South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Lewisham Local Health and Care Partners Strategic Board – Part I
Date: Thursday 23 July 2026, 14.00-16.00hrs (includes 5-minute break)
Venue: MS Teams (meeting to be held in public)
Chair: Neil Goulbourne, Chief Strategy and Transformation Officer & Deputy CEO

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 28 May 2026 (for approval) & Action Log**	Verbal/ Encs 1 & 2	Chair	To Note/For Approval	14.00-14.05 5 mins
2.	**Any questions from members of the public**			n/a	14.05-14.10 5 mins
3.	**PEL (Place Executive Lead) Report**	Verbal	Ceri Jacob	For Noting	14.10-14.15 5 mins
	Delivery *(3)				
4.	**Health Inequalities Budget**	Enc 3	Patricia Duffy / Laura Jenner	For Approval	14.15-14.30 15 mins
5.	**Neighbourhood Prevention Hubs**	Enc 4	Fiona Kirkman	For Discussion	14.30-14.45 15 mins
6.	**Organisational Development work**	Enc 5	Beckie Burn/ Charles Malcolm-Smith	For Discussion	14.45-15.00 15 mins
7.	**ICB Transition**	Enc 6	Ceri Jacob/ Laura Jenner	For Discussion	15.00-15:15 15 mins
	Break – 5 mins				
	Governance & Performance				
8.	**LCP performance data report – May 2026**	Enc 7	Ceri Jacob	For Discussion	15.20-15.30 10 mins
9.	**Risk Register**	Enc 8	Ceri Jacob	For Discussion	15.30-15.40 10 mins

10.	**Finance update**	Enc 9	Chris Dance	For Discussion	15.40-15:55 15 mins
	Place Based Leadership				
11.	**Any Other Business**		All		15.55-16.00 5 mins
			CLOSE		
12.	**Date of next meeting (to be held in public): Thursday 24 September 2026 at 14.00hrs via Teams**				
	Papers for information				
13.	**Minutes/Updates from:** • **Lewisham Neighborhood Programme Board (formerly known as PEG) Minutes** • **Primary Care Group Chairs Report** • **Lewisham Medicines Optimisation and Prescribing (LMOP) Group Chair's report**	Enc 10			

* To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes

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Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 28 May 2026 at 14.00 hrs

via MS Teams

Present:

Dr Helen Tattersfield (HT) (Chair)	Chair, Primary Care Leadership Forum, Lewisham
Ceri Jacob (CJ)	Lewisham Place Executive Lead, SEL ICB
Sabina Dixon (SD)	VCSE representative, SIRG
Michael Kerin (MK)	Healthwatch representative Lewisham
Denise Radley (DR)	Director of Adults Social Care and Health, Lewisham Council
Dr Catherine Mbema (CMb)	Director of Public Health, Lewisham Council
Dr Simon Parton (SP)	Chair, Local Medical Council
Anne Hooper (AH)	Community representative Lewisham
Karen Sadler (KS)	CEO, One Health Lewisham
Vanessa Smith (VS)	Chief Nurse, SLaM

In attendance:

Cordelia Hughes (CH) (Mins)	Borough Business Support Lead, SEL ICB
Jack Howell	Virtual Wards Delivery Manager, SEL ICB
Dr Esther Appleby (EA)	CCPL, Older Adults, SEL ICB
Jonathan McInerny (JMc)	Head of Long-Term Conditions and Cancer, SEL ICB
Kenny Gregory (KG)	Director of Adult Integrated Commissioning, SEL ICB
Beckie Burn (BB)	Associate Director, Improvement and Transformation. LGT
Fiona Mitchell (FM)	Designated Safeguarding Lead, SELICB

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Dr Aaminah Verity (AV)	Lewisham Salaried GP and Health Equity Fellows
Ashley O' Shaughnessy (AOS)	Associate Director of Primary Care Development
Riaz Jethro (RJ)	GP Lead, Primary Care, Lewisham
Hillna Fontaine (HF)	SIRG
Afghan Khan (AK)	Secure Co UK (member of the public)

Apologies for absence: Neil Goulbourne, Sara Rahman, Laura Jenner

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 28 May 2026.** Dr Helen Tattersfield (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. HT advised attendees of the housekeeping rules and apologies for absence were noted as detailed above. The minutes of the previous meeting were agreed as an accurate record. Declaration of Interests (DOIs) – In progress. Minutes of the Lewisham LCP Strategic Board meeting held on 28 March 2026 – these were agreed as a correct record. Action log – The Board reviewed the action log: the action regarding neighbourhood alignment remained open pending further work, while other actions were either completed or reflected within items on the today's agenda Matters Arising – None.	
2.	**Questions from members of the public** The Chair invited questions from members of the public. No questions were raised during the meeting.	
3.	**PEL (Place Executive Lead) report** CJ presented the Place Executive Lead report:	

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	NHS Changes CJ highlighted ongoing progress in relation to the NHS Change Programme, noting that the organisation was moving into the next phase of workforce transition, including role matching and recruitment. It was acknowledged that this continued to be a challenging period for staff and that significant organisational development activity would be required to support the transition, including workforce development, cultural alignment and new ways of working across the system. **Neighbourhood Health Centres** An update was provided on the development of neighbourhood health centres, with proposals submitted to NHS England. It was noted that Lewisham would take a networked approach, making best use of existing estate and community assets rather than relying solely on single-site developments. **National Neighbourhood Framework** The National Neighbourhood Framework has now been published. While it is NHS focused, Lewisham will continue to take a broader, community-wide approach. Overall, Lewisham is in a strong position, with much already in place or underway, although further work remains. MK asked whether sufficient attention was being given to organisational development and workforce integration alongside capital investment. In response, it was confirmed that estates are only one enabler of effective delivery and that workforce and digital capability are equally important. The Board also noted the agreed system priorities for 2026/27, including neighbourhood health delivery, strategic commissioning development and a continued focus on addressing inequalities. **The Lewisham LCP Board noted the PEL report.**	
4.	**Strategic Investment Fund (SIF)** JH presented an overview of the Strategic Investment Fund, outlining its purpose in supporting delivery of neighbourhood health priorities aligned to South East London strategic commissioning objectives. Lewisham has ring fenced strategic investment funding totalling £1.6m in 2026/27 (part-year), rising to £2.14m recurrent from 2027/28.	

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	Funding is aligned to neighbourhood health priorities and SEL strategic commissioning objectives. **Proposed Allocation** • Total programme allocation c. £2.14m across six workstreams, including prevention, frailty, MLTC, CYP, and integrator development. A 25% in-year reduction (Q1 pressure) impacts delivery funding across all workstreams. The Board noted the allocation for Lewisham for 2026/27 and the focus on prevention, long-term conditions, frailty, children and young people, and system development. AG queried the extent to which prevention funding would support children and young people (CYP). JH acknowledged that the current proposals were still in development and had been primarily adult-focused to date, with further design work required to ensure that CYP priorities are appropriately reflected. BB emphasised the importance of clear governance arrangements, including transparent reporting, decision-making and the ability to track outcomes associated with the investment. CJ highlighted the need for proposals to be underpinned by robust data and suggested that areas such as chronic pain could represent an opportunity for targeted investment to address inequalities. It was also noted that the funding provides an opportunity to support pump-priming of initiatives alongside recurrent investment. MK raised a number of concerns regarding governance and accountability, including the clarity of reporting arrangements, the role of public transparency, and the involvement of Healthwatch and wider community voices. CJ confirmed that governance arrangements are evolving in line with wider system changes, that the LCP Board provides a public forum for transparency, and that further proposals would be brought back to future meetings and seminars. SD also emphasised the importance of meaningful community and VCSE engagement, including involvement of strategic VCSE leads. It was confirmed that engagement is embedded within programme design, with further stakeholder and community sessions planned.	

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	Actions: 1. AG to provide further details on children and young people prevention priorities to share with JH. 2. Leads to respond to VCSE / BLACHIR recommendations and strengthen engagement arrangements provided by SD. **The LCP Board noted Strategic Investment Fund**	**AG** **All**
5.	**LCP performance update – April 2026 and Focus on Cancer screening** EA and JMc presented an update on cancer screening programmes, including bowel, breast and cervical screening, as well as the rollout of the lung cancer screening programme. Key highlights include Lewisham has made strong progress in breast cancer screening, Bowel cancer screening performance is stable but below ambition and Cervical screening remains the most significant challenge. The Board noted improvements in breast screening uptake, including a reduction in inequalities, alongside ongoing challenges in cervical screening performance, particularly among younger cohorts. The lung cancer screening programme was highlighted as a significant development, with evidence of early detection and positive outcomes, particularly within more deprived populations. SP sought clarification regarding referral pathways for patients with abnormalities identified through lung screening. EA confirmed that pathways are nationally defined and locally adapted, with clear protocols in place for primary care and direct referral arrangements for urgent cases through secondary care multidisciplinary teams. CJ highlighted the positive impact of screening programmes in reducing inequalities and proposed that further work be undertaken outside of the meeting to explore scaling HPV self-sampling through community and VCSE partnerships. FM asked whether screening targets applied to under 25s. It was confirmed that this cohort is not eligible for either breast or cervical screening based on national evidence-based criteria. **The LCP Board noted the LCP performance update – April 2026 and Focus on Cancer screening**	

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6.	**Risk Register** CJ presented the risk register and noted that there were no new risks and that risks relating to financial efficiencies and the population health platform had been closed following progress against actions. The only risk that had deteriorated related to preventable diseases, linked to vaccination uptake and herd immunity. **The LCP Board noted risk register**	
7.	**Q4 Adults Safeguarding report** FM presented the Q4 safeguarding update and highlighted a continued increase in safeguarding concerns within Lewisham, reflecting both rising demand and increased awareness and reporting. The Safeguarding Adult Reviews and Domestic Homicide Reviews evidence that there are both social, economic and environmental reasons that determine significant inequalities in health outcomes amongst Black African and Black Caribbean communities, both locally and nationally. For this purpose, the aim of the work in Lewisham is to reduce the disparity and safeguard all groups of individuals both children and adults at risk by improving health outcomes and quality of life by learning and by embedding recommendations from such reviews. The Board noted the extensive programme of training and workforce development, including a focus on violence against women and girls, domestic abuse, and complex safeguarding issues. HT asked why Lewisham experiences comparatively high levels of domestic abuse and violence. FM reported that this is multifactorial and linked to wider social determinants including poverty, housing conditions, overcrowding, access to education and employment, and substance misuse. It was acknowledged that these issues are complex and require a system-wide response. **The LCP Board noted the Q4 Adults Safeguarding report**	
8.	**Finance Update** CJ presented a finance update for Month 11 Year End financial position.	

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	ICB Lewisham The ICB had achieved a small surplus against a planned breakeven position. **Wider ICS** The wider ICS also reported a surplus position, supported in part by national funding. It was noted that significant financial pressures remain within local authority services, particularly adult social care and children and young people's services, reflecting increasing demand and complexity. **Lewisham Council** Lewisham Council's financial position is included in the report for noting. CJ stated to Board members that Michael Cunningham, Associate Director of Finance has now left as part of the ICB Change Programme. **The LCP Board noted the finance update**	
9.	**Any Other Business** No other items were raised. HT asked members to note the additional papers for information and thanked everyone for their contributions to the meeting.	
10.	**Date of next meeting** Thursday 23 July 2026 at 14:00hrs (Teams).	
11.	**Minutes of previous meetings/updates** The LCP Board noted the documents attached for information.	

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Lewisham LCP Strategic Board Action Log

Date of meeting & agenda item:	Action:	For:	Update:
1.Strategic Investment Fund (SIF) (Item 4) 28/05/26	AG to provide further details on children and young people prevention priorities to share with JH.	**AG**	
2.Strategic Investment Fund (SIF) (Item 4) 28/05/26	Leads to respond to VCSE / BLACHIR recommendations and strengthen engagement arrangements provided by SD.	**All**	
3.Lewisham VCS Neighbourhood Contract (Item 7) 26/03/2026	LJ to revisit what "neighbourhoods" actually means in terms of alignment/boundaries and work with the partners, Council and primary care colleagues around this.	**LJ**	
LCP Assurance report – Focus on Flu vaccinations (Item 8) 26/03/26	Agreed that relevant leads to continue work with SLaM on physical health checks for people with SMI and bring proposals back to a future meeting. CH to note on forward planner.	**CH**	Added to forward planner – July 2026

System Intentions 2026/27 (item 2) 22/01/26	Identify and assign the appropriate person to provide a response to SD regarding EHCP assessments and school engagement.	**LJ**	Closed
Lewisham GP Access Improvement – Updated Plan (item 7) 22/01/26	AOS to return to a future meeting with comparative data and organise a seminar if needed to explore the findings in more depth. CH to add to forward planner.	**AOS/CH**	Closed
LCP Assurance Performance data report – December 2025 (item 9) 22/01/26	It was agreed to bring a deep-dive report on vaccination uptake, including targeted interventions and any learnings from breast cancer screening campaigns to the next public meeting. CH to add to the forward planner.	**CMb/CH**	Closed

South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 4
Enclosure 3

Title:	Health Inequalities and Equity Programme
Meeting Date:	
Author:	Laura Jenner
Executive Lead:	Ceri Jacob

Purpose of paper:	To provide an update on projects within the Lewisham Health Inequalities and Health Equity Programme To outline the plans for SEL Health Inequalities funding in Lewisham for 26/27	Update / Information	
		Discussion	
		Decision	***Yes***
Summary of main points:	The report provides an update on the progress of the projects funded via the Health Inequalities Programme which is funded by the South East London (SEL) The recommendations section below outlines which projects are proposed to continue beyond April 2026, which have completed, and which require further review. The following programmes are current funded via Health Inequalities Programme: • **Addressing inequalities in elective surgery waiting lists** • **Smokefree Pregnancy Midwives** • **Community based preventative health outreach programme (CommUNITY SPACE)** • **Pharmacy First** • **Health Equity Teams Programme** • **Winter well – outreach support, helping to improve the uptake of flu**		
Potential Conflicts of Interest	**N/I**		
Any impact on BLACHIR recommendations	**Outlined within the papers**		

	Bexley		**Bromley**	

Relevant to the following Boroughs	Greenwich		Lambeth	
	Lewisham	✓	Southwark	

	Equality Impact	The main content of the report relates to projects within the Health Inequalities programme of work that aims to address health inequalities faced by those in protected characteristic groups related to sexuality (those who identify as LGBTQ+) and ethnicity (those in Black and minoritised groups), and those living in areas of higher deprivation. The programme intends to improve outcomes and have a positive impact for those in these groups, and other groups with protected characteristics.
	Financial Impact	The funding for the Health Inequalities programme has been budgeted for and should not result in any cost pressures for the system. However as part of the ongoing work the programme will be reviewing the projects to ensure they are cost effective and providing the performance required to meet the objectives of the programme. 5% saving has been identified for 2026/27 as highlighted within the budget breakdown below
Other Engagement	Public Engagement	The Health Inequalities Programme was conceived with good engagement from a number of community organisations/members of the public via a Health Inequalities event and Community Planning Day. Recently there have been two main events relating to the Health Inequalities programme. The Health Equity celebration event (July 2025) and The Health Equity Teams launch event (January 2026). Some projects within the programme include ongoing engagement with community groups and wider public throughout the course of the programme e.g. Health Equity Teams.
	Other Committee Discussion/ Engagement	Regular updates about the programme are made to the Lewisham Health and Wellbeing Board

Recommendation:	**<u>To agree the following plan for projects funded by the South East Lond on ICB Health Inequalities Fund:</u>** Community based preventative health outreach programme (Lewisham Community space) – will continue 27/26 Addressing inequalities in elective surgery waiting lists – will continue 26/27 Improving collection of special category data – this funding will not continue in 26/27. This funding will be repurposed to deliver community engagement activities

aimed at increasing immunisation and screening uptake. With collaboration from the Inequalities Working Group, we will agree to design the project with the funding.

Smokefree Pregnancy Midwives – will continue 26/27
Health Equity Teams- continue (this includes funding the GP leads within the project – will continue 26/27
Pharmacy First – will continue in 26/27
INT – support the implementation of lifestyle and medication training through the allocation of a GP Lead for Extended Hours.

Additional funding of £3,620 is required for the development and printing of patient leaflets and training materials to support the Integrated Neighbourhood Teams (INTs).

Further £30,000 to enable Primary Care Networks (PCNs) to deliver and operate group consultations, supporting sustained delivery and scalability of the programme. This will only be allocated to PCNs, when required.

See full budget below for sign off

Lewisham Place Health Inequalities – Funding

Project Aim	Status for 25/26	Funding for 25/26	Funding for 26/27
Coproduction of health equity projects by each PCN Fellow and their respective community organisation. Lewisham Health and Wellbeing Community Champions to support health promotion & health equity in the community.	**Continue**	£ 224,000.00	£ 224,000.00
Proactively identifying patients at risk of inequalities to provide health optimisation support so they are fit for surgery without further delays.	**Continue**	£ 103,000.00	£ 103,000.00
Refurbishment of Lewisham Community space in Lewisham Shopping Centre to serve as a central location for community-based preventative outreach. Operational since June 2024.	**continue**	£ 84,000.00	£ 84,000.00
Improving access to data, and improved recording & coding of special category data across Lewisham health system. Plan to recruit specialist data recording role in Community Services.	**Finish 25/26**	£ 70,000.00	
Dedicated funding has been allocated for the 2026/27 financial year to deliver community engagement activities aimed at increasing immunisation and screening uptake	**New (2026/27)**	N/A	£ 70,000.00
Tri-borough Specialist Smoke Free Pregnancy Midwife - responsible for 'Smoke Free Pregnancies' through training, engagement with Stop Smoking services, and support & management of non-specialist staff. Joint funded with Greenwich Public Health.	**Continue**	£ 43,908.00	£ 43,908.00
The service involves pharmacists providing advice and NHS-funded treatment, where clinically appropriate, for seven common conditions. Patients are eligible through presenting at a pharmacy as well as via referral by NHS 111, GPs and others. Lewisham supplements the national scheme with the pharmacy first local scheme which provides OTC meds free of charge to applicable patients.	**Continue**	£ 114,000.00	£ 114,000.00
Lifestyle/ Meds traininng- funding Camille Hirons GP lead extended hours to support the implementation 0.3wte. For 52weeks £39,393.78 Also leaflets and materials for INT and £3,620 (for 26/27- £30,000 for PCNs to operate the group consultations)	**Continue**	£ 43,013.00	£ 73,013.00
	Total Committed Spend =	681921	711921
	Total Inequalities Budget	£ 764,000.00	£764,000

Health Inequalities

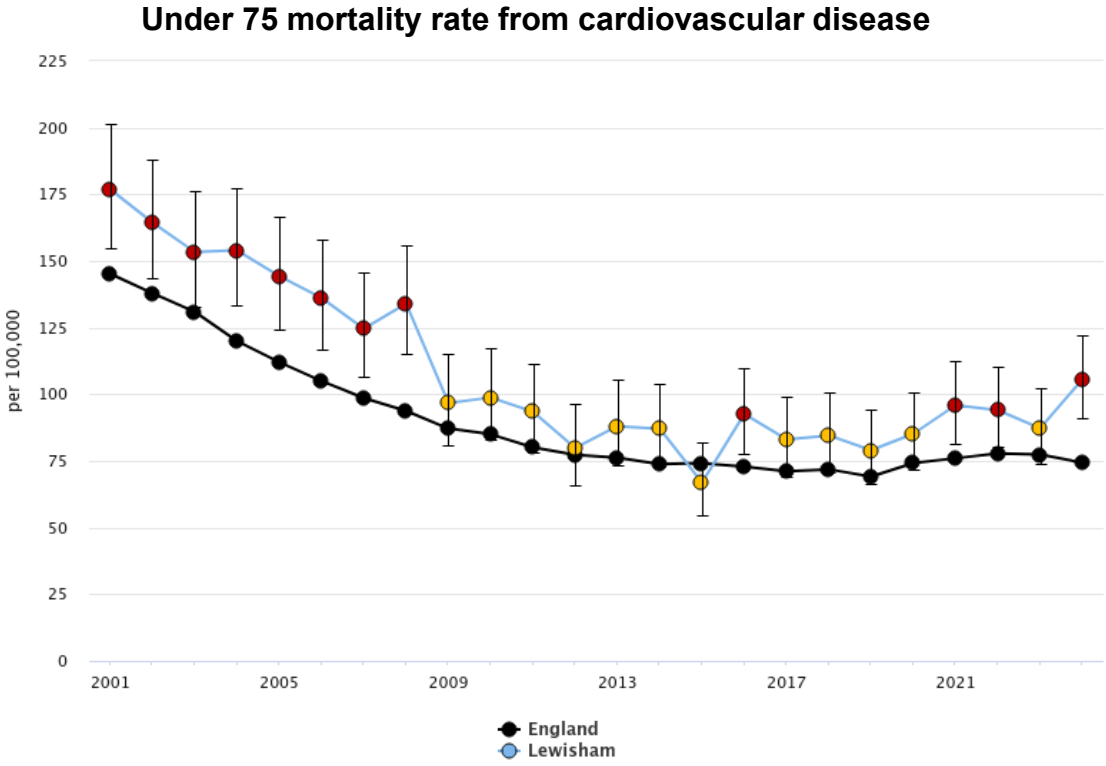
May 2026

Overall Health Inequalities in Lewisham

- Lewisham is the 14th largest borough in London by population size (300,600) and is within the 30% most deprived local authorities in England.
- 14.4% of Lewisham residents are living with a long-term condition that limits their daily activities.
- 7.1% of Lewisham residents provide at least some unpaid care each week and are twice as likely to have poor health compared to those without caring responsibilities .
- Lewisham's Black and Minority Ethnic communities are at greater risk of conditions such as diabetes, hypertension and stroke.

