Lewisham Local Health and Care Partners Strategic Board
Date: Thursday 22 May 2025, 14.00-16.00hrs (includes 5-minute break)
Venue: MS Teams (meeting to be held in public)
Chair: Vanessa Smith, Chief Nurse, SLaM

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 27 March 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
	Governance & Performance				
4.	**Risk Register**	Enc 4	Ceri Jacob	For Discussion	14.15-14.25 10 mins
5.	**Finance update**	Enc 5	Michael Cunningham	For Discussion	14.25-14.35 10 mins
	Delivery				
6.	**SEL Frailty Framework**	Enc 6	Ceri Jacob	For Discussion	14.35-14.55 20 mins
7.	**Plan to increase influenza vaccine 25/26**	Enc 7	Dr Catherine Mbema	For Discussion	14.55-15.15 20 mins
	BREAK – 5 mins				
8.	**Briefing - Community Diagnostic Centre**	Enc 8	Neil Goulbourne	For Discussion	15.20-15:35 15 mins

9.	**Primary Care Group - updated Terms of Reference**	Enc 9	Chima Olugh	For Approval	15.35-15.45 10 mins
10.	**Programme Highlight Reports**	Enc 10	Laura Jenner	For Discussion	15.45-15.55 10 mins
	Place Based Leadership				
11.	**Any Other Business**		All		15.55-16.00 5 mins
CLOSE					
12.	**Date of next meeting (to be held in public): Thursday 24 July 2025 at 14.00hrs via Teams**				
	Papers for information				
13.	**Minutes/Updates from:** • **People's Partnership Action Plan** • **Primary Care Group Chairs Report** • **THAS Quarterly report**	Enc 11			

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 27 March 2025 at 14.00 hrs.

via MS Teams

Present:

Fiona Derbyshire (FD) (chair)	CEO, Citizens Advice Lewisham, Voluntary Sector Representative
Ceri Jacob (CJ)	Place Executive Lead (PEL) Lewisham, SEL ICS
Denise Radley (DR)	Interim Executive Director, Adult Social Care & Health
Pinaki Ghoshal (PG)	Director of Children's Services, LBL
Anne Hooper (AH)	Community representative Lewisham
Dr Simon Parton (SP)	GP, Primary Care representative (LMC)
Barbara Gray (BG)	VCSE representative, KINARAA
Michael Kerin (MK)	Healthwatch representative
Dr Helen Tattersfield (HT)	GP, Primary Care representative
Dan Rattigan (DRt)	Associate Director – Strategy, LGT

In attendance:

Cordelia Hughes (CH) (Mins)	Borough Business Support Lead, SEL ICS
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, SEL ICS
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
Ann Guindi (AG)	Clinical and Care Professional Lead, CYP
Chima Olugh (CO)	Neighbourhood Development Manager SEL ICS
Dr Aaminah Verity (AV)	Heath Equity Fellow, Lewisham
Helen Marsh (HM)	Head of Communication and Engagement
Peter Matthew (PM)	Non-Executive Member, Lewisham

Apologies for absence: Vanessa Smith, Dr Prad Velayuthan, Dr Neil Goulbourne, Dr Catherine Mbema

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 27 March 2025.** Fiona Derbyshire (FD) (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. FD 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 27 March 2025 – these were agreed as a correct record. Action log – 2 x actions will be completed by the next meeting in May 2025. 1 x action deferred to LCP Strategic Board meeting in July 2025. Matters Arising None	
2.	**Questions from members of the public** CJ reported that no questions were raised prior to this meeting. However, a question was raised via the Lewisham Question inbox post today's meeting regarding the impact on benefit cuts and if we intend	

	to monitor the impacts and what these will have on the Lewisham Health and Care Services. Refer to Appendix A.	
3.	**PEL (Place Executive Lead) report** CJ reported on the **NHS Changes** and that the Department of Health and Social Care (DHSC) recently announced a set of changes to the NHS. At the time of wiring this report, there is 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% which was removed over the last 2 years. NHS providers are also required to reduce the growth in corporate costs since 2019 by 50%. To note the ICB does have an employee support scheme in place for all staff. More information will be provided as more information becomes available. **Planning 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. This is the minimum required and further savings may be required to manage in year pressures. 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. **Action:** CH to add to forward plan. **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, which will be delivered through neighbourhood working and the Integrated Neighbourhood Teams (INTs). A LTC framework has been previously agreed across the 6 Places and the focus is now on understanding gaps in provision against the framework for each Place and how these may be addressed within current funding envelopes. A detailed paper on this will be provided at a future meeting. **Action:** CH to add to forward. CJ thanked BG of KINAARA, who is attending her final LCP Strategic Board meeting in March 2025. CJ is grateful for BG's contributions to the work of the LCP Strategic Board and for helping to strengthen the voice of black-led VCSE partners in the decisions of the board. All thanked BG for her contribution.	**CH** **CH**

	AH asked about the recent NHS changes and the potential impact on Lewisham population and communities and if we can take this to our communities. CJ confirmed. SP raised that this is very stressful process for staff, colleagues and as a system partner wanted to thank all for their hard work. BG noted that the Board needs to be aware of having appropriate representation. Also, consistency to help shape and transform services. **The Lewisham LCP Board noted the PEL report.**	
4.	**Joint Forward Plan** CMS said that the purpose of this paper is to review and endorse the Joint Forward Plan (JFP). It has been endorsed by Health and Wellbeing Board and it was discussed at a LCP Strategic Board seminar. The main feedback has been around workforce implications and delivering the plan. Another point to raise is that this is a refresh, built on priorities agreed on a previous plan and links to Health and Wellbeing Strategy, prevention and health inequalities work. The paper included information on outcomes and deliverables expected to be achieved through this plan. SEL JFP is due to be finalised in the next couple of weeks and will be approved at the SEL ICB Integrated Care Board. CJ advised that this paper is to endorse the update of this 5-year plan and to note that a 10-year plan will be coming in due course. DR reflected from a recent LCP Strategic Board seminar and asked if we are confident that the JFP is strong enough in terms of family and family carers as there were not many references to these cohorts. Also, what is the reasoning, as there is an interdependence issue on many of the groups that are being focusing on. CJ responded that carers is woven through the work. In relation to children and young people, the family hubs priority is designed to support the CYP agenda and the Council leads on this priority for the Lewisham system. There is a need to review our programmes and make sure carers are included. We will take an action offline to pick up carers and integration throughout our plans.	

	BG asked if there were any key areas around Black communities and health inequalities that will come from this plan. CMS confirmed and referenced the Integrated Neighbourhood Teams as an area where this will be picked up. PG said that with the ICBs reduction of 50% there will be an impact on the deliverability of the plan and this needs to be noted. **The LCP Board approved the Joint Forward Plan updates.**	
5.	**Community Development Projects and Funding - SDIP** LJ reported on the transformation improvement funding for community services and that the paper sets out the process that took place with joint working with providers such as Lewisham and Greenwich Trust, Local Authority, ICB and Primary Care, to ensure investment was targeted for maximum impact. The paper sets out a list of community services that will receive funding. There is also an additional recurrent of £200k to help the service with back logs. This means teams can recruit to new posts to help with ongoing demand. In addition, funding has been allocated for bladder and bowel, new pharmacists and prescribers for the neighbourhood work to undertake multimorbidity assessments. Funding is also allocated for district nursing service, especially since there has been an increased demand for this service. CJ thanked LJ and partners for getting the system intentions and service development improvement plans agreed early in the year, which means implementation can start much earlier in the year. AG mentioned that some joint commissioners met to discuss the autism posts that were appointed to but mentioned that they are only taking new referrals; therefore, what is happening with the backlog. LJ said there is a meeting with service leads which LJ and KG attend and will ask this question and feedback offline. **Action:** LJ to feedback on autism posts offline to AG. MK asked about engagement as part of the cover sheet and in reference to a sentence regarding 'co-design,' what this meant and if there had been any specific public engagement. LJ mentioned that there is an expectation on each service that public engagement would take place. In reference to co-design, this took place with the	**LJ**

	neighbourhood and children's work in relation to lived experience and with therapies teams who used a Friend's and Family approach. AH suggested that it would be useful to state in the cover sheet exactly what has taken place e.g. what was the question, what did they say. Also, in reference to the Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) recommendations, it would be good to know how this money would support this. BG echoed this statement and suggested using the Equality Impact Assessment (EIA) to provide a detailed breakdown. LJ said that parts had been picked in support of the BLACHIR recommendations, however agreed that going forward there is a need to be more explicit on exactly what they are. **The LCP Board approved the Community Development Projects and Funding.**	
6.	**Neighbourhood health service: SEL Framework, Lewisham Integrated Neighbourhood Team Model of Care** **SEL Framework.** CJ said that the Fuller report in 2022 recommended that all ICBs put in place a neighbourhood care model to deliver care in a more integrated manner. Integrated Neighbourhood Teams (INT) are a key part of neighbourhood working and 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 6 Place Executive Leads (PELs) and their leads worked together 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 Place 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. MK mentioned about capacity to deliver in light of the upcoming cuts and asked about the framework around End-of-Life Care (EOLC) and	

	Palliative Care and what is the timeframe for this. CJ said capacity to implement will be kept under review. In relation to EOLC there have been 3 workshops on Frailty. A plan will need to be signed off in every Place to enable the framework. MK said that trust in community is paramount so suggested not to overpromise, need to manage expectations rather than inspirations. BG mentioned about Frailty and EOLC and the role of VCSE organisation (Hummingbird) who support people who are frail, or at EOLC and support families. Also, that frailty comes at a younger age for Black women so there is a need for some targeted work. HT said the main priority for INTs is chronic disease prevention and addressing health inequalities. Lewisham is set up to work with the voluntary sector which is a positive thing. However, the work with prevention will mean working differently and with less money. CJ agreed but need to get messages right with timelines. FD said integrating VCSE in that preventative stage and looking for grants via Local Authority; need to think how we fit into the Neighbourhood Framework but also need to know if we were being invited to the table. **SEL ICS Neighbourhood.** LJ presented a slide on the Lewisham Integrated Neighbourhood work. In Lewisham, community and social care services are aligned to the same four hubs. The overall element of the model is the formation on the neighbourhoods and INTs with an initial focus on long term condition (LTC) and complex needs such as frailty. There will be community hubs in each neighbourhood to work alongside family hubs. The multi-disciplinary teams are moving to proactively identify patients who require mental health and district nursing services. The Health Equity programme is recruiting GPs to be Health Equity Fellows. The aim is to have 6 working within the local community and services to help patients who have not accessed GP. A design team is also in place to support people with CVD, diabetes, hypertension, atrial fibrillation and kidney disease. This area will in time support other people with LTCs such as respiratory. Targeted support will be provided to people in the Core20 group and those in deprived areas who need lifestyle changes, mental health and social support.	

	AH thanked the comms and engagement programme, particularly for the involvement of people with lived experience but asked if we can ensure we are overt with what has been said, for example "you said, we did." LJ noted that a write up of the engagement would be shared in due course. SP referenced the Multi-Disciplinary Meetings (MDMs) and asked for patience with how they develop. The MDMs will shape for the future and there is a need to work together to get the right outcomes. A question was raised in relation to practices that are in a neighbourhood but close to other boroughs. Will their patients still have access to neighbourhood support. LJ confirmed if they are registered at a practice they will be supported. **The Board approved the SEL ICS Neighbourhood and INT Framework.**	
7.	**Primary Care Access Plan 24/25** AOS highlighted areas of the Primary Care Access plan and progress to date in Lewisham and referred to the examples of data which showed trends and themes across certain areas. There has been ongoing work to improve the primary and secondary care interface, including setting out the issues and putting in place actions to improve communication. HM added that there is a comms and engagement plan that works with our local communities and populations to report on the different changes and access points in primary care. In addition, there is a campaign in May to help people understand various parts of the services in primary care, especially as residents report on being confused etc. The campaign will be simple and will take place via social media, leaflets and with real people in the campaign. In addition, there needs to be consistency with this plan across all practices. MK said that the campaign needs to be simple but sustained and cognisant of the variation of cultures and languages. MK suggested not to rely too much on digital routes due to the older population, who may not know how to use it. All thanked the communications and engagement team for their assistance.	

	BG referred to developing community champions to get the message out there and mentioned a voluntary organisation called Catbytes in Lewisham, who help with digital drop-in centres. HM agreed champions would been good. AOS confirmed that Catbytes are being used. DR mentioned consistency across practices and if this had been incorporated into the plan. SP suggested 'turning the narrative around,' which would be a challenge. **The LCP Board noted the Primary Care Access Plan as detailed above.**	
FD advised there would be a 5-minute break. The meeting resumed at 15:25 hrs.		
8.	**Take Home and Settle & Homeless Patients Legal Advocacy Service update** AL presented on a paper in the January part 2 Board meeting asking for approval to award the Take Home and Settle (THAS) and Homeless Patients Legal Advocacy procurement contracts. AL gave an update on these contracts and who had been successful following the procurement process. **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. There were 2 bidders in total, with 1 successful bidder reaching 81% and that was The Incumbent. **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. AL reported that there were 20 interested parties and a mix of bidders, 1 bidder scored 82.2% and that was the successful bidder - The Incumbent. This also allows for continuity of service and they are highly regarded.	

	The LCP Board noted the Take Home and Settle & Homeless Patients Legal Advocacy Service procurements update.	
9.	**Lewisham Risk Register** CJ reported on the highlights on risk register and the noted the LCP comparative review for January 2025 which is across Place to have oversight of any risks and learning. In addition, the risk appetite is attached. Total risks to date are 15. Financial balance had been reduced to 9 (3x3) but will be reviewed for 25/26. It was also agreed to reduce the GP collective action risk. **The Board noted the Risk Register update.**	
10.	**Finance update** MC provided a M10 financial report under the headings of the Lewisham Place, ICB, Lewisham Council and the Wider ICS. **Lewisham Place** MC reported that for Lewisham against the delegated ICB budget at M10 there is an underspend of £86K and a break-even forecast outturn for 2024/25. This is a considerable improvement during the second half of the year since an overspend position of c.£0.5m was reported at. This reflects ongoing work within CHC and prescribing. However, the two key areas of overspend remain CHC and prescribing – material drivers of our financial position. A savings plan, £3.6m (4%) of the budget excluding some budget areas was identified for 2024/25 and is delivering this in full. **ICB** is reporting a YTD surplus of £5.1m in M10 against the revenue resource limit which is the total allocations the ICB receives. This is £5.2m adverse to plan including £765K due to the Synnovis cyber-attack. There is also a £4.4m movement in the provider positions surplus that the ICB was going to deliver, which will now be delivered by provider sector. **Lewisham Council** MC confirmed that the Adult Social Care services are forecasting an overspend of £5.1m this year, and key drivers of this are inflation requests from providers, complexity of care requirements for discharge patients and the steady increase of children transitioning into adulthood. Children Services forecasting an overspend of £14.2m which reflects the high level of needs and care costs for Looked After Children.	

	The **ICS** is forecasting break-even against plan after receiving £100m of system support in 24/25. YTD deficit of £59.3m adverse to plan by £31m. Key drivers are the Synnovis cyber-attack equating to £34m and slippage in efficiency programmes £29.4m. SP mentioned that there will also be some increase costs pressure within primary care prescribing. CJ agreed and said we all need to cognisant of the pressures and be collective in all our positions across the system. BG mentioned the overspend of the prescribing and long-term conditions in reference to Black communities and that conditions like hypertension - what will this mean for them? MC said there is a saving plan in place to help improve the financial position and national initiatives and guidance for drugs and prescribing are being followed. **The LCP Board noted the finance update.**	
11.	**Any Other Business** FD asked Board members to note the additional papers for information and thanked everyone for their contributions. MK asked about the One Care Lewisham Practice Marvels Lane Estates Business Case (Primary Care Chairs report) and that it was sold to a private investor who now charges rent to the NHS and why was there no provision for offsetting it against the sell price. **Action:** DRt to will take this question to the appropriate contact at LGT for response. AH said that following the Primary Care Chair report there is work around lessons learnt to establish how things came about and how we can work better in the future.	**DRt**
12.	**Date of next meeting.** Thursday 22 May 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. **AOB (item 10) 27/03/25**	MK asked about the **One Care Lewisham Practice Marvels Lane Estates Business Case** (Primary Care Chairs report) and that it was sold to a private investor who now charges rent to the NHS – why was there no provision for offsetting it against the sell price. **Action:** DRt to will take this question to the appropriate contact at LGT for response.	**DRt**	
2. **Community Development Projects and Funding – SDIP (item 5) 27/03/25**	**Autism posts** that were appointed are only taking new referrals; therefore, what is happening with the backlog. LJ said there is a meeting with service leads which LJ and KG attend and will ask this question and feedback offline. **Action:** LJ to feedback on Autism posts.	**LJ**	
3. **PEL report (item 3) 27/03/25**	**SEL Frameworks for LTC and Frailty** agreed to bring a detailed paper to a future LCP Strategic Board meeting or seminar. CH to add to forward planner.	**CH**	Included on forward planner. -Completed March 2025

4. PEL report (item 3) 27/03/25	**Planning Work is continuing to finalise plans for 2025/26.** A summary of these can be provided at a future meeting. CH to add to forward planner.	**CH**	Included on forward planner. -Completed March 2025
5. 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**	Deferred to LCP Strategic Board in July 2025
PEL Report (item 3) 30/01/25	**SEL Overarching Neighbourhood Development Framework** to include at a future LCPSB seminar session. CH to include on forward planner.	**CH**	On the agenda – Thursday 27th March 2025. Closed
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**	On the agenda – Thursday 22nd May 2025. Closed.
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. 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	**CMb** **CMb/CH**	Completed 21/11/24. Add to a future LCP Board meeting. Closed.

	BLACHIR recommendations.CH to add to the forward planner.		
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 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	**KG**	Closed - as being discussed on 21/11/24

	summary for BG and would talk to colleagues about the right people to contribute to the development.		
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

[redacted]
[redacted])
SENT BY EMAIL
[redacted]

09 April 2025

Dear [redacted]

Re: Impact of Benefit Cuts

Thank you for your email dated 27 March 2025 in which you had asked about the impact of benefit cuts and if we intend to monitor the impacts and what these will have on Lewisham Health and Care Services?

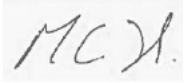
We currently have several performance measures in health that we monitor such as service uptake, GP appointments, referrals to SLaM and VCS welfare benefit services. In addition, Mental Health and Wellbeing (MWAH) workers monitor and record if they are asked to support people with issues related to this.

Lewisham Speaking Up monitor any rise in referrals related to benefits support and financial hardship, particularly within their Non-Citizen Care Act Advocacy and Money Management Advocacy Services and providers will also record any negative impacts faced by the individuals they support. Carers could raise any concerns via our Carers Forum.

We will continue to measure and identify any changes that may arise due to the recent benefit cuts and establish mechanisms to assess the impact.

In the meantime, I do hope this has answered your question. If you would like to discuss this matter further, please do not hesitate to contact me. In the meantime, our next Local Care Partnership Strategic Board public meeting is taking place on Thursday 22nd May 2025, 14:00 and you are welcome to attend and hear about the latest developments in Lewisham.

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:	**22 May 2025**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob, Lewisham Place Executive Lead

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
In March it was announced that nationally, ICBs should reduce their running costs by 50% and for this to be enacted by the end of Q3 (December 21, 2025). ICBs must reduce costs such that they can deliver their existing functions within a cost per head of population of £18.76. This means that the impact on ICBs is variable, dependent on how far away their starting point is from this target. For SEL this equates to a 35% or £21.4m reduction.

In April, SEL ICB ran 3 sprints with the senior management team (SMT) across three key areas; strategic commissioning (including joint commissioning), primary care and neighbourhood working and non-strategic commissioning functions. This was to agree at a high level, the functions and form needed to deliver a smaller organisation focused on strategic commissioning.

Since these sprints, a Model ICB blueprint has been published. This sets out the functions ICBs will be expected to deliver from April 2026 and where functions that will no-longer be provided by an ICB are to be transferred to. There was good coherence between the blueprint and outputs from the 3 sprints.

Information on our approach and our ability to achieve the required reduction will be submitted to NHSE: London Region at the end of May. During June, detailed work to set out the new structures will be carried out. Normal HR processes will be followed in relation to staff consultation. All Staff Briefings are held weekly with the CEO and two SROs for the programme and directors are also keeping their staff informed.

Potential Conflicts of Interest	All ICB staff are potentially impacted.			
Any impact on BLACHIR recommendations	No			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	This will be carried out once for SEL and will look at the impacts on a function by function basis and overall.		
	Financial Impact	The ICB must achieve a 35% reduction in its running costs.		
Other Engagement	Public Engagement	None.		
	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:	**Lewisham Risk Register**
Meeting Date:	**Thursday 22 May 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	**592.** ***Achievement of Recurrent Financial Balance 2025/26.*** *Lewisham borough anticipates achieving financial balance in 2025/26 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material ones being ability to fund required mental health investment and funding of delegated primary care contracts. In addition, there are business as usual risks relating to activity pressures within continuing care and prescribing.*	⟺	Open (10-12)
Financial	**593. Achievement of Efficiency Savings 2025/26.** Lewisham borough has a mandated efficiency savings target of £8.975m (5% on all budget lines). A material element £4.228m is dependent on delivery of efficiency programmes to manage activity within continuing care and prescribing. Given the nature of these activity driven costs there is a risk under achievement of the efficiency programmes will jeopardise the borough's ability to achieve the total £8.975m target.	⟺	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)

Strategic	**334. 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.	⟺	Open (10-12)
Financial	**335. Financial and staff resource risk in 2023/24 of *high-cost packages* through transition**. The financial risk identified in 2023/24 of new high-cost LD packages through transition remains.	⟺	Open (10-12)
Financial	**506. The CHC outturn for adults** will not deliver in line with budget. 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	⟺	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*.** 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.	⟺	Open (10-12)
Governance	**360. 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.	⟺	Open (10-12)
Workforce	**580. Shortage of commissioned nursing capacity in the CLA Health team**. With 1.8 FTE nursing staff, Lewisham's CLA Health Team has the lowest staffing levels in London, at 2.5 FTE fewer than the London average based on CLA population size.	⟺	Eager (13-15)

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 – April 2025.*** **5.New/Closed Risks/Matrix Scores** There are a total of **13 risks** on the Lewisham risk register. 3 risks have been closed – 1 x **562** *GP Collective Action* as no longer considered a risk, 1 x **498** *Achievement of Recurrent 24/25* and 1 x **549** *Achievement of Non-Recurrent Financial Balance 24/25* – due to new risks for the upcoming financial year. There are 3 new risks: 1 x **592** Achievement of Recurrent Financial Balance and 1 x **593** Efficiency savings 25/26 (in lieu of the above). 1 x **594** relates to the Shortage of commissioned nursing capacity in the CLA Health Team. New, closed or reduced risks are detailed below: **New risks** **592** - Achievement of Recurrent Financial Balance 2025/26 **593** - Achievement of Efficiency Savings 2025/26 **594** - Shortage of commissioned nursing capacity in the CLA Health Team **Closed risks** **498.** Achievement of Recurrent Financial Balance 2024/25. **549.** Achievement of Non-Recurrent Financial Balance 2024/25 **562**. GP Collective Action. Closed across all 6 Place There is an issue's log to monitor previous risks considered BAU and/or in development. **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 travel	Risk sponsor	Risk owner	Ongoing controls	Assurances	Impact of ongoing controls	Control gaps
								Finance							
1	592	Financial	**Achievement of Recurrent Financial Balance 2025/26**	Lewisham borough anticipates achieving financial balance in 2025/26 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material ones being ability to fund required mental health investment and funding of delegated primary care contracts. In addition there are business as usual risks relating to activity pressures within continuing care and prescribing.	3x3=9	3x3=9	3x2=6	Open (10–12)	⟺	Cat. 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. 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 Recovery 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.	There are no currently identified control gaps.
2	593	Financial	**Achievement of Efficiency Savings 2025/26**	Lewisham borough has a mandated efficiency savings target of £8.975m (5% on all budget lines) . A material element £4.228m is dependent on delivery of efficiency programmes to manage activity within continuing care and prescribing. Given the nature of these activity driven costs there is a risk under achievement of the efficiency programmes will jeopardise the boroughs ability to achieve the total £8.975m target.	3x3=9	3x3=9	3x2=6	Open (10–12)	⟺	Cat. 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. 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 Recovery meeting. Lewisham Senior Management Team Review.	The impacts of controls will be assessed during the financial year. Regular borough financial focus group meetings with CFO and director of planning.	There are no currently identified control gaps.
								Medicines Optimisation							
3	496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2025/26 may overspend due to: 1- Medicines supplies and cost increases -NCSO/price concessions and Category M. 2- Reduced capacity to implement in year QIPP schemes by borough medicines optimisation teams following NHS reform. 3- Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 4- Increased patient demand for prescriptions including self-care items, LTC. 5- Prescribing budget although uplifted for 25/26 a gap remains with regards to forecast outturn and budget. 6- Priority shifts towards qualitative outcomes such as patient safety issues in Meds Management and supporting prevention hospital avoidance or discharge. 7- Shift in prescribing from acute to community setting which places a pressure on primary care prescribing.	3x4=12	3x4=12	3x3=9	Open (10–12)	⟺	Laura Jenner	Erfan Kidia	1. Monthly monitoring of spend (ePACT 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)	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	No gaps in control identified
								Primary Care / Community Based Care							
4	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)	⟺	Cat. Jacob	Ashley O'Shaughnessy	The current controls in place are: Several priorities from 24/25 will continue into 25/26 including: 1. All practices have now received the full Transformation and Transition funding based on evidence submitted and self-declaration of transition to the Modern General Practice Access model. The ICB will continue to fully embed Cloud Based Telephony and Online Consultation tools and develop and share good practice in respect of their utilisation. 2. Implementation of a public communications and engagement campaign to raise awareness with the public about how best to access primary care and other options e.g. Pharmacy First via community pharmacy, self-management resources, self-referral pathways, NHS APP. 3. Continue to review themes emerging from the SLF practice visits and develop and implement action plans to take forward. 4. Continue to progress local discussions to take forward improvements in the primary / secondary care interface and expand this work to wider system interfaces i.e. mental health, local authority. 5. Consider opportunities to work with dental and community optometry providers/services to support improved access across all primary care services. 6. Continue support for GP practice estates developments planned through the London Improvement Grant and the NHSE Primary Care Utilisation Fund, to increase clinical space for appointments. 7. Continue support for PCNs to maximise use of the increased flexibility within ARRS budgets.	Assurances going forward are outlined in the controls section. Furthermore: Primary care access is reviewed on a monthly basis at the Primary Care Group. Discussions with the Primary Care Leaders at PCLF, PM forum and PLTs about the models of access and delivery.	Highlight of progress made in 24/25 1. All practices have now received full funding based on evidence submitted and self-declaration of transition to the Modern General Practice Access model. 2. All PCNs have confirmed full compliance across all the Capacity and Access Improvement Payment domains and full payment has been released. 3. 17 practices have undertaken the Support Level Framework (SLF) programme delivered by the SEL Primary Care Workforce Academy who have been commissioned to lead this work. The programme will continue into 25/26 with the aim of all practices participating. 4. A PCN level SLF programme is also planned for 25/26 5. All PCNs utilised their total ARRS budgets for 24/25 6. Quarterly reporting is in place for PCN Enhanced Access delivery with all PCNs meeting their contracted required number of additional hours 7. Good progress is being made on the interface with Primary Care and Secondary Care including the sharing of clear contact points, creation of a dedicated WhatsApp group and the implementation of a formal letter to highlight and redirect inappropriate requests that are sent to General Practice from the local acute provider 8. There was a 5.5% increase in patients registered for the NHS APP between Jan 24 and Jan 25 and a plan to further increase this has been agreed 9. Several significant estates developments have been completed through the London Improvement Grant programme which has resulted in increased clinical space for face to face appointments 10. There has been continued promotion and use of Pharmacy First for urgent emergency prescriptions and medicines requests.	A robust and accurate access dashboard which triangulates and reflects data and intelligence from a range of sources across the system.
5	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	Marilyn 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.A universal, core offer in a consistent location/setting to increase efficiency and capitalise on public understanding of 'where to go' 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. 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. 12. Spring booster - all areas are covered for housebound and care homes. This will be picked up as part of our Lewisham Imm Strategy. 13. Flu wrap up session - lessons learnt and we will be proactively implementing lessons pre flu season 25/26.	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
6	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	Marilyn 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. 9. A new system-wide childhood immunisation strategy has been co-produced with system partners including patients and resident. The new strategy is an outcome based strategy and the outcomes are people and community focused. It is a plan for how relevant groups and stakeholders will deliver against the principles and priorities set out in the Lewisham Health and Wellbeing Strategy and is aligned to the SEL Immunisation Board Strategy. 10. Support and engagement from the African Advocacy Group effective May 2025. 11. Jitsuvax training roll out to family hubs and soon engagement with nursery managers.	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.
								Commissioning							
7	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.	3x5=15	2x5=10	3x2=6	Open (10–12)	⟺	Kenny Gregory	Ellen McCabe	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 male 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. Re/establish 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.
8	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	Corinna Moscrop	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 a children's 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.	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.
9	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 MWAH 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	Corinna Moscrop	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 Council/other 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.
								Safeguarding							
10	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=9	3x3=9	2x3=6	Cautious (7 – 9)	⟺	Cari Jacob	Fiona Mensah/Alice Wo	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. 5. Designate Safeguarding Lead due to return in July 2025.	See ongoing controls	Provide assurance in safeguarding team	Gap in cover - raised with Place Executive Lead in Lewisham.
								Children and Young People							
11	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 Rahman	Paul Cowcill	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 reveiing 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.

12	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 Rahman	Paul Cowans	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 52 to 52 to 52 weeks - 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.	Availability of partners to undertake joint ASD assessments. COVID has increased childhood anxiety in some kids.
13	594	Workforce	**Shortage of commissioned nursing capacity in the CLA Health Team**	Risk related to Lewisham Children Looked After (CLA) Health Team commissioned by SEL ICB (provided by Lewisham and Greenwich NHS Trust) The risk relates to a shortage of commissioned nursing capacity in the CLA Health Team. With 1.8 FTE nursing staff, Lewisham's CLA Health Team has the lowest staffing levels in London, at 2.5 FTE fewer than the London average based on CLA population size. The Team is below average capacity for all of the four staff groups (Band 8a Named Nurse, Band 7 Specialist Nurse, Band 6 Nurse, and Admin staff), but most significantly for Band 7 Specialist Nursing. In addition, the team is operating with a nursing workforce significantly below that of the recommendations of the RCN and RCPCH Intercollegiate Guidance. The Impact is: 1) Statutory health assessments will not be completed within timescale, resulting in failure to comply with statutory responsibility. 2) Timely completion and distribution of health reports and care plans could be delayed. 3) Attendance at strategy meetings where health is a core agency is restricted which means that the most vulnerable CYP being discussed won't have a health advocate to contribute to action plans which often require health input. 4) Ability to reduce the breach list is limited which means the vulnerable CLA remain on the list with limited capacity to offer further appts. 5) Delivery of other key elements of the CLA service is restricted such as training and development and drop-in/consultation sessions which means that early intervention and health promotion opportunities are missed. The consequences of this are that the health needs of CLA may not be met. That access for CLA to other services may be delayed and/or compromised. There is a potential for staff burnout, ill health. May increase number of complaints and reputational damage to the ICB/Trust.	4x4=16	5x2	2x3=6	Eager (13-15)	⇔	Simon Whitlock	Carol Jacob	1. LGT are arranging for 19hrs per month additional nursing support in place via a bank nurse. 2. Increased requests for other boroughs to support our CYP placed in their boroughs. Requests coming in from other boroughs are notified of a 12 possible week wait list and advised of capacity issues. 3.Reduction in travel time for CLA nurse by offering virtual health assessments where appropriate. 4.Reduced attendance to strategy meetings. 5. Business case to be considered for inclusion in Service Development and Improvement Planning (SDIP) process. Business case drafted requesting increased funding to support the recruitment of additional Specialist CLA nursing capacity, which will provide adequate staffing levels to meet service specification and KPIs as well as other key elements of the service.	Monthly monitoring of timely completion of Initial and Review Health Assessments in partnership between LGT, LBL and ICB. Quarterly contract monitoring by LBL and ICB commissioners	Controls put in place mean that team is able to maintain good rates of completion of statutory Review Health Assessments within timescale, and there is still timely completion and distribution of health reports and care plans.	Attendance at strategy meetings where health is a core agency is restricted which means that the most vulnerable CYP being discussed won't have a health advocate to contribute to action plans which often require health input. Delivery of other key elements of the CLA service is restricted such as training and development and drop-in/consultation sessions which means that early intervention and health promotion opportunities are missed.

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
7	**Lewisham Intermediate Care Bed provision**	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.	*Medium Impact Issue*	*Medium*	Cautious (7 - 9)	Open	02/04/2025	Lorraine Smedmour / Kenny Gregory	Moved from Risk Register to Issue Log at the request of Lorrane Smedmour Procurement taken place and a contract in place.

Key

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

Key - Direction of Risk

Risk has become worse.

Risk has stayed the same

Risk is improving

Risk Scoring Matrix

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

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

Likelihood Matrix

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

Severity Matrix

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

South East London Integrated Care System

NHS South East London

NHS SEL ICB
Risk Appetite Statement 2023/24

SEL ICB Risk Appetite Statement 2023/24

The statement

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

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

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

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

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

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

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

South East London Integrated Care System

NHS South East London

ICB risk appetite level descriptions by type of risk

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

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

Selected ICB risk appetite level

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

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

Selected ICB risk appetite level

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

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

Selected ICB risk appetite level

South East London Integrated Care System

NHS South East London

Summary of SEL LCP risks

Prepared for the place executive leads (PELs)

Version 2

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 **23 April 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.

