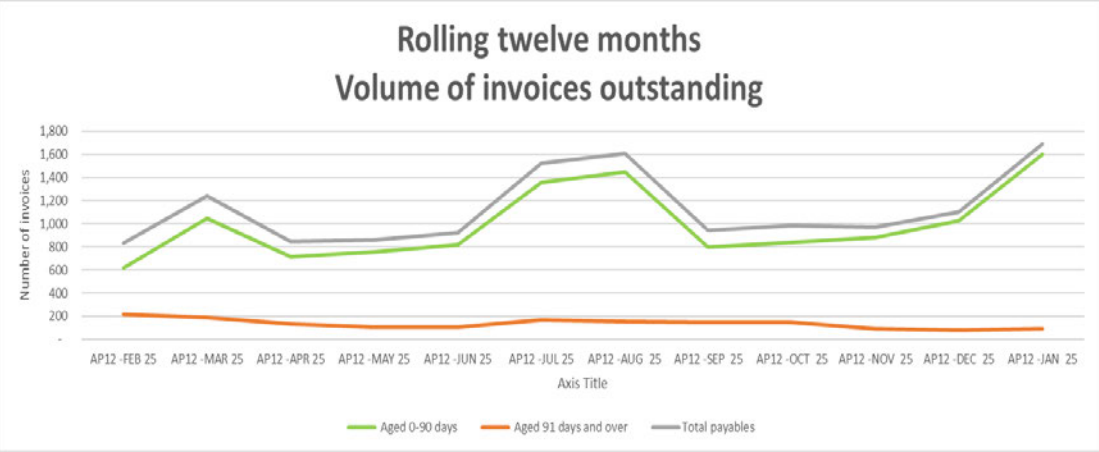
Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-24	340,000	0	340,000	8.30%	4,250	3,101	0.91%
May-24	325,000	0	665,000	16.30%	4,063	237	0.07%
Jun-24	365,000	0	1,030,000	25.27%	4,563	3,114	0.85%
Jul-24	350,000	0	1,380,000	33.70%	4,375	2,608	0.75%
Aug-24	320,000	0	1,700,000	41.57%	4,000	661	0.21%
Sep-24	360,000	0	2,060,000	49.00%	4,500	3,744	1.04%
Oct-24	347,000	106,000	2,513,000	58.10%	4,338	3,419	0.99%
Nov-24	355,000	0	2,868,000	65.90%	4,438	224	0.06%
Dec-24	365,000	25,000	3,258,000	74.70%	4,563	3,286	0.90%
Jan-25	380,000	0	3,638,000	82.80%	4,750	3,036	0.80%
Feb-25	360,000		3,998,000		4,500		
Mar-25							
3,867,000	**131,000**						

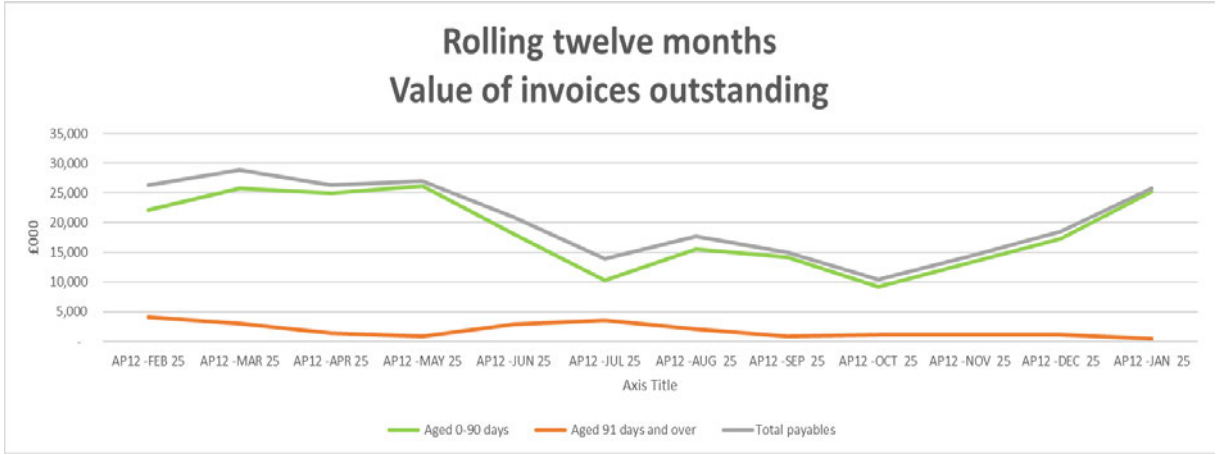
13. Aged Creditors

NHS South East London

- The ICB has been advised by NHS England that the move to a new ledger ISFE2 at the start of 2025/26 has now been delayed and a revised go live date will be issued in due course. However, ICBs need to continue to maintain a focus on the reduction of creditors until such times as the transition to a new ledger takes place. The table below shows that there are **£504k** of invoices outstanding which are **over 90 days**, most of which are non-NHS. **This represents an in-month decrease of over £500k,** as we continue our focus on clearing old invoices. The overall value of creditors **(£25,751k)** has increased in-month, partly a result of large value quarterly invoices received from local authorities, in advance of the year end. These will be validated in the usual manner. Borough Finance leads, and the central Finance team continue to actively support budget holders to resolve queries with suppliers.
- 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	3,662	189	2	0	33	25	3,911
Non-NHS	18,404	1,744	1,246	148	161	137	21,840
Total	**22,066**	**1,933**	**1,248**	**148**	**194**	**162**	**25,751**





14. Metrics Report

- The ICB receives a metrics report from NHS England every month which is compiled from information from our ledger and nationally collated by SBS. **This ranks all ICBs against a set of national key financial metrics.**
- The report below relates to December 2024 as the January report will not be received until the end of February which is too late for this reporting cycle.
- In terms of performance, **SE London ICB has moved back to 1st in the country with an improved score from last time which is very positive.** The metric scores below shows that we now have 2 scores of the maximum 5, with all scores now above 3.
- Each score shown on this dashboard has several metrics sitting behind it, which relate to good financial practice. The ICB is currently scoring especially well in two areas (maximum scores of 5) which are a) Accounts Receivable, showing the work undertaken in this area to reduce and manage debt and b) GL and VAT where all balance sheet reconciliations are up to date with no dated reconciling items. The finance team are continuing to strive to improve the scores in the 3 other areas and this month further improvements have been delivered in Accounts Payable (non-NHS) and General Accounts.
- Further work is ongoing to establish how further improvements can be made.

Organisation Name	NHS South East London ICB			
Organisation Code	QKK		Period	Dec-24
Region	London		Peer Rank	1 / 42 ICB

	Oct-24	Nov-24	Dec-24	3 month average
Overall Score (max 25)	19.52	19.15	19.94	19.54

	Oct-24	Nov-24	Dec-24	3 month average
Accounts Payable - NHS	3.68	3.47	3.32	3.49
Accounts Payable - Non NHS	2.67	2.94	3.39	3.00
Accounts Receivable	4.94	4.59	5	4.84
General Accounts	3.23	3.15	3.23	3.20
GL and VAT	5	5	5	5.00

15. Mental Health Investment Standard (MHIS) – 2024/25

NHS South East London

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2023/24 outturn by a **minimum of the growth uplift of 6.85%, a target of £469,778k.** This spend is subject to annual independent review. The 2023/24 review is currently taking place.

- 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 Service Development Fund (SDF) and other non-recurrent allocations

- Slide 2 summarises the 2024/25 SEL ICB MHIS Plan. As at Month 10 we are forecasting MHIS delivery of **£470,753k**, exceeding the target by **£975k** (0.21%). This is largely made up of over-delivery against the plan on prescribing of approximately £1.9m, noting the potential volatility of prescribing spend based on the supply and cost of drugs. Slide 3 sets out the position by ICB budget area.

Risks

- 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. Actions to mitigate this include ensuring that timely client reviews are undertaken, reviewing and strengthening joint funding panel arrangements and developing new services and pathways.

- Learning disability placements costs continue to grow in some boroughs, with an increase in the complexity of care packages being seen. Mitigating actions include reviewing LD cost per case activity across health and care to understand care package costs, planning for future patient discharges to agree funding approaches and developing new services to prevent admissions.

- 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 a forecast of £3.5m 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.

15. Summary MHIS Position – Month 10 (January) 2024/25

NHS South East London

Mental Health Spend By Category	Category	Total Mental Health Plan 31/03/2025 Year Ending £'000	Mental Health - NHS Actual 31/01/2025 YTD £'000	Mental Health - Non-NHS Actual 31/01/2025 YTD £'000	Total Mental Health Actual 31/01/2025 YTD £'000	Mental Health - NHS Forecast 31/03/2025 Year Ending £'000	Mental Health - Non-NHS Forecast 31/03/2025 Year Ending £'000	Total Mental Health Forecast 31/03/2025 Year Ending £'000	Total Mental Health Variance 31/03/2025 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	45,046	33,769	3,737	37,506	40,523	4,485	45,008	38
Children & Young People's Eating Disorders	2	2,841	2,368	0	2,368	2,841	0	2,841	0
Perinatal Mental Health (Community)	3	9,749	8,124	0	8,124	9,749	0	9,749	0
NHS Talking Therapies, for anxiety and depression	4	35,799	24,573	5,651	30,224	29,487	6,781	36,268	(469)
A and E and Ward Liaison mental health services (adult and older adult)	5	19,376	16,147	0	16,147	19,376	0	19,376	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	13,205	11,004	0	11,004	13,205	0	13,205	0
Adult community-based mental health crisis care (adult and older adult)	7	35,639	29,571	363	29,934	35,485	436	35,921	(282)
Ambulance response services	8	1,173	978	0	978	1,173	0	1,173	0
Community A – community services that are not bed-based / not placements	9a	122,258	92,543	8,311	100,854	111,051	9,974	121,025	1,233
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	25,758	12,419	8,344	20,763	14,902	10,044	24,946	812
Mental Health Placements in Hospitals	20	4,454	2,774	976	3,750	3,329	1,196	4,525	(71)
Mental Health Act	10	6,189	0	5,300	5,300	0	6,471	6,471	(282)
SMI Physical health checks	11	865	580	99	679	696	119	815	50
Suicide Prevention	12	0	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	128,232	107,146	0	107,146	128,575	0	128,575	(343)
Adult and older adult acute mental health out of area placements	14	9,762	7,813	83	7,896	9,376	102	9,478	284
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**460,346**	**349,809**	**32,864**	**382,673**	**419,768**	**39,608**	**459,376**	**970**
Mental health prescribing	16	9,190	0	9,239	9,239	0	11,087	11,087	(1,897)
Mental health in continuing care (CHC)	17	242	0	242	242	0	290	290	(48)
Sub-total - MHIS (inc CHC, Prescribing)		**469,778**	**349,809**	**42,345**	**392,154**	**419,768**	**50,985**	**470,753**	**(975)**
Learning Disability	18a	16,917	12,876	2,472	15,348	15,451	3,012	18,463	(1,546)
Autism	18b	3,837	2,431	86	2,517	2,917	105	3,022	815
Learning Disability & Autism - not separately identified	18c	48,399	4,025	38,994	43,019	4,830	46,936	51,766	(3,367)
Sub-total - LD&A (not included in MHIS)		**69,153**	**19,332**	**41,552**	**60,884**	**23,198**	**50,053**	**73,251**	**(4,098)**
Dementia	19	14,936	11,025	1,432	12,457	13,230	1,719	14,949	(13)
Sub-total - Dementia (not included in MHIS)		**14,936**	**11,025**	**1,432**	**12,457**	**13,230**	**1,719**	**14,949**	**(13)**
Total - Mental Health Services		**553,867**	**380,166**	**85,329**	**465,495**	**456,196**	**102,757**	**558,953**	**(5,086)**

