Lewisham Local Health and Care Partners Strategic Board – Part I
Date: Thursday 24 July 2025, 14.00-16.00hrs (includes 5-minute break)
Venue: MS Teams (meeting to be held in public)
Chair: Ceri Jacob, Place Executive Lead (Lewisham)
AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 22 May 2025 (for approval) & Action Log**	Verbal/ Encs 1 & 2	Chair	To Note/For Approval	14.00-14.05 5 mins
2.	**Any questions from members of the public** *Note response from previous question(s) received from members of the public*	Appendix A		For Noting	14.05-14.10 5 mins
3.	**PEL (Place Executive Lead) Report**	Enc 3	Ceri Jacob	For Noting	14.10-14.15 5 mins
	Delivery				
4.	**Lewisham Integrated Neighbourhood Model of Care**	Enc 4	Laura Jenner	For Approval	14.15-14.35 20 mins
5.	**Better Care Fund (BCF) – updated S75 agreement**	Enc 5	Kenny Gregory	For Approval	14.35-14.45 10 mins
6.	**Lewisham Health Equity Teams – Cycle 1 evaluation**	Enc 6	Dr Catherine Mbema	For Discussion	14.45-15:05 20 mins
	Break – 5 mins				
	Governance & Performance				
7.	**Waldron Health and Wellbeing Hub**	Enc 7	Fiona Kirkman	For Discussion	15.10-15.25 15 mins
8.	**Risk Register**	Enc 8	Ceri Jacob	For Discussion	15.25-15.35 10 mins

9.	**Finance update**	Enc 9	Michael Cunningham	For Discussion	15.35-15.45 10 mins
	Place Based Leadership				
10.	**Any Other Business**		All		15.45-16.00 15 mins
CLOSE					
11.	**Date of next meeting (to be held in public): Thursday 25 September 2025 at 14.00hrs via Teams**				
	Papers for information				
12.	**Minutes/Updates from:** • **Place Executive Group action and decisions log** • **Primary Care Group Chairs Report** • **LIQ&A group minutes – May 2025**	Enc 10			

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 22 May 2025 at 14.00 hrs.

via MS Teams

Present:

Vanessa Smith (VS) (chair)	Chief Nurse, SLaM
Ceri Jacob (CJ)	Place Executive Lead (PEL) Lewisham, SEL ICS
Fiona Derbyshire (FD)	CEO, Citizens Advice Lewisham, Voluntary Sector Representative
Pinaki Ghoshal (PG)	Director of Children's Services, LBL
Sabrina Dixon (SD)	VCSE representative, SIRG
Anne Hooper (AH)	Community representative Lewisham
Nigel Bowness (NB)	Healthwatch representative
Dr Catherine Mbema (CMb)	Director of Public Health, Lewisham Council
Karen Sadler (KS)	CEO, One Health Lewisham
Dr Helen Tattersfield (HT)	GP, Primary Care representative
Neil Gouldbourne (NG)	Chief Strategy and Transformation Officer & Deputy CEO

In attendance:

Cordelia Hughes (CH) (Mins)	Borough Business Support Lead, SEL ICS
Elizabeth Howe (EH)	Governance Lead, SEL ICB
Laura Jenner (LJ)	Director of System Development, SEL ICS
Michael Cunningham (MC)	Associate Director of Finance, 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
Helen Marsh (HM)	Head of Communication and Engagement
Jane Mandlik (JM)	Lewisham Save Our NHS (LewSON)

Apologies for absence: Denise Radley, Michael Kerin, Dr Simon Parton, Kenny Gregory

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 27 March 2025.** Vanessa Smith (VS) (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. There was a particular mention to Karen Sadler joining us for the first time representing One Health Lewisham and Jane Mandlik representing Lewisham Save Our NHS (LewSON). VS advised attendees of the housekeeping rules. Apologies for absence were noted as detailed above. Declaration of Interests – There were no new or amended declarations of interest. Minutes of the Lewisham LCP Strategic Board meeting held on 27 March 2025 – these were agreed as a correct record. Action log – Action 1 – relating to Marvel Lane Estates. CH to contact Dan Rattigan/Neil Gouldbourne to ask for an update. Action 2 – SDIP/LD & Autism posts – LJ confirmed that the service continues to be commissioned to a provider until the staff have been recruited. Matters Arising None.	
2.	**Questions from members of the public** There were no raised questions from a member of the public. A member of the public who attended this meeting, had their question responded to by the ICB within the 14 days' timeframe. Refer to Appendix A.	

3.	**PEL (Place Executive Lead) report** CJ reported on the NHS changes and that nationally ICBs have been mandated to reduce their running costs by 50%, which needs to be enacted by the end of Q3. SELICB must transition into a strategic commissioning organisation by April 2026, as funding will cease beyond that point. Although announced in March 2025, ICBs only received the blueprint in May. SEL ICB is already one of the leaner ICBs and therefore has a lower cost reduction of 35%, which equates to a cut of £21.4m, approximately £18.76 per head. SELICB ran three 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. To note, that the transfer of functions will occur at a later date, but we need to ensure transfers happen safely. Staff are being consulted via All Staff briefings, and we will follow normal HR processes. Engagement is ongoing with system partners including Local Medical Committees (LMCs) via the Primar Care Leadership group. NB thanked CJ for the update but noted that there is little time for public engagement regarding the impacts on the public and asked if there would be some comms around the implications. Also, what is the future of strategic engagement. NG asked about the plans for the Integrated Care Partnership Boards (ICP), and if anybody knows what is going to happen with them, as there may be implications for colleagues. AH mentioned that at a Lewisham People's Partnership meeting a question was raised around public engagement - at least raising the fact of it rather than the detail, but we did say that we would be coming back with more detail in due course, so that there is some level of it in the public engagement. CJ said in response that there has been engagement with our staff, partners and links into our grassroots organisations where we receive feedback from our local populations. In terms of the ICP, the NHS 10-year plan should be coming between June and September this year, but I would expect there to be something in the NHS 10-year plan that might answer that.	

	The Lewisham LCP Board noted the PEL report.	
4.	**Risk Register** CJ reported on the risk register and that the achievement of financial balance is going to remain quite challenging simply because as with every other public sector organisation, funding is difficult and tight. However, there are plans to deliver where we can and we are seeking further savings to make sure we have the headroom for pressures that we know are likely to come through, for example continuing healthcare (CHC) and medicines management. New risks for this year; the achievement of recurrent financial balance (592), achievement of efficiency savings (593) have been updated to reflect the new financial year and temporary shortage of commissioned nursing capacity (594). GP collective action risk is now closed. There is a risk on vaccine uptake which will be discussed at today's meeting. Access to Primary Care (528) and most of the other risks are showing steady at the moment. There is also the LCP risk comparison report which provides comparison across other Places and the risk appetite for ICB. **The LCP Board noted the Risk Register updates.**	
5.	**Finance update** MC reported on the financial outturn 24/25 but noted that it remains subject to external audit, although no changes are expected. **Lewisham ICS** Lewisham achieved an underspend of £5K against a forecast break-even position under the delegated budget agreement. However, considering the YTD position was at £0.5m overspend back in M5, it is a significant achievement for Lewisham to bring the position back into balance during the second half of the year. **ICB** The ICB achieved a surplus of £87k against its revenue resource limit, achieving its statutory duty. The report notes an actual overspend of £38m against plan but this was offset by an agreed surplus to plan reported by the providers, and therefore neutral impact across the ICS.	

	Lewisham Council MC confirmed that there are no reported figures included in the financial report for Lewisham Council as these had not yet been signed off due to different year-end reporting timescales applicable to local authorities. **Wider ICS** The ICS delivered a surplus of £0.5m in 24/25. Four of the providers reported a surplus, and the detailed position was referenced in the final appendix of the report. The system delivered £247m worth of efficiencies against a plan of £270m, with £164m of that or 65% achieved on a recurring basis. However, although a good surplus overall, it is worth noting that only 65% of the efficiencies being delivered recurrently will build up additional pressure for 25/26. NB asked about the medicine optimisation service and if this still sits within the ICB and what are the plans. Also, continuing healthcare (CHC) financial position – it would be helpful to understand why some boroughs are in a different position. CJ confirmed that medicines management service sits in the ICB. MC confirmed that all boroughs were required to achieve a break-even position overall. Surpluses ranged between £5k (Lewisham) and £44k. This is due to different pressures with prescribing costs (medicines management) and CHC being the common pressure. MC concluded that Lewisham has material overspend on CHC, partly because of an increase in learning disability costs, and that we saw this in the second half of 23/24, and are now seeing full year effect in 24/25. We saw improvements during the second half of the year which has seen some reduction in activity in CHC, as well as tightening some of the controls in terms of ensuring regular reviews. **The LCP Board noted the finance updates.**	
6.	**SEL Ageing Well Framework** CJ reported that across South East London, work has taken place to establish our neighbourhoods, such as identifying population groups we want to focus our efforts on and those with Long Term Conditions, Older People, Children and Young People, and with Health Inequalities running throughout. Therefore across South East London, we wanted to have a framework that was common across the three focus areas and reflected best practise that would be implemented at Place through	

	a neighbourhood lens. We have had lots of engagement, spoke to over 100 people as part of this work and had representation from across the system including our local populations. CJ said that the framework is split into three zones: • Promoting independence and wellbeing • Proactive community care via integrated neighbourhood teams • Holistic and person-centred urgent response, intermediate care and frailty attuned hospital The framework will help us to recognise this group of people and their different needs. We want to promote ageing well, for various reasons but to name some: 61% of non-elected beds are utilised by those who are 65+ – this is a high number of utilised beds, also 12% of admissions (154 per day) are due to ambulatory care sensitive conditions and therefore could be avoided with more effective management in the community. In addition, the older population is expected to grow, and long-term conditions are more prevalent the older you become, so there is a huge push here to really try and deal with helping people to remain independent, so not just extending life but extending healthy life. Unpaid carers are a key part of any support to older people, and we must recognise them and the role that they play and how we support them. Also, people living with mental health conditions, dementia and delirium - are also captured for each zone. There has always been a tendency to treat mental health and physical health separately, but we have brought them together through here. We have the Population Health Team to identify population health needs and comprehensive geriatric assessment through our existing Proactively Ageing Well (PAWs) service and we have the Universal Care Plan (UCP) as well, which is something that can be used to help manage people's care. Places will now start to take this forward and in Lewisham it will be presented at the Older People's Board, and we will broaden our engagement and socialisation of it through stakeholders, VCSEs etc. We will report back on the progress quite regularly through the Lewisham Health and Care Partnership. VS thanked CJ for her presentation.	

	NG asked if a gap analysis has been conducted and who would then decide which gaps we should try to fill first. CJ responded and said that it would be same approach as the Long Term Conditions Framework and that the Older People's Board will make the recommendations around where do we go first, but ultimately, it will come through this in terms of new investments or sign off. LJ added that we need to make sure the framework is aligned with the rest of the neighbourhood programme, so we just need to think about how that would work and how that will then feed into this this Board. NB asked a question around sustaining engagement - as you start to develop detailed plans and given the challenges around resources and capacity. CJ said the approach would be to hear the voice of the people who are using the services or whose families are, as we shape and implement this framework. This is not an implementation plan, so ongoing engagement is required to help us shape and reshape it as we go. CMb asked about age friendly communities and if there were any thoughts or reflections on this. CJ responded that age friendly communities will be aligned with the ageing well programme. AH asked about the life course self-assessments and plans around them. CJ confirmed that people can self-refer, and our population health management tool will be able to identify people who are presenting at different bits of the system for different reasons. HT said that this is a great piece of work and echoed LJ point and asked what would be the expectation of general practitioners (GPs). CJ said that general practice is the cornerstone of our services, and we intend to work with our GPs, VCSEs to strengthen our community. We need to think about how we connect with all the people. FD asked about those at risk especially with frailty and if there is a holistic approach. CJ said we are thinking about how we will implement this and how we go forward with it. SD asked about sustainability and what this would look like. CJ said that we do need to make sure that our VCSEs are sustainable and one of the things we had talked about is trying to move to longer term contracts. **The Board noted the SEL Ageing Well Framework**	

7.	**Plan to increase influenza vaccine 25/26** LJ reported on the flu vaccination uptake for the current flu season and some of our planning to improve and increase uptake for the upcoming flu season. CMb added that the factors that influence whether somebody takes a vaccination or not is shown in the presentation. There are also behavioural and social aspects that need to happen, and how people think and feel about vaccinations, social norms, and then the practical things. For Lewisham, there is a lot of work to do around the thinking, feeling and motivation. CMb said that children of 2-3 year olds in Lewisham, vaccination uptake is tracked closely. However, on average in London, Lewisham is a bit below the national average around 40%. For pregnant women, the average is good compared to the national average, although the overall uptake is only 35%. Therefore, the younger age groups, pregnant women are performing in line with others across the country and in London. However, where we start to see some gaps is the older population, 65+ year olds and above. For the older population, Lewisham is far below both the London and national averages and for those under the age of 65 year old, who have long term conditions and are eligible for free flu vaccination. Again, you can see a gap between where Lewisham is and the England and London average. These are the key groups that we would potentially want to target our efforts. There is low uptake typically in those living in the most deprived areas and in terms of ethnicity, there is low uptake with Black British, Caribbean and African groups, and in our mixed heritage groups. Therefore, we really need to understand the reasons why people are not taking it up. We want to conduct engagement with our population and increase the number of community-based vaccination points, working more closely with primary care and pharmacy, which are the main delivery points for flu vaccination. There is a need to think about how the Council could support efforts in terms of social care and frontline staff - can we collaborate with housing colleagues for example. LJ added that we may increase vaccine hubs in certain areas and try to entice people in with different types of incentives, but that it is important that we start doing the work now.	

	HT said it is about changing attitudes as much as anything else and queried some of the vaccination statistics relating to a GP practice/PCN. NB suggested the Tenants of Residents Association which NB is associated with may be able to assist with getting the message out. PG mentioned warm welcomes. However, all agreed with the approach and offered support with getting the messaging out. VS thanked CMb and LJ for the presentation. **The LCP Board noted the Influenza vaccine plan for 25/26 as detailed above.**	
VS advised there would be a 5-minute break. The meeting resumed at 15:20 hrs.		
8.	**Briefing - Community Diagnostic Centre** NG presented on the Community Diagnostic Centres (CDC) and said that the UK has a lot less diagnostic testing sites than other similar countries. In terms of South East London, there was a discussion about where we should have additional capacity and in the end, the two sites that were chosen were Eltham Community Diagnostic Centre, hosted at Eltham Community Hospital and Queen Mary's Community Diagnostic Centre hosted by Queen Mary's Hospital in Sidcup. NG added that it was quite a large building project which cost approx. £20m and that an opening event was held with about 40 or 50 people in attendance from the local community, but also the local MP, councillors. NG said that the aim is to have a one stop approach so that people can go and have a test, see a clinician and get the whole thing sorted in one go. It may be quite difficult to arrange administratively, but it is definitely where we want to get to. We also want to add on more features and functionality at that site, so with colleagues in the Borough of Greenwich, we are looking at whether that should be in one of the hubs for the new neighbourhood model. For the Sidcup site, there have been some financial challenges Therefore, Queen Mary's, in Sidcup is more marginal and we are losing substantial amounts of money by running the service. We are in the	

	process of looking at a financially sustainable way and hope to open in July 2025, but potentially on reduced hours. AG was glad to hear that Feno and Spirometry will be at the CDC at Eltham Community Hospital but asked if there is going to be an adult or children's pathway or a mix of both, and if so, what the is split going to be. NG will email AG offline. CJ asked if we will be able to track where people are coming from. NG confirmed that they will be able to track where people are coming from and would be happy to feedback at this meeting at a later date. **Action:** CH to add to forward planner. NB asked about engagement with residents around where they go for diagnostic tests. NG confirmed that in terms of accessibility GPs and hospital services can book directly into them and reiterated that this is an additional site and does not replace what already exists. **The LCP Board noted the Community Diagnostic Centre update.**	**CH**
9.	**Primary Care Group - updated Terms of Reference** AOS asked the Board to give formal approval on the updated terms of reference (ToRs) for the Primary Care Group. The Terms of Reference clarify the purpose of the Group along with what its duties and responsibilities are and has been reviewed and updated by members of a working group. In addition, changes were made to the financial responsibilities around the signing off process and the 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. **The Board approved the Primary Care Group - updated Terms of Reference.**	
10.	**Programme Highlight Reports** LJ provide an update on the development of the highlight reports which are presented at the monthly Place Executive Group meeting which oversees our transformation programmes. The highlight reports refer to: Neighbourhood, Proactively Ageing Well (PAWs) mental health, UEC programmes and Enablers.	

	There has been a lot of work going on at the moment with the highlight reports, particularly around modelling for the outputs and outcomes. Mental health is making developments; however improvements are required for SMI Physical Health Checks. Overall, there are no risks to highlight. LJ added that a performance framework is in progress for these programmes which LJ and CH are working on. Also, it will provide an easier format for the board to follow. CJ added that we did try to theme the Local Health and Care Partnership Boards agendas around our priorities, but what these highlight reports might do is trigger areas where the Board may want to have a bit more of a detailed discussion or a better understanding of what is happening; it would be useful if we could use them in that way. **The LCP Board noted the Programme Highlight Reports update.**	
11.	**Any Other Business** VS asked Board members to note the additional papers for information and thanked everyone for their contributions.	
12.	**Date of next meeting.** Thursday 24 July 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. **Briefing - Community Diagnostic Centre (item 8) 22/05/2025**	**Community Diagnostic Centres** -Are we able to track where people are coming from. Agreed NG will provide a report on tracking activity at a future LCPSB meeting. CH to add to forward planner.	**NG/CH**	Included on forward planner for August 2025.
2. **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 for August 2025.
3. **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 for August 2025
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	**DRt/NG**	Closed – a response was sent to MK on 26.06.

	question to the appropriate contact at LGT for response.		
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**	LJ confirmed this can be closed on 10/06/25 as the service continues to be commissioned to a provider until the staff have been recruited.
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. Closed
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.	**CMb**	

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

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

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

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 3
Enclosure 3

Title:	**PEL Report**
Meeting Date:	**24 July 2025**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

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

Summary of main points:

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

NHS changes

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 £19. 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 c£21m reduction.

The reduction is being delivered differentially across the ICB directorates to reflect requirements set out in the ICB blueprint. The ask of Places is a 30.3% reduction against staffing budgets that exclude Safeguarding, CHC and CCPLs, which are being reviewed on a SEL wide basis.

All directorates submitted their proposals at the end of June and these were reviewed collectively in early July to ensure consistency of approach and that together, the directorate submissions created a coherent ICB structure. Final tweaks are being made ready to commence consultation in August, subject to regional assurance processes.

The ICB blueprint set out a number of ICB functions that should, over time, transfer to other NHS organisations. An appraisal process is underway of submissions received from local NHS providers. This will conclude in the next two weeks. Many transfers will take place after April 2026 to ensure proper “sender/receiver” processes are followed.

A number of functions have been reviewed at London and/or national level. In particular, safeguarding and CHC have been subject to national reviews with further guidance expected at the end of July. In the interim, these functions have been reviewed as part of the overall ICB Change Programme.

A range of support is available for all ICB staff. Weekly All Staff Briefings with the CEO and the two SROs are continuing alongside HR drop in sessions and weekly newsletter updates.

10-Year Plan: Fit for the Future

On 3 July the new 10-Year Plan was published. The link is here NHS England » Fit for the Future: 10 Year Health Plan for England. The following section is a very high level summary.

As expected, the plan is based around achieving 3 major shifts in how the NHS works and a new operating model for the NHS.

Hospital to Community

Central to this shift is the establishment of a neighbourhood based service with Integrated Neighbourhood Teams at their core. Explicitly, neighbourhood working goes beyond just health or health and care and includes wider system partners such as housing, education and employment.

In London, ICBs are introducing Place based Integrator functions to support neighbourhood ways of working. In Lewisham, as in other SEL Places, a partnership approach has been agreed. This approach is being pursued to ensure an equal voice in decision making across the partnership organisations, which include the Council, LGT, Primary Care, VCSE and SLAM.

Over the next 3 to 4 years, the proportion of NHS funding spent on acute care will fall with a corresponding increase in primary, community and other non-hospital provision. This aligns with the approach SEL ICB has been implementing through its existing Medium Term Financial Strategy (MTFS).

Analogue to Digital

There is significant focus on a shift from analogue to digital, in the 10 year plan. This is designed to improved productivity, give patients greater control over their care and to support the prevention agenda. The NHS App is an important element of this. It will "be the front door to the NHS: patients will be able to book, move and cancel their appointments, and communicate with their health team, with ease" and will eventually hold the Single Patient Record. A series of elements, including but not limited to:

- My NHS GP
- My specialist
- My carer
- My choices
- My vaccines

The NHS already encourages use of the NHS App however, the Lewisham LHCP will need to increase this further in readiness for this shift to digital and consider how it supports people who may find digital access harder.

	Treatment to Prevention The focus prevention is welcomed and aligns with priorities of the LHCP and its partner organisations. The 10-year plan includes a focus on working with Mayors, Local Authorities and businesses to address issues such as obesity, smoking and vaping, healthy starts and the use of genomics. Through the HWBB there is an opportunity to link this work to the work involved in implementing the Health and Wellbeing Strategy in Lewisham. **Operating model** A range of changes are set out in the 10-year plan. The new operating model includes merging of NHSE and the DHSC and a reduction of 50% in running costs. Regional NHSE bodies will continue with a focus on performance. ICBs will be focused on strategic commissioning with provision of care increasingly on a neighbourhood footprint, where this makes sense. There is a greater emphasis on working as commissioners or providers and the LHCP will need to work together to ensure the benefits of planning as a partnership are not lost. The functions of HealthWatch will be absorbed into national and ICB functions with Local Authorities absorbing HealthWatch social care functions. As part of the 10 year plan, Integrated Care Partnerships cease to exist and there is a corresponding increase in the role of Health and Wellbeing Boards at a local level.			
Potential Conflicts of Interest	All ICB staff are potentially impacted.			
Any impact on BLACHIR recommendations	No			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	In relation to the ICB Change Programme, this will be carried out once for SEL and will look at the impacts on a function by function basis and overall.		
	Financial Impact	The ICB must achieve a 35% reduction in it's running costs.		
Other Engagement	Public Engagement	Significant public engagement has been undertaken nationally in relation to the 10 year plan. Local engagement will take place in line with implementation of the plan at a local level.		
	Other Committee Discussion/ Engagement	Not applicable to this paper.		
Recommendation:	The Board is asked to note this update.			

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 4
Enclosure 4

Title:	**Lewisham Integrated Neighbourhood Model of Care**
Meeting Date:	24th July 2025
Author:	Laura Jenner Director of System Development
Executive Lead:	Ceri Jacob Place Executive Lewisham

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

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

	Other Committee Discussion/ Engagement	LGT community Board ASC- DMT, ELT Stronger communities Health and Wellbeing Board Council Scrutiny committee SLaM
Recommendation:	Recommendation: The Board is asked to agree to take forward the Lewisham Integrated Neighbourhood Model of Care and start monitoring the benefits	

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Overview of Integrated Neighbourhood Teams Programme

INT Programme

South East London Integrated Care System

Integrated Neighbourhood Programme

Integrated Neighbourhood Teams (INTs)

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

Health Equity Teams (HETs)

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

CESEL

PHM

Multi-Disciplinary Teams (MDMs)

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

Community Hubs

Waldron Community Centre
Goldsmiths Café Appletree Cafe
Lewisham Shopping Centre

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

Integrated Neighbourhood Programme Comms and Engagement Plan

Integrated Neighbourhood Teams in Lewisham

Integrated Neighbourhood Teams (INTs) are designed to meet the holistic needs of their local population, teams based in the neighbourhood are drawn from a range of partners across the community. INTs are a way of working together as professionals and as a local community to:

ensure people get the right care, at the right time, in the right place, from the right people, first time and to tackle health inequalities.

By using our local data and insights and working together more closely will allow us both to identify when people need our help at the earliest point, and then to know who on the team to contact to agencies the right support

Integrated Neighbourhood Teams:

- are organised around population health needs.
- have the right skills in the right places.
- routinely measure impact.
- help partners with their own priorities.
- avoid unwarranted variation.
- support residents to exercise their power and agency
- are a way of working and a model of care, and not a programme of discrete projects.
- Increase the proportion of resources used to support people to stay well for longer.
- create capacity which is reinvested to scale the model sustainably

Population Health Approach: Proactive Neighbourhood Support for At-Risk Residents

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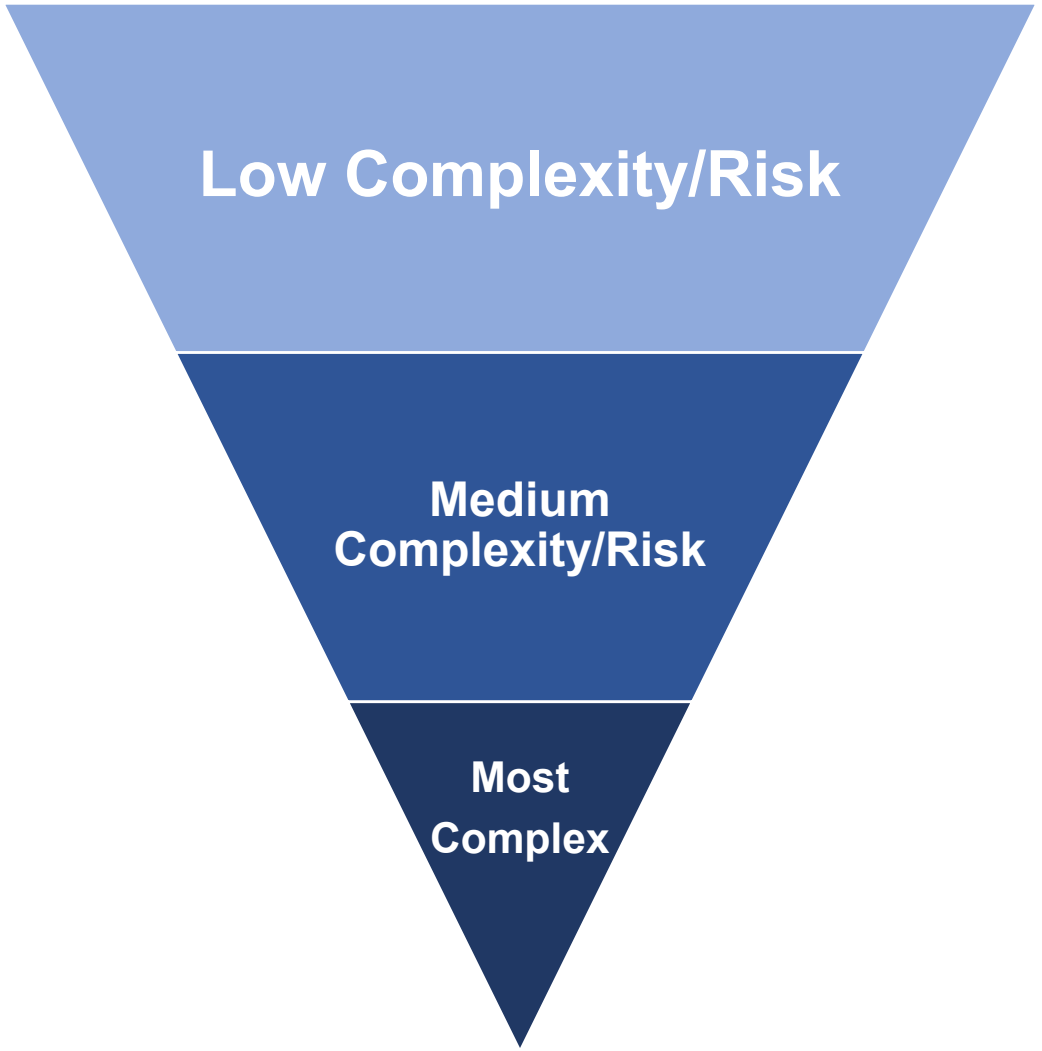

Who?
Generally "well" residents of each neighbourhood, who **may be at risk of** Long-Term Conditions

How do we support them?
Community-Led Approach: support from VCSE, community champions and health & wellbeing coaches. Support residents to access community resources – and resources which support self-management – enabling healthy, independent lives.

Who?
People with 3+ Long-Term CVD Conditions that are unoptimised and/or also undiagnosed. Ranked by risk of being in the top 0.5% of admission. Care home and end of life patients are excluded

How do we support them?
Integrated Neighbourhood Teams (INTs): a Team of Teams, from all health and care providers in Lewisham, casefinding and managing cohorts. Short-term support for immediate needs, and targeted proactive support through identification of preventative needs before they become acute.

Who?
All people in the top 0.5% risk of admission.

How do we support them?
MDMs (Multi-Disciplinary Meetings): a group of professionals from primary care (and other health & care sectors as appropriate) discussing individual patients at practice level, to provide ongoing support for those with acute and complex needs.

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Population Health Data Insights

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Population Segmentation

A. Patients that need complex care

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

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

Approx ~1300

Delivery Vehicle

A. Practice MDMs

Defined as:

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

4012 total

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

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

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

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

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

3485 with any risk factor

C. INT

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

3.0 Project Updates

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

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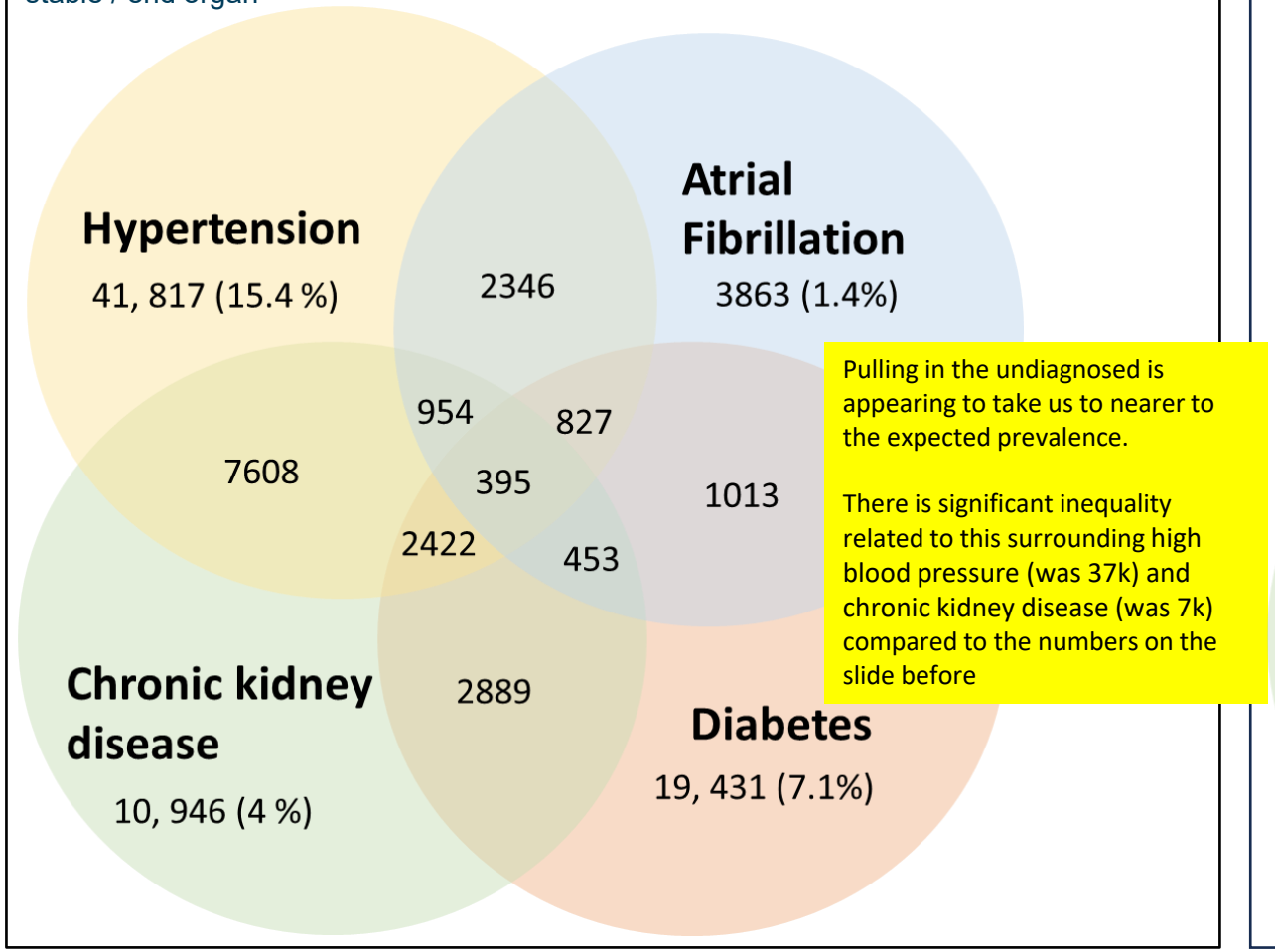
2. Venn diagram of overlaps in those undiagnosed and diagnosed with the 4 x CVD conditions

Conditions: AF / CKD / DM / HT

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



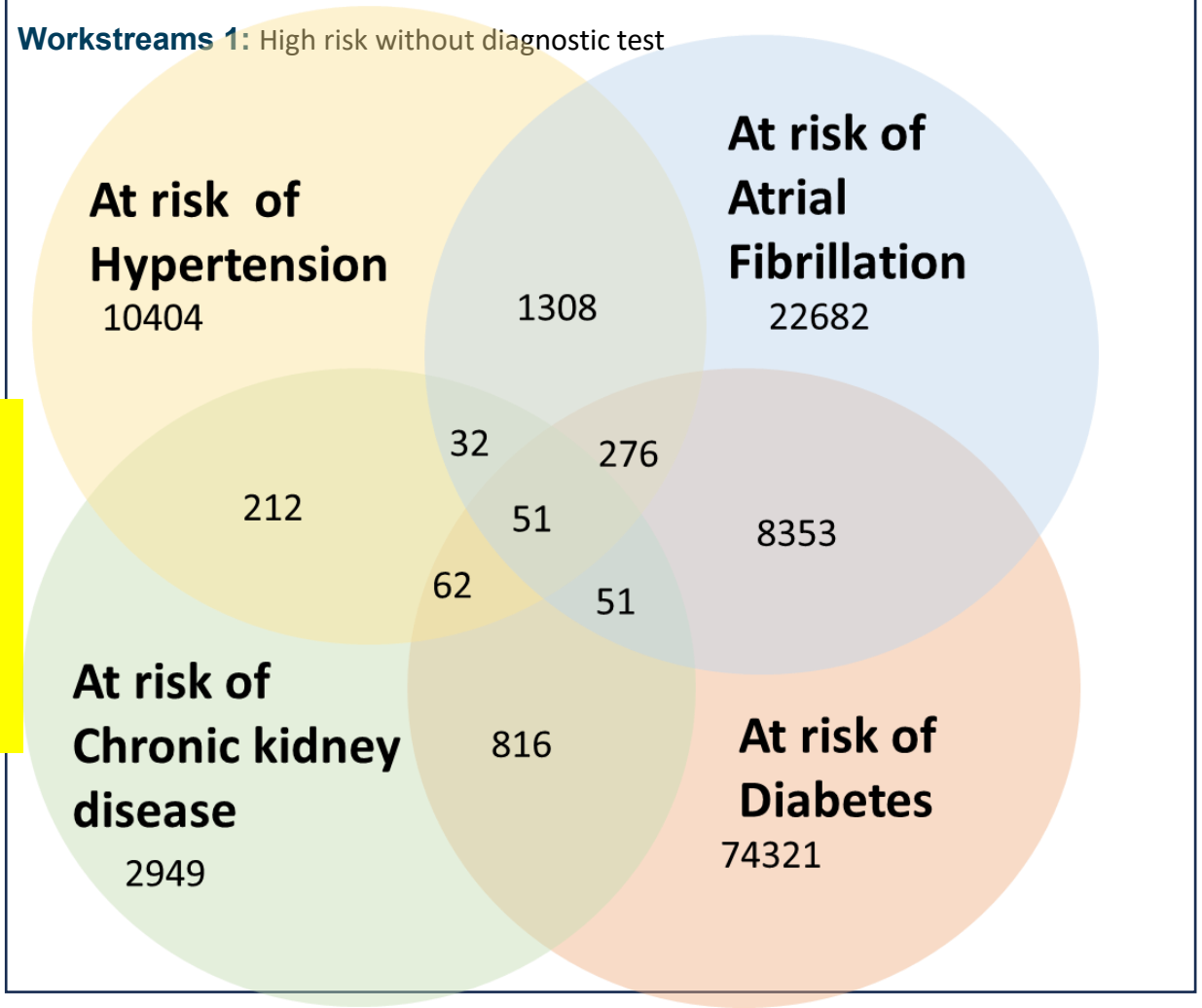
Pulling in the undiagnosed is appearing to take us to nearer to the expected prevalence.