Cardiovascular Disease

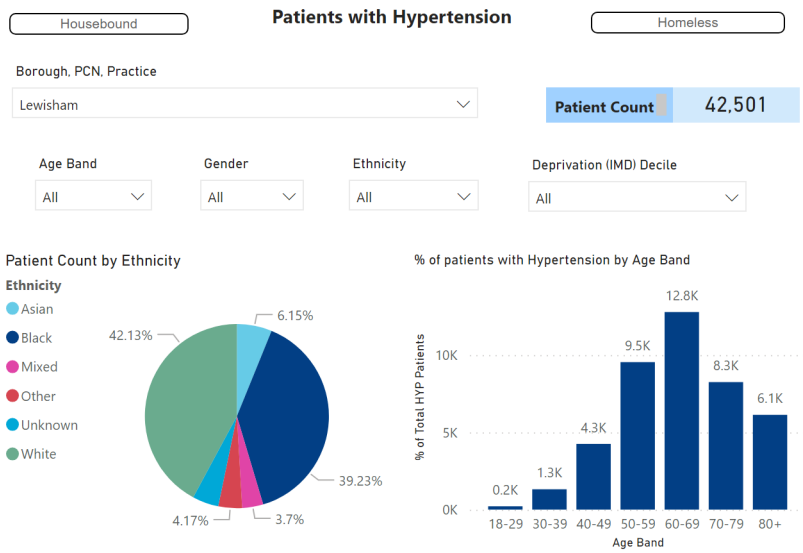
Cardiovascular Disease Mortality

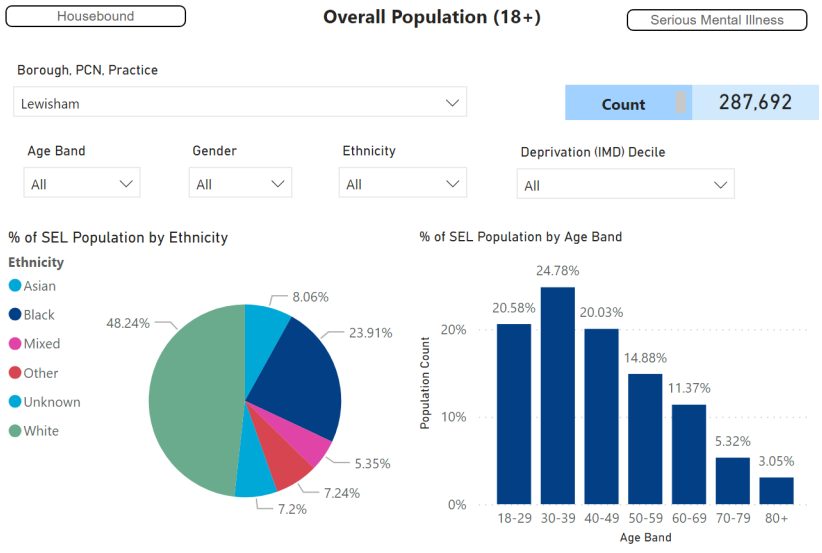


- Following a steady downward trend in under 75 mortality rate there is currently a slight upward trend
- The rate is now significantly above the England average

Source: OHID Fingertips

Hypertension





Black residents represent 24% of Lewisham's population, while the prevalence of hypertension among Black people is over 39%.

Source: SEL Analytics Resources

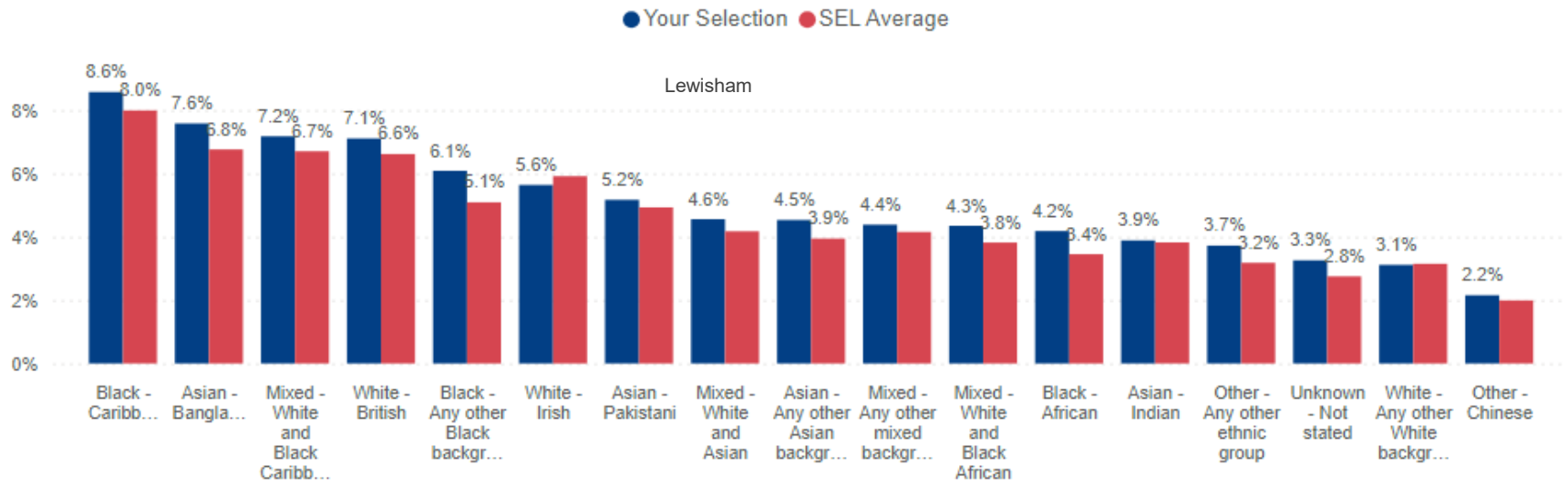
Co-morbidities

Diabetes Prevalence

- Black residents represent 24% of Lewisham's population but account for 41% of people with diabetes, compared with 35% from White ethnic groups despite White residents representing around 48% of the borough's population.
- Diabetes is inversely related to deprivation; those in the most deprived deciles have the highest diabetes prevalence
- Obesity and overweight are high for those with diabetes; only 19% have a healthy BMI

Source: SEL Analytics Resources

Asthma Prevalence by Ethnicity

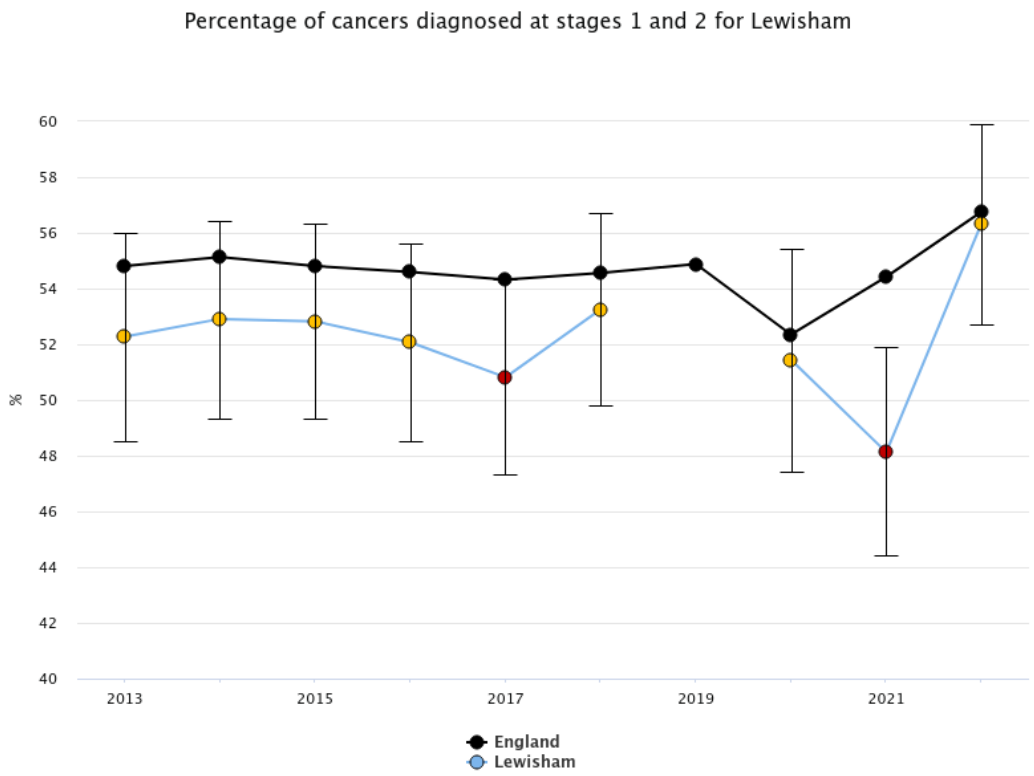


- Asthma prevalence is highest for Black Caribbean residents.

Source: SEL Analytics Resources, data for April 2026

Cancer Screening and Uptake

Cancer Diagnosis



Source: OHID Fingertips

- There is an upward trend in the percentage of cancers diagnosed at stages 1 and 2
- The percentage is now in line with the England average
- Survival rates from cancer improve if caught at an earlier stage (1 or 2)

Cancer Screening Demographics

Please note, the map visual will only work when the latest available month is selected

Month: March 2026

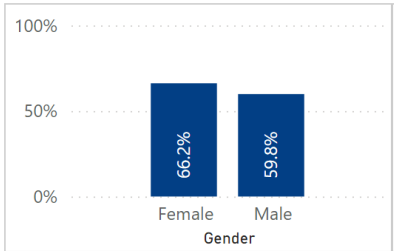
March 2026
Latest Month Available

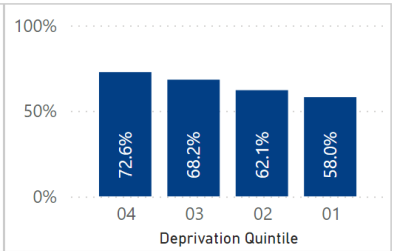
South East London Integrated Care System

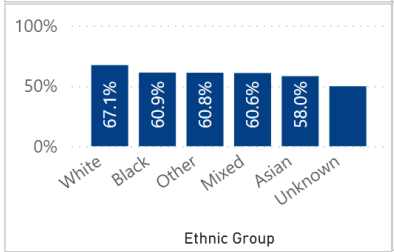
Borough of Residence: Lewisham

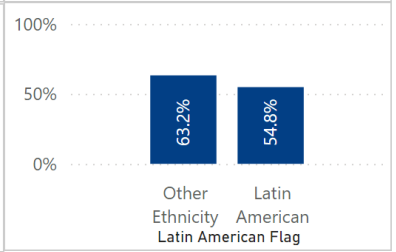
Coverage %: 63.1%

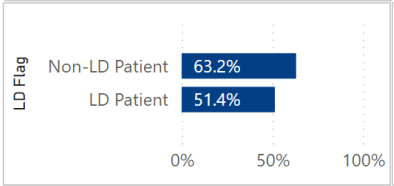
Cancer Screening Type: Bowel Screening | Breast Screening | Cervical Screening

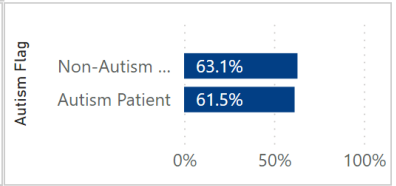


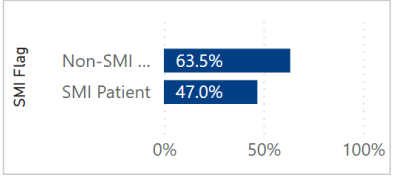




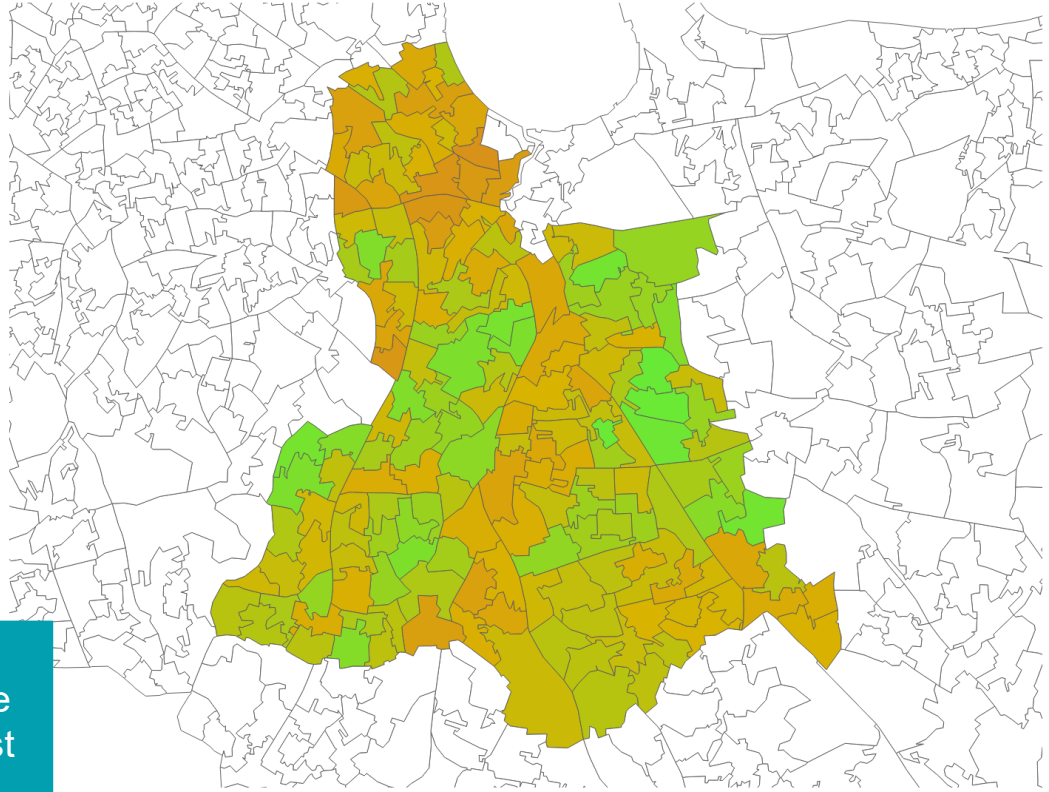








Bowel Screening Uptake of Eligible By LSOA



The highest bowel screening uptake is in the least deprived areas, east & west of the borough, (areas shaded green).

Cancer Screening Demographics

Please note, the map visual will only work when the latest available month is selected

Month: March 2026

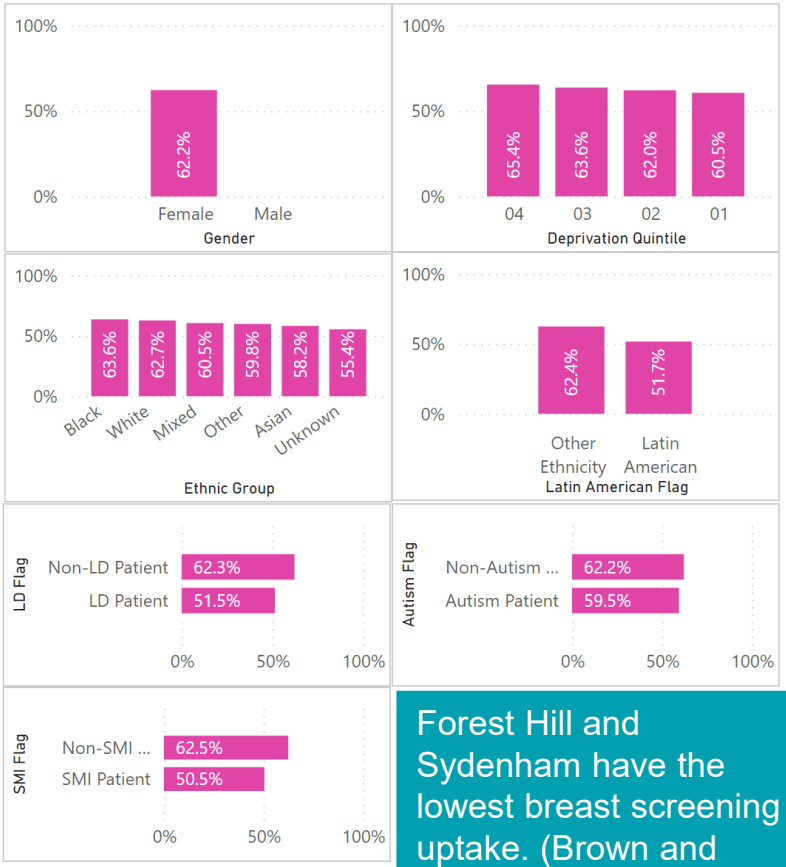
March 2026
Latest Month Available

South East London Integrated Care System

Borough of Residence: Lewisham

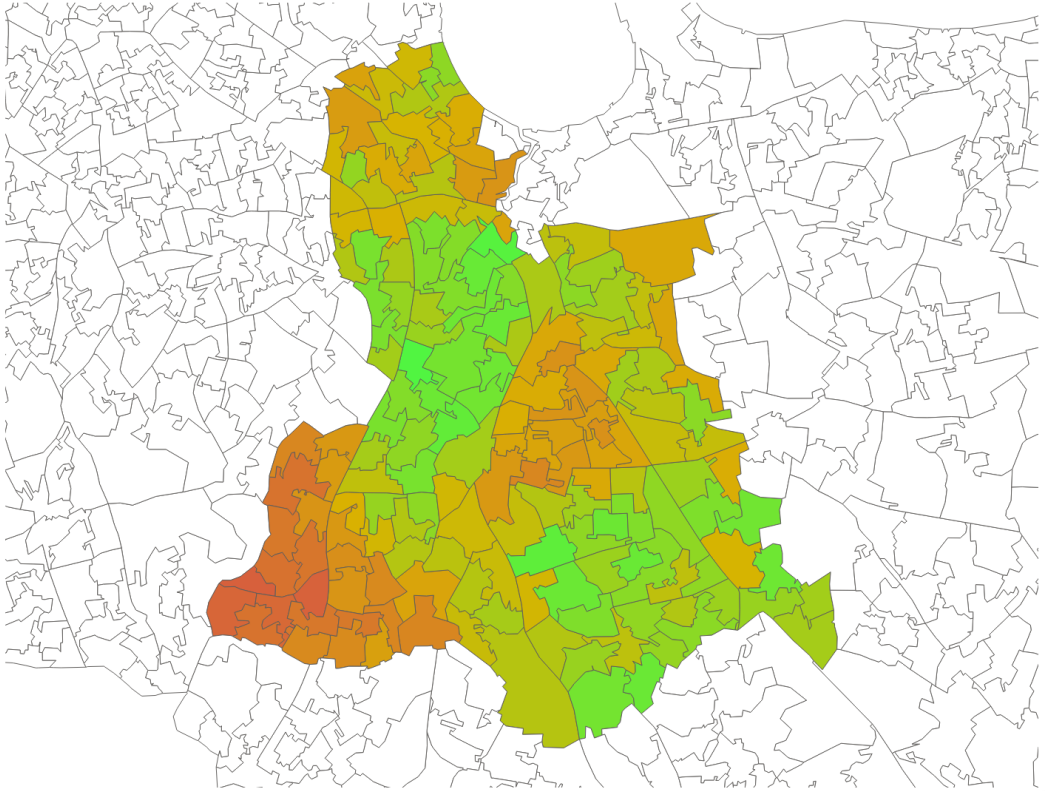
Coverage %: 62.2%

Cancer Screening Type: Bowel Screening | Breast Screening | Cervical Screening



Forest Hill and Sydenham have the lowest breast screening uptake. (Brown and orange shaded areas)

Breast Screening Uptake of Eligible By LSOA



Cancer Screening Demographics

Please note, the map visual will only work when the latest available month is selected

Month: March 2026

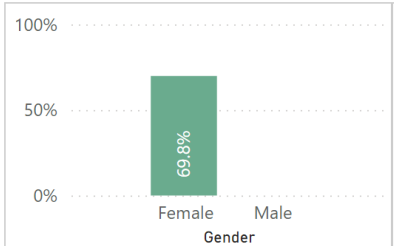
March 2026
Latest Month Available

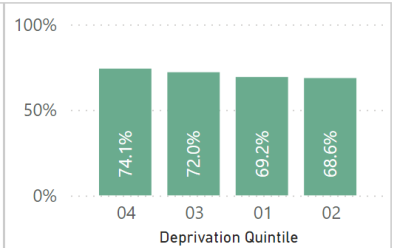
South East London Integrated Care System

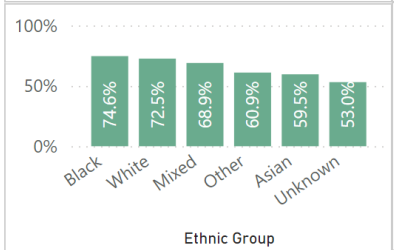
Borough of Residence: Lewisham

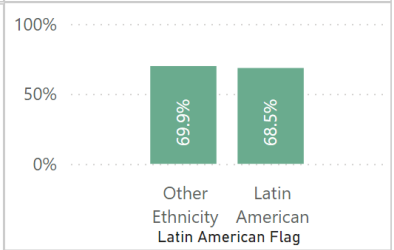
Coverage %: 69.8%

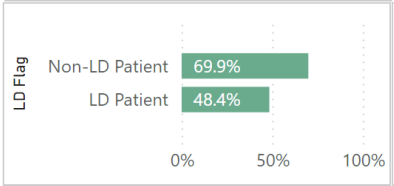
Cancer Screening Type: Bowel Screening | Breast Screening | Cervical Screening