15. Summary MHIS Position M10 (January) 2024/25 - by budget area

NHS South East London

Mental Health Investment Standard (MHIS) position by budget area M10 2024/25		Year to Date position for the ten months ended 31 January 2025						Forecast Outturn position for the financial year ended 31 March 2025					
		Year To Date	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/under	Annual Plan	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/under
Mental Health Investment Standard Categories:	**Category**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Children & Young People's Mental Health (excluding LD)	1	37,539	33,769	3,737		37,506	33	45,046	40,523	4,485	0	45,008	38
Children & Young People's Eating Disorders	2	2,368	2,368	0		2,368	0	2,841	2,841	0	0	2,841	0
Perinatal Mental Health (Community)	3	8,124	8,124	0		8,124	0	9,749	9,749	0	0	9,749	0
Improved access to psychological therapies (adult and older adult)	4	29,833	24,573	5,651		30,224	(391)	35,799	29,487	6,781	0	36,268	(469)
A and E and Ward Liaison mental health services (adult and older adult)	5	16,147	16,147	0		16,147	0	19,376	19,376	0	0	19,376	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	11,004	11,004	0		11,004	0	13,205	13,205	0	0	13,205	0
Adult community-based mental health crisis care (adult and older adult)	7	29,700	29,571	363		29,934	(234)	35,639	35,485	436	0	35,921	(282)
Ambulance response services	8	978	978	0		978	0	1,173	1,173	0	0	1,173	0
Community A – community services that are not bed-based / not placements	9a	101,882	92,543	8,311		100,854	1,028	122,258	111,051	9,974	0	121,025	1,233
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	21,465	12,419	8,344		20,763	702	25,758	14,902	10,044	0	24,946	812
Mental Health Placements in Hospitals	20	3,712	2,774	976		3,750	(38)	4,454	3,329	1,196	0	4,525	(71)
Mental Health Act	10	5,158	0	5,300		5,300	(142)	6,189	0	6,471	0	6,471	(282)
SMI Physical health checks	11	721	580	99		679	42	865	696	119	0	815	50
Suicide Prevention	12	0	0	0		0	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	106,860	107,146	0		107,146	(286)	128,232	128,575	0	0	128,575	(343)
Adult and older adult acute mental health out of area placements	14	8,135	7,813	83		7,896	239	9,762	9,376	102	0	9,478	284
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**383,625**	**349,809**	**32,864**	**0**	**382,673**	**952**	**460,346**	**419,768**	**39,608**	**0**	**459,376**	**970**
Other Mental Health Services:													
Mental health prescribing	16	7,658	0	0	9,239	9,239	(1,581)	9,190	0	0	11,087	11,087	(1,897)
Mental health continuing health care (CHC)	17	202	0	0	242	242	(40)	242	0	0	290	290	(48)
Sub-total - MHIS (inc. CHC and prescribing)		**391,485**	**349,809**	**32,864**	**9,481**	**392,154**	**(669)**	**469,778**	**419,768**	**39,608**	**11,377**	**470,753**	**(975)**
Learning Disability	18a	14,097	12,876	2,472	0	15,348	(1,251)	16,917	15,451	3,012	0	18,463	(1,546)
Autism	18b	3,198	2,431	86	0	2,517	681	3,837	2,917	105	0	3,022	815
Learning Disability & Autism - not separately identified	18c	40,333	4,025	10,365	28,629	43,019	(2,686)	48,399	4,830	12,617	34,318	51,765	(3,366)
Learning Disability & Autism (LD&A) (not included in MHIS) - total		**57,628**	**19,332**	**12,923**	**28,629**	**60,884**	**(3,256)**	**69,153**	**23,198**	**15,734**	**34,318**	**73,250**	**(4,097)**
Dementia	19	12,447	11,025	1,037	395	12,457	(10)	14,936	13,230	1,245	474	14,949	(13)
Sub-total - LD&A & Dementia (not included in MHIS)		**70,075**	**30,357**	**13,960**	**29,024**	**73,341**	**(3,266)**	**84,089**	**36,428**	**16,979**	**34,792**	**88,199**	**(4,110)**
Total Mental Health Spend - excludes ADHD		**461,560**	**380,166**	**46,824**	**38,505**	**465,495**	**(3,935)**	**553,867**	**456,196**	**56,587**	**46,169**	**558,952**	**(5,085)**

- Approximately 89% of MHIS eligible (excluding LDA and Dementia) spend is delivered through SEL wide contracts, the majority of which is with Oxleas and SLaM
- The remaining spend is in borough budgets including voluntary sector contracts and cost per case placements, mental health prescribing and mental health continuing health care net of physical healthcare costs.
- Other LDA spend includes LD continuing health care costs

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	4,170	4,150	20		5,004	4,996	8
Community Health Services	18,806	18,548	259		22,567	22,321	246
Mental Health Services	8,883	8,829	54		10,660	10,564	96
Continuing Care Services	21,782	21,631	151		26,139	25,976	163
Prescribing	31,328	31,910	(582)		37,448	37,952	(504)
Other Primary Care Services	2,814	2,814	-		3,377	3,377	0
Other Programme Services	999	999	0		1,199	1,199	0
Delegated Primary Care Services	33,452	33,452	-		44,612	44,612	-
Corporate Budgets	2,527	2,319	209		3,037	2,830	207
Total	**124,763**	**124,652**	**111**		**154,043**	**153,827**	**216**

- At Month 10 (January 2025) the borough is reporting an underspend of £111k year to date and a forecast underspend of £216k at year end.

- Prescribing reports an overspend of £582k year to date and £504k forecast outturn overspend. Prescribing data is provided two months in arrears; therefore, the year-to-date (YTD) position includes an estimate for this period. The primary driver for the overspend is significant growth in medicines aimed at preventing complications and optimise the management of long-term conditions. The impact of the efficiency and recovery plans is expected to decelerate the prescribing spend run rate for the remainder of the financial year. Close monitoring will continue as prescribing is a key risk area for the borough financial position.

- CHC reports a YTD underspend of £151k and forecast outturn of £163k underspend, this is a favourable movement of £94k in the forecast outturn, which has resulted from a decrease in clients. The overall underspend in continuing care is due to the implementation of efficiency plans, particularly in CHC reviews, personal health budget refunds and improved payment practices with CHC providers. Monitoring will continue due to the inherent volatility of the service and the potential for retrospective claims.

- Community Health Services is reporting an underspend of £259k year to date and £246k forecast outturn due to efficiency delivery within various contracts.

- Mental Health Services is reporting an underspend of £54k year to date and £96k forecast outturn. This is an adverse movement of £116k in the forecast outturn, this is primarily driven by an increase in referrals for ADHD and ASD services.

- Corporate budgets report a £207k forecast underspend due to vacancies through out the year which are now mostly filled.

Appendix 2 – Bromley

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	6,591	6,432	159	7,909	7,718	191
Community Health Services	75,834	75,568	266	91,000	90,681	319
Mental Health Services	12,385	13,100	(715)	14,862	15,803	(941)
Continuing Care Services	22,607	23,141	(534)	27,128	27,706	(578)
Prescribing	42,705	42,534	171	51,047	50,512	535
Other Primary Care Services	1,917	1,917	0	2,301	2,301	(0)
Programme wide projects	-	-	0	-	(112)	112
Delegated Primary Care Services	48,118	48,118	0	64,027	64,027	(0)
Corporate Budgets	2,906	2,508	398	3,480	3,118	362
Total	**213,063**	**213,318**	**(255)**	**261,754**	**261,754**	**0**

- The borough is reporting an overspend of £255k at Month 10 and is fore[cast] on at year end.
- The Community budget is £266k underspent year to date and the forecast underspend is £319k. This is due to some of the cost and volume contacts within the community directorate underperforming.
- The Mental Health budget is £715k overspent year to date and is forecasting an overspend of £941k. This is due to the cost per case budget being overspent due to an increase in client numbers. Cost per case clients are reviewed on a regular basis. A new high-cost client is included in the position this month and non-recurrent funding has been received to cover two-thirds of the cost. This represents a significant cost pressure of £900k next year.
- The Continuing Healthcare budget is £534k overspent year to date and the forecast is £578k overspent. The increase in adult CHC and FNC client numbers which is impacting adversely upon the position. There has been an increase in the number of care home providers in the borough which is putting pressure on the budget. The extra capacity in the borough will cause significant financial pressure, in addition to the current overspend, next year.
- The prescribing budget is £171k underspent year to date and is forecasting a £535k underspend at year end. This position represents an improvement in the forecast position compared to last month of £114k. Prescribing information (PPA) is received 2 months in arrears therefore this position is calculated using eight months of data.
- The Corporate budget is £398k underspent year to date due to vacancies and these are expected to be filled soon. The forecast position is £362k underspent as additional non-pay costs are anticipated due to the costs associated with Place Team moving into the new council offices in March 2025.
- The 2024/25 borough savings requirement is £6,426k. The borough is on track to achieve these savings and is reporting full delivery of the target.