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

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

Conditions: AF / CKD / DM / HT

Workstreams 1: High risk without diagnostic test



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Community Hubs

Community Hubs

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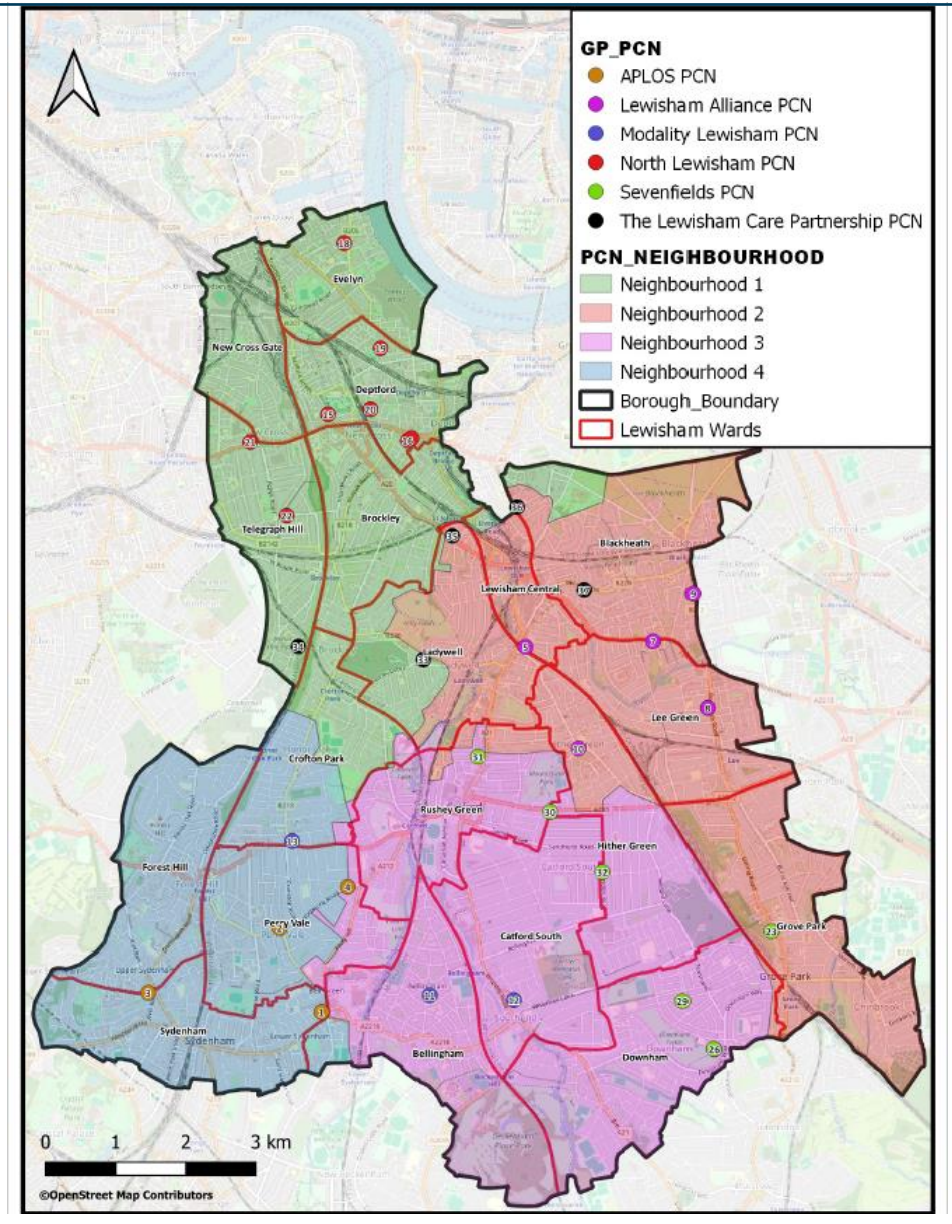
Neighbourhood 1

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

Neighbourhood 4

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



Neighbourhood 2

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

Neighbourhood 3

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

The Waldron Health and Wellbeing Hub

Working together, we will create a welcoming space for everyone, where people can access local health and care services, find the information and advice they need to support their own health, wellbeing and independence and connect with their community and friends.

Introducing Waldron Navigators, the friendly and welcome face of the Waldron, to animate the space and support the coordination of activity within the building

Prioritising use of the Waldron Space:

- Focus on Health inequalities
- Organisations developing community connections, health promotion and wellbeing
- Free use of space

In November, the Navigators **signposted 981 patients at the Waldron**

Groups holding sessions in the new community space

- 360 Lifestyle
- Bouake diaspora
- Broken hearted youth
- Community kitchen/coffee mornings
- Empower care
- Imago community
- Lewisham council – shared lives
- Lewisham council – Fostering advice
- Red ribbon
- DWP
- CITIZENS ADVICE
- Mindful Mums

Opportunity for Development:

- Lewisham Works received £1.8m to organise support people back into employment with health issues

Since November 2024:

84 People have visited the coffee morning.

225 people attended VCS sessions in the new community space.

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Integrated Neighbourhood Model Co – Production with Residents

Working Together: The Power of Co - Design

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Over the past months, we have been collaborating with people with lived experience to shape the Integrated Neighbourhood Team (INT) Programme. Our approach has been centred around:

- ✅ Engaging directly with residents and patients to understand their needs and preferences
- ✅ Running codesign sessions to gather insights and test ideas
- ✅ Iterating and refining the INT model based on real-life experiences

Why Co-Design? We took this approach because:

People are experts in their own experience

Their insights help us design services that truly meet their needs.

Sustainable solutions emerge from collaboration

Testing ideas with real users leads to better outcomes.

Shared decision-making builds trust

By codesigning, we ensure people feel heard and valued.

Recruiting people with Lived Experience

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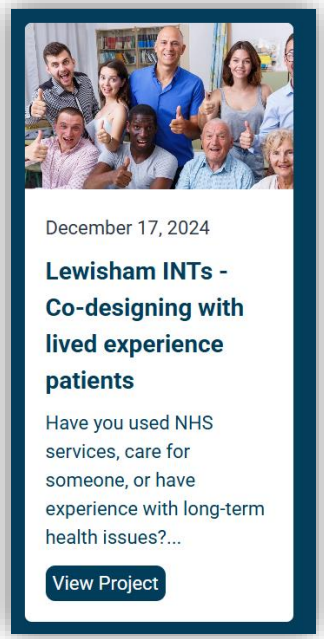
In December 2024, we codesigned the role description with key community leaders and collaborators. We used the Let's Talk Health and Care platform and an Expression of Interest form. Recruitment open from **17 December till 15 January**.

Promotion

- Social media
- Lewisham People's Partnership
- Let's Get Involved newsletter Dec 2024
- Lewisham engagement list
- Lewisham Practice Managers



2 drop-in online information sessions

- 8 January 2025 12-1pm
- 8 January 2025 5-6pm

16 People with Lived Experience recruited

Lewisham residents, with a range of ages, religion, ethnicity, location, disabilities and carer responsibilities.

Co-Design Sessions

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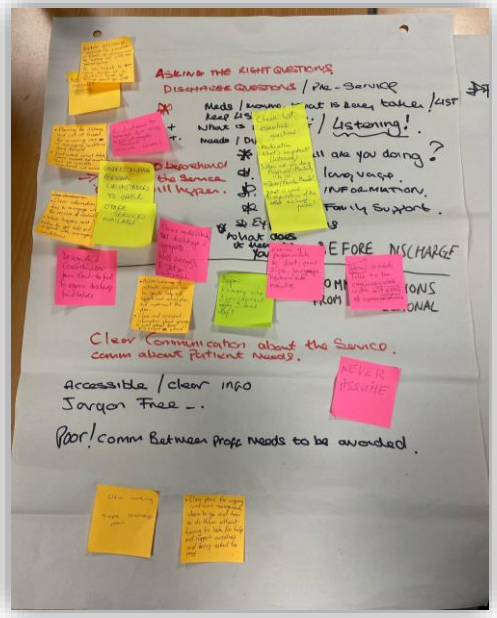
- Anchored to our working principles and aims
- Different methods to participate – verbally, writing, post-its.
- Comments and learning reviewed by patients and INT team throughout sessions and at the end of each event
- Ensured all participants could contribute
- Time for break and informal interaction



INT Design Group Workshop
19 March 2025

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The aims of the workshop were to:

Present the **revised INT Model by providing a comprehensive overview of the updated pathway**

Show the **input from wider stakeholders by demonstrating** how feedback has influenced the development of the model.

Share our co-design work with People with Lived Experience by showcasing how their insights, perspectives, and feedback have shaped the revised model and ensuring their voices remain central to the process.

Identify **opportunities for future refinement and development of the model** by working with system partners and exploring areas where neighbourhood working could be improved.

Feedback from Sessions

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"It went well tonight, good group, who asked lots of questions. I like the mixed group everybody's view is different and everyone has something to add"

"INT staff are professional, helpful and make the sessions enjoyable"

"The session was highlight informative. It felt like an inductive research session. I enjoyed every bit of it"

"INT staff are professional, helpful and make the sessions enjoyable"

"Good variety of people attended and took part in the activity"

"I felt I was able to positively contribute within this group setting (just as I was able to in the previous groups)"

"Once again, I thoroughly enjoyed being part of this co-production!"

"All the presenting staff demonstrated excellent communication skills; empathy, patience and listened to and answered all the questions the groups asked"

"Group Facilitators demonstrated true flexibility on how the group wanted the agenda to progress, so very much patient led."

"Good time keeping. Food provided. Materials provided. Respect for each other. Water provided. Friendly and respectful staff"

"Lots of working together. Everyone putting points and ideas over. Good team work."

Co-Design Sessions – What Went Well

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- Personalised welcome
- Setting the principles helps get ownership from early stage
- Meet and greet important to feel part of the group
- Support them to feel and be part of the team – as equal
- Appropriate supporting material
- Take comments onboard and be honest of challenges
- Be attentive for equal participation and offer different methods
- Keep communication active by sharing summaries soon after meetings
- Multiple interactions strengthen relationships, engagement efficiency and positive experience
- Encourage them to share their voice and represent the group in external sessions
- Close the engagement loop – You said, We did – and show how their work fits in the system

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Integrated Neighbourhood Model

Key ● New Role Enablers

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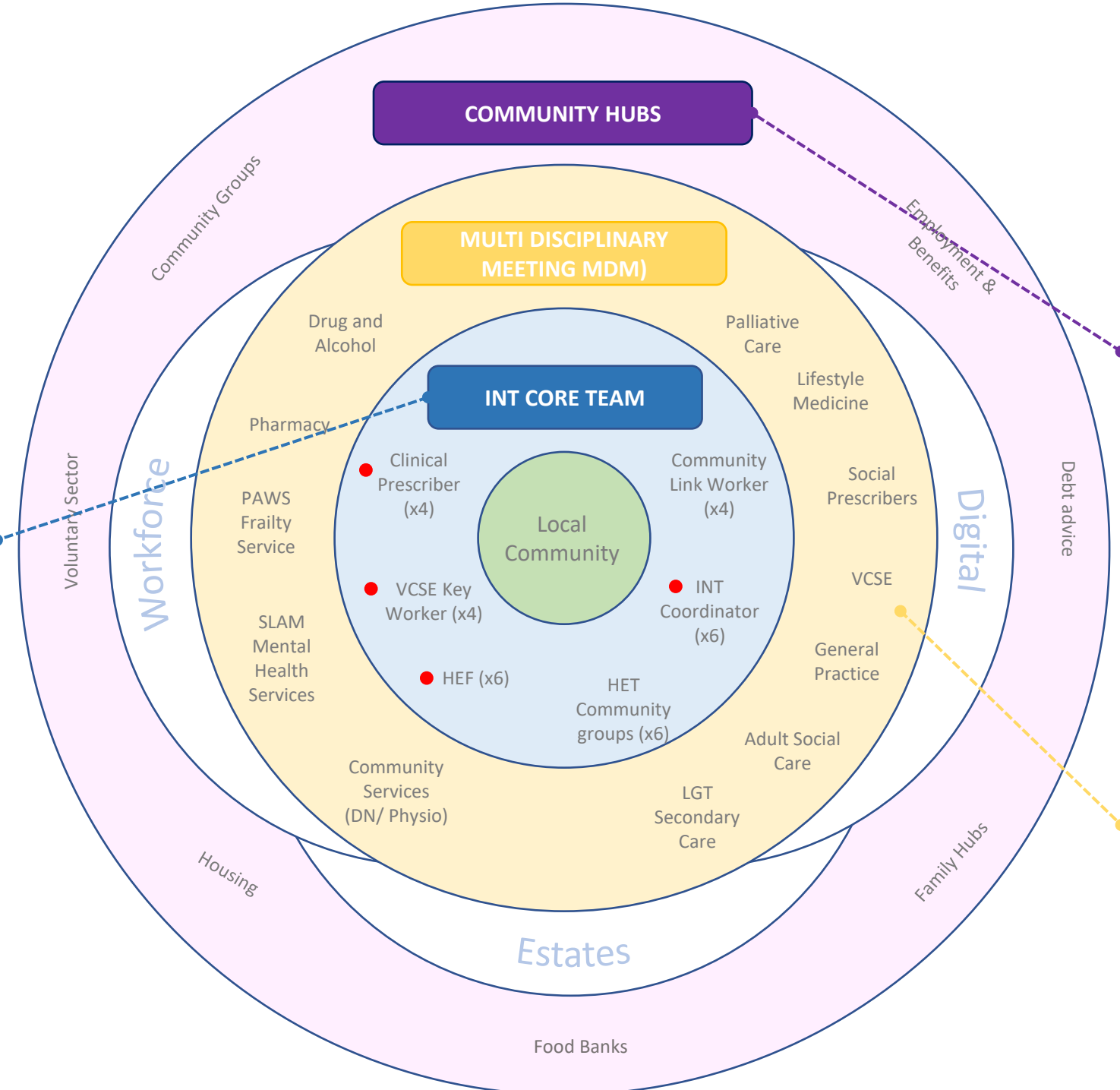
INT Core Team:
The core team includes a variety of professionals working in integrated roles, such as Clinical Prescribers, and Community Link Workers, PCN Coordinators and lifestyle support

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



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

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

Clinical Prescriber*

INT Caseworker*

Key Worker (VCSE)*

Health Equity Team

Community Link Worker*

Health and Wellbeing Coach

*Lifestyle Medicine Service**

Secondary Care MDT

LDA Reasonable Adjustments

- Check if existing care plan in place
- Provide easy read and large font handouts/leaflets
- Initial contact should be a phone call anda reminder call prior to appointment
- Training to include Oliver McGowan and LD Safeguarding??

- Extended appointment length ~90 minutes
- Provide care plans in writing – easy read and no jargon
- LDA Friendly Assessment Template
- Create the right space for holistic assessment – neurodivergent friendly

- Special considerations for medical condition investigations e.g. blood tests and urine
- Extended appointments length ~90 minutes

- Allow LDA patients to observe group consultation before joining
- Link in with existing LDA services and understand adjustments in place e.g. Lewisham Speaking Up

- Extended appointment length ~90 minutes
- Provide care plans in writing – easy read and no jargon
- LDA Friendly Assessment Template
- Create the right space for holistic assessment – neurodivergent friendly

Sc
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- Improve uptake of yearly Health Checks

INT Pathway

Within XX weeks → *Support for up to 12 weeks* → *Within XX weeks*

Patient Contacted	Holistic Assessment	Multi-Morbidity Review	Interventions	Follow Up Holistic Assessment	Discharge (PFIU)
PCN	*PCN*	*Neighbourhood*	*PCN or Neighbourhood*	*PCN*	*PCN*

INT Role

INT Caseworker	INT Caseworker	Pharmacists		INT Caseworker	INT Caseworker

Clinical Supervision

PHM send list.
INT Core Team review list and sends to patient practice to ensure appropriate reaching out and risk management

Patients discussed in INT weekly meeting and raised with patient GP if concerns
Option for direct discussion at MDT
Clinical input or assessment from PAWS team where appropriate

Clinical supervision from LIMOS and patient GP

Community Diabetes team for monthly facilitation clinic for most complex patients

GP
Key Worker
Social Prescriber
Health Wellbeing Coach
Community Link Worker
Lifestyle Medicine
Secondary Care – Community Diabetes
Practice-based MDMs
Other Direct Referrals

Additional Clinical :
Agreed audits with INT core team
Appraisal for clinical staff
Agreed supervision within LIMOS and Community Diabetes Team
Education with Protected Learn Time (PLT)
Induction and Training
Secondary Care MDT
Practice-based MDMs

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Multi-Disciplinary Meetings (MDMs)

Risk Model Use In Practice Based Multi-disciplinary Meetings (MDMs)

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- MDMs bring together staff across several sectors to discuss patient cases where there is felt to be significant social or medical risk
- Hospital admission can be seen as an end result of high medical or social risk
- There is an aim to discuss the top 0.5% at highest risk of hospital admission with a view to reducing these admissions, where able, through proactive collaborative work
- **The risk model for emergency admissions will be able to standardise how this risk of admission is calculated and produce those thought to be highest risk per practice for consideration within the MDM**
- **This will not replace ad-hoc referrals and there may well be overlap in terms of patients identified by both methods**

Multi-Disciplinary Meeting

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

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

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

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

Their role is to:

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

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

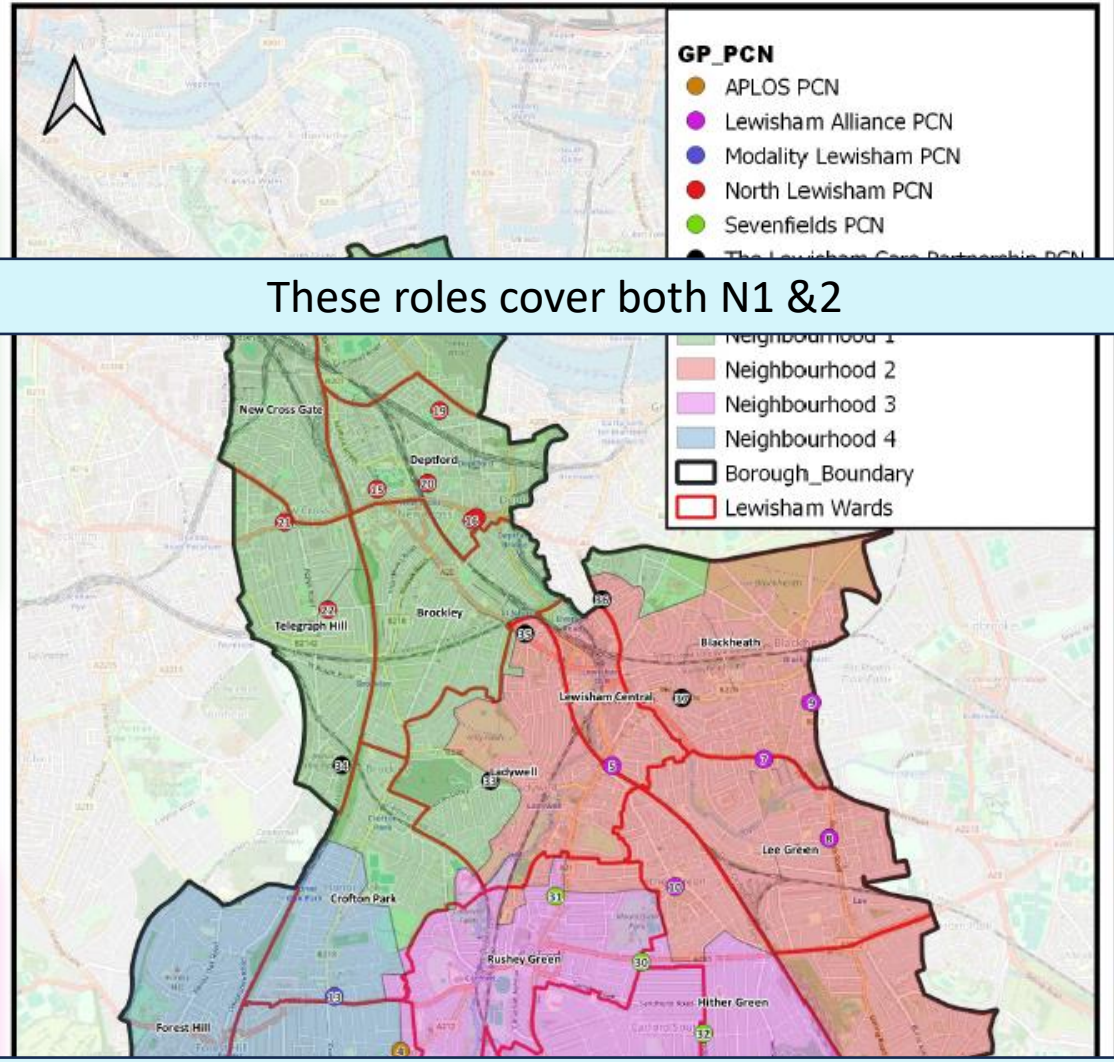
- Mental health specialist(s)
- Home care agency / care worker
- LIMOS
- Clinical psychologist(s)
- Specialist services such as housing, drug and alcohol support services
- Speech and Language Therapy (SALT) team
- Specialist nurses e.g. respiratory, diabetes, dementia
- Pharmacists
- Housing Provider(s)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

Neighbourhood 1

1 Lead ASC Operational Manager
1 ASC Operational Manager
2 ASC Senior SW's
9 ASC Social Workers
3 Case Management Officers

- Neighbourhood Coordinator (Coordinate MDMs)
- District Nursing Team
- PCMHT – Slam (one in each PCN)

These roles cover both N1 &2



Neighbourhood 2

- Neighbourhood Coordinator
- District Nursing Team
- PCMHT - Slam

Neighbourhood 4

1 Lead ASC Operational Manager
1 ASC Operational Manager
2 ASC Senior SW's
9 ASC Social Workers
3 Case Management Officers

- Neighbourhood Coordinator (Coordinate MDMs)
- District Nursing Team
- PCMHT – Slam

These roles cover both N1 &2

Neighbourhood 3

- Neighbourhood Coordinator
- District Nursing Team
- PCMHT - Slam

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Outcomes and Benefits Framework

Impact Pathway

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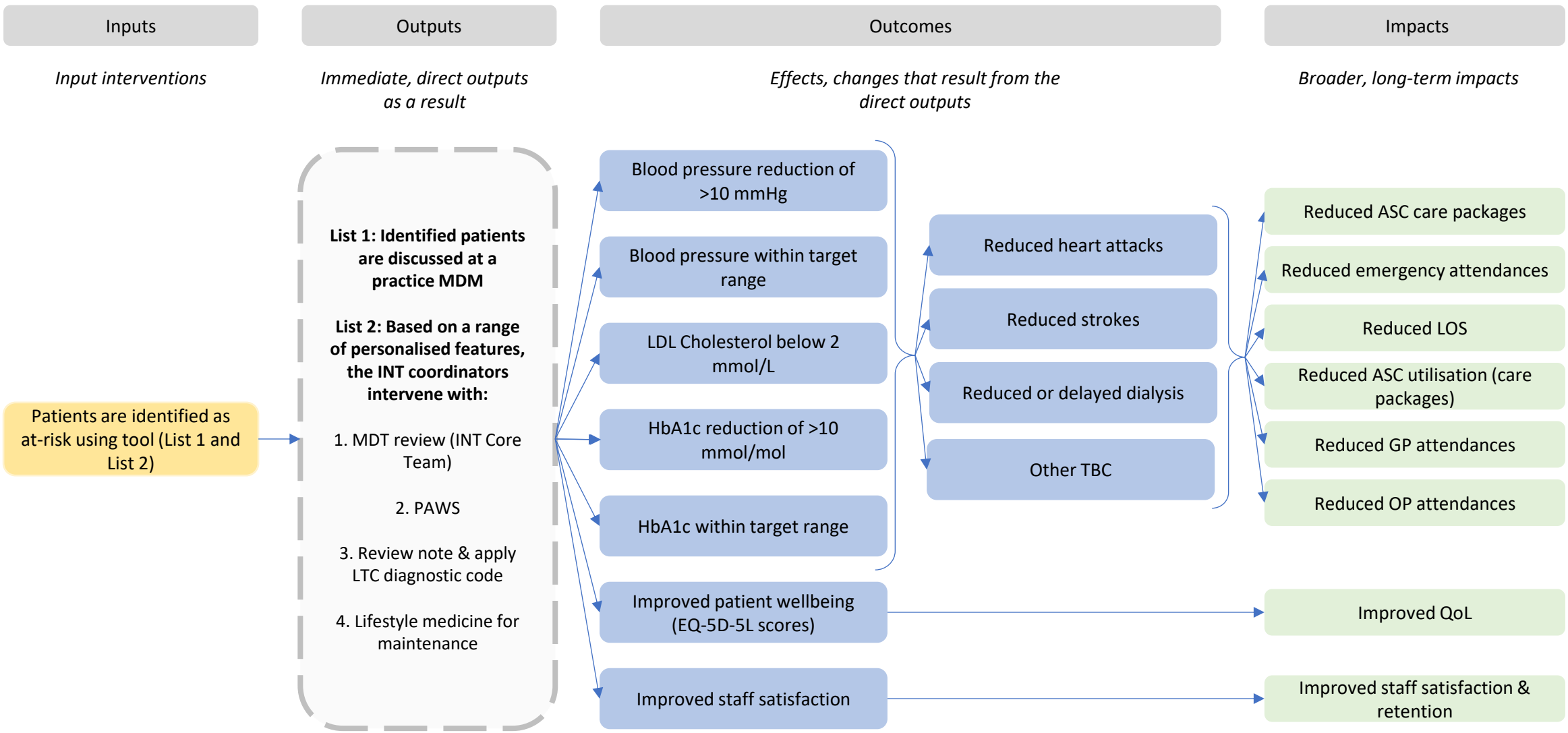

Theory of Change (iterative)

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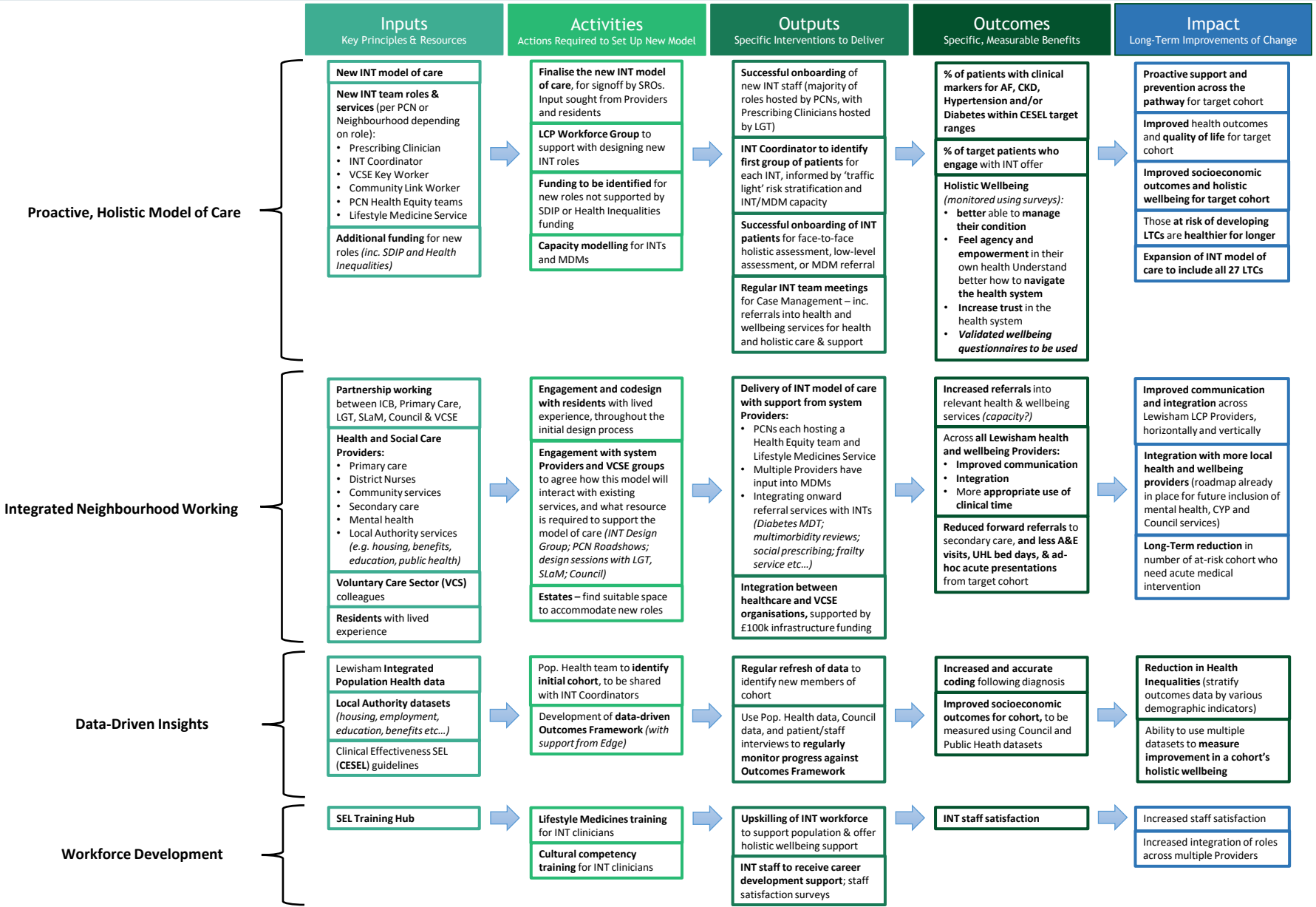

Aim: To implement the INT Model of Care to improve interventions, clinical and holistic wellbeing of those with 3 or more Long-Term Conditions (LTCs) in Lewisham and reduce the need for escalated and emergency care.

This model of care will be integrated across primary, community, mental health, secondary, and local authority Providers - with the goal of to improving health and wellbeing outcomes and reduce health inequalities experienced by this target cohort.

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Integrated Care System

Progress and Next Steps

INT Key Progress – May 2025

- Completion of the INT codesign project in partnership with people with lived experience
- Finalising the INT Model
- Testing the INT Holistic Assessment and Health Assessment with stakeholders
- Refining Population Health data and finalising the target intervention group
- Progressing the predictive case finding tool for Multi- Disciplinary Meetings (MDMs), completing testing on patient groups across four practices
- Modifying INT pathway for people with Learning Disabilities and Autism
- Completion of INT Job Descriptions, including Clinical Pharmacist, Case Manager, Health Coach and Linkworker
- Mapping digital requirements
- Completion of Equalities Impact Assessment and Quality Impact Assessment
- INT Recruitment to be co-ordinated centrally, using Lewisham & Greenwich Trust's recruitment service/online platform
- Developing INT Governance and operating model.
- Mapping data sharing arrangements and completing Data Protection Impact Assessments for INTs and MDMs
- Established INT Impact and Evaluation Framework
- INT/PCN MoU developed

Planned activity May/June 2025

- Business Case sign off
- Celebration event for PWLE Codesign partners
- Completion of INT Impact Evaluation and Performance Framework
- Adult Social Care data to be included in Data modelling
- Completion of testing for MDM predictive case finding tool
- Adult Social Care Data onboarded to Population Health Platform
- INT Job Advert to go live and recruitment underway
- Completion of INT Standard Operating Procedure
- Initial meetings 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
- Estates requirements confirmed (HUBS/INTS)
- Ongoing communications and engagement

INT Mobilisation June – September – Go Live

- ICB Leads partnering with PCNs to support implementation
- Rolling out Communications Plan
- Standard Operating Model agreed
- Information Sharing Protocols in place
- Governance established
- Recruitment and appointment of the new team
- Induction and Training plan implemented
- Acceptance testing for Digital and Population Health Dashboard

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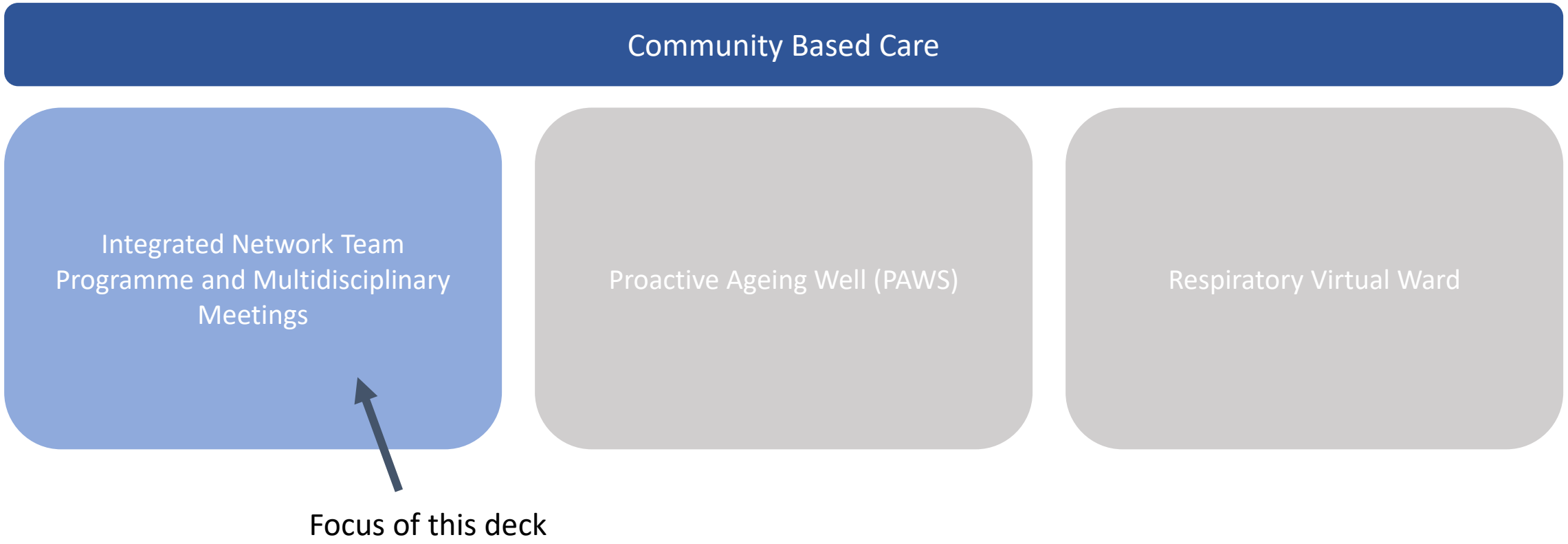
Prospective benefits of INT / MDM

SEL ICB

Overview of Integrated Neighbourhood Teams

INTs within Lewisham and Greenwich are expected to go live in 2025. This will form one part of the Out of Hospital Programme.



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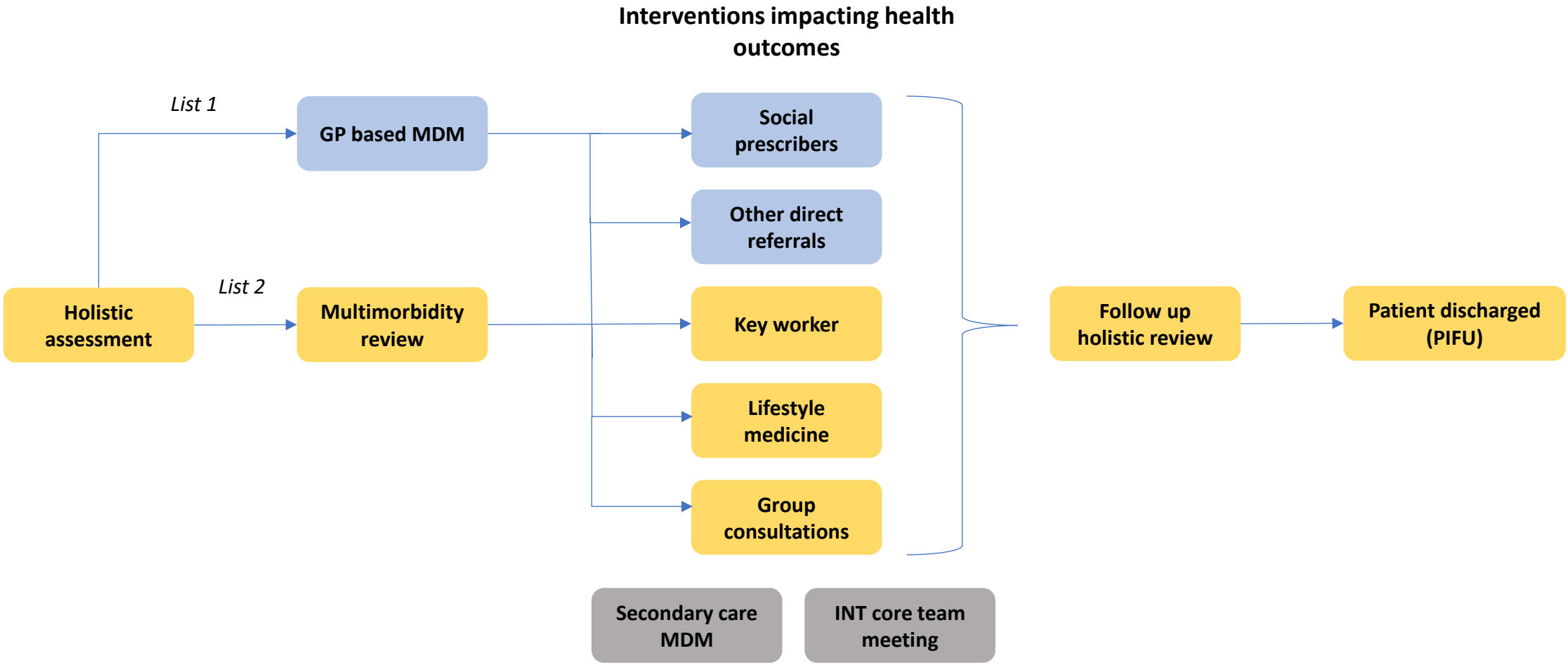
Inclusion Criteria

SEL ICB

INT/MDM Pathway

Following identification of individuals who meet the criteria for List 1 and List 2 (overlap exists), patients are either is reviewed at a practice MDM or handled by the INT Core Team for up to 12 weeks of personalised support. The diagram below outlines this process for both lists:



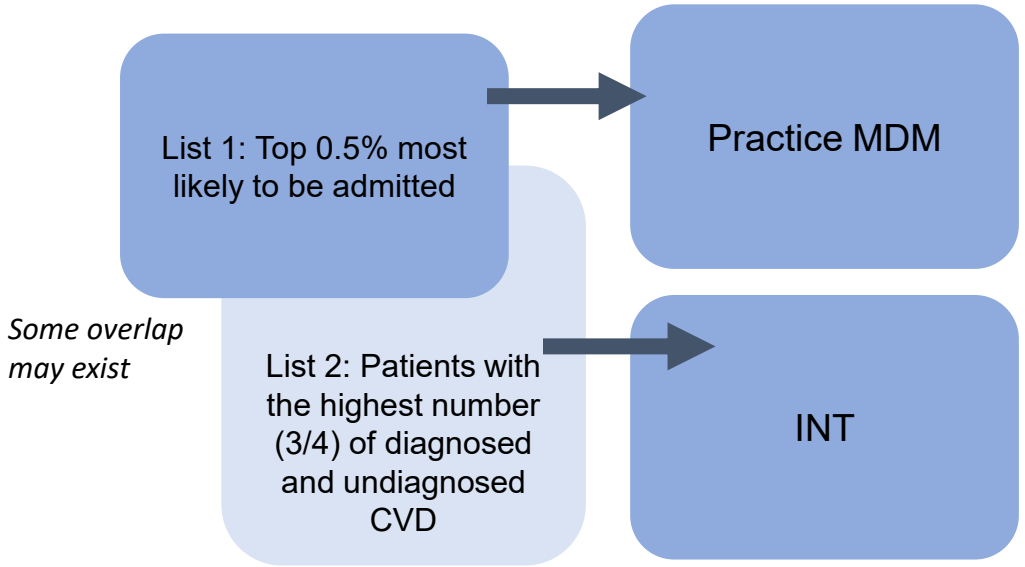
Inclusion Criteria

Inclusion Criteria:

The pilot has focused on those the pilot is expected to have the greatest impact on. The team agreed on 2 key lists. These lists are separate; however, some overlap may exist:

- **List 1 (MDM): Top 0.5% most likely to be admitted**
- **List 2 (INT): Patients with the highest number (3/4) of diagnosed and undiagnosed CVD conditions (AF, Diabetes, Hypertension, CKD)**

These lists are constantly reviewed. For example, it was identified that many of the individuals in List 1 are already in contact with their GP and receiving tailored support. Therefore, this inclusion criteria may need to be adapted to find a cohort in greater need.