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	12 ○	2024/25 risks to be closed and new finance risks to be added for 2025/26.				9 ○
Unable to identify and achieve efficiency savings within the borough	9 ○					12 ○
Overspend against the prescribing budget	12 ☆	9 ▲	12 ▲	12 ▲	12 ▲	closed
Overspend against the borough's delegated CHC budget	9 ☆	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 ↓▲	12, 9, 9* ▲	
Financial risk (legal challenge / poor performance) relating to the community equipment services provider		9 ▲		3 ↓▲		
Performance / poor delivery risk associated with community equipment services provider						6 ↓▲
Patients fit for discharge unable to leave hospital due to pressures in community and social care services / loss of funding	12 ▲		12 ▲			

Key:

- *To be shown on ICB BAF*
- *Newly added risk since last update*
- *Score increased*
- *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*
- *Risk requires a review/update for 2025/26*
- *Risk has been reviewed for 2025/26*

*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 ▲			
CYP diagnostic waiting times for autism and ADHD targets not being met		6 ▲		9 ▲	Overlaps with ASD target risk	9 ▲
Population vaccination targets not met	12 and 12 ○			12 and 9 ☆	9 and 12 ● ▲	9 ○
Primary care premises lost / insecure lease agreements / other estates issues	12 ▲	12 ☆	12 ▲			
Safeguarding risk (due to pressures across partners / vulnerable adults, children in initial accommodation centres…)				6 and 8 ▲		
SMI health checks	12 ○					
Hypertension management	15 ● ○					
Improvements to patient flow and discharge are not made in the local acute system (BCF requirements)	9 ○					

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since last update*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*
- ▲ *Risk requires review/update for 2025/26*
- ☆ *Risk has been reviewed for 2025/26*

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)	↓ 9 ▲					
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 delivery of performance targets delegated to place (these include IAPT access, SMI health checks, children immunisation and cancer screening)			12 ▲			
Interpreting services overspend				8 ☆		

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since last update*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*
- ▲ *Risk requires review/update for 2025/26*
- ☆ *Risk has been reviewed for 2025/26*

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 ▲	
GP Federation faces a risk to its financial stability due to ongoing procurement and contracting for key services					○ 9 ▲	
Access to primary care services					● 12 ▲	
Cost pressures due to rapid increase in patients seeking ADHD and Autism diagnostic services from independent sector providers						6 ▲

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk since last update*
- ↑ *Score increased*
- ↓ *Score decreased*
- ▢ *Primarily ICB risk*
- ▢ *Primarily System risk*
- ▲ *Risk requires review/update for 2025/26*
- ★ *Risk has been reviewed for 2025/26*

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 5
Enclosure 5

Title:	**Month 12 Finance Report 2024/25**
Meeting Date:	**22nd May 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 outturn position at month 12 2024/25. A month 12 position is also included for the wider ICB/ICS.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

Month 12 2024/25 – SEL ICB – Lewisham Place

At month 12 outturn, the borough is reporting an underspend of £5k compared to a target of breakeven. All budget areas individually are showing breakeven or an underspend except for continuing care services (CHC), prescribing, and delegated primary care.

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

Month 12 2024/25 – Lewisham Council

Given differing timescales reflecting year-end processes the Lewisham Council month 12 financial position has not yet been approved for circulation.

Month 12 2024/25 – SEL ICB

The ICB is reporting a year-end **break-even position (£87k surplus)** against its revenue resource limit (RRL) at month 12.

This represents an overspend of £38.9m against the ICB's planned surplus. Agreement was reached across all NHS organisations in the ICS regarding the achievement of the 2024/25 control total, and the month 12 position of each organisation, including the ICB, reflects this. The ICB delivered in full its annual savings requirement.

The detail of the ICB position is shown within Appendix A to this report.

	Month 12 2024/25 – SEL ICS The South East London ICS had an agreed financial plan for 2024/25 of a £100.0m deficit. In year, the ICS was allocated non-recurrent deficit support funding of £100.0m to enable a break-even plan to be set. The ICS is reporting an overall **£0.5m surplus** for the financial year 2024/25, against this break-even plan. 4 out of 5 providers reported a surplus.			
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 outturn financial position 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 outturn financial position for 2024/25.			

NHS
South East London

Lewisham LCP Finance Report

Month 12 – 2024/25

ICB – Lewisham Delegated Budget – Month 12 2024-25

NHS South East London

Overall Outturn Position (subject to external Audit)

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s
Acute Services	1,322	775	547
Community Health Services	29,343	27,874	1,469
Mental Health Services	7,696	7,135	561
Continuing Care Services	23,056	27,084	(4,028)
Prescribing	42,599	44,342	(1,744)
Prescribing Reserves	0	0	0
Other Primary Care Services	2,468	2,017	452
Other Programme Services	3,354	757	2,597
Delegated Primary Care Services	67,006	67,018	(13)
Corporate Budgets	3,146	2,983	163
Total	**179,990**	**179,985**	**5**

- At month 12 outturn, the borough reported an underspend of £5k compared to a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing, and a small overspend on delegated primary care.
- CHC shows a material outturn overspend of £4,028k compared to month 11 FOT of £3,553k. This reflects mainly a movement in children's costs c.£400k between month 11 and month 12. The overall 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.
- Prescribing shows an outturn overspend YTD of £1,744k in line with FOT at month 11 of £1,733k. 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 borough implemented and delivered a 4% efficiency target of £3,576k, and material additional mitigations to offset the financial pressures incurred by the borough.

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Appendix A

SEL ICB Finance Summary

Month 12 2024/25

1. Key Financial Indicators

NHS South East London

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

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

2. Executive Summary

NHS South East London

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

3. Budget Overview

NHS South East London

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

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

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

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

4. Prescribing – Overview

NHS South East London

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

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

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

5. NHS Continuing Healthcare

NHS South East London

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

6. Corporate Costs – Programme and Running Costs

Area		Year to Date		
	Annual Budget	Budget	Actual	Variance
	£	£	£	£
Boroughs				
Bexley	2,629,810	2,629,813	2,365,565	264,248
Bromley	3,314,269	3,314,270	2,872,299	441,971
Greenwich	3,221,499	3,221,498	3,066,907	154,591
Lambeth	3,737,440	3,737,439	3,441,721	295,718
Lewisham	2,930,436	2,930,436	2,778,067	152,369
Southwark	3,320,399	3,320,396	3,074,411	245,985
Subtotal	19,153,853	19,153,852	17,598,971	1,554,881
Central				
CESEL	461,544	461,543	442,545	18,998
Chief of Staff	3,141,259	3,141,260	2,924,270	216,991
Comms & Engagement	1,677,650	1,677,649	1,409,073	268,576
Digital	1,688,342	1,688,342	1,278,463	409,879
Digital - IM&T	3,163,430	3,163,428	3,006,594	156,834
Estates	649,177	649,176	847,329	(198,153)
Executive Team/GB	2,387,601	2,387,602	2,501,717	(114,115)
Finance	3,099,563	3,099,563	2,875,956	223,607
Staff at Risk Costs	0	-	4,836,276	(4,836,276)
London ICS Network	(1)	0	-	0
Medical Director - CCPL	1,604,413	1,604,413	1,551,843	52,570
Medical Director - ICS	271,387	271,386	227,746	43,640
Medicines Optimisation	4,353,888	4,353,886	3,656,521	697,365
Planning & Commissioning	8,402,233	8,554,230	7,552,479	1,001,751
Quality & Nursing	1,937,472	1,937,468	1,807,069	130,399
SEL Other	152,000	-	(258)	258
South East London	0	-	218,497	(218,497)
Subtotal	32,989,958	32,989,947	35,136,121	(2,146,173)
Grand Total	52,143,811	52,143,799	52,735,091	(591,292)

- The table shows the YTD month 12 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 £4,836k)** together with the impact upon the final redundancy payments, given longer employment periods etc. The monthly costs have seen a significant reduction since December. 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 overspend on its corporate costs of circa £591k,** a deterioration in-month, which is a result of vacant posts being recruited into and the final running cost/programme classification being enacted.
- As highlighted in earlier slides, the ICB **underspent (£4,158k)** against its annual **management (running) costs** allocation.

7. Cash Position

NHS South East London

- The ICB's cash limit as at month 12 was **£4,844,574k** - with an **additional £50,756k** of allocations received in month, the majority of which were transferred to NHS provider partner organisations.
- As at month 12, the ICB had essentially drawn down **100.0%** of its available cash limit. Actual cash drawings were **£1,210k (0.02%)** under the cash limit which was mainly due to the late notification of an allocation plus the usual allowances needed for flexibility to manage the top sliced elements such as prescribing, dental, and community pharmacy. A supplementary cash drawdown was used in March so that final allocations could be paid to providers and to ensure the maximum cash utilisation.
- The cash key performance indicator (KPI) was achieved in each month during the year, showing continued successful management of the cash position by the ICB's Finance team. The actual closing cash balance at the end of Month 12 was **£834k**, well within the target set by NHSE **(£4,963k).**
- ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. The ICB had met the BPPC targets in full both each month and cumulatively at the end of the financial year.

ICB Annual Cash Drawdown Requirement for 2023/24	2024/25 AP12 - MAR 25	2024/25 AP11 - FEB 25	2024/25 Month on month movement	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
	£000s	£000s	£000s	Apr-24	340,000	0	340,000	8.30%	4,250	3,101	0.91%
ICB ACDR	4,844,574	4,793,818	50,756	May-24	325,000	0	665,000	16.30%	4,063	237	0.07%
Capital allocation	0	0	0	Jun-24	365,000	0	1,030,000	25.27%	4,563	3,114	0.85%
Less:				Jul-24	350,000	0	1,380,000	33.70%	4,375	2,608	0.75%
Cash drawn down	(4,461,086)	(3,998,000)	(463,086)	Aug-24	320,000	0	1,700,000	41.57%	4,000	661	0.21%
Prescription Pricing Authority	(279,773)	(257,273)	(22,500)	Sep-24	360,000	0	2,060,000	49.00%	4,500	3,744	1.04%
HOT	(2,287)	(2,085)	(202)	Oct-24	347,000	106,000	2,513,000	58.10%	4,338	3,419	0.99%
POD	(96,569)	(84,234)	(12,335)	Nov-24	355,000	0	2,868,000	65.90%	4,438	224	0.06%
Pay Award charges			0	Dec-24	365,000	25,000	3,258,000	74.70%	4,563	3,286	0.90%
PCSE POD charges adjustments	83	43	39	Jan-25	380,000	0	3,638,000	82.80%	4,750	3,036	0.80%
Pension Uplift	(3,731)	(3,731)	0	Feb-25	360,000	0	3,998,000	90.60%	4,500	1,261	0.35%
				Mar-25	397,000	66,086	4,461,086	100.00%	4,963	834	0.21%
Remaining Cash limit	**1,210**	**452,269**	**(447,328)**		**4,264,000**	**197,086**					

8. Summary MHIS Position – Month 12 (March) 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 Outturn 31/03/2025 Year Ending £'000	Mental Health - Non-NHS Outturn 31/03/2025 Year Ending £'000	Total Mental Health Outturn 31/03/2025 Year Ending £'000	Total Mental Health Outturn 31/03/2025 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	44,794	40,281	3,782	44,063	731
Children & Young People's Eating Disorders	2	2,841	2,841	0	2,841	0
Perinatal Mental Health (Community)	3	9,671	9,676	0	9,676	(5)
NHS Talking Therapies, for anxiety and depression	4	35,710	29,400	6,919	36,319	(609)
A and E and Ward Liaison mental health services (adult and older adult)	5	19,056	19,093	0	19,093	(37)
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	13,029	13,031	0	13,031	(2)
Adult community-based mental health crisis care (adult and older adult)	7	35,644	35,495	336	35,831	(187)
Ambulance response services	8	1,150	1,184	0	1,184	(34)
Community A – community services that are not bed-based / not placements	9a	120,942	109,784	10,229	120,013	929
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	25,758	14,576	10,416	24,992	766
Mental Health Placements in Hospitals	20	4,454	3,316	1,402	4,718	(264)
Mental Health Act	10	6,189	0	6,947	6,947	(758)
SMI Physical health checks	11	865	696	119	815	50
Suicide Prevention	12	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	130,481	131,073	0	131,073	(592)
Adult and older adult acute mental health out of area placements	14	9,762	9,376	103	9,479	283
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**460,346**	**419,822**	**40,253**	**460,075**	**271**
Mental health prescribing	16	9,190	0	11,132	11,132	(1,942)
Mental health in continuing care (CHC)	17	242	0	288	288	(46)
Sub-total - MHIS (inc CHC, Prescribing)		**469,778**	**419,822**	**51,673**	**471,495**	**(1,717)**
Learning Disability	18a	16,917	15,463	3,287	18,750	(1,833)
Autism	18b	3,837	2,917	49	2,966	871
Learning Disability & Autism - not separately identified	18c	48,399	4,832	48,216	53,048	(4,649)
Sub-total - LD&A (not included in MHIS)		**69,153**	**23,212**	**51,552**	**74,764**	**(5,611)**
Dementia	19	14,936	13,309	1,748	15,057	(121)
Sub-total - Dementia (not included in MHIS)		**14,936**	**13,309**	**1,748**	**15,057**	**(121)**
Total - Mental Health Services		**553,867**	**456,343**	**104,973**	**561,316**	**(7,449)**

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 23/24 outturn by a **minimum of the growth uplift of 6.85% or £469,778k.** This spend is subject to annual independent review.
- MHIS excludes:
  - spending on LDA and Dementia (Non eligible).
  - out of scope areas such as ADHD and the physical health costs of CHC/S117 placements
  - spend on SDF and other non-recurrent allocations
- The ICB is reporting that it will deliver MHIS of **£471,495k** (£1,717k, 0.37% over delivery). This is attributable to prescribing spend exceeding the 2023/24 plan, additional spend on inpatient and mental health cost per case placements and increased spend over the original plan on an ICB external contract.
- For the continued pressure on S117 mental health and learning disability placements, mitigations include undertaking timely client reviews and developing new pathways.
- ADHD is excluded from MHIS, however there is increasing independent sector spend with approximately £4m in 2024/25. Reducing ADHD and ASD waits remains a priority for 2025/26, and we are working with local providers to review and transform care pathways.

NHS
South East London

Appendix B

SEL ICS Financial Highlights

Month 12 2024/25

South East London Integrated Care System

NHS South East London

Month 12 Outturn

- The values in this report are draft as final year-end figures are not confirmed until after the usual external audit process is completed.
- The ICS had an agreed financial plan for 2024/25 of a £100.0m deficit. In year, the ICS was allocated non-recurrent deficit support funding of £100.0m to enable a break-even plan to be set.
- The ICS is reporting an overall £0.5m surplus for the financial year 2024/25, against this break-even plan.
- 4 out of 5 providers reported a surplus.
- The system has delivered £247.2m of efficiencies for the year against a plan of £270.0m. £164.6m (65%) of the efficiencies were delivered recurrently.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 6
Enclosure 6

Title:	**SEL Ageing Well Framework – "*Age without limits: you say, your way*"**
Meeting Date:	**Thursday 22nd May 2025**
Author:	Kenny Gregory, Director of Adults Integrated Commissioning.
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham) and Denise Radley, Interim Executive Director, Adult Social Care & Health

Purpose of paper:	To introduce the SEL Ageing Well Framework and discuss how this will be implemented in Lewisham.	Update / Information	***X***
		Discussion	**X**
		Decision	
Summary of main points:	The Framework comprises three interconnected zones: Zone 1 Promoting independence and wellbeing Zone 2 Proactive Community Care via Integrated Neighbourhood Teams Zone 3 Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital Care Key principles and requirements for people living with Mental Health Problems, Dementia and/or delirium are captured within each zone. Palliative care and end of life support is also included. Key enablers identified as critical to the development of the framework include – One agreed frailty score, consistent approach to use of CGA, UCP, Workforce Development and Culture and Population Health Management. Draft Outcomes to monitor and evaluate the success of the framework have been defined and will be further refined. Key performance indicators for each outcome are being considered. Next Steps at Place Level are • Broaden the engagement and socialisation of the model with stakeholders. • Individual place led self-assessment against the framework, assess gap/opportunity for development. • Creation of place roadmaps for implementation		

Any impact on BLACHIR recommendations	Key values and principles include: Improved Accessibility, Personalised Care, Positive Ageing and Equity.			
Relevant to the following Boroughs	**Bexley**	✓	**Bromley**	✓
	Greenwich	✓	**Lambeth**	✓
	Lewisham	✓	**Southwark**	✓
	Equality Impact	SEL wide document, therefore EIA to requested from SEL Lead		
	Financial Impact	TBD		
Other Engagement	Public Engagement	Unpaid Carers Engagement sessions held in Lambeth, Bexley, Bromley and Southwark in February and March 2025. 3 Key stakeholder workshop sessions were also held that included Carer and Older Adult Community representatives from Lewisham.		
	Other Committee Discussion/ Engagement	Will be discussion/engagement planning and monitoring via Lewisham Ageing Well Board.		
Recommendation:	Lewisham Local Care Partners to accept the SEL Ageing Well Framework and work together on engagement, implementation, oversight and assurance.			

SEL Ageing Well Framework

'Age without limits: you say, your way'

Final Draft Report
April 2025

Programme supported by:

HEALTH INTEGRATION PARTNERS

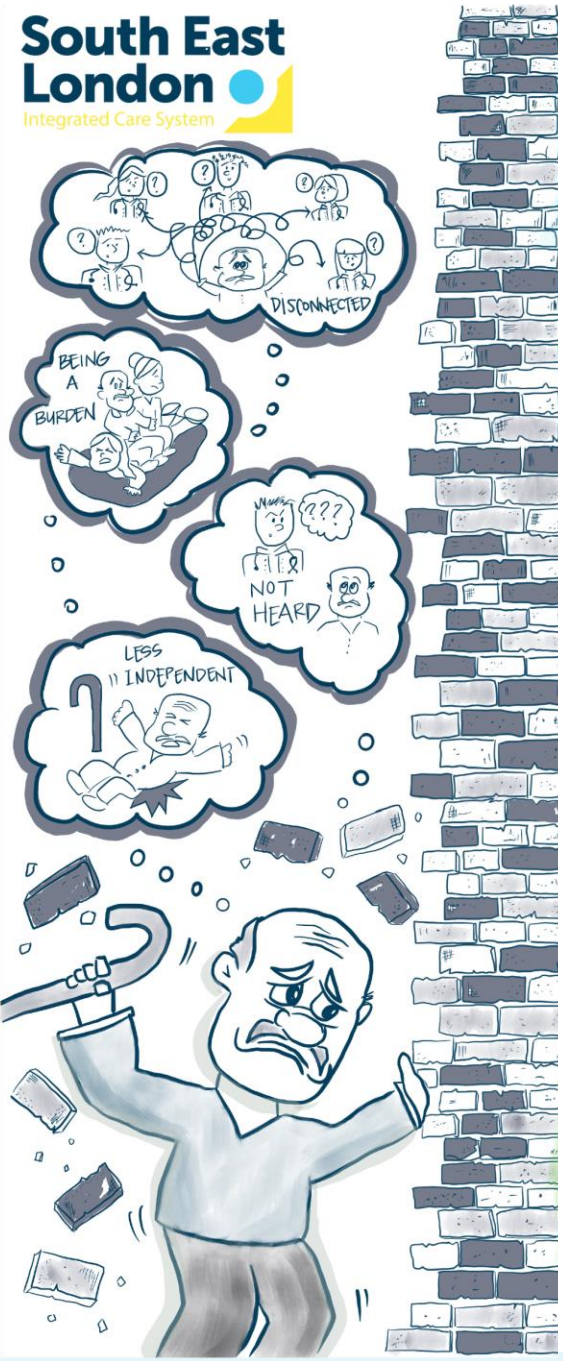
Contents

South East London Integrated Care System

NHS South East London

1. Executive Summary

HEALTH INTEGRATION PARTNERS



Executive summary

Introduction

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

Executive summary .. *continued*

Why we want to promote ageing well

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

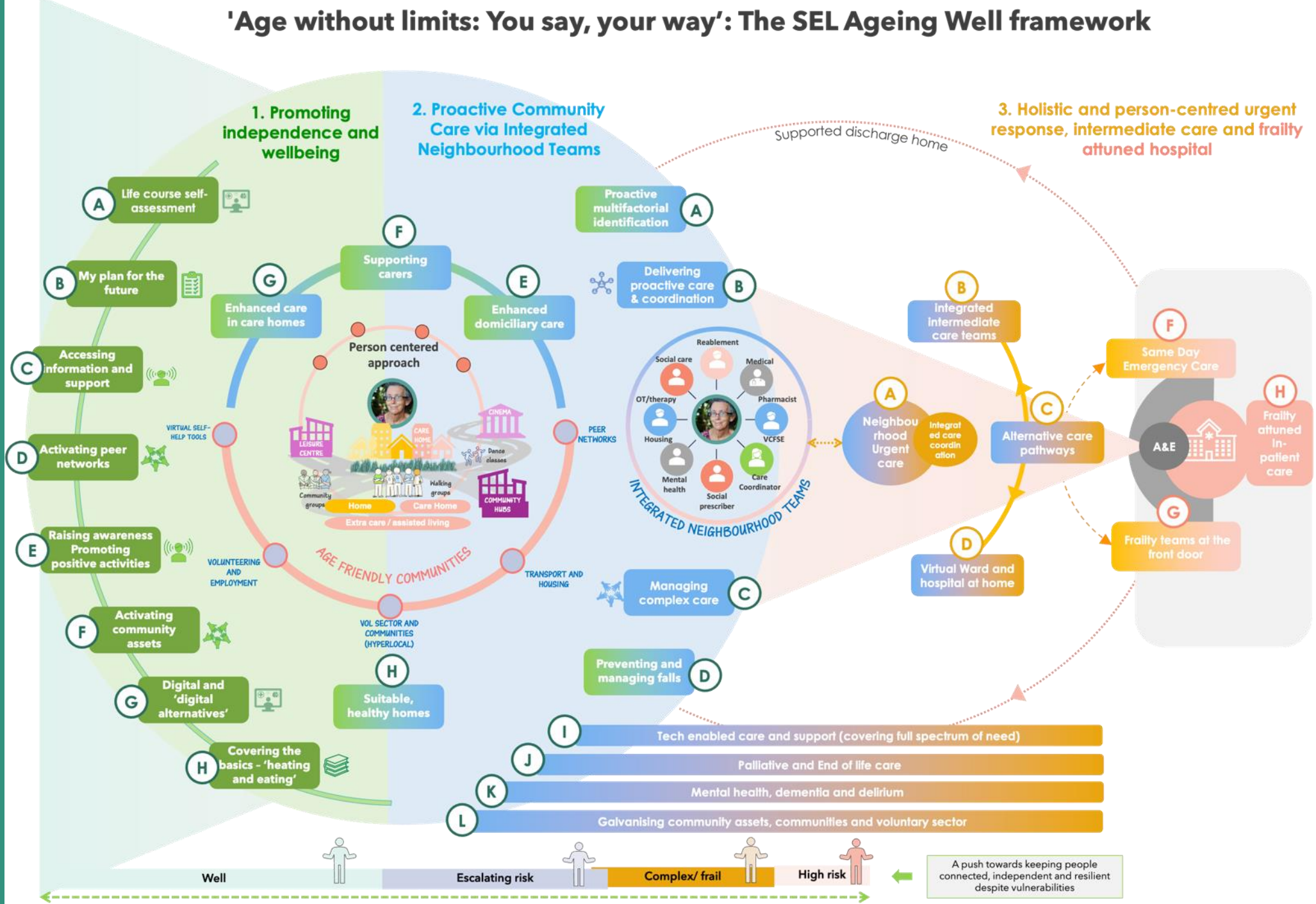
Executive summary .. *continued*

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

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

The SEL Ageing Well Framework

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



This diagram depicts key aspects only for illustration purposes

Executive summary .. *continued*

How will we know we are making a difference?

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

How will we implement the framework?

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

Executive summary .. *continued*

Next steps

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

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

Appendices

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

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

South East London Integrated Care System

NHS South East London

2. Introduction

HEALTH INTEGRATION PARTNERS

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

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

The framework will:

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

Benefits of a shared SEL frailty framework:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

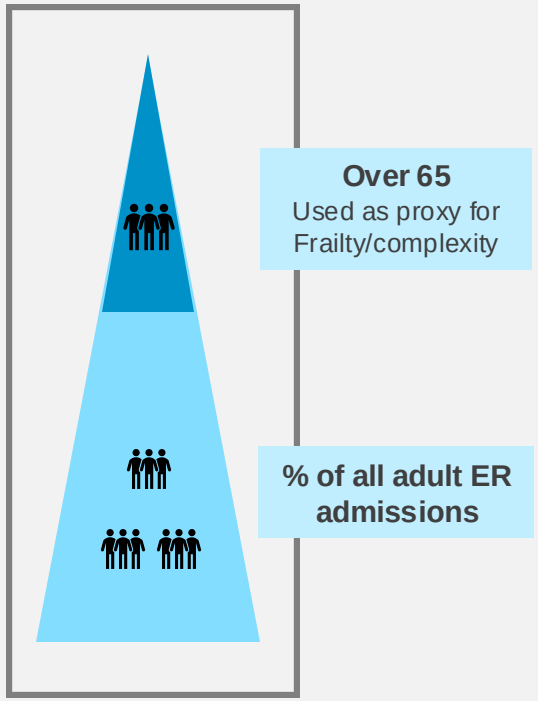
Ageing well *- The ability to maintain low risk of disease-related disability, high mental and physical function, and active engagement with life - including a positive attitude, sense of engagement, purpose and a desire to stay active and healthy in later life, including seeking help when needed and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

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

Ageing well and frailty definitions

3.
Why we want to promote ageing well

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



Over 65
Used as proxy for Frailty/complexity

% of all adult ER admissions

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

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

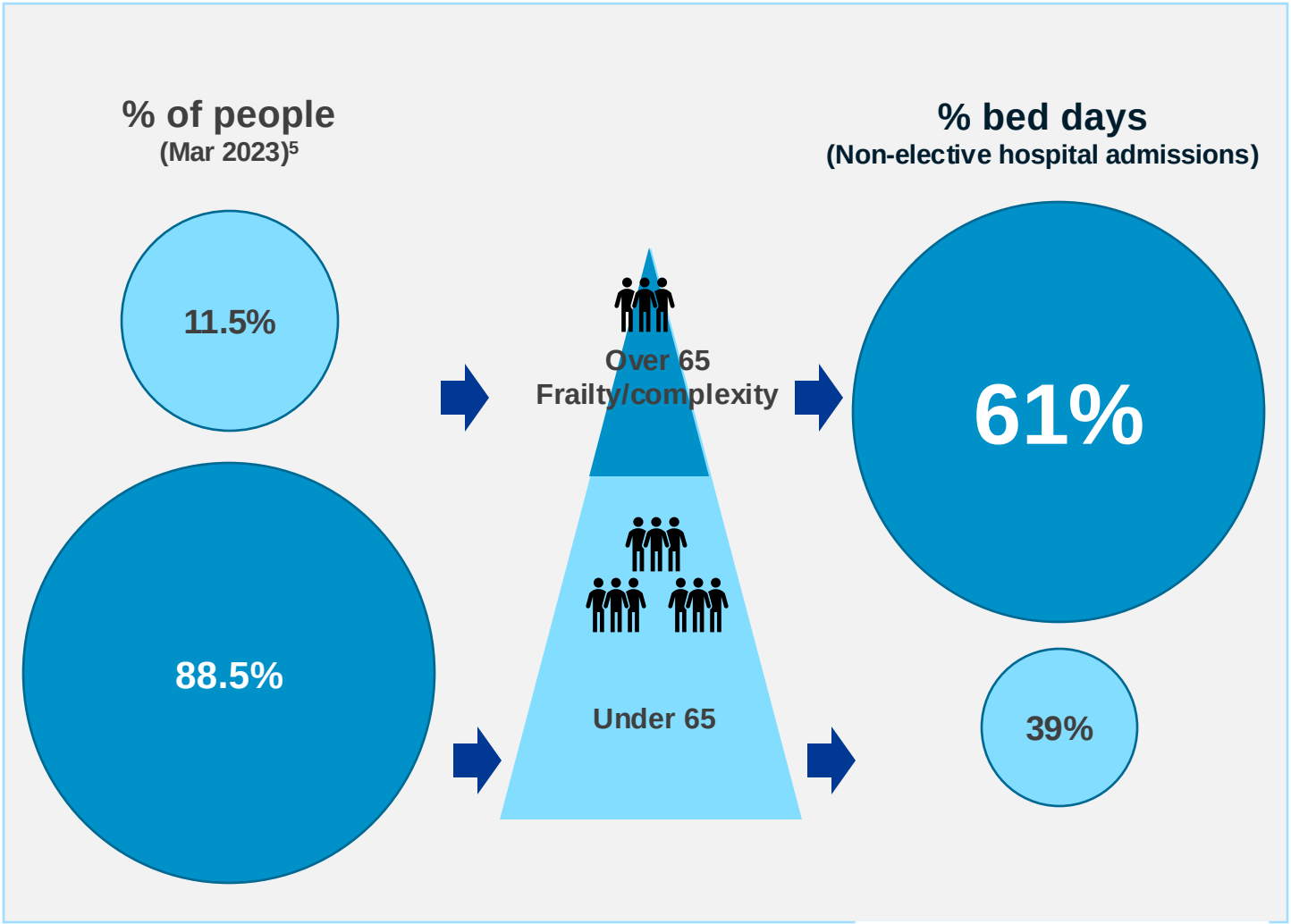
*Please note, data to be validated further
Data source: SUS aggregate download FY 2023/24
[1] Beds utilized calculation (bed-days / 365 and then adjusted for 95% occupancy – BOR)
[2] PBR cost used a proxy for total cost

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

Population growth

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

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

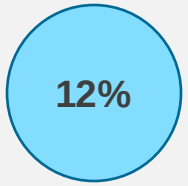


*Please note, data to be validated further
[3] SEL ICS People strategy 2023/24- 2027/28
[4] South East London 2024/25 Joint Forward Plan
[5] Population and Person Insight data (PaPI)

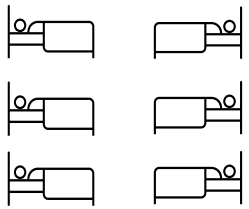
There are a number of admissions that can be avoided through better proactive care in the community

Number of admissions per day (Emergency only)

Ambulatory Care Sensitive Conditions (ACSC)



1 ward in each Place



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

Avoidable admissions

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

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

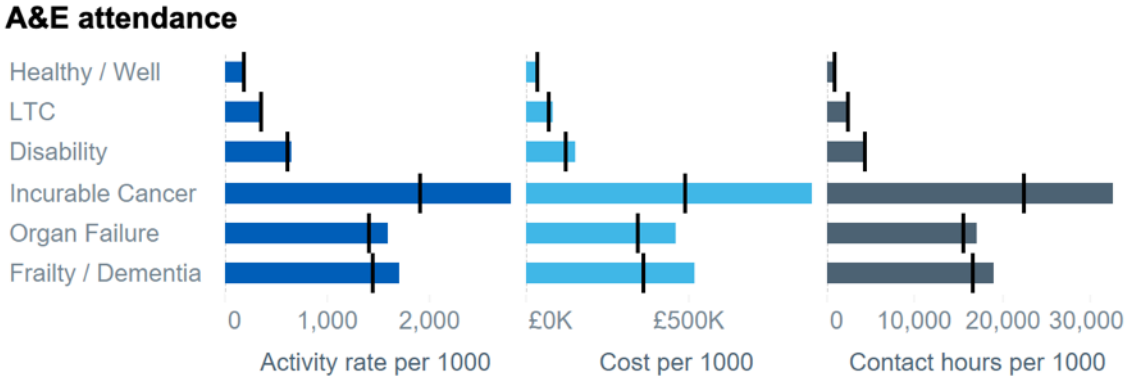
"In 2022/23, within 10 months, there were 1598 avoidable admissions to hospital relating to Ambulatory Care Sensitive Conditions, compared to 2205 in 2021/22. This suggested a 5% reduction target was on course to be met and exceeded.[5]*"*

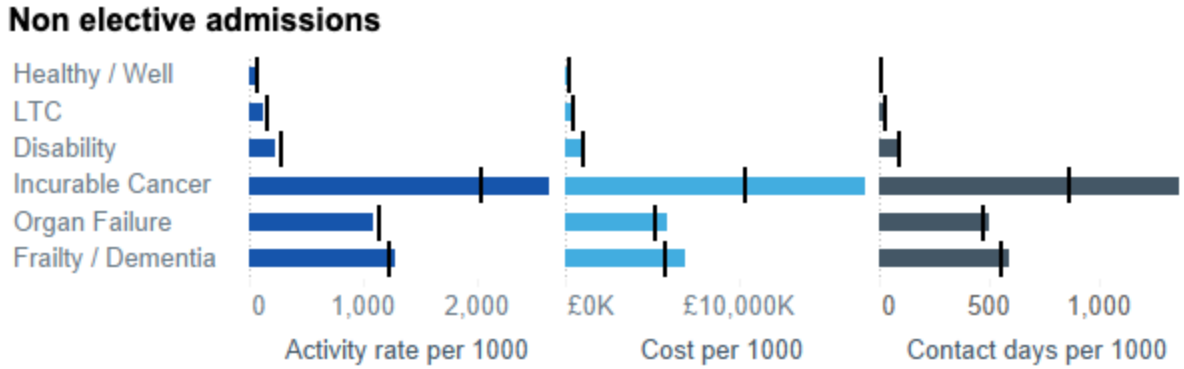
Utilisation of services for those that are frail/ dementia is substantial

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

- SEL 245 per 1000
- England 238 per 1000

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





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

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

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

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

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

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

National Institutes of Health (NIH)

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

(BMC Geriatrics)

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

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

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

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

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

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

National Audit Office (NAO)