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	7,220	6,017	6,058	(42)	7,270	(50)
Community Health Services	39,125	32,604	31,853	752	38,195	930
Mental Health Services	8,593	7,160	7,881	(721)	9,427	(834)
Continuing Care Services	29,220	24,350	24,504	(154)	29,433	(213)
Prescribing	37,290	31,196	32,062	(866)	38,372	(1,082)
Other Primary Care Services	2,283	1,903	1,894	8	2,273	10
Other Programme Services	1,000	833	0	833	0	1,000
Programme Wide Projects	0	0	0	0	0	0
Delegated Primary Care Services	56,945	42,606	42,615	(8)	56,955	(10)
Corporate Budgets	3,503	2,927	2,706	221	3,254	249
Total	**185,179**	**149,597**	**149,573**	**24**	**185,179**	**(0)**

- The overall Greenwich financial position is £24k favourable to the year-to-date plan, with a forecast breakeven position.
- The Prescribing position is £866k adverse to plan. The medicine optimisation team is currently undertaking practice visits to launch the workplan for 2024/25. These visits are now fully completed and anticipating the phased delivery of savings to take traction from Q2 (PPA activity data) to reflect outcome of the practice visits.
- CHC is £154k overspent to date and is attributable to a retrospective increase in children commissioned packages. The underpinning (Care Track) database is being reviewed to ensure accuracy of information reported and is reflecting in the forecast expenditure aligning to plan.
- The £42k overspend within Acute services is higher activity than planned at the Hurley (Bexley) UCC site. The £721k adverse variance in Mental Health is attributable to additional joint funded clients in month (cost per case activity) alongside continued , and sustained pressure from Psych UK reflecting an increasing behavioural change with patients exercising “right to choose”.
- The £833k underspend in Programme Services is the release of contingency funds to mitigate the pressures reported in other service lines.
- Delegated Primary Care is £8k adverse to plan, attributable to growth in population list size. An interim solution has been reached for 2024/25, offsetting the balance with SDF funds (Other Primary Care), albeit, with a recurrent risk of this eventuating into a substantial financial pressure.

Appendix 4 – Lambeth

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	990	729	261	1,188	875	313
Community Health Services	23,525	23,597	(72)	28,230	28,275	(45)
Mental Health Services	19,305	19,704	(399)	23,166	23,819	(653)
Continuing Care Services	28,847	28,499	348	34,616	34,071	545
Prescribing	35,694	35,392	303	42,666	42,588	78
Other Primary Care Services	3,351	3,011	340	4,022	3,614	408
Delegated Primary Care Services	65,971	66,560	(589)	87,212	87,919	(707)
Corporate Budgets	3,264	2,941	323	4,012	3,668	344
Total	**180,948**	**180,434**	**513**	**225,112**	**224,829**	**283**

- The borough is reporting an overall £513k year to date underspend position and a forecast £283k underspend position at Month 10 (January 2025). The reported forecast position includes £653k overspend on Mental Health Services, £45k overspend on Community Health Services mainly driven by increased cost of the Cardiovascular Diagnostics contract and £707k overspend on Delegated Primary Care Services driven by locum reimbursements, retainer scheme and list size growth, offset by underspends in other budget lines.

- The main underlying key risks within the 2024-25 Lambeth's finance position relate to - Mental Health (including learning disabilities) and Delegated Primary Care Services budgets.

- Mental Health budget year to date overspend is driven by increased ADHD, Section 12 assessments claims, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on savings and efficiencies schemes (including Provider-focused service and model reviews, High-cost joint health funded case reviews, etc. to manage cost.

- Delegated Primary Care Services year to date and forecast overspend position is driven by locum reimbursements, retainer scheme and list size growth.

- The CHC team continues to deliver on reducing packages for high-cost (PLD and OP) cases including for 1:1 care, Fast track reviews, PHB clawbacks and reduction, and transfer of out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M10 is 583.

- Prescribing information data is provided two months in arrears by the NHS Business Services Authority (previously PPA - Prescription Pricing Authority). The borough is reporting a YTD underspend position of £303k and forecast £78k underspend at month 10 (January 2025) based on eight months actual data. The borough Medicines Optimisation team saving initiatives via local improvement schemes include undertaking visits to outlier practices, working with community pharmacy to reduce waste and over-ordering, etc. This is being linked with the wider SEL work being undertaken.

- The 2024/25 borough minimum savings requirement is £3.9m and has a savings plan of £5.2m. In addition to the embedded efficiency (£2.3m) as part of the budget setting process, the borough has saving plans for both Continuing Healthcare (£1.4m) and Prescribing (£1.4m) budgets. Year to date delivery at M10 is £1.4m above plan due to plan profile which differs from actual delivery profile. The forecast delivery is £0.9m above plan.

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	1,102	672	430	1,322	783	540
Community Health Services	24,453	23,127	1,326	29,343	27,712	1,631
Mental Health Services	6,413	6,412	1	7,696	7,629	66
Continuing Care Services	19,213	22,170	(2,956)	23,056	26,609	(3,553)
Prescribing	35,629	36,908	(1,279)	42,591	44,323	(1,733)
Prescribing Reserves	0	0	0	0	0	0
Other Primary Care Services	1,981	1,426	555	2,377	1,711	666
Other Programme Services	2,795	1,031	1,764	3,354	1,239	2,115
Delegated Primary Care Services	49,194	49,034	160	65,419	65,227	192
Corporate Budgets	2,624	2,538	86	3,146	3,072	74
Total	**143,404**	**143,318**	**86**	**178,305**	**178,305**	**(0)**

- At month 10, the borough is reporting an underspend year to date (YTD) of £86k (Month 9 underspend £176k) but is retaining a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing.
- CHC shows a material overspend YTD of £2,956k and FOT of £3,553k (Month 9 £3,572k) (outturn 2023/24 £3,638k). The position is driven predominantly by the full year effect of activity pressures seen in the second half of last year, a significant element relating to LD clients.
- The material improvement in forecast outturn for CHC reflects the financial recovery work undertaken in Lewisham including weekly recovery meetings of the Lewisham CHC team to try to mitigate the financial position, focussing on conducting client reviews and price negotiation.
- Prescribing shows an overspend YTD of £1,279k and FOT £1,733k (Month 9 £1,860k). This compares to a risk assessed forecast overspend of £2,737k set out by the Lewisham Borough at the start of the current financial year.
- The overspend is mainly caused by increased costs relating to appliances, central nervous system and Endocrine system prescribing costs. The improved position at month 10 reflects the outcomes of management actions taken as set out in previous reports.
- The Lewisham Borough is taking every measure possible to reduce the forecast overspends on CHC and prescribing and has also identified other non-recurrent mitigations to help ensure a breakeven position is achieved at the year end. At month 10 the YTD position continues to show an underspend.
- The borough 4% efficiency target is £3,576k, is fully identified and forecast to deliver in full, but has been insufficient on its own to mitigate the scale of financial pressures faced by the borough, and material additional mitigations have been implemented.

Appendix 6 – Southwark

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	71	74	(3)	85	89	(4)
Community Health Services	30,228	29,410	819	36,274	35,080	1,194
Mental Health Services	8,547	9,647	(1,100)	10,257	11,759	(1,502)
Continuing Care Services	16,467	15,861	606	19,760	18,968	792
Prescribing	29,374	30,118	(744)	35,112	36,112	(999)
Other Primary Care Services	1,130	1,146	(16)	1,356	1,375	(19)
Other Programme Services	664	-	664	796	-	796
Programme Wide Projects	216	215	0	259	259	-
Delegated Primary Care Services	52,854	52,996	(143)	69,999	70,170	(171)
Corporate Budgets	2,838	2,632	207	3,480	3,287	193
Total FOT	142,389	142,100	289	177,380	177,100	280

- The borough is reporting a YTD underspend of £289k and forecast outturn underspend of £280k as at the end of January 25. Key areas of risk continue to be mental health, prescribing , delegated primary care with underspends in continuing care, community services and corporate budgets absorbing some of overspends.

- For mental health we are reporting a forecast overspend of £1.5m as at month 10. This has deteriorated from month 9 by £139k. This is driven mainly by overspends in Right to Choose adult ADHD/Autism pathways (£363k) and £1,025k on placements. Placements costs for Learning disability continues to be a cost pressures. There is a risk of increased pressure in tri-partite Children and Young People mental health costs. Our expenditure on mental health placements continues to increase. The borough has been reviewing placements spend as part of its recovery plan for 2024/25.

- For Prescribing the borough is reporting a year to date overspend of £744k and forecast overspends of £999k at month 10. This is a slight improvement from month 9. The rate of increase in overspend month on month is reducing. Most of the saving schemes were expected to take effect from September and appears to be having impact. There is significant growth in medicines to prevent and optimise the management of long-term conditions. The Medicines Ops team continue to monitor prescribing spend and prioritise elements of medicines optimisation in the Prescribing Improvement Scheme (PIS) to deliver medicines value.

- Most of the budgets in community services are breakeven due to contracts, however we are showing an overspend in our integrated equipment contract of £242k due to increase in activity and costs.

- Corporate budgets are forecast to underspend by £193k as at month 10 due to vacancies resulting from the MCR process. All the vacancies have now been filled and the monthly spend in Corporate budgets is increasing which is reflected in the forecast position.

- For continuing care budgets, we are reporting a forecast underspend of £792k which is a slight improvement from month 9.

- Delegated Primary Care forecast overspend has improved this month and our forecast overspend is £171k. This position is after non recurrent solutions (£487k) have been identified to manage some of this risk for 24/25. The borough is undertaking a review to identify recurrent solutions to manage this deficit and risks for 25/26.

- The borough is forecasting an overall underspend of £280k and has had to implement some non-recurrent solutions in order to mitigate cost pressures in prescribing, delegated primary care and mental health. Growth in community services has been restricted to manage the overall position. The borough has an underlying deficit position, and a series of financial recovery meetings have been held by Place Executive lead focused on opportunities and recurrent savings proposals to support its underlying position and minimise the risk going into 2025/26.

- Borough has an efficiency target of 4% which on applicable budgets amounts to £3.3m. A savings plan of £3.7m has been identified. Within this figure prescribing savings total £1.1m and are phased to deliver after quarter 1. As at month 10 we are showing over delivery of prescribing savings and under delivery of mental health savings. The borough is reporting year to date actual savings in line with plan. Forecast savings for the year is slightly ahead (£213k) of plan of £3.7m.