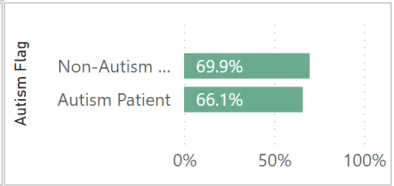


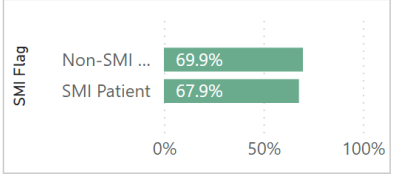




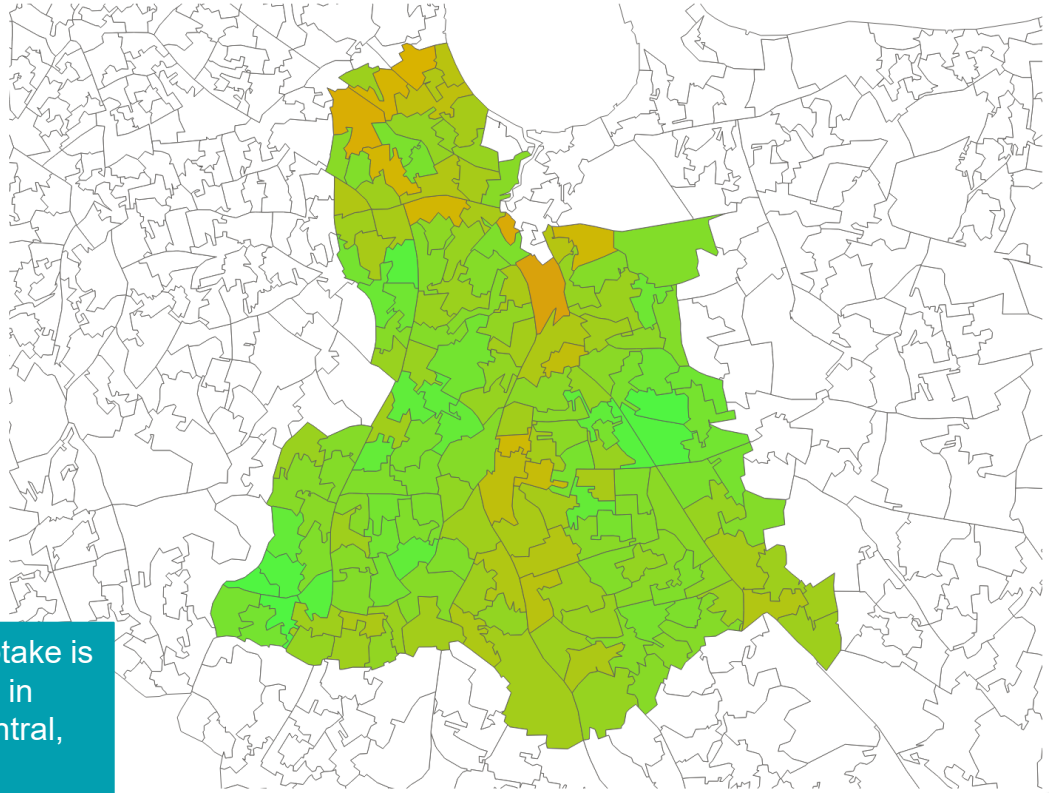








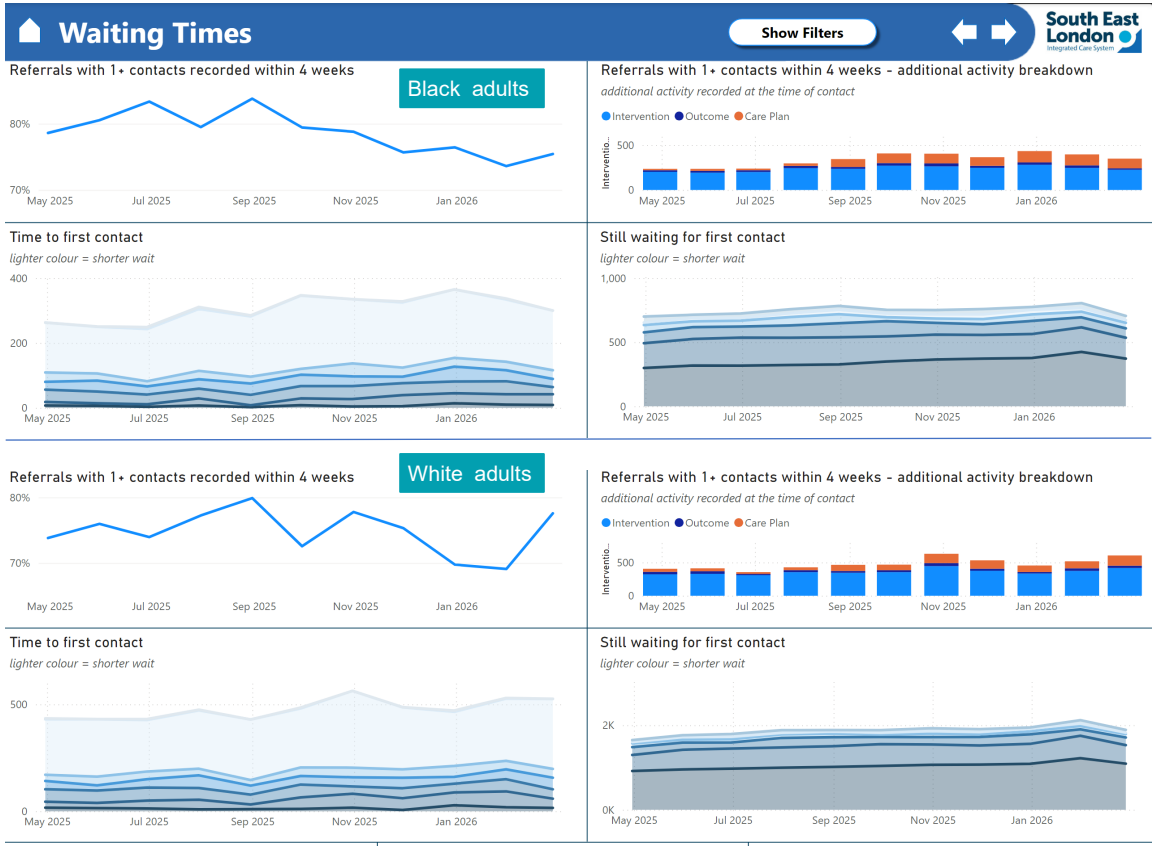
Cervical Screening Uptake of Eligible By LSOA



Overall cervical screening uptake is good with slightly lower rates in small areas of Lewisham Central, Evelyn and New Cross (Orange/brown shaded areas)

Mental Health

Adult Mental Health



For Black adults referred to mental health services 75% are contacted within 4 weeks.

A slightly higher number, (78%) of White adults are contacted within 4 weeks.

No ethnicity is stated for over half (58%) of all referrals to mental health services.

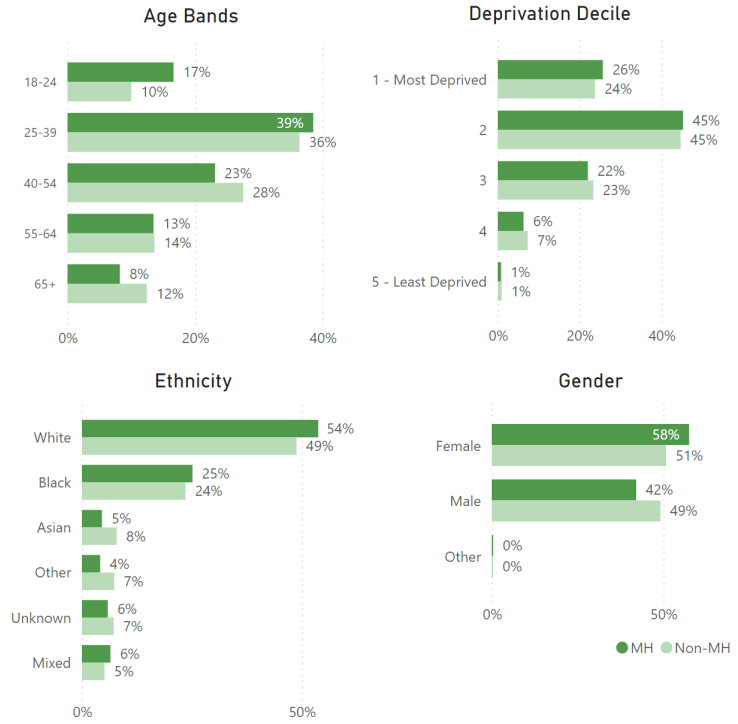
Community Mental Health Services

Referrals Demographics

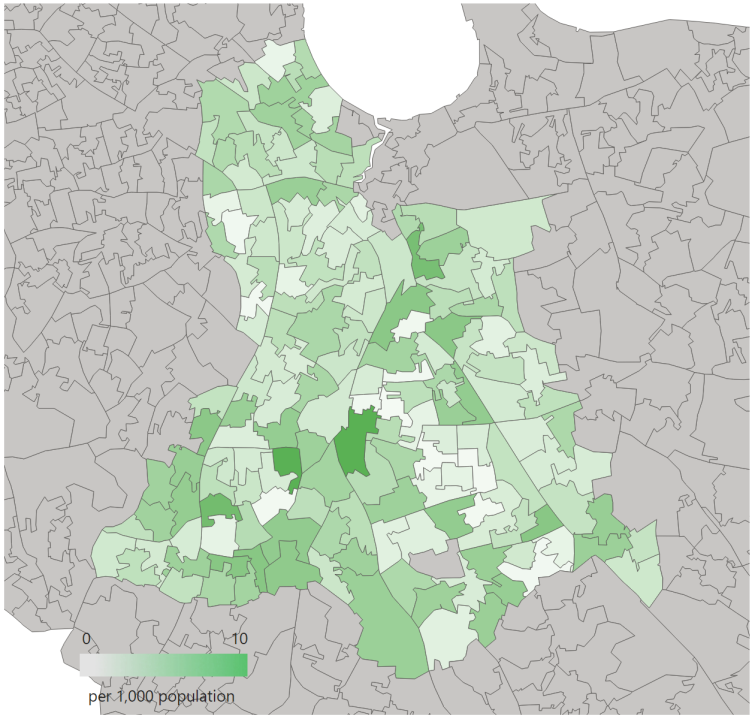
Show Filters

South East London Integrated Care System

Charts showing proportionality to non-MH cohorts

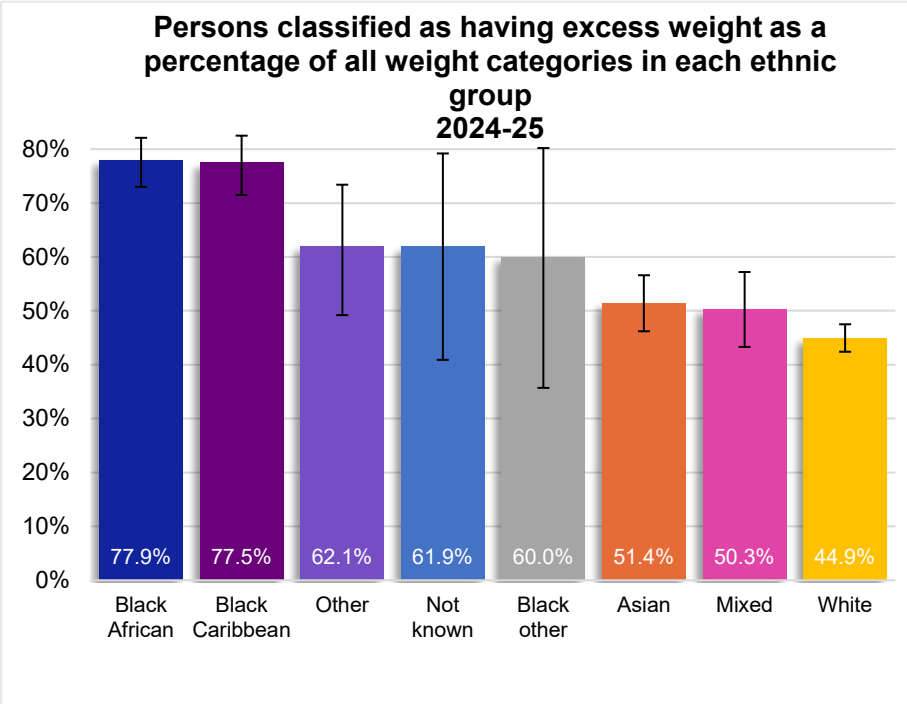


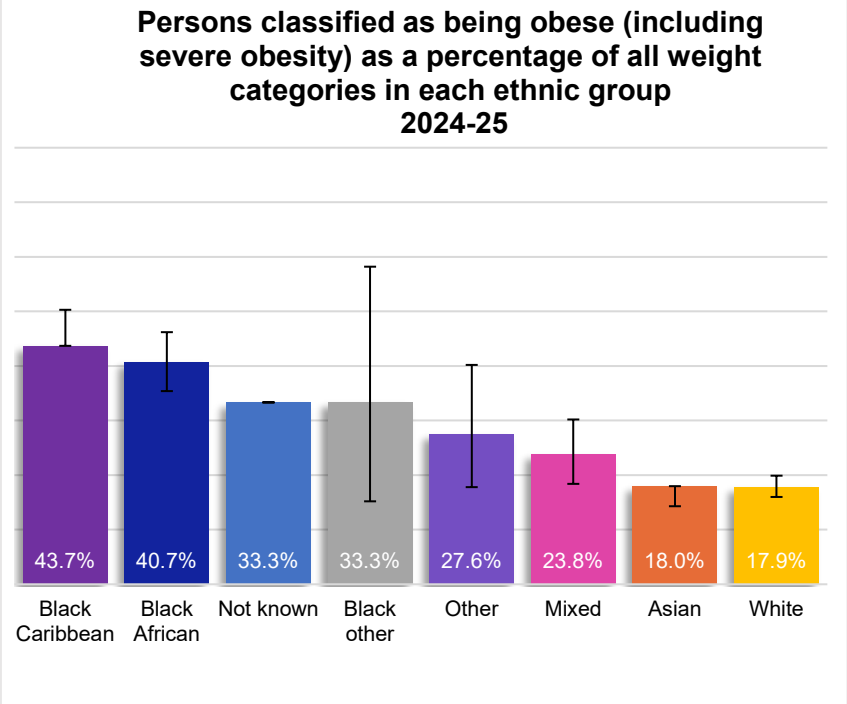
Referrals per 1,000 Residents, by LSOA



Maternity Outcomes

Maternal Weight - as measured at booking appt

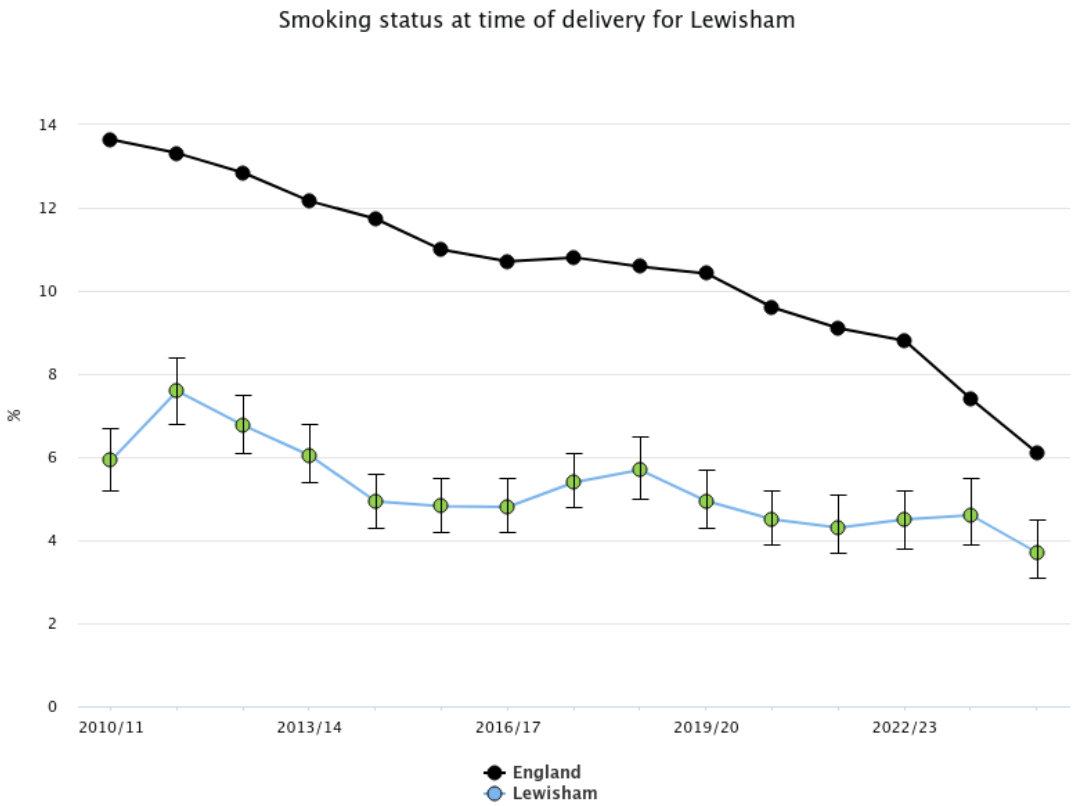




Black African (77.9%) and Black Caribbean (77.5%) women had the highest prevalence of excess weight during pregnancy, while White women had the lowest (44.9%). Similarly, for obesity, Black Caribbean (43.7%) and Black African (40.7%) women had the highest obesity rates compared with White women (17.9%).

Source: University Hospital Lewisham

Smoking Status at the Time of Delivery

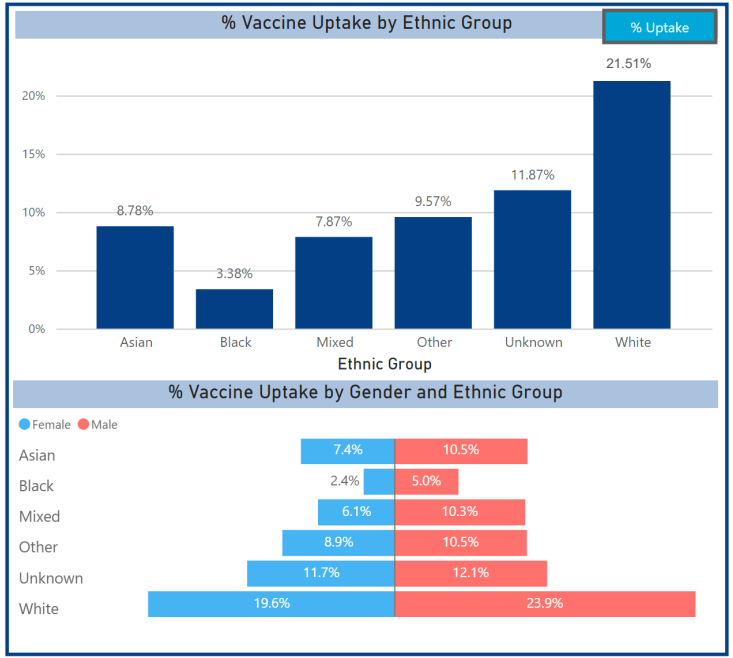


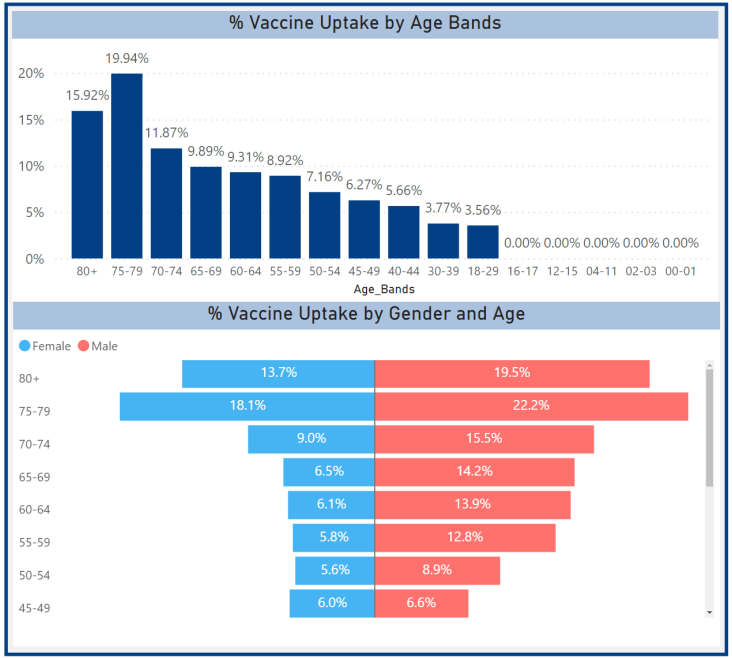
- There is a continuing downward trend in smoking at the time of delivery status in Lewisham
- The percentage of those smoking at the time of delivery is below the England average

Source: OHID Fingertips

Vaccination Uptake

COVID Vaccination Uptake

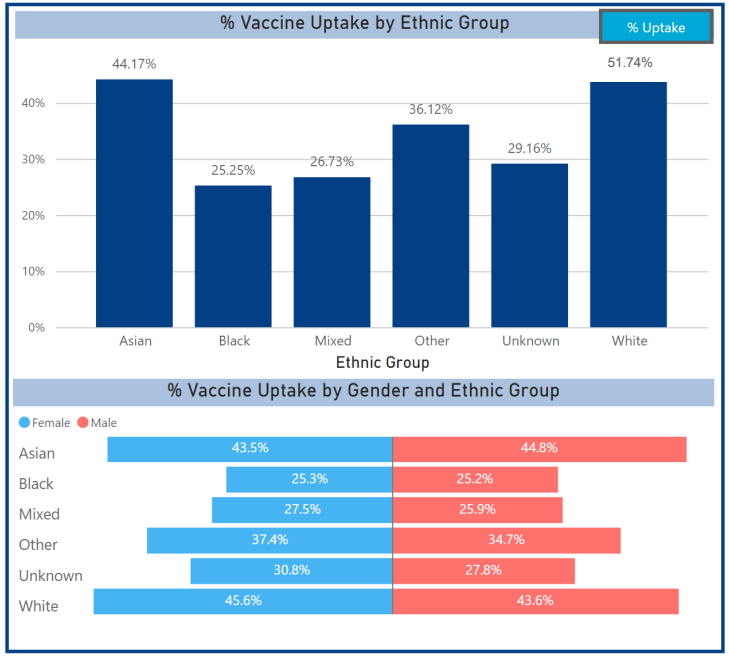


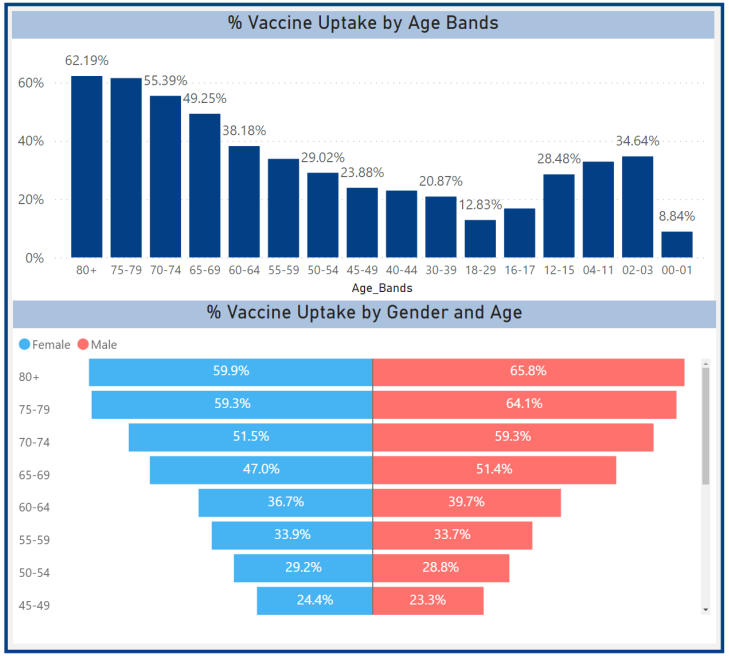


Black ethnic groups have the lowest percentage of COVID vaccine uptake, 7.4% for women and 10.5% for men.