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

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

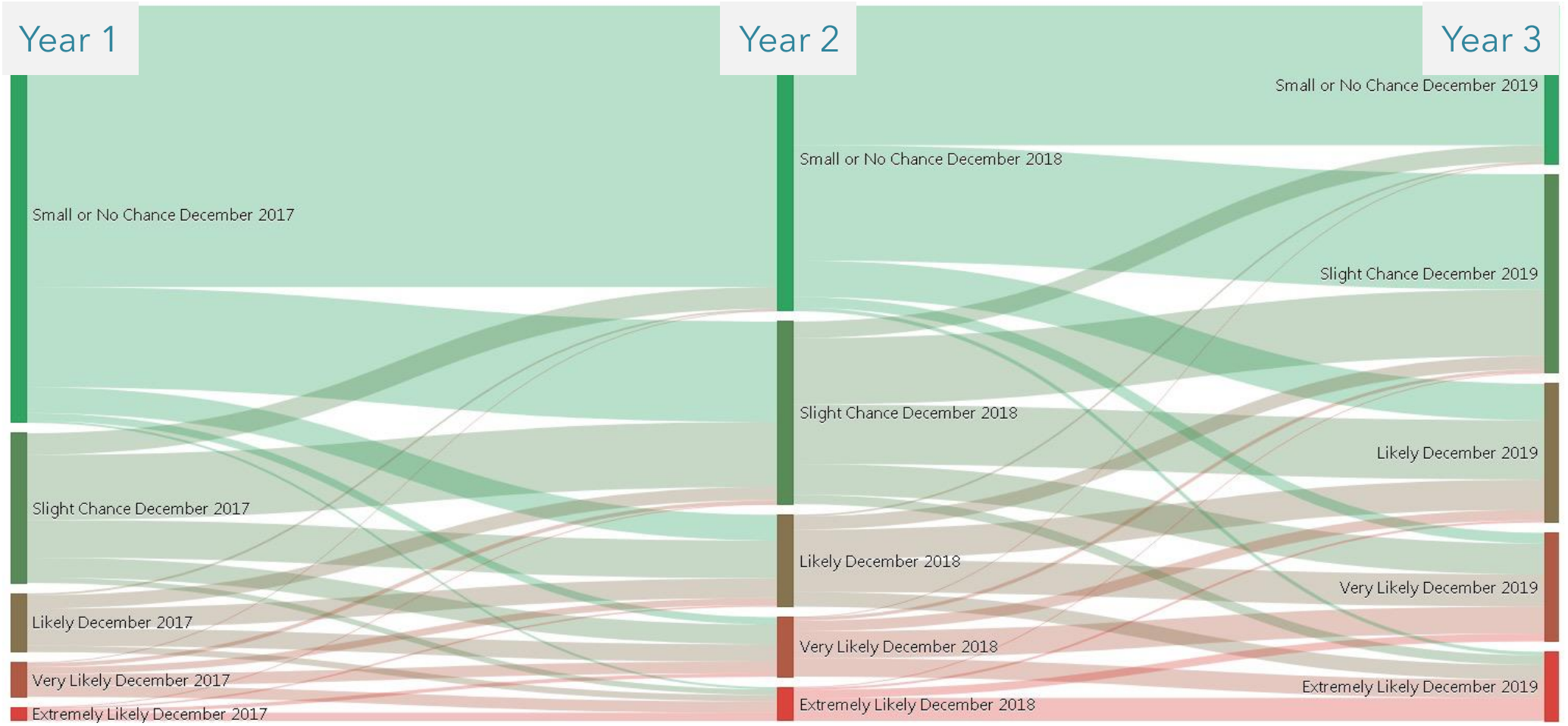
*Please note, data to be validated further. Data source: Frailty and multiple LTC SEL ICB presentation

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

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

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

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



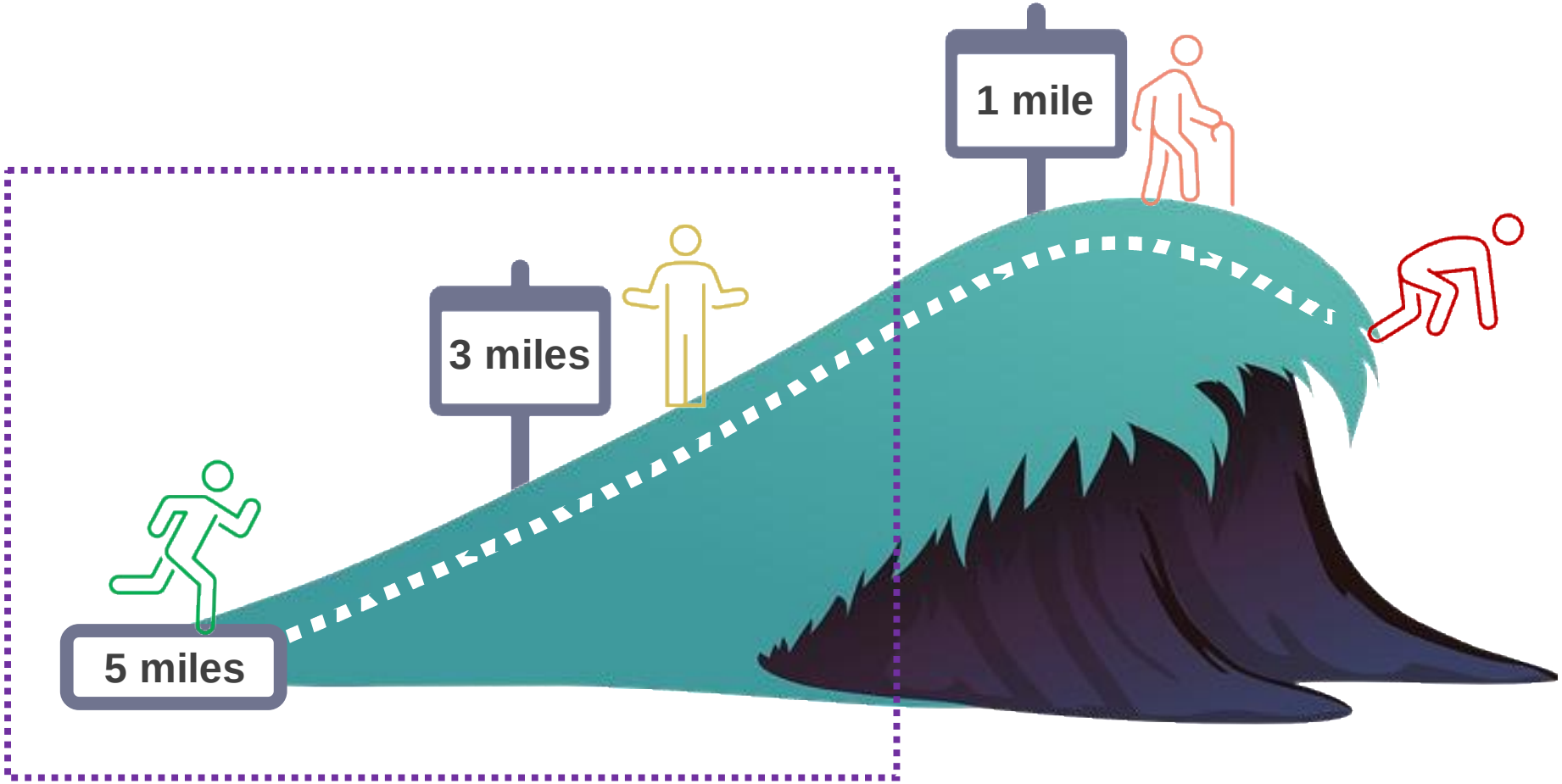
Year 1 profile of exactly the same population – two years ago

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

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

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

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



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

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

4.
What do our SEL residents and carers say?

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

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

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

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

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

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

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

3. Attendance in co-design workshops

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

4. Continued engagement at Place

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

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

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

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

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

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

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

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

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

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

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

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

Resident voice … continued

5

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

6

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

7

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

8

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

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

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

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

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

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

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

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

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

Resident voice … continued

9

Caring role

Access to more flexible, ad hoc support (including respite) instead of an 'all or nothing' arrangement.
Unpaid carers able to get a GP appointment quicker and at a time they need it. Pre-emptive planning for carer crisis – leading to peace of mind and the right action.
Advocacy and earlier respite for carers.

10

Respect and feeling heard

Considering the person's whole life not just seeing a health problem.
Feeling that you must lie and exaggerate to be seen.
Feeling judged and dismissed as a patient or carer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

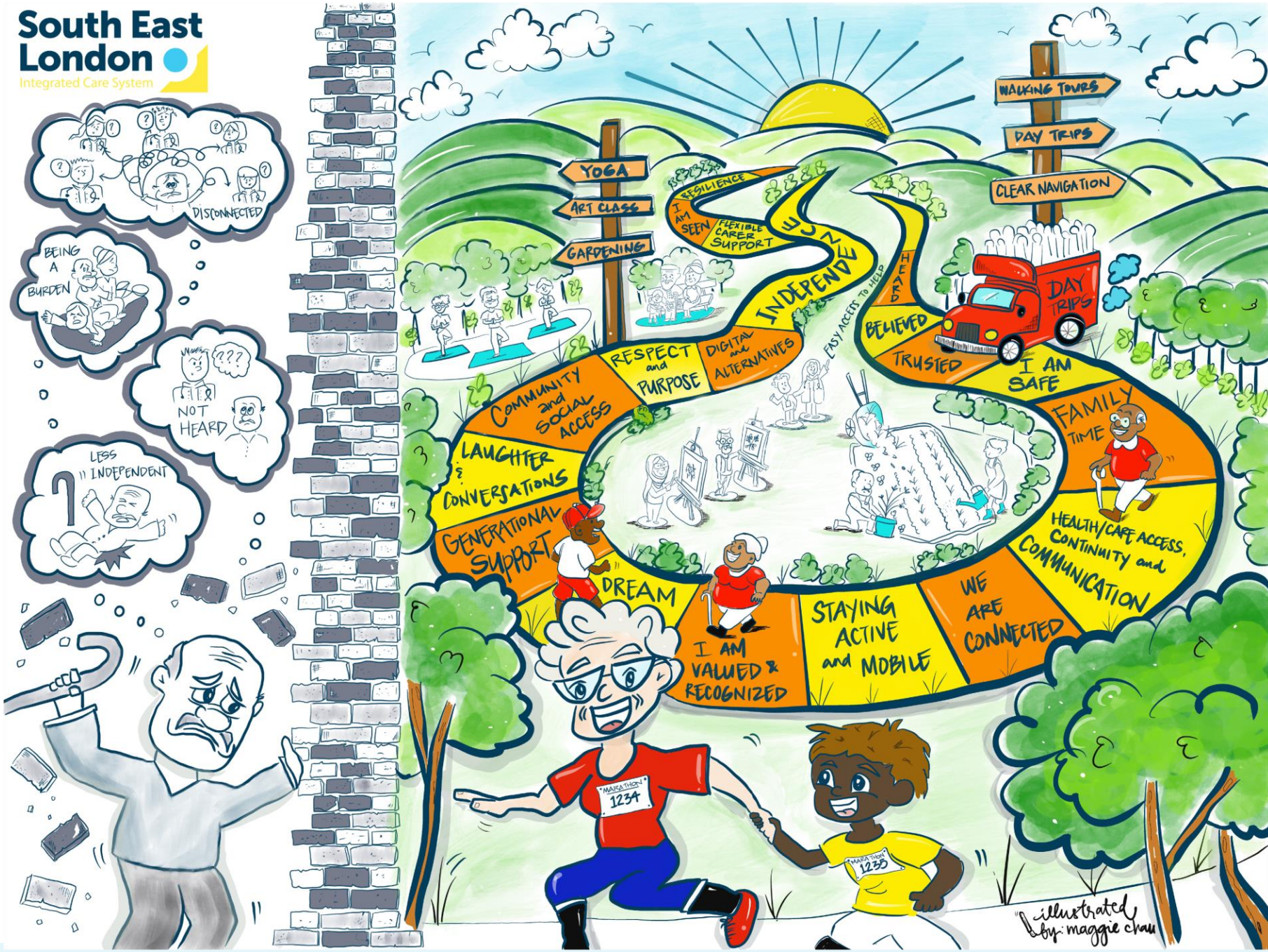
Borough	Resident/Carer organisation	Date of engagement
Southwark	Southwark Carers Cafe	21 February 2025
Southwark/Lambeth	Blackfriars Settlement	11 March 2025
Bromley	Orpington Methodist Church Art Class Group	13 March 2025
Bexley	Bexleyheath Geddes Place Church	10 March 2025

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

Resident voice

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1

Promoting independence and wellbeing- thriving at home

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

2

Proactive community care via integrated neighbourhood teams

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

3

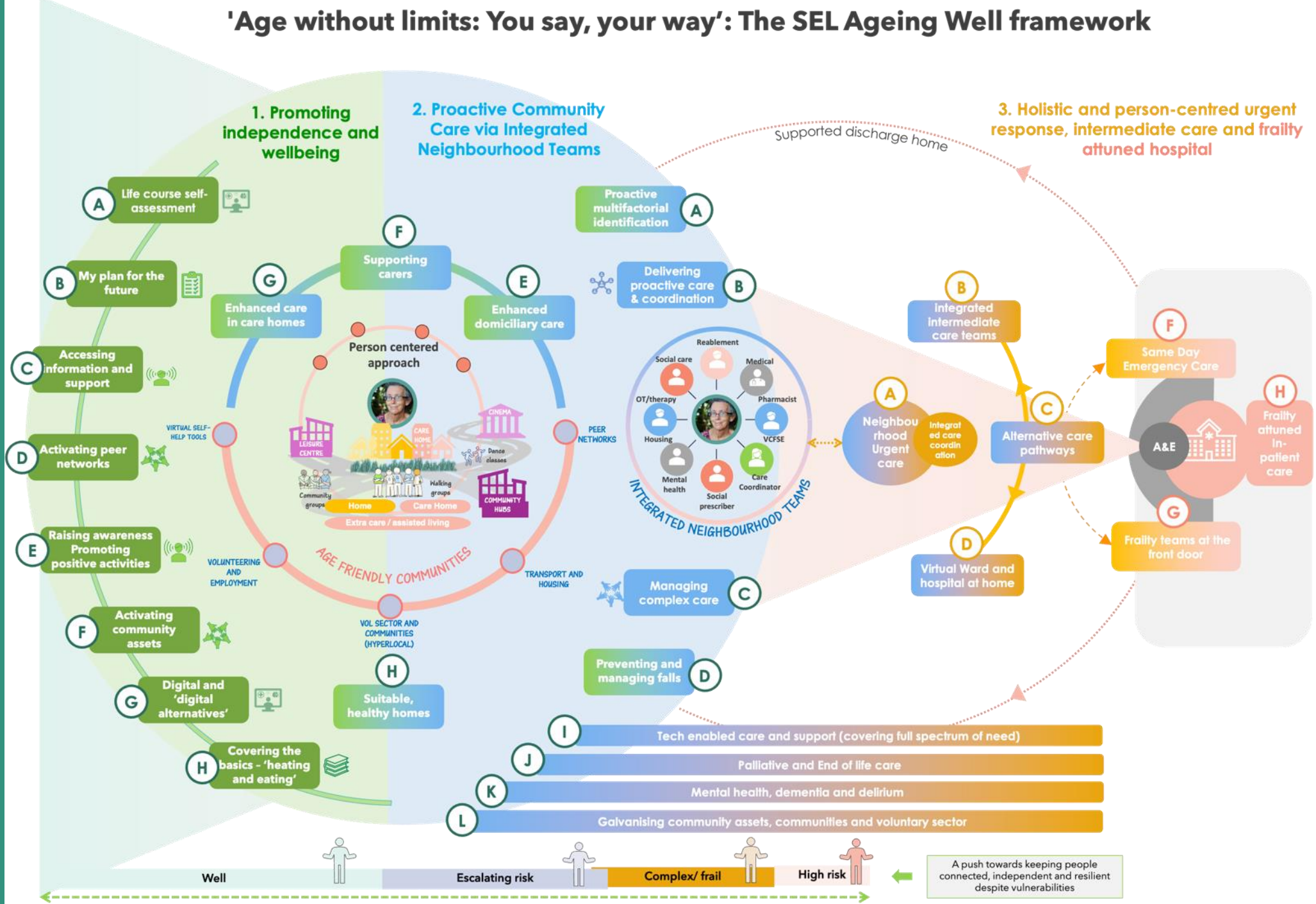
Holistic and person-centred urgent response, intermediate care and frailty attuned hospital

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

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

The SEL Ageing Well Framework

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



This diagram depicts key aspects only for illustration purposes

Zone 1: Promoting independence and wellbeing - thriving at home

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

This zone comprises of the following elements:

- Life course self-assessment, empowering people to self-identify goals and take holistic actions based on 'ageing well milestones' This feeds into 'My Plan for the Future' OR "Planning ahead for what matters to me?"
- 'My Plan for the Future', a self-led holistic tool and plan reflecting personal goals and informed by the ageing well milestones including actions I will take to maintain my health and wellbeing, e.g. adopting a healthy lifestyle and preparing for the future. Includes support and resources I will access, e.g. a community exercise programme or other support through voluntary, community, faith and social enterprise (VCFSE) such as managing money. Plan includes end of life. Can be generated digitally and produced with support from a community champion.
- An easily accessible one stop shop ('access hub') that provides and signposts people to information and knowledge about ageing well and helps them to access local services, support and VCFSE sector offers. Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers.
- Building and delivering local community peer support groups and networks that for example, provide opportunities for older people to contribute, share and learn new skills leading to improved social connections and reduced isolation, and that contribute to building age friendly environments. Inter-generational working e.g. bringing students into care homes/older people into schools and utilising industry e.g. professionals being role models or peer mentors to others.
- Raising awareness of the factors that prevent, slow, and reverse frailty and enable ageing well such as exercise, hydration and nutrition (insights from blue zones). Raising awareness of, normalising and breaking down taboos associated with ageing and dying. Promoting a positive approach and positive representations of older people. Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones as well as other non-digital media.
- Incentivising and activating community assets to provide easy, affordable or free (off-peak) access to local activities, events and facilities (including gyms, cinema, yoga classes, leisure centres, education courses). Asset based community development in which communities do it for themselves. Systems taking an active role in local leadership to influence community developments according to local need.
- Improving the accessibility, knowledge and use of digital tools by residents. Supporting access equity where digital access is not achievable for individuals.
- Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness such as a secure home, heating, cleaning, having access to food and that food is being eaten
- Addressing other wider factors that support independence such as ensuring decent housing, well-lit streets, level pavements and easy to read signage.

Zone 1: Promoting independence and wellbeing - thriving at home

A. Life course self-assessment	• The aim is to focus on prevention by doing the right thing at the right time. This can be enabled through supporting people to self-identify suitable goals and actions based on 'ageing well milestones'. The milestones create a shift in perception, empower people and strengthen understanding of actions that should be taken to 'age well'. This may include information such as "at age 75 focus on this type of exercise, diet and lifestyle to keep your bones healthy and reduce risk of falls". • Milestones will also flag national screening programmes such as the bowel cancer screening kit offered every 2 years for 50–74-year-olds and highlight local resources, e.g. how to access community exercise programmes. It can include continence care information for those over 50. • Milestones can also help educate younger people (e.g., men in their 40s and 50s to take earlier action to prevent issues as they age • The milestones provide a guide to the production of 'my plan for the future'. This should not be a one-off assessment and can form part of the person's universal care plan (UCP).
B. My plan for the future	• A personalised plan, which is self-generated or co-produced with a 'wellness coach' or similar, that captures the person's self-identified goals and actions **they** will take to maintain wellbeing and stay healthy. • The life course self-assessment (above) will help inform and feed into the plan. • The plan will also encourage people to think through what matters most to them, and plan what they want to happen in future, for example if they become unwell – and prompt earlier action, e.g. around producing a lasting power of attorney (LPA) or deciding arrangements for care they may need, including what to do should a crisis be looming or occur, and preferences or arrangements for end of life. • Approach to recognise that changes with ageing can be stressful (e.g., retirement) and therefore be done with empathy.
C. Accessing local information and support	• An easily accessible (to residents, carers and staff) one stop shop ('access hub') that provides and proactively signposts people to information and knowledge about holistic ageing well and helps them to understand and access local services, support and VCFSE offers • Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers. The hub can be co-located with existing community services at Place, with a focus on local health promotion. Hub may also be able to aid professionals with navigation of local resources to support residents. • Public health involvement to promote prevention, working in partnership with residents and resident-facing professionals. • Sharing of information on different partner initiatives, across partners e.g. visibility between health and social care about ambitions, innovations and developments (e.g. falls prevention). A resource that enables staff to understand what is provided in the community and how it helps to get home from hospital earlier with better support or avoid unnecessarily going into hospital. • Sharing self-help information about falls, continence care, mental health and education around diet, hydration and exercise will have a significant impact on quality of life for residents. Practical advice e.g. how to get a hearing check, manage gas and electric, pay bills, get an optician appointment. • Information is sensitive to cultural and generational challenges. • Information be provided to the 'access hub' through people e.g. champions and networks. • Include simplifying existing websites, making them more accessible.

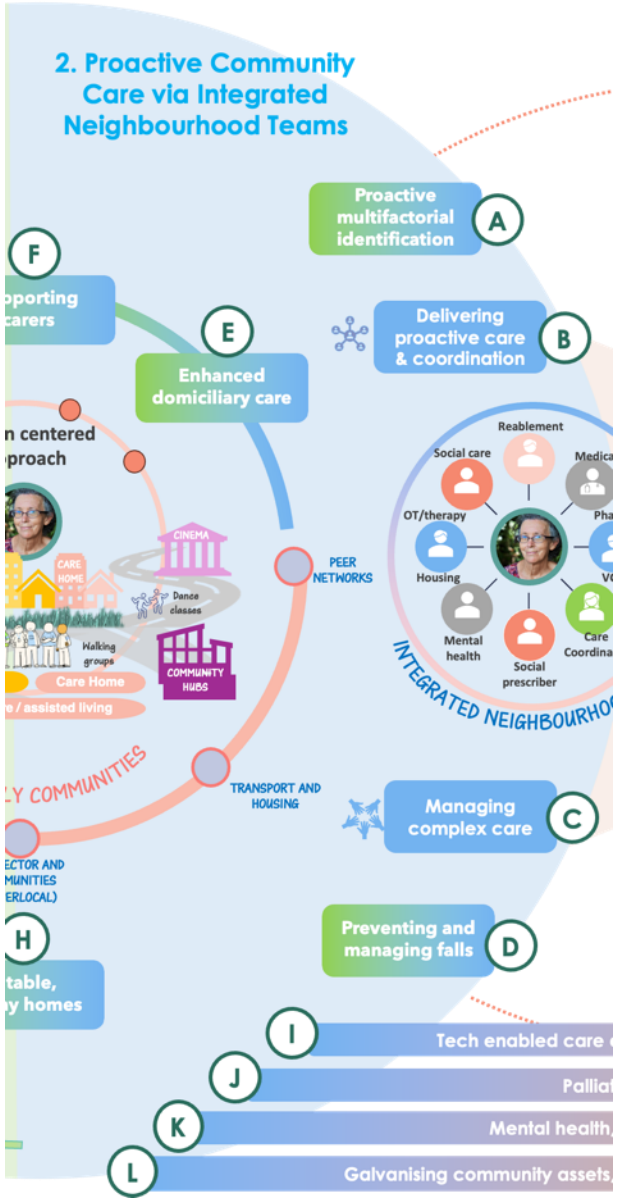
Zone 1: Promoting independence and wellbeing - thriving at home

D. Activating peer networks and intergenerational relationships	• Building local community peer support groups, improving social connections and reducing isolation (therefore improving mental health and reducing depression and anxiety) within the local community. • Utilisation of community champions and creating community networks which are of high value, providing support and resilience. • Creating intergenerational connections to reduce societal ageism barriers e.g. older people mentoring in schools, students volunteering via local VCSFE organisations. • Interventions and activities should be personally relevant (e.g. acceptable in different cultures).
E. Raising awareness and promoting positive activities	• Raising awareness, changing perceptions and activating people to prevent frailty as well as identifying signs of frailty at the earliest opportunity, hence implementing actions to reduce progression. • Early discussions and awareness of palliative care/death literacy. Promoting episodic symptoms support e.g. palliative care. • Raising awareness of the factors that prevent, slow, and reverse frailty (insights from blue zones). • Putting out key messages such as ‘come to us early to prevent illness’ or ‘do this for yourself to take charge of your health’ – or messaging to activate neighbours to look out for older people in their neighbourhood. • Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones and other non-digital alternative media. • Changing the images and photos we use to portray older people, to more positive, breaking down stereotypes.
F. Activating community assets	• Setting up and running social and exercise classes, including strength and balance training, tai chi, yoga, pilates, walking, circuit training, dance, spin, cheerleading, choir and swimming. • Easy, affordable/free access to local activities such as leisure centres/cinema/ gyms to improve connections. • Musical and dance activities from their era, keeping sighted different older people will have grown up in different years and cultures. • 'Expert patients' teaching e.g. exercise groups, how to use gym equipment or other new skills such as DIY, gardening co-ops (e.g. building gardens in care homes or GP surgeries), men in sheds to maximise peer-peer influence and mentorship. • Expert patients may also encompass specific co-morbidity and mental health peer support and identifying champions in key areas e.g. falls, hydration, continence, loneliness, hearing loss, etc. As well as death and technology literacy. • Activating people to contribute to their communities by recognising their contributions and maximising volunteering opportunities and skills. • Providing recognition, accreditation and awards for both those who lead and those who participate in exercise groups. e.g. NHS 'couch to 5k'. • Local and community gyms and swimming pools promoting classes • Corporate social responsibility: connecting with local corporate companies who can support people to age well e.g. local theatre, professionals providing peer mentorship, tapping into philanthropic opportunities. • Having accessible transport links (volunteering opportunities around this). • Community assets need to be dementia-friendly and mental health trained • Consider adopting interventions such the 'paperweight armband'- an easy tool to help identify older people who are at risk of malnutrition, developed by Age UK Salford. Since the introduction of the paperweight armband, Age UK Salford has reported a reduction in hospital admissions, a 50% increase in reporting of underweight BMI in primary care after 1 year and a more appropriate prescribing of oral nutritional supplements).

Zone 1: Promoting independence and wellbeing - thriving at home

G. Tapping into the digital world	• Improving accessibility, knowledge and use of digital tools by residents within the local community. This may be achieved through implementing digital 'drop-in' sessions within local libraries or community centres for instance, or that may be supported by local university student volunteers/peer mentors. • Supported by key FAQ leaflets. • Age friendly support available within libraries. • Providing alternatives to digital (e.g. appointment cards, paper diaries) for people with dementia/others who would benefit e.g. dementia, digital poverty, language barriers / others.
H. Covering the basics – 'heating and eating'	• Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness • Examples include a secure home with working locks, minimising drafts, heating, cleaning, having access to suitable food and checking that suitable food is being eaten and managing money. • Whilst services exist that focus on these 'basics' for people with an identified need, the numbers of people living without them are significant and it is incumbent on all to be alert, identify gaps and problems and help address them, which may include being proactive and notifying VCFSE organisations that can support. • Consider an 'older person's' review in their home, "I want... I need.... I can... I can't..." • Consider what population health management (PHM) data we need and what we want to capture to address the 'basics'.
Wider determinants	• Identifying changes that are required within the wider infrastructure to create an age friendly community (in reference to WHO age-friendly cities framework). • Addressing issues such as pavements, street lighting, access to clean and usable public toilets, access to outdoor seating, support with employment and better transport links. • Uptake of benefits, managing rising cost of living, financial advice and employment support. • Recognising and meeting people's spiritual beliefs, personal values and needs. • Ageing well cafes and death cafes. • Where people are in receipt of extra care, ensuring this is integrated with the wider social/community offer so it supports people to get out and join in rather than become isolated at home.

Zone 2: Proactive community care via integrated neighbourhood teams



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

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

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

Zone 2: Proactive community care via integrated neighbourhood teams

A. Proactive multi-factorial identification	• Proactive multifactorial identification of frailty and its severity (mild, moderate, severe) with a uniform tool across health and social care, e.g. using the clinical frailty scale (CFS) to enable standardisation and one common language. • Using collective local intelligence (wider proactive community flag) to supplement the data e.g. from GP practices in which all system staff (regardless of host organisation) are trained to **help** identify frailty (with a united system language of what we mean by frailty) and connect with others to enable residents earlier access to CGA and help. Making all system interactions count to enabling holistic whole person approach, whether resident accesses help via their GP, secondary care, community pharmacists, social care, district nursing, carers, VCFSE, learning disabilities services, homeless and refugee services, housing, domiciliary care and pharmacy. All partners working together to deliver as an MDT. • No wrong door to an organisation approach. Move organisational navigation from the user to the access point. • Community information hub or 'access hub' to also report and raise concerns about vulnerable people. • Consider an in-reach team with an ageing well skill set (geriatrician, nurse, AHP), working with GPs, allocating whole day going into e.g., sheltered accommodation, Latino centre to test different 'out of the box' ways of finding and responding to people (see Lambeth approach) • Ensuring people with severe mental illness (SMI) and/or dual diagnosis, are not excluded. • Looking at the value of shared records, collected by all, to create a single, shared frailty register. • Use of data and/or artificial intelligence (AI) to identify people with frailty or at a rising risk.
B. Delivering proactive care and coordination	• A dedicated care team of multi-agency professionals formed within the neighbourhood, including primary care, allied health professionals (AHPs), including speech and language therapists (SALT), physiotherapists, occupational therapists (OT), substance use, mental health, housing, community nursing and secondary care specialists. Consider establishing a specific frailty neighbourhood team as part of integrated neighbourhood teams (INT) that visits, conducts CGA/tests, plans, delivers and follows up care. • Frailty neighbourhood team to include CGA & frailty skilled workers working within their scope of practice with support, admiral nurses, social prescriber, pharmacist, council access (social care and housing) as well as geriatrician input feasible to context. • Focus on individual's holistic needs and preferences, established through 'talking to the person', carers and family on 'what matters to them', enabling nuanced decision-making, as well as and providing a personalised and holistic approach, with MDT interventions. • Consistent minimum core actions to be carried out at mild/moderate/severe stages of frailty. • Building a strong social prescribing resource/team who build relationships with individuals. • Seeing people who are teetering before they reach crisis point and galvanising holistic (not just health) interventions straight away before exacerbation occurs. • Above arrangements to include making reasonable adjustments for people with mental health needs and dementia or other characteristics that mean care or care pathways need nuance to facilitate equity.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination .. contd	• Close liaison and optimal use of VCFSE organisations, including hyper local offers. • Definition of a strategy for medicines management and de-prescribing including proactive identification of most vulnerable patients with medication issues, structured face to face medication reviews based on shared decision-making and what matter to the person • Access to pharmacists for a second opinion (including via MDTs with social prescribers for non-drug options), • Clear links to community pharmacy to enable bi-directionally MDT working between primary care, frailty teams and community pharmacist to better identify non-concordance, better access to help, information and health education • Provision of help especially post-discharge (e.g., through the New Medicines Services and Discharge Medicines Service), information and education so that patients better understand their medications – and clear ownership of these elements so professionals know 'who does what'. • Existing examples that incorporate some of these aspects are the integrated clinical pharmacy services – GSTT Integrated Local Service Pharmacy team, Lewisham Integrated Medicines Optimisation Service (LIMOS), Bromley Integrated Medicines Optimisation Service (BIMOS).
C. Managing complex care	• Cohort may include homeless, asylum seekers and prisoners, as well as more obvious groups e.g. severe mental health disorders, care homes. • Manage people with frailty and escalating complexity via complex care coordination. • Bring specialist and acute input into the community MDT e.g. SALT, substance use, secondary care experts. • Strong role for social prescribing and use of VCSFE sector. • Explicit medicines management strategy for complex patients with MDTs including prescribers (e.g., GPs), pharmacists and specialists to make balanced decisions about polypharmacy and de-prescribing for complex patients. Guide by patient-oriented goals, so that complex decisions about stopping/starting medications are supported and made and in a timely way – and complex patients are supported with proactive help and advice to optimise concordance (e.g., via referral to community pharmacy to engage with and support complex patients).
D. Preventing and managing falls	• Falls management model as part of proactive community care. Timely multifactorial assessment for falls addressing additional factors such as eyesight and hearing, for those that are complex and predisposed to falling. • Preventative measures such as activity, strength and balance exercises are highlighted in Zone 1 (Component F).

Zone 2: Proactive community care via integrated neighbourhood teams

E. Supporting carers	• Unpaid carer's assessment completed and reviewed regularly. • Earlier, more flexible and episodic, ad hoc support (including respite) for carers (instead of an 'all or nothing' offer). • Unpaid carers able to get a GP appointment at a time they need it, recognising the importance of their role. • Signposting to appropriate services including financial advice and support groups within the community e.g. carers café. • Pre-emptive planning for carer crisis e.g. contingencies if the carer becomes unwell, leading to peace of mind and the right actions taken. • Carer identity card indicating where to find an 'emergency pack' so that urgent and emergency services know where to find everything in the event of a carer crisis. • Providing training for carers to increase their skill and resilience to managing older people with frailty.
F. Enhanced domiciliary care	• For stable people at home, care which is flexible, high quality and focused on how to support people to achieve their full potential supported by a personalised care plan that is regularly reviewed. • Redesign recognising the holistic opportunity to keep people at home for longer, prevent escalation and delay admission to a care home. Redesign aligned to the CQC framework. • Moving from a 'task and time' approach to outcomes; optimising the person, increasing self-sufficiency and encouraging/supporting social engagement and participation. • Establishing stronger partnership working between domiciliary care providers, informal carers and the health and care system so that issues are identified and acted upon earlier. • Domiciliary care staff upskilled and supported in proactively identifying signs of deterioration early on and able to make direct referral to the resident's nominated coordinator and be involved in MDT meetings. Uniformity in training needs across the borough, to reduce the variation in care delivered by domiciliary care providers including in skills related to frailty to enable earlier escalation of concerns. • Provision of coaches to support workers through oversight, giving advice, coaching and training e.g. in practical ways to optimise the person, identifying and managing concerns such as frailty, delirium and behavioural and psychological symptoms of dementia (BPSD). • Training can be also attended by other formal/informal carers to create local support networks within communities to become the 'eyes and ears' of domiciliary care. • Option for people to select their preferred wellbeing worker using summary info about their profile (experience, style of working). • Health visitor role coordinated with domiciliary care to provide enhanced support. • Ensuring clear expectations are set between wellbeing worker and client at outset e.g. 'I will use my mobile phone as part of my job whilst I am with you'. • Paying workers the London living wage.