Identification of high-risk individuals

South East London Integrated Care System

The first step in this process is the identification of individuals who meet the criteria for List 1 and List 2 (overlap exists). This process is currently being delivered by the Population Health Team. The diagram below outlines this process for both lists:

Cohort Selection Criteria	Prioritisation by Disease State	Prioritisation by Impact on Acute Activity	Flag of Information to Shape/Personalise Care Provided
List 1: Top 0.5% most likely to be admitted	*NA*	*NA*	*NA*
List 2: Patients with the highest number (3/4) of diagnosed and undiagnosed CVD	**3-4** unoptimised LTCs and/or undiagnosed conditions **2** unoptimised LTCs and/or undiagnosed conditions **1** unoptimised LTCs and/or undiagnosed conditions **Subject to refinement*	**Risk of hospital admission**	Personal Information (e.g. digital excluded building blocks, ethnicity, first language, dementia, GP attends, drugs & alcohol, etc) Group into frailty status and presence of a CGA Group into SMI and LD

South East London Integrated Care System

1.) Impact Pathways

SEL ICB

INT Impact Pathway

South East London Integrated Care System

Inputs	Outputs	Outcomes	Impacts
Input interventions	*Immediate, direct outputs as a result*	*Effects, changes that result from the direct outputs*	*Broader, long-term impacts*

Patients are identified as at-risk using tool (List 2) and handled by the INT core team. Based on a holistic assessment and multimorbidity review, the INT coordinator **designs a tailored up to 12-week intervention** which could include:

1. Key worker provision: single point-of-contact who meets with patient, flags issues, and acts as a point of contact for the team.

2. Lifestyle medicine: tailored diet and exercise advice prescribed by INT team to support patient in the community.

3.) Medicine management clinical prescribers review, adjust, and deliver new medication plans.

4.) Group consultations and 1 on 1 support: small workshops and 1-to-1 appointments are conducted to promote adherence and support in the community.

CVD targets are achieved through a combination of medicine management, group consultations, and lifestyle medicine

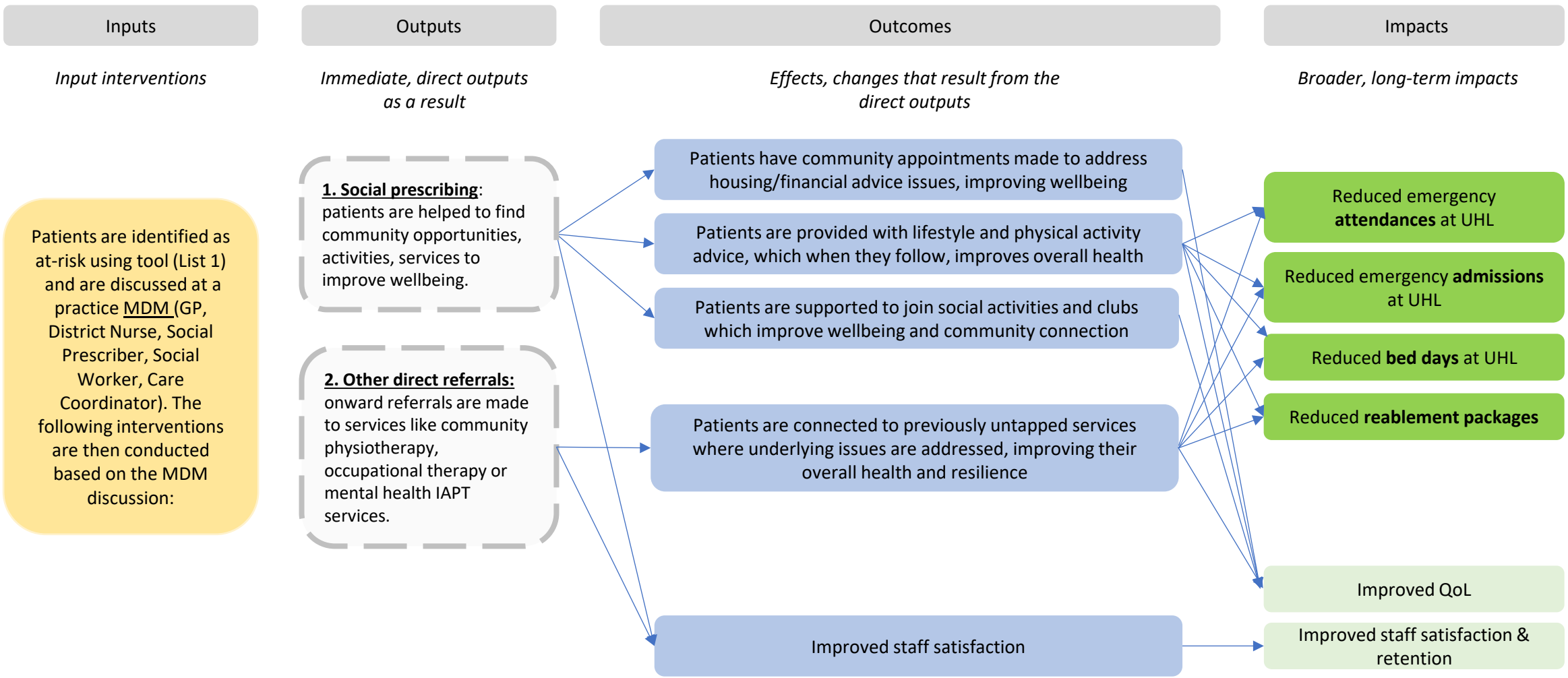
- Blood pressure reduction of >10 mmHg 
- Blood pressure within target range 
- LDL Cholesterol below 2 mmol/L 
- HbA1c reduction of >10 mmol/mol 
- HbA1c within target range 

Medicine management, group consultations, and lifestyle medicine improve general health and resilience

- Reduced **heart attacks admissions** treated at Kings/GSTT
- Reduced **heart attack bed days** treated at Kings/GSTT
- Reduced **heart attacks admissions** treated at Kings/GSTT
- Reduced **heart attack bed days** treated at Kings/GSTT
- Reduced general emergency **attendances** at UHL
- Reduced general emergency **admissions** at UHL
- Reduced in **bed days** at UHL

MDM Impact Pathway

South East London Integrated Care System



South East London Integrated Care System

2.) Baseline Modelling Assumptions

SEL ICB

MDM/INT assumptions – attendance and admissions at UHL

South East London Integrated Care System

Assumptions informing the INT reduction in attendances & admissions

- Preliminary findings from the MMMoC CKD INT pilot were used to inform assumptions for the CVD INT program's impact on A&E admissions and attendances. It was assumed that conducting the INT intervention on the cohort of patients would reduce the 12-month baseline rates amongst the cohort by **65%** and **31.3%** for **admissions** and **attendances** respectively (Table 1).
- Assumptions around intervention effects and population comparability are informed by the CKD "long-list" pilot, which included structured medicines reviews and adherence support—similar to the planned CVD INT. While the two programmes are not the same, many CKD patients had cardiovascular comorbidities (e.g., hypertension, heart failure), supporting the assumption that observed impacts may be reasonably transferable to a CVD-focused population.

Table 1: initial results from MMMoC CKD Pilot

Metric	Long List*	Short List**
Non-elective admissions (per 100 patients)	20 → 7 (–13) = (-65%)*	9 → 9 (0) = (0%)
A&E attendances (per 100 patients)	32 → 22 (–10) = (-31.3%)	21 → 24 (+3)* = (+14.3%)*

Assumptions informing the MDM reduction in attendances & admissions

- It is assumed conducting the MDM intervention would reduce 12-month baseline rates amongst the cohort of patients by **14%** for both admissions and attendances. This figure comes from a comparable UK study, the Somerset Complex Care Team pilot, which delivered practice-based MDT reviews (GP, nurse, care-co-ordinator, social-care links). The pilot reported a single 14 % fall in combined unplanned hospital activity over two years.

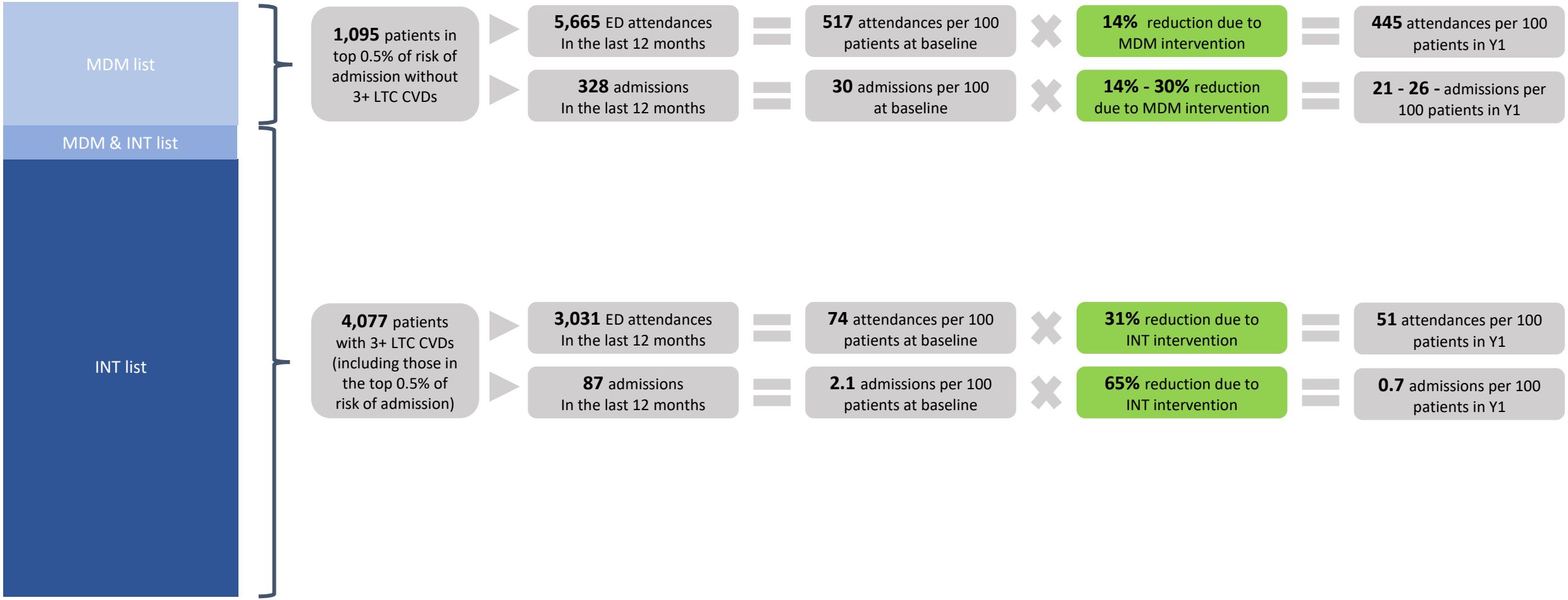
Table 2: Literature and studies of similar MDM programs

Source	Description
LB: Somerset's Complex Care Team PCN Pilot UB: Newquay Pathfinder GP Joined Up Care Programme	~21,000 frail/complex patients across 3 PCNs received coordinated MDT support leading to a **14% reduction in unplanned hospital visits** over 2 years (admissions + attendances). This was sensitivity tested **up to 30%** based on the results from the Newquay Pathfinder Programme.
Wokingham Integrated Care Partnership	566 high-risk patients (frail + recent acute use) received virtual MDT reviews with tailored care plans. There were 270 fewer A&E attendances and 176 fewer admissions. Percentage rate decreases in attendance/admission rate are not able to be obtained as study does not cite them. Reverse engineering with an assumed baseline right is possible but less robust.

* Adults with eGFR > 60 mL/min/1.73 m² and microalbuminuria, **or** eGFR < 60 mL/min/1.73 m² (with or without microalbuminuria). Can be with or without other LTCs. Patients received community outreach + testing + medicine optimisation as the intervention.
** Adults with eGFR 45–60 mL/min/1.73 m² (locally, some sites included down to 30) Plus at least one other LTC (e.g., diabetes, hypertension) and additional complexity (e.g., social factors, severe mental illness). Patients received holistic case management, 1:1 appointments, additional screening for other complexity

MDM/INT attendance and admissions rates for UHL

The logic model below shows how baseline ED attendance and admission rates have been estimated using historic UHL data from the baseline period (12 months before intervention). Assumptions are then applied to estimate impact of the INT/MDM interventions.



MDM/INT assumptions – heart attacks and strokes

Baseline risk estimation and QRISK3 assumptions

To estimate baseline cardiovascular event rates, the QRISK3 calculator was used on two representative profiles: a 60-year-old male and 60-year-old female, each with atrial fibrillation (AF) and chronic kidney disease (CKD). Their 10-year risks (25% and 17.7%, respectively) were averaged to give a cohort-wide estimate of 21.4%. Some important caveats in the modelling to note are:

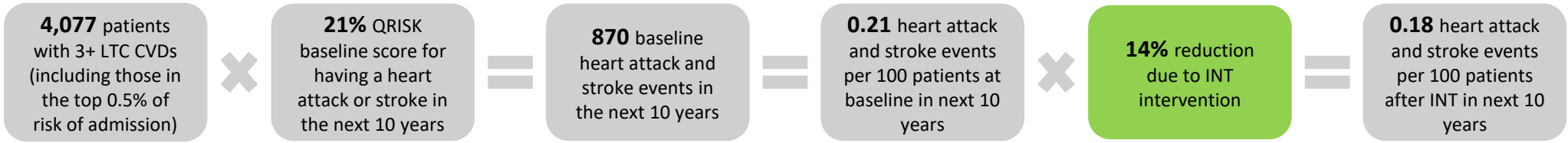
- Primary prevention only: QRISK3 is designed for patients without a prior cardiovascular event (e.g. heart attack, stroke, TIA).
- Simplified cohort representation: the model assumes this average risk applies across the full cohort, despite variation in age, sex, and comorbidity burden, which are especially important in Lewisham.
- Multimorbidity under-estimated: while the cohort includes individuals with ≥3 of AF, CKD, hypertension, and diabetes, the risk estimate was based only on AF and CKD inputs.
- Treatment effects excluded: QRISK3 assumes no baseline statin or anticoagulant use. In reality, many patients may already be on preventive therapy, which may reduce actual risk.
- No adjustment for local risk factors: the model does not account for differences in ethnicity, deprivation, or other specific risk modifiers.

Relative risk reduction due to INT intervention (Important caveat)

- No definitive source was found for estimating the precise impact of an Integrated Neighbourhood Team (INT) on 10-year cardiovascular risk, so a pragmatic assumption was applied based on the best available evidence.
- A 14% reduction in QSRISK3 10-year MI/stroke risk was assumed, anchored to a Swedish nurse-led lifestyle intervention (n = 100, mean age 59) which demonstrated a 14% reduction in 10-year Framingham risk score at 12 months.
- While the Framingham model differs from QRISK3 in its structure and inputs, the study provides a proxy for the potential impact of structured lifestyle interventions. Given the uncertainty, this assumption should be subject to sensitivity analysis to explore a credible range of effect sizes.

INT heart attack and stroke estimation

The logic model below shows how baseline numbers of heart attacks (STEMI) and strokes for the INT cohort have been estimated using the available literature. These health events were separately estimated from UHL general ED attendances and admissions as the site was assumed to not typically treat these types of events.



South East London Integrated Care System

3.) MDM Impact

SEL ICB

MDM - Impact of on attendance and admissions rates at UHL

South East London Integrated Care System

ED attendance Impact

517 attendances per 100 patients at baseline
− **445 (-14%) attendances** per 100 patients after MDM engagement
× **767 patients** engaged with MDM (70%) of total eligible cohort of patients
= **~555 attendances** avoided in Y1 due to the MDM
× **£380 cost** of an ED attendance*
= **£210,965** in total benefits to UHL in Y1

ED admissions Impact

30 admissions per 100 patients at baseline
− **26 (-14%) admissions** per 100 at baseline
× **767 patients** engaged with MDM (70%) of total eligible cohort of patients
= **~32 admissions** avoided in Year 1 due to the MDM
× **7 day LoS** per admission for MDM cohort**
= **~227 bed days** avoided
× **£1,052 cost** of a non elective inpatient stay bed day***
= **£239,297** in total benefits to UHL in Y1

Sensitivity test of ~30% reduction	21 (-30%)		~69		~487		£512,779

*2024/25 A&E guide prices from UHL for 2024/25 were used. The value £380 is an average of HRG VB02Z and VB03Z which assumes that all patients have a category 3 investigation , 50% have a category 1-3 treatment, and 50% have a category 4 treatment.
** Length of stay was estimated using data from HealthIntent for the MDM cohort.
*** Local costing data from UHL provided a vale of £901 for an average non-elective inpatient stay per day (including treatment) for 2021/22. This was inflated by 16.8% to account for current prices to give a value of £1,052.

MDM - Impact of on attendance and admissions rates at UHL

South East London Integrated Care System

ASC reablement packages

30 admissions per 100 patients at baseline	−	26 (-14%) admissions per 100 at baseline	×	767 patients engaged with MDM (70%) of total eligible cohort of patients	=	~32 admissions avoided in Year 1 due to the MDM	×	30% of admissions require 6-week ASC reablement packages*	=	~10 reablement packages avoided	×	£1,638 average cost of a 6-week reablement package*	=	£15,796 in total benefits in Y1
Sensitivity test of ~30% reduction		21 (-30%)				~69				~21				£33,848

Home based social care packages

30 admissions per 100 patients at baseline	−	26 (-14%) admissions per 100 at baseline	×	767 patients engaged with MDM (70%) of total eligible cohort of patients	=	~32 admissions avoided in Year 1 due to the MDM	×	30% of admissions require 6-week ASC reablement packages*	×	39% of reablement packages require some home based care after review**	×	50% of home based packages paid for by LBL ***	×	~2 home based packages avoided funded by LBL	×	£24,076 average cost for home based social care (52 weeks)****	=	£45,621 in total benefits in Y1
Sensitivity test of ~30% reduction		21 (-30%)				~69								~4				£97,760

* Clinical input from discharge team
** Assumption was sourced from Jacobi et.al (2020) which investigated re-ablement episodes in Essex County Council. An upper bound of 39% was taken from Table 2 on the proportion of people after a reablement spell that still needed care.
*** Assumption from ICB team
**** Due to a lack of data, an average continuation of long-term home-based support was assumed to be ~52 weeks, at a weekly average cost of £463 provided by the LBL council.

South East London Integrated Care System

3.1) Summary of MDM Impact

SEL ICB

MDM - Summary of prospective benefits

South East London Integrated Care System

Measure	Year 1	
	Measure	Benefit
UHL ED attendances	**~ 555**	**(+) £210,965**
(1) ED attendance with investigation	~ 555	£210,965
UHL ED admissions	**32 - 69**	**(+) £239,297 - £512,297**
(1) UHL bed days	227 - 487	£239,297 - £512,779
Social care packages	10 - 21	**(+) £61,417– £131,608**
(1) Reablement packages	10 - 21	£15,796 - £33,848
(2) Home base social care packages	2-4	£45,621 - £97,760
Total benefit	**(+) £511,678 - £855,351**	

South East London Integrated Care System

4.) INT Impact

SEL ICB

South East London Integrated Care System

4.1) UHL ED attendances and admissions

SEL ICB

INT - Impact on attendance and admissions rates at UHL

South East London Integrated Care System

ED attendance Impact

74 attendances per 100 patients at baseline − **51 (-31%) attendances** per 100 patients after INT engagement × **2,854 patients** engaged with INT (70%) of total eligible cohort of patients = **~664 attendances** avoided in Y1 due to the INT × **£380 cost** of an ED attendance* = **£252,355** in total benefits to UHL in Y1

ED admissions Impact

2.1 admissions per 100 patients at baseline − **0.7 (-65%) admissions** per 100 at baseline × **2,854 patients** engaged with INT (70%) of total eligible cohort of patients = **~40 admissions** avoided in Y1 due to the INT × **8.6 day LoS** per admission for INT cohort** = **~342 bed days** avoided × **£1,052 cost** of a non elective inpatient stay bed day*** = **£359,669** in total benefits to UHL in Y1

*2024/25 A&E guide prices from UHL for 2024/25 were used. The value £380 is an average of HRG VB02Z and VB03Z which assumes that all patients have a category 3 investigation , 50% have a category 1-3 treatment, and 50% have a category 4 treatment.
** Length of stay was estimated using data from HealthIntent for the INT cohort.
*** Local costing data from UHL provided a vale of £901 for an average non-elective inpatient stay per day (including treatment) for 2021/22. This was inflated by 16.8% to account for current prices to give a value of £1,052.

South East London Integrated Care System

4.2) Non-UHL stroke and heart attack events

SEL ICB

INT - Impact on total number of strokes and heart attacks

South East London Integrated Care System

Total strokes

0.21 heart attack and stroke events per 100 patients at baseline in next 10 years

−

0.18 heart attack and stroke events **(-14%)** per 100 patients after INT intervention in next 10 years

×

2,854 patients engaged with INT (70%) of total eligible cohort of patients

=

~85 heart attack and stroke events avoided over next 10 years due to the INT

×

57% of which are strokes*

=

48 strokes avoided over next 10 years due to the INT that would not be treated at UHL**

Total heart attacks (STEMI)

0.21 heart attack and stroke events per 100 patients at baseline in next 10 years

−

0.18 heart attack and stroke events **(-14%)** per 100 patients after INT intervention in next 10 years

×

2,854 patients engaged with INT (70%) of total eligible cohort of patients

=

~85 heart attack and stroke events avoided over next 10 years due to the INT

×

43% of which are heart attacks*

×

36% of which are STEMI heart attacks that would not be treated at UHL***

=

13 STEMI heart attacks avoided over next 10 years due to the INT that would not be treated at UHL

*Separating out the combined heart attack and stroke event estimates was achieved by using national figures from a BHF Disease Statistics report which reports total stroke (136,839) and heart attack (104,587) figures in 2021.
** It is assumed that all strokes would be taken to HASU and not be treated at UHL
*** NSTEMIs are assumed to be counted within UHL's routine ED/admission data (managed locally); STEMIs—requiring immediate transfer for primary PCI—are estimated separately using a MINAP report which cites the STEMI proportions. These cases would likely be sent to King's / GSTT.

South East London Integrated Care System

4.3) Stroke Impact

SEL ICB

INT - Impact on stroke ED spell

ED spell (ED attendance, thrombolysis)

~48 stroke events avoided over next 10 years due to the INT that would not be treated at UHL

×

£501 average weighted cost of ED attendance and thrombolysis per stroke*

=

£24,609 in total benefits

Note: The Sentinel Stroke National Audit Programme (SSSNAP) was used to build a costings which split the care of strokes into scanning /thrombolysis, acute care in an ASU/HASU and inpatient rehab in an ASU. Each avoided stroke was costed using these three categories which accounted for the majority of total costs. Ambulance conveyance, ESD and CRT therapy, GP visits and social care were not considered due to a difficulty in obtaining robust assumptions.

* Average weighted cost of £501 includes an average ED attendance with category 3 investigation and thrombolysis. The proportions and unit costs were sourced from a 2016 SSSNAP economic report on the costs of a full stroke pathway. The following proportions and unit costs were used; (1) 100% of patients had a ED attendance with category 3 costing £380, (2) 11% of patients received thrombolysis costed at £875. Costs for thrombolysis were inflated to current prices with the GDP deflator from HM Treasury at 34%.

INT - Impact on total number of stroke bed days

South East London Integrated Care System

Hyper acute stroke unit bed days

~48 stroke events avoided over next 10 years due to the INT that would not be treated at UHL

×

100% of patients are admitted to an HASU*

=

~48 admissions avoided to HASU

×

3 day average length of stay in HASU for acute spell**

=

~145 bed days saved in ASU

×

£870 Cost of a bed day in HASU***

=

£126,142 in total benefits

Rehab stroke unit bed days

~48 stroke events avoided over next 10 years due to the INT that would not be treated at UHL

×

65% of patients are admitted to an ASU for rehab*

=

~31 admissions avoided to ASU for rehab

×

16 day average length of stay in ASU for rehab spell**

=

~503 bed days saved in ASU for rehab spell

×

£312 Cost of a bed day in ASU for rehab***

=

£156,994 in total benefits

Note: The Sentinel Stroke National Audit Programme (SSSNAP) was used to build a costings which split the care of strokes into scanning /thrombolysis, acute care in an ASU/HASU and inpatient rehab in an ASU. Each avoided stroke was costed using these three categories which accounted for the majority of total costs. Ambulance conveyance, ESD and CRT therapy, GP visits and social care were not considered due to a difficulty in obtaining robust assumptions.

* HASU admission rates were taken from SSNAP. ASU rehab rates were based on a report stating 35% of patients were discharged home, implying 65% entered ASU rehab.

** A 3-day HASU stay was assumed from a London stroke model study. Total LOS was 19.4 days (HASU + ASU) per a service report, implying ~16 days in ASU rehab.

*** HASU (£649/day) and ASU rehab (£233/day) costs were sourced from SSNAP (2013–14 NHS reference costs, AA35A–F). Costs were inflated to current price with the GDP deflator from HM Treasury at 34%.

South East London Integrated Care System

4.4) Heart attack Impact

SEL ICB

INT - Impact on heart attack ED spell

ED spell (ED attendance, Coronary reperfusion (PCI))

~13 STEMI heart attacks avoided over next 10 years due to the INT that would not be treated at UHL × **£3,392** cost of ED attendance and coronary reperfusion per heart attack* = **£45,125** in total benefits

ICU bed days

~13 STEMI heart attacks avoided over next 10 years due to the INT that would not be treated at UHL × **100%** of patients are admitted to an CCU/ICU** = **~13** admissions avoided to CCU/ICU × **1 day** average length of stay in CCU/ICU for rehab spell*** = **~13 bed days** saved in ASU for rehab spell × **£2,197** cost of a bed day in CCU/ICU**** = **£29,228** in total benefits

* This figure bundles (i) Type 1 A&E attendance with Category-3 investigations (≈ £380) and (ii) the 2023/24 national average tariff for HRG EY41D – standard percutaneous transluminal coronary angioplasty (£3,012). Together they approximate the resource used from first hospital contact through completion of primary PCI, before transfer to CCU/ICU. Alternatives such as emergency coronary-artery bypass grafting are excluded from the base case.
** It was assumed that all patients would be admitted to an CCU/ICU.
*** Length of stay was broadly assumed based on standard guidelines from a national BHF report where it was stated patients normally spend the first 24hrs in an ICU and were then stepped down into a general medical ward for 2 days on average.
**** Local costing data from UHL provided a value of £1,881 for a critical care inpatient stay per day (including treatment) for 2021/22. This was inflated by 16.8% to account for current prices to give a value of £2,197.

INT - Impact on heart attack ED spell

General ward bed days

~13 STEMI heart attacks avoided over next 10 years due to the INT that would not be treated at UHL

×

100% of patients are admitted to general ward*

=

~13 admissions avoided to general ward

×

2 day average length of stay in general ward for recovery**

=

~27 bed days saved in general ward for recovery

×

£403 cost of a bed day in general ward ***

=

£10,721 in total benefits

* It was assumed that all patients would be stepped down to a general ward after the CCU/ICU.
*** Length of stay was broadly assumed based on standard guidelines from a national BHF report where it was stated patients normally spend the first 24hrs in an ICU and were then stepped down into a general medical ward for 2 days on average.
*** Local costing data from UHL provided a value of £345 for a standard ward stay per day for 2021/22. This was inflated by 16.8% to account for current prices to give a value of £345.

South East London Integrated Care System

4.5) Summary of INT Impact

SEL ICB

INT - Summary of prospective benefits

South East London Integrated Care System

The table below summarises the estimated benefits of the INT intervention in Year 1 for ED attendances and admissions, and over a 10-year period of risk for strokes and hear attacks.

Table 1: Summary of general ED attendances and admissions benefits at UHL

Measure	Year 1	
	Measure	Benefit
UHL ED attendances	**~664**	**(+) £252,355**
(1) ED attendance with investigation	~664	£252,355
UHL ED admissions	**~40**	**(+) £359,669**
(1) UHL bed days	~342	£359,669
Total benefit	**(+) £612,024**	

Table 2: Summary of stroke and STEMI heart attack benefits

Measure	Year 1-10	
	Measure	Benefit
Strokes	**~48**	**(+) 307,745**
(1) ED spell	--	£24,609
(1) HASU bed days	~145	£126,142
(3) Rehab SU bed days	~503	£156,994
STEMI Heart Attacks	**~13**	**(+) 85,074**
(1) ED spell	--	£45,125
(2) ICU bed days	~13	£29,228
(3) General ward bed days	~27	£10,721
Total benefit	**(+) 392,819**	

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 5
Enclosure 5

Title:	**Section 75 Agreement – SEL ICB (Lewisham) and Better Care Fund (BCF)**
Meeting Date:	**24.07.2025**
Author:	Jack Howell, Delivery Manager UEC and Virtual Ward (NHS@home), Lewisham
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	Ratify the decision to enter into a Section 75 agreement between Local Authority and SEL Integrated Care Board (Lewisham) to govern the pooled budget arrangements for the Better Care Fund 25/26.	Update / Information	
		Discussion	
		Decision	***x***
Summary of main points:	This paper outlines the need to enter into a new Section 75 agreement between the Local Authority and South East London Integrated Care Board (Lewisham) to govern the pooled budget arrangements for the Better Care Fund. The value of the pooled budget for 2025/26 is £53,440,286. The Council's contribution to this is £21,091,826.		
Potential Conflicts of Interest	None declared		
Any impact on BLACHIR recommendations	See below within Equality Impact		

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

	Equality Impact	Tackling inequalities in health is one of the over-arching purposes of integration. Each new or existing service funded by the BCF has regard to the need to reduce inequalities in access to care and outcomes of care. An equalities assessment/analysis is undertaken as part of the development of any new proposals to assess the

		impact of the new services on different communities and groups. A number of the services being supported by the BCF draw on the Lewisham Population Health team's data analysis work, enabling services to directly target those local populations which are most adversely impacted by certain health or care needs or those demographic groups which are the least likely to engage with service delivery, thus aiming to improve the inequalities experienced by the Lewisham population. The BCF also targets the social determinants of health, particularly housing issues, through the inclusion of Disabled Facilities Grant ("DFG") funding, ensuring that the application of DFG is informed by the wider objectives.
	Financial Impact	The total BCF pooled budget for 2025/26 is £53,440,286. The financial contribution to the BCF from the Council is £21,091,826. The BCF finances a range of services to meet the priorities as set out by Government and by Lewisham Health and Wellbeing Board. The BCF operates within the financial limitations of the pooled budget arrangements.
Other Engagement	Public Engagement	Not applicable to this paper. Engagement takes place in relation to individual services.
	Other Committee Discussion/ Engagement	Lewisham S75 Board
Recommendation:	Ratify the decision to enter into a Section 75 agreement between Local Authority and SEL Integrated Care Board (Lewisham) to govern the pooled budget arrangements for the Better Care Fund.	

Title:	**Section 75 Agreement – SEL ICB (Lewisham) and Better Care Fund (BCF)**
Meeting Date:	**24.07.2025**
Author:	Jack Howell
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Overview:

Better Care Fund (BCF) – Section 75 Agreement 2025/26

The Better Care Fund (BCF), established by the UK Government in 2013, aims to promote the integration of health and social care services at the local level. In Lewisham, the BCF is governed through a Section 75 Agreement between Lewisham Council and the South East London Integrated Care Board (Lewisham), enabling the pooling of resources and joint commissioning of services.

The Section 75 Agreement, made under the NHS Act 2006, facilitates collaborative planning and delivery of services such as intermediate care, community therapies, and voluntary sector support. It is a statutory requirement that this agreement be updated in line with NHS England's BCF planning cycle. The current agreement expired at the end of the 2024/25 financial year, and a new agreement must be in place by September 2025.

The governance of the BCF is overseen by a Section 75 Board, comprising senior executives from both partner organisations. This Board meets quarterly to monitor performance against nationally mandated metrics, including emergency admissions, hospital discharge delays, and care home placements. Reporting is submitted to NHS England on a quarterly basis.

The 2025/26 BCF priorities align with national objectives and the Lewisham Health and Wellbeing Strategy 2025–2030, focusing on:

- Shifting from reactive care to prevention
- Enabling independent living and reducing reliance on hospital-based care

This paper seeks ratification to enter into a renewed Section 75 Agreement for 2025/26 to continue delivering integrated care in line with these strategic goals.

Legal:

- The BCF operates under a Section 75 agreement held between the Council and Lewisham ICB.
- Section 75 of the 2006 Act gives powers to local authorities and NHS bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

This Section 75 agreement sets out the mechanism through which the Partners will work together to commission services.

Recommendation:

Ratify the decision to enter into a Section 75 agreement between the local authority and SEL Integrated Care Board (Lewisham) to govern the pooled budget arrangements for the Better Care Fund and the delegation of BCF oversight to the Section 75 board.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 6
Enclosure 6

Title:	**Lewisham Health Equity Teams – Cycle 1 evaluation**
Meeting Date:	**Thursday 24th July 2025**
Author:	Dr Catherine Mbema
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	This paper is being presented to the Partnership to outline the evaluation and learning from the first cycle of the Lewisham Health Equity Team programme.	Update / Information	
		Discussion	x
		Decision	

Summary of main points:	- The Health Innovation Network South London completed an evaluation for the first cycle of the Lewisham Health Equity Team programme.
	- The evaluation has informed the development of the second cycle of the programme under the leadership of Dr Aaminah Verity, Community of Practice Lead for Health Equity.
	- The key programme impact and learnings from the evaluation include:
	  ○ The Health Equity Team programme directly addressed the opportunities for action highlighted in the Birmingham and Lewisham African and Caribbean Health Inequalities Review. It made direct investments in Black-led organisations and community champions, and improved access by bringing healthcare services directly to the community.
	  ○ A cohort of health equity leaders were developed throughout the programme, reigniting a health equity focus in primary care. They played a pivotal role in starting to transform care pathways, while growing personally and professionally as population level health leaders.
	  ○ The programme evaluation revealed broader learnings, highlighting the need to focus on defined outcomes, enhance programme management and prioritise sustainability.		

Potential Conflicts of Interest	Nil of note		

Any impact on BLACHIR recommendations	The BLACHIR opportunities for action that have been directly met by this work are:			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	This work aims to work towards addressing health inequalities in Lewisham.		
	Financial Impact	This work has been funded by both Lewisham ICB and Lewisham Public Health. A second cycle has also been funded but sustainability beyond the second cycle needs to be considered by the Partnership.		
Other Engagement	Public Engagement	The findings of the evaluation were presented at a recent Lewisham Health Equity event held on 9th July at the Albany Theatre, which was attended by a broad range of Lewisham stakeholders.		
	Other Committee Discussion/ Engagement	The findings of the evaluation have been shared with the Lewisham Health Inequalities working group.		
Recommendation:	Recommendations from the evaluation cover three broad areas: - Strengthening partnership working for health equity teams. - Improving health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham. - Streamlining programme processes and learning.			

Evaluation of the Health Equity Team Programme in Lewisham

Health Innovation Network South London

In partnership with Centric Community Research

April 2025

@HINSouthLondon

healthinnovationnetwork.com

Health Innovation Network South London

Centric

Foreword

Lewisham is on a journey to achieve health equity, and the Lewisham Health Equity Team programme has been an important part of our ongoing work to ensure that everyone in Lewisham has a fair opportunity to attain their highest level of health.

Following on from the publication of the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) and subsequent launch of the Lewisham Health Inequalities and Health Equity programme in 2022, this innovative initiative was developed. It built on learning from an initial Health Equity Fellowship in North Lewisham Primary Care Network and the BLACHIR report to bring clinicians and community groups together to work within teams to address health equity at neighbourhood level.

Though an ambitious and challenging undertaking, I am pleased to see what the Health Equity Teams have achieved in a relatively short space of time. The valuable learning that has been gleaned through the programme and this evaluation is of great benefit for ongoing health equity work in the borough.

It has been a privilege to witness the unwavering commitment of voluntary and community sector partners and primary care clinicians to achieve health equity for Lewisham residents, so I would like to thank all of the pioneering Health Equity Teams for their work.

I would finally like to pay tribute to a member of the programme team, Lisa Fannon, who sadly passed away before this evaluation was finalised. Lisa played an instrumental role in this work and leaves a strong legacy with all of those that she worked with in this programme.

Dr Catherine Mbema, Director of Public Health, Lewisham

About the Health Innovation Network South London

This evaluation was led by the Health Innovation Network South London (HIN) on behalf of Lewisham Council.

The HIN is the health innovation network for south London, one of 15 across England. We are the bodies uniquely established to connect NHS and academic organisations, local authorities, the third sector and industry, in order to increase the spread and adoption of innovation across large populations, at pace and scale.

The HIN is embedded within and understands south London's health and care system. We bring a wealth of experience in delivering real-world evaluations of health and care programmes in south London (and beyond) that provide insights and actionable recommendations.

Acknowledgements

The evaluation would not have been possible without the scale of input from the health equity teams. We thank all participants who took part in this evaluation who generously shared their experiences of the programme, and particularly the voluntary and community sector organisations, community champions and health equity fellows.

The HIN partnered with Centric Community Research (Centric) on the evaluation. They are a community-led research organisation, building the capacity and capability of local communities to get involved in research. We would also like to thank the following staff at Centric: Muhammed Rauf, Paul Addae and Sophie Johnson St-Vie for their input in the evaluation.

Finally, we would like to thank the programme management team: Dr Aaminah Verity (South East London Integrated Care Board), Dr Catherine Mbema (Lewisham Council), Jason Browne (Lewisham Council), Lisa Fannon (Lewisham Council), Naomi Alexander (Lewisham Council) and Piers Johnson (Lewisham Council).

Centric's Community Research Model

Centric recruit, train and upskill researchers from local communities who solve local problems through research.

- They are part of the communities being served.
- Their team has a diverse range of skills, cultural backgrounds and expertise.
- They have a bespoke ethics approval process that champions community consent and ownership.
- Their model has been designed and is run by community researchers themselves.
- Their programme is accessible and offers unique progression routes for community researchers.

COMMUNITY LED AND OWNED | **AUTHENTIC INSIGHT** | **CULTURALLY NUANCED**

Glossary

Term and acronym	Definition and meaning
Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)	A joint research project between Lewisham and Birmingham City Councils. It has begun ground-breaking work to gather insights on health inequalities experienced by Black African and Caribbean communities.
Core20PLUS5	A national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
Health Equity Team programme (HET)	An innovative model that aims to address health inequalities for the Black African and Black Caribbean community in Lewisham. This is the programme being evaluated.
Health Innovation Network South London (HIN)	The health innovation network for south London and the team commissioned to carry out the evaluation.
Hemoglobin A1c (HbA1c)	HbA1c is the haemoglobin in the red blood cells that has glucose attached to it. If the blood glucose levels are high the HbA1c will be high. If the blood glucose levels are low, the HbA1c will be low.
Human immunodeficiency virus (HIV)	A virus that damages immune system cells and weakens the body's ability to fight everyday infections and disease.
Primary care network (PCN)	They are groups of practices working together and with other local health and care providers (e.g., hospitals, mental health or community trusts, community pharmacies and charities) within what are considered natural local communities, to provide coordinated care through integrated teams. There are six in Lewisham.
South East London Integrated Care Board (SEL ICB)	The statutory NHS organisation in south east London responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the integrated care system area.