Source: SEL Analytics Resources

Flu Vaccination Uptake

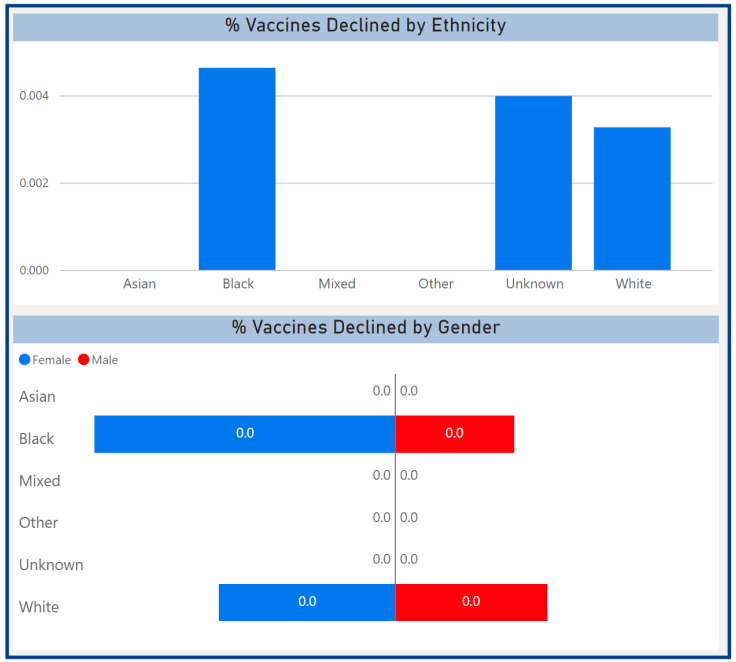


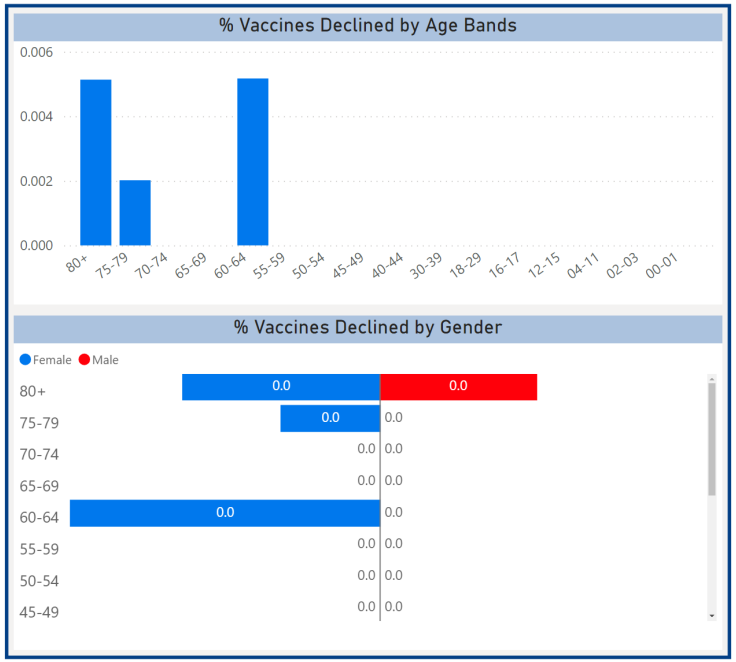


Black ethnic groups have the lowest percentage of flu vaccine uptake, 25.3% for women and 25.2% for men.

Source: SEL Analytics Resources

COVID Vaccinations Declined

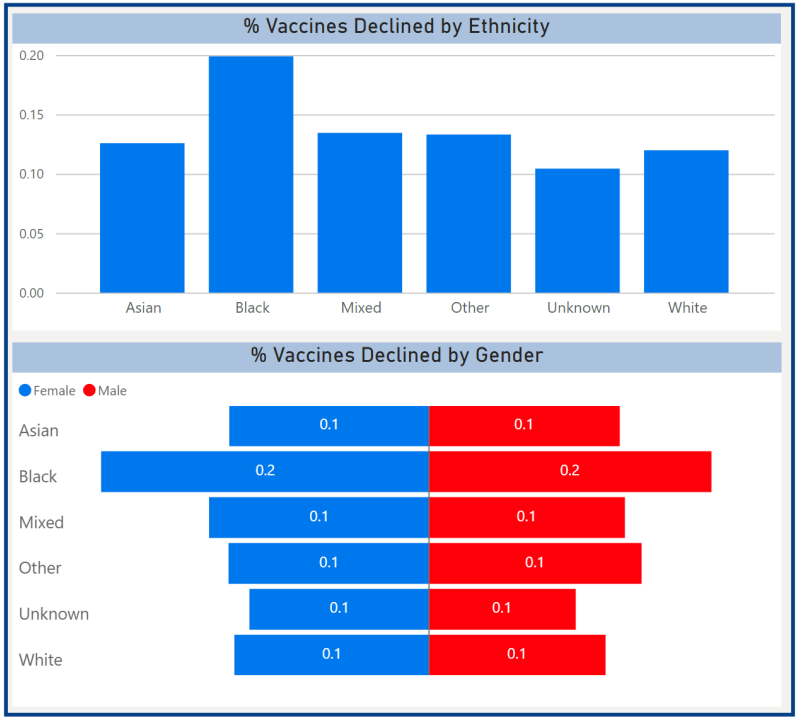


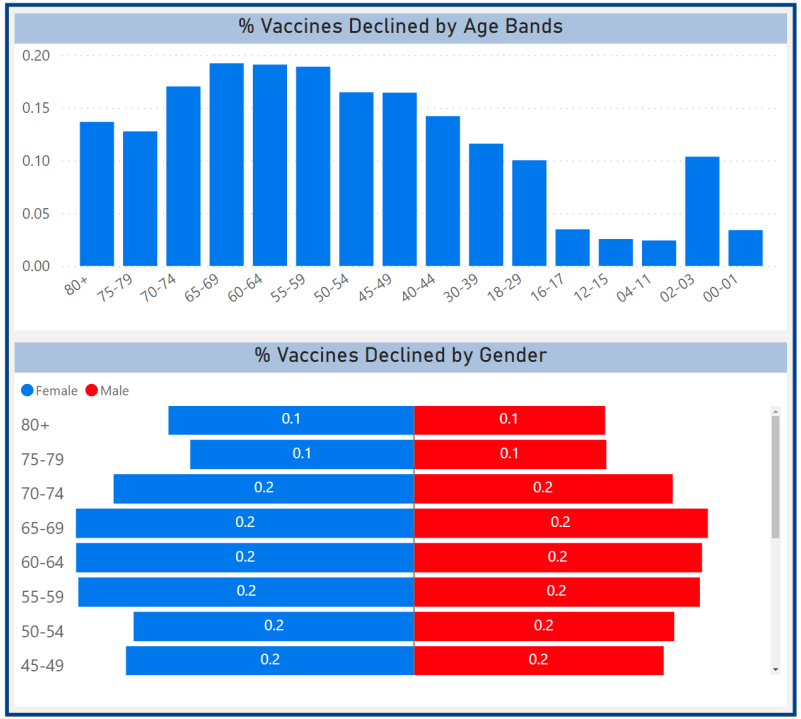


- The highest levels of COVID vaccine decline are seen in Black ethnic groups, especially among women.
- The largest proportion declining COVID vaccinations are women aged 60-64 years old.

Source: SEL Analytics Resources

Flu Vaccinations Declined





- Black ethnic groups are the largest percentage declining the flu vaccination.
- The highest proportion declining flu vaccinations are adults aged 55-69 years old.

Source: SEL Analytics Resources

MMR Ethnicity Breakdown

South East London Integrated Care System

Borough, PCN, Practice Name: Lewisham

Latin American: Yes / No

Age Band: Multiple selections

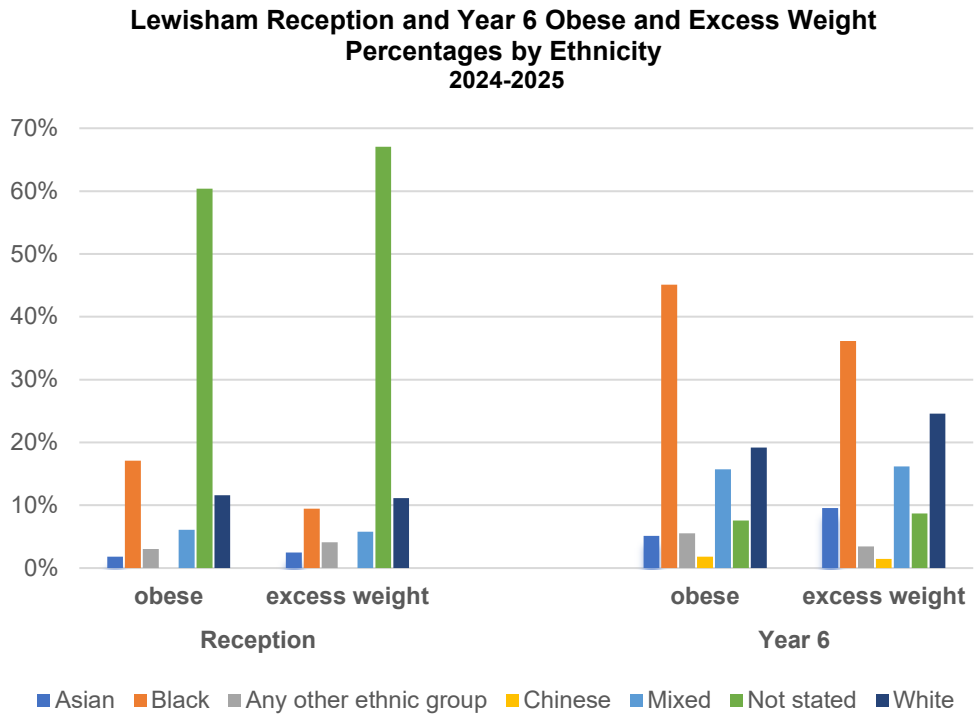
MMR Vaccination Ethnicity Breakdown

Ethnicity	Population Count	MMR Fully Vaccinated for their Age	MMR Partially Vaccinated for their Age	% MMR Fully Vaccinated for their Age	% MMR Partially Vaccinated for their Age
Chinese	123	96	17	78.0%	13.8%
White and Asian	452	326	88	72.1%	19.5%
British	5,207	3,690	1,048	70.9%	20.1%
Any other Asian background	693	488	136	70.4%	19.6%
Indian	328	228	66	69.5%	20.1%
Irish	82	54	13	65.9%	15.9%
Any other White background	2,194	1,394	464	63.5%	21.1%
Any other mixed background	1,218	718	274	58.9%	22.5%
Any other ethnic group	806	466	189	57.8%	23.4%
White and Black African	353	195	84	55.2%	23.8%
African	1,709	938	402	54.9%	23.5%
Bangladeshi	134	72	41	53.7%	30.6%
Not stated	1,644	878	337	53.4%	20.5%
Pakistani	141	75	33	53.2%	23.4%
White and Black Caribbean	596	309	142	51.8%	23.8%
Any other Black background	926	448	226	48.4%	24.4%
Caribbean	764	291	186	38.1%	24.3%
Total	**17,370**	**10,666**	**3,746**	**61.4%**	**21.6%**

- The greatest inequalities exist for Caribbean and Other Black ethnic groups who are least likely to be fully vaccinated.
- Black, Asian and Mixed ethnic groups tend to be partially vaccinated for their age

Modifiable Risk Factors

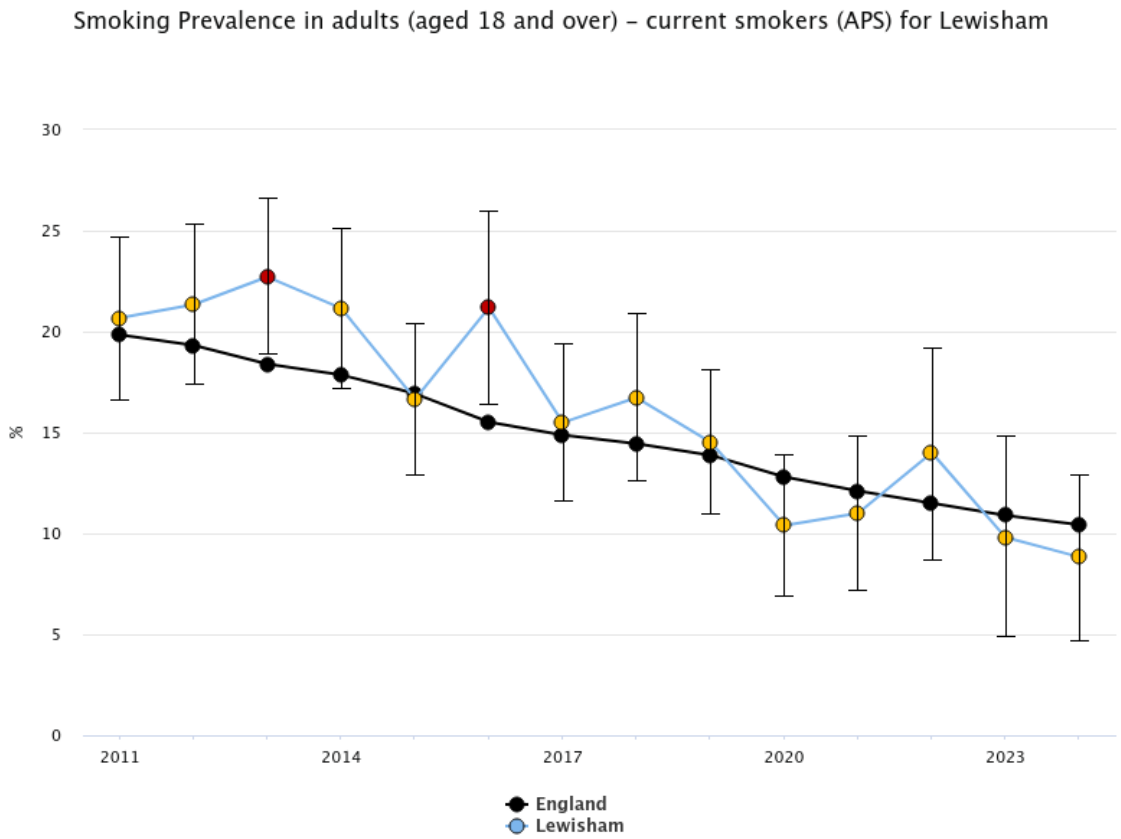
Childhood Weight



Source: The National Child Measurement Programme

- Lack of data on ethnicity for reception children
- Ethnic inequalities are more pronounced by Year 6
- Obesity and excess weight levels are highest for children from a Black ethnic groups

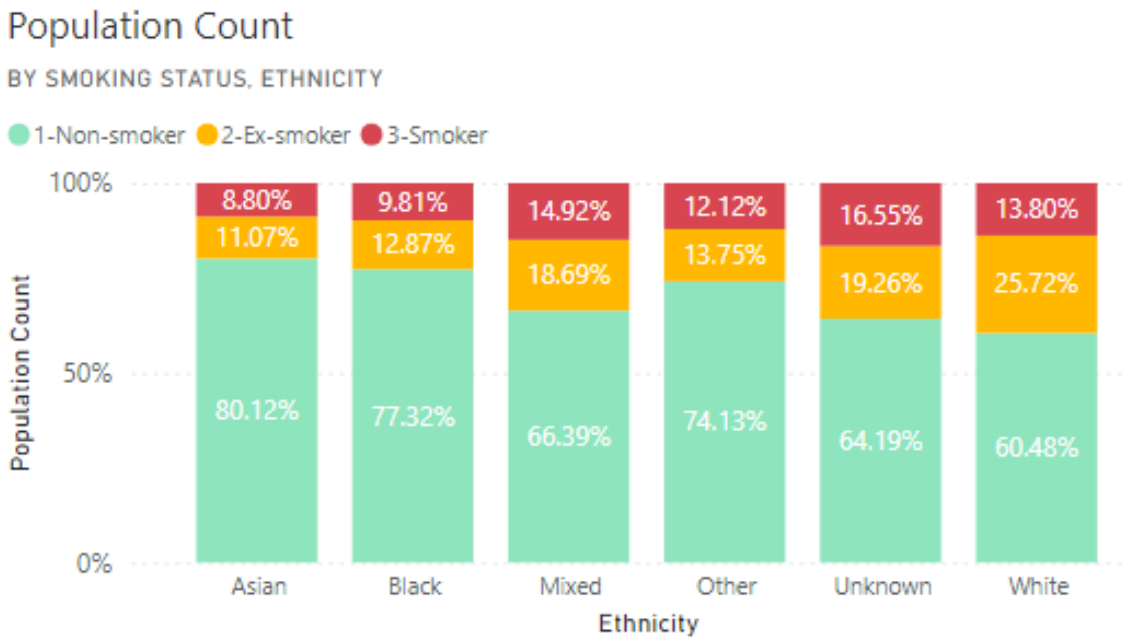
Smoking prevalence



- There is a continuing downward trend in smoking prevalence in Lewisham
- The percentage of smokers aged 18 and over is below the England average

Source: OHID Fingertips

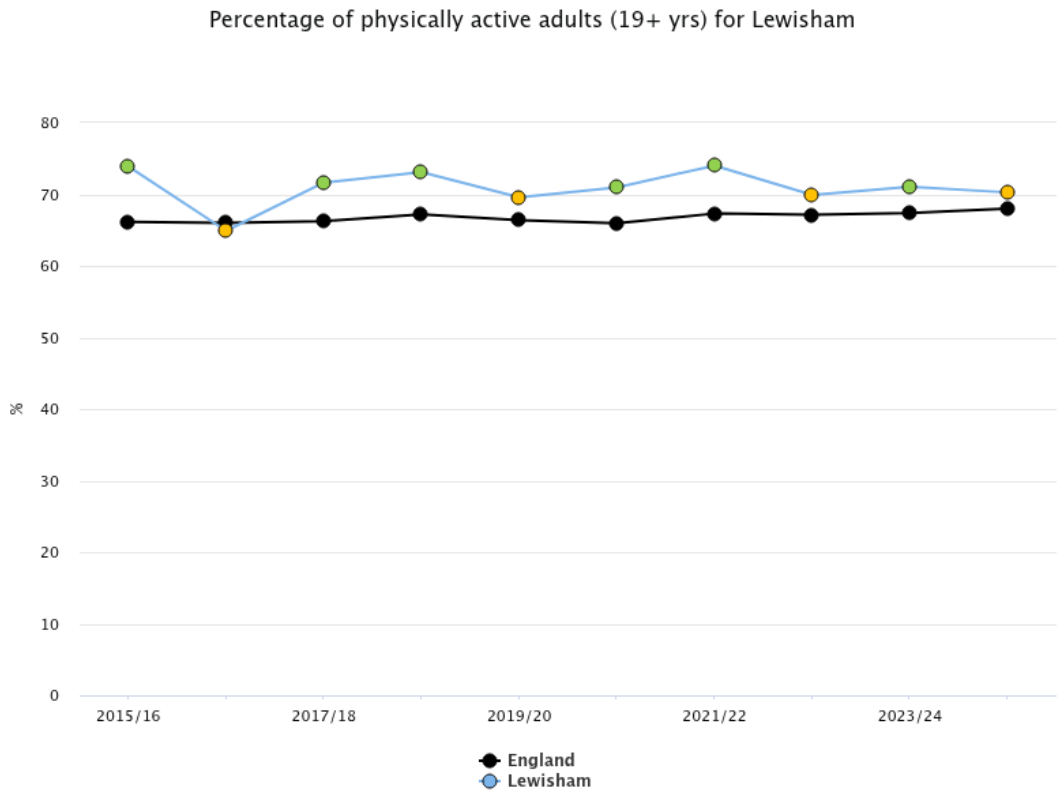
Smoking by Ethnicity



- The percentage of smokers in the unknown ethnicity group is the highest at 16.55%
- Where ethnicity is stated mixed and White ethnic groups have the greatest proportion of smokers

Source: SEL Analytics Resources

Physical Activity - Adults



- For Lewisham residents, the level of physical activity for adults has remained around 70% for the last three time periods reported.
- The percentage of physically active adults aged 19 and over is currently inline with the England average

Source: OHID Fingertips

Summary

Overall findings

- Health inequalities remain evident across a number of priority conditions affecting Black communities in Lewisham
- The greatest inequalities continue to be seen across cardiovascular disease, diabetes, maternal weight, childhood obesity and vaccination uptake
- Some indicators show a different pattern e.g. White and Mixed ethnic groups have the highest proportion of smokers where ethnicity is recorded
- Some health indicators show improvement, demonstrating positive progress in prevention and early diagnosis e.g. smoking
- Current quantitative evidence provides an updated picture of population need to support the ongoing Health Inequalities Programme Review.

Evidence gap

- Ethnicity recording remains incomplete in some datasets, particularly for over half of adult mental health referrals, and ethnicity data for Reception Year childhood weigh (any where were data is missing)

Next Steps

- Findings will be used to inform the Health Inequalities Programme Review
- Compare the quantitative findings with community priorities identified through BLACHIR and SIRG to identify evidence gaps and opportunities to improve inequalities data where required.

Health Inequalities & Health Equity Programme highlight report

Projects:

- Addressing inequalities in elective surgery waiting lists - **Project lead: Matt Hopkins**
- Lewisham Pharmacy First Plus - **Project lead: Erfan Kidia**
- Community based preventative health outreach programme (CommUNITY SPACE) **Project lead: Jason Browne**
- Targeted Adult Weight Management - **Project lead: Jason Browne**
- Smokefree Pregnancy Midwives – **Project lead: Emily Newel**
- Health Equity Teams- **Project lead: Aaminah Verity (WS2)**

Lewisham

Health Inequalities & Health Equity Programme highlight report

Addressing inequalities in elective surgery waiting lists

June 2026

Workstream 1: Addressing inequalities in elective surgery waiting lists

Overall RAG (Red, amber, green)	Delayed	Ongoing	On track

Lead: Matt Hopkins/Elizabeth Aitken

Aim: Implement proactive approach to identifying patients at risk of inequalities to provide health optimisation support so they are fit for surgery without further delays.

Milestones	Start	Finish	Progress (On track /on going/delayed
24-month evaluation	Q1 2026/27	Q2 2025/26	Complete
Review approach across Trust	Q3 2025/26	Q1 2026/27	On track
Establish Vital 5 prevention service in Gynaecology pathway	Q3 2025/26	Q4 2025/26	Delayed
Establish interim solution to access PHM data	Q4 2025/26	Q4 2025/26	Complete

Total funding allocation	Projected spend
£103,422 (plus £94k from APC)	£103,422K

Updates

- 798 patients reviewed throughout project, with high level of diversity (39% White British, 70% from most two most deprived quintiles)
- Patients have high level of health needs, with frailty and anaemia being the key areas where optimisation was needed ahead of surgery.
- 215 patients reviewed have completed the surgical pathway. The impact of the project has been:
  - Reduction in mean length of stay of 0.7 days compared to pre-project patient cohort
  - Reduction in on the day cancellations – 0.9% compared to 3.4% of elective orthopaedics cancelled due to patient ill health
  - Reduction in readmission rate – 3.7% compared to historical rate of 7.6-18.7%
- Working with KHP and Greenwich Health on prevention based Vital 5 model in the Gynaecology elective pathway – funding from ICB has gone to Greenwich Place but is now being reviewed against wider priorities.
- Have shared learning from project with colleagues at KCH/PRUH to support them to develop a similar model.
- Interim solution for access to data has been implemented following the end of the Healtheintent contract.

BLACHIR OFA (opportunities for action)

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

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

Health Inequalities & Health Equity Programme highlight report

Lewisham Pharmacy First Plus

June 2026

Workstream _: Lewisham Pharmacy First Plus

Overall RAG (Red, amber, green)	Delayed	Ongoing	Ontrack

Lead: Erfan Kidia

Aim: -
- To promote self-care and educate patients on the appropriate utilisation of healthcare services
- To alleviate pressure on prescriber-led services for management of common illness.
- To improve access to healthcare, by increasing healthcare availability locally
- To reduce health inequity, through provision of healthcare advise and treatments especially to economically deprived areas of Lewisham.
- To support the local healthcare infrastructure by reducing inappropriate demand on other primary care and emergency related services.