NHS
South East London

Appendix B

SEL ICS Financial Highlights

Month 10 2024/25

Month 10 Headlines

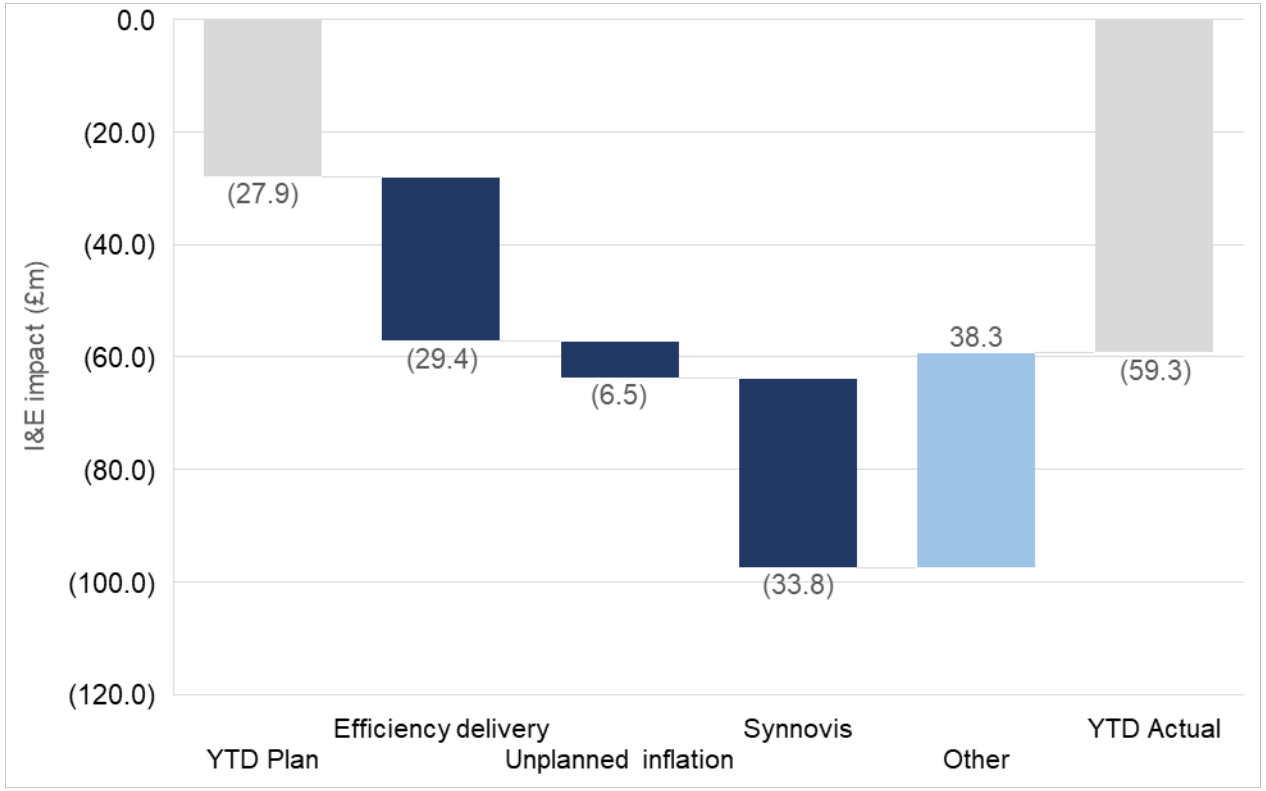
- At month 10 the system is forecasting to deliver breakeven, in line with the plan.
- The ICB is forecasting a £39.0m surplus, offset by a forecast (£39m) deficit in providers. The ICB surplus includes £33.3m of improvement that will be delivered by providers but has been held, to date, in the ICB for planning purposes.
- For month 10 SEL ICS is reporting a YTD deficit of (£59.3m), £31.3m adverse to plan. The main drivers are the impact of the Synnovis cyber-attack (£33.8m), and slippage in efficiency programmes (£29.4m).
- Details of these key drivers are shown on the following slides.

Analysis of month 10 system YTD position

At month 10 SEL ICS is reporting a YTD deficit of (£59.3m), £31.3m adverse to plan. The main drivers are:

- **The Synnovis cyber-attack incident is reported to have an adverse impact on the I&E of £33.8m;** The biggest impact is on the loss of income due to the impact on activity. This is marginally offset by a reduction in pathology related costs.
- The **under-delivery of the efficiency programme is a driver of £29.4m of the variance**.
- **Inflationary pressure of £6.5m YTD** related to the pay award.
- Offsetting favourable variances are the most significant elements of the remaining difference. **These are mainly non-recurrent prior year benefits and non-recurrent underspends**.

Drivers of month 10 variance to plan



Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 13
Enclosure 10

Title:	**Primary Care Group**
Meeting Date:	27 March 2025
Author:	Chima Olugh, Neighbourhood Development Manager
Executive Lead:	Ceri Jacob

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 at the February meeting of the Primary care Group.	Update / Information	X
		Discussion	
		Decision	

Summary of main points:

The following items were discussed at the February 2025 Primary Care Group meeting:

1. Access - Modern General Practice

The Delivery plan for recovering access to primary care published in May 2023 set out two central aims to improve patient experience of access:
a) to tackle the 8am rush and reduce the number of people struggling to contact their practice and
b) for patients to know on the day they contact their practice how their request will be managed.

To achieve these aims and support the transition to a modern general practice model, the plan sets out support, funding and other actions that would be put in place to help practices to move to a modern general practice access model over a two year period, 2023/24 and 2024/25.

The Transition and Transformation Funding allocation for South East London was £2.88 million over the 2 years. The total borough allocation for this funding in Lewisham was £465,000 over 2 years.

All practices are required to make the transition to the modern general practice access model by March 2025. All Lewisham practices have confirmed full transition.

The Group will continue to monitor improvements in General Practice access.

2. Transformation - 2024/25 GP Practice Resilience Programme Report

The GP Practice Resilience programme is designed to help vulnerable practices who may be struggling to cope with current workload pressures and build sustainability now and in the future.

NHS England provides a Service Development Fund each year for ICBs, as additional programme funding on top of ICB baselines.

Lewisham was allocated £30,000.00 to be invested in initiatives that support practices and primary care networks to deliver high quality primary care services.

The Primary Care Group was asked to approve the disbursement of £23,000.00 of the GP Practice resilience funding to the selected practices.

3. Contractual

a) PMS Premium 25/26 Commissioning Intentions

- The PMS Premium is a locally commissioned service which enables practices to provide key services that are additional to the General Medical Services in the core national GP Contract.
- The ICB suggested an amendment to the Multi-disciplinary Team Meetings service area of the Premium with a renewed focus on prevention and admission avoidance and as a result, the ICB will proactively identify people at the highest risk of hospital admission for discussion at practice Multi-disciplinary Team Meetings.
- The Primary Care Group was asked to approve the 2025/26 PMS Premium Commissioning Intentions.

b) Lewisham Care Home practice PCN allocation

- The Lewisham Care Home APMS Practice went live on the 1st April 2024 following a competitive procurement process. The provider of the practice is One Health Lewisham, the GP Federation in Lewisham.
- All practices have the right to join a Primary Care Network (PCN) and there is a national NHS England expectation of 100% geographical coverage.
- Following formal approach to all 6 Lewisham PCNs by the Lewisham Care Home APMS Practice, none agreed to accept the Practice as a member. As such, the ICB proposed to “allocate” the Lewisham Care Home APMS Practice to a PCN.
- The Primary Care Group was asked to approve the formal allocation of the Lewisham Care Home APMS Practice to North Lewisham PCN.

c) One Care Lewisham Practice Marvels Lane Estates Business Case

	▪ Commissioners asked to vary the contract to support reimbursement of estates rental costs related to back office functions in the same way as is the case for other general practice contracts. This is to support the viability of the practice and contract and has become a live issue as previously estates were available to the practice at no cost with is no longer the case. ▪ The Primary Care Group was asked to approve a retrospective contract variation to the Lewisham Care Home Practice to allow for rent reimbursement for back office space and also rent reimbursement for the practice's occupation of the Marvels Lane Health Centre between 1st April 2024 and 31st March 2025. d) ICO Health Group Partnership Dispute The Primary Care Group was informed of a GP partnership dispute and the process taken by the ICB to resolve it and confirm the successor to the ICO Health Group GMS contract.
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	The PMS Premium Commissioning Intentions have been endorsed by the SEL Lewisham Local Medical Committee.
Recommendation:	The Lewisham Local Care Partners Strategic Board is asked to note the report.	

1. Access - Modern General Practice

The Delivery plan for recovering access to primary care which was published in May 2023 sets out two central aims to improve patient experience of access:
a) to tackle the 8am rush and reduce the number of people struggling to contact their practice and
b) for patients to know on the day they contact their practice how their request will be managed.

To achieve these aims and support the transition to a modern general practice model, the plan sets out support, funding (transition cover and transformation support funding, an average of £13,500 per practice) and other actions that would be put in place to help practices to move to a modern general practice access model over a two year period, 2023/24 and 2024/25.

The Transition and Transformation Funding allocation for South East London was £2.88 million over the 2 years. The total borough allocation for this funding in Lewisham was £465,000 over 2 years.

All practices are required to make the transition to the modern general practice access model by March 2025.

In order to transition to a modern general practice access model practices needed to implement the following elements in table 1 below.

Table 1:

Modern General Practice Requirement	Components that need to be in place
Better digital telephony	Digital telephony solution implemented, including call back functionality.
Simpler online requests	Online consultation is available for patients to make administrative and clinical requests at least for the duration of practice core hours.
Faster navigation, assessment and response	Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.

A complete transition to the modern general practice access model will enable practices to be better able to see and understand expressed demand and all current capacity; reduce avoidable appointments and allocate capacity equitably and according to need; and make full use of the multi-professional team and improve the working environment for staff, as well as improve access and experience for patients.

Local approach

The total borough allocation for this funding in Lewisham was £465,000 over the 2 years.

The ICB is committed to ensure the funding is fully invested to support General Practice and agreed that the funding be allocated based on a first instalment as an equal pump-priming investment (£5000 per practice) and further instalments based on practice weighted list sizes.

To be eligible to receive the £5000 pump priming monies in 23/24, practices had to sign a Memorandum Of Understanding (MOU) which confirmed their commitment to move to the modern general practice

operating model and outline their plan and timelines to do so with further funding released on evidence of delivery against plans. Lewisham disbursed a total of £220,688.15 in 2023/24.