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing)	• Care homes are not a separate ecosystem and residents are to receive equivalent care and support as those in other settings, recognising they are of equal importance and that the model may need nuance to enable equity of access. For example, ensure use of the life course self-assessment in care homes (see Zone 1), and use of CGA, UCP and ACP. • Care home settings are often poorly understood by health teams. There is a need to shift to a positive approach, listening and championing care home staff and asking them what they most need. Consider a care home champion post per Place. • Training and support to maintain competency are key, so that care home staff feel confident (recognising they sometimes do tasks infrequently so get out of practise e.g. using a syringe driver). Healthcare should play an active role in supporting health-related training, e.g. in falls prevention, wound care etc. • Provision of training around early recognition of deterioration with supportive tools (e.g. RESTORE2) and 4AT (screening tool used to assess delirium and cognitive impairment). • Consider establishing a care home support team (CHS) and/or primary care, to provide a transparent, uniform offer into care homes, supporting e.g. bedside training, clinical supervision (around topics such as falls prevention/management, tissue viability, polypharmacy reduction, nutrition and hydration) to build trust and dissipate fear (see Penninsula Practice, Greenwich as an example). This support to be provided to care home health care assistants (HCAs), not just registered staff. • Consider a specific care home mental health/dementia team as part of the above provision, to provide training and support to e.g. mental health, dementia, delirium and BPSD. • Consider a geriatrician in-reach model reaching into care homes to support MDTs, training and to visit specific residents to prevent admission (Whipps Cross Hospital model). • Regular feedback to relatives regarding the resident's progress and proactively addressing any relative's concerns. • Care homes direct referral pathway to same day emergency care (SDEC). London Ambulance Service (LAS) transfer to SDEC, SDEC provide treatment and LAS return to care home). • Specifically ensure an Alzheimer's support worker supports transitions into care homes to settle the person and resolve issues. • Include care homes within a telecare and telehealth strategy, e.g. providing the opportunity for wearables to be utilised where this shows evidence-base to support its utility. • Involvement of activity coordinators within care homes to keep residents engaged with social activities and group activities and to promote self-help and independence and include accessing the community where possible. • Include a spell in care homes as part of student training, e.g. to enable deeper understanding of frailty. • Align with the national framework for enhanced health in care homes (EHCH).
H. Suitable homes	• Develop processes to swap social homes with others to get a home that meets changing needs and preferences as you grow older (e.g. moving from a high rise flat to a ground floor flat with a balcony if you develop knee problems and have a dream of having a place to sit outside). • Prioritising housing adaptations and changes for people with specific needs via making a link between health, social and housing services - working together to respond to people's changing needs in a coordinated way. • Influencing the design of new build housing and estate infrastructure so that it is suitable for older people's future needs.

Zone 2: Proactive community care via integrated neighbourhood teams

I. Technology enabled care and support (TECS)	• Consider development of an integrated telecare and telehealth strategy and approach that optimises the ability to keep people living with frailty safe and independent at home (aligned to virtual ward offer). • As part of strategy scan the market to identify new products to innovate the offer, move from analogue to digital and upgrade the user experience. • Examples of TECS include community alarms and detectors, door alarms, home activity detectors (e.g. falls), TECS supporting daily activities of living such as picture clocks with visual, audible clues, and wearables (e.g. blood pressure monitors), low tech items like walking sticks also included. • Consider same day TECS delivery to expedite timely discharge of people with frailty from hospital. • Consider VCSFE ability to directly source smaller items themselves to increase speed of response and source at cheaper prices. • Monitor clinical and cost effectiveness outcomes, satisfaction levels and benefits gained as part of rigorous evaluation process.
J. Palliative and end of life care (PEoLC)	• The narrative should be focussed on what is right for the individual and include shared decision making, not on what is best for the system. • Recognising 'ordinary dying' – palliative and end of life care should be everyone's business, not just that is the palliative care specialists. • Build PEoLC skills within the neighbourhood teams to reduce over-dependence on specialists. Recognise the need for a personal navigator role at the end of life. • Recognising that domiciliary care and district nursing play a vital role at the end of life, alongside GPs and community services. • Social care plays a huge role in the holistic care for a person – palliative care is not just about medical care needs. • Palliative care does not just happen at the end of life – it can be episodic and last a number of years. • Creating a culture where people are more comfortable to talk about death and see it as part of the continuum of care, 'planning for the end'. • Recognising that advanced care planning (ACP) is not a one-off conversation, rather should be ongoing and it is not the responsibility of a single role – it is everyone's responsibility. • Embedding early advanced care planning as a standard, before a crisis happens, 'planning for the future is key', particularly for people living with dementia. • Having difficult conversations regarding PEoLC earlier to enable care, and death, to happen in the person's place of preference, with family members/friends present. • Outcome measures should be focussed on quality of advance care planning rather than preferred place of death, as well as learnings from national audit of care at the end of life (NACEL), and the emphasis on staff and bereaved carer feedback. • Timely support to carers is key and gaps in bereavement services need to be filled and offers made more transparent (e.g., in a brochure). (Greenwich public health team undertaking pilot bereavement project).

Zone 2: Proactive community care via integrated neighbourhood teams

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

Mental Health/Dementia & delirium within the framework

ZONE 1

- Knowing exactly who our population with mental health problems and dementia are
- Equally promoting independence and wellbeing for people living with mental health problems and dementia ensuring parity of provision for these groups and reducing stigma.
- Early identification: spotting and responding proactively to early signs of deterioration.
- Supporting people to engage with their health, e.g. to address excessive drinking and resultant low mood.
- Early support and advocacy to good decision-making about what to do e.g. post diagnosis
- Supporting people to build resilience post-diagnosis
- Understanding and acting upon carer risk

ZONE 2

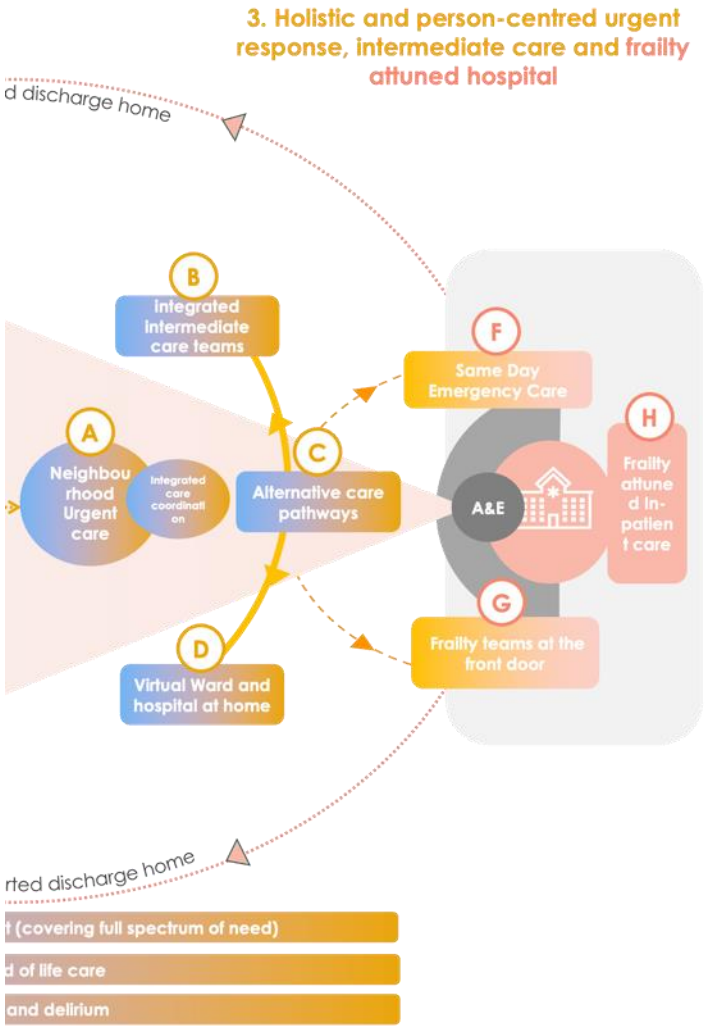
- Clear support post-diagnosis (instead of being sent all over the place)
- Dementia care home team providing advice, training and coaching to staff e.g. managing BPSD, monitoring hydration, etc.
- Upskill domiciliary care workers to reduce avoidable escalation and admission with earlier detection and action to deterioration and delirium.
- Strong connections with social care link workers
- Pre-planned crisis escalation support (including e.g. giving carers urine pots so testing can be expedited quicker).
- Carers as full partners in decision making and effective carer support and respite
- Managing behavioural issues associated with dementia (across zones). Understanding people's unmet needs and what they are trying to communicate via their behaviours to keep people in the least intensive setting.
- Access to substance use specialists e.g. to take part in MDT discussions
- Making reasonable adjustments e.g. providing paper appointment cards, using paper diaries (instead of automation).

ZONE 3

- Timely step-up/step-down to intermediate care
- Provision of specialist input e.g. speech, language, nutrition.
- Integrated, wrap around offer (housing, homecare, domiciliary care).
- Speedy return to normal place of residence
- Skilled management of emergency presentations to avoid admission.
- Timely identification and assessment of dementia/delirium in hospital (4AT).
- Strong focus on nutrition, hydration and constipation checks at all stages of the journey.
- Minimal ward moves and improving the patient experience
- Nuanced decision-making based on what and who matters to the person.
- Optimising the discharge process for people with mental health problems and dementia, so they experience parity.
- Being more empathetic and proactive when appointments are missed, e.g. following up, taking time to explain and re-setting appointments.
- Consider Admiral nurse as part of team to provide support to and help to navigate/coordinate and signpost care for people living with dementia (including support to carers).

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

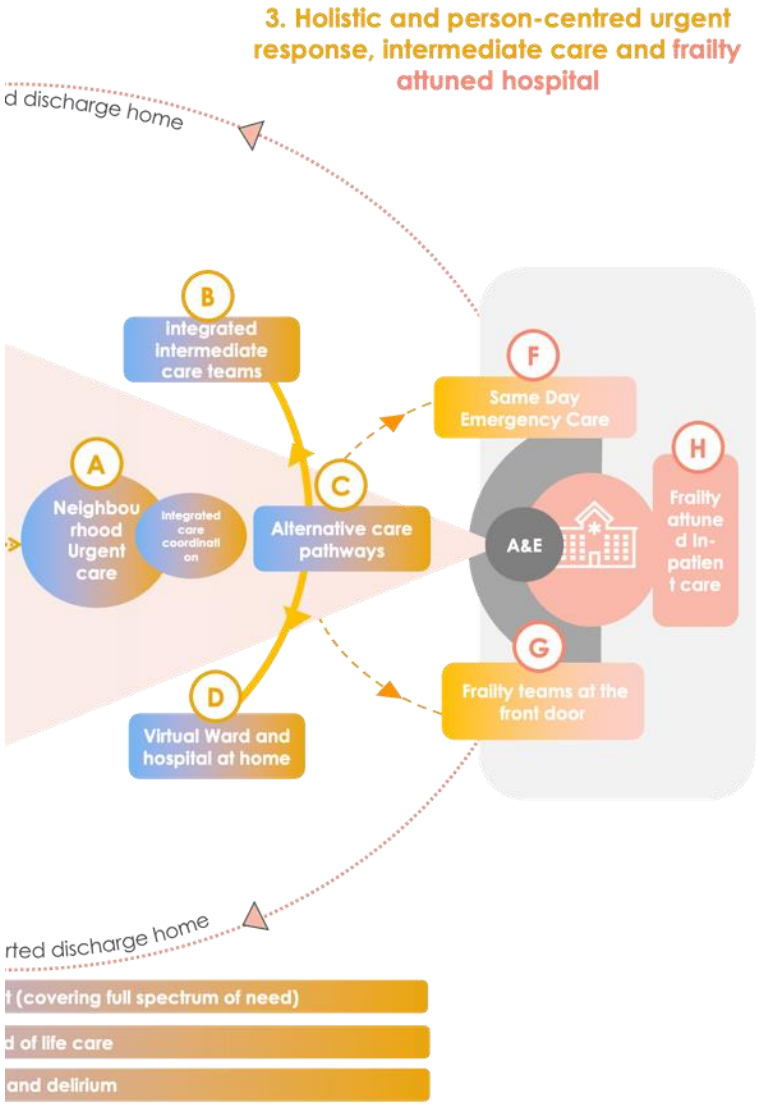
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Neighbourhood-based urgent community care preventing escalation for those at home
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Step-up intermediate care and/or hospital@home helping to avoid unnecessary hospital attendance or admission.
- Step-down intermediate care and/or hospital@home for those at the hospital front door or who have been admitted, enabling timely discharge and avoidance of readmission.
- Strong focus on step-up provision to ensure fewer people are unnecessarily admitted to hospital in the first place.
- Simplified and coherent community escalation attuned to the holistic needs of older people and those living with frailty to keep people at home for as long as possible. Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Provision of timely, strengths-based and coordinated intermediate care (recovery, reablement and rehabilitation) based on people's goals and focused on wellbeing and independence, for those who need a continued period of managed care in the community or following presentation at or admittance to hospital.
- Intermediate care needs identified in the community or hospital front door escalated into a single point of access for advice or acceptance for rapid therapeutic transfer of care, including real time review of any existing package of care in place.
- Timely delivery of intermediate care and support without delay that would otherwise lead to deterioration at home or deconditioning in hospital, e.g. therapy starts immediately post discharge to avoid person becoming bed bound and to optimise independent living.
- Includes advice and support to help people manage life events such as bereavement, organising care requirements and planning lasting power of attorney.
- Ability to make direct referral to a virtual ward to prevent admission or expedite earlier discharge from hospital.
- Inclusive of direct access to medical support (including via advice and guidance) and a solid out of hours provision.
- The ability to align mental health resources to the more urgent mental health and dementia cases to ensure parity of care for people with mental health problems and dementia. For example, admiral nurse involvement to expedite swifter hospital discharge and provision of a short period of specialised support at home to enable earlier discharge for people with delirium.

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



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

- Frailty team at the front door to proactively identify frail people, carry out holistic assessment and care planning and where possible transfer directly back to community-based care before the person becomes 'medicalised'.
- Establishing realistic independence and activities of daily living (ADL) baseline and making nuanced decisions based on this and 'what and who matters to the person'.
- SDEC - assessment and care by specialist clinicians on the day of arrival to hospital as an alternative to admission, ensuring those that would not benefit from hospital admission are discharged back into the community.
- Acute frailty unit - a multidisciplinary assessment unit, to address the urgent medical needs for those that are frail and require a short stay (less than 3 days) in hospital.
- Fracture liaison service - identification of people who have suffered a fragility fracture, providing a bone health assessment to identify future falls risks and to reduce the risk of future fractures.
- An inpatient older people's ward for those who require a longer inpatient stay due to medical reasons – including a focus on reablement, mobility, exercise and cognitive stimulation to reduce deconditioning during their stay.
- Transfer of care hub providing coordinated discharge back to the community, including taking actions from day of admission (as part of discharge planning) to expedite timely discharge without delay.
- Frailty and dementia/delirium skilled and attuned staff in all key hospital roles, so that for example, decision-making about care is more nuanced and driven by *what and who matters* to the person.
- Defined standards for frailty-attuned care for people in other settings such as surgery, oncology and other non-geriatrician led inpatient services.
- Consider use of summary acute medicine indicator table (SAMIT 75+) offering national comparative data for frailty at site level. Metrics cover demand, flow and outcome for both the admission and recovery phases of frailty care.

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

A. Neighbourhood urgent care with integrated care coordination	• Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined). • Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate. • Seamless flow and pathways between services and in-reach into neighbourhoods as a shared resource. • Core MDT: An MDT approach consisting of paramedics, nurses, OT, dietician, social care professionals, advanced care practitioners and managers. • Connected teams: Direct interface with health and social care provision such as GP, 111, pharmacy, INT, Virtual ward, LA front door, Housing, • System collaboration: Access to other professionals including UEC, GP, hospital, mental health, housing, urgent response mental health placement etc • System integration/technology: ensuring visibility of patients, access to shared records, data transfer between MDT and use of tele-monitoring/tele-care • Care navigator/ co-ordinator with clear ownership of cases. Strong key relationships and conversations-with clear communication lines • Holistic approach with focus on prevention, e.g. ensuring that lower-level or emerging social needs are not missed
B. Integrated intermediate care teams	• MDT working to deliver a timely step-up and step-down service focused on recovery, wellbeing and independence • MDT comprising of medical, therapy, mental health, nursing, VCSFE, pharmacy, reablement, night carers, handyman service. • Access to extended MDT and/or advice including housing, geriatricians, cardiologists, etc. • Coordinated, proactive support, putting everything in place, working closely with a carer or family where present • Real time review and adjustment of support and ability to increase or decrease care to optimise outcomes • Access to existing CGA or ability to carry out a CGA, aligned to an urgent care plan • Specific liaison role with care homes to ensure proportional access and utilisation of service by care homes • Utilisation of service by specialist palliative care, hospice and end of life care teams • Timely access to equipment to ensure care and support commence rapidly.

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

C. Urgent community response and alternative care pathways	• Consistent UCR offer across SEL aligned to national standards and population health. Seamless flow/pathways into/in-between ACP :virtual wards, frailty units, SDEC • Intermediate care needs identified in the community, at the hospital front door or at discharge from hospital are escalated into the single point of access for advice, guidance or referral for a rapid, therapeutic transfer of care, including real time review of existing packages of care • Specifically for frailty, which is delivered at a place level, and may differ operationally between places based on local requirements. • Anyone can access and be signposted, including professionals working in zones 1 and 2, care homes, palliative care, etc. • Timely, direct access to reablement and rehabilitation via one and done process (no hand-offs). • A senior experienced clinician and social care led service, with authority and decision-making capabilities. • Rotation of staff within the system for care alignment and development. • Standardisation and simplification of proforma.
D. Virtual ward and hospital at home	• Direct referral pathway from intermediate care teams, urgent community response teams, front door frailty teams, SDEC, discharge teams and transfer of care hub (TOCH) to virtual ward. • Virtual ward teams specifically skilled in frailty care and falls management.

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

F. Same day emergency care (SDEC)	• An MDT led frailty SDEC approach (geriatrician, advanced frailty practitioner, case manager, pharmacist). • Conduct investigations and delivery of short-term treatment e.g. iron infusion. • Assessment of acute issues referred from LAS, community teams, outpatients, care and nursing homes and front door frailty team • Direct link to virtual ward.
G. Frailty Teams at the Front Door	• Proactive screening and identification of frailty in ED through seeing all people age 65+ • Automatic CGA for CFS frailty score 6 and above and for those living in care homes. • An MDT approach: geriatrician, advanced frailty practitioner, physician associate, frailty pharmacist, frailty dedicated physiotherapist, social worker, community advanced nurse practitioner (ANP) and mental health representation. • Assessment and planning, including redirecting people back home, referral to community-based care, falls clinic, intermediate care, fast-tracking to the acute frailty unit or admission. • Providing advice to the ED team. • Geriatrician-led frailty advice line for GPs, community health services and ambulance service. • Good links to community teams, virtual ward, equipment services and voluntary sector (e.g. for meals, shopping, etc.).
H. Frailty Attuned In-patient Care	• An acute MDT bed base utilised to address urgent medical needs for those that require assessment and/or a short stay (less than 3 days) in hospital. • Utilised by the frailty at front door team. • Direct and easy referral to intermediate (step down) care. • A dedicated environment providing patient-centred care (and continuity) via a frailty and dementia/delirium trained MDT (including a frailty consultant and access to mental health specialist) that focuses on the patient, carer(s) and families. • Routine screening for delirium (4AT). • Timely access to CGA e.g. to identify/avoid people being constipated, dehydrated, becoming delirious, resulting in falls. • Increased VCSFE involvement, expediting early action to support timely discharge such as making home ready for person to go home. • Focus on food and feeding and hydration. • A focus on reablement, mobility, exercise, continence care and cognitive stimulation on the ward to reduce deconditioning and hospital acquired disability (HAD), helping to minimise the need for packages of care once discharged. • Dementia support worker present with time to have the conversations and help plan and put support in place. • Focus on early discharge recognising every day in hospital has detrimental outcomes and leads to loss of independence.

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

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

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

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

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

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

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

Outcomes and measures

Introduction

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

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

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

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

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

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

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

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

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

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

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

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7.
How we implement the framework

HEALTH INTEGRATION PARTNERS

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

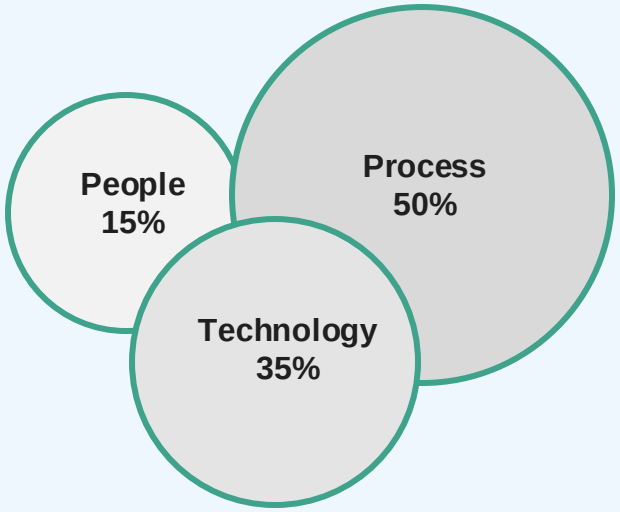
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

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

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

Proportion of effort showing less focus on people led change



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

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

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

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

Implementation planning – key elements

Change initiation planning at Place

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

SEL parallel review

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

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

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

Implementation planning – key elements

Demand and capacity modelling

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

Creating a dashboard

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

Enablers

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

Roadmap for implementation

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

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

Stage 3: Phased QI led implementation

SEL Ageing well framework

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

Demand and capacity modelling

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

Defining outcomes

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

1. Self assessment @ Place

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

2. Analysis of opportunities

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

3. Priorities for delivery

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

6. Change management, OD and enablers

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

5. Demand and capacity

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

4. Operating model

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

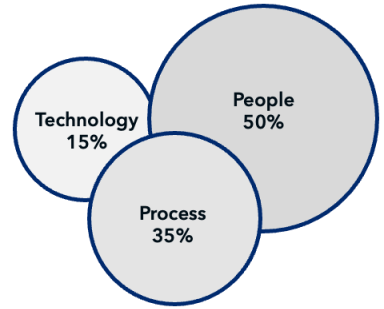
Key tenets of delivery

Regular touchpoints

System-wide cross learning workshops

System governance, oversight and review

Achieving the right focus for change



Phased implementation

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

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

8.
Appendices
(circulated as a separate document)

Appendices - contents

1. Project Plan
2. Summary of baseline positions at Place
3. Outputs from workshops
    - Ambition and vision
    - What must change?
    - What else must change?
    - Ageing well and frailty definitions
4. Governance
5. What ageing well and frailty mean in SEL
6. Resident and carer voice
7. Mantra
8. Case Studies
9. List of stakeholders who participated in developing the framework
10. References

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Programme supported by:

HEALTH INTEGRATION PARTNERS

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 7

Title:	**Plan to increase influenza vaccine uptake in Lewisham in Autumn / Winter 2025-26**
Meeting Date:	**22nd May 2025**
Author:	Dr Catherine Mbema, Director of Public Health/Laura Jenner, Director of System Tranformation
Executive Lead:	Ceri Jacob, Place Executive Lead and Denise Radley, Interim Executive Director, Adult Social Care & Health

Purpose of paper:	Request feedback on the Plan to increase influenza vaccine uptake in Lewisham in Autumn / Winter 2025-26. Consideration on how wider council departments and Partners can support the uptake of influenza vaccines. Request support with promoting influenza vaccines to council staff.	Update / Information	
		Discussion	x
		Decision	

Summary of main points:	In your Organisations are there current/future workstreams where we could collaborate to: • Gather further community insights into facilitators and barriers to flu vaccine uptake • Promote flu vaccine uptake • Deliver flu vaccines in community settings • To support promoting influenza vaccines to council staff
Potential Conflicts of Interest	None
Any impact on BLACHIR recommendations	The Plan includes analysis of inequalities in influenza vaccine uptake, including by areas of deprivation, primary care network, ethnicity and age group. Actions within the Plan aim to tackle inequalities in vaccine uptake, through working with communities who are less likely to take up the vaccine and addressing barriers that are specific to different population groups.

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

	Equality Impact	Actions within the Plan aim to tackle inequalities in vaccine uptake, through working with communities who are less likely to take up the vaccine and addressing barriers that are specific to different population groups.
	Financial Impact	N/A

Other Engagement	Public Engagement	The Plan to increase influenza vaccine uptake in Lewisham in Autumn / Winter 2025-26 identifies actions to tackle barriers and promote vaccine uptake, with some work areas starting in the Spring / Summer of 2025. The Plan includes gathering insights through resident's views, engagement and communications, and using population health management data. There are actions to increase flu vaccine uptake through work with communities and partners, such as primary care and pharmacy, and different population groups – people who are housebound, people living in care homes, school-aged, pregnant women, health and social care staff, council staff and council departments.
	Other Committee Discussion/ Engagement	There are also opportunities to address identified barriers to delivering flu vaccines in different settings, and for different population groups (such as people who are housebound). Through working with different population groups, and addressing specific barriers, there are opportunities to reduce inequalities in influenza vaccine uptake in the borough. The plan collates actions for partners across the Lewisham system, and there are opportunities to share learning from different elements of this work through the Plan's oversight and Governance structure.
Recommendation:	To support the plan for increasing influenza vaccine uptake in Lewisham in Autumn / Winter 2025-26: To identify if there are current / future workstreams in your organisations where we could collaborate to: • Gather further community insights into facilitators and barriers to flu vaccine uptake • Promote flu vaccine uptake • Deliver flu vaccines in community settings. • To support promoting influenza vaccines to council staff	

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Plan to increase influenza vaccine uptake in Lewisham Autumn Winter 2025-26

Slide pack contents

This slide pack includes:

- Strategic context for increase influenza vaccine uptake
- Framework for increasing vaccine uptake
- Evidence of barriers and enablers to vaccine uptake from the recent Lewisham Joint Strategic Needs Assessment (JSNA) on Immunisations
- Percentage uptake of flu vaccination in different population groups, 2024-25
- What we have learnt from partners about recent vaccine campaigns (including influenza) – barriers, enablers and recommendations
- Plan to increase influenza vaccine uptake for 2025/26
- Plan oversight and monitoring, risk and mitigations
- Governance
- Requests to members of EMT

Strategic context

NHSE Vaccination Strategy – Shaping the future delivery of NHS vaccination services

The NHSE Vaccination Strategy was borne from drivers including the NHS COVID-19 vaccination programme as well as to reduce the decline in take up of vaccinations like MMR, deliver it in a way to give local systems the ability to build an effective, flexible, integrated, local delivery network for vaccination in collaboration with a range of local partners. The vaccination strategy builds on the collective learning and outlines three priority areas:

- Have a simple, convenient and consistent 'Front Door'
- Pro-actively reach into under-served communities
- Are delivered by integrated neighbourhood teams

South East London Immunisation Strategy

The SEL ICS strategy for Vaccination and Immunisation was developed in collaboration with the London Region Vaccination and Immunisation Board, borough commissioning teams, public health and operational vaccination teams. The strategic priorities are:

- Reduce inequalities and do more to reach under-served communities, including through new service models and targeted outreach.
- Pilot new and innovative ways of improving access to vaccination and immunisation services to reduce unwarranted variation.
- Promote diverse and culturally competent educational materials to reach hesitant communities and bolster confidence/trust in our vaccination and immunisation services
- Move away from siloed IMT teams when new health priorities, outbreaks, or other vaccination needs arise.
- Maintain a skilled and appropriately trained workforce that reflects the communities it serves and is able to deliver more flexible clinics with multiple vaccines on offer to maximise coadministration opportunities.
- Optimise data flow and interoperability of point of care systems. A universal data dashboard for all vaccinations will foster better understanding of inequalities and drive decision-making

Strategic context

Lewisham Immunisation Strategy, 2023-25

The current Lewisham Immunisation Strategy aims to increase uptake and coverage of immunisation for Lewisham residents and reduce inequalities by:

- System and community engagement and promotion
- Improve data quality and sharing across the system
- Reducing inequality and Improving uptake in priority groups
- Increasing awareness and addressing vaccine hesitancy
- Guidance, training and development

Plans to update the Lewisham Immunisation Strategy

The current Lewisham Immunisations and Vaccinations Strategy was written for 2023 – 2025. Since this strategy development:

- The Lewisham Joint Strategic Needs Assessment (JSNA) for immunisations has been completed, with recommendations
- A new school aged immunisation provider started in Sept 2024, Children's and Young People Community Immunisation Service (CYPCIS)
- There has been ongoing work from multiple stakeholders across Lewisham to increase vaccine uptake

We are working to update this strategy, which will cover vaccinations across the life-course (including the influenza vaccine).

Framework for considering vaccine demand and uptake

The World Health Organization outlines steps for increasing vaccination demand and uptake:

Understanding the drivers of immunisation uptake (see Figure 1)

Engagement with communities, as the drivers for vaccine uptake vary depending on the local context.

Strengthening the quality of services may be needed to address practical issues that are barriers to uptake.

Supporting health workers, so they are well equipped to build trust and share information about vaccination.