Milestones	Start	Finish	Progress (On track /on going/delayed
Continue current service provision	April 2025	Ongoing	On track
Review and update service specification, formulary and SLAs	June 2025	December 2025	COMPLETED
Provide FY 24-25 Pharmacy First Plus Report	April 2025	August 2025	COMPLETED
Review service, and scope move to a SEL wide service	June 2026	October 2026	In Progress

Total funding allocation	Projected spend
£114k	£114k

BLACHIR OFA (opportunities for action)	Project
Theme 3: Children and Young People	Lewisham Pharmacy First Plus is mostly utilised by parents for their children – addressing treatment needs for those who would ordinarily not be able to afford Over-The-Counter treatments and may seek treatment from other primary care services or emergency services.
Theme 4: Ageing Well	The second largest group of users for the scheme are Older Persons, from income deprived areas of Lewisham. This frees up capacity in primary care for patients with more complex needs, and supports access to healthcare.

Updates
- A SEL wide review of Pharmacy First Plus services is being scoped,with the view that a single service spanning across SEL will replace individual Place services.
- Updates will be provided with regard to the move to this group as it progresses.
- The service delivered within it's allocated budget for the FY.

Risk ID	Title	Description	Risk owner	Risk Score (Residual)	Potential impact	Mitigating actions taken so far	Mitigating actions to be taken
1	Project funding	The service has a defined budget. If the budget envelope is forecast to be exceeded by the end of the FY, the service may need to be paused.	Erfan Kidia	3	4	The budget for the service is monitored monthly	Continue monitoring the budget monthly

Health Inequalities & Health Equity Programme highlight report

CommUNITY SPACE

June 2026

Workstream 1: Community based preventative health outreach programme (CommUNITY SPACE)

Overall RAG (Red, amber, green)	Delayed	Ongoing	Ontrack

Lead: Jason Browne

Aim: Designing, testing and scaling up new models of service provision that achieve equitable access, experience and outcomes for all

Milestones	Start	Finish	Progress (On track /on going/delayed
2nd permitted extension implemented	1st June 26	31st May 27	
Officers to explore service review/evaluation	TBC	TBC	
Officers to explore possible extension to current contract and procurement of new service.	TBC	TBC	

Total funding allocation	Projected spend
£130,000 p/a	£130,000

Updates

- Performance in Q4 was strong overall, with all key KPIs exceeded, including delivery of 16 weekly sessions (exceeding the minimum of 10) and 90% of sessions meeting the minimum attendance threshold, alongside 9 community events delivered against a target of 8. Workforce capacity was robust, with 17 active volunteers plus 5 new recruits, and service provision was comprehensive with 8 regular health and support services in place. Outcomes relating to reach and delivery were also strong, including 98% of food packages distributed, consistent social media engagement, and regular collection of service user feedback and case studies.

BLACHIR OFA (opportunities for action)

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

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

Workstream 1: Community based preventative health outreach programme (CommUNITY SPACE)

Risk ID	Title	Description	Risk owner	Risk Score (Residual)	Potential impact	Mitigating actions taken so far	Mitigating actions to be taken
	Budget	Recurrent funding is not confirmed	PH/PH Commissioning Team/Provider	Med	High	Flagged with internal stakeholders and discussions with providers e.g. income generation	Ongoing discussions with PH and provider
	Relocation	Lewisham Centre being redeveloped and site will be moved.	PH Commissioning Team/Provider	Low	Med	Meeting with provider and communications from site managers.	Confirmation of moving date/location.

Health Inequalities & Health Equity Programme highlight report

Targeted Tier 2 Adult Weight Management

June 2026

Workstream 1: Targeted Tier 2 Adult Weight Management

Overall RAG (Red, amber, green)	Delayed	Ongoing	Ontrack

Lead: Jason Browne

Aim: Targeted weight management services aimed at Black African and Black Caribbean populations.

Milestones	Start	Finish	Progress (On track /on going/delayed
Current procurement delayed, officers will be entering into a new contract with the current provider, while a new procurement exercise is undertaken.	June 2026	31st December 26	
Procurement exercise undertaken and service to go live January 2027	July/Aug	Jan 27	

Total funding allocation	Projected spend
£114,179 p/a	£114,179 p/a

Updates

- Q4 performance shows a positive picture, with strong programme delivery and engagement alongside outcome challenges. The service exceeded patient start targets and maintained high eligibility compliance, with good reach into priority communities, achieving 86% participation from BABC groups and high data capture for baseline measures. Participant experience was consistently strong, with 100% of respondents likely to recommend the service and 69% reporting improved quality of life. However, performance against core outcome KPIs was weaker, with only around 46% achieving ≥2% weight loss and 17% achieving ≥5% weight loss, and completion rates remaining below target, indicating the need for improvements in retention and intervention effectiveness – performance remains better than national averages.

BLACHIR OFA (opportunities for action)

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

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

Workstream 1: Targeted Tier 2 Adult Weight Management

Risk ID	Title	Description	Risk owner	Risk Score (Residual)	Potential impact	Mitigating actions taken so far	Mitigating actions to be taken
	Procurement	Recommissioning the new service is delayed	PH/PH Commissioning Team/Provider	Low	High	Timelines developed to allow for delays	Partners to be kept informed

Health Inequalities & Health Equity Programme highlight report

Smokefree Pregnancies

June 2026

Workstream: Smokefree Pregnancies

Overall RAG (Red, amber, green)	On track

Lead: Emily Newell

Aim: To fund a Specialist Midwifery post within the LGT Maternity Service to lead on the ambition to reduce rates of smoking in pregnancy

Milestones	Start	Finish	Progress
Explore future models of delivery to better integrate pathways and ensure Tobacco Dependency Advisors are embedded within maternity care	January 2025	December 2025	In progress
Commence CO Clinic to increase CO-validated quit numbers	February 2026	Ongoing	Not started
Train specialist midwives in Risk Perception, to offer enhanced interventions to pregnant smokers	May 2026	September 2026	In progress

Total funding allocation	Projected spend
£43,908	£43,908

BLACHIR OFA (opportunities for action)	Project
Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality	Data on deprivation levels, age and ethnicity of women smoking at time of delivery across LGT was collected and analysed by the Smokefree Pregnancy Midwife. This showed that pregnant women that smoke at time of birth are more likely than the general birthing population to be White British; to be aged under 30; to live in a third most deprived IMD area. This aligns with national data on the issue. This audit is being repeated in June 2026 and will also include Smoking at Time of Booking.

Updates

- The rate of women **Smoking at Time of Booking** at UHL for Q4 is 4.4% and Smoking at Time of **Delivery** is 2.4%. This is a decrease from Q3.
- Rate of **carbon monoxide monitoring at 36 weeks** has remained stable this quarter and is sitting at 87% for Q4.
- The % of **smokers referred to Stop Smoking Services** is now at 98%. 16% of pregnant smokers in Lewisham in Q4 have set a quit date. 6% of smokers that set a quit date with the Stop Smoking Services in Q4 were CO verified ex-smokers at 4 weeks.
- As of March 2026, 91% of midwives have been **trained to provide brief interventions** on smoking cessation, 71% of junior doctors, and 91% of consultants
- The CO clinic has not yet commenced due to sickness within the team
- Plans are in place to train the Indigo vulnerable women's midwifery team to be able to offer Stop Smoking Support and consent people into the Incentive Scheme.
- LGT are currently organising new Risk Perception Training, which will include the specialist midwives and Indigo Team

Health Inequalities & Health Equity Programme highlight report

Health Equity Teams

June 2026

Workstream 2: Health Equity Teams

Overall RAG (Red, amber, green)	Delayed	Ongoing	Ontrack

Lead: Aaminah Verity

Aim: Recruit HEF and commission VCSO to form Health Equity teams. Primary care and VCSO partnership working to co-design interventions to address health inequalities for black and underserved residents

Milestones	Start	Finish	Progress (On track /on going/delayed
First Cycle Evaluation by Health Innovation Network and Centric	Sep 2024	Feb 2025	Completed
Codesign of Next cycles with HEF/VCSOs from previous cycle and other stakeholders	Sep 2024	Jan 2025	Completed
Integration of HETs into INTs	Sep 2024	Dec 2025	Completed
Recruitment of HEFs and Commissioning of VCSOs	Feb 2025	April 2025	Completed
Forming of Health Equity Teams (HETs) induction and training	5th May 25	30th May 25	Completed
Codesign of HET projects	2nd June 25	30th Sept 25	Completed
Delivery of HET projects	1st Oct 25	Mar 27	Ongoing

Risk ID	Title	Description	Risk owner	Risk Score	Potential impact	Mitigating actions taken so far	Mitigating actions to be taken
1	One team ongoing operational delay	Diversity and their HEF delayed. Significant progress made. Still no activity data. Prolonged leave planned for HEF.	Lead	Med	High	Significant support offered to team. DUT mediation, 9 x one to one meetings with HEF, joint extra progress checks to help unblock. Cover for leave period provided to allow training for community champions to continue and to operationalise project plan	Partnership session planned for HEFs return from leave with coproduction lead trainer
2	Champion governance	All HETs have a champion model as part of their projects but no central champion program live in public health now	Lead	Low	Med	Champion governance overview given	Plan for PH strategist role to own this action

Health Equity Team Projects

Neighbourhood Four

Modality PCN

Dr Ama Sogbodjor

Therapy 4 Healing

Outreach Community events for CVD screening

Group consultations leading to peer support

Complementary therapies

Improving PCN ethnicity coding and HTN management

Aplos PCN

Dr Tan Nair

AFRICA ADVOCACY FOUNDATION

Codesign new annual review template for SMI CVD

Community Champions outreach screening

Neighbourhood Three

Sevenfields & Ravensbourne PCNs

Dr Lola Brown

Discover – community health events and support groups

Detect – screening for BP and CKD in barbershops/ salons

Neighbourhood One

North Lewisham PCN

Dr Lucy Baxter

RED RIBBON LIVING WELL

Community engagement – healthy hearts champions, health literacy guides

Case finding – pop up health fairs BP checks

Ongoing support – support group, podcast, equity champions

Neighbourhood Two

The Lewisham Care Partnership

Dr Emily Symington

MAB ADI LIKO

Group consultation model for CVD (focusing on CKD population)

Cultural Humility training for the PCN

Lewisham Alliance PCN

Dr Thilee Thevarajan

Ital community clinic – garden based screening with champions

Plantain programme -12 week therapeutic gardening for those not engaging

Inreach model – to develop a method of reengagement

Workstream 2: Health Equity Teams

HET activity Updates for Q4 26

- Activities included champion training, community venue mapping, co-design sessions, barber shop blood pressure screening, CKD awareness activity. Extensive community outreach events including: neighbourhood hypertension events, food giveaways, coffee mornings, community lunches, housing support, libraries…

- **59 community champions** trained
- **12 work experience students** spent **29 hours** with HETs (within 2 teams)
- **1040 residents engaged** through **442.5 hours** of HET activity
- **356 residents screened** and **125 found to have abnormal results = 35%**
  - **75% were Black and 40% had not seen own GP in last year**
  - **18% of BPs and 9% of urines** tested were **abnormal**
  - **58% of weights** measured were **abnormal**
- 40% of those recorded were from the PCN of the HET but **86% were registered with a Lewisham GP**
- **300+ primary care staff** attended Health Equity PLT
- ~15 HET representatives at the Citizens Election Assembly with mayoral candidates making asks about housing conditions

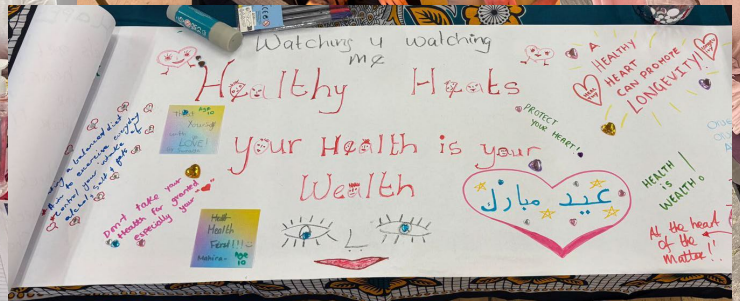
Case Studies

- AAF and Aplos
  - Redesigning the SMI Health Check
  - Identified several key barriers to attendance from co-design group
    - “feel like info goes into a black hole”
    - “doctor/nurse just looks at the screen and doesn’t care about you”
  - Direct link to referrals, changed invites, linked with SLAM working group
- Red Ribbon & NLPCN
  - Holistic Support for a sofa surfing, recently release from prison Homeless Attendee
  - During a blood pressure check, a homeless individual was identified by a Red Ribbon Living Well community champion. This triggered a coordinated response
    - Immediate engagement and trust-building by the community champion
    - Support to register with a GP via social prescribing
    - Completion of a full NHS Health Check with a care coordinator
    - Ongoing social prescribing input to address wider social needs
    - Connection with Emmaus charity for housing and practical support

- Therapy 4 Healing and Modality
  - PCN engagement in Group Consultation design
  - Recruited 2 PCN pharmacists and administrators to support with data entry and patient management
  - Identified through PCN data query for Black residents: 114 undiagnosed HTN (coded high reading but no confirmation) and 252 with suboptimal control for targeted invites to group consultations
  - Whilst delivering extensive outreach screening at four community venues and identifying 7 new screening locations including confirming the Catford Bus garage to reach more young men

Lewisham Health Equity Teams (HETs):
RED RIBBON LIVING WELL
Red Ribbon Living Well was founded in 2009 and has grown from its grass-roots beginnings.
We support and empower people to live healthy lives free from stigma.
What we offer
HEALTHY HEARTS
ISLAM

Therapy 4 Healing
modality
Together


Watching u watching me
Healthy Hearts
Your Health is your Wealth
A HEALTHY HEART CAN PROMOTE LONGEVITY
PROTECT your HEART!
HEALTH IS WEALTH
عيد مبارك
At the heart of the matter!!

REPORT

Lewisham Minor Ailments Scheme (MAS), the Lewisham Pharmacy First Plus Service Outcomes for 2025-26

Senior Responsible Owner: Ceri Jacobs, Place Executive Lead (Lewisham)

Report Author: Erfan Kidia, Assistant Director, Medicines Optimisation Pharmacist (Lewisham)

Distribution: Restricted

Document Control

Document Title	Lewisham Minor Ailments Scheme (MAS), the Lewisham Pharmacy First Plus Service 2025-26
Version	1
Author	Erfan Kidia, Assistant Director, Medicines Optimisation Pharmacist (Lewisham)
Date	15 July 2026

Approvals

Approver	Role	Date
Erfan Kidia	Assistant Director, Medicines Optimisation Pharmacist (Lewisham)	tbc
Laura Jenner	Director for System Transformation (Lewisham)	tbc
Ceri Jacobs	Place Based Executive Lead (Lewisham)	tbc

Background & Rationale

What is a Minor Ailments Service (MAS)?

Many minor ailments are self-limiting, with treatments available to alleviate symptoms or reduce illness duration. The majority of treatments for a range of common illnesses are available without a prescription from a community pharmacy; items that are licensed as pharmacy (P) or General Sales List (GSL) medicines.

It is estimated that nationally over 50,000,000 GP appointments are made for minor illnesses. Studies have also shown that a proportion of GP appointments and Emergency Department attendances are for minor illnesses that could otherwise have been managed by a community pharmacy.

A locally commissioned minor ailments service provides residents with free advice and treatment, free if exempt from prescription charges, for a wide range of common illnesses directly from a local community pharmacy without the need for an appointment or prescription.

What is the difference between a locally commissioned MAS and the nationally commissioned Pharmacy First service?

The nationally commissioned Pharmacy First service is comprised of a referral service for minor ailments or urgent repeat medicines supply, and the seven common conditions consultation and treatment service. Referrals made to the community pharmacy for minor ailments are for a consultation only. A decision to supply an OTC treatment is charged to the patient, regardless of prescription-exemption status.

Where a locally commissioned MAS is present, and a decision is made to supply an OTC treatment, the treatment may be provided free of charge to the patient where they are normally exempt from prescription charges.

A locally commissioned MAS supports urgent and emergency care redirection plans, where patients who would be better managed by a local pharmacy are redirected rather than being seen or treated by urgent and emergency care services. With restrictions in place on OTC prescribing in Primary Care and the need to reduce urgent and emergency care demand, the locally commissioned MAS service supports access to OTC medication without patients needing to be medically assessed elsewhere where this is clinically appropriate.

Lewisham Pharmacy First Plus

In Lewisham, the locally commissioned MAS is called the Lewisham Pharmacy First Plus service. The service is freely available to Lewisham residents who are registered with a Lewisham GP. The service comprises a consultation and medicines supply service without an appointment, provided through participating community pharmacies and covering 28 minor ailments.

The aims of the service are to:

- Promote self-care and educate patients on the appropriate utilisation of healthcare services.
- Alleviate pressure on prescriber-led services for the management of common illness.
- Improve access to healthcare by increasing healthcare availability locally.
- Reduce health inequity through provision of healthcare advice and treatments, particularly for economically deprived areas of Lewisham.
- Support the local healthcare infrastructure by reducing inappropriate demand on other primary care and emergency related services.

Executive Summary

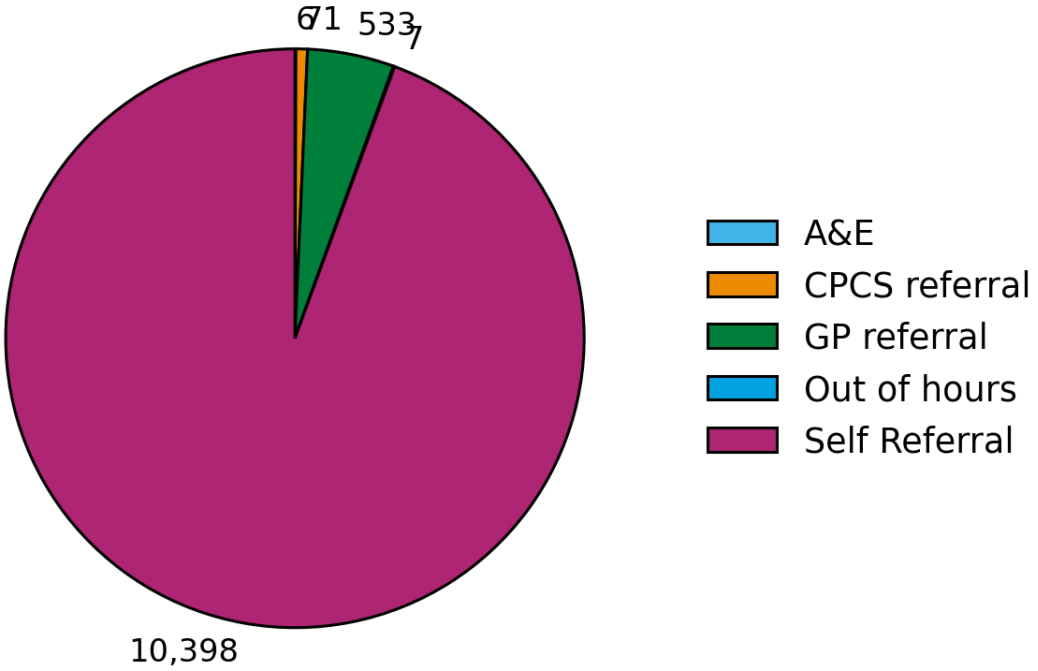
Metric	2025-26 value	Interpretation
Consultations completed	11,015	-19.7% compared with 2024-25 activity of 13,711
Registrations recorded	3,714	41 providers recorded at least one registration
Unique service users	7,286	1,966 service users had more than one consultation
Self-referrals	10,398 (94.4%)	The service remains predominantly accessed directly by patients
Would otherwise have gone to GP	10,248 (93.0%)	Estimated GP appointment cost avoidance: £430,416
Active providers	39	Top 3 providers delivered 5,074 consultations (46.1%)
Youngest age group (0-10)	3,894 (35.4%)	Children remain a major user group
Older people over 60	2,760 (25.1%)	Continued use by older residents supports access without GP attendance

The 2025-26 extract shows **11,015** consultations and 3,714 registrations between 1 April 2025 and 31 March 2026. Activity remained heavily dominated by self-referral, with **10,398** consultations (**94.4%**) recorded as self-referrals. This indicates that the service continued to provide direct, appointment-free access without requiring patients to consult another healthcare service first.

The most significant access and system benefit remains GP demand avoidance. In 2025-26, **10,248** users (**93.0%**) reported that they would otherwise have accessed their GP. Using the £42 GP appointment unit cost used in the 2024-25 report, this equates to an estimated cost avoidance of **£430,416** before any additional benefit from avoided urgent or emergency care attendance is considered.

Activity

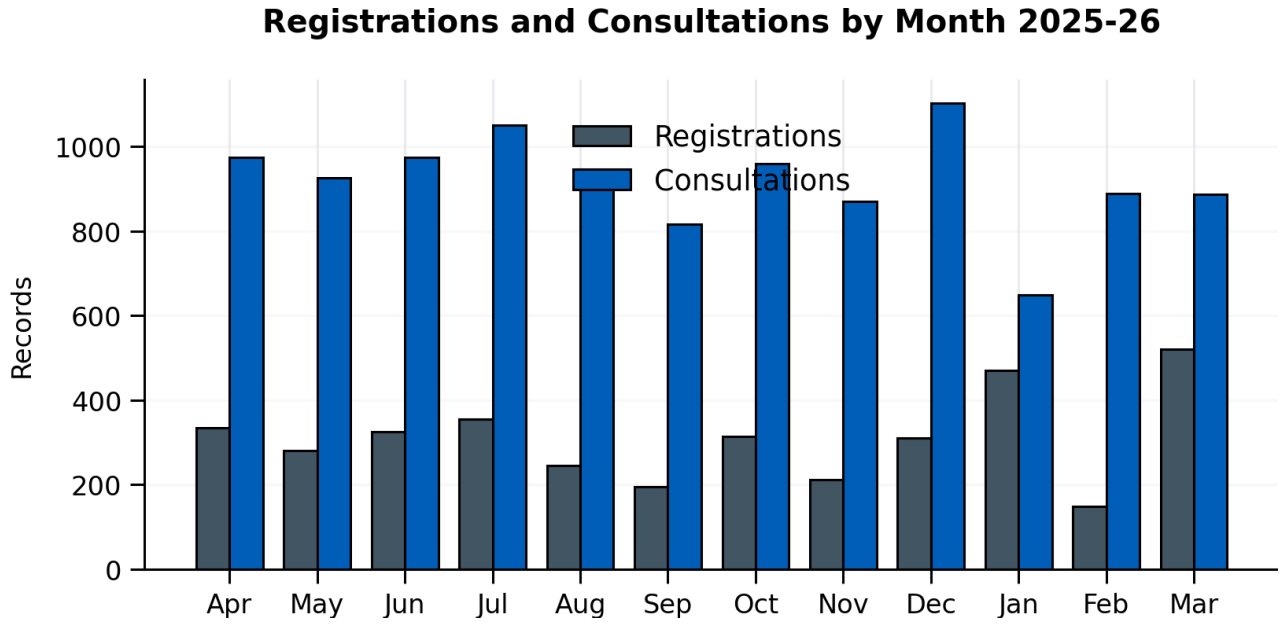
Lewisham Pharmacy First Plus Activity 2025-26



In 2025-26, **11,015** consultations were completed under the Lewisham Pharmacy First Plus service. Of these, **10,398** (**94.4%**) were self-referred, meaning the patient did not consult another healthcare service prior to attending the pharmacy. GP referrals accounted for **533** consultations (4.8%), while CPCS, out-of-hours and A&E referral routes accounted for much smaller numbers.