The ICB has continued to work with practices to fully embed the changes that enable the Modern general practice access model.

In December 2024, to assure itself that all practices had transitioned to the modern general practice access model, and facilitate the release of the remaining allocations, the ICB asked all practices to complete and submit a self-declaration to confirm full transition.

Following receipt of self-declarations from all practices the remaining £246,000 was disbursed in February 2025.

Some examples of what practices have done to demonstrate they have implemented the modern general practice access model include:

- Effective use of Cloud Based Telephony; call queuing, call-back and other functionalities.
- Implementation and embedding of a centralised call handling hub with increased call handling capability.
- Increased Face to Face capacity where necessary.
- Ensuring reception staff have completed care navigation training.
- Data analysis to map demand and allocate resources accordingly.
- Adoption of effective total triage systems to ensure patients are seen at the right place, by the right person, first time.

More work is needed to engage with the public to explain the modern general practice access model of total triage as the general expectation is still of booking face to face appointments with a GP.

Appendix A outlines the overall transition cover and transformation support funding that was available to practices.

2. 2024/25 GP Practice Resilience Programme Report

The **GP Practice Resilience programme** is designed to help vulnerable practices who may be struggling to cope with current workload pressures and build sustainability now and in the future.

NHS England provides a Service Development Fund each year for ICBs, as additional programme funding on top of ICB baselines. Lewisham was allocated £30,000.00.

The funding is invested in initiatives that support practices and primary care networks to deliver high quality primary care, and specifically in delivering the ambitions of the Primary Care Access and Recovery Plan and other primary care improvement programmes.

The Primary Care Group was asked to approve the disbursement of £23,000.00 of the GP Practice resilience funding to the selected practices

The ICB wrote to all practices and invited them to formally apply for resilience funding support by completing and submitting a self-nomination application form. A total of 7 practices submitted self-nomination applications.

i) Wells Park Practice
ii) Amersham Vale Training Practice
iii) Novum Health Partnership

iv) New Cross Health Centre
v) Deptford Medical Centre
vi) The Lewisham Care Partnership
vii) Modality Lewisham

The applications have been assessed and reviewed by the ICB.
The Primary Care Group approved the disbursement of £23,000.00 to 5 practices.
The remaining £7,000.00 will be accrued into the primary care 2025/26 budget.

3. 2025/26 PMS Premium Commissioning Intentions

The Primary Care Group was asked to approve the 2025/26 PMS Premium Commissioning Intentions.

The PMS Premium is a locally commissioned service which enables practices to provide key services that are additional to the General Medical Services in the core national GP Contract.

The PMS Premium services are agreed locally and focuses on priority areas and also aligns with the Lewisham Health and Care Partnership priorities. The investment is worth c £3.2million.

The ICB suggested an amendment to the Multi-disciplinary Team Meetings service area of the Premium with a renewed focus on prevention and admission avoidance and as a result, the ICB will proactively identify people at the highest risk of hospital admission.

The proactive list for practices to consider for their Multi-disciplinary Team Meetings will consist of patients with 3 or more Long-Term Conditions, and a severe frailty score and if over 65 or younger than 65 years with poly pharmacy and in Core20PLUS (deprived, ethnicity, and vulnerable).

The proactive list which will consist of 0.5% of the adult population will be provided to practices to consider for their Multi-disciplinary Team Meetings.

The Primary Care Group approved the 2025/26 PMS Premium Commissioning Intentions.

A detailed list of the 2025/26 PMS Premium Commissioning Intentions can be at appendix B.

4. Lewisham Care Home APMS Practice – PCN allocation

The Primary Care Group was asked to approve the formal allocation of the Lewisham Care Home APMS Practice to North Lewisham Primary Care Network (PCN).

The Lewisham Care Home APMS Practice went live on the 1st April 2024 following a competitive procurement process on a 5+5+5 year contract. The provider of the practice is One Health Lewisham, the GP Federation in Lewisham.

All practices have the right to join a Primary Care Network and there is a national NHSE expectation of 100% geographical coverage - https://www.england.nhs.uk/wp-content/uploads/2019/04/pcn-faqs-000429.pdf

Following formal approach to all 6 Lewisham PCNs by the Lewisham Care Home APMS Practice, none agreed to accept the Practice as a member.

In addition, the contract value for the Lewisham Care Home APMS Practice is dependent on the Care Home Premium payment (£127.20 per bed) which can only be paid to a PCN through PCN membership.

As such, the ICB proposed to “allocate” the Lewisham Care Home APMS Practice to a PCN.

The process that governs this situation can be found in the Network contract DES: Contract specification 2024/25 – PCN requirements and entitlements (full document available here), page 12 onwards.

In accordance with the stated process, the ICB undertook an assessment across all Lewisham PCNs to ascertain the most appropriate PCN to allocate the Practice to.

Factors that were considered included:

- Impact and considerations for the PCN
- Impact and considerations for the Practice
- Location and nature of Lewisham Care homes

Based on the above, North Lewisham PCN was identified by the ICB as the preferred PCN to allocate the Lewisham Care Home APMS Practice to, with the following supporting rationale:

- North Lewisham PCN is already a multi-practice PCN (9 practices) so the addition of another practice would be marginal and represent only a small increase in PCN population size of approx. 1.1%.
- Conversely, the other PCNs have fewer practice members (Aplos 4, Alliance 5, Sevenfields 6) and for the two Lewisham super-practices who are also PCNs in their own right (Modality and The Lewisham Care Partnership) an additional practice would constitute a 100% increase and inevitably complicate their single-organisation structures and governance. In addition, the two super-practices/PCNs do not currently have network agreements as these are not necessary with effectively only one practice member
- As discussed at the Primary Care Group previously, Sevenfields PCN have submitted a request to expel the SEL Special Allocation Scheme practice, which is also provided by One Health Lewisham, as such, allocation to Sevenfields PCN would likely cause further issue/disruption.
- Within the geography of North Lewisham PCN is Manley Court which is the biggest care home in Lewisham. Patients from Manely Court have already registered with the Lewisham Care Home APMS Practice.

As per the national guidance, the ICB engaged both the local and London-wide Local Medical Committee on this matter and the proposed approach and has taken their views into account.

Engagement was also undertaken with North Lewisham PCN on this proposal and the following feedback was received:

- Assurances were sought around the expectations for the Practice and PCN regarding the Network Contract DES specifications and requirements including (but not limited to) Enhanced Access, Investment and Impact Fund (IIF) and the Additional Roles Reimbursement Scheme (ARRS) and also any local programmes/schemes associated with PCN delivery.
- Clinical Oversight/responsibility for care home patients was queried and it was confirmed that this would remain with the practice and not the PCN. In addition, it was also confirmed that there are no anticipated clinical implications to the PCN in terms of the management of care home patients as this will all be picked up directly by the care home practice.
- Clarity was sought around the practice's interaction with the PCN i.e. responsibilities, liabilities and governance including management of any real/perceived conflicts of interest and board representation etc. These matters can be clarified as part of the updated Network agreement.
- It was acknowledged that there will be a financial benefit to the PCN associated with the increased list size and payments linked to this which will need to be quantified, and agreement reached between parties as to how this might be utilised

The Primary Care Group approved the formal allocation of the Lewisham Care Home APMS Practice to North Lewisham PCN.

Next Steps

- North Lewisham PCN and the Lewisham Care Home APMS Practice have been informed of the official decision and ultimately the *PCN ODS Change Instruction Notice* will be completed to formalise this.
- Further work will be undertaken to confirm the expectations for the Practice and PCN regarding the Network Contract DES specifications and requirements including (but not limited to) Enhanced Access, IIF and the ARRS. This will also extend to any local programmes/schemes associated with PCN delivery.
- The ICB will seek to mitigate any negative impacts for both the PCN and practice where possible, especially in regard to any financial impacts so as not to destabilise either organisation.
- The ICB is keen to ensure the allocation is enacted by the end of the financial year (March 2025) in particular so that the Care Home Premium payment for 2024/25 can be paid to the Lewisham Care Home APMS Practice to avoid any potential destabilisation.
- As agreed with the LMC, the ICB would be open to potentially reviewing the allocation decision in future if material changes were to be made to PCN boundaries/set up, which may open up alternative solutions and indeed changes to PCN membership can also be made outside of the allocation process by mutual agreement of PCNs and practices and agreement by the ICB.

5. Lewisham Care Home Practice Marvels Lane Estates Business Case

The Primary Care Group was asked to approve a retrospective contract variation to the Lewisham Care Home APMS Practice to allow for rent reimbursement for back office space and rent reimbursement for the practice's occupation of the Marvels Lane Health Centre between 1st April 2024 and 31st March 2025.

The initial APMS contract that was issued included the following clause regarding estates:

i) The Contractor shall have in place premises infrastructure for call handling during Core Hours, physical records storage and administrative procedures. The provider will identify the sites from which these functions will be managed.

ii) For the avoidance of doubt, any costs associated with the premises specified in paragraph 1 above shall be managed by the contractor within the Core Services Price as defined in Schedule 4 of this contract.

Commissioners asked to vary the contract to support reimbursement of estates rental costs related to back office functions in the same way as is the case for other general practice contracts. This is to support the viability of the practice and contract and has become a live issue as previously estates were available to the practice at no cost with is no longer the case.

It was proposed to back date the variation to the 1st April 2024 when the practice and contract become operational as estates costs that are now payable date back to this period.

As detailed in the business case at appendix C, the Lewisham Care Home APMS Practice is seeking reimbursement of rental costs at Marvels Lane for the period 1/4/24 to 31/3/25 at £29,357.

On the basis that the above retrospective contract variation is approved, the rent reimbursement would be in accordance with the NHS Premises Directions 2024.

As described in the business case, One Health Lewisham provide two other APMS General Practice contracts that have also been operating back office functions from the Marvels Lane site. For simplicity, this approval relates solely to the Lewisham Care Home APMS Practice, but the wider context should be noted.

This approval covers the period 1/4/24 to 31/3/25 only, as the practice has given notice to vacate Marvels Lane after this time.

There is an associated business case that will address the practice's ongoing estates requirements from the 1st April 2025 that will need to be considered by the Primary Care Group.

The Primary Care Group approved the retrospective contract variation to the Lewisham Care Home APMS Practice to allow for rent reimbursement for back office space and rent reimbursement for the practice's occupation of the Marvels Lane Health Centre between 1st April 2024 and 31st March 2025.