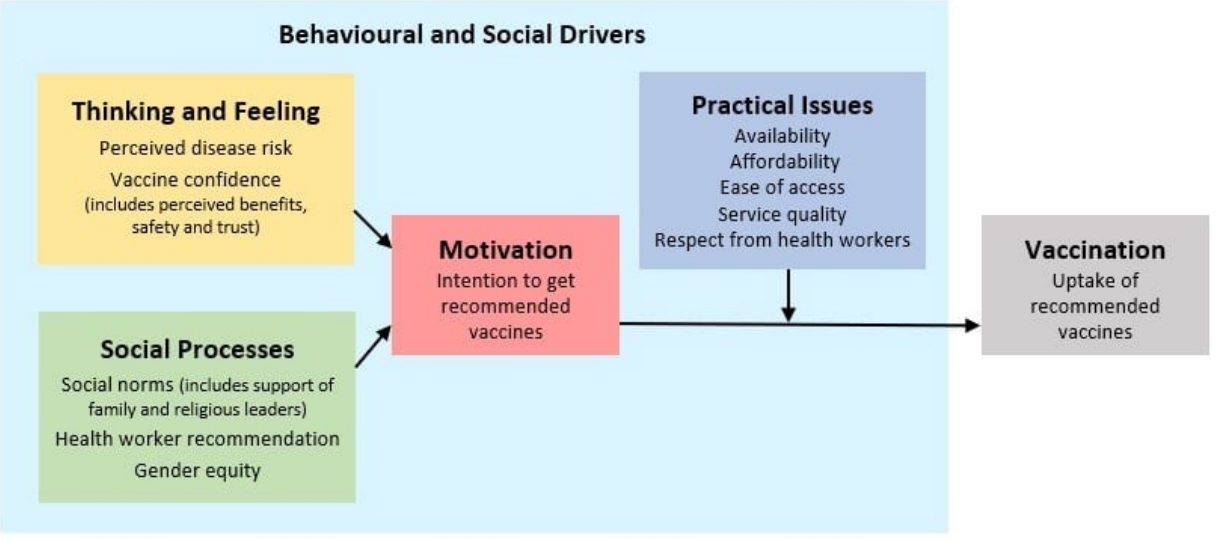
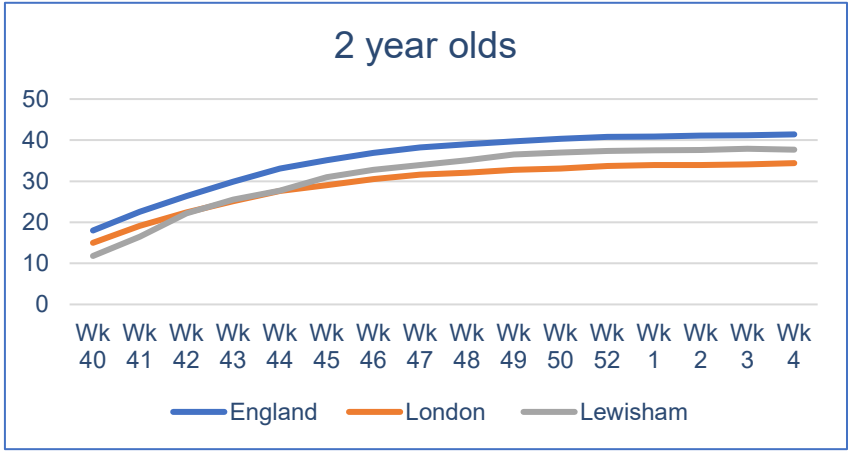
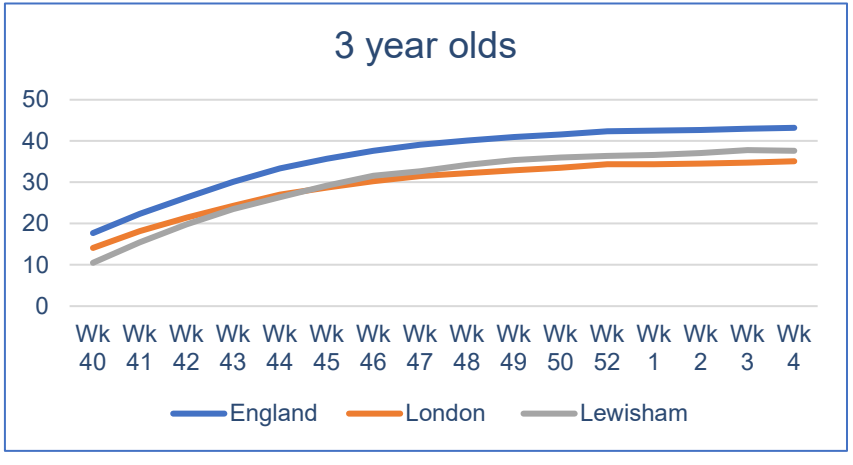


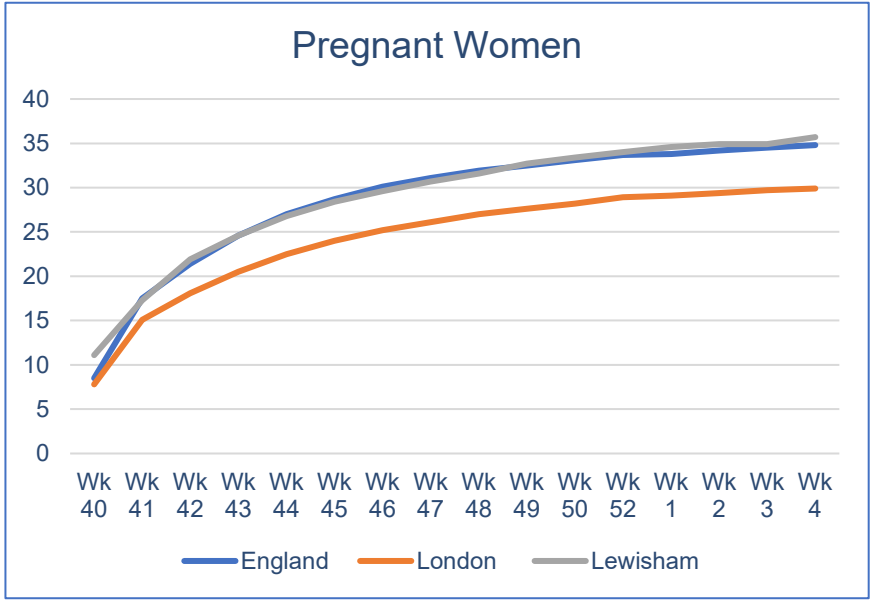
Figure 1 Behavioural and Social drivers of vaccine uptake, World Health Organization

Source: The BeSD working group. Based on Brewer et al. *Psychol Sci Public Interest*. (2017).
Reference https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/demand

Percentage uptake of flu vaccines in 2y & 3y olds and pregnant women over time in 2024/25

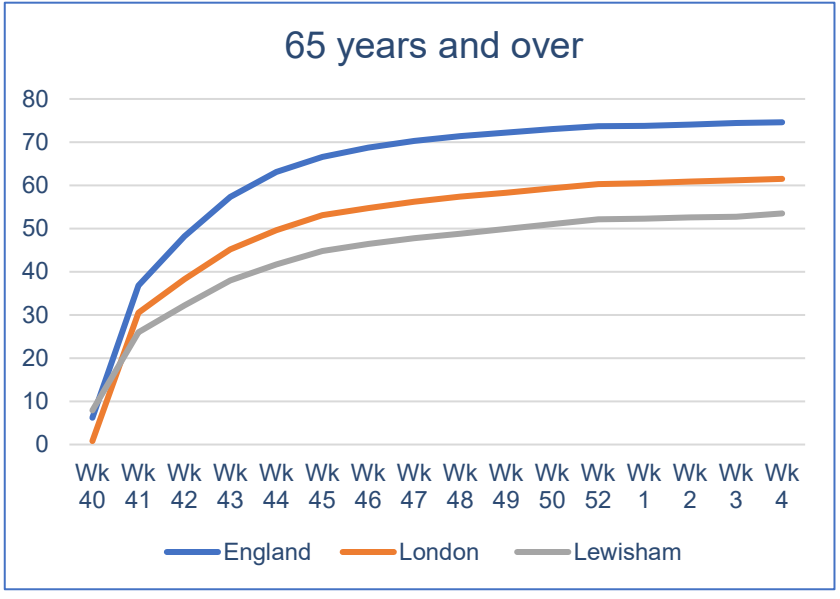


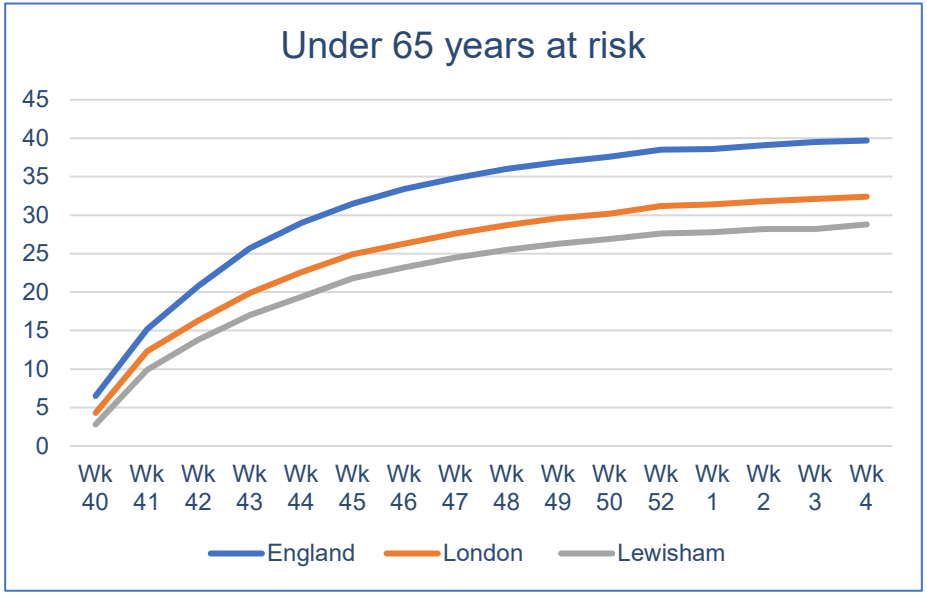




Data source: Imm Form

Percentage uptake of flu vaccines in 65y & over and under 65 at risk groups over time in 2024/25





Lewisham Council's Corporate KPIs include:
Uptake of flu vaccines in persons over 65-year olds: 71%
This 71% target is based on local performance from previous years.

Data source: Imm Form

Population Health Management data for influenza vaccine uptake in Lewisham, 2024-25

Overall % Uptake of Flu vaccine among all eligible cohorts 2024/25 – 02 Apr 2025

PCN	All eligible cohorts Vaccinated Percentage
Aplos Health PCN	31.90%
Lewisham Alliance PCN	36.40%
Lewisham Care Partnership PCN	28.90%
Modality Lewisham PCN	31.90%
North Lewisham PCN	26.50%
Sevenfields PCN	29.90%
Grand Total	29.42%

Data source: Lewisham PHM, Oracle Flu Dashboard

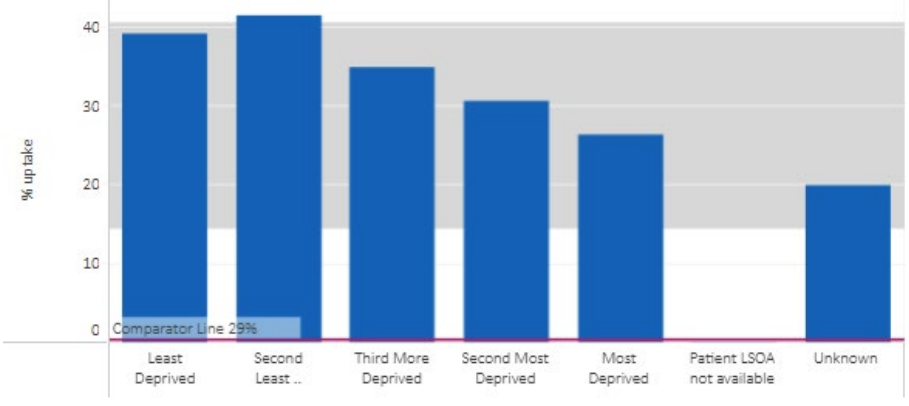
% Uptake among age 65 and over 2024/25 – 02 Apr 2025

PCN	Age 65 and Over Vaccinated Percentage
Aplos Health PCN	54.60%
Lewisham Alliance PCN	60.20%
Lewisham Care Partnership PCN	51.70%
Modality PCN	51.20%
North Lewisham PCN	49.00%
Sevenfields PCN	53.30%

Data source: Lewisham PHM, Oracle Flu Dashboard

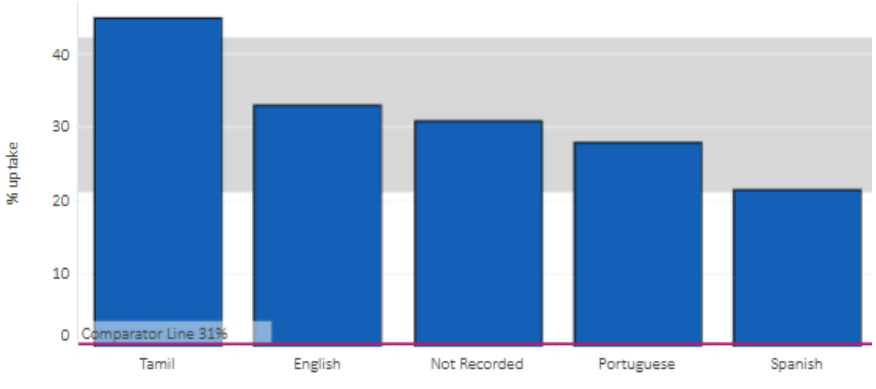
Population Health Management data for influenza vaccine uptake in Lewisham, 2024-25

% Uptake split by index of multiple deprivation – 02 Apr 2025



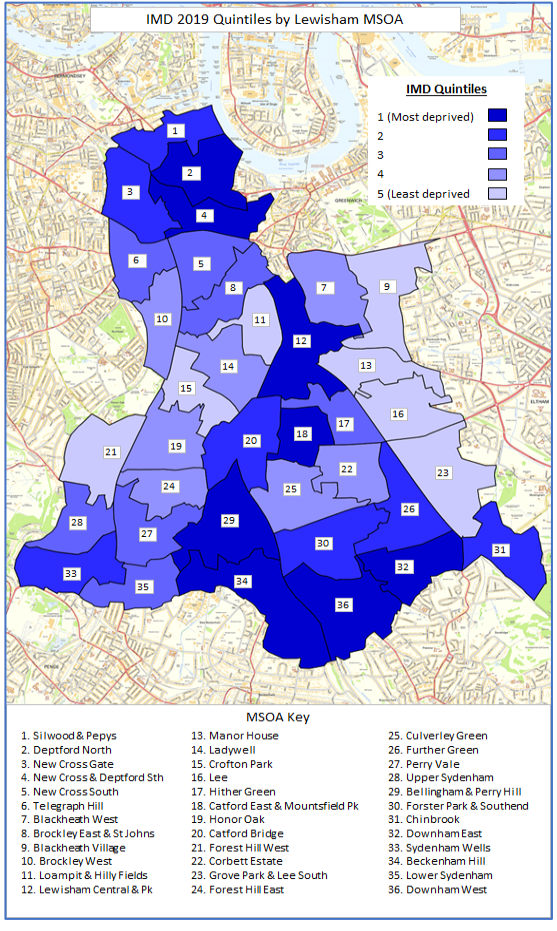
Data source: Lewisham PHM, Oracle Flu Dashboard

% Uptake by first language spoken – 02 Apr 2025



Data source: Lewisham PHM, Oracle Flu Dashboard

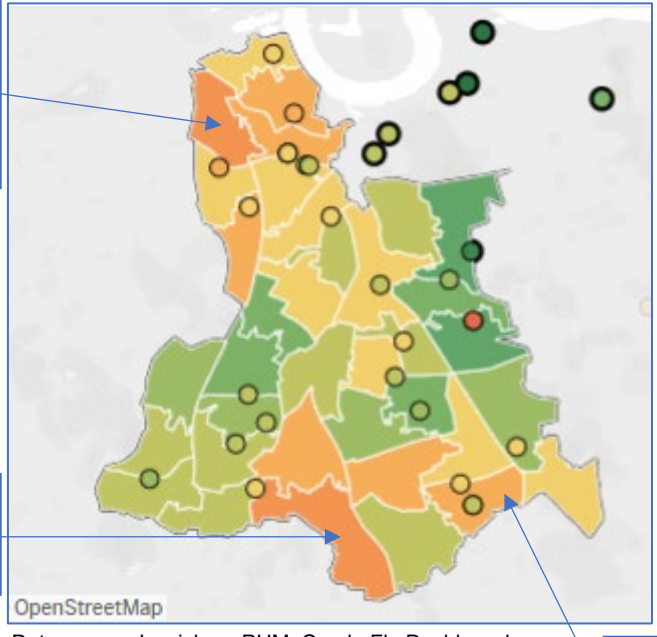
Index of Multiple Deprivation compared with flu vaccine uptake in MSOAs in Lewisham



% Flu vaccine Uptake by MSOAs (top 3 with low uptake)

Lewisham 03 with 21.50% - Adjacent to the north of **Queen's Road Partnership**

Lewisham 034 with 19.91% - **South of The Jenner Practice**

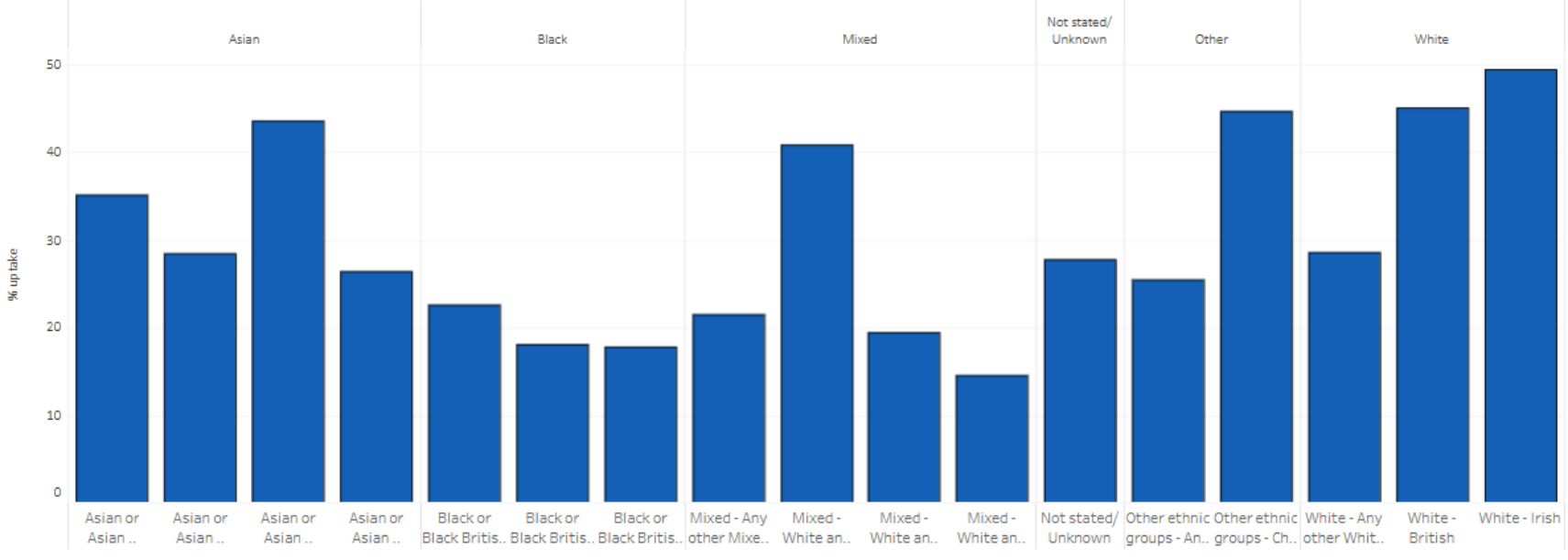


Data source: Lewisham PHM, Oracle Flu Dashboard

Lewisham 037 with 23.40% - This contains **Oakview Family Practice** and **Downham Family Medical Practice.**

Green: Higher uptake
Gold: Moderate uptake
Orange: Lower uptake

Percentage of flu vaccine uptake by ethnicity in Lewisham, 2024-25



Data source: Lewisham PHM, Oracle Flu Dashboard

Evidence of barriers to vaccine uptake in Lewisham

The recent Lewisham Immunisations JSNA, 2024 identified barriers to vaccine uptake.

These included:

- **Social and cultural barriers**. Stemming from historical mistrust in the medical profession, particularly among minority ethnic communities due to past discriminatory practices. Vaccine hesitancy is also fuelled by misinformation and lack of trust in government institutions.

- **Informational barriers:** Insufficient information on vaccine benefits and side effects, lack of trust in information sources, and confusion caused by conflicting local and national vaccine schedules.

- **Practical barriers**: Inconvenient appointment times and difficulties navigating appointment booking systems, particularly for families from low socioeconomic backgrounds.

- **Technical barriers**: Data inaccuracies and outdated records due to population mobility. These inaccuracies underestimate vaccination rates, making it difficult to identify and address inequalities.

Evidence of enablers to vaccine uptake in Lewisham

The recent Lewisham Immunisations JSNA, 2024 also identified enablers to vaccine uptake.

These included:

- **Working with trusted organisations and people**: Collaborating with trusted organisations, community leaders, and utilizing community networks are essential for engaging communities and building confidence in vaccination programs.

- **Reliable information**: Clear, accurate, and accessible information that addresses community-specific concerns can combat misinformation and build trust.

- **Improved access**: Improving access involves offering vaccinations in various locations, including community centres, pharmacies, and mobile units, with flexible appointment times to accommodate busy schedules.

- **Primary care workforce**: Primary care improvements include implementing robust call and recall systems, offering opportunistic vaccinations, and providing training for healthcare professionals on effective communication and engagement strategies to address vaccine hesitancy.

Recent feedback from partners about vaccine uptake

From February to March 2025, we sought feedback about facilitators and barriers to vaccine uptake (including the influenza vaccine) in Lewisham

An influenza vaccine wrap up session was held on 19.03.25, with representation from the following departments and organisations:

- Primary Care, South East London ICB (Lewisham)
- NHS England Immunisations Co-Ordinator for Lewisham
- Population Health Management, South East London ICB (Lewisham)
- Penrose Health
- Lewisham Hospital NHS Foundation Trust, Maternity
- South London Children and Young People's Community Immunisations Service, Kingston and Richmond NHS Foundation Trust
- Lewisham Council Communications and Engagement Team

To discuss vaccine uptake in Lewisham more broadly, we had also had 1-to-1 conversations with some of the partners mentioned above, and from the following organisations:

- NHS England, London Region
- Child Health Information Service (CHIS)

We also attended the following meetings to discuss vaccine uptake in Lewisham:

- Primary Care Leadership Forum, 26.02.25
- Lewisham People's Partnership, 05.03.25
- Lewisham Practice Manager's Forum, 27.02.25

The following slides summarise themes from these discussions.

Resident's views, engagement and communication

Barriers

- Some people have had covid vaccines and think enough is enough. There is vaccine fatigue
- There are big issues with lack of trust, being treated badly in the past
- The world is changing and it's unclear what is true
- There is disinformation and multiple sources of information
- Vaccines are promoted using jargon. If people don't understand, then why would they agree to putting something in their body, how do they know that they're not being experimented on
- Inconvenience is a barrier to taking up vaccines
- From recent flu comms campaign, there was little engagement with the council's social media messages
- Translated materials were disseminated late in the 24/25 flu season

Enablers and recommendations

- Need to gain greater understanding of the barriers to flu vaccines, understand where residents get their information from
- Discuss vaccines with residents in ways that are meaningful to them.
- Work with patients, carers and communities, rather than just giving information
- Work with faith groups, community groups, Patient Participation Groups to understand and engage
- Start this work to increase understanding and engagement in Spring/ Summer 2025, before the flu season
- Flu vaccine community outreach clinics worked well when held in same place for several weeks, could be promoted and residents could return the following week
- Use national and regional resources, but also local Lewisham residents to promote the flu vaccine
- Jitsuvax training are now offered with staff at the family hubs were provided with this. There are plans to offer Jitsuvax training to other community groups including the champions.
- Education & Awareness Campaigns: Myth-Busting & Transparency: Provide clear, evidence-based information to counter vaccine hesitancy.

Primary care and pharmacy

For the flu vaccine, primary care deliver vaccines to 2–3-year-olds, adults <65 years at risk and adults >65 years. Pharmacies deliver flu vaccines to adults <65 years at risk and adults >65 years.

Barriers

- For children aged 2 to 3 years, only GP practices can deliver the flu vaccine, from the Patient Group Directive (PGD)
- Primary care vaccine stock was not underwritten by the ICB in 24/25, so GP practices had financial losses if not all flu vaccines were used.
- With pharmacies providing flu vaccines, GP practices are ordering less stock
- Primary care is required to order flu vaccines before the season starts, whereas pharmacies can order stock throughout the flu season
- Pharmacies deliver flu vaccines to patients who present, and who do require call and recall processes. Primary care has patients who require resource intensive call and recall.

Enablers and recommendations

- Could the PGD be flexible in Lewisham, so flu vaccines could be delivered to 2-3-year-olds in settings other than just primary care?
- Could health visitors vaccinate?
- Could there be local financial incentives for flu vaccines in the future? (Eg, at PCN level, or broader for primary care and pharmacies)
- In primary care, extended hours clinics helped parents who were working during the day to access flu vaccines for their children
- Primary care would like to have accurate, local information, in patient's language, to share about vaccines
- To increase accessibility, would like vaccines to be delivered locally in hubs, pharmacies

People who are housebound and living in care homes

Housebound vaccinations are usually delivered by the patients' registered GP practice/PCN. In 2024/25, where practices/PCNs were struggling to deliver flu (and covid) vaccinations, Penrose Health (a GP practice group with 4 practices in Lewisham) undertook this on their behalf.
Care homes residents received vaccines from the various practices across Lewisham who support their care including the new dedicated care home practice that began operating in April 2024.

Barriers

- It is resource intensive and increasingly financially unviable based on the national contract incentives for GP practices/PCNs to deliver flu (and covid) vaccines to housebound patients
- Many patients declined the offer of the flu (and covid) vaccination. Reasons given included they were opposed to vaccines, thought the vaccine was unnecessary, had adverse reaction to vaccine in the past, already received the vaccine
- Consent is a specific consideration when vaccinating care home patients as this needs to be explicitly obtained in advance
- Transport is an issue, some vaccinators receiving parking tickets, organising vaccine delivery around Low Traffic Neighbourhoods (LTNs).

Enablers and recommendations

- Could district nurses support the vaccination of housebound patients where they are already going into these patients' homes?
- Do we want to consider local incentives to support the vaccination of housebound patients to make more viable for providers?
- Can we do more to work with the council parking team to support parking dispensations when providers are delivering vaccinations to patients who are housebound?
- Would it be more viable to transport housebound patients to fixed vaccination clinics rather than trying to vaccinate them at home?
- Is there more we can do with our care home providers to promote the flu campaign with their patients and their families?
- The PCNs that saw their own housebound patients had the advantage of patient familiarity

School-aged children and young people

In Lewisham, the flu vaccine is delivered to school-aged children and young people (CYP) by the South London Children and Young People's Community Immunisations Service, Kingston and Richmond NHS Foundation Trust.

Barriers

- The provider only sees CYP who are home-schooled when they present to the service, so some may be missed
- Several schools are reluctant to provide contact phone numbers for parents and carers, to give consent (this barrier is being reviewed regionally)
- The provider is the Kingston and Richmond NHS Foundation Trust – this name can be confusing for parents and carers in Lewisham.

Enablers and recommendations

- The provider could work with other partners (incl. council, ICB) to promote vaccine uptake to groups less likely to access the flu vaccine, such as CYP who are home-schooled, looked after children.
- The provider's call centre workers are trained with vaccine information, can access language line if needed and help parents and carers complete consent forms.
- Schools would benefit from information about the flu vaccine campaign early in the season
- There are community clinics for CYP who have missed the vaccine at school. Need to find more accessible and convenient locations in the borough for these.

Pregnant women

In Lewisham, vaccines in pregnancy are delivered by the Lewisham & Greenwich NHS Trust Maternity Service. Pregnant women can also receive the flu vaccine from primary care and pharmacies.

Barriers

- Flu vaccines were not available at the start of the season (the provider had not delivered them) so there was a delay in starting
- Maternity vaccine clinics ran out of flu vaccines 1-2 weeks before the campaign formally finished at the end of March 2025.
- Parents can be concerned about side effects of vaccines, concern about the baby's immune system with multiple vaccines, want to know the detail and information to decide about vaccines

Enablers and recommendations

- In 24/25 there were drop-in vaccine clinics for pregnant women 4 days a week, so many opportunities to receive vaccines
- Flu vaccines can be given at any gestation, so there is large window to receive the vaccine. It can also be combined with covid and whooping cough over 16 weeks gestation.
- Information about vaccines was shared at community midwife meetings, so they could promote the vaccines
- Introduction of RSV in pregnancy seems to have prompted demand for other vaccines in pregnancy

Health and care staff, Lewisham Council staff

At Lewisham and Greenwich NHS Trust in 2024/25, staff uptake of the flu vaccine was 18%.
Lewisham Council offered free flu vaccines to staff, focusing on frontline and social care staff. In 2024/25, flu vaccines were delivered to 142 staff members.

Barriers

- Staff shortages and high workloads make it difficult for healthcare and social care workers to find time for vaccination.
- Shift patterns may not align with vaccination clinic availability.
- Challenges in reaching agency or temporary workers who are not attached to a single workplace.
- Other barriers include vaccine safety concerns, fear of side effects, doubts about efficacy, and perceived low risk of influenza.
- Council staff have different places of work, including at home, and so it may not be convenient to take up the Lewisham Council offer of a free flu vaccine when they are available.

Enablers and recommendations

- LGT starting flu vaccination promotion to all its staff from the beginning of September across both sites to ensure staff can plan to attend flu clinics in spite their busy schedule.
- Offer incentives like coffee for flu vaccination like 2022-23 season.
- Flu roaming teams can be deployed across both sites of LGT to offer flu vaccination while roaming through various wards and clinics.
- Managers to be encouraged to talk about flu vaccination to staff to assure less staff sickness during the season.
- The immunisation partnership group in Lewisham is making this a priority across the partnership to ensure staff are vaccinated to protect vulnerable residents.
- Promotion to council staff via multiple channels and clinic on convenient days for staff

Plan for 2025/26 (1 of 6)

Area	Action	Outcome	Partners	Timeframe
Resident's views, engagement and comms	Seek community insights about barriers and enablers to flu vaccine uptake – from residents, communities and patient groups.	Increased understanding of barriers and enablers to flu vaccine uptake – used to inform 25/26 campaign	Public Health Comms Team ICB	May - July 2025
Resident's views, engagement and comms	Recent commission for Africa Advocacy Foundation to deliver community engagement for MMR vaccine – include influenza insights where possible	Increased understanding of barriers and enablers to vaccines in Black African and Black Caribbean communities - to inform flu vaccine promotion	Comms Team ICB Public Health	April – July 2025
Resident's views, engagement and comms	In response to community insights, design engagement and comms work to promote flu vaccines.	Culturally competent engagement and comms, to promote flu vaccines for different groups in Lewisham	Comms Team Public Health ICB	July – Sept 2025
Resident's views, engagement and comms	Co-design VCS community support to improve awareness and flu vaccine uptake, commission later in the summer	Culturally competent community engagement, in groups with low flu vaccine uptake – increased awareness and uptake	ICB Public Health Comms Team	May – December 2025

Plan for 2025/26 (2 of 6)

Area	Action	Outcome	Partners	Timeframe
Resident's views, engagement and comms	Embed regional and national flu comms and engagement into Lewisham campaign	Flu vaccine promotion aligns with regional and national resources, avoid duplication of work	Comms Team	When resources available Sept onwards?
Population Health Management data	Use population health management data about inequalities in flu vaccine uptake to inform community and health system engagement work	Data from previous flu vaccine campaigns informs where to focus community engagement work, and engagement with GP practices in 25/26. Use live dashboard in 2025/26.	ICB Population Health Management Comms Team ICB Primary Care Primary Care Public Health	April 2025 onwards
Primary care and pharmacy	Ask GP practices with low flu vaccine delivery in 2024/25 about barriers	Understand reasons for low vaccine delivery / uptake in lowest performing practices	Imms co-ordinator ICB primary care	May – July 2025
Primary care and pharmacy	Recent survey sent to all GP practices about vaccine delivery reasons patients decline vaccines to inform flu vaccine work	Use insights from GP practice general immunisations survey to identify and address barriers to flu vaccines	Imms co-Ordinator ICB primary care Public Health	April – June 2025

Plan for 2025/26 (3 of 6)

Area	Action	Outcome	Partners	Timeframe
Primary care and pharmacy	Collate local, accurate information about flu vaccine campaign 2025 for GP practices and pharmacies, Translate when needed.	GP practices and pharmacies have local, accurate information to share at start of season	Comms Team ICB Primary Care ICB Pharmacy Public Health	June – August 2025
Primary care and pharmacy	Review options for delivering flu vaccines to 2–3-year-olds outside of GP practices (e.g. in Hubs, by Health Visitors)	Identify possible models of delivery of flu vaccines for 2-3-year-olds outside GP practices, plan trial of model if possible	ICB Primary Care ICB CYP Commissioning Primary Care	May – July 2025
People who are housebound	Review options for providing vaccines (incl. influenza) to people who are housebound.	Agreed approach to funding and delivery of flu vaccines to people who are housebound	ICB Primary Care Primary Care	April – July 2025
People living in care homes	Engagement with Care Homes not yet registered with the new GP provider	Older Adult Care Homes registered with the new GP practice for consistency and ease of vaccine delivery programmes.	Primary Care	Ongoing

Plan for 2025/26 (4 of 6)

Area	Action	Outcome	Partners	Timeframe
School-aged	Review options for promoting flu vaccines to CYP who are not in mainstream education.	Agreed approach and promote flu vaccines to CYP not in mainstream education	Education Dept, Lewisham Council ICB Public Health	April – July 2025
School-aged	Promote flu vaccines in schools at start of September	Greater school awareness of upcoming flu vaccine campaign	Comms Education Dept, Lewisham Council Public Health ICB	September
Pregnant women	Determine when flu vaccine stock will be available in maternity clinics in 2025, aim to receive at start of campaign	Have accurate information about flu vaccines when promoting in maternity clinics	Maternity, LGT ICB NHSE	July – August 2025
Health and care staff	Scope models for engagement and delivering flu vaccines to care home staff and care workers at work	Agreed approach to offering flu vaccines to care staff. Trial if this is a new model.	Adult Social Care ICB primary care Primary Care	June – Sept 2025

Plan for 2025/26 (5 of 6)

Area	Action	Outcome	Partners	Timeframe
Health and care staff	LGT to start promotion of flu and COVID vaccination to its staff from the beginning of the season.	All staff and managers are encouraged to get the flu vaccination, are aware of where to receive it.	Lewisham and Greenwich Trust across both sites – UHL and QE.	June – Sept 2025
Health and care staff	Promotion of flu vaccination to start by the end of summer to all primary care staff. Encourage GP staff to complete staff vaccination questionnaires on ImmForm	All GPs to encourage all their practice staff to protect their patients from flu	ICB Primary Care with GPs	July – Sept 2025
Vaccine Supply and costs	.Support mutual aid by sharing vaccine between providers where necessary	Reduce vaccine wastage and mitigate financial loses	Primary care LGT ICB Primary Care ICB Pharmacy	September – March
Lewisham Council staff	Promote flu vaccine uptake to Lewisham council staff through multiple comms channels and offer vaccines at convenient times	Greater awareness and uptake of flu vaccines by frontline council staff	Public Health Occupational Health Communications	September – December

Plan for 2025/26 (6 of 6)

Area	Action	Outcome	Partners	Timeframe
Collaboration with different council departments and services	Collaborate with different council departments to identify communication channels and other ways to promote flu vaccines to residents e.g. Lewisham Housing	Increased resident awareness of which groups are eligible to receive flu vaccines, increased awareness of where to receive the vaccine, increased vaccine uptake	Communications Children and Young People Housing	July – December
Collaboration with different council departments and services	Explore the possibility of promoting and / or delivering flu vaccine in community settings (e.g. Family Hubs, Warm Welcomes)	Flu vaccines are promoted and / or delivered in local, familiar community settings	Communications Children and Young People Libraries	May – September 2025

Roles and risks

Roles and oversight

The Lewisham Influenza Vaccine Uptake Plan will have joint oversight and monitoring from the South East London ICB (Lewisham Community Based Care Team) and the Lewisham Council Public Health Team.