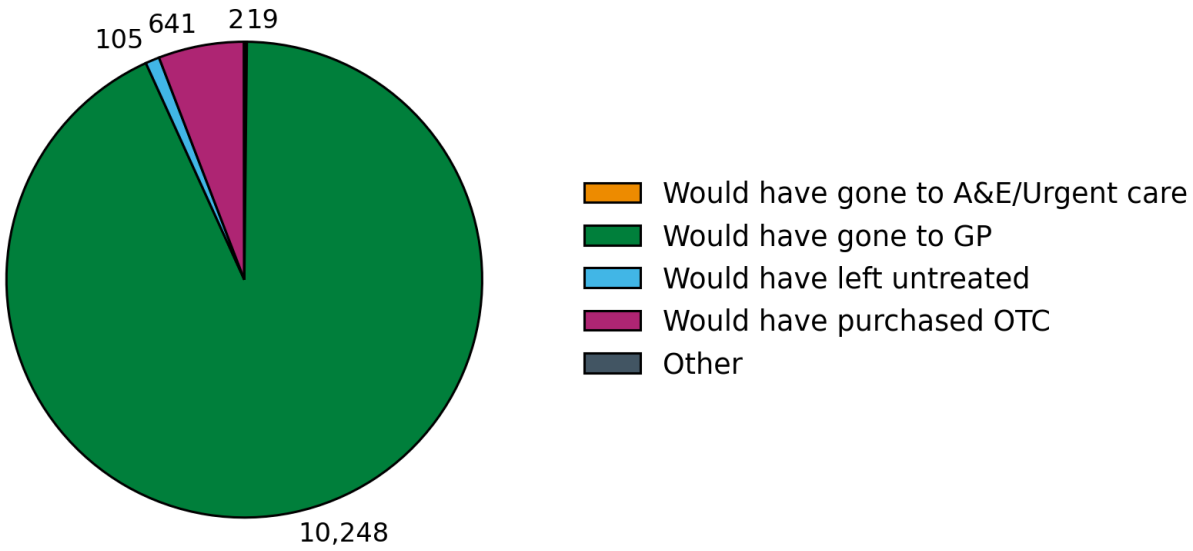
Referral route	Consultations	Share
A&E	6	0.1%
CPCS referral	71	0.6%
GP referral	533	4.8%
Out of hours	7	0.1%
Self Referral	10,398	94.4%

Compared with the 2024-25 consultation total of **13,711** in the historical extract, 2025-26 activity was **19.7%** lower. Despite this reduction in overall volume, the referral route profile remained consistent with the prior report: the service continued to operate primarily as a direct-access community pharmacy route rather than as a pathway dominated by professional referral.


Registrations and Consultations by Month 2025-26
Registrations
Consultations
Records
0
200
400
600
800
1000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

Right Service, Right Time

Right Service, Right Time 2025-26



Of the total number of interactions made under the Pharmacy First Plus service in 2025-26, **10,248** (**93.0%**) service users reported that they would have accessed their GP in the first instance for their minor ailment. With the average cost of a GP appointment retained at £42, use of the Pharmacy First Plus service represents an estimated GP cost avoidance of **£430,416**.

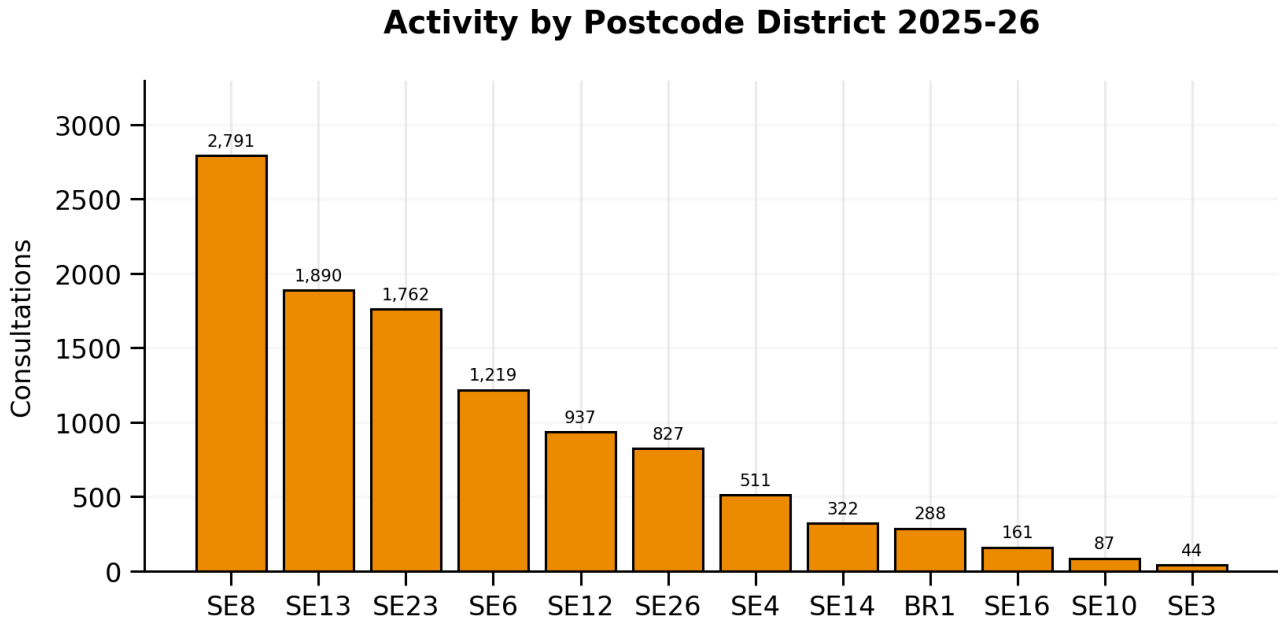
A further **19** users reported that they would have gone to A&E or urgent care, **105** would have left their ailment untreated, and **641** would have purchased an OTC medicine. This suggests the service contributes not only to GP workload avoidance but also to timely treatment, prevention of untreated symptoms, and support for urgent and emergency care redirection.

Alternative disposition	Consultations	Share
Would have gone to A&E/Urgent care	19	0.2%
Would have gone to GP	10,248	93.0%
Would have left untreated	105	1.0%
Would have purchased OTC	641	5.8%
Other	2	0.0%

Health Inequities and Access

The 2024-25 report included analyses of activity by IMD, IDACI, IDAOPI and pharmacy IMD decile against service user IMD. These fields are not present in the supplied 2025-26 registration or consultation extracts, due to the data supplied last by the IT supplier.

Available 2025-26 indicators still suggest broad access across Lewisham communities. Consultations were recorded across multiple postcode districts, with the highest activity in **SE8** (2,791), **SE13** (1,890), **SE23** (1,762), **SE6** (1,219) and **SE12** (937). These postcode-level patterns should be interpreted cautiously because postcode district is not a direct deprivation marker, but it provides a view of geographic spread from the available extract.

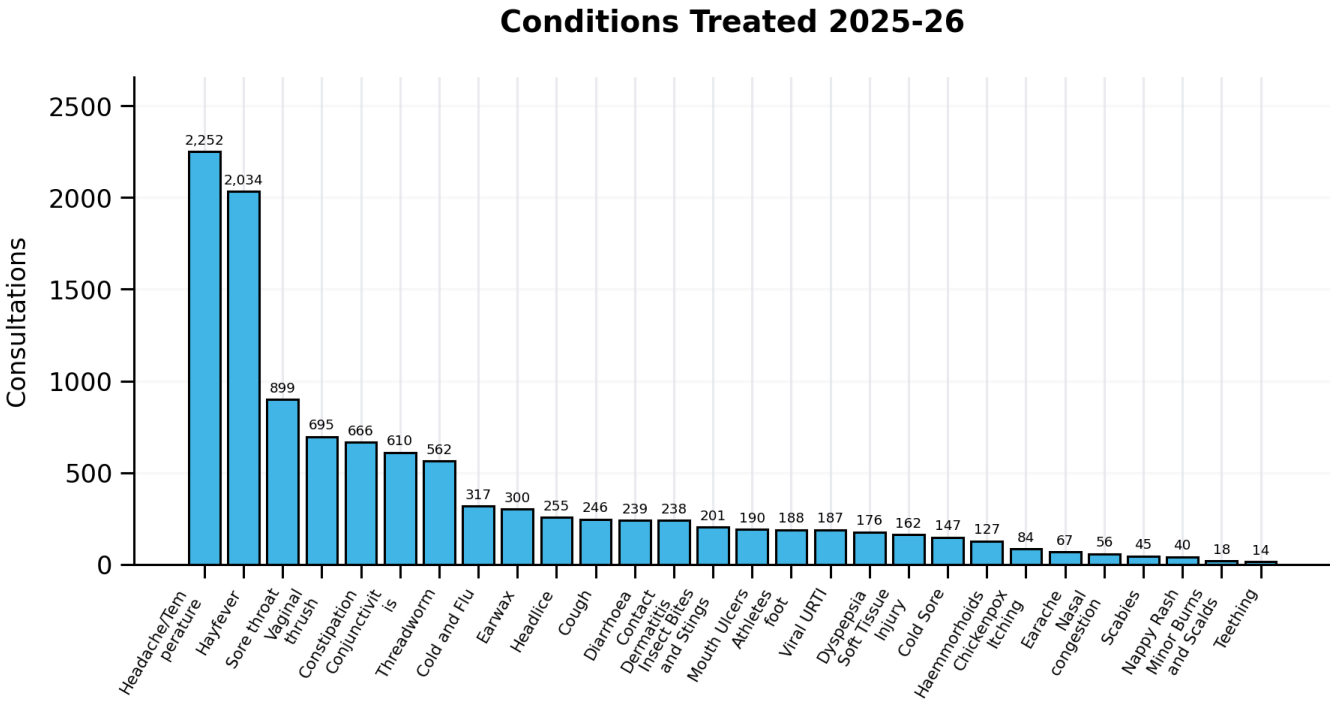


Ethnicity recording

Ethnicity recorded	Consultations	Share
Not stated	3,721	33.8%
Prefer not to say	2,934	26.6%
White - British	1,817	16.5%
White - Other	462	4.2%
Black or Black British - African	431	3.9%
Black or Black British - Caribbean	358	3.3%
Any other ethnic group	321	2.9%
Asian or Asian British - Indian	188	1.7%
Black or Black British - Other Black Background	168	1.5%
Mixed - Other mixed groups	120	1.1%
Asian or Asian British - Other Asian Background	107	1.0%
Mixed - White and Black Caribbean	84	0.8%

Ethnicity data completeness remains a key limitation for equity analysis: **6,655** consultation records (**60.4%**) were recorded as Not stated or Prefer not to say. Improved data completeness would support stronger analysis of access and potential inequities in service utilisation.

Minor Ailments

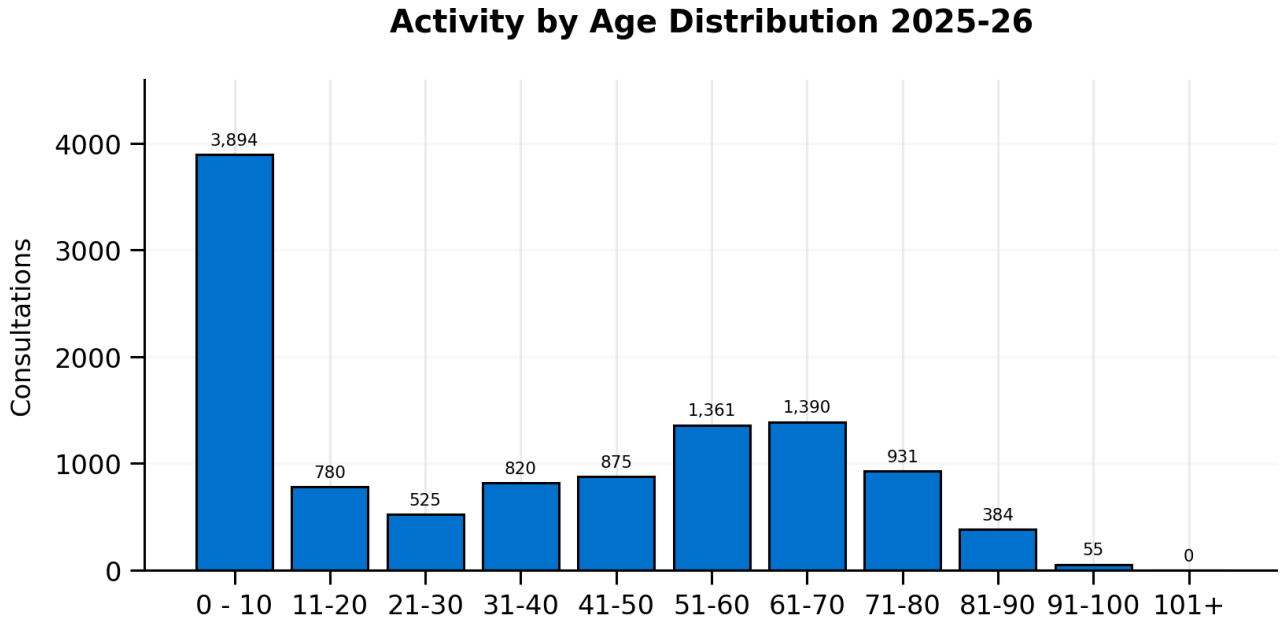


A range of minor ailments were treated by community pharmacy, covering conditions that patients may have otherwise presented to their GP practice for. The most common presenting conditions were **headache/temperature** (2,252), **hayfever** (2,034), **sore throat** (899), **vaginal thrush** (695), **constipation** (666) and **conjunctivitis** (610).

Together, the six most common conditions accounted for **7,156** consultations (**65.0%**).

Condition	Consultations	Share
Headache/Temperature	2,252	20.4%
Hayfever	2,034	18.5%
Sore throat	899	8.2%
Vaginal thrush	695	6.3%
Constipation	666	6.0%
Conjunctivitis	610	5.5%
Threadworm	562	5.1%
Cold and Flu	317	2.9%
Earwax	300	2.7%
Headlice	255	2.3%
Cough	246	2.2%
Diarrhoea	239	2.2%

Age

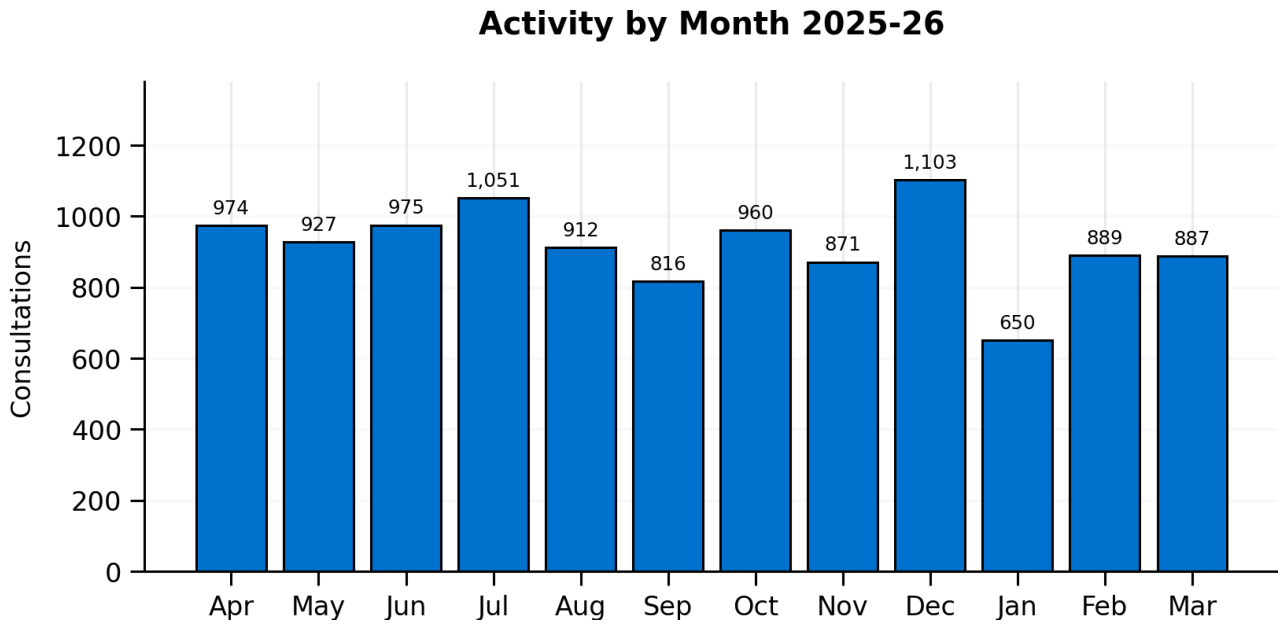


In 2025-26, **3,894** consultations (**35.4%**) were for the youngest age group, 0-10 years. Children under 16 accounted for **4,435** consultations (**40.3%**). This indicates continued reliance on the service for children and families seeking rapid access to advice and treatment for minor illness.

Older people over the age of 60 accounted for **2,760** consultations (**25.1%**). This remains important, as older residents may benefit from accessible, local, walk-in support for minor ailments without the need to secure a GP appointment or attend urgent care.

Monthly Utilisation

Service utilisation varied throughout 2025-26. Peak activity was recorded in December 2025, with a further high point in July 2025. Lower activity was recorded in January 2026. These patterns may reflect seasonal demand, school-term effects, respiratory illness and hayfever patterns, but the attached extract does not contain explanatory variables that would allow these drivers to be tested directly.

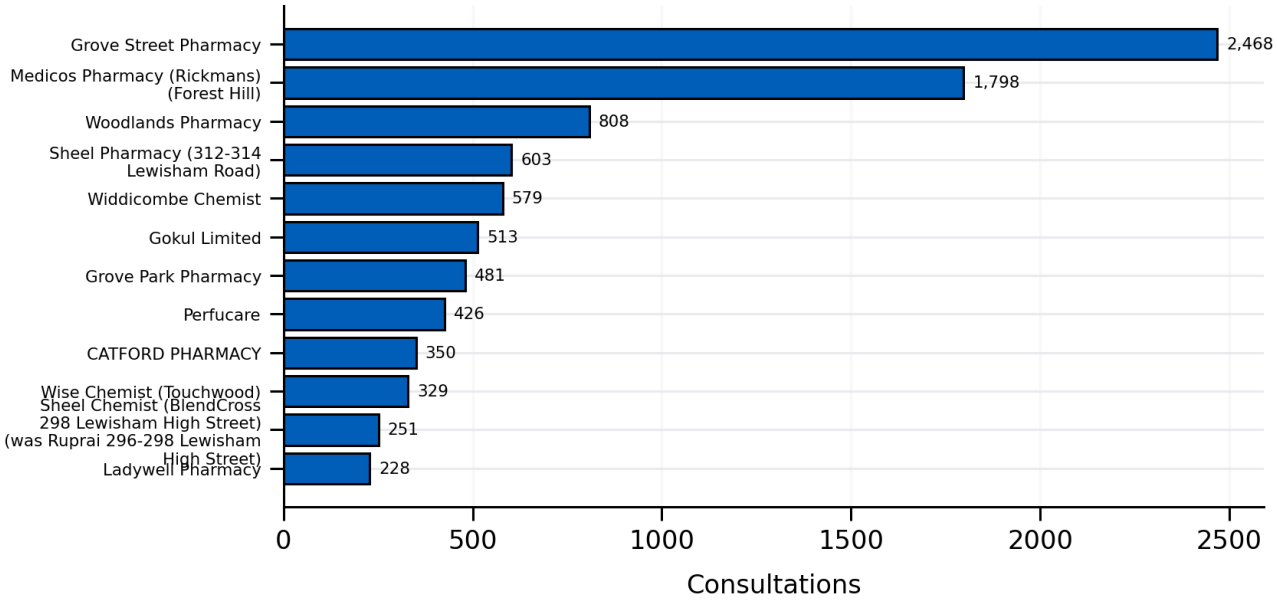


Month	Consultations
Apr 2025	974
May 2025	927
Jun 2025	975
Jul 2025	1,051
Aug 2025	912
Sep 2025	816
Oct 2025	960
Nov 2025	871
Dec 2025	1,103
Jan 2026	650
Feb 2026	889
Mar 2026	887

Provider Utilisation

The 2025-26 consultation extract recorded activity from **39** providers. Activity was concentrated in a small number of high-volume providers: the top three providers delivered **5,074** consultations (**46.1%** of all consultations). This concentration should be considered when reviewing equity of access, resilience, service promotion, and future activity planning.

Top Provider Activity 2025-26



Provider	Consultations	Share
Grove Street Pharmacy	2,468	22.4%
Medicos Pharmacy (Rickmans) (Forest Hill)	1,798	16.3%
Woodlands Pharmacy	808	7.3%
Sheel Pharmacy (312-314 Lewisham Road)	603	5.5%
Widdicombe Chemist	579	5.3%
Gokul Limited	513	4.7%
Grove Park Pharmacy	481	4.4%
Perfucare	426	3.9%
CATFORD PHARMACY	350	3.2%
Wise Chemist (Touchwood)	329	3.0%

Financial

The total service budget is **£114k**, with payments to community pharmacy split between consultation and medicines supply. The 2025-26 budget remains the same at **£114k**. The GP cost-avoidance calculation below uses the **£42** GP appointment value and the **£114k** service budget:

Financial metric	Value
Consultations where user would otherwise have gone to GP	10,248
GP appointment unit cost used in template	£42
Estimated GP appointment cost avoidance	£430,416
Template service budget assumption	£114,000
Estimated net cost avoidance if £114k budget unchanged	£316,416
Users who would otherwise have gone to A&E/urgent care	19

Based solely on GP appointment avoidance, the service delivered an estimated **£430,416** gross cost avoidance in 2025-26. this represents an indicative net cost avoidance of **£316,416**, excluding any further savings from avoided urgent and emergency care attendance and wider qualitative benefits such as improved access, timely treatment and reduced inequity.

Summary

The Lewisham Pharmacy First Plus service continued to meet its core objectives in 2025-26 by providing accessible community pharmacy-based advice and treatment for minor ailments, reducing inappropriate demand on GP appointments, and supporting timely care closer to home. The service recorded **11,015** consultations, with direct self-referral remaining the dominant access route.

The service provides a measurable contribution to GP demand avoidance, with **10,248** users reporting that they would otherwise have accessed their GP. This equates to an estimated GP appointment cost avoidance of **£430,416** using the template GP appointment unit cost. Further benefits are likely through avoided A&E/urgent care attendance, prevention of untreated symptoms and improved access for children, families and older people.

A key limitation of the 2025-26 extract is the absence of deprivation fields. Therefore, the report cannot make evidence-based 2025-26 claims about CORE20, IMD, IDACI or IDAOPI distribution.

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South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 5
Enclosure 4

Title:	**Neighbourhood Prevention Hubs**
Meeting Date:	**23rd July 2026**
Author:	Fiona Kirkman, System Development Lead, Lewisham Council/ NHS SEL ICB Lewisham.
Executive Lead:	Catherine Mbema, Director of Public Health, Lewisham Council.