Contents

Executive summary

Executive summary

Lewisham Council commissioned the Health Innovation Network South London to undertake a summative, largely qualitative, evaluation of the Health Equity Team programme.

The Health Equity Team programme implementation

- The programme was piloted for just over 18 months in Lewisham, with joint oversight from Lewisham Council and the South East London Integrated Care Board.
- Six health equity teams were formed, bringing together Black-led voluntary and community sector organisations and primary care health equity fellows to address locally identified health inequalities in Lewisham.
- Teams developed a rich understanding of place and community through population level data analysis and community engagement.
- They delivered a range of activities, including health fairs, health promotion workshops, culturally tailored programmes and workforce training.

70+

Community champions

2500+

Residents reached

Teams experienced some co-production challenges initially, albeit there was a clear consensus about how to achieve meaningful co-production in the future.

Effective collaboration, leveraging community resources and strong relationships facilitated project delivery.

Executive summary

Action for Community Development & Aplos Health Primary Care Network

- Community health and wellbeing awareness programme
- Focus on mental health, long-term conditions and racism

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

- Community based research and listening
- Mobile health clinics and targeted health promotion events

Holistic Well Women & Lewisham Alliance Primary Care Network

- Community outreach and mental health workshops
- Local form filling events offering health checks, advice and educational tutorials

Red Ribbon Living Well & North Lewisham Primary Care Network

- Community survey on health concerns and barriers
- Health hubs and checks
- HIV stigma training

Therapy 4 Healing & Modality Primary Care Network

- Community listening and engagement
- Health fairs and events
- Evidence-based complementary health clinic

360° Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

- Community-led, culturally-tailored group consultation programme for Black and Asian people living with type 2 diabetes

Executive summary

Programme impact and learnings

- The Health Equity Team programme directly addressed the opportunities for action highlighted in the Birmingham and Lewisham African and Caribbean Health Inequalities Review. It made direct investments in Black-led organisations and community champions, and improved access by bringing healthcare services directly to the community.
- A cohort of health equity leaders were developed throughout the programme, reigniting a health equity focus in primary care. They played a pivotal role in starting to transform care pathways, while growing personally and professionally as population level health leaders.
- The programme evaluation revealed broader learnings, highlighting the need to focus on defined outcomes, enhance programme management and prioritise sustainability.

Recommendations

- The evaluation providers key insights to guide future iterations and maximise the programme's potential in addressing health inequalities in Lewisham.
- The recommendations focus on three core areas:

Strengthening partnership working for health equity teams

Improving health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham

Streamlining programme processes and learning

About the programme and evaluation

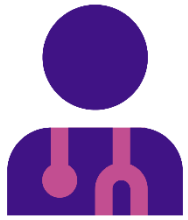
About the Health Equity Team programme

The Health Equity Team (HET) programme is an innovative, integrated care, partnership model that aims to address health inequalities for the Black African and Black Caribbean community in Lewisham.

The programme brought together Black-led voluntary and community sector organisations and primary care health equity fellows to form health equity teams for each of Lewisham's six primary care networks (PCNs). Teams were tasked with co-producing a project to address locally identified health inequalities. The model was piloted for just over 18 months, with joint oversight from Lewisham Council and the South East London Integrated Care Board (SEL ICB).

The programme sits within Lewisham Council's Health Inequalities and Health Equity Programme 2022-24. This broader strategy is supported by SEL ICB funding and is the key programme of work to support, prioritise and implement the recommendations from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR).

Programme timelines



October 2022

Health equity fellows were recruited for their PCNs. This was led by the SEL ICB community of practice lead, with fellow's contracts held by individual PCNs. In-house training took place from October to January 2023, and external training was delivered January to December 2023 by King's College London.

March 2023

Voluntary and community sector organisations were commissioned by Lewisham Council's public health team to partner with the community, health equity fellows and the PCN. Their contracts were managed by Lewisham Council.

June 2023

Most teams were formed, bringing together the voluntary and community sector organisations and health equity fellows to co-produce and implement a health inequalities focussed project.

September 2024

Health equity team programme pilot ended.

About the evaluation

Lewisham Council commissioned the HIN to undertake a summative, largely qualitative, evaluation. The evaluation aimed to inform the recommissioning of the HET programme, due to start in 2025.

Evaluation objectives

This evaluation explored the implementation and impact of the HET programme through the following evaluation questions:

Implementation

- How has the HET programme been implemented overall? Were there **adaptations** made to suit the **specific needs** of different PCNs?
- How has the HET programme resulted in cross-sectional learning and **partnership collaboration** between PCNs and voluntary and community sector organisations?
- What were the **essential features** of both programme-level and team-level delivery that enabled success?

Impact

- Has the HET programme been successful in responding to **BLACHIR priorities**?
- Have and how health equity fellows become **leaders on health equity** within their PCN?
- Has the HET programme resulted in any **wider changes** to existing practices and/or any **wider learning**?

About the evaluation

Evaluation design

Evaluation activities took place between September-December 2024.

The HIN partnered with Centric Community Research to conduct the fieldwork with the voluntary and community sector organisations, given their strong community research expertise. Interviews were attended by both Centric Community Research and HIN to gain a holistic view.

Cross critical case and thematic analysis were employed, and recommendations were formulated in partnership with Centric Community Research and the programme management team.

Limitations

The evaluation is limited by patient perspectives, input from few community champions and robust quantitative data.

Key evaluation activities

Focus groups
- Programme management team
- Lewisham primary care leaders

Document review
- Programme level resources
- Impact reports and presentations

Interviews
- Six health equity fellows
- Six voluntary and community sector organisations
- One community champion
- One PCN community link worker
- One BLACHIR community partner



Implementation insights

Delivering the HET programme

The phased roll-out hindered co-production

The HET programme was rolled out in phases. After the fellows were recruited and trained, voluntary and community sector organisations were commissioned. Teams were then formed. From the outset, there was a disconnect between the voluntary and community sector organisations and fellows regarding the co-production of initiatives. Some voluntary and community sector organisations and health equity fellows had already independently designed projects, while some anticipated a more collaborative, joined up approach initially. This misalignment hindered the co-production process.

There was a clear consensus from the teams about how to achieve meaningful co-production.

Start the journey together, at the same time

They wanted the chance to get to know one another personally and professionally and understand the expectations of co-production. They wanted to be open and honest about their individual motivations.

Facilitate a round table discussion to co-produce their project

Teams wanted to avoid bringing fixed ideas, and to collectively write and design their approach instead.

Establish a clear partnership approach from the outset

Through open dialogue they wanted to agree expectations around roles, responsibilities, communication, and time commitment. This was to ensure alignment and facilitate smoother project delivery.

> “Let's start from the beginning together. Let's find out about each other's story. Let's find out about each other's (…) backgrounds and where we're coming from so that we can kind of work together.
>
> Health equity fellow

Effective collaboration was a critical success factor

Collaboration was a defining feature of the HET programme. Whilst a few teams developed an equitable and professional working relationship, the majority experienced challenges, with one team parting ways entirely.

There were several barriers to developing a successful partnership between voluntary and community sector organisations and health equity fellows. This ranged from fundamental structural and systemic issues, including the distribution of power, as well as differing communication and working styles. These challenges, in some cases had an emotional impact on individuals, underscoring the importance of incorporating a trauma-informed approach to provide appropriate support.

Many teams, overtime, established good working relationships. Key facilitating factors are outlined as follows.

Understand each other and commit to the programme's ethos

- Cultivate the right attitude and self-awareness.
- Understand each other's patches and strengths.
- Maintain a shared focus on the programme's ultimate goal.

Support from the programme management team and other stakeholders

- Inclusive communication and decision-making.
- Proactive conflict resolution and trust building.

Practical and standardised processes to enhance collaboration

- Early engagement and regular communication.
- Dedicated time for developing professional relationships.
- Structured project management.

> "She [voluntary and community sector organisation] took me around Lewisham…and gave me like a tour and like the history of kind of social prescribing and neighbourhoods (…) she really educated me from a community perspective.
>
> Health equity fellow

> "Everyone was happy because they can't do anything without consult[ing] me and I can't do anything without consult[ing] them. So we build this good (…) partnership.
>
> Voluntary and community sector organisation

Community levers and fostering strong relationships facilitated project delivery

A range of activities were delivered as part of the HET programme. This ranged from health fairs, health promotion workshops to culturally tailored programmes and workforce training. Recruitment and training of community champions was a consistent approach. Many also conducted community engagement activities to build relationships, map assets and understand local priorities. Individual team projects are showcased further in this document.

Teams reflected on the factors that challenged their project delivery. They identified issues around funding, clinical accountability, as well as the need for realistic community-led solutions that prioritise active participation and authentic community engagement over passive consultation. The need to optimise clinical resources, given the administrative burden, was also commonly reported.

On the contrary, successful delivery was enabled by:

Leveraging community expertise

- Data driven and deep understanding of community.
- Momentum and cultural competency from the voluntary and community sector.
- Multi-agency working, signposting and addressing the social determinants.

Engaging key stakeholders

- Involve community and health stakeholders early to bring them along the journey.
- Maximise and leverage community champion input.
- Build meaningful connections.

Effective programme design and delivery

- Draw on existing spaces and groups.
- Develop multiple patient recruitment strategies to maximise reach.
- Be agile, flexible and encourage iterative learning.

Community levers and fostering strong relationships facilitated project delivery

> Let's actually build a proper project. Let's sit down and say, 'where do we want to be in five years?'
>
> Voluntary and community sector organisation

> I (…) used all of the networks (…) that we have here and (…) we were able to access hundreds of people because it was a community event.
>
> Voluntary and community sector organisation

> We chose to engage residents in kind of pre-existing groups rather than trying to put on events and trying to get people to come, but we didn't want to do something new, we wanted to go to where the people already were.
>
> Health equity fellow

Impact and wider learnings

Opportunities for Black-led organisations to contribute to NHS service delivery, improving outcomes for residents

The HET programme worked towards addressing some of the fundamental areas that need to change to close the inequality gap and improve outcomes for Black African and Black Caribbean communities. There is a clear link to the BLACHIR opportunities for action (OfA) and specifically towards:

- Providing investment in Black African and Black Caribbean grass roots organisations (OfA 29 and 34).
- Partnering with them to co-create and deliver culturally appropriate and accessible support (OfA 35).
- Raising awareness and providing targeted services to increase access and uptake (OfA 27 and 35).

The initiatives delivered cut across the BLACHIR themes and achieved the following outcomes.

Improving access by bringing healthcare to the community	• Invested in and developed multi-service hubs and pop-ups in the community. • Provided an equal footing and addressed wider social determinants of health. • Leveraged existing resources and expanded their reach by engaging individuals and organisations from other localities.
The growth of community champions	• Pivotal and instrumental role in project execution. • Personal and professional development, including enhanced healthcare knowledge, strengthened community leadership skills and increased confidence.
Gains for voluntary and community sector organisations	• Direct investment in Black-led organisations. • Reported impact ranged from broadened and strengthened relationships, raised profile and cause awareness, scope to consider further funding.

Opportunities for Black-led organisations to contribute to NHS service delivery, improving outcomes for residents

> The investment we've put in, (…) hopefully that enables them to go on and secure different funding in different areas or come back and work with us again. But that growth is something that I just think you can't put a price on. It is priceless for me.
>
> Programme management team

> What was really, good, was about the community health champions, who we recruited locally, their learning process was great, you know, and seeing the change in them.
>
> Voluntary and community sector organisation

> It's like a one stop shop and it was in the community rather than in a clinical setting. Patients felt it was really useful.
>
> Health equity fellow

A cohort of health equity leaders were developed

The HET programme cultivated a cohort of clinical leaders equipped with a population health perspective to effectively address local health inequalities. Key outcomes reported are highlighted below.

Re-invigorating Lewisham PCNs' focus on addressing health inequalities	Contributing to care pathway transformation	The personal growth and development of health equity fellows
The health equity team model began to establish sustainable capacity within primary care to address health inequalities. It supported PCNs to: • Raise awareness of health inequalities. • Engender movement and cultural change amongst primary care leaders. • Prioritise managing the health of Lewisham residents through a health equity lens.	Fellows recognised that their work represents a gradual step towards systemic change and care pathway transformation. They observed that the seemingly small-scale adaptations implemented throughout the programme yielded a broader impact. These adaptations included: • Facilitating direct engagement between GPs and community initiatives. • Leveraging the expertise of community organisations to deliver training to GPs and encourage open dialogue regarding health inequalities. • Tailoring and adapting primary care resources to be culturally accessible. • Reassessing primary care procedures.	Fellows described their involvement in the programme as a profoundly transformative experience, with its significant personal and professional rewards. It supported them to live and spread their passion, make a wider difference, and build connections. Through this, they also learnt from each other and developed their leadership skills.

A cohort of health equity leaders were developed

> It was really good to have a dedicated person to do some outreach work and look at prevention as a positive thing, rather than something that there was no resource for (…). Reach[ing] out into communities who weren't coming to the practice. So the whole concept was invigorating.
>
> Primary care leader

> So personally, I love the job because sort of the networks across the local community, across the whole of Lewisham borough, with the other PCNs, and the other fellows. I thought that was it (…) was really great and actually just like professionally, personally that was a real positive for me.
>
> Health equity fellow

Wider learnings for the programme

Beyond their specific health equity team work, participants identified valuable programme learnings and opportunities to further improve health outcomes for Lewisham residents. These were primary centred around outcomes, programme management and sustainability.

A clearer focus on achieving defined outcomes

Project stakeholders emphasised the need for clearly defined key performance indicators and measurable outcomes, coupled with more rigorous monitoring to demonstrate return on investment. As part of this, there should be standardisation and alignment with primary care leaders.

Improving overall programme management

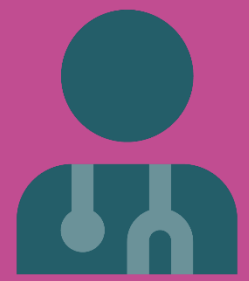
The first iteration of the programme provided valuable learning opportunities, revealing areas for improvement in programme management, particularly around aligning leadership aims, optimising monitoring meetings and enhancing programme visibility and impact.

Not losing sight of sustainability

Several perspectives on programme sustainability highlighted the importance of continued investment. Key considerations mentioned by participants included:

- Programme continuation to achieve its full potential and deliver lasting impact.
- Knowledge retention to safeguard against learning loss.

> “What more can we do to […] outwardly promote what we are doing, because I think this stuff […] snowballs.
>
> Primary care leader



Conclusion and recommendations

Conclusions and recommendations

The HET programme demonstrated the value in fostering partnership working between the primary care sector and voluntary and community sector organisations.

While the teams faced some implementation and delivery challenges and impact could not be robustly demonstrated across all projects, all participants recognised the value of enabling small voluntary sector, Black-led organisations to directly contribute to NHS service delivery to improve the outcomes of Lewisham residents.

The evaluation offers key learnings to guide future iterations and ensure the programme reaches its full potential to address health inequalities in Lewisham.

The recommendations were developed in collaboration with Centric Community Research and the programme management team. They aim to inform delivery of the second iteration of the programme and centre on three core areas:

1. Strengthening partnership working for health equity teams.
2. Improving health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham.
3. Streamlining programme processes and learning.

The programme management team is actively exploring ways to integrate and apply these recommendations in the next phase of the programme.

1. Strengthening partnership working for health equity teams

Improve programme roll out

To achieve a cohesive and equitable start, the programme should:

- **Foster shared understanding of the programme objectives and expectations** from the outset, especially around co-production.
- **Synchronise recruitment** of voluntary and community sector organisations and health equity fellows, if possible.
- **Refine the application** to assess an understanding and commitment to co-production principles, leadership and collaborative capabilities, and knowledge of the local community and health inequalities.
- **Continue the application support** to further build organisational capacity.
- **Broaden recruitment reach** to attract a diverse and larger pool of applicants.
- **Enhance pre-launch engagement** to address questions, concerns, and potential challenges proactively.

Support co-production

To achieve meaningful co-production, the programme should:

- **Offer joint training sessions** to build a shared understanding and skills.
- **Partner with independent experts to guide teams** in co-production principles and practices, ensuring equitable power-sharing.
- **Promote collaborative proposal development**.

1. Strengthening partnership working for health equity teams

Prioritise team onboarding

To build strong, collaborative partnerships and to avoid the silos observed, the programme should:

- **Convene a kick-off meeting** for teams to foster a shared vision.
- **Develop a comprehensive programme starter pack** that outlines expectations including: (a) programme vision and phases; (b) roles and responsibilities; (c) guidance for effective project management, decision making, budget management and joint reporting; (e) working hours expectations; (f) information on programme monitoring, outcomes and timeframes; and (g) a framework to build and maintain team trust.
- **Outline a clear rationale for pairing** voluntary and community sector organisations and fellows.
- **Support team formation by facilitating activities** that promote personal and professional understanding, opportunities to experience each other's work environments, open communication about working styles and preferences, and team reflexivity.

Invest in capacity building and trauma informed support

To enhance collaboration, the programme should:

- **Provide tailored training and structured peer support** to strengthen the skills and knowledge of voluntary and community sector organisations and fellows.
- **Offer independent trauma-informed support and supervision** to help address power dynamics and foster a safe and open environment.

2. Improving outcomes for Lewisham residents

Focussed action and sustainable practices are needed to improve health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham. In order to achieve this, the second iteration of the programme will need to:

Optimise resource allocation, for instance by introducing coordinator and administrative support for fellows to improve efficiency and oversight, allowing for better use of clinical resources.

Prioritise Black community needs, by maintaining a clear and explicit focus on improving outcomes for Black African and Black Caribbean residents and emerging Black populations locally. This could be achieved through following an asset-based approach that builds on existing social capital within the community and through fostering meaningful engagement and community participation, with consideration given to public relations activities.

Drive transformation in primary care, by creating opportunities for general practitioners to actively participate in shaping the programme, fostering a culture of change and buy-in, and empowering fellows to establish themselves as leaders in clinical spaces and sustain their influence beyond the fellowship programme.

Promote knowledge sharing and sustainability, by building a sustainable knowledge base and repository to facilitate shared learning within and outside the programme, as well as considering the intellectual property of initiatives developed.

3. Streamlining programme processes and learnings

The programme management team proactively optimised processes from the outset. This commitment to refining and improving will be essential as the programme carries on and could be extended as follows.

Revitalise programme oversight

To ensure programme success and long-term sustainability, the programme should focus on:

- **Empowered teams** (as described on slides 23 and 24).
- **Stronger leadership** to articulate ambitious yet attainable goals, and clearly communicate the rationale behind decisions, especially when top-down decisions are necessary.
- **Continued visibility** to showcase the programme's reach and impact by inviting external stakeholders to events to raise awareness, as well as publishing and promoting outputs for wider audiences.

Sharpen the focus and streamlining reporting

To maximise the programme's impact and ensure alignment with the BLACHIR priorities, the following elements should be prioritised:

- **Outcome-driven monitoring**, co-creating key performance indicators and monitoring strategies with stakeholders to clearly define desired outcomes and track progress.
- **Revamped monitoring meetings**, simplifying requirements, providing clearer upfront expectations to ensure focused discussions.

The strategic choice to focus on a single clinical area (i.e. cardiovascular disease) in the second iteration will also facilitate clearer identification of outcomes and more effective testing and comparison of different interventions. Collectively, this will help to identify and disseminate best practices.

Foster ongoing learning and improvement

To continue the investment in learning and programme development, the programme should:

- **Consider commissioning a developmental evaluation or learning partner** to offer critical insights into implementation, enable real-time iterations and maximise effectiveness.
- **Further empower community champions** by expanding methods to capture their learning and reflections, deepening their community leader capabilities.

The Health Equity Team projects

Action for Community Development & Aplos Health Primary Care Network

Action for Community Development is non-profit charitable organisation dedicated to empowering individuals and developing communities. Their mission is to promote community building and social transformation in diverse and under-resourced communities. They give impartial, reliable and professional training, information, career advice and guidance.

Aplos Health Primary Care Network comprises four practices:

- The Vale Medical Centre
- Sydenham Green Practice
- Woolstone Medical Centre
- Wells Park Practice

Aplos Health
primary care network

Action for Community Development & Aplos Health Primary Care Network

Action for Community Development and Apolos Health Primary Care Network delivered a community health and wellbeing awareness programme, focusing largely on mental health and long-term conditions.

Throughout October 2023 to March 2024, they:

- Recruited and trained 25 community champions.
- Promoted and disseminated event information through targeted outreach including the distribution of leaflets at key community spaces such as high street shops, community centers, and libraries to ensure broad visibility of events across the neighborhood.
- Engaged over 24 local organisations to participate in the health promotion events and showcase their services to increase healthcare access and signpost residents.

Seven workshops were delivered across the themes below. There was a consistent approach to intervene early, address stigma and discrimination, ensure cultural relevance and tailored content, and facilitate access through effective signposting to local services.

Mental health and wellbeing

Diabetes

Behaviour change

High blood pressure

Racism in public health

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

Downham Dividend Society Community Land Trust was founded to continue the wider regeneration work of Fusions Jameen's Black-led community self-build schemes. It considers the Downham community as an asset and its social bonds of economic value and promotes a community wealth building approach to tackle the intergenerational poverty and health inequalities.

Social Life was created by the Young Foundation in 2012, to become a specialist centre of research and innovation about the social life of communities.

Sevenfields Primary Care Network comprises eight practices:

- Ashdown Medical Group – Burnt Ash Surgery
- Ashdown Medical Group – Downham Family Medical Practice
- ICO Health Group – The Moorside Clinic
- Novum Health Partnership – Baring Road Medical Centre
- Novum Health Partnership – Rushey Green Group Practice
- Oakview Family Practice
- Park View Surgery
- Torridon Road Medical Practice

DCLT

SOCIAL LIFE

Sevenfields
Primary Care Network

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

Downham Dividend Society Community Land Trust, Social Life and Sevenfields Primary Care Network collaborated to a maximise community assets and tackle health inequalities. Across June 2023 to September 2024, their project was delivered in four phases.

Key project components and highlights:

- Four local residents recruited as community champions, building on the existing network of champions locally.
- Rich understanding of place and community developed, underpinned by listening in depth to residents, employing accessible research methods and analysing local data.
    - Key findings: Loneliness, isolation, and stress are increasing. Housing and financial pressures are significant. Health requires a holistic approach. Disparate community power and activism, and the impact of local history.
- Trauma informed approach implemented, partnering with the Deborah Ubee Trust to provide team emotional and wellbeing support and a resident health and wellbeing workshop.
- Nine interactive events and mobile health clinics were delivered to improve access to healthcare and promote wellbeing.
- Team expertise and passion leveraged, with a specific focus on the health of the Caribbean, Sri Lankan and Tamil community, housing and trauma, stress management, healthy eating and roller-skating and gardening.

Holistic Well Women

Holistic Well Women is a non-profit grass-roots organisation dedicated to empowering community health and well-being, with a primary focus on women. Their mission is to foster positive change through a range of activities and services that extend beyond traditional boundaries.

Lewisham Alliance Primary Care Network

Lewisham Alliance Primary Care Network comprises six practices:

- Burnt Ash Surgery
- Lee Road Surgery
- Lewisham Medical Centre
- Nightingale Surgery
- Triangle Group Practice
- Woodlands Health Centre

Holistic Well Women & Lewisham Alliance Primary Care Network

Holistic Well Women's delivery model centred on cultural appropriateness, holistic care and early intervention. Creative and social approaches to address wellbeing was a common thread throughout.

They delivered a mental health awareness campaign, including a series of workshops and courses covering topics such as mindfulness, self-care, healthy living, and gardening. Participants reported:

- Improved wellbeing and reduced isolation.
- Increased understanding and access to mental health support.
- New and strengthened support networks.

Outreach community engagement was conducted alongside, as well as their champion and community leader programme, with sessions on trauma informed approaches, cultural awareness and BLACHIR.

Lewisham Alliance provided a weekly, multifaceted form filling service in a local shopping centre. Key features of their model included:

- A dedicated outreach team involving social prescribers, care coordinators, mental health workers, trained community volunteers and clinical staff.
- Health checks, advice and mental health and wellbeing support provided alongside form filling activities (e.g. personal independence payment forms).
- Educational tutorials on topics such as mental health, arthritis, diabetes and hypertension.

200+

Patients engaged in the service and educational tutorials

82%

Encountered problems with form filling before

Red Ribbon Living Well & North Lewisham Primary Care Network

Red Ribbon Living Well is a community organisation for individuals affected by and living with human immunodeficiency virus (HIV), mental health, family experience domestic violence and other comorbidities illness. The group was founded in 2009 by members who recognised a need for peer support in the community, and it has grown from its grass-roots beginnings.

North Lewisham Primary Care Network comprises nine practices:

- Amersham Vale Practice
- Clifton Rise Family Practice
- Deptford Medical Centre
- Deptford Surgery
- Grove Medical Centre
- Kingfisher Medical Centre
- New Cross Health Centre
- Queens Road Partnership
- Vesta Road Surgery

Red Ribbon Living Well & North Lewisham Primary Care Network

Red Ribbon Living Well and North Lewisham Primary Care Network co-produced a three-pronged project drawing on population health management data, community and Red Ribbon Living Well expertise and input from primary care network stakeholders.

Health equity and wellbeing champions

26 champions were recruited and trained on topics such as HIV prevention and testing and local health inequalities and services. Champions also received additional accredited training.

140 local residents surveyed to understand health concerns and barriers to healthcare access.

Coordination and data gathering at community health hubs.

Community health hubs

678 individuals attended nine health hubs over the 12-month period. Hubs took place in strategically identified community spaces to increase access.

33 community and health care stakeholders collaborated, delivering integrated care and support, within a single space.

400 health checks performed, with 42% coded as CORE20Plus.

HIV stigma training

144 participants engaged in the co-designed HIV stigma and awareness training reaching both clinical and non-clinical staff.

Animation co-developed with people with lived experience to promote stigma free care.

Higher abnormal results were observed at the community health hubs, relative to standard NHS health check datasets.

98% would recommend the community health hub to others.

83% trust their GP surgery.

83% want improved primary care access.

76% would prefer health information and services to be promoted in public and community spaces.

Therapy 4 Healing & Modality Primary Care Network

Therapy 4 Healing was born in 2009 from a passion to 'service the community'. They work with many groups, organisations, companies and individuals to deliver our health and well being services across London and the south east.

Modality Primary Care Network comprises three practices:

- Bellingham Green Surgery
- South Lewisham Group Practice
- The Jenner Practice

Therapy 4 Healing & Modality Primary Care Network

Therapy 4 Healing and Modality Primary Care Network's partnership was deeply embedded in the community, prioritised and targeted health needs and established a health equity presence within the primary care network.

Community listening and engagement

- Community assets mapped and key data analysed.
- Listening at pre-existing community events, with 48 local venues attended, 95 community health outreach visits conducted, 1200 residents reached, and 159 residents interviewed.
  - Resident insights: Lack of GP access (digital exclusion and appointment system barriers), patient experience at point of access, appetite for socially prescribed complementary therapies.
- Local community champions and primary care network social prescribers engaged to support listening, offer health advice and signpost residents.

Health fairs and health promotion events

- Health fair hosted the Hummingbird Club as part of their Black History Month celebrations for Black African and Caribbean elders.
- Events delivered offered educational talks, blood pressure checks, complementary therapies and signposting information and resources from partnering voluntary and community sector organisations and community health services.
- Enhanced focus on hypertension, with a co-produced culturally sensitive blood pressure protocol, community organisation training workshop and re-designed practice systems.

Complementary health clinic

- 12-week evidence-based complementary health clinic with 72 sessions for 24 patients.
- Patients reported a reduced reliance on painkillers, improved mental health and a reduction in chronic pain levels.

360° Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

360° Lifestyle Support Network was set up in 2021 by a brother and sister duo and aims to make healthcare more accessible for Black African and Black Caribbean individuals.

Mabadiliko is passionate about creating workplaces and communities that are inclusive and provide equity for all racial groups. Their primary goal is to create opportunities for open and honest conversations about race.

Lewisham Care Partnership comprises five practices:

- Belmont Hill Surgery
- Hilly Fields Medical Centre
- Honor Oak Group Practice
- Morden Hill Surgery
- St Johns Medical Centre

360 Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

360° Lifestyle Support Network, Mabadiliko and The Lewisham Care Partnership co-produced and delivered a community-led, culturally-tailored group consultation programme for Black and Asian people living with type 2 diabetes.

The project was developed through extensive co-design with community members, community organisations and healthcare professionals. A Task and Finish Group helped shape the intervention's principles, content and delivery approach. Key features of the programme included:

- Cultural competency at the core of all materials and delivery.
- Integration of community knowledge and clinical expertise, drawing on lived experience.
- A focus on holistic wellbeing beyond medical management, with sessions covering nutrition, physical activity, emotional wellbeing, and medication.
- Building sustainable peer support networks and behaviour change.
- Empowerment of community members as champions, with training and support provided to eight former participants, building sustained community capacity.

Co-design insights

- Diabetes cultural stigma
- Lack of culturally appropriate dietary advice
- Limited access to community-based support
- Mental health is overlooked
- Systemic racism in healthcare

24
participants

9.5
mmol/mol average reduction in HbA1c

Reported behavioural outcomes

- Enhanced diabetes management understanding
- Improved dietary choices and portion control
- Increased physical activity and better stress management
- More proactive health-seeking behaviours

Reported wellbeing outcomes

- Increased confidence in self-management
- Stronger peer-to-peer support
- Better engagement with healthcare services
- Improved emotional wellbeing
- Enhanced cultural pride and identity

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Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 7

Title:	**Waldron Health and Wellbeing Hub**
Meeting Date:	**24th July 2025**
Author:	Fiona Kirkman, System Transformation Lead, NHS SEL ICS
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	To update the LCP Board on the new Waldron Community Space and Waldron Navigator roles.	Update / Information	**X**
		Discussion	
		Decision	
Summary of main points:	The Waldron Hub is a welcoming space for all, where residents can access local health and care services, find the information and advice they need to support their own health and wellbeing, and connect with their community and friends. The community space has been made freely available for voluntary, community, and social enterprise (VCSE) groups to run health-supporting activities and engage with residents, based on local health priorities. This report provides an overview of the key activities.		
Potential Conflicts of Interest	This report is for information.		
Any impact on BLACHIR recommendations	The activity at the Waldron supports opportunities for action as set out in the BLACHIR Report. Including: • Using life course approach and consider relevant findings to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people. • Work with Black African and Black Caribbean communities and organisations to cocreate and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.		

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

	Lewisham	✓	**Southwark**	
	Equality Impact	The aim of the community space at the Waldron is to support health and wellbeing, with specific focus on reducing health inequalities in the Black African and Black Caribbean community in North Lewisham. The model was established and tested as part of the Health Equity Fellow Programme; working with the community to build a thriving neighbourhood community hub" prioritising use of the community space based on local health priorities.		
	Financial Impact	**Report for Information.**		
Other Engagement	Public Engagement	In 2019 a Stakeholder Advisory Group was established to support the co-design process, advise on and direct the approach to stakeholder engagement for the Waldron Programme. Central to the community engagement was meaningful co-production, working with stakeholders with different needs and interests to co-create the ground floor space. Agreed principles were to: • Take an action-oriented approach that builds on innovative and evidenced practice to rapidly design, develop and test ideas for working differently • Focus on the Waldron and its surrounding community to demonstrate the potential of new ways of working and generate meaningful and tangible learning.		
	Other Committee Discussion/ Engagement	• Waldron Programme Board • North Lewisham Community Forum • New Cross Assembly Meeting 2020		
Recommendation:	To note the content of the report.			

South East London Integrated Care System

Lewisham Local Health and Care Partners Strategic Board

Waldron Health and Wellbeing Hub

24th July 2025

Fiona Kirkman, System Transformation Lead
NHS South East London ICS (Lewisham)

The Waldron Health and Wellbeing Hub

The Waldron Health Centre was built in 2008 to offer residents a range of integrated health and social care services. It quickly became a vital part of the community, offering GP surgeries, pharmacy, contraception and sexual health clinics, dentistry and a variety of community services to enhance physical and mental wellbeing.

Over the last 18 months, the Waldron Health Centre has received an investment of £2.3m to improve the space and has undergone significant change to remodel and update the building. Improvements delivered include:

- **Increased clinical and health space, works included creating** a new reception area, more clinical space to support the delivery of a wider range of services, and an interview room for medical appointments.

- A new community hub: situated on the ground floor, the hub is a welcoming space for all, where residents can access local health and care services, find the information and advice they need to support their own health and wellbeing, and connect with their community and friends. The community space has been made freely available for voluntary, community, and social enterprise (VCSE) groups to run health-supporting activities and engage with residents, based on local health priorities.

Waldron the vision

“Working together, we will create a welcoming space for everyone, where people can access local health and care services, find the information and advice they need to support their own health, wellbeing and independence and connect with their community and friends”

Prioritising use of the Waldron Space:

- Focus on Health inequalities
- Organisations developing community connections, health promotion and wellbeing
- Free use of space

Waldron Community Space

The new community space is provided free for local Community Groups, designed to support health and wellbeing and reduce health inequalities in North Lewisham. North Lewisham Primary Care Network ustilise NHS funded scheme to employ two Waldron Navigators and a Community Linkworker.

Use of the Community Space, there has been a steady increase in Voluntary and Community Sector groups using the space, this is increasing each month. 40% increase in bookings since January.

- Waldron Navigators signposting 1500 visitors every month
- High demand for the DWP advisor (Disability Advisor). New groups continue to be identified.
- International Women's Day, Social Prescribing event and Wellbeing days held in the Community space.
- Building relationships with other services in the building

Communications Review

- The ICB Comms and Engagement Team conducted a review to assess opportunities for maximising health promotion.
- **Waldron Content plan** produced. This includes making better use of digital screens, 'What's On', seasonal messaging and events.
- Waldron online Newsletter and links to online events and booking

Further development – Priorities

- Developing measures to evaluate the impact. Detailed report due in late July.
- Promoting the offer at the Waldron.
- Social Impact Review currently underway.
- Working with VCSE groups to support monitoring and evaluation - Priority.
- Strengthening links with wider community and stakeholders.
- Building creative health opportunities with local culture and arts organisations.
- Review role of the staff on the front desk.

Groups holding regular sessions in the community space

- 360 Lifestyle – Diabetes Peer support
- Action for Community Development
- Art sessions
- Bouake Diaspora
- Unakan
- Diamond Ecoute
- Broken Hearted Youth
- The Living Centre (Community Kitchen/Coffee Mornings)
- Empower Care
- Proud Feathers
- Imago Community (carers organisation)
- Lewisham Council – Shared Lives/Fostering Advice
- Red Ribbon
- DWP
- CITIZENS ADVICE Lewisham
- Reiki Sessions (Staff & Patient Wellbeing)
- Head & Neck Social Support Group
- Mindfulness & Meditation Sessions (PCN)
- Exercise Wellbeing Class (PCN)
- Eklohoun
- Bladder Bowel and pelvic health
- Sharing Real with Parents (early Years)
- Mindful mums
- Living well/Ending Well

The role of the Community Development Linkworker is critical in building links with local organisations to curate the offer at the Waldron. Priority booking is given to groups that reduce health inequalities in the Black African and Black Caribbean community.

250 - 300 people now attending sessions each month

Waldron Celebration – June 2025

On the 18th June 2025, the Mayor of Lewisham, Brenda Dacres, joined guests from across the local health and care system and community, to officially launch the Waldron.

The event, offered a chance for partners and service users to celebrate the progress made so far in delivering enhanced health and care services to residents.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 8
Enclosure 8

Title:	**Lewisham Risk Register**
Meeting Date:	**Thursday 24 July 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)
Strategic	**528. Access to Primary Care** There is a risk that patients may experience an inequality (and inequity) in access to primary care services.	⇔	Cautious (7–9)
Strategic	**529. Increase in vaccine** *preventable diseases* due to not reaching herd immunity coverage across the population. ***Childhood Immunisations***	↓	Cautious (7–9)
Strategic	**561. Increase in vaccine** *preventable diseases* due to not *reaching herd immunity coverage across the population* - ***Seasonal Vaccinations***	↓	Cautious (7–9)

Strategic	**334. Reduce acute pathway pressures and increase physical health checks for people with SMI** There is a risk that Lewisham does not deliver on key ambitions such as to reduce pressures in the acute mental health pathway and strengthen our early intervention and prevention offer and delivering physical health checks.	⟷	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)
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 (ASD) 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)
Operational	**610. INT Estate** There is a risk that one or more Integrated Neighbourhood Teams (INTs) will not have a base to work from at service go-live.	⟷	Eager (13-15)
Operational	**611. INT Digital** The Neighbourhood model may not operate optimally if there are issues with IT infrastructure and data interoperability	⟷	Eager (13-15)
Financial	**612. Healtheintent** Memorandum of Understanding (MOU) for funding the HealtheIntent (HI) platform, provided by Lewisham and Greenwich Place ICSs, is set to expire at the end of March 2026	⟷	Open (10-12)

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

↓ Risk has become worse.

⟷ Risk has stayed the same.

↑ Risk is improving.

2.Process

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

3. Risk Appetite Statement and Levels

The ICB's stated appetite for risk provides a framework within which decisions can be made in a way that balances risks and rewards, costs and benefits. The ICB risk appetite framework is designed to allow NHS SEL ICB to tolerate more risk in some areas than others as it seeks to deliver its responsibilities and achieve the ambitious aims for the local health and care system. Risk appetite is not about the extent to which the ICB will seek to make changes or maintain the status quo. It is about the extent to which the organisation is willing to take risks in the process of securing the change we know is needed. ***Appendix 1 – Risk Appetite Statement***.