6. ICO Health Group Partnership Dispute

The Primary Care Group was informed of a GP partnership dispute and the process taken by the ICB to resolve it and confirm the successor to the GMS contract.

- When a General Medical Services (GMS) contract is made with a partnership, it is made with the partnership as from time to time constituted and will continue regardless of the retirement, death or expulsion of partners or the addition of partners.

- Unless the commissioner has grounds to terminate the contract, it will continue indefinitely, irrespective of changes in the partners, as long as all the partners at any one time are eligible to be contractors under the contract and satisfy the conditions in the GMS regulations.

- The ICB holds a GMS contract with a partnership, under the name of ICO Health Group.

- The ICO Health Group is a GP practice which had 3 partners.

- On 5 September 2024 the ICB was notified of a change in composition of the ICO Health Group partnership. There was a dissolution of the Original Partnership, and a New Partnership formed which constituted 2 of the original 3 GP partners.

- One GP partner asserted to the ICB that there had been no dissolution of, or change to, the constitution of the Original Partnership.

- The ICB had to intervene and facilitate the process to identify a successor to the GMS contract from 5 September 2024.

- Th ICB decided to seek legal advice when it became clear that there was no formal partnership arrangement in place indicating a *partnership at will* under the Partnership Act.

- The legal advice, based on the Bhat v NHS Litigation Authority case, was to follow the guidance in the newly introduced Annex 6C - *Managing circumstances where a partnership dissolves with no clear successor* - of the Primary Medical Services Policy and Guidance Manual to identify the partnership which held the GMS contract.

- An evaluation panel was set up to consider the applications and confirm a successor to the GMS contract.
- The ICB progressed to Step 3 of the Annex 6C process to determine which parties of the dissolved partnership should be confirmed as successor for the GMS contract. Step 3 included a fair and transparent procedure, and through the application of pre-agreed criteria and questions.

- The evaluation panel carefully considered the submissions from both parties, and with legal support, concluded that there was a dissolution of the Original Partnership on 5 September 2024.

- The panel decision was that the successor to the GMS contract was the New Partnership nominated by and comprised of the 2 GP partners. The panel considered this outcome to be the only logical conclusion based on the evidence presented.

- The outcome of the process was formally communicated to all parties, on 16 December 2024, who were given 28 days to inform the ICB if they planned to challenge the outcome.

- Both parties accepted the outcome of the process, that the Original ICO Health Group Partnership dissolved on 5 September 2024.

- Following formal written acceptance of the outcome, the ICB issued a Contract Variation which was completed and signed by all parties.

- While the dispute was ongoing, Primary Medical Services were delivered by the 2 GP partners and their team to ensure there was no disruption to patient services.

Appendix A - Overall transition cover and transformation support funding available to practices.

Practice Name	Practice Normalised Weighted list size from GSUM 1 Jan 23	Fixed £5k Per Practice pump priming monies	Additional Payment Based on Normalised Weighted List Size	Total
SYDENHAM GREEN GROUP PRACTICE	15,416	£ 5,000.00	£ 14,847.29	£ 19,847.29
VALE MEDICAL CENTRE	13,409	£ 5,000.00	£ 12,913.59	£ 17,913.59
WELLS PARK PRACTICE	11,691	£ 5,000.00	£ 11,259.23	£ 16,259.23
WOOLSTONE MEDICAL CENTRE	7,947	£ 5,000.00	£ 7,653.31	£ 12,653.31
BURNT ASH SURGERY	6,512	£ 5,000.00	£ 6,272.09	£ 11,272.09
LEE ROAD SURGERY	12,382	£ 5,000.00	£ 11,925.27	£ 16,925.27
LEWISHAM MEDICAL CENTRE	13,199	£ 5,000.00	£ 12,711.62	£ 17,711.62
NIGHTINGALE SURGERY	5,805	£ 5,000.00	£ 5,590.25	£ 10,590.25
TRIANGLE GROUP PRACTICE	6,825	£ 5,000.00	£ 6,573.49	£ 11,573.49
WOODLANDS HEALTH CENTRE	9,190	£ 5,000.00	£ 8,851.15	£ 13,851.15
THE LEWISHAM CARE PARTNERSHIP	52,869	£ 5,000.00	£ 50,917.15	£ 55,917.15
MODALITY LEWISHAM (ML)	37,434	£ 5,000.00	£ 36,052.13	£ 41,052.13
AMERSHAM VALE TRAINING PRACTICE	14,271	£ 5,000.00	£ 13,744.23	£ 18,744.23
CLIFTON RISE FAMILY PRACTICE	4,843	£ 5,000.00	£ 4,664.46	£ 9,664.46
DEPTFORD MEDICAL CENTRE	3,674	£ 5,000.00	£ 3,538.50	£ 8,538.50
DEPTFORD SURGERY	9,854	£ 5,000.00	£ 9,490.49	£ 14,490.49
GROVE MEDICAL CENTRE	10,964	£ 5,000.00	£ 10,559.22	£ 15,559.22
KINGFISHER MEDICAL CENTRE	14,280	£ 5,000.00	£ 13,753.21	£ 18,753.21
NEW CROSS CENTRE (HURLEY GROUP)	9,723	£ 5,000.00	£ 9,364.15	£ 14,364.15
THE QRP SURGERY	9,483	£ 5,000.00	£ 9,133.09	£ 14,133.09
VESTA ROAD SURGERY	6,754	£ 5,000.00	£ 6,504.83	£ 11,504.83
DOWNHAM FAMILY MEDICAL PRACTICE	6,141	£ 5,000.00	£ 5,914.78	£ 10,914.78
ICO HEALTH GROUP	10,146	£ 5,000.00	£ 9,771.82	£ 14,771.82
NOVUM HEALTH PARTNERSHIP	20,727	£ 5,000.00	£ 19,961.85	£ 24,961.85
OAKVIEW FAMILY PRACTICE	5,393	£ 5,000.00	£ 5,193.65	£ 10,193.65
PARKVIEW SURGERY	7,632	£ 5,000.00	£ 7,350.58	£ 12,350.58
SEL SPECIAL ALLOCATION PRACTICE	185	£ 5,000.00	£ 178.41	£ 5,178.41
TORRIDON ROAD MEDICAL PRACTICE	10,959	£ 5,000.00	£ 10,554.19	£ 15,554.19

Appendix B – 2025/26 PMS Premium Commissioning Intentions

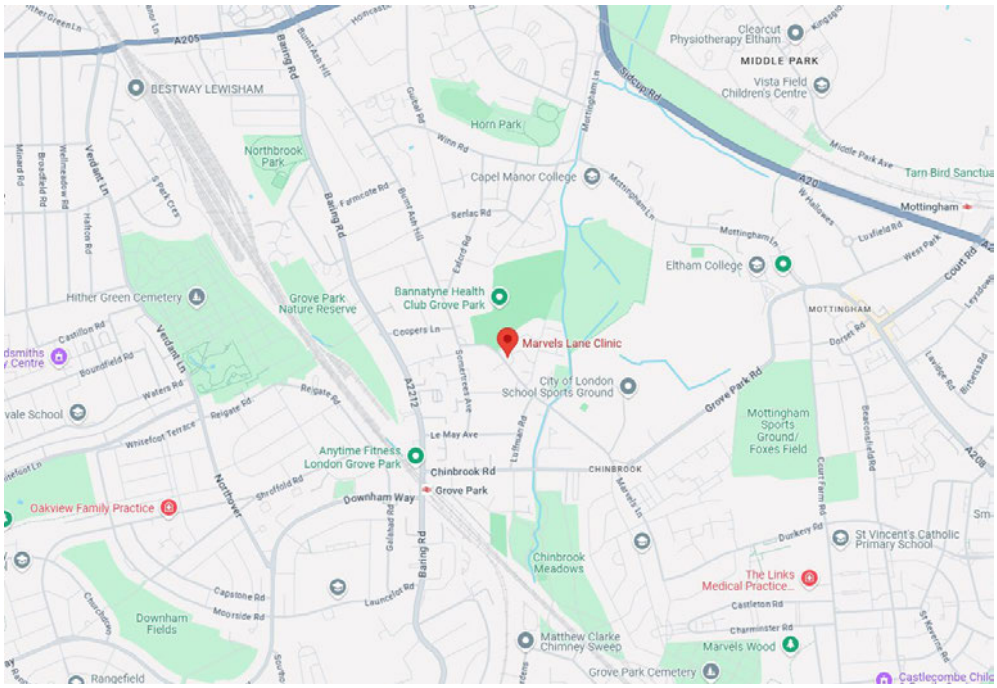
Priority Area	Value (£pwp)	Description
1. End of Life Care	1.00	**Retain and review.** a) Percentage of patients on register = 0.3%. b) Preferred place of death recorded. c) Number of patients with a UCP that died at their preferred place of death. (This will help Improve quality and reduce avoidable admissions). Practices required to carry out an annual self- assessment which the ICB will use to audit outcomes.
2. Risk Profiling & MDMs	2.00	**Retain and review.** ▪ The ICB will provide practices with a proactive list of patients at the highest risk of hospital admission. ▪ The list will be 0.5% of the adult practice population who are complex and high risk. ▪ Practices will be required to consider if the patients are appropriate to discuss and support at the MDMs. ▪ Practices can also include patients who would benefit from a MDM that are not on the proactive list provided by the ICB. *The proactive list will consist of patients with 3 or more Long-Term Conditions, and a severe frailty score if >65yr or <65yr with poly pharmacy and in Core20PLUS (deprived, ethnicity, and vulnerable).*
3. Bowel Cancer Screening	1.00	**Retain and review.** Practices to contact at least 90% of non-responders within 1 month of being notified by the Hub and offer advice and further information about bowel cancer screening including ordering a new kit if necessary. Programme expanded to people aged 50.
4. Childhood Obesity	0.50	**Retain and review.**

		Practices to provide a Child Screening Review, targeting those children 3-5 years old who come to the practice for their pre-school booster. Children will have a weight and height measurement check and have their BMI centile calculated and recorded.
5. Post-operative wound and suture removal	0.75	**Retain and review.** Supports access, convenience, and choice of location for patients. Include information on training and guidance around prescribing in the PMS Premium guidance pack.
6. High Risk Drug Monitoring	0.75	**Retain and amend.** ▪ Patients have their monitoring and/or administration of medication prescribed and completed, as indicated as per the SEL Joint Medicines Formulary and SEL IMOC recommendations. ▪ Any prescribing, monitoring or administration in primary care is to be conducted in accordance with locally agreed guidelines. ▪ Practices to ensure a systematic patient call and recall is in place for any given medication for follow up where needed. i.e. where MHRA alerts or follow-up as needed.
7. Referral Management	1.00	**Retain and review** Practices are expected to have in place initiatives and schemes to manage demand on a sustainable basis. New Advice & Guidance incentive for GPs. No detail yet.
8. Patient Experience	1.11	**Retain and amend.** ▪ Practices are required to review their GPPS results, FFT submissions in addition to any other local intelligence sources. ▪ Practices are required to demonstrate they are engaging with their populations and listening to views discussed.
9. Alcohol Intervention	0.60	**Retain and review.** Patients with diabetes, ischemic heart disease and heart failure to have an AUDIT C.
10. Breast Cancer Screening	1.15	**Retain and review.** Practices are expected to identify and contact at least 80% of women who have not taken up their breast screening invitation within the quarter.