Purpose of paper:	To update the Board on the development of the Lewisham Neighbourhood Prevention and Hub Programme, funded through the Strategic Investment Fund (SIF), and to outline the proposed delivery model, investment, implementation timeline, and anticipated benefits.	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	Lewisham has secured £600,000 Strategic Investment Funding to establish a neighbourhood based prevention model in Neighbourhood 2 (East) and Neighbourhood 3 South, also to include Bellingham. The programme aligns with the NHS 10 Year Plan ambition for neighbourhood health centres providing integrated health, local authority and community support services. The programme will deliver a hub-and-spoke prevention model, combining proactive health checks, outreach, social support, and coordinated multi-agency working to address health inequalities and improve population health outcomes.		
Potential Conflicts of Interest	There are no explicit conflicts of interest identified within the paper. However, as the programme moves into commissioning and implementation, potential conflicts should be recognised and managed through appropriate governance arrangements.		
Any impact on BLACHIR recommendations	The programme's focus on health inequalities, prevention, outreach, trusted community settings, and Core20PLUS5 targeting is likely to deliver benefits for Black African and Black Caribbean communities' who experience poorer health outcomes across a range of indicators. This approach supports the findings of the BLACHIR Report.		

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

	Lewisham	X	Southwark	
	Equality Impact	An Equality Impact Assessment (EIA) will be undertaken as the programme develops to assess the potential impact on people with protected characteristics and those experiencing health inequalities. Findings will be used to inform the final service design, delivery model and mitigation actions to ensure equitable access, experience and outcomes.		
	Financial Impact	The programme has secured £600,000 of Strategic Investment Fund (SIF) funding for 2026/27, with £300,000 allocated to each of the two priority neighbourhoods (East and South Lewisham). Increased focus on prevention and early intervention may reduce future demand on primary, community, urgent and acute care services. Earlier identification of hypertension, obesity, smoking, alcohol misuse and poor mental health can help avoid higher cost treatment later in life. Improved coordination between NHS, council and VCSE services may reduce duplication and make better use of existing resources. Addressing wider determinants such as housing, financial hardship and social isolation has the potential to reduce avoidable service demand across the wider health and care system.		
Other Engagement	Public Engagement	Public engagement is a key enabler of the programme and is essential to achieving the intended prevention and neighbourhood model. A multi-agency stakeholder workshop was held on 15 May 2026, attended by 59 stakeholders from across health, local authority and VCSE sectors. Participants strongly supported a model focused on better coordination, community-led delivery and outreach rather than creating additional standalone services. The programme has been developed with an explicit commitment to further engagement and co-design across the East and South neighbourhoods before finalising the service model.		
	Other Committee Discussion/ Engagement	The programme proposes: • Co-design sessions with residents and community groups.		

		• Dedicated neighbourhood design groups for East and South Lewisham. • Engagement with VCSE organisations as delivery partners. • Development of outreach services based on community feedback and local needs. • Use of trusted community venues and existing community networks to reach residents.
Recommendation:	1. Note progress on the Neighbourhood Prevention and Hub Programme. 2. Support the continued development of the hub and spoke prevention model. 3. Endorse ongoing engagement and co-design with community and VCSE partners.	

South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Neighbourhood Hubs & Prevention

July 2026

South East London Integrated Care System

Lewisham Strategic Investment Fund – Neighbourhood Prevention Offer

lhcp Lewisham Health and Care Partnership

The NHS 10-Year Plan recently laid out the ambition for all neighbourhoods to contain a health centre hosting a variety of health, local authority, and community-based support services for residents.

As part of Lewisham's Strategic Investment Fund (SIF) for 2026/27, we have been allocated £600,000 (£300,000 per neighbourhood) for the development of a prevention offer in two Lewisham neighbourhoods.

Locally, we have decided that embedding this prevention offer in Neighbourhood Hubs is crucial to the development of holistic, preventative neighbourhood working in Lewisham. The two neighbourhoods we have chosen for the initial rollout in 26/27 are:

1. **South (Neighbourhood 3):** chosen based on the needs of the population. Downham Health & Leisure Centre has also been included in a national funding programme for Neighbourhood heath centres.
2. **East (Neighbourhood 2):** chosen based on the needs of the population.

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Codesigning the Neighbourhood Prevention Offer – Workshop, 15th May

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The workshop focused on designing a holistic neighbourhood prevention offer, including which services to include, what the prevention model may look like for residents, and how we might measure successful outcomes.

Excellent turnout, with 59 people attending the session in total. The table discussions generated a great deal of energy, insight, and valuable ideas. There was strong agreement across all groups – the system does not need more services, it needs better connection, coordination, and community-led delivery.

The preferred future model is:

- Integrated, partnership-led hubs
- Strong outreach into communities
- Co-produced, targeted prevention
- Supported by better data, digital systems, and communication

The workshop marked the beginning of an important conversation. Based on the feedback and discussions from the session, our next steps are developing a draft Prevention Offer for the Strategic Investment Fund template, alongside planning further engagement and co-design sessions with stakeholders across the East and South Neighbourhoods.

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Neighbourhood Prevention: The Core Offer

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Key elements of the Core Offer include:

1. **A Neighbourhood based-hub and spoke model** (flexible and outreach focused) with emphasis on multi-generational prevention.
2. **Providing Vital 5 checks on-site and through community-based outreach** (building on VCSE, Health Equity and CHEWies work).
3. **Initial focus on South and East Lewisham neighbourhoods,** plus hyper-local delivery based on Core20PLUS5 indicators and feedback from partners & communities.
4. **Access to financial, housing, carer, and wraparound holistic support.**
5. **Identifying and prioritising population groups** using dashboard data, Core20PLUS5, and local insight:
    - Improve data sharing and integration
    - Include VCSE data in system insight
    - Use real-time/local data to target need
    - Embed on-the-spot and ongoing evaluation

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How do we prevent ill health? – Focus on Vital 5+

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- "Vital 5":
  - Hypertension.
  - Unhealthy weight and lifestyle factors (physical activity, nutrition).
  - Poor mental health and wellbeing.
  - Tobacco dependency.
  - Alcohol harm.

- "Plus":
  - Financial security
  - Employment
  - Social connectivity
  - Housing.

Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

- Underpinned by "Making Every Prevention Count" (vaccinations, screening uptake, and small actions that support healthier lifestyles).

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What is a Vital 5 Health Check?

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Vital 5 Health Check	NHS Health Check
For **adults aged 18-40**	For **adults aged 40-74**
Free 5 to 30-minute appointment	**Free** 20 to 30-minute appointment
One Health Lewisham commissioned by LBL to offer these checks	One Health Lewisham manage these checks, offered in GP practices
Prevention-based offer, identifies **five key risk factors** to help prevent serious conditions like heart disease, stroke, and diabetes. Particularly focussed on residents living in areas with health inequalities. The five key risk factors are: • Blood pressure • Weight *(maintaining a healthy range)* • Smoking *(offering quit support)* • Alcohol *(monitoring safe consumption levels)* • Mental health	**General health check – patients not eligible if they already have** any of the following: • heart disease • chronic kidney disease • diabetes • high blood pressure (hypertension) • atrial fibrillation • transient ischaemic attack • inherited high cholesterol (familial hypercholesterolemia) • heart failure • peripheral arterial disease • stroke • currently being prescribed medicines such as statins to lower cholesterol • previous checks have found that you have a 20% or higher risk of getting cardiovascular disease over the next 10 years

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Neighbourhood Prevention Core Offer: SIF Submission

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Activity	How we will meet the delivery model and minimum requirements
Proactive identification	Navigators in Primary Care to proactively identify eligible patients (1 per neighbourhood)
Follow-up and proactive support	Support offered in neighbourhood hubs, healthcare settings, leisure centres and other community sites. Various providers across Lewisham will be included in the support offer, including: - Primary Care (general practice and pharmacy) - Secondary Care - Community NHS services - NHS Mental Health Services - Council Public Health - Other local authority services - VCSE and community groups
Outreach	Build upon work with Health Equity Teams; Community Health & Wellbeing Workers (aka Chewies); INT LTC staff and VCS Neighbourhood Leads - meeting residents in the community. We will use some of our funding to undertake outreach work at community sites, with support from VCS groups.
Monitoring and evaluation	Lewisham Population Health Team to measure activity data, as well as clinical outcomes. Need to capture holistic wellbeing outcomes. Use toolkit to monitor developments.

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High-Level Funding Proposal

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Funding Area	Amount
Vital 5 health checks will be funded and hosted in hub/spoke sites and community outreach settings. Full model of care, and which services to be included in each Neighbourhood, to be finalised.	£300,000
Recruitment of a Manager/Delivery Lead to oversee the operation of the Neighbourhood Hubs/Prevention programme.	£70,000
The outreach offer will be coproduced with community and VCS in N2 & N3. The Community and VCSE will lead the codesign and delivery of outreach, including CHEWies.	£160,000
Set up Independent Prescribing Community Pharmacy Prescribing (IPCP) LTC Clinics in each Neighbourhood at existing interested pharmacy premises (1 pharmacy per neighbourhood)	£70,000
TOTAL FUNDING ALLOCATION	**£600,000**

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Proposed Lewisham Hub & Spoke Sites

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East *(Neighbourhood 2)* – Proposed Hub and Spoke Sites

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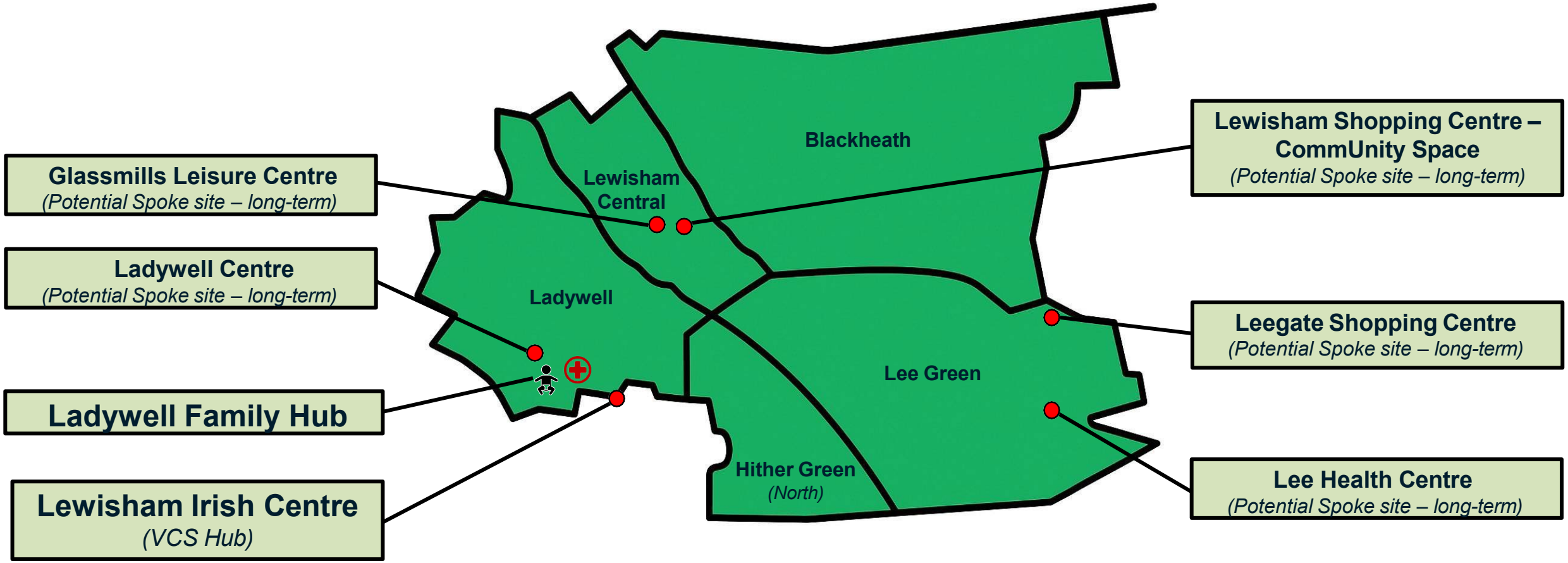

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South *(Neighbourhood 3)* – Proposed Hub and Spoke Sites

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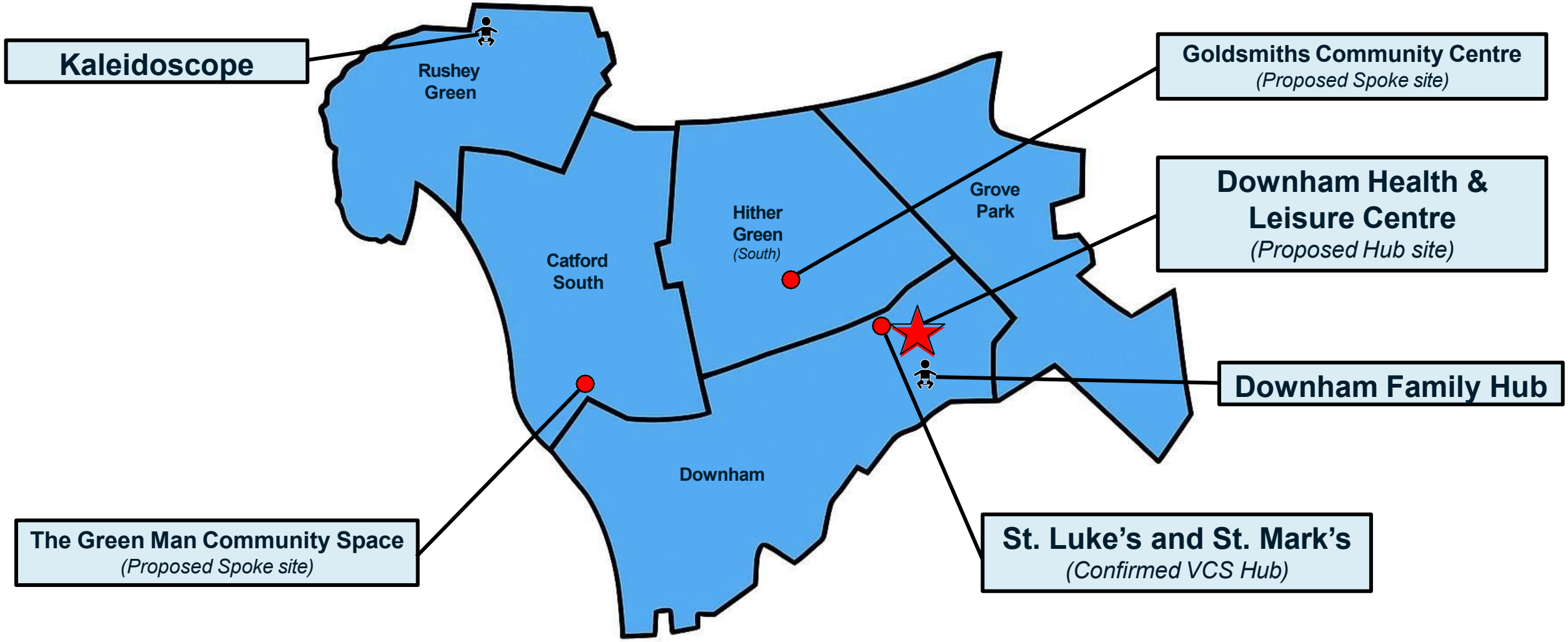

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Neighbourhood Prevention: Timelines

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Neighbourhood Prevention: Key Milestones

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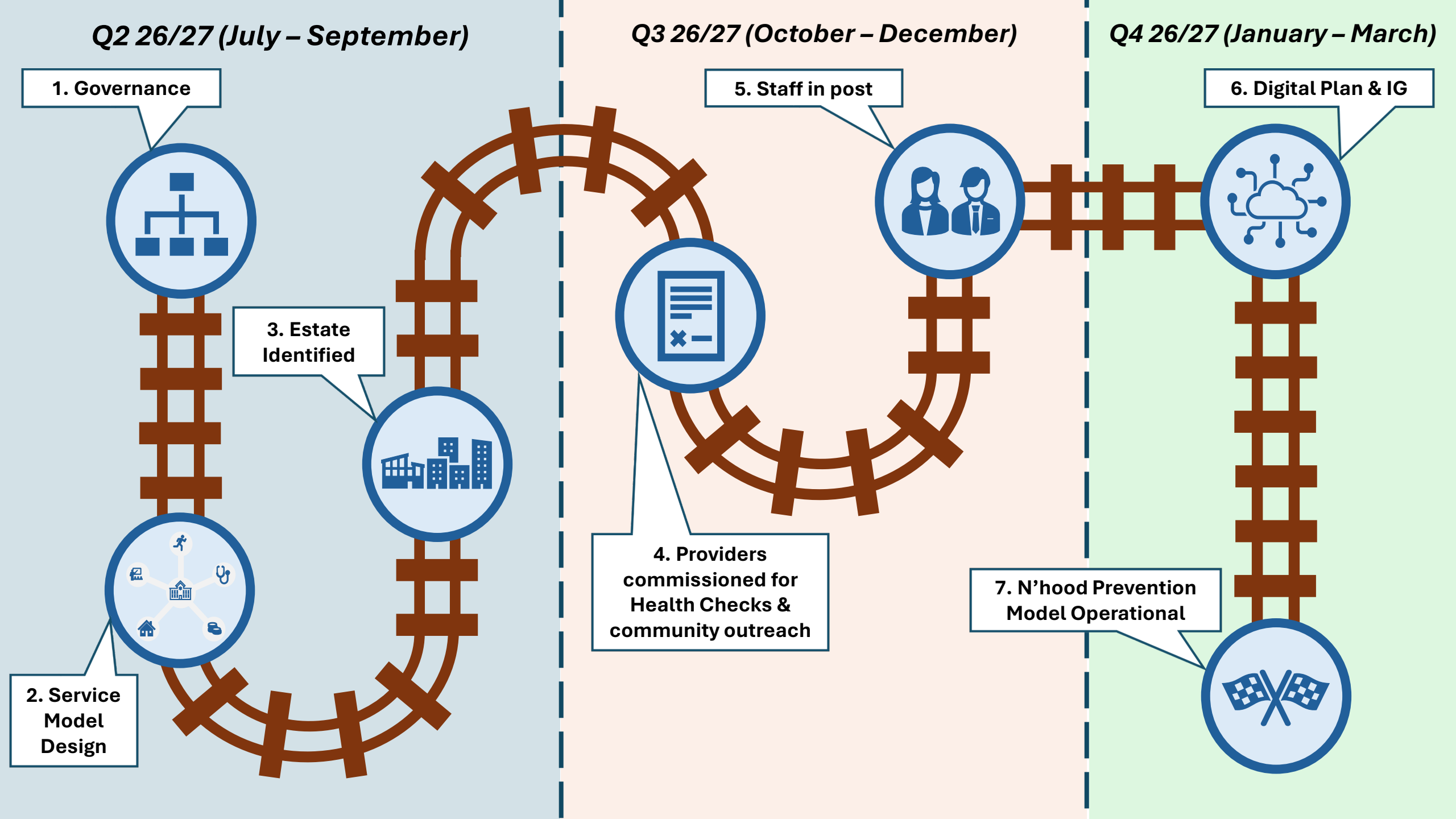
Milestone	Target Date
Programme governance agreed	June/July 2026
Service Model codesigned (inc. engagement with partners, VSE groups & residents)	August/September 2026
Hub & Spoke estates identified	August/September 2026
Providers commissioned for Health Check delivery and community-based outreach	October/November 2026
Staff in post – N'hood Delivery Manager (ICB); N'hood Navigators (Primary Care)	November 2026
Digital plan in place; all **IG documentation** complete	November/December 2026
Neighbourhood Prevention Model operational in East (N2) and South (N3)	January – March 2027


Q2 26/27 (July – September)
Q3 26/27 (October – December)
Q4 26/27 (January – March)
1. Governance
2. Service Model Design
3. Estate Identified
4. Providers commissioned for Health Checks & community outreach
5. Staff in post
6. Digital Plan & IG
7. N'hood Prevention Model Operational

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Neighbourhood Prevention: Detailed Milestones

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1. Governance in place

(June/July 2026)

Regular Working Group to be set up with attendance from all system partners. This group will feed into PEG, the INC, and then onto the Provider Alliance.

2. Service Model codesigned

(August/September 2026)

Two workshops have been held already to help plan this programme – Neighbourhood Estates & Prevention. Further engagement and codesign sessions to be planned with internal stakeholders, VCSE, & residents.

Need two design groups to enable a neighbourhood-specific approach.

3. Hub & Spoke sites identified

(August/September 2026)

Hub site for South (N3) identified as Downham – this space will be used for prevention offer, with input from stakeholders and residents.

Spoke sites for South, and hub or spoke sites for East (N2), must be identified.

4. Providers commissioned

(October/November 2026)

2 providers will need to be commissioned – one to build and deliver the core offer & NHS Health Checks at hub sites; the other, to build and deliver proactive outreach model in VCSE/community spaces.

5. Staff in post

(November 2026)

Staff to be recruited:

- Neighbourhood Delivery Manager *(organisation tbc)*
- 4x Neighbourhood Navigators *(Primary Care)*
- Other support roles *(commissioned providers to organise)*

6. Digital & IG signed off

(November/December 2026)

A full digital plan ,including any digital offer for residents, will be produced.

Data-sharing agreements; DPIAs; and any other IG or clinical governance documents must be signed off by all stakeholders.

7. Prevention Model operational

(January – March 2027)

Model operational and seeing patients by Q4 26/27. A Test & Learn approach will be used to gather outcomes data and continually develop the model.