	4.Local Care Partnership Risks - Comparative Review A comparative risk review takes place quarterly to ensure a proactive review across all 6 risk registers and their respective scores. The aim is to identify potential risks that should be considered for inclusion in LCP risk registers, comparable analysis of risks with suggestive similarities and/or contrasts. A new comparative review is attached, please refer to ***Appendix 2 – LCP Risks Comparative Review – April 2025.*** **5.New/Closed Risks/Matrix Scores** There is a total of **14 risks** on the Lewisham risk register. New, closed or reduced risks are detailed below: **New risks** **610 - INT Estates** – concern regarding limited suitable spare capacity within existing estate **611 - INT Digital** - issues with IT infrastructure and data interoperability **612 - Platform HealtheIntent** – contractual concern **Closed risks** **335** - Financial and staff resource risk in 2023/24 of high-cost packages through transition has been amalgamated into risk **334**. **347** - Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days. No longer considered a risk but listed on the issues log. **571** - Limited capacity in Adults Safeguarding. No longer a risk as lead has returned to role. An issue log is available 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)	↔	Ceri Jacob	Michael Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 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)	↔	Ceri Jacob	Michael Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 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	Strategic	Access to Primary Care Services	There is a risk that patients may experience an inequality (and inequity) in access to primary care services. The inequality in access may be caused by: 1.Patients not understanding the various routes to access primary care services and the appropriate alternatives that are available 2.GP Practices operating different access and triage models 3.Digital exclusion 4.Workforce challenges 5.Increasing demand It could lead to: Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls.	4x4=16	4x3=12	4x2=8	Cautious (7 – 9)	↔	Ceri 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	Strategic	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x4=12	3x4=12	3x3=9	Cautious (7 – 9)	↓	Ashley O'Shaughnessy	Mervlyn 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/Covid/polio. 9. Collaborative working with Population Health team to target smaller cohorts for flu vaccinations. 10. Seasonal vaccinations for 24/25 - targets 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. 12. The Lewisham Immunisations Strategy is currently being refreshed, led by Public Health. A review is scheduled for the next quarter in August, in preparation for the Autumn/Winter campaign. 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	Strategic	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Childhood Immunisation Programme	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x3=9	3x4=12	3x2=6	Cautious (7 – 9)	↓	Ashley O'Shaughnessy	Mervlyn 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. 12. Childhood vaccination programme is changing from July 2025 which will raise awareness to populations.	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. Following a review of the immunisations survey that was shared with all practices, we are now taking steps to act on the suggestions received.
Commissioning															
7	334	Strategic	Lewisham does not deliver on key ambitions committed to externally either in the operating plan or published in the Joint Forward Plan. Specific areas include (1) reduce acute pathway pressures (2) meet corporate objective of physical health checks for people with SMI	There is a risk that Lewisham does not deliver on key ambitions in the operating plan or published in the Joint Forward Plan, in part due to system financial pressures that impact ability to fund additional capacity to support specific project; improvement projects require repurposing of existing spend and engagement across stakeholders. Specific areas of challenge for delivery outlined in key strategy and operating plan submissions include: A. Ambition to reduce pressures in the acute mental health pathway and strengthen our early intervention and prevention offer if (1) community and voluntary sector mental health provisions, including the 24/7 community mental health offer for N2, do not deliver their intended objectives and (2) pathway flow is not optimised due to lack of transformation in discharge planning processes and access to suitable onward step-down options relevant to presenting needs (either in supported housing or specialist placements). B. Corporate objective of delivering physical health checks to 66.3% of the SMI GP registered list, and appropriate following up interventions will not be offered to this group, resulting in Lewisham not delivering on published ambitions to reduce health inequalities and close the mortality gap for people living with SM	4x4=16	3x4=12	2x3=6	Open (10–12)	↔	Kenny Gregory	Ellen McGale	1. Mental Health Alliance holding oversight of the all-age delivery of mental health provision, bringing together stakeholders across health, social care and the voluntary sector with a view to collectively agreeing priorities for change/improvement and solutions and seeking system buy-in. A specific area of focus through the Alliance is the CRFD/flow position, reviewing with system stakeholders the drivers and blockages and how these may be managed and better planned for. 2. Alliance sub-group established and work plan developed with key objectives for improvement in the adult community offer and outcomes to be delivered ; action plan from CMH stocktake developed. 3. N2 pilot in 'initial phase' of delivery, offering a new model of care, and group established to oversee delivery of transformation, with updates routinely being brought to the Alliance for scrutiny. 4. Programme of reviews of voluntary sector provisions to scheduled to explore delivery against specifications and value for money. 5. MH Alliance assurance framework includes elements of flow and CRFDs from SLAM IQ&P report and is being brought to the Alliance. 6. Physical health checks and SMI working group meeting fortnightly with key leads across commissioning, primary care and SLAM with a clear milestone/delivery plan for delivering improvements e.g. practices identified that are under-delivering and improvement plans put in place with monthly check-in calls, and working with SLAM and LGT to ascertain what data has been collated on physical health checks elsewhere.	Alliance assurance framework - scrutiny of IQ&P reports Alliance working group on community transformation and crisis care SLaM Stocktake of CMHS through Quality Centre to understand impact of CMHS transformation. Physical health check and SMI data dashboard reviewed during monthly sub-group meetings; enables interrogation by sex, ethnicity, age etc for more targeted engagement work	Initial improvement in healthchecks; GP practices currently delivering <40% have agreed to submit improvement plans to meet the 66.63% by Jan 25.	1. N2 community pilot delayed and lack of clarity around how initial offer is differing from existing model and adding value and how any learning will be shared 2. Need to review drivers of acute presentations and CRFDs to explore both upstream and downstream changes to provision that may be required 3. Update on action plan from community stocktake to be undertaken 4. Improvement plans from practices to be reviewed/ratified and monitoring plans to be put in place 5. Improvement plans to target population groups with 0 health checks to be developed 6. Working group to develop understanding of follow up plans for those receiving checks and share best practice to ensure checks are not just undertaken but findings are enacted upon to enable progress to be made in addressing health inequalities
8	506	Financial	The CHC outturn for Adults will not deliver in line with budget	Pressure in adult spend is being driven by a number of variables: Activity and Acuity The number of complex transition cases at high cost appears to have decreased during 2024/25, but this is still a risk due to high long term care costs associated with these cases. CHC continues to see an increase in patient acuity in the 24/25 year particularly in terms of PoC at home for patients requiring tracheotomy care and other health related tasks needing specialist care worker input. There has been an increase in Home Care Packages in 2024/25. The numbers that required tracheotomy care increased by 3. Numbers of newly eligible for CHC appear to have decreased in 2024/2025 for all Care Categories. Uplifts Alongside this is the pressure caused generally by costs of existing packages being driven up by inflation and increases in both NLW and LLW and the hourly rate for homecare included within the MWAH framework. There was a 5.1% increase in the AQP rate (2025/26). New rate is £1,247 per week. 1.5% uplift has been offered to Fairlie Group and we are awaiting to see if they accept. Local Authority are recommending 5% uplift for Direct Payment rate. SEL ICB have been alerted to the Stoke Judgement and may need to change their approach to Uplift Offers to social care providers. Recovery Work We have made good progress in decreasing the number of delayed reviews, especially during the second half of 2024/25. However, opportunities for savings are still being delayed whilst we await Social Care input to the DST. Workforce Staff vacancies and sickness in the CHC Team which were impacting on timely reviews and completion of Decision Support Tools have largely been addressed by the use of agency staff and overtime. However, many of these solutions are short term and likely to be impacted by the ongoing MCR/ICB Change process.	5x4=20	4x3=12	4x3=12	Open (10–12)	↔	Kenny Gregory	Corinne Moocarme	1. Interim Nurse Assessor concentrating on high-cost packages to deliver savings. Prioritisation of reviews of long-term fast track packages 2. Attendance at quarterly Transition panels to support better understanding of demand and potential cost, supports improvement of <18 assessment in line with the Framework, increases possibility of deflecting unnecessarily high costs/ SEND decisions 3.Quarterly review of joint funding funded packages to divert risk 4.Cost avoidance of the increase in the existing ICB contract with Fairlie/ Highfield Consideration through identification of more cost-effective packages with other providers (e.g. RHND and PoCs at home. 5. Monthly budget review meetings 6. Weekly review of CHC eligibility decisions and related cost of packages 7. Monthly review of neuro specialist patients to manage associated trim point costs and escalating earlier where there are blockages to discharge not in the control of the ICB	Prioritising review of all new LD packages transferring from LBL to look for savings opportunities Prioritise outstanding reviews and ensure that annual reviews revert to BAU for CHC Nurse Assessors Participating in wider SEL ICB CHC savings programme	Pressure from other CHC priorities (particularly appeals/ LRMs/ IRPs) continue to take significant management time and attention Allocation of Social Worker by LBL may still delay timely completion of DST	1.Potential patient safety issues through the reduction in packages – all reductions are reviewed in dialogue with both patient and service provider 2. Reputation of the ICB with Council/other partners – LBL regularly updated on progress against assessment, though there are several long term outstanding disputes 3. Increase in complaints because of reduction in packages, or decision to remove CHC eligibility. 4. Assessing nurse to be clear about the rationale for the reduction in package or no longer eligible and this explanation to be put in writing at time decrease/change from CHC eligible is being enacted.
Children and Young People															
9	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 Creech	1.GPs are being rotated from Primary Care into community paediatrics to support some activity and free time for statutory CMPS work. There has been limited uptake from GPs so no further scope to expand. 2. Paediatric Nurse in place to support medical work which does not require a Paediatrician. 3. Ongoing recruitment - Recruitment has improved, demand still higher than capacity. 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. 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. 7. SDIP to recruit additional staff and increase the number of nurses supporting assessments.	Monitoring ongoing to gauge impacts of controls. New Head of Integrated SEND is now in place and attending monitoring meetings. SDIP - monitoring meeting as part of the SDIP process	Increase in EHCPs health assessments being completed on time.	1. Families not attending appointments., 2. Appointments changed. 3. Delayed paperwork (service user end). 4. Increase in EHCP requests.
10	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 Creech	1.Quarterly review of ASD assessments with LCG, includes audit of initial assessments. 2.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.Recruitment ongoing. 1.2wte vacancies at present and another round of recruitment due. In terms of capacity, clinical staff assessing ECHP will prioritise where possible ASD assessments too to assist with work demands. 5. Outsourced some assessment capacity for CYP waiting the longest to reduce the backlog (outsourced 200 assessments in progress). 6. SDIP in progress to increase capacity. 7.Steering group meeting to review the Autism transformation pathway.	Monitoring ongoing to gauge impacts of controls via Quarterly monitoring meetings. Steering group for transformation work.	Reduction in waiting times for assessments.	Availability of partners to undertake joint ASD assessments. Biggest control gap is staffing capacity and increasing demand.

11	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	Ceri 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.
Enablers															
12	610	Operational	**INT Estate**	There is a risk that one or more Integrated Neighbourhood Teams (INTs) will not have a base to work from at service go-live. It is caused by: • Limited suitable spare capacity within existing estate •Lack of financial resources to extend, repurpose existing estate or secure new opportunities It could lead to: • Service is not able to start or will not operate to desired state • Difficulty recruiting to posts	3x3=9	3x3=9	4x1	Eager (13-15)		Charles Malcolm-Smith	Laura Jenner	1. AD System Development has provided scope and requirements for INTs for ICB Estates team to undertake an estates search 2. ICB Estates team have established relationships with PCNs and primary care. ICB Estates team have commissioned a comprehensive review of PCN estate 3. Regular Lewisham Estates Forum meetings bring together partner estates leads to share issues; AD System Development has provided INT updates 4. Neighbourhood 1 admin and clinical/consultation space identified at Waldron Health Centre 5. Neighbourhood 2 and Neighbourhood 3 potential community hub space identified; to be assessed for admin and clinical/consultation use capacity and suitability	ICB Estates team is undertaking an estates search to meet INT team and community hub requirements	Further work required for Neighbourhoods 2,3,4	Quality of service will be affected if suitable space not identified, for instance patient and team communication, access to systems, individual assessments and team interventions may not be possible.
13	611	Operational	**INT Digital**	The Neighbourhood model may not operate optimally if there are issues with IT infrastructure and data interoperability. It is caused by: •Reliance on data sharing using digital systems for coordinating care and between multiple service providers It could lead to: •Duplication and lack of truly integrated approach	4x3=12	4x3=12	4x2=8	Eager (13-15)		Charles Malcolm-Smith	Laura Jenner	1. System Development Manager has developed digital pathway for INT service, reviewed by INT programme team and shared with ICB and LGT digital leads to ensure understanding of digital requirements 2. Regular meetings with ICB digital leads and completed INT digital needs assessment 3. Demonstrations and discussions on potential platforms to integrate systems including Blinx PACO, Patienteer and Accurx	Continuing development of digital requirements with partner IT/Digital Teams and IG Leads; potential to procure digital platform to help integrate patient data from multiple providers. Current as-is INT digital pathway allows for existing data-sharing process, so service can still operate without integrated data platform if solution is not sourced prior to September 2025.	Lack of clarity of optimal solution Lack of identified funding to procure optimal digital solution	Quality of service will be affected if data cannot be shared between service providers.
14	612	Clinical, Quality and Safety	**HealtheIntent (HI)**	The current Memorandum of Understanding (MOU) for funding the HealtheIntent (HI) platform, provided by Lewisham and Greenwich Place ICSs, is set to expire at the end of March 2026. It is unlikely that LGT would be able to continue funding the platform independently beyond that point. The HI contract itself runs until March 2027, in parallel with the Oracle Millennium contract. As such, a decision needs to be made regarding the future of the HI platform, with the following options available. HealtheIntent is a digital platform which allows healthcare professionals to provide more proactive care to residents and communities. Options for HI Platform Contract: 1.Terminate at March 2026. Give six months' notice to Oracle by the end of September 2025. Platform would cease in March 2026. 2.Extend Beyond March 2026 (Temporarily). Continue for a TBC defined period beyond March 2026. Six months' notice can technically be served at any point during the contract period. 3.Maintain HI Until Contract End (March 2027). No early termination; platform remains active through the full contract term. If Termination Notice is served a plan will be needed to: •Pause, archive, or store the existing work at the end of the notice period •Or transfer some or all of the work and data to another environment where delivery can continue.	4x4=12	4x4=12	4x2=8	Cautious (7 – 9)		Rachael Smith	Laura Jenner	1. We are setting out the data and platform requirements for PHM, the timelines and the decommissioning plans 2. We will set out the initial view of our requirements, indicative timelines, and a draft decommissioning plan. 3. We are engaging with the SEL PHM team to explore and gather options for meeting our requirements through alternative solutions and to understand the gaps. E.g. LDS, SEL BI Team July to end of September.	This period will be used to assess the available options, consider the implications, and ultimately decide whether to give notice on the HealtheIntent contract by the end of September 2025.	There is a lack of information available across London and SEL on what the options are for meeting our requirements	The quality of case finding to support MDMs, INTs, PAW, and other delivery arms will be significantly compromised if we are unable to continue or replicate the work currently being undertaken to generate and maintain cohort lists.

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.*

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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

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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 9
Enclosure 9

Title:	**Month 2 Finance Report 2025/26**
Meeting Date:	**24th July 2025**
Author:	Michael Cunningham
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board on the ICB - Lewisham Place financial position at month 2 2025/26. A month 2 position is also included for the wider ICB/ICS and Lewisham Council (2024/25 outturn also included).	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

Month 2 2025/26 – SEL ICB – Lewisham Place

At month 2, the borough is reporting an underspend of £24k compared to a target of breakeven. All budget areas individually are showing breakeven or an underspend except for continuing care services (CHC), prescribing, and primary care. At month 2 the forecast outturn for the year overall is breakeven.

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

Month 2 2025/26 – Lewisham Council

At month 2 Adult Social Care is forecasting an underspend of £2.5m. it should be noted this is non recurrent assuming bring forward of 2026/27 savings schemes for which budget has not yet been removed. Further details are included in this report.

Month 2 2025/26 – SEL ICB

The ICB is reporting a break-even position at month 2 in line with plan. The forecast outturn is also breakeven

Further details of the ICB position are shown within Appendix A to this report.

	Month 2 2025/26 – SEL ICS The ICS financial plan is to deliver a breakeven position. This is after receipt of non-recurrent deficit support funding of £75m. At month 2 the ICS is reporting a YTD deficit of £21.1m, £6.9m adverse to plan. The main driver is slippage in efficiency programmes £6.6m. The forecast outturn is breakeven in line with the ICS financial plan. Further details of the ICS position are shown at Appendix B to this report.			
Potential Conflicts of Interest	Not applicable			
Any impact on BLACHIR recommendations	Not applicable			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Not applicable		
	Financial Impact	The paper sets out the financial position at month 2 2025/26.		
Other Engagement	Public Engagement	Not applicable		
	Other Committee Discussion/ Engagement	The ICB Finance Report Appendix A is a standing item at the ICB Planning and Finance Committee.		
Recommendation:	The Lewisham Health & Care Partners Strategic Board is asked to **note** the month 2 financial position for 2025/26.			

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Lewisham LCP Finance Report

Month 2 – 2025/26

ICB – Lewisham Delegated Budget – Month 2 2025-26

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Overall Position

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	226	226	(0)	1,358	1,358	(0)
Community Health Services	5,677	5,081	597	34,064	30,478	3,586
Mental Health Services	1,329	1,452	(123)	7,906	8,605	(699)
Continuing Care Services	4,236	4,714	(477)	25,418	28,282	(2,864)
Prescribing	7,060	7,060	0	43,920	43,920	0
Prescribing Reserves	0	0	0	0	0	0
Other Primary Care Services	341	344	(4)	2,043	2,065	(22)
Other Programme Services	4	4	0	26	26	0
Delegated Primary Care Services	11,967	11,967	0	71,800	71,800	0
Corporate Budgets	529	498	31	3,176	3,176	0
Total	**31,370**	**31,346**	**24**	**189,712**	**189,711**	**1**

- At month 2, the borough is reporting an underspend year to date (YTD) of £24k and a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC), mental health and a small overspend on other primary care.
- CHC shows a material overspend YTD of £477k and FOT overspend of £2,864k . The run rate on adults CHC is reasonably constant with the closing position from 2024/25, whilst the run rate on children's services has increased c.£500k reflecting new packages of care. Twice monthly recovery meetings continue with the adult's team and a meeting is being set up with the children's team to understand the current position compared to 2024/25 outturn.
- The mental health position is driven by costs incurred with independent providers for ADHD which are reflecting a significant increase in demand for these services impacting all places across SEL and beyond. A co-ordinated review of these costs and activity has been conducted at an SEL level with local input to better understand these cost movements. There appears little opportunity in year for mitigation given levels of demand and the borough will need to plan to mitigate this pressure from other budget lines within the delegated budget.
- Current year activity and cost information is not yet available for prescribing which is therefore being shown as a breakeven position for month 2 YTD and FOT.
- The borough 5% efficiency target is £8,975k, is fully identified and at this stage forecast to deliver in full, although there is slippage of £127k in adult CHC achievement at month 2.

Month 2 2025-26 – Lewisham Council

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Overall Position M2 2025/26

2025/26 Efficiencies	Year-to-date Month 2 2025/26				Full-Year Forecast 2025/26		
	Plan	Forecast	Variance		Plan	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	0.6	0.6	0.0		3.7	3.7	0.0
Childrens Care Services	TBC	TBC	0.0		TBC	TBC	0.0
Total	**0.6**	**0.6**	**0.0**		**3.7**	**3.7**	**0.0**

2025/26 LBL Managed Budgets	Year-to-date Month 2 2025/26				Full-Year Forecast 2025/26		
	Budget	Forecast	Variance		Budget	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	15.3	14.9	0.4		91.9	89.4	2.5
Childrens Care Services	TBC	TBC	0.0		TBC	TBC	0.0
Total	**15.3**	**14.9**	**0.4**		**91.9**	**89.4**	**2.5**

Overall Position 2024/25 Outturn

2024/25 Efficiencies	Full-Year Forecast 2024/25		
	Plan	Out-turn	Variance
	£m	£m	£m
Adult Care Services	3.7	3.0	(0.7)
Childrens Care Services	TBC	TBC	0.0
Total	**3.7**	**3.0**	**(0.7)**

2024/25 LBL Managed Budgets	Full-Year Forecast 2024/25		
	Budget	Out-turn	Variance
	£m	£m	£m
Adult Care Services	77.9	86.5	(8.6)
Childrens Care Services	TBC	TBC	0.0
Total	**77.9**	**86.5**	**(8.6)**

Adults Commentary: M2 2025/26

The Adult Social Care & Health Directorate is forecasting a (£2.5m) underspend for 2025/26. This forecast is predicated on a number of assumptions around full delivery of 25/26 savings target and additional early delivery of 26/27 savings target.

There however remain underlying pressures in demand for packages of care driven by increase in number of clients and higher average weekly cost per package. In fact, one of the greatest challenges will be around fee uplift negotiations with Providers as there continues to be a mismatch between their expectations driven by general inflation and LLW and available resources constrained by Government funding

Other areas of risk as similar to prior year as we continue to manage early discharge from hospitals and complex care demand from that cohort. There is also ongoing risk in costs of packages of children transitioning into . The council is working full tilt to manage these risks.

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

Adults Commentary: 2024/25

The Adult Social Care & Health Directorate out-turn is £8.6m overspend. There is a £3.5m variance to forecast from last reported position. The movement relates to shortfall in planned savings as well as higher than expected packages of Care spend. There was also significant income contributions for S117 (£1.4m) that did not materialise.

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

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Appendix A

SEL ICB Finance Report

Month 2 2025/26

Contents

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Appendices

1. Key Financial Indicators

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 2, the ICB is reporting a year to date (YTD) and forecast out-turn (FOT) **break-even position** against its revenue resource limit (RRL) and financial plan. Within this reporting, the ICB has delivered circa 93% of its YTD savings requirement.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year-end.**
- The ICB is showing a YTD overspend of **£26k** against the running cost budget. However, this is expected to be break-even at the year end.
- All other financial duties have been delivered for the year to month 2 period.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	956,635	956,635	5,692,667	5,692,667	
Operating Under Resource Revenue Limit	956,635	956,635	5,692,667	5,692,667	
Not to exceed Running Cost Allowance	5,088	5,114	30,528	30,528	
Month End Cash Position (expected to be below target)	5,688	2,164			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	100.0%			
95% of non-NHS creditor payments within 30 days	95.0%	95.4%			
Mental Health Investment Standard (Annual)			534,854	544,483	

2. Executive Summary

NHS South East London

- This report sets out the month 2 financial position of the ICB. The financial reporting is based upon the final plan submission. This included a **planned break-even position** for the ICB.
- The ICB's financial allocation as at month 2 is **£5,692,667k.** In month, the ICB has received an additional **£51,058k** of allocations. These are as detailed on the following slide.
- As at month 2, the ICB is reporting a year to date (YTD) **break-even** position. Within this reporting, the ICB has delivered **£8.7m of savings** compared to the plan value of £9.4m.
- Due to the usual time lag, the ICB has not yet received any 2526 prescribing data - a break-even position is being reported against these budgets. We have received the final prescribing position for 2425, which was in line with the estimate made in the year-end accounts. Therefore, this will have no adverse impact upon 2526.
- The **continuing care** financial position is **£756k overspent** at month 2. The boroughs which are most impacted with overspends are Lewisham, Greenwich and Bromley which is a continuation of the trend from last year. Southwark has a small underspend, and Lambeth and Bexley are reporting break-even positions.
- The YTD position for **Mental Health** services is an overall **overspend** of **£1,093k**. The pressures on cost per case services are differential across boroughs with Bromley, Greenwich, Lambeth and Southwark being the most impacted. ADHD and ASD assessments are a pressure in all boroughs and the activity and costs have increased significantly in the early part of this financial year.
- The ICB is continuing to incur pay costs for the remaining displaced staff following the original MCR process. All associated costs are charged to the balance sheet provision which was set up for this purpose. Some staff will be leaving the ICB in June, which will still leave a small number of impacted staff who remain at the ICB.
- Three places are reporting overspends YTD at month 2 – **Bromley (£198k), Greenwich £329k, and Lambeth £78k**. However, a break-even position is forecast for all places. More detail regarding the individual place financial positions is provided later in this report.
- In reporting this month 2 position, the ICB has delivered the following financial duties:
    - Minor overspend **(£26k YTD)** against its management costs allocation, with the monthly cost of displaced staff being charged against the provision. The forecast outturn position on running costs is break-even.
    - Delivering all targets under the **Better Practice Payments code**;
    - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance.
- As at month 2 the ICB is reporting a **forecast break-even position** against its financial plan. More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

3. Revenue Resource Limit (RRL)

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	**161,660**	**273,947**	**194,703**	**237,803**	**189,711**	**187,894**	**4,395,891**	**5,641,609**
M2 Internal Adjustments								
In month internal movements	-	-	-	-	-	-	-	-
M2 Allocations								
25/26 Opening Baseline - Delegated Acute adj	-	-	-	-	-	-	17,818	**17,818**
Depreciation/amortisation - Additional Ringfenced Funding	-	-	-	-	-	-	20,290	**20,290**
Adjustment to reflect DPR plan details	-	-	-	-	-	-	-5,800	**(5,800)**
Q1 Deficit Support Funding	-	-	-	-	-	-	18,750	**18,750**
M2 Budget	**161,660**	**273,947**	**194,703**	**237,803**	**189,711**	**187,894**	**4,446,950**	**5,692,667**

- The table sets out the Revenue Resource Limit (RRL) at month 2.
- The start allocation of **£5,641,609k** is consistent with the Operating Plan submissions.
- During month 2, no internal adjustments were actioned.
- In month, the ICB has received an additional **£51,058k** of allocations, giving the ICB a total allocation of **£5,692,667k** at month 2**.** The additional allocations received in month were in respect of a delegated acute adjustment for specialised commissioning **£17,818k**, depreciation funding for providers **£20,290k**, an adjustment for specialised commissioning **(-£5,800k)** and **£18,750k** in respect of deficit support funding for Q1.
- Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

4. Budget Overview

NHS South East London

	M02 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	838	1,353	1,152	81	226	43	546,300	**549,994**
Community Health Services	4,235	15,767	6,731	4,978	5,677	6,295	46,670	**90,354**
Mental Health Services	1,775	2,438	1,459	3,956	1,329	1,777	106,654	**119,387**
Continuing Care Services	4,452	4,689	5,051	5,985	4,236	3,420	-	**27,833**
Prescribing	6,288	8,459	6,180	7,069	7,060	5,819	(72)	**40,802**
Other Primary Care Services	250	338	322	659	341	167	2,299	**4,375**
Other Programme Services	204	-	299	-	-	99	4,558	**5,160**
Programme Wide Projects	-	-	-	-	4	43	1,085	**1,133**
Delegated Primary Care Services	8,179	11,718	10,464	15,900	11,967	12,784	(338)	**70,674**
Delegated Primary Care Services DPO	-	-	-	-	-	-	36,729	**36,729**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	491	585	577	758	529	667	6,587	**10,194**
Total Year to Date Budget	**26,712**	**45,347**	**32,234**	**39,386**	**31,370**	**31,112**	**750,473**	**956,635**

	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	838	1,353	1,152	81	226	43	546,283	**549,976**
Community Health Services	4,235	15,767	6,731	4,978	5,081	6,108	46,671	**89,571**
Mental Health Services	1,786	2,627	1,815	4,048	1,452	2,054	106,698	**120,480**
Continuing Care Services	4,452	4,776	5,327	5,985	4,714	3,337	-	**28,590**
Prescribing	6,288	8,459	6,180	7,069	7,060	5,819	(72)	**40,802**
Other Primary Care Services	250	338	322	659	344	167	2,299	**4,379**
Other Programme Services	204	-	-	-	-	99	4,170	**4,473**
Programme Wide Projects	-	-	-	-	4	36	1,085	**1,125**
Delegated Primary Care Services	8,179	11,718	10,464	15,900	11,967	12,784	(338)	**70,674**
Delegated Primary Care Services DPO	-	-	-	-	-	-	36,729	**36,729**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	454	507	573	743	498	632	6,428	**9,836**
Total Year to Date Actual	**26,686**	**45,545**	**32,562**	**39,464**	**31,346**	**31,078**	**749,954**	**956,635**

	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	(0)	0	0	(0)	(0)	0	18	**18**
Community Health Services	(0)	0	0	0	597	187	(0)	**783**
Mental Health Services	(11)	(189)	(357)	(92)	(123)	(278)	(44)	**(1,093)**
Continuing Care Services	0	(86)	(275)	0	(477)	83	-	**(756)**
Prescribing	-	-	-	-	-	-	-	-
Other Primary Care Services	(0)	(0)	0	(0)	(4)	(0)	0	**(4)**
Other Programme Services	-	-	299	-	-	-	387	**687**
Programme Wide Projects	-	-	-	-	-	7	0	**7**
Delegated Primary Care Services	-	-	-	-	-	0	-	**0**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(0)	**(0)**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	37	77	4	15	31	35	159	**358**
Total Year to Date Variance	**27**	**(198)**	**(329)**	**(78)**	**24**	**35**	**520**	**0**

- As at month 2, the ICB is reporting an overall year to date (YTD) **break-even** position, with emerging pressures in specific budgets.
- Due to the usual time lag, the ICB has not yet received any 25/26 prescribing data and so is reporting a break-even position against these budgets. For next month, the ICB will have the YTD information for April.
- We have received the final prescribing position for 2425, which was in line with the estimate made in the year-end accounts. Therefore, this will have no adverse impact upon 2526.
- The continuing care financial position is £756k overspent at month 2. The boroughs which are most impacted with overspends are Lewisham, Greenwich and Bromley which is a continuation of the trend from last year. Southwark has a small underspend and Lambeth and Bexley are reporting breakeven positions for these budgets.
- The YTD position for Mental Health services is an overall overspend of £1,093k. The pressures on cost per case services are differential across boroughs with Bromley, Greenwich, Lambeth and Southwark being the most impacted. ADHD and ASD assessments are a pressure in all boroughs and the activity and costs have increased significantly in the early part of this financial year.
- The ICB is continuing to incur pay costs for the remaining displaced staff following the original MCR process. All associated costs are charged to the balance sheet provision which was set up for this purpose. Some staff will be leaving the ICB in June, which will still leave a small number of impacted staff who remain at the ICB.
- Three places are reporting overspends YTD at month 2 – Bromley (£198k), Greenwich £329k, and Lambeth £78k. However, a break-even position is forecast for all places. More detail regarding the individual place financial positions is provided later in this report.

5. NHS Continuing Healthcare

NHS South East London

- As of Month 2, the CHC budget reflects an overall overspend of **£756k**. Cost pressures vary across boroughs: **Lewisham, Bromley, and Greenwich** are reporting overspends, while **Bexley and Lambeth** are break-even, and **Southwark** shows an **underspend of £83k**.

- **Lewisham** is the largest contributor to the overspend at **£477k**, primarily driven by high costs among palliative care clients. The reported figure includes **£176k** for anticipated provider price increases.

- **Bromley** is reporting an **£86k overspend**, largely due to a provision of **£131k** for potential future price increases agreed with providers.

- **Greenwich** has an overspend of **£275k**, mainly attributed to a **£179k** provision for provider price increases and costs associated with Funded Nursing Care (FNC) clients.

- To manage provider price uplifts, an **ICB panel** has been established to review all price increase requests exceeding **1.5%**, meeting weekly to ensure consistency across the ICB, and to contain cost escalation. All borough financial positions include a provision for a **4% inflationary uplift**.

- On savings delivery, all boroughs have identified and made progress against their CHC savings plans, with **one borough exceeding its target**. However, increasing levels of activity and the prevalence of high-cost patients continue to create ongoing financial pressures on the CHC budget.

6. Provider Position

NHS South East London

Overview:

- This is the most material area of ICB spend and relates to contractual expenditure with NHS and Non-NHS acute, community and mental health providers, much of which is within block contracts.

- In year, the ICB is forecasting to spend circa **£4,275,527k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£1,075,902k**
    - Kings College Hospital **£1,162,501k**
    - Lewisham and Greenwich **£747,918k**
    - South London and the Maudsley **£365,160k**
    - Oxleas **£325,176k**

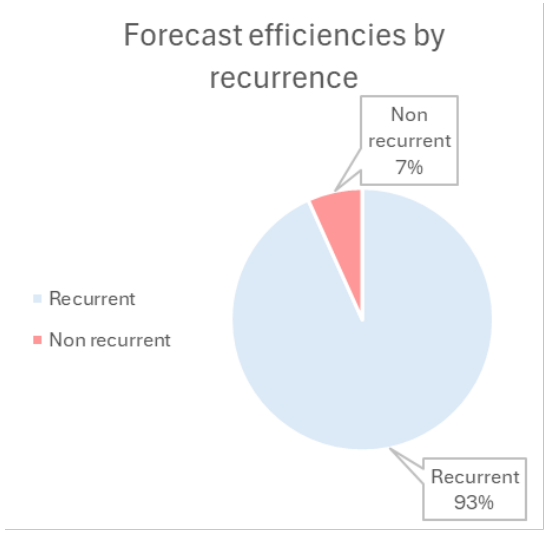
- In month, the ICB position is showing a break-even position on these NHS services, and a break-even position has also been reflected as the forecast year-end position.

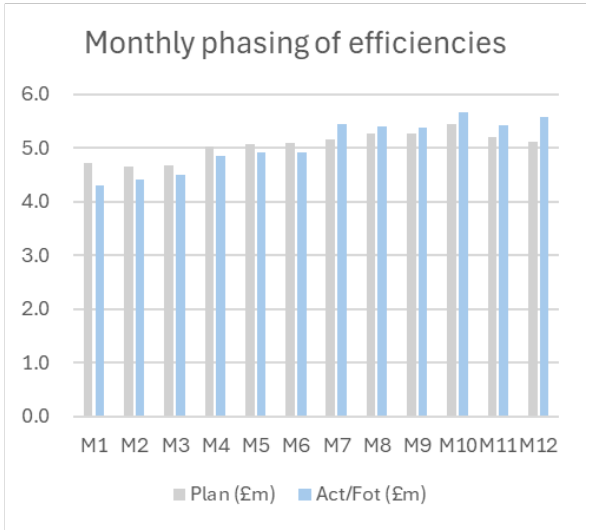
7. ICB Efficiency Schemes at as Month 2

NHS South East London

- The 6 places within the ICB have a total savings plan for 2025/26 of **£60.7m.** In common with the previous financial year, the key elements of the savings plans are in prescribing, continuing healthcare (CHC) and community services.
- The table to the right sets out the YTD and forecast status of the ICB's efficiency schemes as at month 2.
- **As at month 2, overall, the ICB is reporting actual delivery of £8.7m slightly behind of plan (£9.4m).** At this stage in the financial year, it is too early for trends to emerge, but the annual forecast is to slightly exceed the efficiency plan **(by £0.1m),** although this will need ongoing close monitoring.
- The current risk rating of the efficiency plan is also reported. At this stage in the year, **£4.4m** of the forecast outturn of has been assessed by the places as **high risk.**
- Most of the savings **(93%)** are forecast to be delivered on a recurrent basis.

	M2 YTD			Forecast YE			Forecast - Risk		
	Plan	Actual	Variance	Plan	Forecast	Variance	Low	Medium	High
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	1.3	1.3	0.0	7.7	7.7	0.0	4.7	3.1	0.0
Bromley	2.2	2.2	0.0	13.1	13.1	0.0	8.6	3.9	0.6
Greenwich	1.6	1.6	0.0	9.4	9.4	0.0	6.8	1.6	1.1
Lambeth	1.7	1.2	(0.5)	12.6	12.6	0.0	1.0	9.1	2.4
Lewisham	1.5	1.4	(0.1)	9.0	9.1	0.1	3.0	6.0	0.0
Southwark	1.2	1.2	(0.0)	8.9	8.9	(0.0)	6.7	1.8	0.3
SEL ICB Total	**9.4**	**8.7**	**(0.7)**	**60.7**	**60.8**	**0.1**	**30.8**	**25.5**	**4.4**





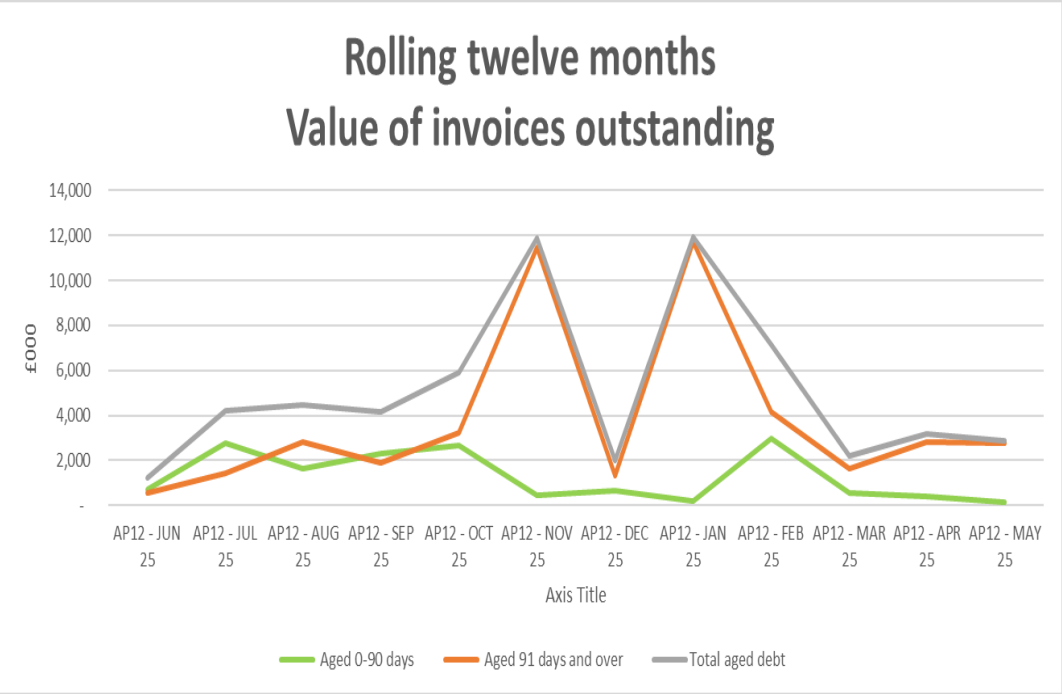
8. Corporate Costs – Programme and Running Costs

NHS South East London

Area		Year to Date		
	Annual Budget	Budget	Actual	Variance
Boroughs	£	£	£	£
Bexley	2,690,709	448,451	411,033	37,419
Bromley	3,343,200	557,200	479,824	77,376
Greenwich	3,179,603	529,934	525,860	4,074
Lambeth	4,189,976	698,329	683,761	14,568
Lewisham	2,960,448	493,408	462,424	30,984
Southwark	3,758,559	626,426	591,470	34,957
Subtotal	20,122,495	3,353,749	3,154,371	199,378
Central				
CESEL	461,543	76,924	38,762	38,162
Chief of Staff	3,252,466	542,078	531,269	10,809
Comms & Engagement	1,702,148	283,691	261,064	22,628
Digital	1,696,449	282,742	250,261	32,481
Digital - IM&T	3,251,039	541,840	532,571	9,269
Estates	670,163	111,694	146,455	(34,761)
Executive Team/GB	2,516,029	419,338	381,752	37,586
Finance	2,844,256	474,043	408,878	65,164
General Reserves	-	-	0	(0)
London ICS Network	(0)	-	0	(0)
Medical Director - CCPL	1,613,413	268,902	276,231	(7,329)
Medical Director - ICS	278,282	46,380	38,589	7,791
Medicines Optimisation	4,583,281	763,880	645,129	118,751
Planning & Commissioning	8,555,671	1,425,945	1,266,311	159,634
Quality & Nursing	1,990,734	331,789	278,059	53,730
SEL Other	-	-	0	(0)
South East London	-	-	36,912	(36,912)
Subtotal	33,415,473	5,569,246	5,092,244	477,001
Grand Total	53,537,968	8,922,995	8,246,615	676,380

- The table shows the YTD month 2 position on programme and running cost corporate budgets.
- The ICB is continuing to incur the pay costs for staff at risk from the original MCR process, but these costs are not included in the table opposite as the costs are being charged to the provision made for the final pay costs and redundancy costs for this group of staff.
- The process of issuing notices to at risk staff has largely been completed with most of redundancy payments now having been made. Some staff will leave the ICB in June, which will leave just a small number of people who remain but have been displaced through this process.
- Work is ongoing to comply with latest request to restructure the ICB per the NHSE blueprint document. The impact of this work will be seen via this report later in the year.
- **Overall, the ICB is reporting an overall YTD underspend on its corporate costs of circa £676k,** which is largely a result of vacant posts.
- As highlighted in earlier slides, the ICB is **overspending (£26k YTD)** against its **management (running) costs** allocation of **£30,528k, however a year end break-even position is being forecast.**

9. Debtors Position



Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	66	0	75	(11)	2	0	132
Non-NHS	507	1,217	77	23	461	462	2,747
Unallocated	0	0	0	0	0	0	0
Total	**573**	**1,217**	**152**	**12**	**463**	**462**	**2,879**

- The ICB has an overall debt position of **£2,879k** at month 2. This is circa **£314k lower** when compared to last month. The age profile of debtors is very similar to last month. Of the current debt, there was only **£925k** of debt over 3 months old, of which **£923k** has now been **settled. The largest debtor values are with partner organisations and the ICB does not envisage any risk associated with settlement of these items.**
- The ICB has implemented a BAU approach to debt management, focusing on ensuring recovery of its larger debts, and in minimising debts over 3 months old. This will be especially important as we move to a new ISFE2 ledger on 1st October 2025. Regular meetings with SBS are assisting in the collection of debt, with a focus on debt over 90 days.
- The top 10 aged debtors are provided in the table below:

Number	Supplier Name	Total Value £000	Aged 0-90 days Value £000	Aged 91 days and over Value £000
1	LONDON BOROUGH OF BROMLEY	1,483	561	922
2	BROMLEY HEALTHCARE LIMITED	642	642	-
3	ROYAL BOROUGH OF GREENWICH	257	257	-
4	NHS ENGLAND	110	110	-
5	SOUTHWARK LONDON BOROUGH COUNCIL	81	81	-
6	LEWISHAM LONDON BOROUGH COUNCIL	70	70	-
7	CHANGE GROW LIVE	69	69	-
8	GREATER LONDON AUTHORITY	50	50	-
9	GREAT ORMOND STREET HOSPITAL FC	46	44	2
10	ETHYPHARM UK LTD	21	-	21

10. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at month 2 was **£5,691,833k**. The MCD available as at month 2, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing, community pharmacy and primary care dental expenditure) was **£4,717,883k**.
- As at month 2 the ICB had drawn-down 17.1% of the available cash compared to the budget cash figure of 16.7%. In month 2, the ICB did not need to request a supplementary cash drawdown, nor has it in June. A supplementary cash drawdown was requested for April 2025, to clear old year creditors.
- The cash key performance indicator (KPI) has been achieved in all months so far this year, showing continued successful management of the cash position by the ICB's Finance team. The actual cash balance at the end of Month 2 was **£2,164k**, well within the target set by NHSE **(£5,688k). The ICB expects to utilise its cash limit in full by the year end.**
- ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. To date the ICB has met the BPPC targets each month, and it is expected that these targets will be met in full both each month and cumulatively at the end of the financial year.