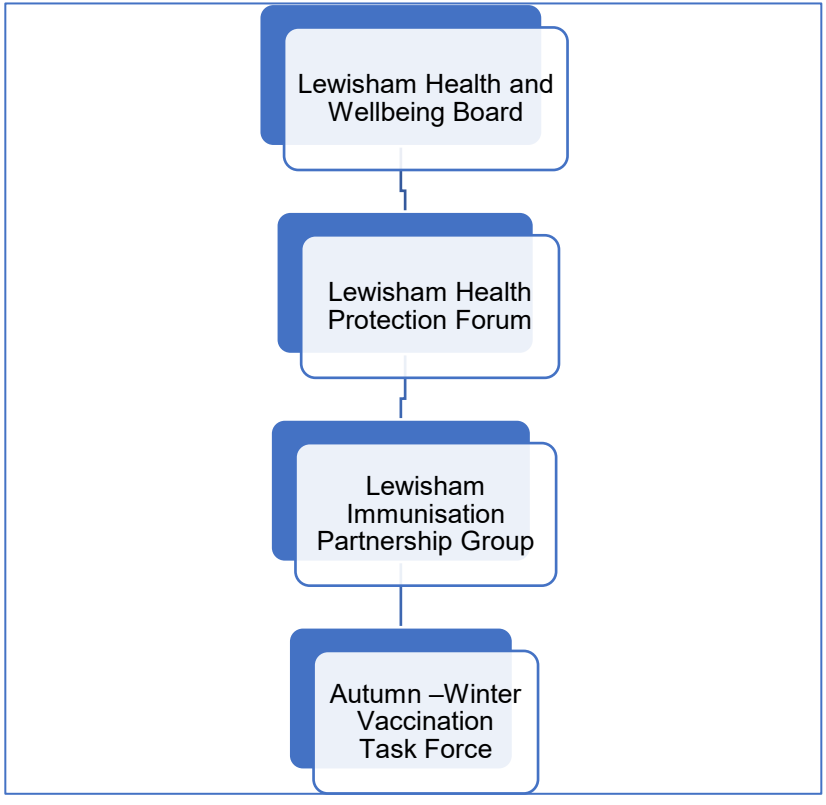
Within this oversight and monitoring, it is expected that the ICB will focus on delivery models for the vaccines and Public Health will focus on community engagement and promotion. Both will have oversight of the data analysis.

Risks and mitigations

Risk	Mitigation
There are expected cuts to the South East London ICB in 2025, which is likely to reduce capacity	Changes are not expected until late 25/26 but plans should be put in place to mitigate any reductions in resources including clear sharing of plans, actions and key contacts – *this should be picked up through the Autumn – Winter Vaccination Task Force once operational*. Outsourcing of work could also be considered but funding would need to be found.
There is limited financial and staff resource to deliver community engagement and flu vaccine promotion work	Use recent population health data and other intelligence to determine where to focus community engagement and promotion. Consider commissioning community organisations to engage with different groups. Learn from previous work, and from other boroughs about what is likely to be effective.

Governance for immunisation and vaccination in Lewisham

- The Autumn – Winter Vaccination Task Force (co-chaired by public health and ICB) reports into the Lewisham Immunisation Partnership Group meeting, which reports into the Lewisham Health Protection Forum, which reports into the HWBB.
- The Autumn – Winter Vaccination Task Force met every two weeks from September 2024 and continued until March 2025, which was followed by flu wrap up meeting with partners and stakeholders.
- The Lewisham Immunisation Partnership Group meeting, meets quarterly and in coordination with the release of the vaccination COVER data.
- The Lewisham Health Protection Forum meets twice a year and chaired by the Director of Public Health or her nominated deputy. The Forum reports back to Health and Well-being Board.
- Flu vaccinations are an ICB corporate objective and as such it is regularly discussed at the Lewisham SMT and also at the Integrated Quality and Assurance Group and LCP Strategic Board as necessary.



Requests to members of EMT

In your Directorates, are there current/future workstreams where we could collaborate to:

- Gather further community insights into facilitators and barriers to flu vaccine uptake
- Promote flu vaccine uptake
- Deliver flu vaccines in community settings

Request support with promoting influenza vaccines to council staff

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 8
Enclosure 8

Title:	**Briefing – Community Diagnostic Centre**
Meeting Date:	**22nd May 2025**
Author:	Natasha Crawford, Senior Programme Manager - Community Diagnostic Centre
Executive Lead:	Dr Neil Goulbourne, Chief Strategy and Transformation Officer & Deputy CEO

Purpose of paper:	To provide an update on Eltham Community Diagnostic Centre, hosted at Eltham Community Hospital	Update / Information	*x*
		Discussion	
		Decision	

Summary of main points:	• In 2023, Lewisham and Greenwich NHS Trust successfully secured £12.8m capital investment to establish a Community Diagnostic Centre (CDC) at Eltham Community Hospital • The CDC has been delivered to time, specification and within budget and formally launched on 22nd April 2025 • Eltham CDC will deliver more than 90,000 appointments in 25/26 to patients across South East London, with extended hours in key services to maximise patient choice and access • Work is now underway to identify opportunities to further maximise the estate and smooth patient pathways and experience
Potential Conflicts of Interest	None
Any impact on BLACHIR recommendations	N/A

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

	Equality Impact	Completed as part of CDC business case development
	Financial Impact	Completed as part of CDC business case development

Other Engagement	Public Engagement	Undertaken by ICB at initial proposal and design stages
	Other Committee Discussion/ Engagement	LGT and APC governance structures, including SEL APC Diagnostics Board.
Recommendation:	For update only.	

Lewisham and Greenwich NHS Trust

Eltham Community Diagnostic Centre update

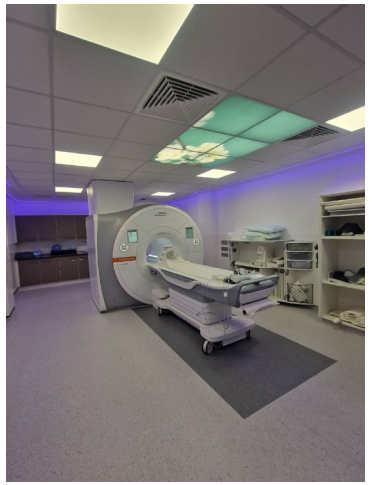
Lewisham LCP Strategic Board
May 2025

To be exceptional

LGT, in 2023, successfully secured £12.8m capital investment to establish a Community Diagnostic Centre at Eltham Community Hospital, serving patients from across South East London

Lewisham and Greenwich NHS Trust

- The CDC was planned across two phases, with some services operational from 2023, and a major construction programme required to enable the addition of CT and MRI on site from 2025
- The CDC has been delivered to time, specification and within budget, with construction and commissioning completed in March-25 as planned
- The CDC formally launched phase two services (CT and MRI) in April-25



Eltham CDC will deliver more than 90,000 appointments this year across imaging, physiological sciences and pathology, with extended hours in key services to maximise patient access and choice

NHS
Lewisham and Greenwich
NHS Trust

Diagnostic	Operating hours	Annual capacity 25/26
CT	Monday – Sunday, 08:00 – 20:00	13,860
MRI	Tuesday – Saturday, 08:00 – 20:00	8,115
X-ray	Monday – Friday, 09:00 – 17:00	16,006
Ultrasound	Monday – Friday, 08:00 – 18:00	14,748
Echocardiogram	Monday – Friday, 09:00 – 17:00	1,968
Ambulatory electrocardiography (Holter)	Monday – Friday, 09:00 – 17:00	1,968
Ambulatory BP monitoring	Monday – Friday, 09:00 – 17:00	104
Full lung function test	Monday – Friday, 09:00 – 17:00	596
Sleep studies	Monday – Friday, 09:00 – 17:00	1,769
Fractional exhaled Nitric Oxide (FeNo)	Monday – Friday, 09:00 – 17:00	1,008
Spirometry with Bronchodilator Response	Monday – Friday, 09:00 – 17:00	1,199
Blood test	Monday – Saturday, 08:00 – 18:00 (14:00 Saturday)	28,867
Teledermatology	Monday – Friday, 09:00 – 17:00	4,084

The CDC offers an opportunity to establish new pathways to smooth patient care pathways and improve patient experience

Lewisham and Greenwich NHS Trust

- In March-24, a Peri-operative medicine of Older People undergoing Surgery (POPS) one-stop was established
- Patients on the elective waiting list at risk of experiencing inequitable care and outcomes are identified using Lewisham's population health management tool (PHMT) or referred directly from the Surgery team
- Patients are invited to a 1-hour appointment with an Advanced Nurse Practitioner, where they undertake a suite of tests/ investigations and discuss their care plan and support needed to optimise their health pre-surgery
- Patient feedback has been positive to date, and work is now underway to further expand the service at Eltham
- Work is also underway to identify other clinical pathway opportunities at the CDC, including establishing an adult breathlessness pathway

LGT is hosting a second CDC, at Queen Mary's Sidcup

Lewisham and Greenwich NHS Trust

- Sidcup CDC is a spoke site, complementing the main hub at Eltham, and will include Imaging and phlebotomy only
- Construction and commissioning concluded at Sidcup last month and limited activity is scheduled to commence in Q2
- Following changes to the national CDC Pricing Regime for 25/26, tariffs for Imaging modalities were significantly reduced, leading to a challenged financial position
- Further work is therefore underway to assess the longer-term viability of the site, including:
  - Model potential other services that could be delivered at the site within the available funding envelope
  - A more detailed review of demand assumptions to ensure the right services are being offered in the right location to best meet population need

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 9
Enclosure 9

Title:	**Primary Care Group Terms of Reference**
Meeting Date:	**22nd May 2025**
Author:	Chima Olugh, Neighbourhood Development Manager
Executive Lead:	Ceri Jacob

Purpose of paper:	The purpose of this paper is to seek approval of the updated Lewisham Primary Care Group Terms of Reference from the Lewisham Local Care Partners Strategic Board.	Update / Information	
		Discussion	
		Decision	**X**
Summary of main points:	The Terms of Reference for the Primary Care Group are designed to set out the responsibilities of the Group in relation to primary care matters to ensure strong governance, transparency, assurance and robust decision making processes to ensure the ICB fulfils its responsibilities under the Delegation Agreement. The Terms of Reference also clarify the purpose of the Group along with what its duties and responsibilities are. The Lewisham Primary Care Group Terms of Reference have been reviewed and updated by members of a working group. The review was carried out to ensure the Primary Care Group continue to fulfil its duties and responsibilities. Part of the review process involved understanding what the Group is responsible for and how it delivers those responsibilities. Changes were made to the financial responsibilities to ensure better clarity on what the Group was responsible for signing off. A change was also made to make provision for the chair of the Primary Care Leadership Forum to sit on the Group to strengthen the leadership of the Group, and facilitate learning and sharing of information. A work plan, based on the Terms of Reference, has been developed to support the Group carry out its duties and responsibilities. The updated Terms of Reference was discussed and endorsed at the March 2025 Primary Care Group. The Terms of Reference will remain under constant review.		

South East London Integrated Care System

NHS South East London

Potential Conflicts of Interest	There may be a potential conflict of interest for Dr Helen Tattersfield who is a member of the Group and Anne Hooper who is the chair of the Group. Suggested mitigation: Dr Helen Tattersfield and Anne Hooper can be involved and input to any discussion as this would be valuable, however not in any decision.			
Any impact on BLACHIR recommendations				
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Not Applicable		
	Financial Impact	The Group will consider options around utilisation of primary care funding and make recommendations to the Lewisham Senior Management Team and the Place Executive Lead.		
Other Engagement	Public Engagement	None		
	Other Committee Discussion/ Engagement	▪ Lewisham Senior Management Team – May 2025 ▪ Primary Care Group - March 2025. ▪ Primary Care Group - November 2024.		
Recommendation:	**The Lewisham Local Care Partners Strategic Board is asked to approve the updated Primary Care Group Terms of Reference.**			

South East London Integrated Care System

NHS South East London

South East London Integrated Care Board (Lewisham)

Lewisham Primary Care Group

Terms of Reference

May 2025

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

Version Control and Document Review Information

Version	Summary of changes	Date	Author/Reviewer
1.0	Initial Review	19/09/2024	Chima Olugh, Neighbourhood Development Manager
1.1	Updated following discussion of the working group.	21/11/2024	Chima Olugh, Ashley O'Shaughnessy and Anne Hooper
1.2	Reviewed by members of the working group and including feedback from our Place Executive Lead.	21/02/2025	Chima Olugh, Ashley O'Shaughnessy and Anne Hooper
1.3	Review of the financial statement	04/02/2025	Chima Olugh, Neighbourhood Development Manager
1.4	Reviewed and agreed at the March 2025 Primary Care Group	20/03/2025	Chima Olugh, Neighbourhood Development Manager
1.5	Updated to include the Integrated Neighbourhood Teams Governance structure.	6/05/2025	Chima Olugh, Neighbourhood Development Manager

Terms of Reference

1. Introduction

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

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

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

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

2. Purpose

The purpose of the Group is to:

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

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

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

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

3. Duties and Responsibilities

The Group will:

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

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

Decisions in relation to its Delegated Authority;

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

- The management of poor performance, which could include use of remedial and breach notices and application of wider contract terms;

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

Decisions in relation to its Delegated Financial Responsibility;

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

Key areas of responsibility include:

- Local Incentive Schemes and any associated funding;

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

The Group will also;

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

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

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

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

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

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

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

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

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

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

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

4. Membership

The core membership of the Group is outlined below.

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

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

Other persons may be invited to attend, as appropriate, to enable the Committee to discharge its functions effectively. The Group may also invite guests to attend to present information and/or provide the expertise necessary for the Group to fulfil its responsibilities.

5. Role of the Chair

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

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

6. Quorum

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

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

The Group will make decisions by consensus.

7. Accountability and reporting arrangements

The Group is accountable to the LCP Strategic Board.

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

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

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

8. Conflicts of Interest

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

Compliance will be overseen by the Chair of the Group.

9. Meeting frequency

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

10. Administration

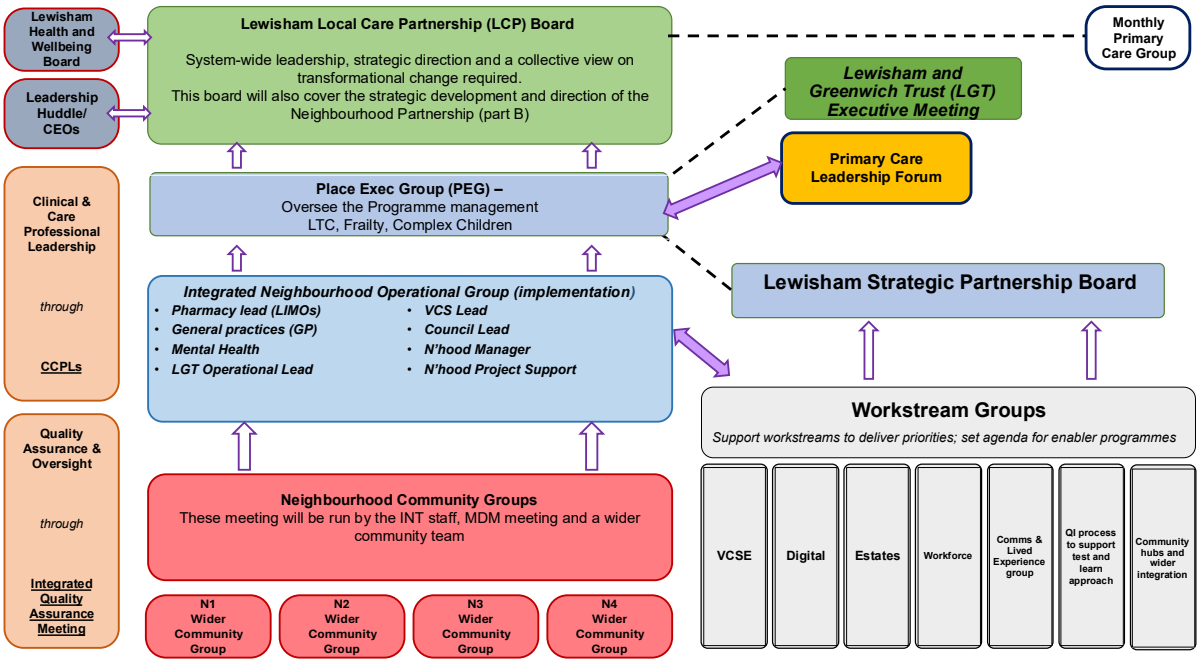
Administrative support will be responsible for completing minutes of meetings and the action log tracker.

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

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

11. Integrated Neighbourhood Teams

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



12. Monitoring adherence to the Terms of Reference

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

13. Policy and Best Practice

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

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

14. Review arrangements

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

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

Date approved:
Date of next review:

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 10
Enclosure 10

Title:	**Place Executive Group – Transformation update**
Meeting Date:	**22nd May 2025**
Author:	Laura Jenner Director of System Development & Beckie Brun Associate Director – Improvement and Transformation (LGT)
Executive Lead:	Ceri Jacob Place Executive Lead

Purpose of paper:	The Report outlines the purpose of the Place Executive Group and the transformation programmes that reported to the meetings. The report also includes highlight reports: • Lewisham Neighbourhood programme • Urgent & Emergency Care programme • Older people's Transformation • Mental Health Transformation • Enablers	Update / Information	***Yes***
		Discussion	
		Decision	

Summary of main points:

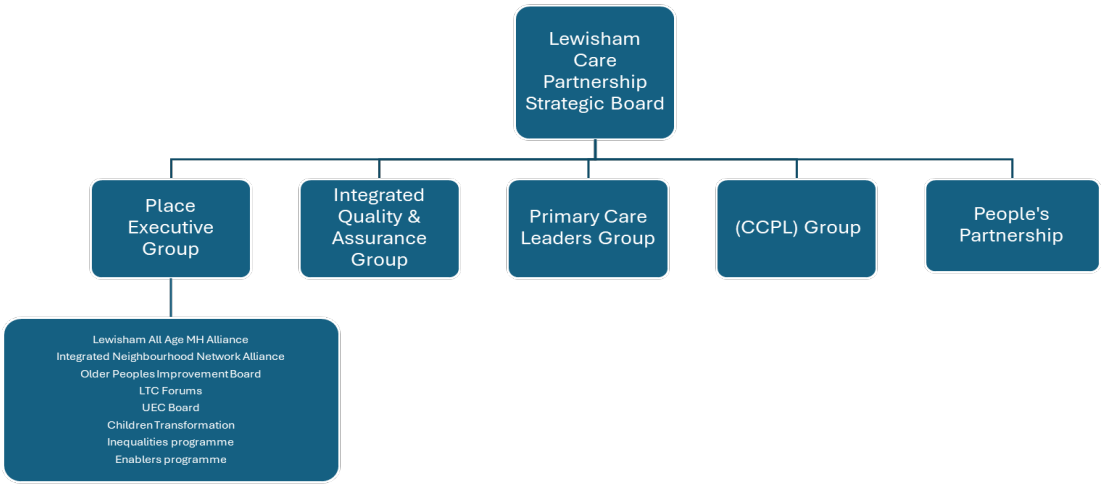
Introduction

The Place Executive Group (PEG) has been established to translate and drive the delivery of Lewisham's strategic intentions, plans and priorities as determined by the LCP Board. The Group hold the LCP's various programme and project steering groups to account and ensure that the LCP Board is fully updated on key deliverables, performance (positive and negative), risks and challenges.

The Place Executive Group will provide leadership, direction and oversight of Lewisham's programmes, proactively identifying opportunities within the system to improve health and care outcome, to transform and integrate services and improve partnership working.

The Place Executive Group will be solutions focused and seek to understand and resolve complex problems affecting health and care in Lewisham that no single organisation working on their own would be able to resolve or improve.

A key role of the Place Executive Group each year will be to bring together all system partners to longlist, shortlist and prioritise the development of Lewisham's system intentions for the coming financial year. All members will be responsible for inputting into our shared system intentions, and for cascading and socialising the system intentions at the appropriate levels of seniority within their own organisations.

	Programmes feeding into the Board: • Lewisham All Age MH Alliance • Integrated Neighbourhood Network Alliance • Older Peoples Improvement Board • LTC Forums • UEC Board • Children Transformation • Inequalities programme • Enablers programme • Same Day Urgent Care SDUC Other work that also reported into the board over the six months are: • Draft System Intentions (25-26) • Outpatient Transformation Programme • SDIP Please see attached the current programme and four highlight reports (Integrated Neighbourhood, UEC, Older People, Mental Health) 
Potential Conflicts of Interest	**N/A**
Any impact on BLACHIR recommendations	The business of the Place Executive Group will be mindful at all times of: • the entrenched and complex health inequalities that exist within Lewisham, including but not limited to the findings and recommendations of the BLACHIR report (2022) and Lewisham's high levels of social and economic deprivation • feedback from patient and public engagement including the Lewisham People's Partnership • the operating context of the NHS, local authority and voluntary sector in recent years, including the post-Covid pandemic recovery and escalating pressures on resources such as our workforce, estates and finances

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Each programme that reports to the board has completed an EQIA		
	Financial Impact	Each programme that reports to the board has completed a Business Case include Financial Impact of the programme		
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 Each programme has its own agreed comms and engagement plan outlining how the public are being engaged on the work taking place.		
	Other Committee Discussion/ Engagement			
Recommendation:	Going forward the PEG highlight reports, and performance reports and risks will be included in the LHCP papers to improve transparency and countability to the overall performance of the programme.			

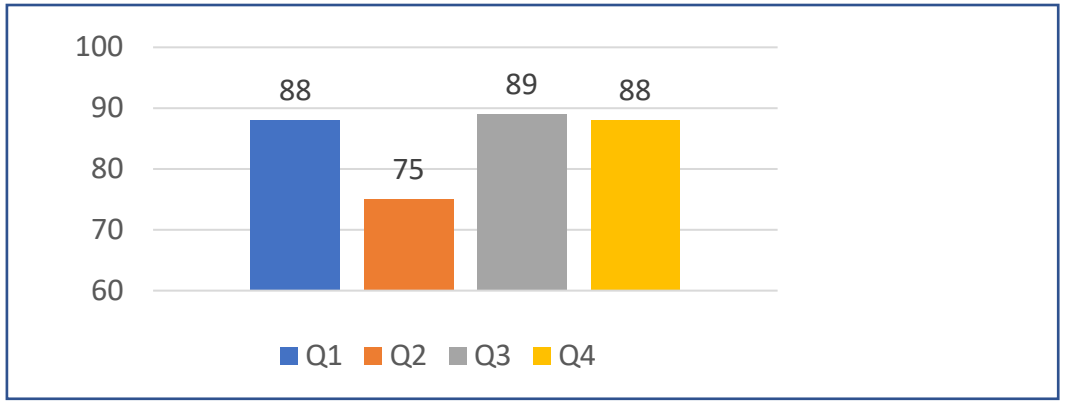
Neighbourhood Programme Highlight Report: April 2025

Programme	Lead	Sponsor	Exec
Integrated Neighbourhood Programme	**Fiona Kirkman** *System Development Lead*	**Laura Jenner** *Director System Development*	**Ceri Jacob** *Lewisham Place Executive Lead*

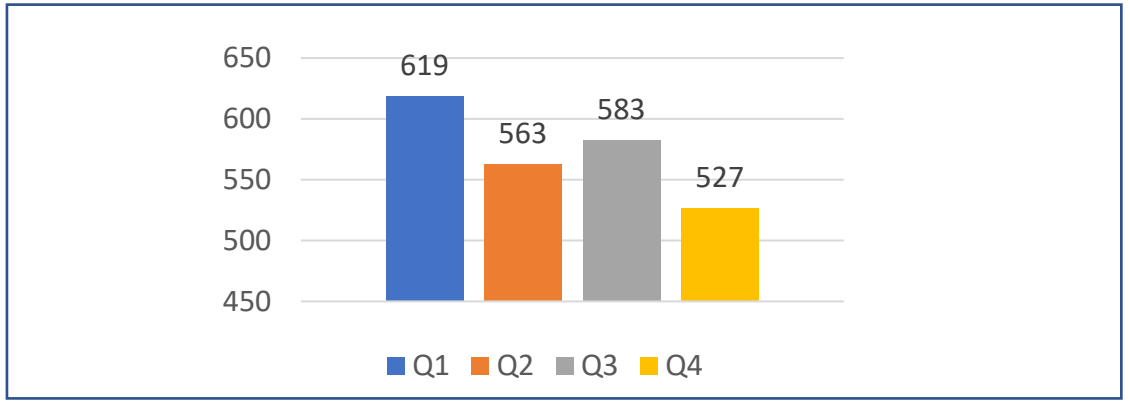
Programme Vision

The Integrated Neighbourhood Team (INT) programme aims to deliver person-centred care for patients with multiple long-term conditions and complex health needs by integrating primary, secondary, community, and voluntary services. Through collaboration, early intervention, and holistic support, the INT seeks to improve health outcomes, enhance self-management, and reduce hospital admissions, ensuring equitable and accessible care for all.

Indicator: No. of MDM Meetings held per quarter



Indicator: No. of Patients discussed in the MDMs per quarter



Top Contributors

- Population Health Team, data analysis for MDM and INT Risk models.
- PCN and Neighbourhood Coordinator Leads, testing MDM patient cohort.
- Enabler Leads for Digital and Estates.
- INT Mobilisation Planning Team.
- LGT HR Team.
- Waldron Front of House Team, for navigation and co-ordinating community space/activity.
- Imago, links with unpaid carers and INT.

Actions Taken

- Modifying INT pathway for people with learning disabilities and Autism.
- Completion of INT Job Descriptions.
- Mapping the digital requirements for INTs.
- Presenting INT model at the All-Age Mental Health Alliance meeting. Further actions identified.
- Developing INT Holistic Assessment, meeting with stakeholders to review.
- Completion of the Equalities Impact Assessment and Quality Impact Assessment for INTs.
- Agreement - recruitment for INTs to be co-ordinated centrally, using Lewisham & Greenwich Trust's recruitment service and online platform.
- Developing INT Governance arrangements.

Planned Activity

- Completion of Business Case for INTs.
- Further development of INT Performance Framework
- Risk model for admission MDM and INTs completed.
- Adult Social Care data to be included in Data modelling.
- Confirmation of Waldron Launch and planning.
- INT Job Advert to go live and recruitment underway.
- Completion of INT Standard Operating Procedure.
- First meeting to have taken place with Neighbourhoods/PCNs and ICB Lead partner.
- Completion of DPIA for MDM and INT.
- Second digital mapping session to have taken place and digital requirements identified.

Deliverable	Expected Delivery Date	Completed Date	RAG Rating	Update
INT Model of Care Defining and implementing a coordinated model of care for patients with multiple long-term conditions and complex needs by integrating primary, community, and secondary care services.	July 2025			• Reviewed the current INT care model for complex cases to ensure alignment with system priorities. • Co-design sessions have taken place with patients with lived experience (PWLE) and system partners. • Refining the pathway and embedding the model within alongside existing services.
INT Mobilisation Recruiting, training, and deploying the workforce required for the INT, ensuring operational readiness	September 2025			• Drafting JDs for INT roles in progress • Recruitment to INT roles will begin mid-April • Workforce planning ongoing to ensure appropriate skill mix across the team. • Next steps include induction, training, and establishing clear roles and responsibilities for staff.
INT Governance Establishing governance structures to ensure effective oversight, decision-making, and accountability in the INT programme	April 2025	April 2025		• Designed the INT performance and outcome framework • Business case completed and submitted for approval. • Service specification developed, outlining key objectives, eligibility criteria, and service delivery approach. • Formalising reporting mechanisms and finalising governance arrangements.
Deliver Communication and Engagement Activity across INT Programme Ensuring effective communication with stakeholders, patients, and system partners to support the successful implementation of the INT	June 2025			• Initial workshops held with system partners to gather input and share programme updates. • Engagement with specific groups, such as Learning Disability and Autism services, carers, and PWLE, • Next steps include creating patient-friendly materials
Multi-Disciplinary Meeting (MDM) Implementation Ensuring effective MDT structures to support collaborative and proactive patient identification	May 2025			• Implemented a new Standard Operating Procedure (SOP) for MDMs to support proactive approach • Multidisciplinary Meeting (MDM) Information Sharing Agreement completed • DPIA (Data Protection Impact Assessment) finalisation in progress • Next steps include evaluating MDM effectiveness by testing in one practice.

Scorecard: Risk Management

Risk	Pre-mitigation	Mitigation	Post Mitigation
Low levels of partner engagement due to lack of workforce capacity	M12	Programme developed in partnership. Development of metrics, track impact and capacity to demonstrate value.	L6
Lack of buy in by stakeholders	M12	Development of programme in collaboration, ongoing engagement with stakeholders, regular updates.	L6
Lack of system capacity to mobilise Integrated Neighbourhood Teams (INTs).	H16	Robust Programme planning, INT modelling, Workforce and financial modelling. Learning lessons from early adopter sites.	M12
Inability to measure the impact of the INTs.	L4	Build evaluation into the model, robust impact analysis and methodology.	VL2
Inability to recruit staff into key roles.	M12	Early understanding of workforce requirement and planning.	M9
Delivery at scale not achievable.	H15	Evaluation of performance framework, dedicated programme resource to support implementation. Learning from early adopter sites.	M9
Multi-disciplinary Meetings will not be able to take a proactive approach to care if programme is delayed by lack of resources/ change of focus to Integrated neighbourhood Team Development	M9	Align with Population Health Team for careful resource allocation. Mapping of the MDM cohort to improve planning.	L6
MDM Data Sharing. Negative impact on Multi-disciplinary Team meetings if data Sharing is not resolved.	M12	Mapping data flows, meeting with IG Leads, to review and update DPIA.	L4

Scorecard: Outcome Measures

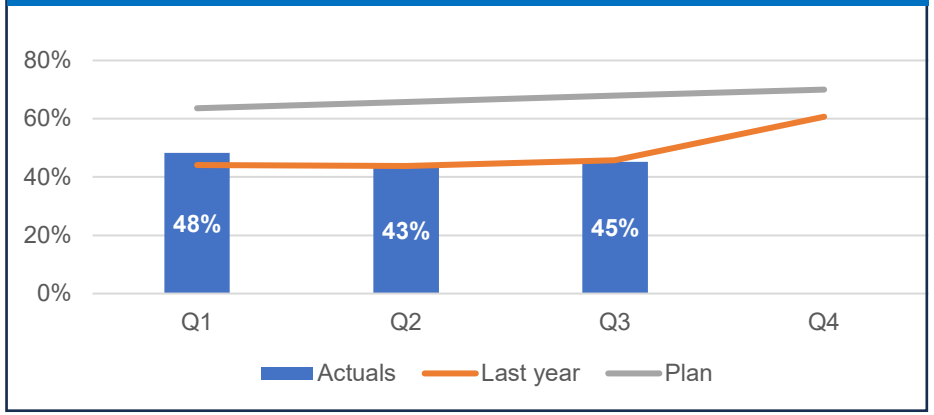
Programme	Lead	Sponsor	Exec
All Age Mental Health Alliance	Ellen McGale	Kenny Gregory Adeniyi Aderinto	Ceri Jacob

Programme Vision
The All-Age Mental Health Alliance plans, oversees, and facilitates integration of mental health and social care provision for residents, carers and families that access our services. The Alliance aims to create sustainable models of care through partnerships with voluntary sector and statutory services to deliver needs-led, culturally relevant and person-centered.

Alliance priority areas	Proposed metric	Latest data	Target 25/26 end	Comments
Community - CYP	1+ contact including MHSTs (12 month rolling)	4322 (Jan 25)	5804	LSL operational planning target submitted, Lewisham ambition to be agreed with SLAM
Community - Adults	2+ contacts in Adult Community	TBC	LSL target= 11,628	LSL operational planning target submitted, Lewisham ambition to be agreed with SLAM Metric to be developed by SLAM at Place level.
	Physical health checks and SMI	TBC	3330	Working group reconvened
Community - Older Adults	Dementia Diagnosis Rate (%)	62.5% (Feb 25)	66.7%	Low rate understood to be data quality issue
Crisis	All age MH attendances at UHL (% known to services)	320 (43%) (Feb 25)	N/A	Ambition for reduction in MH attendances to UHL not set/agreed, TBC
Inequalities	% of MHA detentions where service user is Black	26% (Mar 25)	N/A	Ambition for detentions under MHA not yet set/agreed, TBC

ICB Corporate Objective: Physical Health Checks for People with SMI

24/25 performance vs planned trajectory



Key areas of work over last period

- The All Age Mental Health Alliance assurance framework is being developed. Expectation that Alliance Working Groups determine the relevant quantitative metrics for their work programmes to monitor delivery and that they report on these. The above table is a DRAFT select set of metrics reflecting priority areas of work - the summary Alliance scorecard to report to PEG will be reviewed with Alliance members and may evolve with collaborative agreement over metrics for inclusion.
- Progression of establishment of Alliance sub-groups and refinement of work plans for 25/26. Plan to align sub-groups to the core priority areas of the Alliance: (1) Understanding and addressing inequalities in mental health care (2) Strengthening front door and community services (3) Rehabilitation and complex care (4) Crisis pathway
- N2 pilot launched ‘initial offer’ which aims to deliver some aspects of the new model without access to estates.
- VCSE procurement concluded 2/3 lots
- Physical health checks and SMI plan developed
- Southwark developed complex care PID

Scorecard: Process Measures

Deliverable	Expected Delivery Date	RAG Rating	Update
Effective planning and oversight through Mental Health Alliance Through development of an assurance and outcomes framework, support members of All Age Mental Health Alliance's ability to plan and shape service delivery and improvements in Lewisham.	Jun '25		• MH Alliance subgroups being established with clear aims, outcomes and metrics to monitor for improvements. • A draft assurance framework has been developed; further work on metrics and format will be led by the MH Alliance sub-groups who will take ownership of relevant sections.
Mental health pathway transformation **A. Test new model of care through N2 24/7 Community Pilot:** Deliver transformation on time and to plan; initial offer launch Ap-Jun, enhanced offer launch Sept-Oct, and beds opening in Dec). **B. Reprocure VCSE offer: Lot 1** mental health and wellbeing; Lot 2 assertive outreach; Lot 3 culturally and faith appropriate support. **C. Evolve existing offer, including evaluation of MHPs/ARRS roles**	Dec '25 May '25 Aug '25		A. Draft specification for the 24/7 Community model revised. 'Initial offer' launched/trialled while estates is under development (enhanced offer launch expected Sep) Workstreams established: care model & coproduction; communications and engagement; estates; staff support; culture and OD; VCSE integration; evaluation and monitoring. B. Procurement completed for lots 1&2 (mental health and wellbeing; assertive outreach); moderation is still underway for lot 3 (culturally and faith appropriate) C. An evaluation framework for MHPs/ARRS roles is under development
Physical health checks and SMI Meet SEL operational planning target of 63% of those on the SMI register having received an annual physical health check.	Mar '26		• Plan developed including data analysis to ascertain which practices and PCN's have low levels of completion of physical health checks for people with SMI and targeted engagement with GPs/primary care; however, gap between current delivery and ambition is substantial.
Financial sustainability Identify financial savings, and aim to deliver improvements in existing resource envelopes	July 2025		• Finance Task and Finish Group established.