Appendix C - One Health Lewisham – APMS GP Practice

Business Case for the reimbursement of rent at Marvels Lane Clinic for its three GP contracts

November 2024 v4



Contents

Executive Summary – case on a page

One Health Lewisham (OHL) is a GP Federation that covers the whole of Lewisham, and which holds three APMS contracts:

1) SEL Special Allocation Scheme APMS Practice
2) NEL Special Allocation Scheme APMS Practice
3) Lewisham Care Homes APMS Practice

OHL occupies space at Marvels Lane Clinic to deliver these services

Until 1st April 2024 OHL was not charged any rent or rates for its occupation of Marvels Lane Clinic by its landlord Lewisham and Greenwich NHS Trust. Since that date and following the sale of the property to a commercial landlord, OHL is being charged rent.

OHL is seeking reimbursement from SEL ICB for the following commencing on 1st April 2024 :

- Rent at £29,357 per annum

all as provided for in the NHS Premises Directions 2024

OHL are at present not being charged Business Rates by either the local Council or the landlord. We estimate that these would be in the order of £20,000 per annum. OHL is therefore at present not seeking reimbursement of Business Rates by the ICB but will wish to do so if they are charged to them in the future.

OHL is looking at its premises options going forward and will be preparing a more detailed and comprehensive Business Case that it will present to the ICB in due course.

1. Proposal and background

1.1 Background and Purpose

One Health Lewisham (OHL) is a GP Federation that covers the whole of Lewisham and which holds three APMS contracts:

1) SEL Special Allocation Scheme APMS Practice
2) NEL Special Allocation Scheme APMS Practice
3) Lewisham Care Homes APMS Practice

Marvels Lane Clinic provides by far the majority of space occupied by OHL. It delivers clinical services from the premises and it also acts as the back office to its APMS contracts. It has occupied this site since 2018.

For the past few years OHL has been the only occupier at Marvels Lane Clinic and until earlier this year the Clinic was owned by Lewisham & Greenwich NHS Trust (LGT) but it was sold in June 2024 to a private company via auction with little or no prior notice.

OHL did not have a formal, written lease in place with LGT for Marvels Lane but through its occupation had gained certain occupancy rights. OHL instructed solicitors to confirm and protect its property interests with the new owner. See Appendix A. This also places certain obligations on OHL with regards dilapidations if it was to vacate unless the landlord was to demolish and wholly redevelop the site.

Until the time of the sale, OHL had occupied the Marvels Lane Clinic premises at nil cost to itself in respect of both rent and rates but did pay LGT a small service charge payment. This is because LGT did not raise a rent or rates demand to OHL.

The new landlord is now demanding payment of rent from OHL for its occupation of the space at Marvels Lane. This is £29,357 per annum in rent together with a service charge of circa £5,000 per annum. The purpose of this report is to seek SEL ICB reimbursement of this rent to OHL all as provided for in the NHS Premises Directions 2024.

The property at Marvels Lane Clinic suffers considerable backlog maintenance and OHL are fearful that the new landlord will expect OHL to meet a share of the backlog maintenance cost. They are also concerned that the landlord will attempt to increase the level of rent being sought and/or try to ‘force’ the practice out of occupation so as to redevelop the site.

This Business Case only deals with the immediate request by OHL for rent reimbursement at the level being currently sought by the landlord. A further / expanded case will need to be prepared to deal with any potential increase in rent demanded, as well as Business Rates if charged and also to set out what the premises options in the short term to medium term are for OHL if the need arises to vacate Marvels Lane.

1.2 Organisational Overview
1.2.1 Practices Location and Patient List Size

At present OHL delivers its APMS contracts from Marvels Lane Clinic

1.2.2 Current activities

The table below confirms the space occupied at Marvels Lane Clinic by the 3 GP contracts :

OHL CARE HOMES GP SERVICES	MON		TUE		WED		THUR		FRI	
ML clinical space	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OHL CLINICAL ROOM 1	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES	CARE HOMES

		MON		TUE		WED		THUR		FRI	
ML Admin space	DESK	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OPERATIONS HUB	1	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN
	2	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN
	3	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN
	4	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN
	5	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN
RECEPTION	1	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN	CARE HOMES ADMIN

OHL SEL SAS GP SERVICES	MON		TUE		WED		THUR		FRI	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OHL CLINICAL ROOM 2 (no window)	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS
OHL CLINICAL ROOM 3	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS	SEL SAS

		MON		TUE		WED		THUR		FRI	
	DESK	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OPERATIONS HUB	1	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	2	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	3	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	4	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	5	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	6	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
RECEPTION	1	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN	SEL SAS ADMIN
	2	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY	SEL SECURITY

OHL NEL SAS GP SERVICES	MON		TUE		WED		THUR		FRI	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OHL CLINICAL ROOM 4	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS	NEL SAS

		MON		TUE		WED		THUR		FRI	
	DESK	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
OPERATIONS HUB	1	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN
	2	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN
	3	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN
	4	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN
	5	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN
RECEPTION	1	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN	NEL SAS ADMIN

This only deals with core space but in addition there is a need for associated support space such as waiting area, w.c's, staff room, IT and Plant Room as well as circulation. The table below adds the core and support space together to show that the three GP contracts between them use 312m2 of rentable space.

MARVELS LANE CLINIC SCHEDULE OF ACCOMMODATION FOR GP CONTRACTS													
		1	2	3	4								
		Care Home	SEL SAS	SEL SAS	NEL SAS								
Clinical Room No.	m2	1	1	1	1		4	No.at	16	m2		**64**	**m2**
Admin Desk	No.	5	6	6	5				22	No. at			
	m2	5	5	5	5				5	m2		**110**	**m2**
		Shared											
Reception		1	1	1	1		4	No. at	5	m2		**20**	**m2**
Waiting area							16	chairs at	1.5	m2		**24**	**m2**
w/c													
patient	2												
staff	2						4	No. at	3	m2		**12**	**m2**
Staff Room	1								12	m2		**12**	**m2**
Storage	1						1	No. at	4	m2		**4**	**m2**
IT Room	1						1	No. at	8	m2		**8**	**m2**
Plant room	1						1	No. at	6	m2		**6**	**m2**
Circulation							260	m2	at		20%	**52**	**m2**
											TOTAL	**312**	**m2 NIA**
											Excludes wall thicknesses, etc.		

When the rent that is being charged of £29,357 is divided by 312m2 it results in a rent per m2 of £94 per m2 whilst a realistic market rent would be circa £200 per m2. This suggests that a rent of £29,357 per annum is value for money for the space occupied by OHL to deliver its three contracts.

1.3 The Current Problem

The Practice is now being charged rent by the landlord for the space it occupies at Marvels Lane and so needs to secure reimbursement of rent from the ICB (in line with the NHS Premises Directions 2024) as it is not included in its core contract payment.

Additionally, OHL is in a predicament regarding its occupation of Marvels Lane Clinic which is its primary accommodation. The premises condition is not good, security of tenure is relatively weak and occupation costs are potentially going to increase as the rent currently being charged by the landlord is considerably lower than the market rent for the space occupied.

2. Financial Assessment

The following is currently being charged by the landlord:

Rent: £29,357 with no VAT applicable (see Appendix B)

Service Charge: £4,767 inclusive of any VAT

OHL is seeking reimbursement from SEL ICB for :

- Rent at £29,357 per annum

For future reference it is anticipated that the estimated market rent that could be charged to OHL by the landlord is as follows:

RENT		
Gross area say	9100	ft2
	846	m2
say 90% NIA	761	m2
say	£200	per m2
Rent	£152,230	pa
say 40% occupancy	**say £60,800**	**per annum**
		Excluding VAT

It should also be noted that OHL is not receiving a Business Rates demand direct from the Council or via the landlord and so is not incurring this cost at present but may do so in the future.

Appendices:

Appendix A - Letter sent by OHL to agent of new landlord of Marvels Lane Clinic

C/O Mr R Gustein MRICS
Avon Group of Companies
London
N16 6DB

T: 02078221963
E: susan.le-sage@weightmans.com
Office: London (Hallmark)

Our ref: W31513-1/SLe-S/7311

By first class post

July 2024

Dear Mr Gustein

One Health Lewisham - 37 Marvels Lane, Lewisham SE12 9PN ("the Property")

We are instructed by One Health Lewisham in relation to the Property, which is otherwise known as Marvels Lane Surgery.

We understand that you are acting as agent for the current landlord of the Property, Avon Estates (London) Limited ("**the Landlord**"), pursuant to its recent purchase of the Property by auction.

We are informed by our client that the Landlord would like some further information regarding its current tenancy of the Property, in relation to which, we have provided a brief summary below:

1. Our client is tenant of part of the Property only. The tenancy is undocumented.
2. The rent for the Property is paid by the ICO Health Group, acting as agent for our client.
3. The annual rent for the Property is £29,357 per annum, with no VAT payable in relation to the same. This includes an assumed element for insurance in respect of the Property, with reference to paragraph 6.
4. The service charge for the Property is £4,767.00 per annum, with no VAT payable in relation to the same.
5. The Property is used by our client to provide NHS primary care services to the London Boroughs of Lewisham and Greenwich.

With reference to clause 4.1of Form CPSE2, which was enclosed with the seller's legal pack, we understand that your client was fully aware of our client's tenancy prior to completion.

We are told that Coleman Coyle of Upper Street, Islington, are your client's instructed solicitors in this matter, and have therefore written to them upon equal terms, upon equal date.