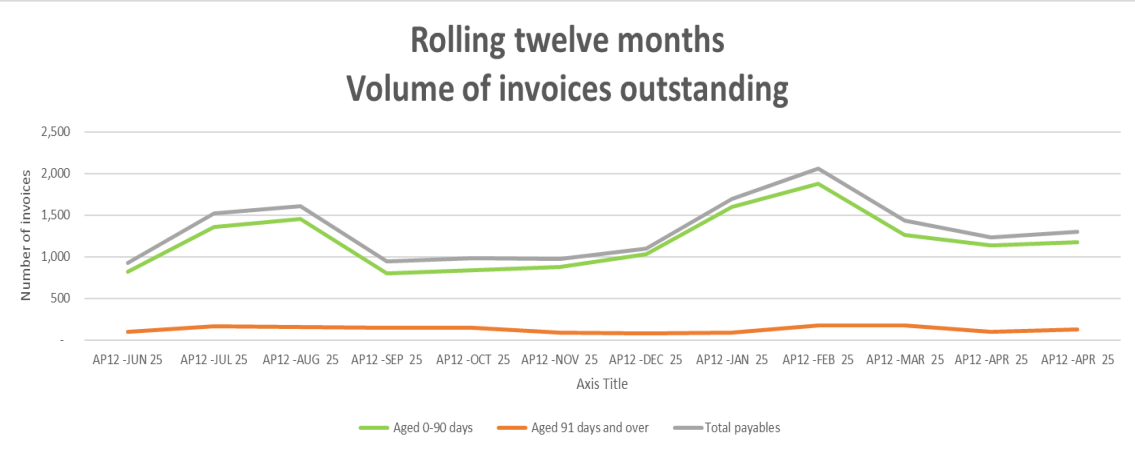
ICB Annual Cash Drawdown Requirement for 2023/24	2025/26 AP2 - MAY 25	2025/26 AP1 - APR 25	2025/26 Month on month movement
	£000s	£000s	£000s
ICB ACDR	5,691,833	5,607,194	84,639
Capital allocation			0
Less:			
Cash drawn down	(910,000)	(455,000)	(455,000)
Dental	(16,520)	(8,469)	(8,050)
HOT	(379)	(188)	(191)
Prescription Pricing Authority	(47,052)	(22,867)	(24,184)
Pay Award charges			0
PCSE POD charges adjustments			0
Pension Uplift			0
Remaining Cash limit	**4,717,883**	**5,120,669**	**(402,786)**

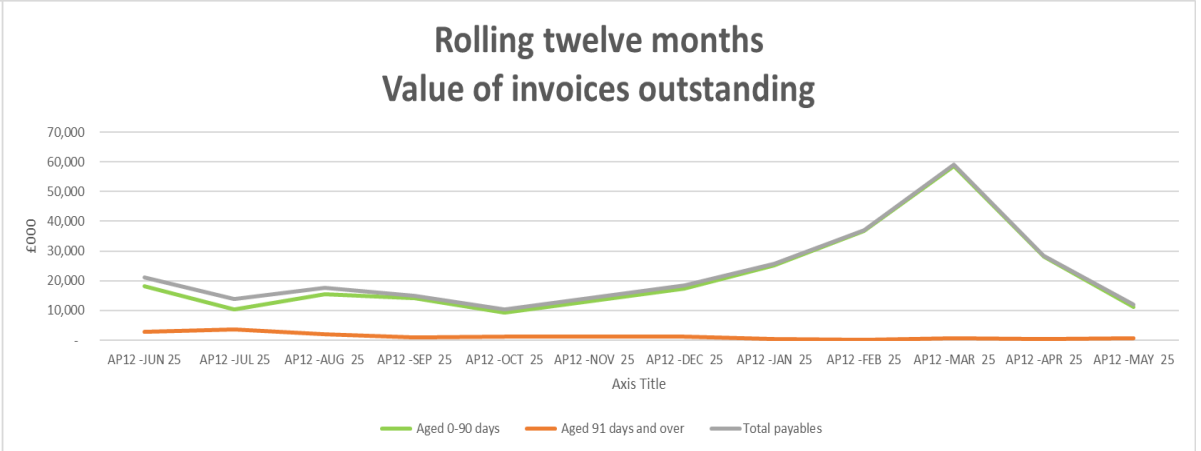
Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR cummulative %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-25	435,000	20,000	455,000	8.70%	5,438	50	0.01%
May-25	455,000	0	910,000	17.10%	5,688	2,164	0.48%
Jun-25	440,000	0	1,350,000		5,500		
Jul-25							
Aug-25							
Sep-25							
Oct-25							
Nov-25							
Dec-25							
Jan-26							
Feb-26							
Mar-26							
	1,330,000	**20,000**					

11. Aged Creditors

- The ICB has been advised by NHS England that the move to a new ledger ISFE2 has a revised go live date of 1st October 2025. This means that ICBs need to continue to maintain a focus on the reduction of creditors during the months until go live. The table below shows that there are **£754k** of invoices outstanding which are **over 90 days**, most of which are non-NHS. **This represents an increase of circa £600k from month 11 when this was last reported; these items will be reviewed as a matter of urgency** as we continue our focus on clearing old invoices. The overall value of creditors **(£11,918k)** has decreased significantly in-month from when this was last reported at month 11 (circa **£25,000k**), which is partly due to the ICB receiving large value quarterly invoices from local authorities, in advance of the year end which have now been cleared. Borough Finance leads, and the central Finance team continue to actively support budget holders to resolve queries with suppliers.
- As part of routine monthly reporting, high value invoices are being reviewed on a regular basis to establish if they can be settled quickly, and budget holders are being reminded on a constant basis to review their workflows.

Customer Group	Aged 0-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121-180 days £000	Aged 181+ days £000	Total £000
NHS	72	651	241	61	1	36	1,062
Non-NHS	7,540	1,753	907	312	174	170	10,856
Total	**7,612**	**2,404**	**1,148**	**373**	**175**	**206**	**11,918**





12. Metrics Report

- The ICB receives a metrics report from NHS England every month which is compiled from information from our ledger and nationally collated by SBS. **This ranks all ICBs against a set of national key financial metrics.**
- The report below relates to April 2025 as the May report will not be received until the end of June which is too late for this reporting cycle.
- In terms of performance, **SE London ICB has achieved 1st in the country again this month which is very positive.** The metric scores below shows that we now have 1 score of the maximum 5, with one score at 4.41 and all other scores above 3.
- Each score shown on this dashboard has several metrics sitting behind it, which relate to good financial practice. The ICB is currently scoring especially well in two areas (maximum score of 5 and one of 4.41) which are a) Accounts Receivable, showing the work undertaken in this area to reduce and manage debt and b) GL and VAT where all balance sheet reconciliations are up to date with no dated reconciling items. The finance team are continuing to strive to improve the scores in the 3 other areas.
- Further work is ongoing to establish how further improvements can be made.

Organisation Name	NHS South East London ICB			
Organisation Code	QKK		**Period**	Apr-25
Region	London		**Peer Rank**	1 / 42 ICB

	Feb-25	Mar-25	Apr-25	3 month average
Overall Score (max 25)	19.61	19.93	19.52	19.69

	Feb-25	Mar-25	Apr-25	3 month average
Accounts Payable - NHS	3.89	3.63	3.42	3.65
Accounts Payable - Non NHS	2.78	3	3	2.93
Accounts Receivable	4.71	4.76	4.41	4.63
General Accounts	3.23	3.54	3.69	3.49
GL and VAT	5	5	5	5.00

13. Mental Health Investment Standard (MHIS) – 2025/26

NHS South East London

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2024/25 outturn by a **minimum of the growth uplift of 4.37%, a target of £534,854k.** This spend is subject to annual independent review.

- There are two changes in the MHIS target for 2025/26.
  - the MHIS target now includes £42,754k of Service Development Funding (SDF) transferred into the ICB baseline
  - there is now a separate MHIS target for Delegated Specialised Commissioning of £89,325k where responsibility has been transferred to the ICB from NHSE for services delivered through contracts managed by the South London Partnership (the Mental Health Provider Collaborative)

- MHIS excludes:
  - spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
  - spend on SDF and other non-recurrent allocations, noting that the majority of SDF funding has been transferred into the ICB baseline.

- The 2025/26 planned spend exceeds the MHIS target as result of funding to support financial recovery and further investment in areas formerly funded through SDF and forming part of ICB core allocations.

- Slide 3 summarises the 2025/26 SEL ICB MHIS Plan. As at Month 2 we are forecasting MHIS delivery of **£544,483k**, exceeding the target by **£9,629k** (1.80%). This is made up of planned over-delivery as described above. Slide 4 sets out the position by ICB budget area.

13. Mental Health Investment Standard (MHIS) – 2025/26

NHS South East London

Risks and Mitigations

- We continue to see growth in mental health cost per case spend, in terms of client numbers, cost and complexity, for example on S117 placements. Mitigating actions include ensuring that timely client reviews are undertaken, reviewing and strengthening joint funding panel arrangements and developing new services and pathways. For LSL clients, in particular, work is being undertaken collaboratively with SLaM and SLP to review the complex care client cohort.

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

- ADHD is outside the MHIS definition and is therefore excluded from this reported position. There is, however, significant and increasing independent sector spend on both ADHD and ASD services, with a spend exceeding £4.5m across a growing number of independent sector providers for Right to Choose referrals.

  The following actions are being taken:
  - increasing local provider capacity to reduce waiting times
  - working with local providers across adult and CYP ADHD services to review and transform care pathways to create sustainable services
  - undertaking an accreditation process to ensure the quality and VFM of independent sector providers.
  - working to agree contracts with high value independent sector providers to attempt to mitigate financial risk and ensure quality

13. Summary MHIS Position – Month 2 (May) 2025/26

NHS South East London

Mental Health Spend By Category	Category	Total Mental Health Plan 31/03/2025 Year Ending £'000	Mental Health - NHS Actual 31/05/2025 YTD £'000	Mental Health - Non-NHS Actual 31/05/2025 YTD £'000	Total Mental Health Actual 31/05/2025 YTD £'000	Mental Health - NHS Forecast 31/03/2026 Year Ending £'000	Mental Health - Non-NHS Forecast 31/03/2026 Year Ending £'000	Total Mental Health Forecast 31/03/2026 Year Ending £'000	Total Mental Health Variance 31/03/2026 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	54,741	7,981	1,103	9,084	47,884	6,614	54,498	243
Children & Young People's Eating Disorders	2	3,632	605	0	605	3,632	0	3,632	0
Mental Health Support Teams in Schools	21	9,779	1,116	514	1,630	6,694	3,085	9,779	0
Perinatal Mental Health (Community)	3	9,834	1,639	0	1,639	9,834	0	9,834	0
NHS Talking Therapies, for anxiety and depression	4	37,007	5,011	1,145	6,156	30,068	6,872	36,940	67
A and E and Ward Liaison mental health services (adult and older adult)	5	19,597	3,266	0	3,266	19,597	0	19,597	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	13,337	2,223	0	2,223	13,337	0	13,337	0
Adult community-based mental health crisis care (adult and older adult)	7	43,005	7,095	73	7,168	42,569	436	43,005	0
Ambulance response services	8	1,211	202	0	202	1,211	0	1,211	0
Community A – community services that are not bed-based / not placements	9a	140,738	20,393	2,919	23,312	122,361	17,758	140,119	619
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	32,371	3,779	1,747	5,526	22,676	10,437	33,113	(742)
Mental Health Placements in Hospitals	20	7,928	1,155	118	1,273	6,931	685	7,616	312
Mental Health Act	10	6,405	0	1,486	1,486	0	7,593	7,593	(1,188)
SMI Physical health checks	11	831	119	20	139	712	122	834	(3)
Suicide Prevention	12	486	81	0	81	486	0	486	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	142,443	23,741	0	23,741	142,443	0	142,443	0
Adult and older adult acute mental health out of area placements	14	9,680	1,598	17	1,615	9,587	20	9,607	73
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**533,025**	**80,004**	**9,142**	**89,146**	**480,022**	**53,622**	**533,644**	**(619)**
Mental health prescribing	16	10,533	0	1,755	1,755	0	10,533	10,533	0
Mental health in continuing care (CHC)	17	242	0	51	51	0	306	306	(64)
Sub-total - MHIS (inc CHC, Prescribing)		**543,800**	**80,004**	**10,948**	**90,952**	**480,022**	**64,461**	**544,483**	**(683)**
Learning Disability	18a	14,641	1,978	609	2,587	11,871	3,589	15,460	(819)
Autism	18b	4,367	711	5	716	4,269	27	4,296	71
Learning Disability & Autism - not separately identified	18c	47,723	1,423	7,192	8,615	8,539	42,193	50,732	(3,009)
Sub-total - LD&A (not included in MHIS)		**66,731**	**4,112**	**7,806**	**11,918**	**24,679**	**45,809**	**70,488**	**(3,757)**
Dementia	19	15,225	2,250	289	2,539	13,501	1,731	15,232	(7)
Sub-total - Dementia (not included in MHIS)		**15,225**	**2,250**	**289**	**2,539**	**13,501**	**1,731**	**15,232**	**(7)**
Total - Mental Health Services		**625,756**	**86,366**	**19,043**	**105,409**	**518,202**	**112,001**	**630,203**	**(4,447)**
Delegated Mental Health Commissioning Services (Specialised Commissioning MHIS categories):									
Specialised Mental Health (excluding Adult Eating Disorders)	22	195	33	0	33	196	0	196	(1)
Adult Eating Disorders	23	3,114	519	0	519	3,114	0	3,114	0
Adult Secure (excluding High Secure)	24	69,965	11,661	0	11,661	69,965	0	69,965	0
CAMHS and Low Secure CAMHS	25	14,510	2,418	0	2,418	14,510	0	14,510	0
Other CAMHS (excl T4 and Low Secure)	26	0	0	0	0	0	0	0	0
Perinatal (Mother and Baby Units)	27	1,850	308	0	308	1,850	0	1,850	0
Sub-total - Delegated Mental Health Commissioning Services (SC MHIS)		**89,634**	**14,939**	**0**	**14,939**	**89,635**	**0**	**89,635**	**(1)**
Total - Mental Health Services		**715,390**	**101,305**	**19,043**	**120,348**	**607,837**	**112,001**	**719,838**	**(4,448)**

13. Summary MHIS Position M2 (May) 2025/26 - by budget area

NHS South East London

Mental Health Investment Standard (MHIS) position by budget area M2 2025/26		Year to Date position for the two months ended 30 May 2025						Forecast Outturn position for the financial year ended 31 March 2026					
		Year To Date	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/und	Annual Plan	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/under
Mental Health Investment Standard Categories:	**Category**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Children & Young People's Mental Health (excluding LD)	1	9,123	7,981	1,103	0	9,084	39	54,741	47,884	6,614	0	54,498	243
Children & Young People's Eating Disorders	2	605	605	0	0	605	0	3,632	3,632	0	0	3,632	0
Mental Health Support Teams in Schools	21	1,630	1,116	514	0	1,630	0	9,779	6,694	3,085	0	9,779	0
Perinatal Mental Health (Community)	3	1,639	1,639	0	0	1,639	0	9,834	9,834	0	0	9,834	0
Improved access to psychological therapies (adult and older adult)	4	6,168	5,011	1,145	0	6,156	12	37,007	30,068	6,872	0	36,940	67
A and E and Ward Liaison mental health services (adult and older adult)	5	3,266	3,266	0	0	3,266	0	19,597	19,597	0	0	19,597	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	2,223	2,223	0	0	2,223	0	13,337	13,337	0	0	13,337	0
Adult community-based mental health crisis care (adult and older adult)	7	7,167	7,095	73	0	7,168	(1)	43,005	42,569	436	0	43,005	0
Ambulance response services	8	202	202	0	0	202	0	1,211	1,211	0	0	1,211	0
Community A – community services that are not bed-based / not placements	9a	23,456	20,393	2,919	0	23,312	144	140,738	122,361	17,758	0	140,119	619
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	5,395	3,779	1,747	0	5,526	(131)	32,371	22,676	10,437	0	33,113	(742)
Mental Health Placements in Hospitals	20	1,321	1,155	118	0	1,273	48	7,928	6,931	685	0	7,616	312
Mental Health Act	10	1,067	0	1,486	0	1,486	(419)	6,405	0	7,593	0	7,593	(1,188)
SMI Physical health checks	11	139	119	20	0	139	0	831	712	122	0	834	(3)
Suicide Prevention	12	81	81	0	0	81	0	486	486	0	0	486	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	23,741	23,741	0	0	23,741	0	142,443	142,443	0	0	142,443	0
Adult and older adult acute mental health out of area placements	14	1,613	1,598	17	0	1,615	(2)	9,680	9,587	20	0	9,607	73
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**88,836**	**80,004**	**9,142**	**0**	**89,146**	**(310)**	**533,025**	**480,022**	**53,622**	**0**	**533,644**	**(619)**
Other Mental Health Services:													
Mental health prescribing	16	1,755	0	0	1,755	1,755	0	10,533	0	0	10,533	10,533	0
Mental health continuing health care (CHC)	17	40	0	0	51	51	(11)	242	0	0	306	306	(64)
Sub-total - MHIS (inc. CHC and prescribing)		**90,631**	**80,004**	**9,142**	**1,806**	**90,952**	**(321)**	**543,800**	**480,022**	**53,622**	**10,839**	**544,483**	**(683)**
Learning Disability	18a	2,440	1,978	609	0	2,587	(147)	14,641	11,871	3,589	0	15,460	(819)
Autism	18b	728	711	5	0	716	12	4,367	4,269	27	0	4,296	71
Learning Disability & Autism - not separately identified	18c	7,954	1,423	2,020	5,172	8,615	(661)	47,723	8,539	11,185	31,008	50,732	(3,009)
Learning Disability & Autism (LD&A) (not included in MHIS) - total		**11,122**	**4,112**	**2,634**	**5,172**	**11,918**	**(796)**	**66,731**	**24,679**	**14,801**	**31,008**	**70,488**	**(3,757)**
Dementia	19	2,537	2,250	209	79	2,538	(1)	15,225	13,501	1,257	474	15,232	(7)
Sub-total - LD&A & Dementia (not included in MHIS)		**13,659**	**6,362**	**2,843**	**5,251**	**14,456**	**(797)**	**81,956**	**38,180**	**16,058**	**31,482**	**85,720**	**(3,764)**
Total Mental Health Spend - excludes ADHD		**104,290**	**86,366**	**11,985**	**7,057**	**105,408**	**(1,118)**	**625,756**	**518,202**	**69,680**	**42,321**	**630,203**	**(4,447)**
Specialised Mental Health (excluding Adult Eating Disorders)	22	33	33	0	0	33	0	196	196	0	£0	196	0
Adult Eating Disorders	23	519	519	0	0	519	0	3,114	3,114	0	£0	3,114	0
Adult Secure (excluding High Secure)	24	11,661	11,661	0	0	11,661	0	69,965	69,965	0	£0	69,965	0
CAMHS and Low Secure CAMHS	25	2,418	2,418	0	0	2,418	0	14,510	14,510	0	£0	14,510	0
Other CAMHS (excl T4 and Low Secure)	26	0	0	0	0	0	0	0	0	0	£0	0	0
Perinatal (Mother and Baby Units)	27	308	308	0	0	308	0	1,850	1,850	0	£0	1,850	0
Sub-total - Delegated Mental Health Commissioning Services (SC MHIS)		**14,939**	**14,939**	**0**	**0**	**14,939**	**0**	**89,635**	**89,635**	**0**	**0**	**89,635**	**0**
Grand Total Mental Health Services		**119,229**	**101,305**	**11,985**	**7,057**	**120,347**	**(1,118)**	**715,391**	**607,837**	**69,680**	**42,321**	**719,838**	**(4,447)**

SEL ICB Finance Report

Updates from Boroughs

Month 2

Appendix 1 – Bexley

NHS South East London

Overall Position

	Year to date Budget	Year to date Actual	Year to date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	838	838	0	5,026	5,026	0
Community Health Services	4,235	4,235	0	25,410	25,410	0
Mental Health Services	1,775	1,786	(11)	10,633	10,633	0
Continuing Care Services	4,452	4,452	0	26,709	26,709	0
Prescribing	6,288	6,288	0	39,134	39,134	0
Other Primary Care Services	250	250	0	1,500	1,500	0
Other Programme Services	204	204	0	1,225	1,225	0
Delegated Primary Care Services	8,179	8,179	0	49,075	49,075	0
Corporate Budgets	491	454	37	2,947	2,947	0
Total	**26,712**	**26,686**	**26**	**161,658**	**161,658**	**0**

- At Month 2 (May 2025) Bexley place is reporting an underspend of £26k year to date and a forecast breakeven position at year end.
- Prescribing reports a breakeven position for year to date and year end forecast. Prescribing data is provided two months in arrears therefore the year-to-date position includes an estimate for this period.
- Mental Health Services is reporting an overspend of £11k year to date and forecast breakeven position. The year to date overspend relates to increased costs relating to ADHD and ASD services.
- Corporate budgets are reporting a £37k underspend year to date due to existing vacancies.
- All other budgets are reporting a year to date and forecast breakeven position.
- Bexley place has an annual efficiency plan of £7,750k, which is forecasted to deliver in full by year end.

Appendix 2 – Bromley

NHS South East London

Overall Position

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	ICB Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	1,353	1,353	0	8,119	8,119	(0)
Community Health Services	15,767	15,767	0	94,605	94,086	519
Mental Health Services	2,438	2,627	(189)	14,601	14,601	0
Continuing Care Services	4,689	4,776	(86)	28,137	28,656	(519)
Prescribing	8,459	8,459	0	52,642	52,642	(0)
Other Primary Care Services	338	338	(0)	2,026	2,026	(0)
Delegated Primary Care Services	11,718	11,718	0	70,310	70,310	(0)
Corporate Budgets	585	507	77	3,509	3,509	0
Total	**45,347**	**45,545**	**(198)**	**273,948**	**273,948**	**(0)**

- The borough is reporting an overspend of £198k at Month 2 and is forecasting a breakeven position at year end. It should be noted that the Primary Care and prescribing budgets have been reported as breakeven for Month 2 reporting purposes.
- The Mental Health budget is £189k overspent year to date due to pressures on cost per case and diagnostic assessment budgets. The forecast position is breakeven as the number of cost per case clients has reduced since the end of May.
- The Continuing Healthcare budget is £86k overspent year to date and the forecast is £519k overspent. This is due to a continuation of the gradual increase in adult CHC and FNC client numbers which has been seen over the past few years. This is partially due to an increase in the number of care home providers in the borough.
- The Community budget is forecasting a £519k underspend. This will be monitored as the year progresses and expenditure trends become clearer.
- The Corporate budget is £77k underspent year to date due to vacancies and the forecast is breakeven.
- The 2025/26 borough savings requirement is £13,130k. At month 2 the borough is on track to achieve these savings and is reporting full delivery of the target.

Appendix 3 – Greenwich

NHS South East London

Overall Position

Description	Annual Budget £'000s	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	6,912	1,152	1,152	0	6,912	0
Community Health Services	40,387	6,731	6,731	0	40,387	0
Mental Health Services	8,676	1,459	1,815	(357)	10,453	(1,778)
Continuing Care Services	30,307	5,051	5,327	(275)	32,141	(1,834)
Prescribing	38,454	6,180	6,180	0	38,454	0
Other Primary Care Services	1,929	322	322	0	1,929	0
Other Programme Services	1,795	299	0	299	0	1,795
Programme Wide Projects	0	0	0	0	(1,816)	1,816
Delegated Primary Care Services	62,782	10,464	10,464	0	62,782	0
Corporate Budgets	3,461	577	573	4	3,461	0
Total	**194,703**	**32,234**	**32,562**	**(329)**	**194,703**	**(0)**

- The overall Greenwich financial position is £329k adverse to the year-to-date plan, with a forecast breakeven position.
- The Prescribing position is reporting breakeven in lieu of data (two-month lag). The final reported position for 24/25 was £38.7m and the continued use of tools like OptimiseRx and targeted QIPP interventions will be essential to maintaining financial stability while meeting patient care standards.
- CHC is £275k overspent to date and is attributable to individual placement costs.
- Mental Health is £357k overspent to date and is attributable to 8 additional joint funded (S117) clients in month alongside continuing pressure through the 'right to choose' patient pathway for ASD/ADHD assessments.
- The £299k favourable variance on programme services reflects no spend incurred to date and is in mitigation for pressures elsewhere.
- Delegated Primary Care is reported breakeven for M2. Initial projections for payments as based on register patient list size indicates a prospective pressure albeit the reporting methodology is under refinement and will be confirmed for M3 reporting.
- The forecast spend is aligned with plan.

Appendix 4 – Lambeth

NHS South East London

Overall Position

Service Area	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	81	81	0	488	488	0
Community Health Services	4,978	4,978	0	29,867	29,867	0
Mental Health Services	3,956	4,048	(92)	23,639	23,976	(337)
Continuing Care Services	5,985	5,985	0	35,911	35,574	337
Prescribing	7,069	7,069	0	43,998	43,998	0
Other Primary Care Services	659	659	0	3,957	3,957	0
Delegated Primary Care Services	15,900	15,900	0	95,399	95,399	0
Corporate Budgets	758	743	15	4,545	4,545	0
Total	**39,386**	**39,464**	**(78)**	**237,803**	**237,803**	**0**

- The borough is reporting an overall £78k year to date overspend position and a forecast breakeven position at Month 02 (May 2025). The reported forecast position includes £337k overspend on Mental Health Services (including Learning Disabilities) and £337k underspend on Continuing Health Care (CHC) Services.

- The underlying key risks within the 2025-26 Lambeth's finance position remain associated with demand driven budgets (Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Mental Health including Learning Disability Services, Continuing Health Care Services and Prescribing).

- Mental Health budget year to date and forecast overspend is driven by increased ADHD spend, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on efficiency and productivity schemes including right sizing projects with providers to enable service users to live more independently though either stepping down restrictive levels of care or moving to more independent settings.

- Delegated Primary Care Services is reporting a breakeven position against in year budget at month 2, noting previous year (2024-25) overspend position is driven by locum reimbursements, retainer scheme and list size growth.

- The Continuing Healthcare budget is forecasting £337k underspend as the CHC team continues to deliver on reviewing high-cost packages and out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M02 is 532.

- Prescribing actual data is provided two months in arrears and the borough is reporting a breakeven position against in year budget at month 2.

- The borough 2025-26 minimum (5%) efficiency and productivity target is £11.3m and has a savings plan of £12.6m. In addition to the embedded efficiency (£5.6m) as part of the budget setting process, the borough has saving plans for Continuing Healthcare (£1.9m), Prescribing (£1.1m) and Mental Health Services Learning Disability Services (1.2m). The borough efficiency and productivity target is forecast to deliver in full.

Appendix 5 - Lewisham

NHS South East London

Overall Position

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	226	226	(0)	1,358	1,358	(0)
Community Health Services	5,677	5,081	597	34,064	30,478	3,586
Mental Health Services	1,329	1,452	(123)	7,906	8,605	(699)
Continuing Care Services	4,236	4,714	(477)	25,418	28,282	(2,864)
Prescribing	7,060	7,060	0	43,920	43,920	0
Prescribing Reserves	0	0	0	0	0	0
Other Primary Care Services	341	344	(4)	2,043	2,065	(22)
Other Programme Services	4	4	0	26	26	0
Delegated Primary Care Services	11,967	11,967	0	71,800	71,800	0
Corporate Budgets	529	498	31	3,176	3,176	0
Total	**31,370**	**31,346**	**24**	**189,712**	**189,711**	**1**

- At month 2, the borough is reporting an underspend year to date (YTD) of £24k and a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC), mental health and a small overspend on other primary care.
- CHC shows a material overspend YTD of £477k and FOT overspend of £2,864k . The run rate on adults CHC is reasonably constant with the closing position from 2024/25, whilst the run rate on children's services has increased c.£500k reflecting new packages of care. Twice monthly recovery meetings continue with the adult's team and a meeting is being set up with the children's team to understand the current position compared to 2024/25 outturn.
- The mental health position is driven by costs incurred with independent providers for ADHD which are reflecting a significant increase in demand for these services impacting all places across SEL and beyond. A co-ordinated review of these costs and activity has been conducted at an SEL level with local input to better understand these cost movements. There appears little opportunity in year for mitigation given levels of demand and the borough will need to plan to mitigate this pressure from other budget lines within the delegated budget.
- Current year activity and cost information is not yet available for prescribing which is therefore being shown as a breakeven position for month 2 YTD and FOT.
- The borough 5% efficiency target is £8,975k, is fully identified and at this stage forecast to deliver in full, although there is slippage of £127k in adult CHC achievement at month 2.

Appendix 6 – Southwark

NHS South East London

Overall Position

	Year To Date Budget	Year To Date Actual	Year To Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	43	43	0	257	257	0
Community Health Services	6,295	6,108	187	37,771	36,762	1,009
Mental Health Services	1,777	2,054	(278)	10,584	12,090	(1,506)
Continuing Care Services	3,420	3,337	83	20,517	20,020	497
Prescribing	5,819	5,819	-	36,208	36,208	-
Other Primary Care Services	167	167	(0)	1,001	1,001	-
Other Programme Services	99	99	-	593	593	-
Programme Wide Projects	43	36	7	259	259	-
Delegated Primary Care Services	12,784	12,784	0	76,701	76,701	-
Corporate Budgets	667	632	35	4,002	4,002	-
Total	**31,112**	**31,078**	**35**	**187,894**	**187,894**	**(0)**

- The borough is reporting an underspend of £35k as at the end of May 25. Key areas of risk continue to be mental health, delegated primary care and prescribing with underspends in corporate budgets and continuing care absorbing some of overspends.

- For Mental Health we are reporting a year to date overspend of £278k and a forecast overspend of £1.5m. This is driven mainly by overspends in Right to Choose adult ADHD/Autism pathways and placements. Our forecast overspend of £1.5m is largely due to overspend (£1m). on Right to Choose adult ADHD/ASD. Placements costs for Learning disability continues to be a cost pressures. There is a risk of increased pressure in tri-partite Children and Young People mental health costs. The borough has been reviewing placements spend as part of its recovery plan started in 2024/25. A structured process of reviews with support from clinical leads has been implemented as part of our savings plans for 2025/26..

- Prescribing actual data is provided two months in arrears and the borough is reporting a breakeven position against in year budget at month 2. It is important to note that in 2/25 the borough overspent by £1.4m on prescribing. Medicine Optimisation team continue to monitor prescribing spend and also delivering savings plans on prescribing,

- Corporate budgets are £35k underspent as at month 2 due to vacancies.

- All other budget lines are at breakeven or showing relatively small underspends. Continuing Care whilst showing a small underspend is another risk area in 24/25 as AQP rate increases are likely to impact and will need to be managed within a budgeted uplift of 2.4%.

- Borough has an efficiency target of 5% which on applicable budgets amounts to £8.8m. Within this figure prescribing savings total £3.6m and most of these phased to deliver after quarter 1. As at month 2 the borough is reporting a small under delivery against plan and forecast savings in line with plan.

- The year end forecast position is breakeven overall with overspends expected in mental health budgets and underspend in continuing care and community health services. It is too early in the year to accurately assess the year end position for Prescribing and Delegated Primary Care and therefore these areas are reported as breakeven for month 2.

NHS
South East London

Appendix B

SEL ICS Financial Highlights

Month 2 2025/26

South East London Integrated Care System

NHS South East London

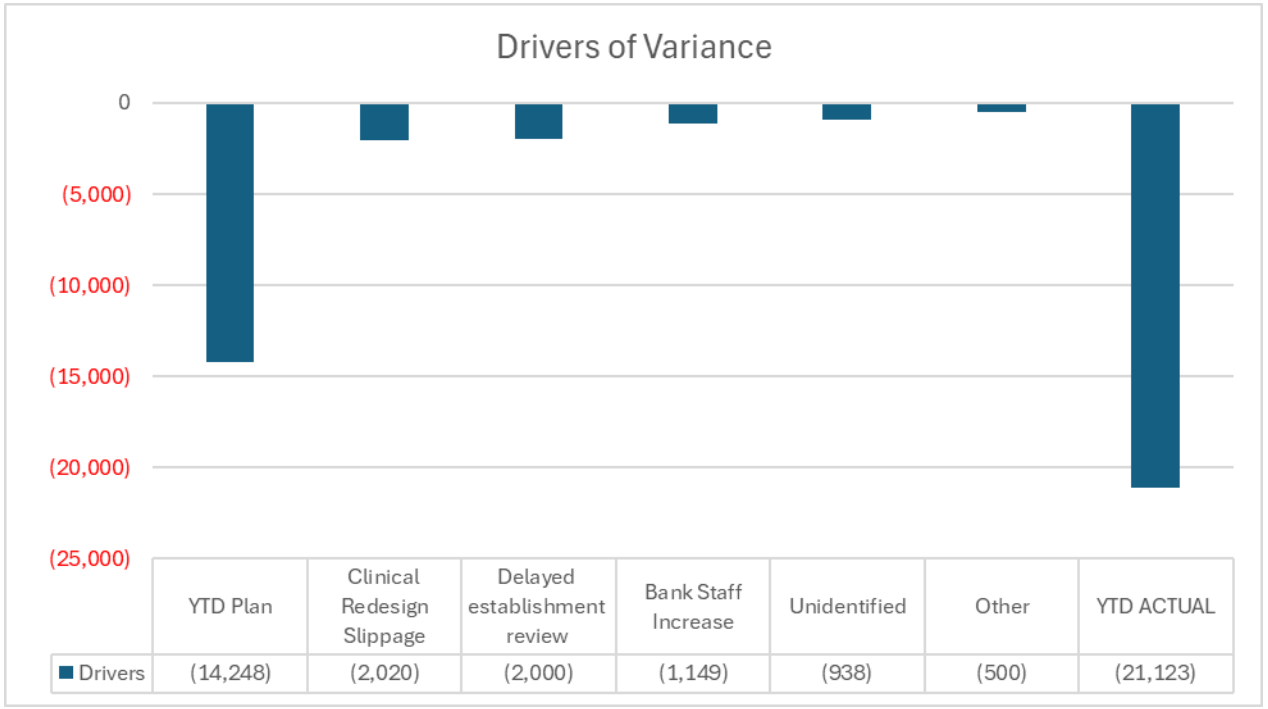
Executive Summary

- This report sets out the month 2 financial position of the ICS.
- The ICS financial plan is to deliver a break-even position. This is after the receipt of non-recurrent deficit support funding of **£75.0m**. The Q1 allocation of which (£18.75m) was received in month 2.
- At month 2, the ICS is reporting a YTD deficit of **(£21.1m), £6.9m** adverse to plan. The main driver is the slippage in efficiency programmes **(£6.6m).**
- As at month 2, each of the individual organisations is forecasting a break-even year-end position – this is in line with the overall ICS financial plan submitted on 30 April.
- The following slide shows a bridge from YTD plan to actual.

Analysis of month 2 YTD position

At Month 2, SEL ICS is reporting a year-to-date deficit of (£21.1m), which is £6.9m adverse to plan. This is primarily driven by under-delivery against efficiency programmes of £6.6m detailed below:

- Delayed delivery of clinical service re-design schemes £2m.
- Slippage in establishment reviews and corporate services transformation schemes of £2m.
- Increase in bank staff activity against savings plan of £1.15m.
- £0.94m unidentified schemes.
- ICB (0.5m) due to slippage in the adult CHC schemes and primary care schemes which are expected to recover within the financial year.



Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 10
Enclosure 10

Title:	**Primary Care Group Chairs Report**
Meeting Date:	**24 July 2025**
Author:	Chima Olugh, Neighbourhood Development Manager
Executive Lead:	Ceri Jacob, Place Executive Lead

Purpose of paper:	The purpose of this report is to provide the Lewisham Local Care Partnership with an update on key primary care priorities discussed the Primary Care Group.	Update / Information	*x*
		Discussion	
		Decision	

Summary of main points:	The following items were discussed at the May and June 2025 Primary Care Group meetings: **Contractual:** a) Transfer of SEL Special Allocation Scheme APMS Contract and ODS code to Lewisham – Recommended for approval. b) Penrose Health Centralisation of back-office estate business case - Recommended for approval. c) SEL ICB Managing Late/Retrospective GP Claims Policy - Recommended for approval. **Updates:** a) Public Health Update. b) Primary Care Access Comms Campaign.
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 transfer of SEL Special Allocation Scheme APMS Contract and ODS code to Lewisham and the SEL ICB Managing Late/Retrospective GP Claims Policy were endorsed by the SEL Primary Care Executive in June.		
Recommendation:	The Lewisham Local Care Partners Strategic Board is asked to note the report.			

Contractual
a. Transfer of SEL Special Allocation Scheme APMS Contract and ODS code to Lewisham ▪ The Primary Care Group was asked to approve the transfer of the SEL Special Allocation Scheme (SAS) APMS Contract and ODS code from Bromley to Lewisham. ▪ The SAS has a relatively small patient list of about 180 patients. ▪ Over time, Lewisham has increasingly assumed the operational lead for contract management due to the local relationship with providers, One Health Lewisham, and the service's Lewisham-centric operational base. ▪ The move would enable clearer contract management but would require further work on estates access, cost-sharing arrangements with the 5 other boroughs, funding uplift requests, Primary Care Network membership, and governance. ▪ The prescribing budget code has already been transferred to Lewisham and there would be no disproportional risk to Lewisham. The Primary Care Group approved the request. The Group will continue to receive updates on the progress with the other elements of work to be completed.
b. Penrose Health Centralisation of back-office estate business case ▪ The Primary Care Group was asked to support the reimbursement of rent and rates at the Penrose Health Group London Bridge site from the 1st April 2025, and also the continuation of the lease at these premises for a further 5 years from January 2026. ▪ The Penrose Health Group have been struggling with space for back-office services for a long time. ▪ Following extensive conversations between the ICB and Penrose Health Group who have 4 GP practice contracts in Lewisham (Deptford Surgery, Kingfisher Medical Centre, Lewisham Medical Centre and Nightingale Surgery), a business case was received which sought support for estates costs to support the centralisation of back-office services. ▪ Following consideration of options, Penrose Health Group proceeded to occupy office space in London Bridge to centralise back-office services in March 2023 however this was not formally agreed by the ICB with the final business case at appendix being received in June 2025 following several iterations informed by feedback from the ICB. ▪ The business case, in appendix A, outlined Penrose Health Group estates challenges across its sites in Lewisham, and in line with ICB strategy has sought to centralise back-office services to free up capacity at its practice sites for face-to-face clinical work. ▪ The business case also sought support for retrospective running costs, current running costs and non-recurring setup costs.

- The benefits of the centralisation to all stakeholders have been detailed in the business case, including quantifiable data where available.

Costs the ICB was asked to support included:

a) Rent reimbursement between 1st April 2025 and 31st January 2026 of £55,706+vat @20% = £66,847.20.
b) Rent reimbursement increasing from 31st January 2026 to £57,650+VAT = £69,180.
c) Business rates reimbursement of £15,489+vat @20% = £18,587.

- The ICB is not in a position to support any retrospective estate running or setup costs as this would not be in line with the NHS Premises Cost Directions.

- It was considered reasonable and justifiable by the ICB to support costs from the start of this financial year (25/26) as significant engagement has been taking place over the last few months to finalise the business case ready for consideration by the Primary Care Group in June 2025.

- Additionally, part of the considerations for the approval of costs was the monies released as part of the merger between the Kingfisher Medical Centre and Mornington Surgery in 2020/2021. The Mornington Surgery site was closed which released approximately £40k in reimbursable rent and £12k in reimbursable business rates.

- It is acknowledged that Penrose Health Group have practices in Southwark and Lambeth who may benefit from the centralisation of back-office services however it is considered that the principal benefit will be to the practices in Lewisham and so it is appropriate for the business case to be considered and approved through the Lewisham Primary Care Group.

- It was recommended that if further expansion of space at London Bridge is proposed that this be considered across the 3 boroughs, particularly in terms of funding.

- The potential risk of not supporting this reimbursement is the ongoing operational and financial viability of the Penrose Health group of practices and associated impact to service delivery.

The Primary Care Group approved the:

- **Rent and rates reimbursement for the Penrose Health Group of practice's centralised back-office services estate from 1st April 2025 and;**

- **The continuation of the lease at these premises for a further 5 years from January 2026.**

Approval was subject to a value for money assessment which is being carried out by the SEL ICB estates team.

c. SEL ICB Managing Late/Retrospective GP Claims Policy

- The Primary Care Group was asked to approve the Managing Late/Retrospective GP Claims Policy.

- The policy creates financial pressures for the ICB budget hence the decision to have a SEL wide policy.

- Practices will be asked to seek prior approval for Locum Reimbursement Claims or need to notify the ICB within 28 days of the GP performer's first date of absence.

- The approval of claims will be managed in line with the SEL ICB's Standing Financial Instructions.

The policy will be implemented from 1 July 2025.
From 1 October 2025, late or retrospective claims relating to previous financial years without an accrual in place will only be considered in exceptional circumstances subject to budgetary targets.

Practices will be asked to demonstrate that they had met the exceptionality criteria outlined in the policy.

The Primary Care Group approved the Managing Late/Retrospective GP Claims Policy.

Updates

a. Public Health Update

The Primary Care Group received an updated from the Public Health team.

- Measles cases are on the rise. The public health team is working with communications team on raising awareness of childhood vaccination. Also working on the Immunisations strategy with local partners.

- There is a planned shift in the delivery of MMR vaccine. The second dose of the MMR vaccine is being considered for earlier administration, potentially at 12 months of age, instead of the current recommendation of 18 months.

- The aim of change is to improve vaccination uptake and provide earlier protection against measles, mumps, and rubella.

b. Primary Care Access Communications Campaign

The Primary Care Group received an update on progress with the Primary Care Access Comms Campaign.

Following the Covid-19 pandemic and the change to how general practice operates it became clear that work was needed to engage and update the public on best ways to access healthcare support.

The aim of the Primary Care Access Communications campaign is to educate and inform the public on the ways of working of general practice, and to help our population better understand the services, how to access them and manage expectations around triage.

The campaign covers the following core areas:
- The NHS App
- Access & Triage
- NHS Pharmacy First
- GP Teams

The LPP has had extensive discussions on the primary care communications campaign.
They have also been working through the updated Immunisations Strategy, making comments and feedback.
The LPP have agreed to a systematic approach which will be to describe where organisations have actively listened to feedback, taken action and shared some results (you said we did).

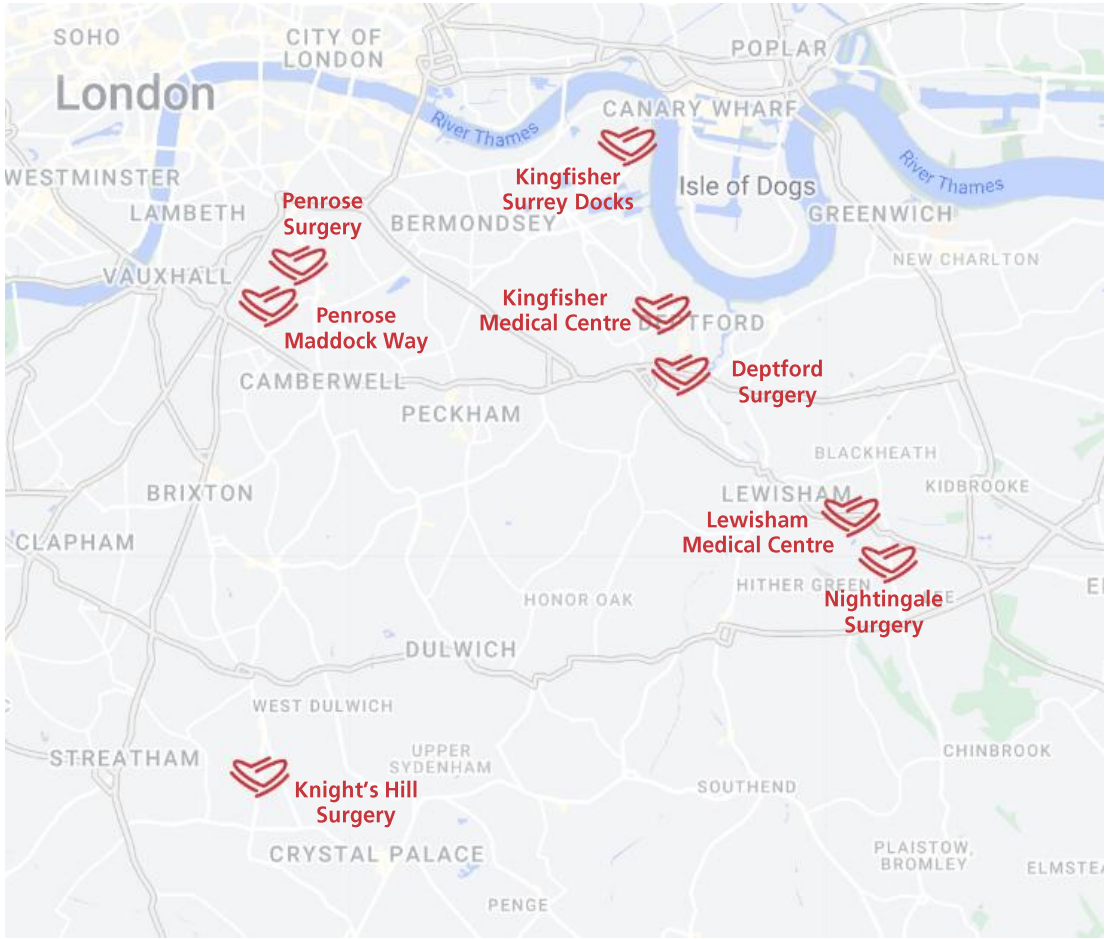
See appendix B for the detailed campaign pack.

Penrose Patient Support Hub

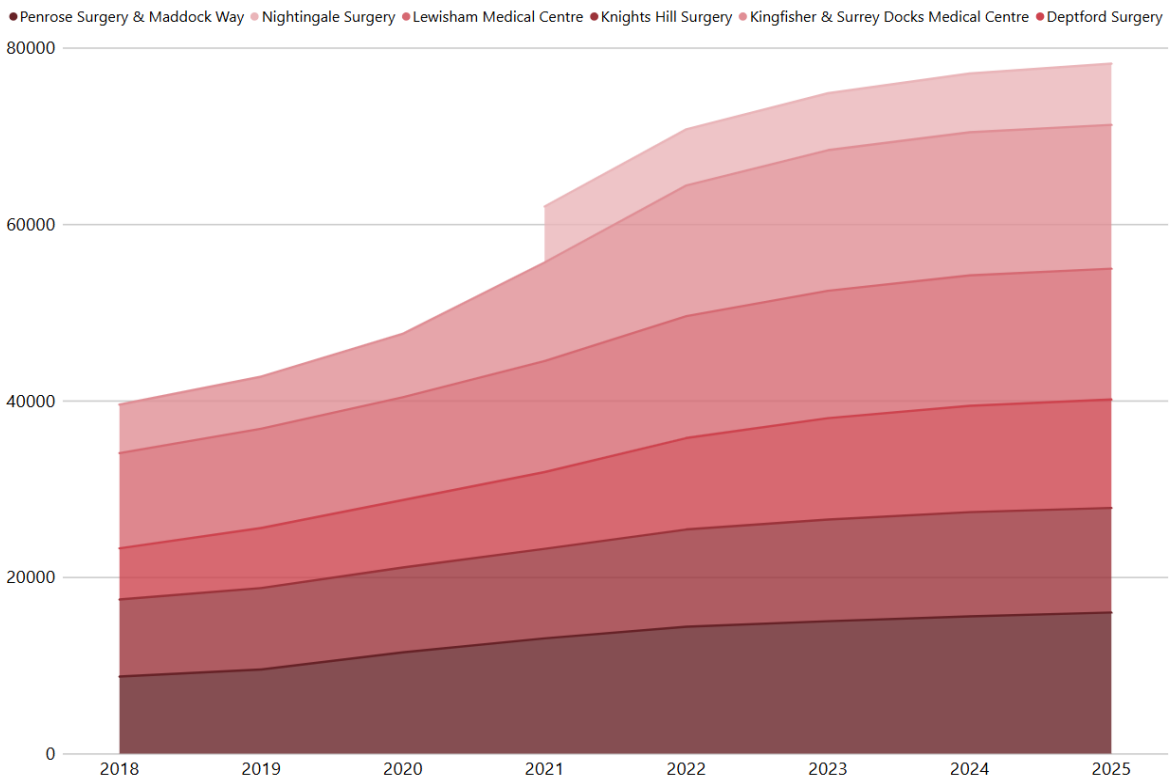
9 Holyrood Street Business Case

Penrose Health Overview

- ‘Penrose Health’ or ‘Penrose’ is the Partnership between Dr Sarah Hawxwell and Mr Sunil Gupta providing NHS GP services in SE London since 2006
- Penrose serves over 78,000 patients in 6 GMS/PMS contracts across Lambeth, Southwark and Lewisham
- Through high quality care and strong patient feedback, Penrose has seen strong list size growth over the last decade – the group has more than doubled in size since 2018
- Penrose runs an integrated, MDT model – our GPs are supported by a variety of AHPs including Nurses, HCAs, Paramedics, Pharmacists, Mental Health Nurses, Care Coordinators, and Physician Associates
- With a single management and central operations team, Penrose is a true, at-scale model that has provided support and leadership across our various PCNs and neighbouring practices
- This is evidenced by our outcomes – we have excellent patient feedback, Good CQC ratings and strong staff retention rates.



Strong list growth over the last decade has tested the capacity of our premises



- Currently at 78258 patients (*as per EMIS at 28/02/25*) – a growth of over 2x over the last 7 years
- Majority of the growth has been through organic patient registrations due to high quality of care, positive feedback and patient preference
- All sites are now 'maxed-out' in terms of room utilisation and ability to house more staff / provide more sessions is limited – see next slide for headcount information
- There is also limited space for expansion at existing premises
- Premises across Penrose Health are providing very strong value in terms of £/sqft and rent/rates £/patient

Significant increase in staffing levels to keep up with the workload and patient demands

- Since January 2018, the list has more than doubled – this has necessitated significant increases in both clinical and non-clinical staffing cover
- We currently have c. 220 permanent staff members + locums + partners – up 75% from 2020. The vast majority of these staff are patient-facing and need clinical space.
- All practices utilise a mix of GPs and AHPs (including ARRS roles). Practice triage teams ensure that patients see the right clinician first time – minimising wasted appointments and maximising GP utilisation
- Where relevant / safe / in-line with patient preference, the practices use telephone consultations – this currently makes up 22% of our current book

Premises utilisation is extremely high and forecast to increase further

- Independent reports from Howarth Litchfield and Gleeds commissioned by South East London ICB in Aug 2021 highlighted severe space shortages across Penrose sites, forecast to worsen in line with further increases in list size. For example:
  - Nightingale Surgery was short of 4 clinical rooms to meet the demands on the service in 2021, forecast to rise to 6 rooms by 2030
  - Lewisham Medical Centre was short of 1 clinical room to meet the demands of the service in 2021, forecast to rise to 5 rooms by 2030
  - Deptford Surgery was short of 6 clinical rooms in 2021, forecast to rise to 7 rooms by 2030
  - Penrose Surgery was short of 5 clinical rooms in 2021, forecast to rise to 8 rooms by 2030, while its room utilisation rate was estimated at 95%, well above the NHS target of 85%

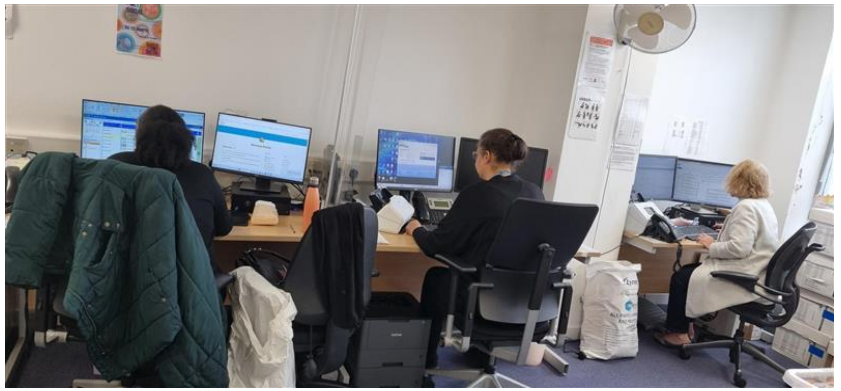
Figure 7.3a // Demand By Practice

Lewisham Medical Centre	Year					
	2021	2025	2030	2035	2040	2045
Available	11	11	11	11	11	11
Demand	12	13	16	17	18	22
Difference	-1	-2	-5	-6	-7	-11

Nightingale Surgery	Year					
	2021	2025	2030	2035	2040	2045
Available	4	4	4	4	4	4
Demand	8	8	10	10	11	13
Difference	-4	-4	-6	-6	-7	-9

A serious lack of working space in GP practices is creating cramped conditions for staff

The loft at Kingfisher Medical Centre



The back room at Lewisham Medical Centre

The server room at Penrose Surgery

The server room at Deptford Surgery

Lack of adequate physical space is impacting services and staff welfare

- Restricts access by limiting face-to-face appointment with GPs and other clinical teams (e.g. nursing where the vast majority of work requires f2f interaction)
- Limiting proactive care and public health initiatives including immunisations, vaccinations, cancer screening and LTC management (due to limited space for nursing)
- 7 out of 8 of our practices do not have any space that is suitable for staff meetings and trainings. Staff end up doing everything remotely, limiting engagement and negatively impacting staff cohesion
- The cramped quarters of existing space, makes recruitment and retention tough – 'no space to even eat lunch' is one of our top employee complaints
- Minimal space to accommodate GP training, GPN Academic Programme and FCP training – all of which our teams are keen to participate in
- Minimal space to offer to PCN Clinicians, blocking our objectives to make best use of PCN services and work collaboratively with local practices
- No space to expand triage and outbound calls team for proactive care bookings – all areas highlighted in our historical National Patient Survey results

Remote working has a number of key drawbacks in Primary Care

Delaying access to face-to face

- GPs reporting an increasing number of cases being rebooked from telephone to F2F appointment as it's often not safe or complete to examine the patient in a telephone / video consultation
- More and more patients expressing preference for F2F over telephone consultation – this again results in more rebookings or unhappy patients
- Can't use remote working for core nursing services including immunisation, vaccinations, smears and physical health checks (as part of long-term conditions management)

Workload allocation and staff support

- There are *significant* challenges in training, support and supervision of colleagues who are working remotely – this is unsatisfactory for both supervisors and employees, with poorer outcomes for patients as a result
- Where remote clinicians are in a supervisory role (e.g. remote GPs), they often struggle to provide an adequate level of support and supervision to AHPs on the ground
- Some remote working leads to 'unfair' allocation of f2f work (e.g. home visits) for remaining clinicians working on site

An innovative solution to these challenges was required

- The SEL PCN Estates Review issued in 2022 emphasised the importance of using space effectively, including **'undertaking triage consultations from telephone hubs and other non-clinical settings'**
- The Review also proposed creating additional clinical space at practices by moving administrative activities out of clinical spaces into other accommodations
- For example, it was recommended that Deptford Surgery move storage off-site to create additional space for e-consultations
- The Howarth Litchfield report explicitly proposed that the Lewisham Medical Centre relocate all admin facilities off site as there are no feasible ways to fit more facilities on site

Back in 2021, what were our options?

Chosen option

Do nothing

- Not a solution to existing premises problem
- Did not allow us to manage the high demand placed on GP services in the area
- Constrained the Practice's ability to grow both in terms of list size and services it offers
- Did not serve the needs of the growing local population

Wait for new premises

- This option has been explored with Lewisham, Southwark and Lambeth CBC teams
- No viable options in most places and no concrete plans drawn yet for most sites
- Did not offer immediate solution to current critical problems

Create new central space

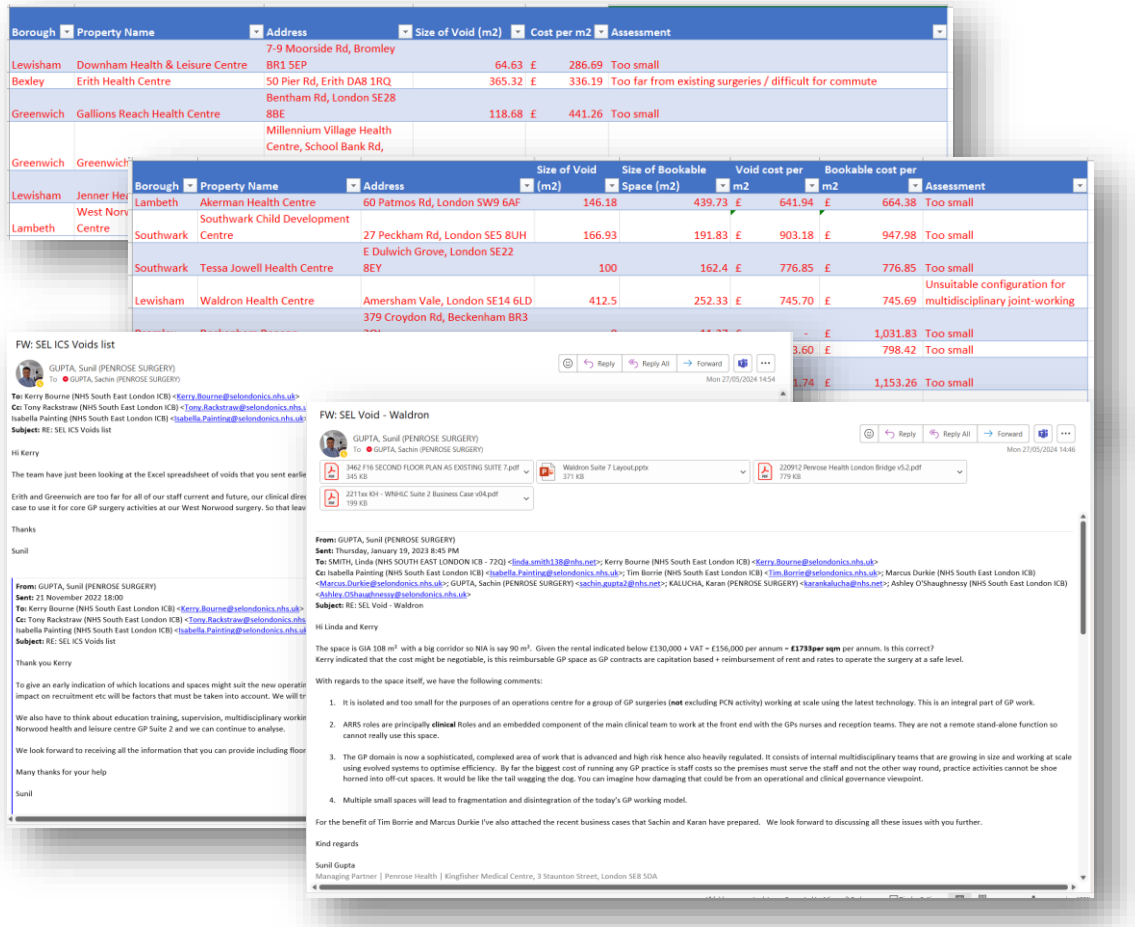
- Offered value-for money solution in short timeframe without long-term obligations
- Enabled repurposing of non-clinical space at current sites into clinical
- Enabled hiring of additional clinicians in central space
- In line with national and local priorities, **including SEL ICS Estates and Infrastructure Strategy** - using digital technology and promoting delivery at scale

Any other?

- Historically it has proven difficult to identify and secure affordable opportunities in inner-city areas
- Similar developments in the area have not included space for increased provision in medical services
- Patient list size growing by c. 1,000-1,500 per year exacerbating issues

Assessment of other NHS spaces / voids

- Penrose have been engaged with local estates teams (for example Kerry Bourne, Tim Borrie, Marcus Durkie) since as early as 2018
- As part of a deeper dive exercise in November 2022 to January 2023, we were sent a full list of the voids available across SEL
- We did a desktop assessment of these spaces and found that there were unfortunately no suitable spaces for our proposed expansion.
- Many spaces were either too small for required operating space or too far for existing staff.
- Two void spaces met the basic space / location requirements (the Jenner Health Centre and Waldron Health Centre). However, these were unsuitably configured for the proposed multidisciplinary joint working plan and would require significant capital investment to reconfigure.



Extracts from void discussion and desktop analysis of void spaces

Unsuitable alternatives in Lewisham

- Lee Health Centre in Handen Road, SE12 – there was no suitable space available
- The Biscuit Factory in Bermondsey - this location was explored, but it lacked a space large enough and with a sufficiently long tenure, which was crucial for installing HSCN connections and establishing a long-term desking solution for all staff
- Underutilised space at Goldsmiths College Music School in New Cross - despite our interest in purchasing the land at market price for primary care use, Goldsmiths College ultimately declined
- 31-37 Laurie Grove, Lewisham – this was a row of terrace houses converted into offices. It had been used by Goldsmiths College but was deemed surplus to requirements and was being auctioned off. This option was deemed not viable because of the auction mechanism, the size of the investment required and the unsuitability of the space.
- The Old Town Hall Catford – this space did not meet the size and layout requirements
- Waldron Health Centre – this space was not appropriately configured for the Support Hub function and it was hard to quantify the exposure to service charges which were anticipated to be high
- Other options were generally **more expensive, less appropriate in terms of layout, style, and design, location and contractual availability**

Why London Bridge stood out

The London Bridge space stood out as the best option for the following reasons:

- Its size and layout offered a unique environment crucial for Penrose's **innovative new way of remote working** which is distinct from simply working from home. This requires a dedicated hub for various healthcare professionals, including paramedics, pharmacists, and other additional clinical roles to work alongside call handlers, care coordinators and other ARRS staff to promote integrated working. This approach enables a higher level of supervision and support for call handlers and other ARRS staff, increasing the quality of patient communication and triaging.
- London Bridge offers a centralised training space with its own conference facilities, frequently used for meetings and training sessions involving paramedics, pharmacists, care coordinators, and GP leads from across the Penrose group.
- Locating in London Bridge provides centralised travel links across London, with the Northern Line connection being particularly helpful in terms of access by public transport. These transport links enable the organization to tap into a London-wide talent pool for its hiring needs rather than being restricted to any regional borough.
- With its private, commercial landlord, the London Bridge space was able to proceed much more quickly compared to other spaces under consideration, which often involve lengthy consultation processes and a lack of clarity on service charges.
- London Bridge was a more viable proposition than other options due to it being a less risky investment. The lease included a notice period, meaning Penrose was not locked into a long-term, high-value commitment upfront. This allowed for a more flexible and financially safer arrangement.

Why Penrose proceeded to move into the London Bridge space when we did

1. Overwhelming Need for Space

- Even before the addition of 7,000 patients from Mornington Surgery, Penrose was facing a severe and documented shortage of space across its existing facilities. Reports by Howarth Lichfield and Gleeds had already flagged Penrose practices in Lewisham as having woefully inadequate space.

- This pre-existing problem was exacerbated by natural patient list growth at all other Lewisham locations. An increase in staff including pharmacists, paramedics, and care coordinators due to a focus on more proactive healthcare further strained the already insufficient working areas.

2. Need to act quickly

- Given this urgent need, seeking a rapid solution was paramount. Penrose found that commercial providers were the only viable option for a quick solution. Support for Penrose's innovative approach came from specific individuals like Ashley O'Shaughnessy and Tim Borrie. However, the NHS estates teams (including Kerry and others) indicated that the support hub – representing a new style of working outside traditional primary care pathways – would not receive immediate support due to the need to go through health authority approval processes.

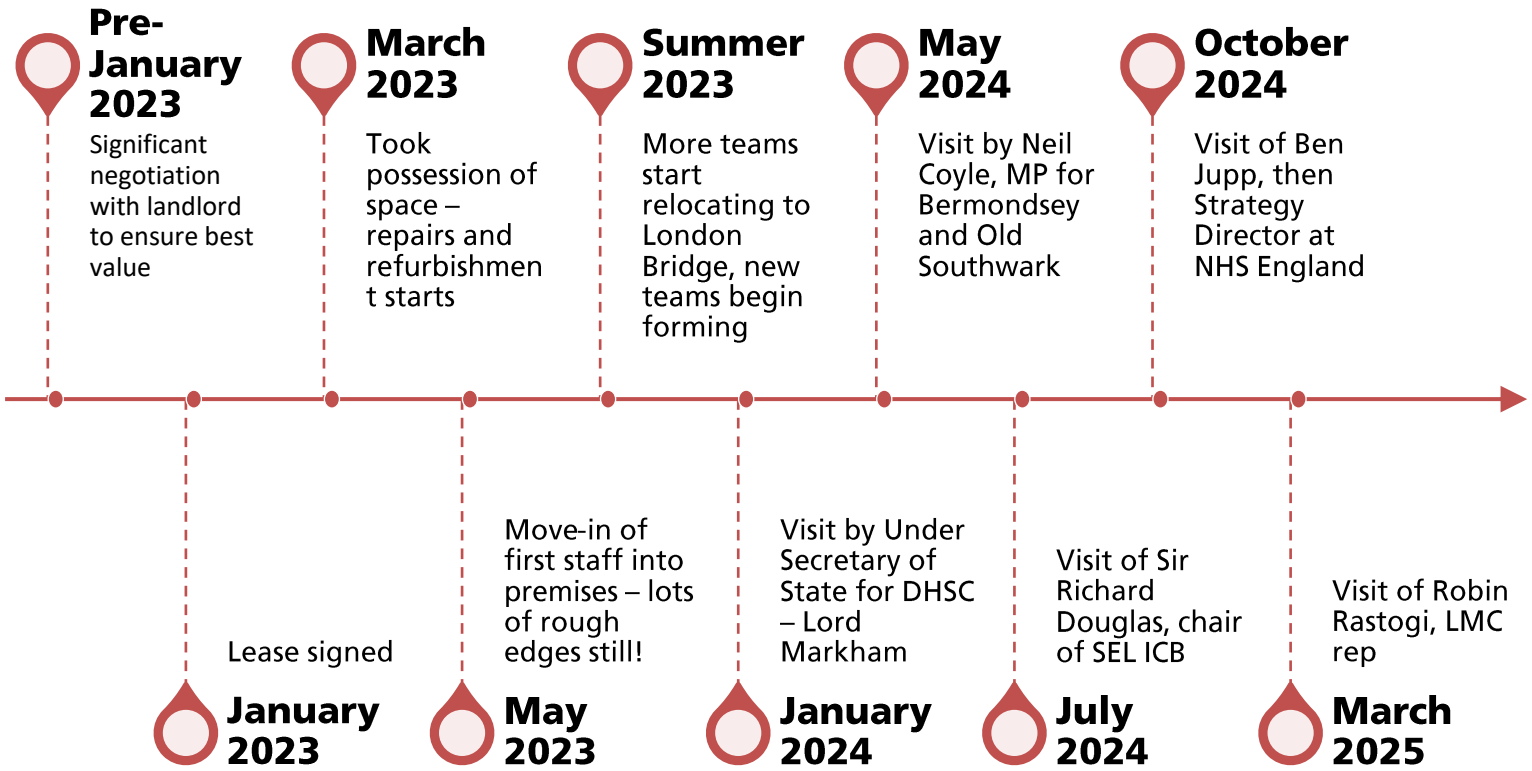
3. London Bridge was too good an opportunity to pass up

- The London Bridge lease offered key flexibility that made proceeding without immediate formal approval a calculated and acceptable risk. Crucially, the lease included a notice period, which significantly reduced the financial commitment and risk. This meant Penrose wasn't locked into a long-term, high-value agreement, making it a safer investment in an uncertain environment. Compared to the extensive list of alternatives that were considered, London Bridge stood out as by far the best option across all key criteria. After careful consideration, the Penrose partners took a business decision to avoid losing this suitable space in a good location at a sensible price.

Holyrood Street Patient Support Hub

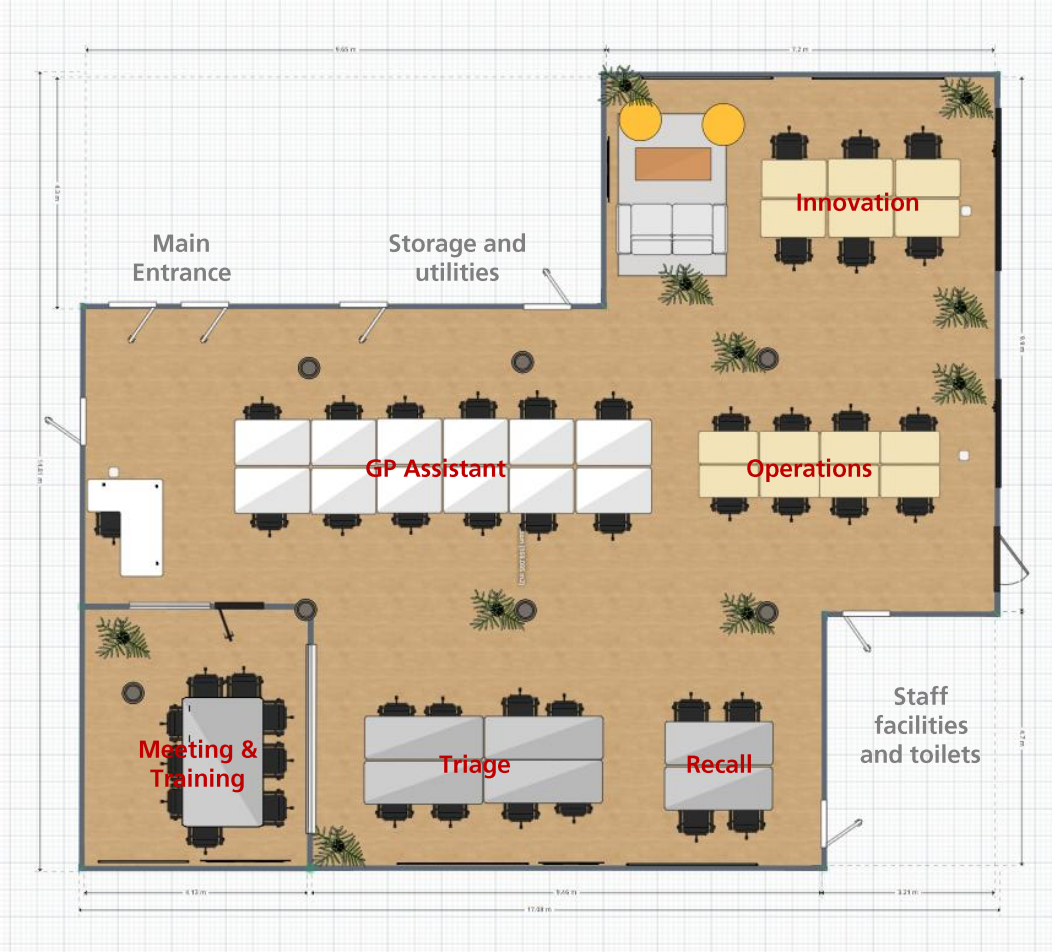
- Located at 9 Holyrood Street SE1 2EL
  - Lower ground floor
  - 2,433 sqft / 225 sqm
  - Open-plan space
  - Already fitted out and fully occupied by Penrose teams
- Favourable term lease made available by Southwark Council landlord.
- Good value for NHS tenants – rent of £39.50 / sqft, significantly lower than local averages
- Secure bicycle storage and 5 minutes walk to London Bridge station – major transport hub that enables hiring from across London
- Scalable – with the option to expand to use a second floor in 2025 to further take advantage of economies of scale

Support Hub timeline



Support Hub Floor Plan

- Significant capacity created in a co-working layout - 38 desks available in current format
- Key teams positioned together as currently laid out (see diagram on the right)
- As far as we're aware – **this is a first of its kind space which does not have comparable examples in the UK Primary Care environment**
- Space available for meeting and training, plus key staff facilities such as toilets & tea point
- Access to garden and significant natural light from north and south aspects
- Space has been fully furnished and fitted out already by practice
- Already had a number of visitors interested in the concept – everyone from PCNs to Parliament!
- Teams already working well and integrated with sites



The Support Hub in action

The new space has significantly improved core operations

Providing space for a dedicated team of Care Navigators

- The Care Navigator team centrally triage all incoming patient requests through all modes - calls, emails, web forms, online consultations
- This has led to better patient communications: across 2024, 91% of calls were answered in time, compared with 83% in 2023
- Reduced call waiting time: In 2024, average phone queue time before answer was 3 minutes, compared to 4 minutes in 2023, a 25% improvement

Freeing up clinical space in satellite sites

- Centralisation of administrative roles has enabled the repurposing of administrative space in the practices into additional clinical space
- We have created
  - 2 additional clinical rooms at Kingfisher Medical Centre
  - 1 additional clinical room at Penrose Surgery
  - 1 additional clinical room at Penrose/Maddock Way
  - Additional desks at Deptford Surgery, Knights Hill and Lewisham Medical Centre for ARRS colleagues to work from the practice

Enabling additional clinical capacity (GPs and AHPs)

- Since 2023, 22 additional staff have been hired
- Offering clinical oversight and escalation routes for Care Navigators
- Enabling more F2F appointments at satellite practices: in Feb 2025 there were 5,000 F2F appointments at impacted practices, vs 3,000 in Oct 2023, a 66% increase
- Enabling the onsite Welcome Team approach: freeing up staff at GP practices to provide more in-depth, proactive patient care

Promoting innovation, partnerships, and working at scale

- Platform to build new teams and test new technologies aimed at improving operations across practices
- New teams and tools have been used to support wider PCNs including with recalls for public health initiatives e.g. Polio, COVID/Flu housebound immunisation campaigns
- Improved operations through better teams and tools have positively impacted patient experience and outcomes both in our practices and local PCNs

The Support Hub has benefited all stakeholders

Patients

- Centralised effort on outbound texts, calls to book patients proactively for LTC management resulting in improved population health outcomes and reduced health inequalities
- Improved clinical indicators: 33,682 additional patient recalls in in past 12 months, with 9,953 additional appointments made. This includes 1196 cervical smear bookings, 2908 LTC review, 519 Serious Mental Illness, 2521 immunisation, 2093 Health check/hypertension/statins
- 66% increase in F2F appointments at impacted practices, which result in better health outcomes for patients and are preferred
- Improved patient experience in making appointments, with 8% increase in calls answered and 25% reduction in call waiting time

Workforce

- Allowed for onboarding of extra 10% staff, increasing clinical capacity
- An additional layer of cover has increased operational resilience
- Fair distribution of workload across all sites and teams
- Central location – close to major transport hub making it easy for existing staff to commute and easier to attract new candidates from across the capital
- Dedicated space to focus with patient calls without external factors / disturbances

PCNs

- Frees up space at our local practices to host PCN / ARRS colleagues onsite including Social Prescribers, First Contact Physios and new services like the Community Ultrasound clinic
- Space and infrastructure has enabled us to build teams to benefit PCNs e.g. team to arrange outbound proactive care booking for PCN led services such as NHS Health checks, Polio immunisations, COVID vaccination etc.
- The Support Hub has provided opportunities for more joined, up, community-based services, supporting a neighbourhood-based approach to primary care

Practices

- Relocation of existing roles from Lewisham practices to central hub has enabled repurposing of the space they were occupying
- Provided breathing room to house more staff to manage current workload, benefiting patients at Lewisham practices
- Long term solutions for demand management and proactive care will benefit practices, patients and staff across Lewisham

Lewisham-based practices are the primary beneficiaries of the hub

This initiative is principally supporting Lewisham practices in the first instance. The rationale for this Lewisham-centric approach is underpinned by significant local need:

- **Patient Demographics and Growth:** More than 50% of Penrose patients reside in Lewisham, and the four Penrose surgeries located in Lewisham serve the most deprived areas within the group. As can be seen on slide 3, these surgeries have experienced substantial patient growth since 2020.
- **Increased Workload from Mornington Surgery:** This growth includes a significant extra workload following the takeover of Mornington Surgery patients, who largely re-registered at Kingfisher Surgery and Deptford Surgery. Since 2020, Deptford Surgery has grown from 7,400 to 12,200 patients, and Kingfisher Surgery from 6,600 to 16,400 patients, both with no additional physical footprint.