Risk	Pre-Mitigation Rating	Mitigation	Post-Mitigation Rating
Financial Pressures – the current financial climate across the system is a risk to service delivery. With an anticipated workforce reduction for the ICB and financial pressures being experienced for LBL and SLaM, the system is experiencing increased on service delivery.		**A Finance Task and Finish group** has been established as part of the MHA workstreams. The purpose of this Task and Finish Group, is to identify cost-saving opportunities by conducting reviews of current expenditures to pinpoint areas where costs can be reduced without compromising service quality and provision.	
No primary care lead identified for programmes of work, impacting on level of input into key workstreams (crisis, INTs, physical health checks and SMI)		Opportunities being scoped for identifying GP involvement through existing networks.	

Scorecard: Process Measures

Programme	Lead	Sponsor	Exec	Annual Budget	YTD Budget	YTD Spend	YTD Variance
Older Adults Transformation	Corinne Moocarme	Kenny Gregory	Ceri Jacob/Denise Radley				

Deliverable	Expected Delivery Date	Completed Date	RAG Rating	Update
Business Case agreed for Lewisham Greenwich NHS Trust (LGT) to deliver a Proactive Ageing Well Service (PAWS) providing care and support to people living at home with moderate or severe frailty. Clinical Programme Manager appointed to start end of September 2024. Mobilisation plan being developed to include Communication with all Stakeholders, Recruitment, Community Assets, IT Systems, Case Finding/Evaluation/Learning from other models.	**October 2024 – start date**			The PAWS Team will be in full establishment by the end of April 2025. PAWS performance is being reported internally to LGT LMC's monthly performance reviews, giving the team access to the monthly data. PAWS was discussed at the LGT Community Board Meeting in March 2025, and the service evaluation model was agreed, including key outcome measures to be captured. The PAWS specification has been drafted and is currently being reviewed by ICB clinical leads, this will then be reviewed by the ICB contracting Team. Good progress has been made to deliver Comprehensive Geriatric Assessments (CGA) in people's homes. In Phase 1, 98 people were identified and split into control and intervention groups, with 43 CGAs completed. This led to the completion of 36 care plans, 43 medication reviews (reducing anticholinergic burden by 16 points), and 40 osteoporosis assessments - identifying 7 people needing DEXA scans and bone health treatment. In Phase 2, 38 more people were invited, with 8 CGAs completed so far — all received medication reviews. Outcomes are still pending for this group. Referrals from GPs and external practitioners are planned to open by mid-May. Case finding activities will continue in parallel with referrals, through a pendulum approach. Referral pathways will be open to all GPs and community services for eligible patients. Discussions are ongoing with regards to integrating PAWS and aligning Age Well agendas with the wider Neighbourhood and MDT models. The key focus of the discussions was to Identify and address potential overlaps between INT and PAWS patients to avoid duplication of efforts and ensure efficient patient management.
There was a need to establish an Ageing Well Board for Lewisham to support older adults to improve health and care outcomes for older adults through collaboration and shared priorities. The aim was to have a Board to provide overall strategic oversight, coordination and governance for the delivery and development of a proactive ageing well programme within the London Borough of Lewisham.	**April 2025**	Ongoing		The Older Adult Transformation Board has been re-focused to become the Lewisham Ageing Well Board. The Board's intention is to have a holistic wellbeing approach to support older adults. The Board met for the first time on April 10th, where the draft Terms of Reference (ToR) were presented for members feedback and approval. The Board aims to improve health and care outcomes for older adults through collaboration and shared priorities. It will interpret and implement national and regional frameworks while coordinating with other partnerships to avoid duplication. Key focus areas for the Board include frailty prevention, integrated pathways, care home quality, dementia, and end-of-life care, with housing suggested as an additional focus.
Develop a Lewisham wide mechanism for capturing the voice of older adults.	**June 2024**	Ongoing		A meeting took place with Positive Ageing Council (POSAC) to discuss engagement and coproduction in the development of an Ageing Well Strategy. POSAC have also attended SEL wide Ageing Well Workshop where ongoing engagement with older people is being discussed. A suggested engagement plan will be discussed at the July Ageing Well Workshop.

	Pre-Mitigation Rating	Mitigation	Post-Mitigation Rating
Lack of shared IT access across the system may create duplication if PAWS/Primary Care/Acute/Community do not all have access to the same level of patient data/information.		Emis access remains an ongoing challenge, it is £500 per license, so further £2,000 need to be identified for PAWS clinicians to have access. There are plans to include CGA in the UCP.	

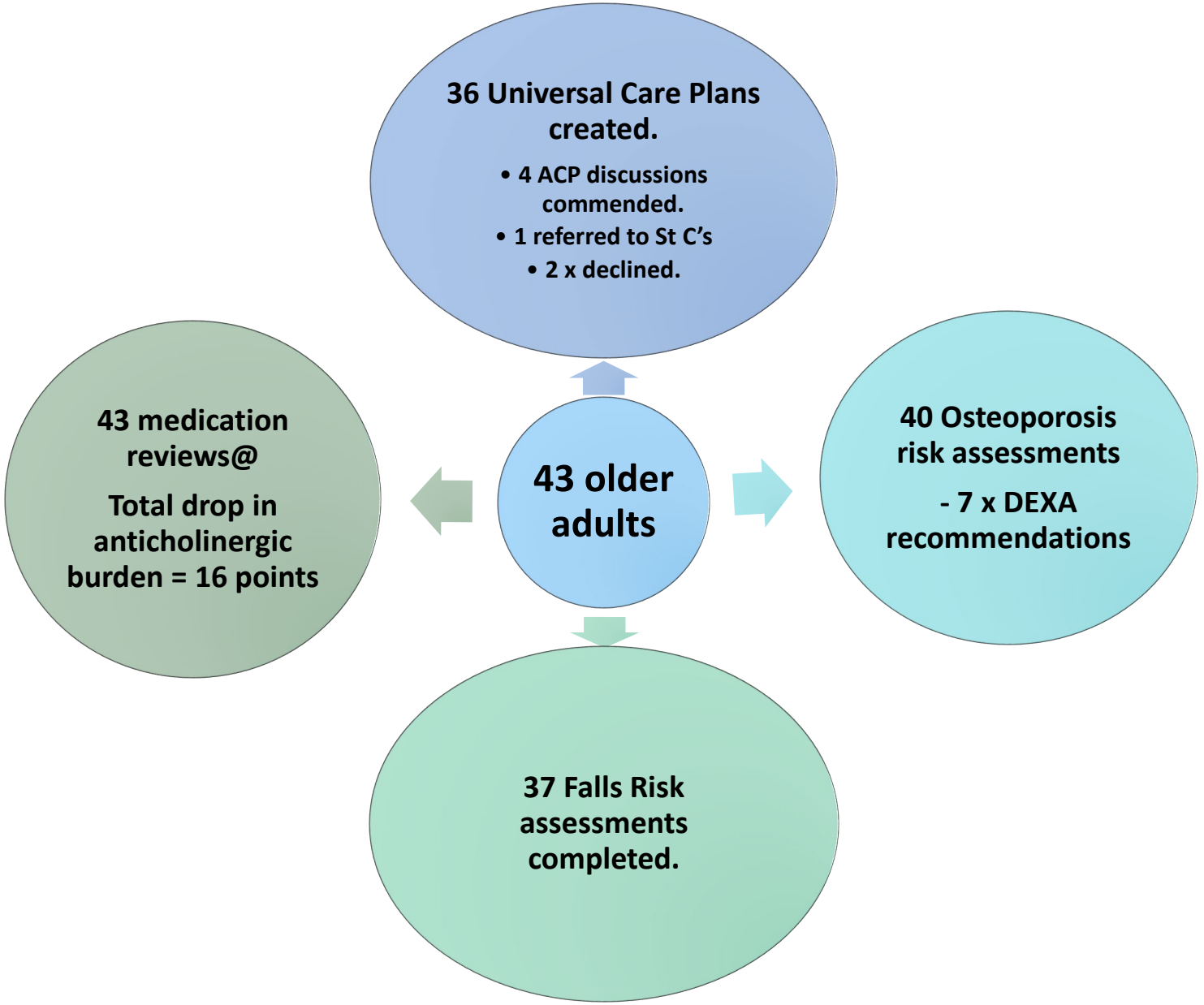
PAWS CGA Project Summary

Phase 1: Initial Cohort:

- **Participants:** 98 individuals proactively identified and randomised into two groups for a comparison study:
  - **Control Group:** 49 people
  - **Intervention Group:** 49 people
- **CGA Engagement:**
  - 39 individuals accepted a PAWS CGA
  - 4 additional individuals referred in
  - **Total CGAs Completed:** 43
- **Outcomes from Phase 1:**
  - **Universal Care Plans Created:** 36
  - **Medication Reviews:** 43
    - Reduction of anticholinergic burden by 16 points
  - **Osteoporosis Risk Assessments:** 40
    - Identified 7 patients needing DEXA scans
    - These patients were subsequently started on bone-protective medication

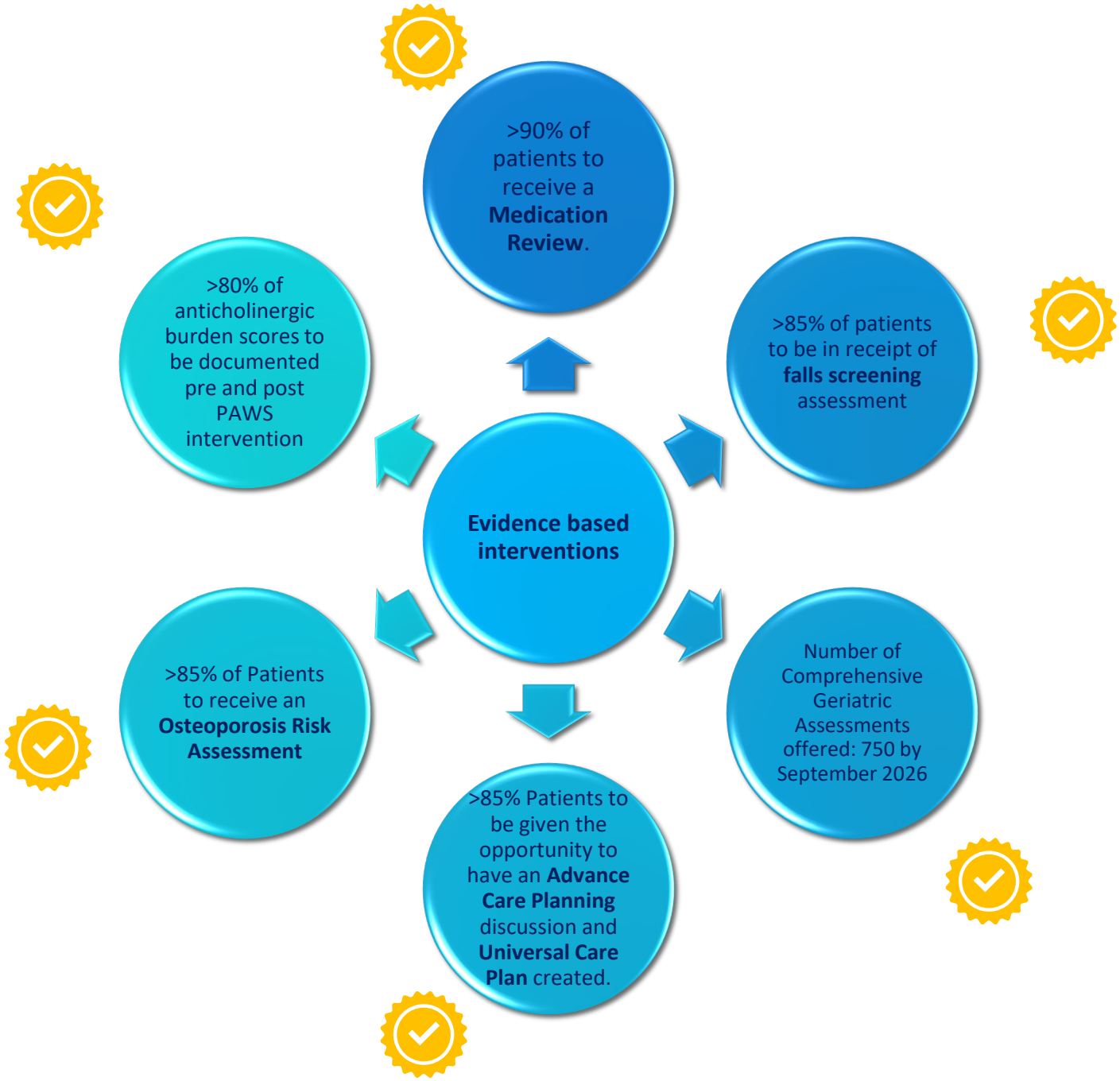
Phase 2: Ongoing:

- **New Participants Identified:** 38 individuals proactively invited for a CGA
- **CGAs Completed (so far)** 8.
  - All received:
    - Medication review
    - Falls risk assessment
    - Bone health assessment
    - Offer of future care planning discussion
- **Outcomes:** The outcomes are still pending for this group.



Measuring Success…

Evidence Based Interventions



Looking to the future….

- Earlier identification of frailty within the Borough.
  - ≥75 years old national population expected to almost double from 2.5% to 4.3% by 2045.
  - Currently 26,230 people aged ≥65 years old living in Lewisham representing 9.6% of the total population (9.8% increase since 2011, ONS, 2021).
    - eFI Fit = 7,417 people
    - eFI Mildly Frail = 9,485 people
    - eFI Moderately Frail = 6,526 people
    - eFI Severely Frail = 2,802 people

    (Electronic Frailty Index (eFI) to identify individuals considered "fit" or not frail)

- Work in collaboration with the implementation of the Integrated Neighbourhood Teams.
- Continue to develop an integrated model of care with other health, social and voluntary sector services.
- Work toward Universal Care Plans being created and updated regularly.

NHS
Lewisham and Greenwich
NHS Trust

Transformation Scorecard

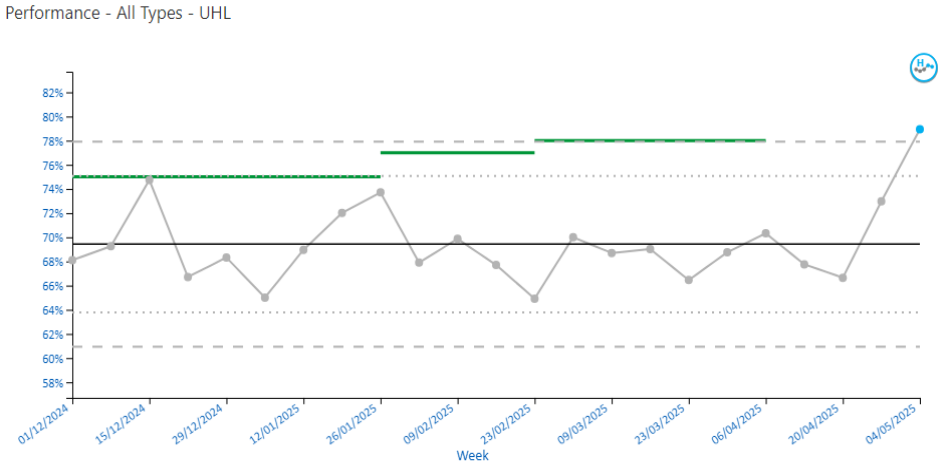
UEC Transformation Scorecard: Outcome Measures

Programme	Lead	Sponsor	Exec
Lewisham Unplanned Care	Amanda Lloyd / Jen Cassettari	Jo Sutcliffe	Miranda Jenkins

Programme Vision

To make unplanned care services accessible and relevant to patients needs and available in a community or hospital environment, based on clinical need

Indicator: Performance



April 2025

Performance for all types improved following reduction early April

Common Cause Variation

Best April performance 73%
Best Type 1 performance 59%
Best Type 3 performance 99.5%

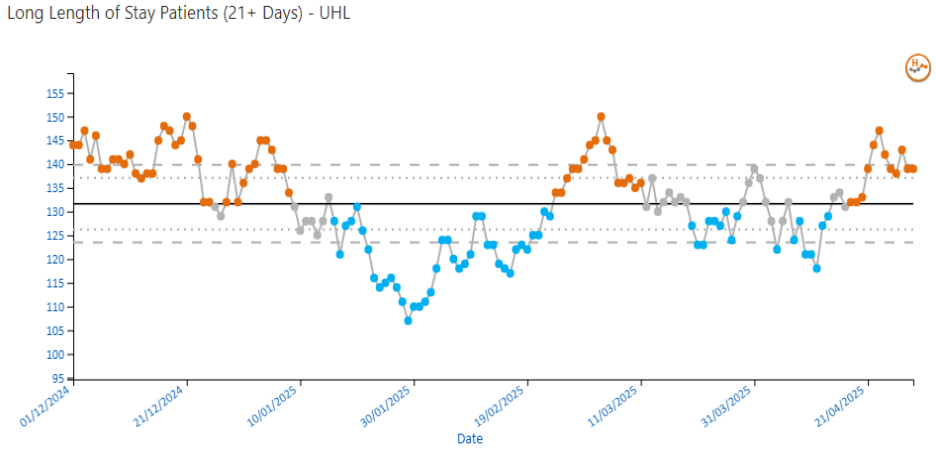
Target

78%

Plan

Target is to keep working towards 78%

Indicator: 21+ LOS



April 2025

Lowest average LoS 8 days, Geriatric Medicine highest specialty with mean of 13 days LoS

High Cause Variation

Lowest amount of 21+ LoS 118 patients, but rose to 147 patients
Increase in internal delays end of April
Largest external delay Residential/Nursing home not available

Plan

Target is to keep numbers low

Top Contributors to performance

- LGT UTC- opened 12th March 2025
- Red to Green Project improving flow on selected wards
- Expansion of passports project improving flow on selected wards
- Care Homes Liaison Nurse and work with care homes to reduce delays in discharges for pathway 3 evidenced better P3 LOS

Actions Taken

- Review of all Flow workstream projects including metrics and plans
- Ambulatory RATting started 28/04/2025
- Ongoing collaborative working for surgical pathways, including new SOP development to be named Surgery SDEC
- Clarification of data collection for Pathway 0 and UTC
- Partners exploring options of step up admission avoidance Virtual Ward
- Care Homes Liaison – improved P3 discharges
- Discharge incentive scheme

Planned Activity

- Frailty SDEC to start June 2025
- Roll out of Red To Green on Older Adult Wards
- Plan for increased engagement with Doctors to support Length of Stay projects
- Winter Wash-Up
- 111 activity mitigation plan across SEL being developed
- TOCH governance proposal going to board
- Intermediate Bedded Care –procurement outcome announced
- Virtual ward procurement launch

UEC Scorecard: Process Measures

Programme	Lead	Sponsor	Exec	Annual Budget	YTD Budget	YTD Spend	YTD Variance
UEC Delivery	Amanda Lloyd / Jen Cassettari	Jo Sutcliff	Ben Travis	n/a	n/a	n/a	n/a

Deliverable	Expected Delivery Date	Completed Date	RAG Rating	Update
Appropriate Admissions Convening refreshed reference & Steering group Agreed metrics for workstream	Complete	April 2025		• First Reference group meeting completed • Prioritisation of projects that support workstream • Increasing capacity in UCR work started • Increasing patient complexity of NHS@Home wards work started • NHS@Home procurement launched
ED Front Door Delivery against performance	Ongoing	Ongoing		• UTC Opened 12th March 2025 • EDSDEC started Nov 24 • RATting at front door commenced Dec 24
Flow	Ongoing	Ongoing		• Passports project to roll out to 3 other wards • Discharge Incentive scheme to increase SW and therapy provision: part completed, impact being measured • Improvement in LOS on a number of wards due to red to green project & P3 work
Discharge Reducing pathway 3 delays Therapies / Enablement C&D & Time and Motion study outputs Intermediate Care Strategy	09/24 – 09/25 Complete Nearing Completion	09/24		• Hospital single point of contact for care homes pilot, evidenced impact on P3 delays • Therapies/enablement - SDIP funding agreed to improve therapies' capacity • Intermediate Care Strategy – draft out for comment • TOCH governance proposal to be presented to HFSG • Intermediate Care Beds – procurement completed, comms out 28/04/2025

Risk	Pre-Mitigation Rating	Mitigation	Post-Mitigation Rating
Changes in ICB funding / structure will lead to inadequate resources to deliver against plans	16	• Part time Change Mgmt resource continue to lead/drive delivery • Prioritise work plans to meet capacity to deliver	9
Change in governance due to ICB changes, and planned/potential changes in senior executive posts in LGT/LBL will lead to lack of continuity, and impact on focus, oversight and decision-making	12	Continuity of plans and intentions driven by Change Mgmt lead, AD Discharge Lead & Therapies Lead	9
Given recent announcements of ICB cuts; LBL and LGT overspends there will be a lack of funding to invest in delivery of improvements	12	• BCF ringfenced funding • Change BCF-funded locum posts to substantive – savings and continuity • Drive change through improving efficiency (ECT) / flex (combining D2A & SD) • Re-purpose vacant BCF project manager post to support delivery	9

Lewisham Health & Care Partnership

Enablers Update May 2025

Lead: Charles Malcolm-Smith, Associate Director for System Development, SEL ICB (Lewisham)

Enabler Area	Progress & Activity from Last Report	Future Plans & Development
Workforce	**Workforce Priorities**, oversight by LHCP Workforce Steering Group: • Community Workforce (sub-streams Career Pathways and Joint Appointments) • Joint Recruitment Initiatives • Joint Training & Development **INTs** Draft of job descriptions for INT roles and recruitment planning. Engagement with SEL ICS People Programme for development of Workforce Support for INTs	**INTs** To proceed with recruitment to INT roles through LGT recruitment service; finalise JDs; co-ordinate shortlisting and interview panels. Suggest interventions to support these areas of work for INTs when teams in place and on-going: • Cross-Organisational Integrated Working Establish local operational frameworks, joint HR policies, and shared data systems for integrated teams. • Values, Culture, and Behaviours Joint induction, team-building, and collaborative working norms. • Training – Upskilling in Data, QI, and Digital Develop place-based training hubs for data, digital skills, and QI methodologies. • Skill Mix & New Roles Test and refine new integrated roles (e.g., care coordinators, digital navigators) within local services.

		Joint recruitment - Forward plan (shared calendar) for recruitment events run by partners to establish better co-ordination (LGT lead).
Estates	Continuing meetings of the **Lewisham Estates Forum** led by ICB Estates Team, brings together local partners to identify and monitor funding and development. Regular primary care estates meetings and partner meetings. **Waldron Programme** - Programme Board review of Development Group, sensor data and lifecycle maintenance. Development programme for **Kaleidoscope Centre** Revised expected completion July 2026. Architects and Healthcare Strategy and Planning consultants appointed.	**Neighbourhood Estates** Assessment of INT estates requirements and potential availability in each of the neighbourhoods: (where the INT teams will be based and the 4 hubs) **Waldron Centre** - further review of clinical room usage through room sensor data, potential re-allocation of space and lease arrangements for service providers.
Digital	**LHCP Digital Plan**: themes as the basis for a digital plan for the LHCP: • Digital Inclusion & engagement – empowering people • Data quality • Digital solutions • Linked Electronic Patient Records (EPR) & connected care • Linked data – data insights **INT Digital Needs** SEL ICB Digital Team and LGT attendance at INT design session 19th March. Follow-up SEL ICB Digital Team and LGT action for INT development. Digital pathway mapping,	**INT Digital Needs** On-going development planning for INTs with SEL ICB team and with LGT digital lead. ICB digital enablement plan covering: • Data-driven insight and care • Connected Care • Empowering people • Supporting our workforce • Drive continuous improvement and innovation • System Resilience, Data Integrity and Cyber Security

	and ICB Digital Enablement initial needs assessment completed. Information Governance requirements assessment underway.	**LHCP Digital Plan** Next steps: • Establish oversight group and leads for themes and key actions areas amongst oversight group
VCSE Capacity Building	**Capacity Building** Funding from SEL ICS to strengthen the capacity and capability of VCSE organisations, particularly those that serve marginalised communities. Lewisham Local progress for this programme • Governance & Procurement Frameworks: formalising structures, policies, and frameworks to deliver services during the project. • Recruitment of Development Roles finalise job descriptions and advertise two part-time VCSE Development & Fundraising lead roles. • VCSE Outreach & Engagement: Early engagement activities began in April, and the SEL programme was formally announced 27th March • Micro-Grant Scheme Design: planning initiated for the LBVN Micro-Grant Scheme.	**Capacity Building Mobilisation and Monitoring** Responsibility for delivery and employment by Lewisham Local working in partnership with the Lewisham Black Voluntary Network to establish priority areas of support, identify appropriate grassroots organisations for targeted support and oversee programme delivery. • Recruitment of Development Roles Shortlisting and interviews are scheduled for mid-May. • Micro-Grant Scheme Design Key elements, including assessment panel guidance, eligibility criteria, and initial draft guidelines and workflow timelines, are being developed and a comprehensive package will be shared with LBVN steering group on May 15th for clarification and finalisation.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 11
Enclosure 11

Title:	**Lewisham People's Partnership**
Meeting Date:	**22nd May 2025**
Author:	Anne Hooper
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The purpose of this paper is provide an overview of the intentions in the Lewisham People's Partnership Action Plan for 2025/26	Update / Information	X
		Discussion	
		Decision	

Summary of main points:	The Lewisham People's Partnership has two key objectives: • Support people and communities to exercise power, build trust, enable participation and work together to achieve more with what we have • Ensure that the lived experiences and needs of Lewisham's many and diverse people and communities drive local partnership decision making and that we have the evidence to show this The focus for the Lewisham People's Partnership Action Plan for 2025/26 is to: • Support Lewisham's communications and engagement plans/campaigns focusing on access to services, integrated neighbourhood teams and prevention • Support engagement delivery and effectiveness through widening participation and improved co-ordination • Support improvements in engagement outcomes and influence • Support shifting the balance of power from within the system towards people and communities Further details can be found in the attached Action Plan.
Potential Conflicts of Interest	
Any impact on BLACHIR recommendations	**BLACHIR Opportunities for Action 34** Ensure the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments.

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact			
	Financial Impact			
Other Engagement	Public Engagement			
	Other Committee Discussion/ Engagement			
Recommendation:	This report is for update and information			

LEWISHAM PEOPLE'S PARTNERSHIP – ACTION PLAN FOR 2025/26

The Lewisham People's Partnership has two key objectives:

- support people and communities to exercise power, build trust, enable participation and work together to achieve more with what we have
- ensure that the lived experiences and needs of Lewisham's many and diverse people and communities drive local partnership decision making and that we have the evidence to show this

The focus for the Lewisham's People's Partnership 2025/26 Action Plan is to:

- support Lewisham's communications and engagement plans/campaigns focusing on access to services, integrated neighbourhood teams and prevention
- support engagement delivery and effectiveness through widening participation and improved co-ordination
- support improvements in engagement outcomes and influence
- support shifting the balance of power from within the system towards people and communities

ACTION PLAN

What	How	Who	When	Expected outcomes

Access to services	• Provide a continuous forum for engagement on:
	  • Lewisham's Primary Care comms campaign
	  • Lewisham's plans to improve access to primary care
	  • Pharmacy First comms campaign
		LPP Chair/Comms & Engagement Team	Ongoing	Feedback/responses/influence recorded
				Ensure continuity of engagement and longer term, more meaningful conversations

What	**How**	**Who**	**When**	**Expected outcomes**

Integrated Neighbourhood Teams	• Promote and support the co-production of neighbourhood programme service design and development:
	  • Update from members of the INT Lived Experience group
	  • Final presentation from the Lived Experience Group
	• Support the development of neighbourhood engagement and comms hubs aligned to INT
	• Link Neighbourhood Programme engagement activity into Lewisham People's Partnership engagement activity e.g., through LPP outreach activity
	• Involve local people and community groups in conversations about health prevention and barriers to health equity
		INT Lived Experience Group
		
		Comms & Engagement Team
		INT Leadership Team
		
		LPP Chair/Comms & Engagement Team
			Mar25
			May25
			Ongoing
			Ongoing
			Ongoing
				Feedback/responses/influence recorded
				Ensure continuity of engagement and longer term, more meaningful conversations

Prevention	• Provide a forum for engagement on:
	  • Lewisham's Immunisation and Vaccination strategy re-fresh
	  • Lewisham's hypertension pilot
		Dr. Deborah Jenkins Africa Advocacy Foundation	Mar-Jul25
			May25
				Feedback/responses/influence recorded
				Ensure continuity of engagement and longer term, more meaningful conversations

Widen LPP engagement participation	• Take LPP into communities:
	  • Agree and implement a more proactive outreach approach to community representative groups, community support groups, VCSE and grass roots organisations delivering engagement focused on Lewisham's priorities
	  • Agree and implement a LPP outreach plan with Patient Participation Groups, Lewisham Carers Forum, Lewisham Healthwatch and Citizen's UK
		LPP Chair/Comms & Engagement Team
		
		LPP Chair/Comms & Engagement Team
			2025/26
			
			2025/26
				Providing more opportunities for people and communities to participate
				Recognising the value of local people and communities in facilitating dialogue
				Continuing to build relationships and trust

What	**How**	**Who**	**When**	**Expected outcomes**

Improve engagement outcomes	• Support the development of an engagement feedback framework:
	  • Engagement/comms activity to have clear objectives
	  • Identify where the activity sits on the engagement ladder and method of evaluation
	  • Process for collecting feedback
	  • Identify responsibility for follow-up answers and timescale
	  • How and with whom to share (e.g. We Said We Are Doing format) including report to LHCP Strategic Board
		LPP Chair/Lewisham Comms & Engagement Team	Apr-May25	A clear process for providing feedback
				Share both success and failure
				Evidence of influence on decision making

	• Pilot engagement feedback framework – primary care access, INT co-production, immunisations refresh	Comms & Engagement Team	Jun-Dec25	Lessons learnt from pilot
	• Lessons learnt report and next steps in wider implementation of framework across LHCP	LPP Chair/Comms Engagement Team	Jan26	Outcomes framework implemented
Shifting the balance	• Discussion within LHCP to find out if there is a desire – and a clearer way – to demonstrate a willingness to shift the balance of power between people, communities and the system • Building on the outcomes of the Board seminar discussion, support the development and implementation of the co-production framework • Hold open forums to find out what is important to people and communities to focus on	Place Executive Group LPP meetings	 Ongoing	Meaningful co-production with better outcomes Continuing to build trust and partnership with people and communities People and communities contributing to decisions that influence all determinants of health

LEWISHAM PEOPLE'S PARTNERSHIP

Discussions and actions from the meeting held on 5th March 2025

AGENDA

Time	Activity
1.45pm – 2.00pm	Arrivals
2.00pm - 2.15pm	What voices do we have at this meeting?
2.15pm - 2.40pm	Integrated Neighbourhood Programme – Co-design sessions update
2.40pm – 3.00pm	Improving Primary Care – Communication and Engagement Plan update
3.00pm – 3.10pm	Break
3.10pm – 3.50pm	Lewisham Immunisation Strategy
3.50pm – 4.00pm	Any other business and dates for 2025/26 Lewisham People's Partnership meetings

Voices at the meeting:

Present at the Civic Centre, Catford

Anne Hooper – Chair of Lewisham People's Partnership
Caz Fox – Chair, Rainsborough Avenue Tenants
Carolyn Denne – Lewisham Carers Forum and Local Advisory Committee Member, Healthwatch
Husseina Hamza – Living Well Red Ribbon
Rachel Ellis – Table Talk
Catherine Shobiye – People with Lived Experience Group
Malachy McAleer – People with Lived Experience Group
Hilary Davies – People with Lived Experience Group
Chima Olugh – NHS South East London (SEL) Integrated Care Board (ICB) Neighbourhood Development Manager, Community Based Care and Primary Care (Lewisham)
Deborah Jenkins – Senior Consultant in Public Health, Lewisham Council
Fiona Kirkman - System Development Lead, NHS SEL Integrated Care System (ICS) and Lewisham Council
Helen Marsh – SEL ICB Head of Communications and Engagement (Lewisham and Bromley)
Layla Egwenu – Programme Manager, System Transformation & Change, Integrated Programme Management Team, Lewisham and Greenwich NHS Trust
Mervlyn Clarke - SEL ICB Primary Care team (Lewisham)
Sophy Jeremy – SEL ICB Communication and Engagement Assistant (Lewisham and Bromley)

Online – MS Teams

Kelvin Whelan – Carer's Consultant for Older Adults with Dementia and PCREF???
Alex Camies – Chair, Modality Patient Participation Group and People with Lived Experience Grouo
Peter Ramrayka - Indo Caribbean Group and Air Cadets
Sabrina Dixon – SIRG London
Iris Till – People with Lived Experience and Chair Positive Aging
Jasmine – Lewisham Refugee and Migrant Network
Adrian Ingram – People with Lived Experience
Mo – People with Lived Experience
Busara Drezgic – St Christopher's Hospice
Ashley O'Shaughnessy – South East London Integrated Care Board (SEL ICB) Associate Director of Primary Care and Community-Based Care (Lewisham)
Shaniqua Pinnock – SEL ICB Communications and Engagement Admin Assistant

Agenda Item 1 – Integrated Neighbourhood Team (INT) Programme – co-designing the programme with Lewisham's People with Lived Experience Group

Background

NHS England and the Department of Health and Social Care are advocating for a shift towards a neighbourhood health service to improve access, experiences, outcomes, and sustainability. With more people living with complex conditions, the current system faces challenges like fragmentation, poor communication, and duplication. To address these issues, a 10-year health plan will be published in 2025, aiming to create a more integrated and efficient healthcare system.