Please note that all correspondence in respect of the tenancy should be directed to Weightmans LLP by email, to both susan.le-sage@weightmans.com (02078221963) and Edwina.farrell@weightmans.com (020 7822 1926).

Should you have any questions about the contents of this correspondence, we recommend that you seek independent legal advice.
Yours faithfully

Weightmans LLP

Appendix B - Invoice received from new landlord

AVON
ESTATES (LONDON) LIMITED

Invoice

One Health Lewisham Limited
37 Marvels Lane
London
SE12 9PN

Date: 30 Sep 2024
Invoice No: A236375
Tenant Ref: AVO1/MA2/01

Re: Marvels Lane Clinic

From	To	Description	Net	VAT	Gross
1 Apr 2024	31 Mar 2025	Annual Rent Due	29,357.00		29,357.00
1 Apr 2024	31 Mar 2025	Annual Service Charge Due	4,767.00		4,767.00
			34,124.00		34,124.00
			Brought forward arrears		
			Total Due		**£34,124.00**

NOTICE IS HEREBY GIVEN in pursuant to the Landlord and Tenant ACT 1987 Section 47 and Section 48 that all Notices (including Notices in proceedings) may be served upon your landlord:
Avon Estates(London) Ltd Avon House 2 Timberwharf Road London N16 6DB

Telephone: 020 8211 1500 email: management@avonestates.co.uk
Registered in England and Wales - Company Registration No: 03058835
Registered Office: Avon House, 2 Timberwharf Rd, London, N16 6BD

Interest and Costs may be charged on late payment.
Please make cheques payable to: Avon Estates (London) Limited.

"

Remittance Advice

Please Return this remittance advice with full payment to: Avon Estates (London) Ltd

Direct BACS payments can be made to sort code 60-05-37 account number 81468008 payee Avon Estates (London) Limited.Please Include Reference as stated below

Payment Address: Avon Estates (London) Limited, Avon House, 2 Timberwharf Road, London N16 6DB, UK

From: **One Health Lewisham Limited**
Ref: **AVO1/MA2/01**
Property **AVO1/MA2 , Marvels Lane Clinic**

Date of Meeting	Agenda Item	Presenter
6th Jan - Cancelled		
3rd Feb - Online (Extended) Beckie to chair	Good News Stories	ALL
	ED Front Door issues	Jen Cassettari
	Highlight Report: Autism Deep Dive	Dorett Davis & Simon Whitlock
	Highlight Report: MH Community Pilot Update	Kenny Gregory & Lesa Bartlett
	Paws, Older People Update	Sirajul Islam, Integrated Commissioning Manager
	SDIP transformation BC 205/26	Tom Hastings
	Review Risk Register	ALL
	AOB	ALL
3rd March - Online Laura to chair (LW on annual leave)	Outpatients	Tom H
	Lewisham Start for Life Perinatal Mental Health and Parent-Infant Relationship Programme: Evaluation and plan for future investment: BC	SR/SWh
	GP Access	AOS
7th April - Online Beckie to chair	Older Auldts transformation	CM/SI
	LTC	Jonathan
	Updates on each partner	ALL
	SDEC/UCR Update	Amanda / Jack
12th May - Online	Highlight Report: Autism Deep Dive	Dorett Davis & Simon Whitlock/Paul Creech

Place Executive Lead Action Tracker

Commenced - 3rd March 2025

Date of Meeting	Agenda Item	Description	Responsible	Deadline	Update
03/03/2025	(Agenda item 1) Welcome, apologies for absence & minutes/actions of 3rd February 2025 & declarations of interest.	NO attendance from LGT / No council operational			
	(Agenda Item 3) GP Access	for SDUC / ED Redirect element AL to circulate slides			7th April 2025
	(Agenda item 4) Highlight Reports - Enablers	CMS to touch point AA to provide contact for SLaM procurement			7th April 2025
		CMS to touch point with Donna around integrating different databases and potentially linking EMIS as part of that			7th April 2025
	(Agenda item 5) - SDIP transformation BC 2025/26 Update (Action from last meeting)	to bring back the allocations to the April meeting			7th April 2025
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
03/02/2025	(Agenda item 2) Good News Stories	AOS to circulate the PCN videos which was presented at the Lewisham GP Awards once finalised with the PCN clinical directors and mangers in how best to share more Broadley	AOS/LW	7thh April 2025	AOS to touch point with PCN Leads to work how and where to populate the videos
	(Agenda item 4 Highlight Report) Autism	LW to add agenda item onto forward planner for agenda item to come back to a future meeting	LW	12th May 2025	
	(Agenda item 4 Highlight Report) MH Community Pilot Update	Outcomes measures for agenda item needed to be added onto highlight report	KG/AA	7th April 2025	LJ highlighted that there are still issues when it comes to the data on the outcomes on the highlight reports and is encouraging colleagues to assist and to let LJ know of any issues. A Performance session will be scheduled to have a better understanding.
		share very high level of the implementation plan which will set out key dates for when the service will go live and what the key interface will be	KG/AA	7th April 2025	AA to circulate the high level of the implementation plan with LJ
		BB to check with NG in how information is bringing shared with LGT	BB	7th April 2025	
	(Agenda item 4 Highlight Report) Paws Older People update	CM to touch point with Pop Health Team around CGAs high referrals into social care and track that against what they have been referred into and the outcome.	CM/RS	7th April 2025	Meeting scheduled with the Pop Heath Team to confirm which data will be collected going forward in a way of an evaluation with the PAWS Service
	(Agenda item 5) SDIP transformation BC 2025/26	TH to come back to March meeting to provide an update	TH	7th April 2025	
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
06/01/2025		No meeting			
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
02/12/2024	(Agenda item 3) Lewisham Start for Life Perinatal Mental Health and Parent-Infant Relationship Programme: Evaluation and plan for future investment:		SR / SMh & LB to pull together a business case on what the programme has been able to do and potential shortcomings.	3rd May 2025	
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
07/10/2024 - In Person	(Agenda item 2) Highlight Reports	Helen Laing agreed to come back to a future meeting to feedback from Self-referral for Physiotherapy Pilot	LW/HL	12h May 2025	
		Scott Pendleton to come back to a future meeting to share service plan in terms of which services and where they fit.	LW/SP	On going	
		JMc/LJ/BB to touch base in terms of how Respiratory would fit into PEG	JMc/LJ/BB	7th April 2025	
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
		SR agreed to come to a future meeting to give an update in terms of CYP & Adults.	LW/SR	On going	

Date of Meeting	Description	Responsible	Deadline	Update	Completed Date
03/02/2025 - Online	(Agenda Item 6) Risk Register	AOS to touch point with TH and JC around updating the Dermatology Risk	AOS/TH/JC	3rd March 2025	03/03/2025
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
02/12/2024 - Online	UEC / UEC front door building works: Amanda Lloyd & Jen Cassettari. AL highlighted that there will be a new post and going out for advert with the view that potentially the new post will provide support to the wider system	KG/LJ/AL to look at the JD for the new post	3rd February 2025		03/01/2023
04/11/2024 - Online	Was agreed for the Community Pilot project to come back to a future meeting	KG/AA to come back to provide an update	3rd February 2025		03/01/2023
	It was agreed for the two highlighted risks to be added onto the PEG risk register:- - Placement overspend has a financial risk, which has an impact on SLaM, Local Authority and ICB recognising that is doesn't have an impact on all partners but does have an impact on majority of our LCP age partners noting the MH Alliance Committee are in works to secure a plan to mitigate the risk. - ED risk potentially needs to be reviewed in terms of presentation and flow in which has an impact on ICB, Local Authority and the Acute sector recognising been an ongoing risk and with systems in place to mitigate the risks but will have a impact on those that are fit for discharge and wait times in ED.	KG to come back to provide an update in terms of Placement overspend	3rd February 2025		03/01/2023

07/10/2024 - In Person	It was agreed for MH/Children Highlight Reports and to do a deep dive around Autism and ADHD		LW/Simon Whitlock and Dorett Davis	3rd February 2025	03/01/2023
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
02/12/2025 - Online	AOS to circulate wording around the 'Community Dermatology Service - waiting times' issues to identify what the issues are.	AOS	3rd February 2025		31/01/2023
02/12/2025 - Online	agreed LJ would touch base with FK in terms of MDMs/attendance and to come back to the 2nd of December meeting around Neighbourhoods, model of care and how can we involve patients in delivering the work.	LJ	2nd December		31/01/2023
	Agreed that director of housing, Lewisham Council needs to be brought into the conversation regarding system intentions. LJ to arrange.	LJ	On going	07/10 - LJ to touch base with Ellie Eghtedar to attend a future meeting. 02/09 – Action to remain open, KG to provide update at next PEG Meeting on 7th of October or beforehand. Action from PEG meeting held on 2nd October 2023. 10.06 KG raised at a LBL meeting but will go back to ask who from housing will be able to attend PEG.	31/01/2023
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**

	agreed a touch point meeting to be scheduled between JH/AL/LJ and MC with potentially someone from acute	LJ/MC	2nd December		2nd December
04/11/2024 - Online	MC/RS to touch base around pop health data.	MC/RS	2nd December		2nd December
	Agreed MH Pilot needs to be added onto MH intentions	LJJ	2nd December		2nd December
	The working on the community dermatology risk needs to be revised and consolidated into one	AOS/LJ	2nd December		2nd December
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
	LJ agreed to take the principles to discuss at a future LCP meeting to get Primary Care and voluntary sector input.	LJ	7th October	Being managed through the Lewisham & Peoples Partnership	4th November
07/10/2024 - Online	LJ to set up a SDIP focused meeting which will also discuss where MSK reports into and look at other services and to look around how dermatology fits together	LJ	4th November	SDIP meetings have been scheduled , which will occur the third Monday of every 1 month, these meetings will support the development of the community services, agree SDIP funding for next year and pick up on areas where are unclear where they fall too.	4th November
	LJ agreed to take the principles to discuss at a future LCP meeting to get Primary Care and voluntary sector input.	LJ	7th October	Being managed through the Lewisham & Peoples Partnership	4th November
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**

20/07/2024 - In Person	TH mentioned around including planned care and elective care in some capacity via the programmes as sometimes this can get lost – is there something specific for Lewisham residents such as MSK in order to do some coherent planning. BB agreed with TH and mentioned health inequalities work in the surgical pathway and bringing this to this meeting.	LJ/BB/CH	7th October	07/10 - Action to be closed as agenda item 02/09 – Action to remain open and to be Include as part of the future agenda.	7th October