The table on the right shows improved clinical indicators across the Lewisham-based Penrose sites as a result of the Support Hub.

Additional recalls and bookings made from the Support Hub since 1 June 2024

	Lewisham Medical Centre	Deptford Surgery	Kingfisher Medical Centre	Nightingale Surgery	Lewisham sites total
Total Recalls	6,614	3,907	6,139	4,373	21,033
Bookings made	1,801	1,095	1,507	1,232	5,635
Screenings	307	144	182	106	739
LTC reviews	506	396	381	502	1,785
SMI	99	31	109	64	303
Immunisation	328	210	323	175	1,036
Other	405	243	411	239	1,298

Medium/long term financial viability

Lease extension

- The current lease for the London Bridge space is set to expire on January 31, 2026. Negotiations are underway with the landlord, Southwark Council, for an extension of either three or five years, with a preliminary agreement already reached.
- The terms of the renewed lease are expected to be very favourable, with only a minimal increase in rent. It has been agreed that the rent will rise from £55,700 to **£57,650**, on a five-year lease with a tenant's third year break clause (subject to contract).

Mitigation of potential cost increases and long-term financial viability:

- Market-driven rates: Commercial office space prices in the area are not expected to rise significantly over the next 5-10 years. Market projections indicate average annual rent increases in the range of 4% to 6% over the next five years (Source: Knight Frank, *London Office Market Report Q1 2025*).
- Protection against price gouging: The landlord, Southwark Council, is a sensible commercial landlord expected to behave in accordance with market norms, rather than a rogue, independent landlord who might try to exploit the situation.
- Mobility and flexibility: The organization has the manpower and infrastructure to relocate within a three-month period if necessary, which acts as a safeguard against unreasonable price hikes.
- In the event of having to end the lease, Penrose do not expect any high level of dilapidation or relocation costs related to cabling or lighting. This is because the space is inherently an office, and the enhancements to cabling and lighting implemented by Penrose would only be of benefit to the landlord and subsequent tenants. In addition, no structural alterations have been made.

Patient Feedback on Support Hub

- Penrose held PPG meetings on 1st January 2025, 27th February 2025, and 28th February 2025 at Deptford Surgery and Kingfisher Medical Centre to discuss, among other matters, patient perspectives on the use of the support hub at London Bridge and the improved onsite service it has enabled at the GP practices.
- Patients expressed support for the shift to the London Bridge site for call handling, primarily due to the potential for reduced call wait times and enhanced triage, along with the Welcome Team approach enabling more proactive patient care at the GP practices.

Key patient sentiments included:

- Positive outlook on reduced call wait times: Patients appreciated the decrease in call wait times due to the London Bridge team's dedicated call handling and better support and supervision for call handlers
- Approval of the Welcome Team concept: The idea of staff at GP practices being freed up to provide more in-depth, proactive patient care (including vital signs checks, ensuring up-to-date tests and appointments, and monitoring for long-term health issues) was well-received. One patient specifically expressed confidence that this was a "good development."
- Interconnectivity of sites: The understanding that London Bridge, Kingfisher Medical Centre and Deptford Surgery were all in contact and sharing system access was viewed favourably.

Wider engagement and support

- The London-wide London Medical Commitee has been consulted on the use of the Support Hub and have been supportive of it as an initiative that uses economies of scale, innovation and technology to make primary care more efficient
- Amy Elliott, GP Support at London-wide LMCs said that this kind of initiative was 'very much at the top of the LMC agenda', while Robin Rastogi, Penrose's LMC representative who visited the Hub in March 2023 supported the initiative as a system design which 'improves operations and patient outcomes'

Broader estates strategy for Penrose

- By centralising the call handler and non-clinical functions, the Holyrood Street space is supporting all practices across our group as well as enabling us to work more closely with PCNs and INTs
- Although the patient support hub at Holyrood Street represents a major step forward in addressing significant space issues across Penrose Health practices across the ICB, there remains a shortage of direct patient-facing space at certain sites (as demonstrated by the PCN Gleeds / Howarth Litchfield reports)
- We are continuing to engage with ICB estates colleagues to assess need and provide space for f2f consulting at sites where the need for greater patient-facing space is most acute:
  - Knights Hill Surgery (Lambeth) – currently 9 clinical rooms serving almost 12k patients. Business case approved for expanding into 'Suite 2', neighbouring void space at West Norwood Health and Leisure Centre (subject to service charge discussions with NHSPS).
  - Penrose Surgery (Southwark) – currently 7 clinical rooms serving over 16k patients. In process of submitting business case for surgery to move to new space on in the Manor and Braganza Durkan development on the north side of Pasley Park.
  - Deptford Surgery (Lewisham) – currently 4 clinical rooms serving over 12k patients. Exploring the possibility of expansion to a new space in the car park at Vanguard Street. Discussions are still early stage and subject to council willingness to sell.

There was an agreement that rent and rates from Mornington Surgery would be recycled into the London Bridge hub

- When Mornington Surgery was closed and its patient list taken on by Penrose (2020/2021), the core understanding was that the reimbursement for the surgery's estate would be reinvested into additional primary care estate and resources to follow the approximately 6,000-7,000 patients.
- The understanding that the Mornington Surgery rent would be allocated for the London Bridge project was confirmed by Ashley O'Shaughnessy in a discussion with Dr Krishna, who then sent a confirmatory email to Penrose on 18th March 2022
- The original planning consent for Mornington Surgery was D1 (for a doctor's surgery). For the local council to approve a switch from D1 to residential use, assurances would have been required that there would be no reduction in NHS facilities for the local community. This reinforces the assumption that the money from the Mornington Surgery estate would follow the patients and be recycled into primary care via the London Bridge hub.
- The estimated annual rent for Mornington Surgery was £39,900, with an additional £10,000-£12,000 for rates. This totals roughly £50,000 annually.
- On this basis, Penrose believes it is not unreasonable to ask for the earmarked money to be allocated to where it was agreed

One-off and ongoing costs

Non-recurring setup costs

Cost	Notes	£ excl. VAT	£ incl. VAT
Survey and Legal fees	*Predominantly legal fees to Weightmans for lease management*	£ 2,055	£ 2,466
Internal fixtures and fittings	*Estimated materials + labour in May-23. Redecoration, refurbishment, floor repair, waterproofing.*	£ 13,500	£ 16,200
Sundry kitchen/bathroom setup	*Estimated total across multiple orders from various suppliers. Mainly bought in May-23*	£ 2,300	£ 2,760
Wiring	*Estimated materials + labour. Initially May-23 and then gradual works with further occupancy*	£ 18,000	£ 21,600
Desks and chairs	*Estimated total across multiple orders from various suppliers. Gradually bought since May-23*	£ 25,200	£ 30,240
HSCN Fibre Optic Installation	*Carried out by Redcentric. Already incurred by practice (Jun-23)*	£ 1,461	£ 1,753
Access Point Installation	*Carried out by Redcentric. Already incurred by practice (Jan-24)*	£ 1,745	£ 2,094
IT Hardware (computers, mice, keyboards etc.)	*Estimated total across Dell orders. Gradually bought since May-23*	£ 43,655	£ 52,386
Multifunctional Device (incl. Printer)	*Procured from Principal. Already incurred by practice (Jan-24)*	£ 4,962	£ 5,954
Total			**£ 135,453**

Ongoing annual charges (3-year lease starting 1st January 2023 + IT charges)

Cost	Notes	£/year (excl. VAT)	£/year (incl. VAT)
Rent	*Paid quarterly to Workman by practice from 30-Apr-23*	£ 55,706	£ 66,847
Service charges (incl. utilities)	*Paid quarterly to Workman by practice from 1-Jan-23*	£ 16,319	£ 19,582
Business rates	*Paid yearly to Southwark Council by practice from 1-Jan-23. No VAT.*	£ 18,587	£ 18,587
Microsoft 365 Licenses	*Procured from Kratos IT directly. Gradual build up to 38 licenses.*	£ 8,254	£ 9,904
HSCN Fibre connection + Managed WLAN	*Paid monthly to Redcentric by practice from 1-Jun-23*	£ 4,524	£ 5,429
Total			**£ 120,350**

The ask

We ask that the ICB support with retrospective running costs, current running costs and non-recurring set up costs.

Retrospective running costs – 1st Jan 2023 – 31st Dec 2024
• Rent- £66,847 pa • Business Rates - £18,587 pa • IT costs - £15,333 pa • Total annual costs = £100,767 • **Total retrospective running costs requested incl. VAT (over 2 years) = £201,534**

Current running costs– 1st Jan 2025 - present
• Rent- £66,847 pa • Business Rates - £18,587 pa • IT costs - £15,333 pa • Total annual costs = £100,767 • **Total annualised current running costs requested incl. VAT = £100,767**

Non-recurring set up costs
• IT Hardware – £52,386 • Wiring - £18,000 • HSCN Fibre Optic Installation - £1,461 • Access Point Installation - £1,745 • Multifunctional Device - £4,962 • **Total non-recurring set up costs requested incl. VAT = £83,787**

Thank you for your time

From the team at Penrose Health

Cover Sheet

Better Access Lewisham campaign strategy

South East London Integrated Care System

NHS South East London

Purpose

To update the Primary Care Group on progress of the Primary Care Access Campaign.

Summary of Main Points

- The Better Access Lewisham campaign aims to educate and inform the public on the ways of working in general practice.
- It also aims to help people to better understand the services available , how to access them and manage expectations around triage.

The campaign will cover the following core areas:

- ✓NHS App
- ✓Access & Triage
- ✓Pharmacy First
- ✓GP Practice Teams

South East London Integrated Care System

NHS South East London

Lewisham Primary Care

’Better Access Lewisham’ campaign strategy

Campaign focus and objectives

The campaign aims to educate and inform the public on the new ways of working in general practice, helping people to better understand the services, how to access them and manage expectations around triage.

Campaign objectives include:

- To explain the ‘total triage’ model and how it guides the appointment offered - could be face to face, telephone or online
- To relaunch existing services to Lewisham residents that they may have been unaware of and to better communicate the support on offer.
- To introduce new services to Lewisham residents, all the while informing them that they can now better access primary care across the board – GP and pharmacy services.
- To build confidence amongst the public of the services on offer, clearly explaining the support and how each service works.
- To increase patients’ trust in first point of contact (GP/other primary and healthcare providers) which will help alleviate pressure on emergency and other urgent care services.

The campaign will cover the following core areas:

1. NHS App

2. Access & Triage

3. Pharmacy First

4. GP Teams

Message house

Overarching message:
People in Lewisham can choose from a range of NHS services, providing appropriate care, when you need it.

- Lewisham GP surgeries offer a range of appointments based on clinical need
- Lewisham GP teams are made up of a range of expert health professionals
- Your local pharmacy team can help with medicines and minor health concerns
- You can access a range of services through the NHS App

Building on the work in Bexley

This campaign has been tried and tested in Bexley across 2024/25. The 'Better Access Bexley' initiative is showing positive results with residents feeling better informed, using the NHS App more frequently and making increased use of the Pharmacy First service.

Adapting the visuals for Lewisham

* Final design and colour palette to be decided

Key Messages & Timeline

PHASE 1:	PHASE 2:	PHASE 3:	PHASE 4:
Promoting the NHS App to residents	Communicating total triage, access and enhanced access	Promoting the community pharmacy services	Focusing on GP teams and the breadth of roles
JUNE-JULY 25	AUG-SEPT 25	OCT-DEC 25	JAN-MAR 26

NHS App - Key Messages

1. The NHS App is a simple and secure way to access a range of NHS services on your smartphone or tablet. Your NHS is at your fingertips. Find out more at www.nhs.uk/nhsapp

2. Millions of people are using the NHS App to manage their health the easy way, from ordering a repeat prescription to checking their records. Start using the App today. Find out more at www.nhs.uk/nhsapp

3. Join the millions using the NHS App by downloading it on your smartphone or tablet via the Google play or Apple App store. Your NHS is at your fingertips

Channels & Content:

- **We will use existing national campaign content, modifying copy for Lewisham.**
- **We will utilise external and internal advertising to maximise uptake and impact.**

Access - Key Messages

1. Local GP practices are working differently, the ‘total triage’ model allows us to allocate appointments based in clinical need. The appointments offered - could be face to face, telephone or online.

2. As well as phoning us or visiting to arrange an appointment, you can now use an online form on the practice website to get in touch. One of our team of doctors, nurses or other healthcare professionals will respond with the help you need. Speak to our reception team for more information.

3. We are working together to offer patients a range of appointments in Lewisham – that means you will be able to see a GP, nurse or other health professional at a time which is most convenient for you.

Channels & Content:

- **We will create printed materials, social media assets, digital screens (GP waiting rooms), posters, website banners (GP websites)**

- **Use the national messaging but localised with Lewisham staff**

Pharmacy First - Key Messages

1. Going to your local pharmacy offers an easy and convenient way to get clinical advice on minor health concerns - you don't need an appointment, and you can be seen in a private consultation room.

2. Available on the high-street, community pharmacy teams have the right clinical training to give people the health advice they need, with no appointment necessary and private consultations available. Community pharmacists will signpost patients to other local services where necessary.

3. Don't wait for minor health concerns to get worse – think pharmacy first and get seen by your local pharmacy team. For more information, visit nhs.uk/thinkpharmacyfirst

Channels & Content:

- **We will create social media assets and copy, content for digital screens, printed materials**
- **Use national campaign content but with Lewisham pharmacies**

GP Teams - Key Messages

1. Your general practice's reception team is specially trained in ‘triage’ they use the information you provide to help identify which health professional or service is best placed to help, so it is important to give them as much information as possible.

2. General practice teams are made up of a range of health professionals who work at your practice and in the wider community to help you get the right care when you need it.

3. The practice team can help you get the right care. They can help you by:

    - Getting you an appointment with the right healthcare professional as quickly as possible.
    - Identifying services you can access with a GP referral.
    - Making appointments for new kinds of care or services you may not be aware of.

Channels & Content:

- **We will create videos, social media assets and copy, posters, leaflets, digital screens**

- **Use national campaign content but with Lewisham staff**

Campaign visibility

LHCP & ICB channels:

- Lewisham ICB webpage
- LHCP socials – X, Facebook, Instagram
- Paid-for social targeting Lewisham residents
- GP screens across the borough
- Digital screens in other NHS spaces (LGT etc)
- Printed materials – posters and leaflets

Partner channels:

- Lewisham Council social media and web pages
- Lewisham Council Newsletter
- Lewisham Life Magazine
- JC Decaux across the borough (tbc)
- Local libraries and community spaces
- Community champions network

Next steps

- Complete the campaign design and colour palette
- Agree which staff will be featured in the campaign
- Complete the staff photoshoot and prepare video content
- Draft messaging for phase 1 & 2

Lewisham Integrated Quality and Assurance Group meeting

Minutes of the meeting held in public on 12th May 2025 at 11.00 hrs.

via MS Teams

Present:

Louise Crosby (LC) (chair)	Chief Nurse, LGT
Ceri Jacob (CJ)	Place Executive Lead (PEL), SELICB
Laura Jenner (LJ)	Director of System Transformation, SELICB/LBL
Caroline Walker (CW)	Senior Quality Lead, SELICB
Kenny Gregory (KG)	Director of Adults Integrated Commissioning, SELICB
Ashley O'Shaughnessy (AOS)	Associate Director of Primary and Community Based Care, SELICB/LBL
Sara Rahman (SR)	Director of Families, Quality & Commissioning, LBL
Michael Kerin (MK)	Healthwatch representative
Helen Magnusen Baker (HWB)	Lead Pharmacist, SELICB
Joanne Peck (JP)	Site Director of Nursing, LGT
Iain McDiarmid (IMd)	Assistant Director - Adult Integrated Commissioning, LBL
Fergie Downie (FD)	Service Manager, Homelessness Prevention and Assessment Service, LBL
Paul Creech (PC)	Senior Commissioner, CYP Joint Commissioning, LBL
Folake Jacobs (FJ)	Designated Clinical Officer, CYP Joint commissioning LBL
Nicole Zwane (NZ)	Head of Care Resources, LBL
Matthew Agbolegbe (MA)	Head of Nursing and Quality, SLaM

Gamu Matsau (GM)	Clinical Nurse Officer for CYP & Mental Health, LBL
Tolulope Olaniyan (TO)	Programme Lead & Local Area Contact, SELICB
Margaret Mansfield (MM)	Designated Nurse Children Looked After, SELICB
Cordelia Hughes (CH)	Borough Business Support Lead, SELICB

Apologies for absence:

Dr Catherine Mbema
Dr Tom Simpson
Carolyn Denne (represented by Michael Kerin)
Marylyn Nathan Smith
Ann Guindi
Vanessa Smith
Helen Woodford
Joan Hutton

		Actioned by
1.	**Welcome, introductions, apologies for absence & Minutes from the previous meeting held on 10 January 2025.** LC (Chair) welcomed everyone to the meeting. LC advised attendees of the housekeeping rules. Minutes from 10 January approved. Action log – all actions were completed.	
2.	**Performance, Caroline Walker** CW presented highlights from the performance report and noted that hypertension and LD and Autism health checks had improved. AOS mentioned that dementia diagnosis rates have a dip in performance but that this is due to a data issue as a result of care home data not flowing through.	
3.	**Lewisham Flu Action plan, Laura Jenner** LJ presented on the flu action plan and provided some initial data and noted that plans are in place for the upcoming flu season and that it would be great to get feedback on the plan. Performance is mixed for flu vaccination: for over 65+ the target is 61%, but reached 54.6%, under 65+ target of 35%, but reached 29.3%. This highlights a need to radically change our approach if we want to see an increase. For children aged 2-3 years, they reached 39.2%, however, there are cultural issues going on and analysis shows people over 65+ and those under 65+ who are vulnerable; there is a disconnect in those getting vaccinated. In the presentation is a heat map which shows areas such as north and south Lewisham and Black communities who	

	have a low uptake. LGT staff reported at 18% and housebound patients are also low – so lots to do in these areas. There is also a low uptake in children of school ages due to a low return of permission slips, so an admin process concern. **Action:** LJ to provide a breakdown of schools in which children of school age have a low return on permission slips. There are many places where people can be vaccinated and there are messages around this, but we need to understand the real reasons why people are not getting vaccinated. As a result, the flu vaccine plan is commissioning two pieces of work. 1) to connect with residents and why they do not want to be vaccinated and what support we can offer, 2) and work with VCSEs on identifying areas such as community faith leaders for example to build relationships and increase vaccines hubs in Lewisham. Also conduct some myth busting around the fears of having the flu jab. AOS mentioned that for school age children, there is new provider to help drive our new campaign. In addition, the cohort of pregnant women in Lewisham and Greenwich outperformed London and the South East with the flu vaccination. Housebound patients is more resource intensive but have had some positive conversations with the LGT district nursing so working on a proposal. CJ commented that it is good we are engaging with our community leaders, but all need to look at opportunistic vaccinations. LC echoed this comment. PC said that when reviewing analysis of children of school age, analysis showed that those in the highest deprived area were more likely to uptake, whereas those in affluent areas would be more likely to reject. Also, enduring consent (where parents/carers agree once via a permission slip) is a possible option but unable to action at present. GM mentioned that the mental cohort should not be forgotten as this impacts on physical health and annual health checks for example, also how can we link to increase uptake. JP mentioned that co-administration has worked well in maternity services, also conducted some webinars to myth bust, co-location vaccinators in kaleidoscope such as ‘one stop, one location.’ In regard to staff vaccinations, not sure what else we can do as numbers are going down and down. KG referred to the vulnerable adults’ cohorts, mental health colleagues and social care workforce, care home/domiciliary care who are local. There are some opportunities with these groups. HMB said that staff	**LJ**

	need to be on the PGD list to administer vaccinations. LJ agreed with KG regarding domiciliary care and would facilitate a conversation with them around flu uptake. MA agreed with the points raised and said that SLaM had done something similar and held a staff recharge event which doubled up as clinics or shared learning event. **Action:** SLaM will share their flu uptake figures for the next meeting as saw a slight increase. AOS confirmed that Primary Care are working with Public Health as part of a wider programme to refresh the vaccination strategy.	**MA**

4.	**Homelessness, Fergus Downie**
	
	FD presented on homelessness and rough sleepers providing insights to the reason for homelessness and rough sleepers, demographics and the approach in managing this service area. FD reported on some of the financial pressures for Councils mainly driven by housing costs, adult social care which has been responsible for bankrupting a few Councils.
	
	LC thanked FD for his presentation and asked if there was anything as a borough, we could improve on and what would that be? FD mentioned rough sleepers and understanding what is driving people who would not usually be rough sleepers and mentioned that they do not meet the priority needs. Also, HMO is another thing to weed out less desirable landlords.
	
	SR referred to children and young people in temporary accommodation and the outcomes in relation to school, mental and physical health – there is a need for a holistic approach.
	
	Action: Invite FD back to a future LIQ&A group meeting to see how developments have taken place. CW to add to planner.
	
	AOS added that the Enhanced Services (OOO) provides additional support and health to support the homeless population and rough sleepers:
	
	• The Rough Sleepers nurse works with the outreach team undertaking health needs assessment as part of first contact.
	
	• The GP enhanced homeless service delivers provision at
	
	  ○ 999 club for rough sleepers,
	  ○ Fairway Lodge (first stage accommodation for rough sleepers),
	  ○ Spring Gardens, LARC @ Pagnell Street and Honor Lea
		CW

	• Total capacity across all sites can support approx 195+. • Currently trying to recruit to a homeless health HCA to support the above service provision • The nurse led Health Inclusion Team (HIT) also deliver weekly sessions across the above hostels. • Awaiting confirmation on whether funding for the Diagnosis Homeless Outreach Practitioner (DD HOP) had been extended into 2025/26. The role works with people experiencing rough sleeping, mental ill health and substance use.	
5.	**SEND Inspection, Paul Creech and Folake Jacobs** FJ presented on the SEND Inspection which took place in September 2024. Overall, there were many positives from the inspection. However, there were some areas for improvement which pertains to: "*The local area partnership's current arrangements lead to inconsistent experiences and outcomes for children and young people with SEND and urged the partnership to work collaboratively to implement necessary improvements*." As a result, an improvement plan is in place which will be sent to the DfE, with 3 key areas to improve on which are to: increase assessment, wait times and Autism and LD assessments. A strategic plan has been sent to DfE, awaiting feedback. To note the next inspection is in 3 years' time. LC thanked all for the presentation and asked if there is the resource available to deliver this**.** PC confirmed a Service Development Improvement Plan (SDIP), and pathway is under review to increase the number of staff and changing the mix of staff such as nursing staff for example. **Action:** CW to add to forward planner and invite PC/FJ to a future meeting later in the year, to share how progress has developed and self-assessments.	**CW**
6.	**Unregulated Providers, Nicole Zwane, Gamu Matsau** GM presented on unregulated provider which had been discussed at January's LIQ&A group meeting. Children with mental health conditions and escalating behaviours are under a 3:1 (over supervised) and placed into Lewisham houses with carers – most are out of borough such as Kingston Local Authority who placed out of borough placements in Lewisham. However, over supervising can add	

	to their mental health and often there is no Deprivation of Liberty Safeguards (DoLs) in place. GM said they have had a number of discussions with LGT colleagues, CAMHS regarding the challenges, NZ said that health is routinely informed but that there is no process for children that are placed with unregulated providers and that there is a need to offer best practice and monitor. NZ went through a presentation to highlight the main concerns regarding unregulated providers. KG asked if the adults and child safeguarding board are looking at this? CW confirmed that Rebecca Saunders, HoN SELICB Safeguarding Lead is aware of the situation. CJ suggestion an approach would be to have better communication and lobbying across ICBs, and if not at that level, then can do across SEL and push out to other ICBs. SR confirmed that there is a lot of lobbying going on in the borough. MM said that this is a risk and needs to be escalated, potentially nationally and agreed to meet offline with CW/NZ/MM to discuss this further. **Action:** NZ/CW/MM to link up and discuss further and feedback to this group at a later date. CW to add to forward planner.	**CW/NZ/ MM**
7.	**Forward planner** CW presented the forward planner for the upcoming months.	
8.	**Any Other Business** Due to the time, it was agreed to defer LeDeR agenda item the next LIQ&A group meeting in July 2025. CW to add to forward planner. LC closed the meeting at 13:02pm	**CW**
9.	**Date of next meeting.** Thursday 11 July 2024 at 11.00 hrs via Teams	

Date of Meeting	Agenda Item	Presenter
4th August	Meeting Stood Down (Half Term)	
1st September	PAWS Deep Dive	CM/KG
	feedback from Self-referral for Physiotherapy Pilot	Helen Laing
	N2C Community Pilot Project	Lesa and Kenny
	Risk (Community Dermatology Service - waiting times)	Ashley / Tom
6th October	Lewisham Start for Life Perinatal Mental Health and Parent-Infant Relationship Programme: Evaluation and plan for future investment:	SR / SMh & LB to pull together a business case on what the programme has been able to do and potential shortcomings.
3rd November	Community Paediatrics Neurodevelopmental Pathway Clinical Transformation	Dorett Davis / Stacey Jarrett
5th January 2026	Community Paediatrics Neurodevelopmental Pathway Clinical Transformation	Dorett Davis / Stacey Jarrett

Place Executive Lead Action Tracker

Commenced - 7th July 2025

Date of Meeting	Agenda Item	Description	Responsible	Deadline	Update
04/08/2025		No meeting			
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
07/07/2025	Community Paediatrics Neurodevelopmental Pathway Clinical Transformation	Primary Care need to chase if going to have input ahead of event on 14th July - LJ to touch point with SEL Colleagues on the workshop / hub	LJ	1st September 2025	
		Agreed to come back in 6 months time - LW to add onto fwd planner	DD/ CYP Colleagues	1st September 2025	
	INT virtual ward PAWS modelling	Agreed to take slide deck presented by JH to the LGT community service board and the Lewisham Care Partnership Board (LCP) along with the read across plans.	JH/LJ	1st September 2025	
		TH to touch point with Joanna Peck to ensure sighted then for TH/LJ/JP to have a touch point meeting on JP return.	TH/LJ/JP	1st September 2025	
		LW to share the read across slide deck that was presented by LJ	LW	1st September 2025	
		For the INT model to be presented at the LGT all staff webinar which links in with the 10 Year Health Plan for England and in particular the roles that LGT will be hosting and what that will mean.	LJ/FK	1st September 2025	
	Updates on each partner	KG to add onto the risk register in terms of accommodation for the Pilot Project and the Pop health Platform.	KG	1st September 2025	
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
02/06/2025		No meeting			
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
12/05/2025	N2C Community Pilot Project	AA to confirm on numbers that is able to be supported through the model and potentially what geographical area they are covering	AA	1st September 2025	7/7 - remain open with view of getting an overarching update at Septembers meeting
		AA/LC/FK/LJ offline to look at how to improve the interface between N'hood working. FK is leading on and the N2C Community Pilot and align the Governance.	AA/LC/FK/LJ	2nd June	7/7 - LJ has reached out in in terms of having a meeting around N'hood 2 and SLaM Team are looking at extending their boundaries to ensure they align better with the unhood working. LW/LJ to chase
	Highlight Reports	Agreed to use June meeting to do a deep dive on Highlight Reports and look at the metrics and to agree on what we want and don't want and what we can do and cant do	ALL	2nd June	Agreed to pick up in autumn
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
07/04/2025	(Agenda item2 - Highlight Report) Older Adults Transformation	Agreed to move PAWS deep dive to July 2025 meeting / use 2nd June meeting as workshop for HRs including edge work	CM	2nd June 2025	Agreed to pick up in autumn
	AOB - Risk Register	agreed for Risk 1- ED Front Door to be closed following update from JC and confirming seeing great results since the UTC opened. Agreed to change wording for ED Front Door risk. Ongoing estates work for 25/26	LW/JC	2nd June 2025	7/7 TH to look through and confirm offline
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
06/01/2025		No meeting			
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
02/12/2024	(Agenda item 3) Lewisham Start for Life Perinatal Mental Health and Parent-Infant Relationship Programme: Evaluation and plan for future investment:		SR / SMh & LB to pull together a business case on what the programme has been able to do and potential shortcomings.	?	
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**
07/10/2024 - In Person	(Agenda item 2) Highlight Reports	Helen Laing agreed to come back to a future meeting to feedback from Self-referral for Physiotherapy Pilot	LW/HL	12h May 2025	Agreed to arrange for September meeting - LW to arrange
		Scott Pendleton to come back to a future meeting to share service plan in terms of which services and where they fit.	LW/SP	On going	BB to touch base with Scott Pendleton replacement
		LJ o touchpoint with AL/JH/JMc to touch base in terms of how Respiratory would fit into PEG	LJ/AL/JH/JMc	12th May 2025	meeting being arranged with service area and ICB on the clinical arrangements
Date of Meeting	**Agenda Item**	**Description**	**Responsible**	**Deadline**	**Update**

Date of Meeting	Description	Responsible	Deadline	Update	Completed Date
03/02/2025	(Agenda item 4 Highlight Report) MH Community Pilot Update - LB share very high level of the implementation plan which will set out key dates for when the service will go live and what the key interface will be	LB	12th May 2025		7/7/2025
07/04/2025	Update on each partner - Risk (Community Dermatology Service - waiting times) AOS to provide an update in June Meeting following the new contract due to go live in May 2025. Agreed to change wording for ED Front Door risk.	LW/AOS	2nd June 2025	7/7 - agreed to bring to September - added onto fwd planner and close action as picked up through the risk register. 12/5 - waiting times issue still persist and new provider are in the process of transferring patients over from OHL and part of that process they will do a waiting list validation exercise to check the patients that are on the waiting need to be. it will continue to be an issue rather then a risk. 7/4 AOS noted that following the procurement process, contract has formally be awarded and due to go live on 1st May 2025 and in the process of patient transition	7/7/2025
07/10/2024 - In Person	(Agenda item 2) Highlight Reports LJ to touchpoint with AL/JH/JMc to touch base in terms of how Respiratory would fit into PEG	LJ/AL/JH/JMc	12th May 2025	meeting being arranged with service area and ICB on the clinical arrangements	7/7/2025

Date of Meeting	Description	Responsible	Deadline	Update	Completed Date
07/04/2025	(Agenda item2 Highlight Report) Older Adults Transformation - agreed action for offline to look around the mentoring/what's happening/what's been delivered/what's been tracked for the outcomes and where that's been reporting too to ensure its not been duplicating	agreed action for offline to look around the mentoring/what's happening/what's been delivered/what's been tracked for the outcomes and where that's been reporting too to ensure its not been duplicating	BB/LJ/CM/SA	12th May 2025	27/06/2025
03/03/2025	(Agenda item 5) SDIP transformation BC 2025/26 Update (Action from last meeting) - to bring back the allocations to the April meting	TH/LJ	12th May 2025	CLOSED - LJ confirmed schemes have been signed off with the view of confirming that the funding has been allocated to the correct places.	27/06/2025
	(Agenda item 4) Highlight Reports - Enablers - CMS to touch point AA to provide contact for SLaM procurement	LJ/CMS	12th May 2025		27/06/2025
	(Agenda item 2) Good News Stories- AOS to circulate the PCN videos which was presented at the Lewisham GP Awards once finalised with the PCN clinical directors and mangers in how best to share more Broadley		AOS/LW	12th May 2025	27/06/2025 - AOS to touch point with PCN Leads to work how and where to populate the videos
	(Agenda item 4 Highlight Report) Autism - LW to add agenda item onto forward planner for agenda item to come back to a future meeting	LW to add agenda item onto forward planner for agenda item to come back to a future meeting	LW	12th May 2025	27/06/2025
		SR agreed to come to a future meeting to give an update in terms of CYP & Adults.	LW/SR	On going	27/06/2025
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**

	(Agenda item 1) Welcome, apologies for absence & minutes/actions of 3rd February 2025 & declarations of interest.	(Agenda item 1) Welcome, apologies for absence & minutes/actions of 3rd February 2025 & declarations of interest.		NO attendance from LGT / No council operational	07/04/2025
	for SDUC / ED Redirect element AL to circulate slides			7th April 2025	07/04/2025
	Outcomes measures for agenda item needed to be added onto highlight report	KG/AA		7th April 2025	07/04/2025
03/03/2025	BB to check with NG in how information is bringing shared with LGT	BB		7th April 2025	07/04/2025
	CM to touch point with Pop Health Team around CGAs high referrals into social care and track that against what they have been referred into and the outcome.	CM/RS	7th April 2025	Meeting scheduled with the Pop Heath Team to confirm which data will be collected going forward in a way of an evolution with the PAWS Service	07/04/2025
	TH to come back to March meeting to provide an update	TH	7th April 2025		07/04/2025

Date of Meeting	Description	Responsible	Deadline	Update	Completed Date
03/02/2025 - Online	(Agenda Item 6) Risk Register	AOS to touch point with TH and JC around updating the Dermatology Risk	AOS/TH/JC	3rd March 2025	03/03/2025

Date of Meeting	Description	Responsible	Deadline	Update	Completed Date
02/12/2024 - Online	UEC / UEC front door building works: Amanda Lloyd & Jen Cassettari. AL highlighted that there will be a new post and going out for advert with the view that potentially the new post will provide support to the wider system	KG/LJ/AL to look at the JD for the new post	3rd February 2025		03/01/2023
	Was agreed for the Community Pilot project to come back to a future meeting	KG/AA to come back to provide an update	3rd February 2025		03/01/2023

04/11/2024 - Online	It was agreed for the two highlighted risks to be added onto the PEG risk register:- - Placement overspend has a financial risk, which has an impact on SLaM, Local Authority and ICB recognising that is doesn't have an impact on all partners but does have an impact on majority of our LCP age partners noting the MH Alliance Committee are in works to secure a plan to mitigate the risk. - ED risk potentially needs to be reviewed in terms of presentation and flow in which has an impact on ICB, Local Authority and the Acute sector recognising been an ongoing risk and with systems in place to mitigate the risks but will have a impact on those that are fit for discharge and wait times in ED.	KG to come back to provide an update in terms of Placement overspend	3rd February 2025		03/01/2023
07/10/2024 - In Person	It was agreed for MH/Children Highlight Reports and to do a deep dive around Autism and ADHD		LW/Simon Whitlock and Dorett Davis	3rd February 2025	03/01/2023
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
02/12/2025 - Online	AOS to circulate wording around the 'Community Dermatology Service - waiting times' issues to identify what the issues are.	AOS	3rd February 2025		31/01/2023

02/12/2025 - Online	agreed LJ would touch base with FK in terms of MDMs/attendance and to come back to the 2nd of December meeting around Neighbourhoods, model of care and how can we involve patients in delivering the work.	LJ	2nd December		31/01/2023
	Agreed that director of housing, Lewisham Council needs to be brought into the conversation regarding system intentions. LJ to arrange.	LJ	On going	07/10 - LJ to touch base with Ellie Eghtedar to attend a future meeting. 02/09 – Action to remain open, KG to provide update at next PEG Meeting on 7th of October or beforehand. Action from PEG meeting held on 2nd October 2023. 10.06 KG raised at a LBL meeting but will go back to ask who from housing will be able to attend PEG.	31/01/2023
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
04/11/2024 - Online	agreed a touch point meeting to be scheduled between JH/AL/LJ and MC with potentially someone from acute	LJ/MC	2nd December		2nd December
	MC/RS to touch base around pop health data.	MC/RS	2nd December		2nd December
	Agreed MH Pilot needs to be added onto MH intentions	LJJ	2nd December		2nd December
	The working on the community dermatology risk needs to be revised and consolidated into one	AOS/LJ	2nd December		2nd December
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
	LJ agreed to take the principles to discuss at a future LCP meeting to get Primary Care and voluntary sector input.	LJ	7th October	Being managed through the Lewisham & Peoples Partnership	4th November

07/10/2024 - Online	LJ to set up a SDIP focused meeting which will also discuss where MSK reports into and look at other services and to look around how dermatology fits together	LJ	4th November	SDIP meetings have been scheduled, which will occur the third Monday of every 1 month, these meetings will support the development of the community services, agree SDIP funding for next year and pick up on areas where are unclear where they fall too.	4th November
	LJ agreed to take the principles to discuss at a future LCP meeting to get Primary Care and voluntary sector input.	LJ	7th October	Being managed through the Lewisham & Peoples Partnership	4th November
Date of Meeting	**Description**	**Responsible**	**Deadline**	**Update**	**Completed Date**
20/07/2024 - In Person	TH mentioned around including planned care and elective care in some capacity via the programmes as sometimes this can get lost – is there something specific for Lewisham residents such as MSK in order to do some coherent planning. BB agreed with TH and mentioned health inequalities work in the surgical pathway and bringing this to this meeting.	LJ/BB/CH	7th October	07/10 - Action to be closed as agenda item 02/09 – Action to remain open and to be Include as part of the future agenda.	7th October