Lewisham is developing a local preventative healthcare model for people with long-term conditions. Currently, the focus will be on four key conditions – diabetes, high blood pressure, heart disease and chronic kidney disease. By delivering services within communities, the approach aims to improve health outcomes and reduce inequalities. Effective communication and engagement across South East London will be key to ensuring better access and coordination of care.

Lewisham co-design approach – People with Lived Experience Group

To support Lewisham's integrated neighbourhood team programme work, 16 Lewisham residents with lived experience have been recruited and they will focus on four main elements of the local INT approach: patient access, group consultations, patient discharge and holistic approach. Two members of the People with Lived Experience Group - Catherine and Malachy – gave the meeting feedback from two of their meetings which had discussed patient access and patient discharge process highlighting the following issues:

Patient access	**Patient discharge:**
• Discussing communication challenges and service access issues. • Exploring connections between different services. • Shared diverse experiences and needs. • The importance of how information is provided. • Recognising multiple factors affecting service access. • Advocate for a considerate, person-centred approach. • Highlight the need to accommodate communication abilities and learning difficulties.	• Discharge poses challenges for those with limited capacity or health issues. • Suggested implementing a discharge plan checklist. • Co-design process generated many new ideas.

Following discussion, the meeting gave the following responses for consideration:

- That access to INT services is uniform and equally accessible for everyone who needs them
- It was acknowledged that achieving uniformity can be difficult but that providers should be challenged to find meaningful ways to do it – who will monitor that this is achieved and how will this be reported?
- Communications about INT services should be free of jargon and abbreviations with people able to choose how they are received i.e. letter, text, email, voicemail in languages other than English
- Include South London and Maudsley NHS Trust Patient and Carer Race Equality Forum (PCREF) and Proactive Ageing Well Service (PAWS) in the Lewisham INT co-design discussions
- Make clear that INT services are for all people over with no upper age limit
- INT co-design needs to articulate the ways in which all adults will get knowledge of INT services
- The meeting congratulated everyone involved in the Patient Lived Experience group and the INT team for a very positive co-design process

Actions:

- **The Lewisham People's Partnership to forward these responses to the Integrated Neighbourhood Team and to receive from them feedback as to how the responses have influenced policy and service design decision making**
- **To circulate that feedback to the Lewisham People's Partnership**
- **To invite the People with Lived Experience Group to the Lewisham People's Partnership meeting in May 2025 to provide final feedback on the co-design process**

Agenda Item 2 – Improving Primary Care – Communication and Engagement campaign update

Background

At the Lewisham people's Partnership meeting in November, we discussed Lewisham's plans (part of a national initiative) for improving access to primary care/general practice and how the Lewisham People's Partnership can support the development and implementation of a primary care communications and engagement campaign.

Helen Marsh, SEL ICB Head of Communications and Engagement (Lewisham and Bromley) gave an overview of the campaign which aims to:

- highlight the changes in how people can access help and receive care in general practice
- raise awareness of the different health professionals in general practice teams who are there to help people get the right care, more easily, first time

- highlight the important role of the reception team in using the information patients provide to help identify which health professional or local services is best placed to help
- support general practice by having materials available for them to use to communicate messages which support peoples' understanding of general practice
- ensure that people at risk of inequalities in access are targeted

Helen highlighted some of the campaign's messages and approaches:

- **Navigating changes –** understanding of the range of appointments on offer, how to register for the NHS App and what it's for, providing clarity, combating misunderstanding, fear and other barriers
- **Meet the Team –** using real people to connect with residents, meet your reception team, say hello to social prescribers, how your community pharmacy can help, celebrating our award winning staff
- **Routes to care** – raising awareness of the range of services on offer, when and how to use them, Pharmacy First, social prescribers, voluntary, community and social enterprise groups
- **Methods** – printed materials, updated website messaging, messaging across GP screens, social media, in person at community events and spaces, sharing information via champions

The meeting was asked to consider the following questions with regard to the primary care communication and engagement campaign:

- Are we comfortable with the messages – are there any missing from the plan?
- What is the best way to get these messages out to Lewisham residents?
- Are there specific groups or organisations that need to be engaged or informed?

Following discussion, the meeting gave the following responses for consideration:

- It was acknowledged that the national GP contract means that there are issues we can influence and issues that we cannot
- Improving access to general practice means moving away from first come first served principle to total triage – the campaign needs to explain that concept with messages that are meaningful without jargon i.e., what does triage mean???
- The NHS is making too many assumptions, such as expecting people to understand system and processes, have access to technology, and know where and how to seek care
- Positive challenge to general practice to find ways where there can be more uniformity in messaging and service delivery
- Access to services needs to be uniform – it was acknowledged that general practice is made up of independent businesses but there should be some messages about access that are uniform across all general practices

- For example - there are three ways to get in touch with your GP – telephone, online, in person – there should be the same approach to all three - there is no right or wrong way – people make the choice that meets their needs at the time
- For example - how to get messages out to people and communities – use videos and post on all GP websites – most of the messages in the video will be the same irrespective of individual practices e.g., 60% message the same – 40% message relevant to individual practices
- Communication needs to be two way – people and communities don't know what they can access or how they can access it – general practices don't always know how frustrating it is for patients – need a better understanding on both sides and a willingness to work together to find solutions
- The current mindset is that surgeries dictate how services are accessed, leading to confusion about how to reach necessary care. Issues with the NHS app and self-referral processes further complicate access. Messaging needs to be simple, accessible to all with translations/large print available – not too wordy and jargon free
- There were examples of how difficult it is to get into services – there is a lack of basic understanding of what is available, and the technology does not always work and when it doesn't there is no support or helpline available
- Older people often feel pushed out and not listened to, especially as many struggle with managing technology and uneven services. This highlights the need for more inclusive and accessible methods of communication and more training for receptionists
- Use local shops and school newsletters to spread messages re primary care access
- Consideration should be given to what types of communications patients would appreciate from their GP. Could the Lewisham People's Partnership support a more effective and meaningful way to work with patient participation groups (PPGs)? How could PPGs help to get messages to everyone – would GP sending out newsletters help with meaningful communications and expectations?
- Ask how Lewisham People's Partnership participants how they could support sharing information and messages in their neighbourhoods/communities

Actions:

- **The Lewisham People's Partnership to forward these responses to the Lewisham Communications and Engagement Team and the Lewisham Primary Care Group and to receive from them both feedback as to how the responses have influenced the messages, approach and delivery of the primary care communications and engagement campaign and the plans to improve access to primary care**
- **To circulate that feedback to the Lewisham People's Partnership**
- **To continue engagement on improving access to primary care at future Lewisham People's Partnership meetings**

Agenda Item 3 – Lewisham Immunisation and Vaccination Strategy

Dr Deborah Jenkins, Senior Consultant in Public Health, Lewisham Council, shared a presentation on the plan to refresh Lewisham's Immunisation Strategy.

About Lewisham's Immunisation and Vaccination Strategy

The current Lewisham Immunisation and Vaccination Strategy was written for 2023-205 strategy and is now being refreshed following the completion of Lewisham's Joint Strategic Needs Assessment (JSNA) for Immunisations and the introduction, in September 2024, of a new school aged immunisation provider.

Dr. Jenkins highlighted that the refreshed strategy aims to:

- increase vaccine uptake over time
- reduce inequalities in vaccine uptake in the borough
- Use learning from recent vaccine promotion to inform strategy
- Involve stakeholders from across the system to develop and then use the strategy
- Within the refreshed strategy, agree actions with associated timelines and roles

Dr. Jenkins outlined evidence of barriers to vaccine uptake in Lewisham which included:

- Information barriers - lack of information about vaccine benefits and side effects, lack of trust in information sources and confusion caused by conflicting local and national vaccine schedules
- Social and cultural barriers - stemming from historical mistrust in the medical profession particularly among minority ethnic communities due to past discriminatory practice, Vaccine hesitancy fuelled by misinformation and lack of trust in government institutions
- Practical barriers – inconvenient appointment times and difficulty navigating appointment booking systems
- Technical barriers – date inaccuracies and outdated records due to population mobility which underestimate vaccination rates making it difficult to identify and address inequalities

Dr. Jenkins identified that the recent Lewisham Immunisations JSNA identified the following enablers to vaccine uptake:

- Reliable information – clear, accurate and accessible information that addresses community specific concerns can combat misinformation and build trust
- Working with trusted organisations, community leaders and utilising community networks are essential for engaging communities building confidence in vaccination programmes
- Improving access involves offering vaccinations in various locations - community centres/pharmacies/mobile units with flexible appointment times
- Primary care workforce – implement robust call and recall systems and providing training on effective communication and engagement strategies

The meeting was asked to consider the following questions with regard to the plans to refresh Lewisham's immunisation and vaccination 9strategy:

- Vaccine demand – what makes different populations groups more/less likely to take up vaccines in Lewisham?
- Vaccine supply – what works well/could be improved with how vaccines are delivered in Lewisham?
- Links between different organisations involved in vaccination in Lewisham – what works well/where could links be strengthened?
- Overall, what should be prioritised to increase uptake and reduce inequalities in uptake in Lewisham over the next 3-5 years?

Following discussion, the meeting gave the following responses for consideration:

- Clearer messaging to explain why access/eligibility to vaccinations changes e.g., Covid and flu vaccine changing age limits and how to challenge these changes
- Improved messaging for carers and their entitlement to vaccinations
- Trust and confidence is limited – if people don't understand the why and the how they won't take it up vaccination offers
- It is essential to use clear, simple language, free of jargon and acronyms, when communicating about vaccinations – this will ensure better understanding, reduce misinformation and help build trust – how will communications be equally available to everyone?
- The strategy needs to identify more effective plans to counter misinformation - collaboration with patients, carers, and communities to counter conspiracy theories and promote vaccination and immunisation.
- Messaging needs to reflect both societal benefits e.g., flu/covid/MMR etc. and personal benefits e.g., screening
- Messaging needs to be more nuanced – respectful to different people and different communities
- Need to listen to increase trust and to reduce stigmatization – listen to understand language and culture
- Continue to develop productive partnerships with communities – work with them to deliver meaningful messages – use patient participation groups/community champions/health equity fellows and teams/voluntary and community organisations
- Engage with Chairs of Tenants and Residents Associations to share vaccine information - they are well-connected in the community and communicate through WhatsApp and neighbourhood conversations.
- Work with community groups, churches, ethnic community groups, clubs, businesses such as supermarkets etc.
- Use 'Positive Aging' magazine to share information.
- Taking positive messages to Black community churches, radio stations and newspapers.

Actions:

- **People can share further comments on Lewisham's immunisation and vaccination strategy by email to publichealth@lewisham.gov.uk**
- **The Lewisham People's Partnership to forward these responses to Dr Jenkins and to receive feedback as to how the responses have influenced the immunisation and vaccination strategy**
- **To circulate that feedback to the Lewisham People's Partnership**
- **To invite Dr. Jenkins to a future Lewisham People's Partnership for an update on Lewisham's Immunisation and Vaccination Strategy**

AGENDA ITEM 4 – Dates for Lewisham People's Partnership meeting for 2025/26

Date	Time	Venue
21st May 2025	10.00am to 12 noon	Civic Suite, Catford
9th July 2025	2.00pm to 4.00pm	Civic Suite, Catford
10th September 2025	10.00am to 12 noon	Civic Suite, Catford
12th November 2025	2.00pm to 4.00pm	To be confirmed
4th February 2025	10.00am to 12 noon	To be confirmed

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 11
Enclosure 11

Title:	**Primary Care Group Chairs Report**
Meeting Date:	**22nd May 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 March and April 2025 Primary Care Group meetings: **Lewisham Care Home APMS Practice Estates** (Jenner HC and Laurence House) The purpose of this paper is to seek agreement for rent reimbursement to be approved for the practice's occupation of space on the Jenner Health Centre site from 1st April 2025. The estates costs for the space in the Dental Suite is £10,241.91per annum. **PMS Premium Update** In quarter four 17/26 practices were performing below the required threshold(s). Officers will arrange formal contract meetings with the practices to discuss under-performance and mitigations. The PMS Premium has been rolled over unchanged except for a change to the Risk Profiling & MDT working service specification which will transition to a more proactive approach to case finding. **Child Protection Information Sharing Pilot** The Child Protection Information Sharing (CP IS) Pilot aims is to facilitate information sharing between the local authority and health relating to Children subject to Child Protection Plans and Children Looked After.		
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. Lewisham Care Home APMS Practice Estates (Jenner HC and Laurence House)

The Group received a paper supported by a business case which sought approval for eligible estates costs for, the relatively new, Lewisham Care Home APMS Practice occupation of space at the Jenner Health Centre site from 1st April 2025.

The paper also proposed the occupation of some space at Laurence House, ICB offices, for staff who will support the operation of the practice. The occupation of space at Laurence House would not attract any estates costs.

The paper was considered alongside a previous paper which asked for support for reimbursement of back office estates costs at the Marvels Lane Health Centre site which the practices has decamped from due various issues and risks to continued occupation.

The Group also considered the potential risk of not supporting the rent reimbursement which included the ongoing financial viability of the Lewisham Care Home APMS Practice and the associated impact on service delivery to vulnerable care home residents.

At the February meeting, the Group agreed, in principle, to approve the rent reimbursement for the practice's occupation at the Jenner Health Centre site from 1st April 2025, pending further information on how much the costs would be.

Further information on the estate's costs for occupation at the Jenner Health Centre were provided at the April meeting.

Total annual estates costs for the practices' occupation at the Jenner Health Centre is £10,241.91.

2. PMS Premium Update

a) 2024/25 Quarter 4 Performance

In quarter four 17/26 practices were performing below the required threshold(s).
Officers will arrange formal contract meetings with the practices to discuss under-performance and mitigations. Meetings will take place between May and June 2025.

As part of the performance review officers will endeavour to understand which practices might need support and how this is offered.

b) 2025/26 PMS Premium Arrangements

Following a review of the 25/26 PMS Premium the ICB agreed to roll over all service areas unchanged except for a change to the Risk Profiling & MDT working service specification which will transition to a more proactive approach to case finding.

The ICB Population Health Team will provide practices with a proactive list of patients at the highest risk of hospital admission.

The new approach is aligned to the Integrated Neighbourhood Teams model and aimed at delivering proactive care to the most complex & vulnerable patients to reduce avoidable exacerbations of ill-health and improve quality of care.

A practice workshop has been planned in May to help practice staff refresh and enhance their knowledge of the PMS Premium commitments.

3. Child Protection Information Sharing Pilot

The Group received a progress update on the Child Protection Information Sharing Pilot.

The Child Protection Information Sharing (CP IS) Pilot is to facilitate information sharing between the local authority and health relating to Children subject to Child Protection Plans and Children Looked After.

This is CP IS for Phase 2, scheduled care setting. Phase 2 includes the following services: primary care, CAMHS, Community Paediatric, 0-19 services (LGT), Dentistry and Therapists.
Phase 1 was implemented several years ago to unscheduled care settings.

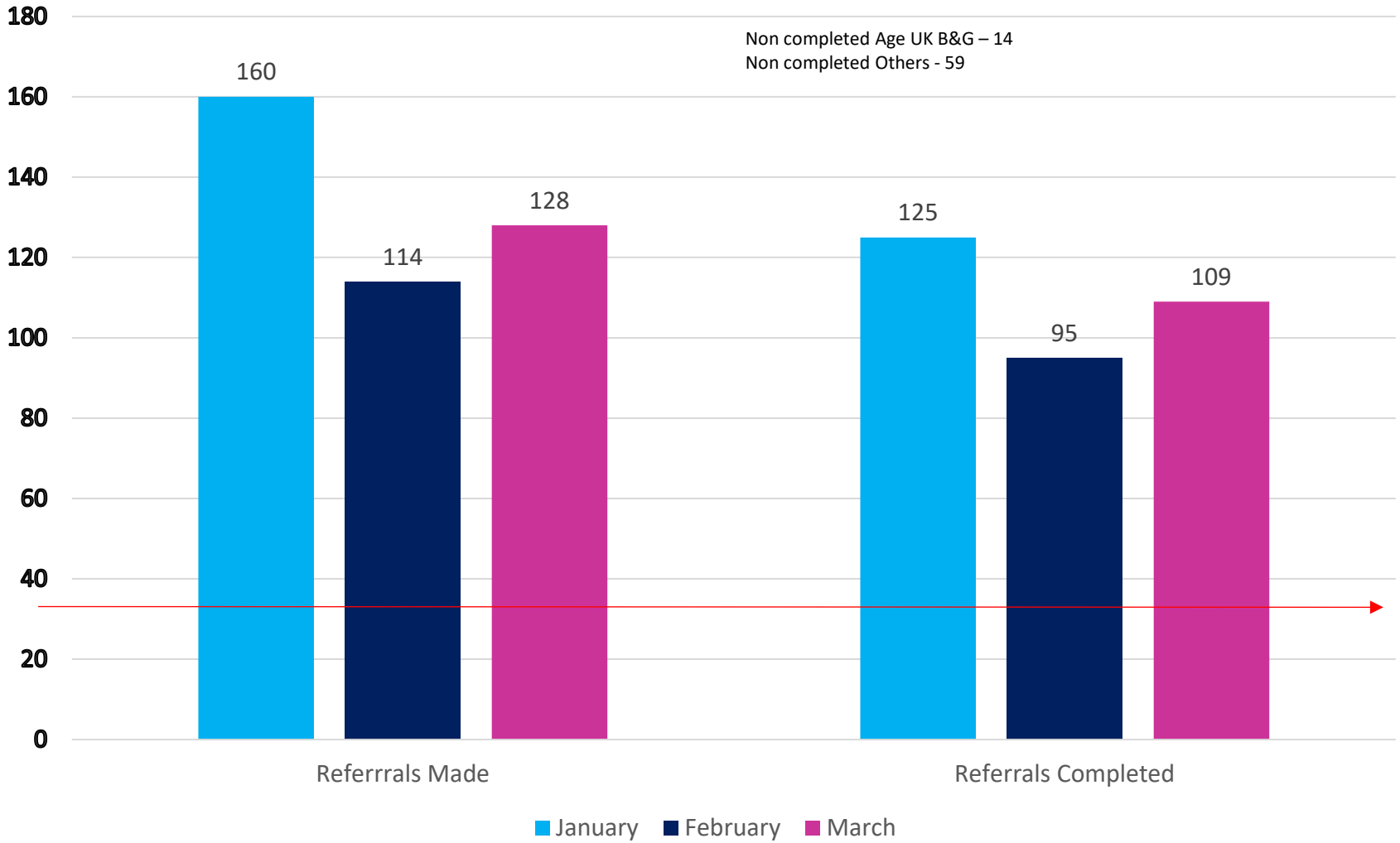
With this in place GP practices will be able to identify vulnerable children if they attend at a practice.
Lewisham is the only borough to pilot this before it is rolled out to other SEL ICB boroughs.
Roll out in Lewisham will be supported with detailed communications.
The Group will continue to monitor progress of the pilot.

Bromley & Greenwich age UK

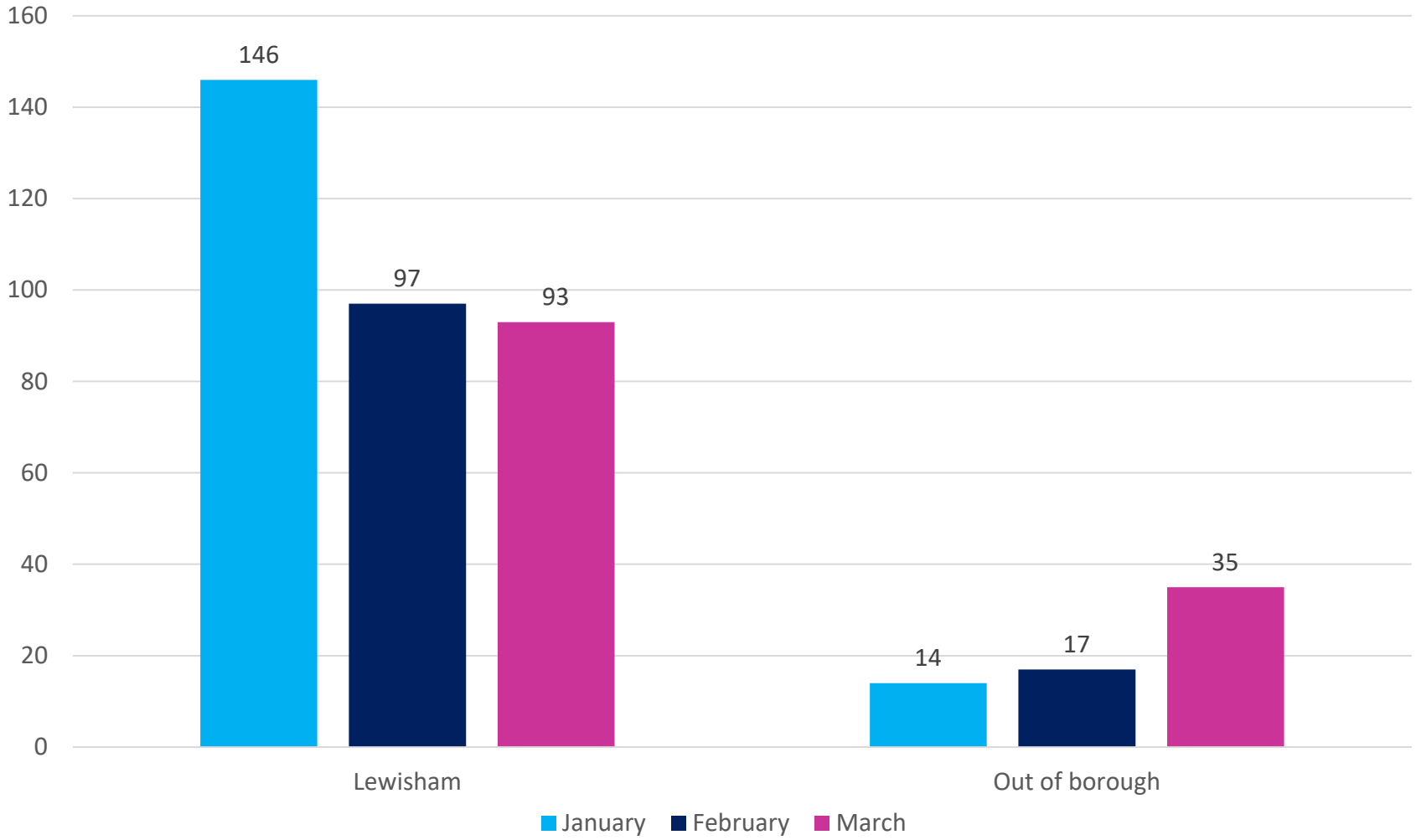
Take Home & Settle Quarterly Report

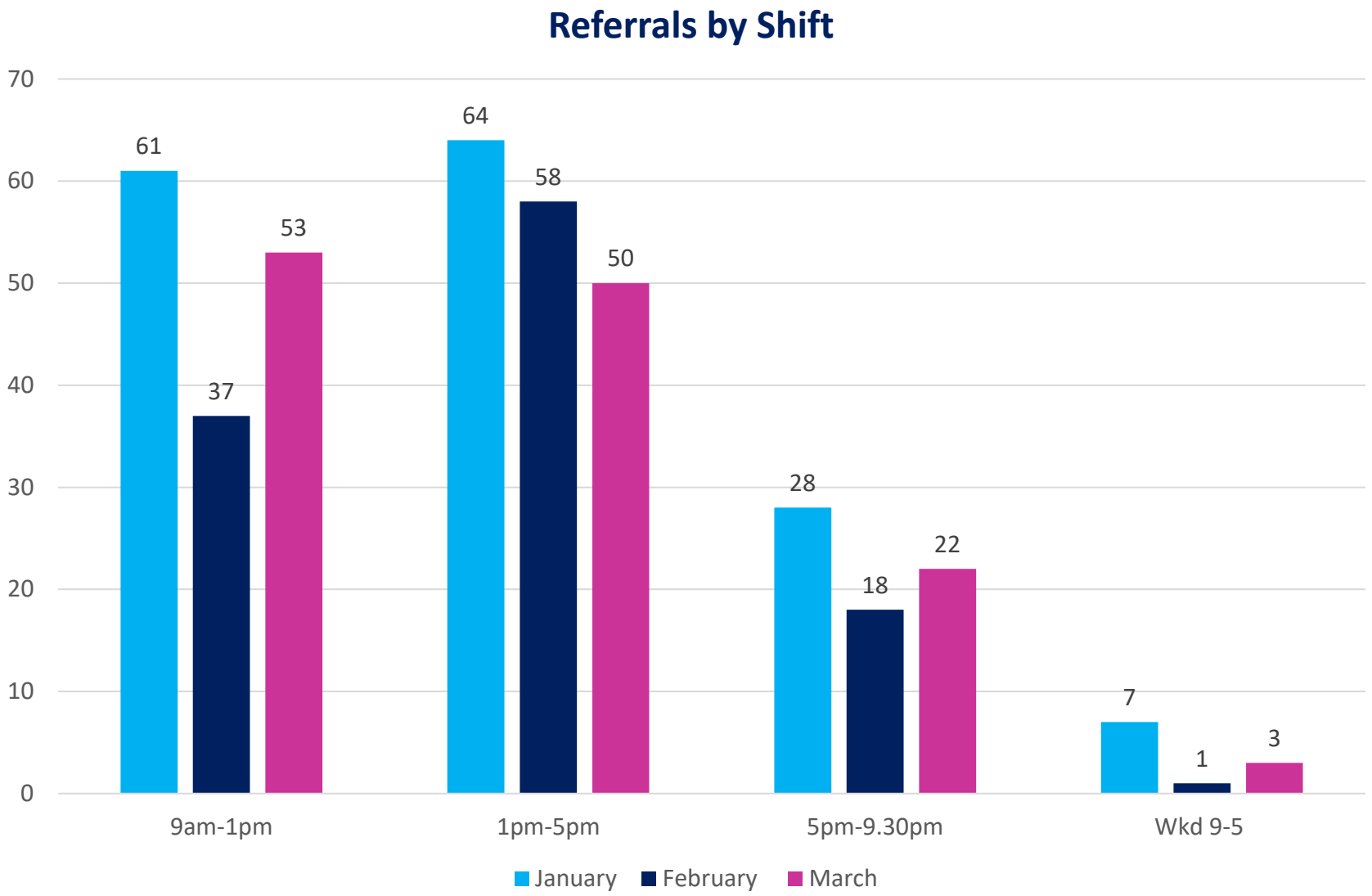
January - March 2025

THAS Referrals October to December 2024

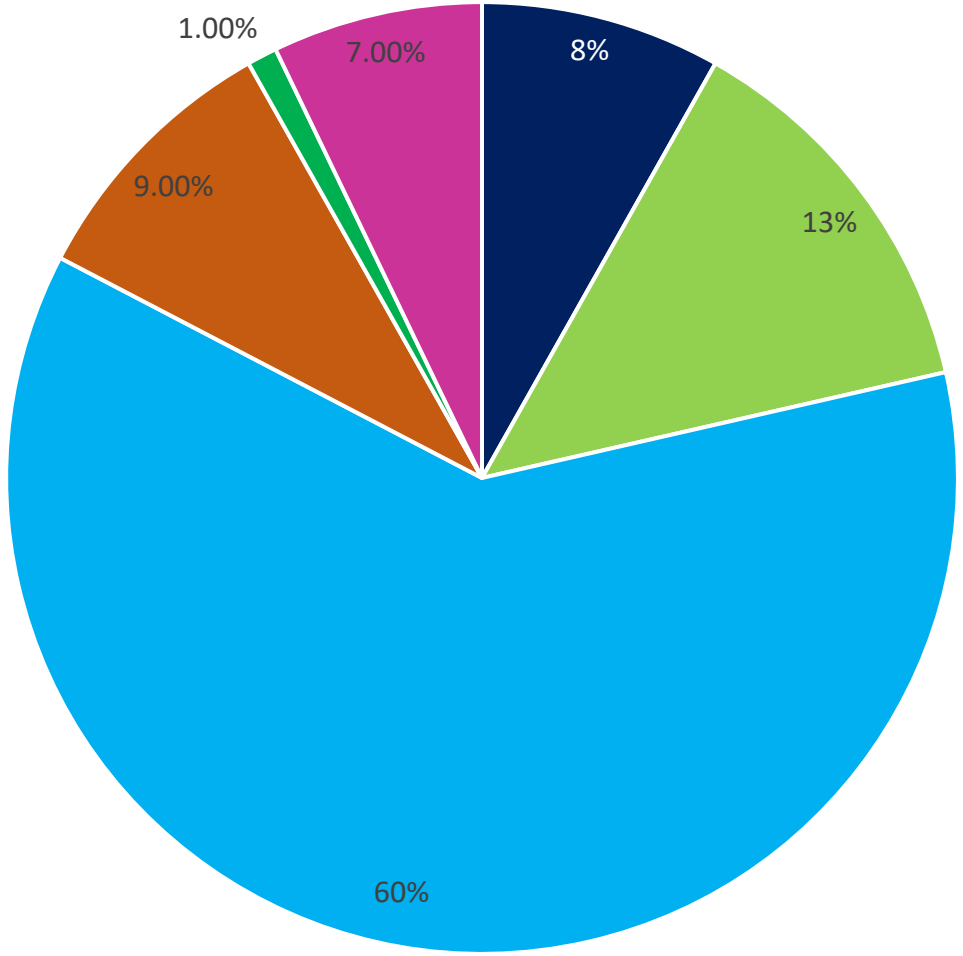


Referrals by Borough




Referrals by Shift
70
60
50
40
30
20
10
0
61
37
53
64
58
50
28
18
22
7
1
3
9am-1pm
1pm-5pm
5pm-9.30pm
Wkd 9-5
January
February
March

Response Times



81% of call outs are met within 30 minutes

10 Minutes 20 Minutes 30 Minutes 40 Minutes 50 Minutes 60+ Minutes

Take Home & Settle (THAS)

- This again has been a really rewarding quarter, January was our best month for referrals ever with an increase of 61 on last years total. We also received the great news that we have secured the new contract for the next five years. This was warmly received by the Coordinator and team who will continue to strive to improve the service wherever possible

- Take Home and Settle Referrals continue to remain at healthier numbers though it is still felt these could be improved so we continue to promote within the hospital when possible

- The Team have had to become a bit more ‘assertive’ with Wards & Departments in terms of ‘hanging about’ for patients, meds etc when previously advised were ready and weren’t, as this has been impacting on unnecessary declined/delayed referrals during busier periods

- Unfortunately, we still have one vacant evening/weekend shift though we continue to avidly recruit for the post, though on a brighter note we have managed to retain our two newest members of staff, and they have become a valued part of the Team and well known on the Wards & Depts.

In Other News

Our aim for the next quarter will be :

- Continue to retain great target figures and completed referrals for the next quarter.
- We aim to successfully recruit for the vacant post.
- Cover vacant shift with existing assistants where possible.
- Continue to promote for more THAS referrals
- Regularly advise hospital staff of the importance of cancelling referrals where necessary to optimize the efficient delivery of service. The team also needs to ensure that they make it clear that the patient, meds, etc, need to be ready before accepting a referral.
- Continue to provide an efficient, empathic, flexible and respected service in a timely manner.
- Continue to monitor and adhere to Government guidelines regarding Covid 19

Case Study THAS

- We received a request from the Complex Discharge Team to support an 81yr old gentleman who had spent a long spell in hospital and discharge was still not imminent.

- He was extremely hard of hearing and awaiting new hearing aids and finding it very upsetting and frustrating not being able to hear.

- He had no community support other than a long-term lady friend who herself was older and had been unable to visit him or collect them on his behalf as she had been unwell.

- THAS were asked to collect the hearing aids and deliver them to the gentleman on the Ward. This isn't the type of referral that is typically within our ‘remit’. The morning shift was quiet, and under the circumstances, one of our lovely assistants happily completed the task.

- The following day, the Coordinator received an email from the referrer expressing gratitude, saying, "Thank you so much!" ”I’ve just been to the ward and Mr M was so pleased to have his hearing aids” They made a phone call to his NOK that he hadn’t seen for over 3 weeks. he was so emotional to be able to talk to her.

“Thank you for your team’s support! It really makes a big difference”

Client/Staff Feedback

- ‘I just wanted to get in touch firstly to say how very much we value the great service you are providing in supporting discharges from UHL, the team constantly sing the praises of the service **!’- Sue Robinson Assistant Director of System Integration & Development**
- ‘Without your service I would have returned home after 3 traumatic stays in hospital without warm house, upset and vulnerable without any family to go home to however you were the only one to show compassion’ - **THAS client**
- Thank you for your prompt support. You have been very quick to respond to our requests, always accommodating, positive, approachable and flexible. Received positive feedback from NOK from today's visit , we always appreciate AGEUK for supporting our hospital discharges. - **Chandan Goyal- CD**
- You couldn't make this service any better than it is’ **– THAS client**
- Thank you so much for all you do for us. You all are very much appreciated. Karen **– Laurel Ward**
- ‘Discharge Lounge was in turmoil, extremely busy, without service and great kindness of Liston would have been lucky to get home after 10pm’- **THAS Client**
- Thank you so much for your support. You and your team are always appreciated.’ – **Shujuan Xu- Senior Nurse Complex Discharge Advisor**