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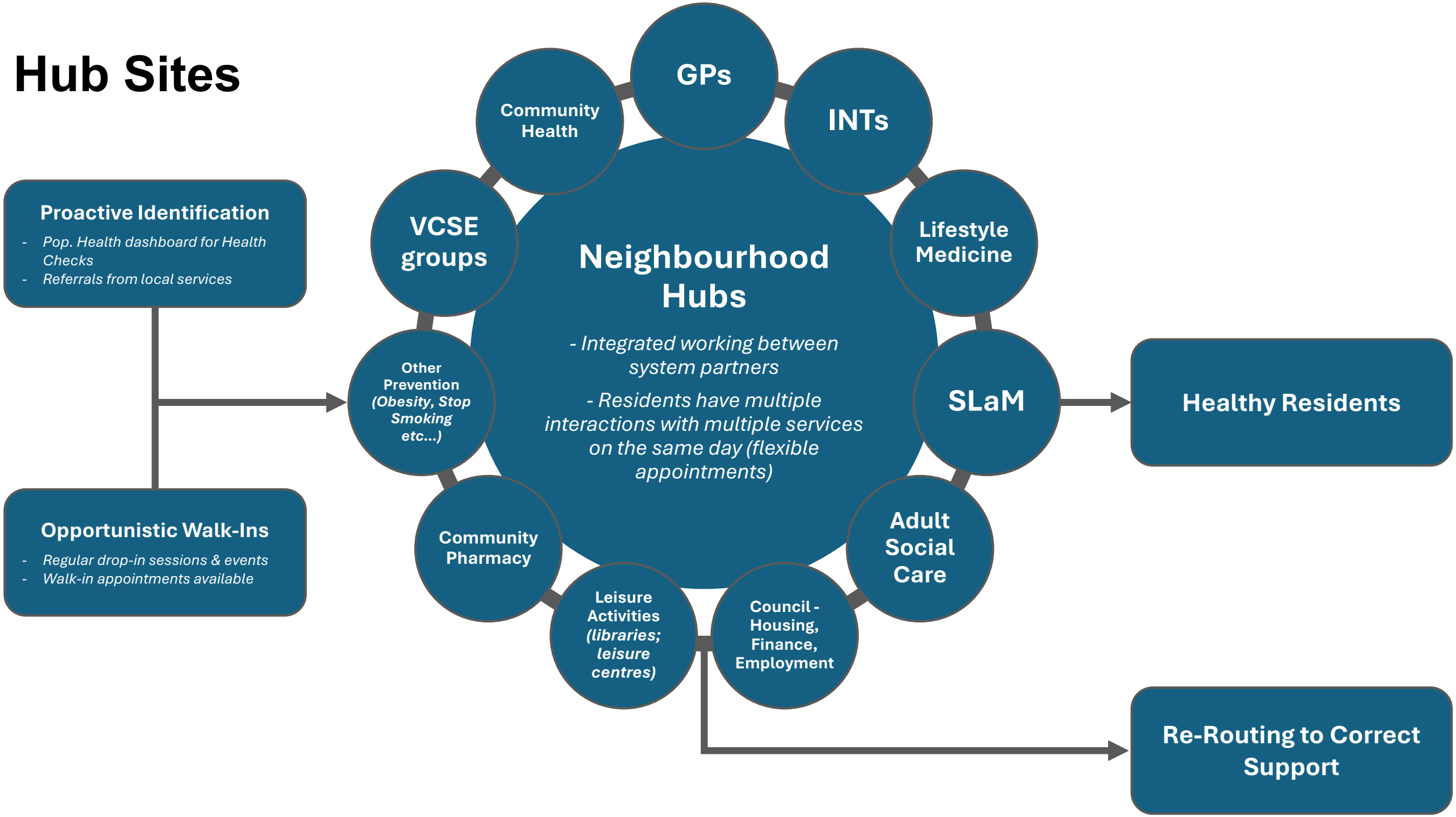
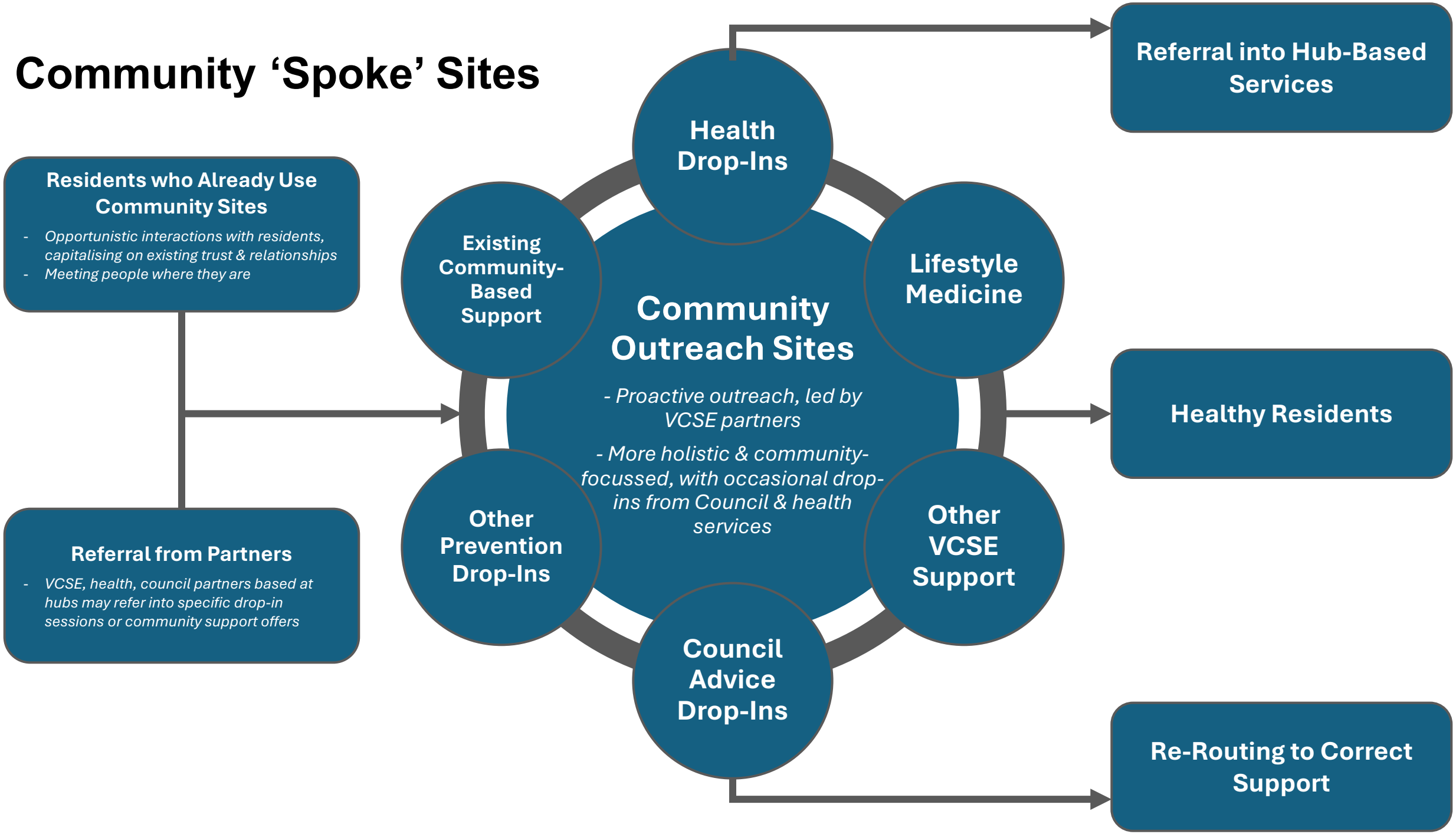
High-Level Model of Care

Hub Sites


Proactive Identification
- Pop. Health dashboard for Health Checks
- Referrals from local services
Opportunistic Walk-Ins
- Regular drop-in sessions & events
- Walk-in appointments available
Neighbourhood Hubs
- Integrated working between system partners
- Residents have multiple interactions with multiple services on the same day (flexible appointments)
GPs
INTs
Lifestyle Medicine
SLaM
Adult Social Care
Council - Housing, Finance, Employment
Leisure Activities (libraries; leisure centres)
Community Pharmacy
Other Prevention (Obesity, Stop Smoking etc...)
VCSE groups
Community Health
Healthy Residents
Re-Routing to Correct Support

Community 'Spoke' Sites



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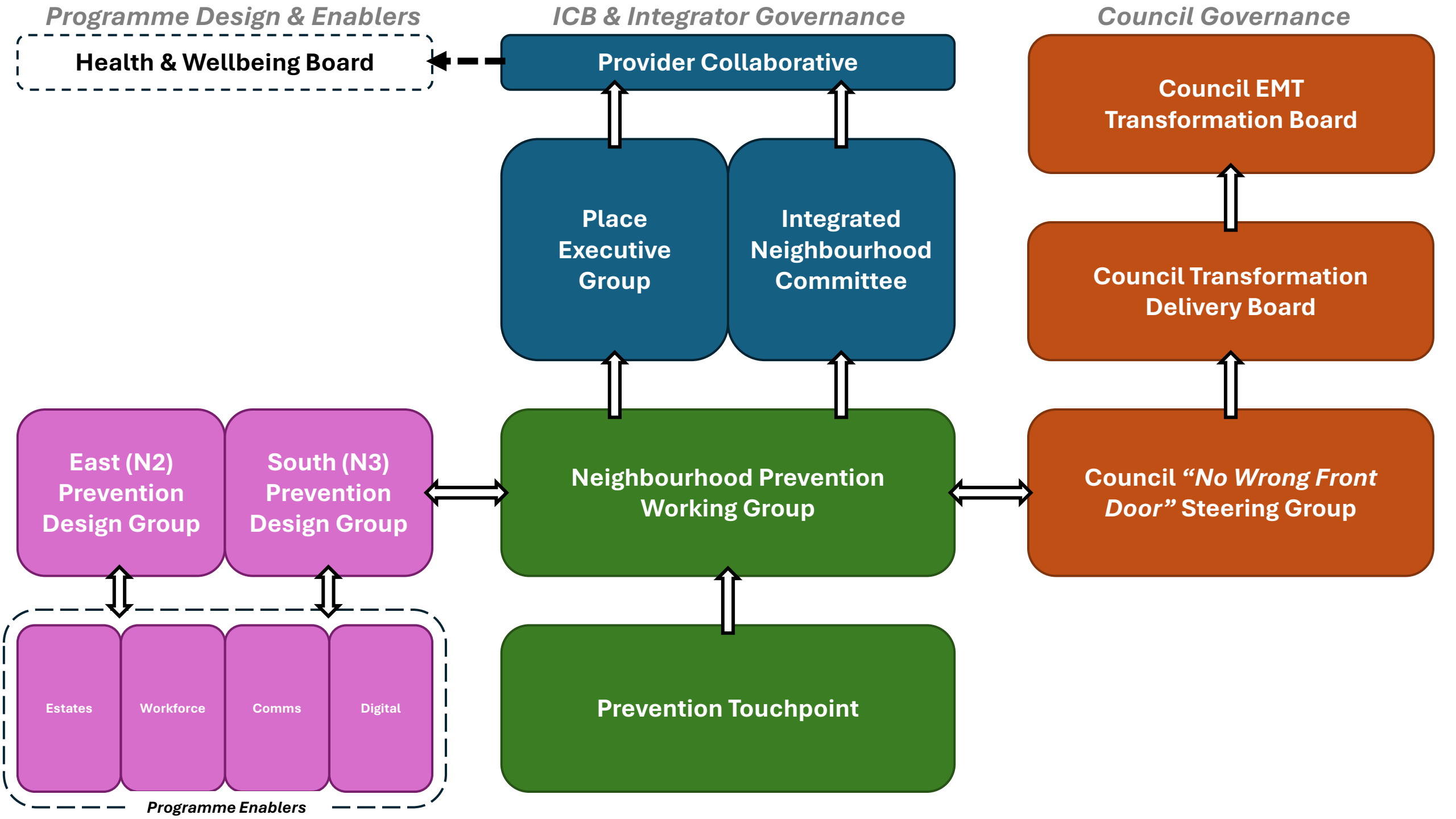
Programme Governance


Programme Design & Enablers
ICB & Integrator Governance
Council Governance
Health & Wellbeing Board
Provider Collaborative
Council EMT Transformation Board
Place Executive Group
Integrated Neighbourhood Committee
Council Transformation Delivery Board
East (N2) Prevention Design Group
South (N3) Prevention Design Group
Neighbourhood Prevention Working Group
Council "No Wrong Front Door" Steering Group
Estates
Workforce
Comms
Digital
Prevention Touchpoint
Programme Enablers

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Neighbourhood Health and care – Framework

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Defined Neighbourhood Footprint
Neighbourhoods are defined by PCNs, local authority boundaries, and communities for clear population responsibility.

Shift to Community Care
The NHS is moving from hospital-focused to proactive community-based care centred on populations and individuals.

Integrated Care Systems
Aligning health, social care, and voluntary sectors at neighbourhood level for coordinated and efficient support.

Population Health Management
Data and insights are used proactively to identify risks and target support to improve population health.

Local Leadership and Governance
Shared governance and decision-making cut across organisations fostering collaborative local leadership.

Addressing Health Inequalities
Services aim to reduce variations in access and outcomes, focusing on health inequalities and equitable care

The Neighbourhood Hub - National Strategy

Strategic Importance

There is an expectation that every N'hood will have a hub and spoke model. Locally we have completed a return to NHSE on our assessment of what is currently available and what requires investment. Downham Health & Leisure centre has been selected as the first health and wellbeing hub with an investment of £500k.

Core Role of Neighbourhood Hub

Neighbourhood hubs anchor the hub and spoke model, providing physical or virtual spaces for local health collaboration.

Integrated Team Collaboration

Hubs enable Integrated Neighbourhood Teams to work together closely through co-location and regular multidisciplinary meetings.

Access and Community Support

Aligning health, social care, and voluntary sectors at neighbourhood level for coordinated and efficient support.

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The Neighbourhood Spokes

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Local Delivery Points

Neighbourhood spokes include local venues like GP practices, pharmacies, schools, and faith settings providing accessible care.

Reducing Barriers to Access

Spokes bring services closer to people's daily environments, improving engagement with underserved populations.

Integration with Hub Model

Spokes connect to hubs through shared systems and pathways, ensuring coordinated and consistent care delivery.

Role in Prevention and Management

Spokes support outreach, prevention efforts, and ongoing management of long-term health conditions locally.

Lewisham Neighbourhood Model

Working together to deliver **holistic, person-centred care** in our communities

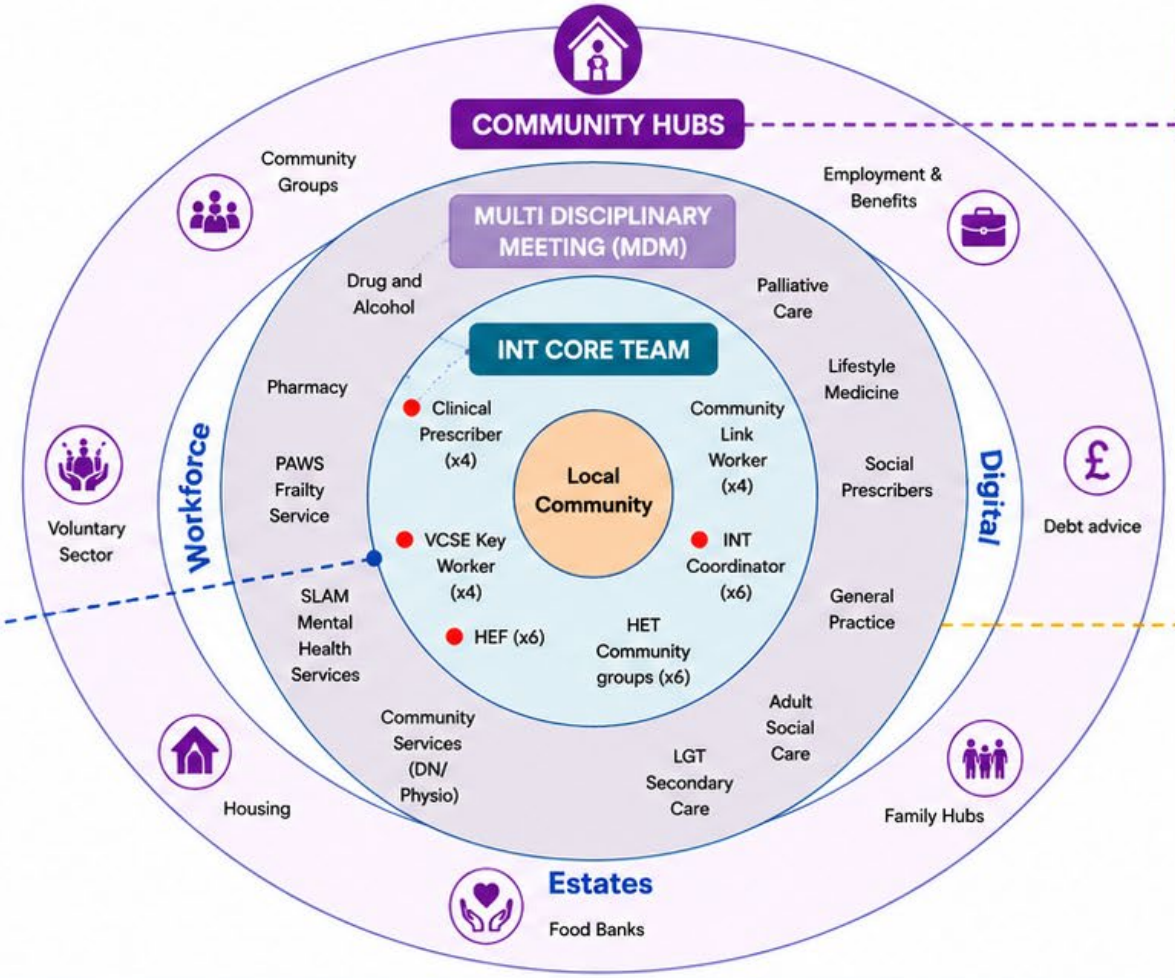
INT Core Team

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

Note: The INT Core Team will vary for each workstream. The current team shown here is specific to the Long Term Conditions (LTC) INT workstream.

Key ● New Role Enablers



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.

At the heart of our community

Putting people and communities at the centre of everything we do.

Integrated teams, better together

Working across roles and organisations to deliver joined-up, seamless care.

Holistic support for healthier lives

Addressing health, wellbeing and the wider determinants of health.

Stronger connections, better outcomes

Building resilient communities where everyone can live well and thrive.

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The Importance of Community

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Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 6
Enclosure 5

Title:	**Organisational Development Update**
Meeting Date:	**23rd July 2026**
Author:	Charles Malcolm-Smith, Associate Director for System Development (Lewisham),
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The Board is asked to note the outcomes of the recent leadership development day and further organisational development activity to support effective neighbourhood working in Lewisham	Update / Information	
		Discussion	*x*
		Decision	

Summary of main points:

Kaleidoscope Health & Care consultancy were commissioned in January to support the Lewisham Neighbourhood Organisational Development (OD) programme.

The aims of the programme include:

- Raising awareness of neighbourhoods and the new models of care we are delivering
- Improving shared decision-making within neighbourhood teams
- Developing collaborative problem solving and upskilling in the use of improvement tools and methodologies
- Developing a shared purpose across senior leaders, programme and operational leads and neighbourhood teams for the next 3-5 years

The programme has included development sessions with the INTs for long-term conditions, with service leads and with the SRO group.

The attached slide pack (appendix 1) provides a summary of the outputs from the leadership development day held on 12th June. The session included a review of personal styles amongst senior leaders, and the operating model and workplan for the neighbourhood health programme. There was detailed work on the workstreams for wider prevention, acute to community shift, frailty and complex children and young people (CYP). As a result of the session, the neighbourhood workstream structure has been revised.

Further sessions are planned for INTs and service leads, and for the SRO group with input from the Nuffield Trust to share their perspectives around the 'left shift' of activity from acute to community settings.

A refreshed OD plan will be developed in the autumn.

Potential Conflicts of Interest	**None identified**			
Any impact on BLACHIR recommendations	Effective neighbourhood and partnership working will support workstreams and programmes to address inequalities including access, prevention, co-design and VCSE development.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	As above, effective neighbourhood and partnership working will support workstreams and programmes to address inequalities including access, prevention, co-design and VCSE development		
	Financial Impact	The OD programme supports efficiency, service design and sustainability in the neighbourhood programme.		
Other Engagement	Public Engagement	There has been no public engagement on the OD programme.		
	Other Committee Discussion/ Engagement	Integrated Neighbourhood Committee 22nd January 2026Review by Lewisham Neighbourhood Programme Board 6th July 2026;		
Recommendation:	The Board is asked to note the report.			

Lewisham Health and Care Partnership Neighbourhood Health programme - leadership development day

12 June 2026

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A bit of context

On Friday 12 June 2026 partners from across the Lewisham health and care system came together for a development day focused on leadership of the Neighbourhood Health programme. The day built on a co-design session held with the Senior Responsible Officers (SRO) group on 5 May.

In the morning, the SROs came together to think about how they work well together as leaders and to build a shared understanding of the fundamentals of the programme (particularly the vision, the operating model and the workplan).

In the afternoon, we were joined by the programme and operational leads. Together we took a closer look at four specific workstreams through the lens of distributed leadership as the organising idea: what did each group of leaders need from the other to work effectively?

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The morning: SROs

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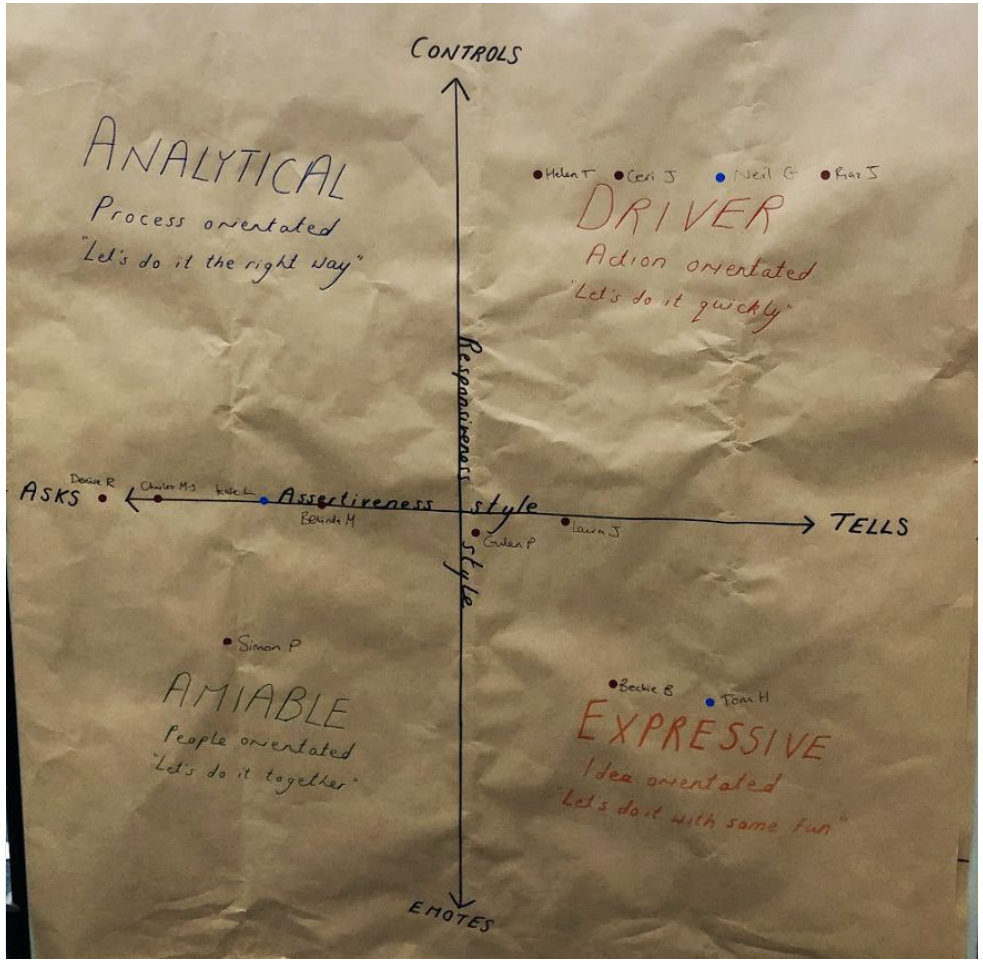
Personal Style Inventory

See appendix for larger image

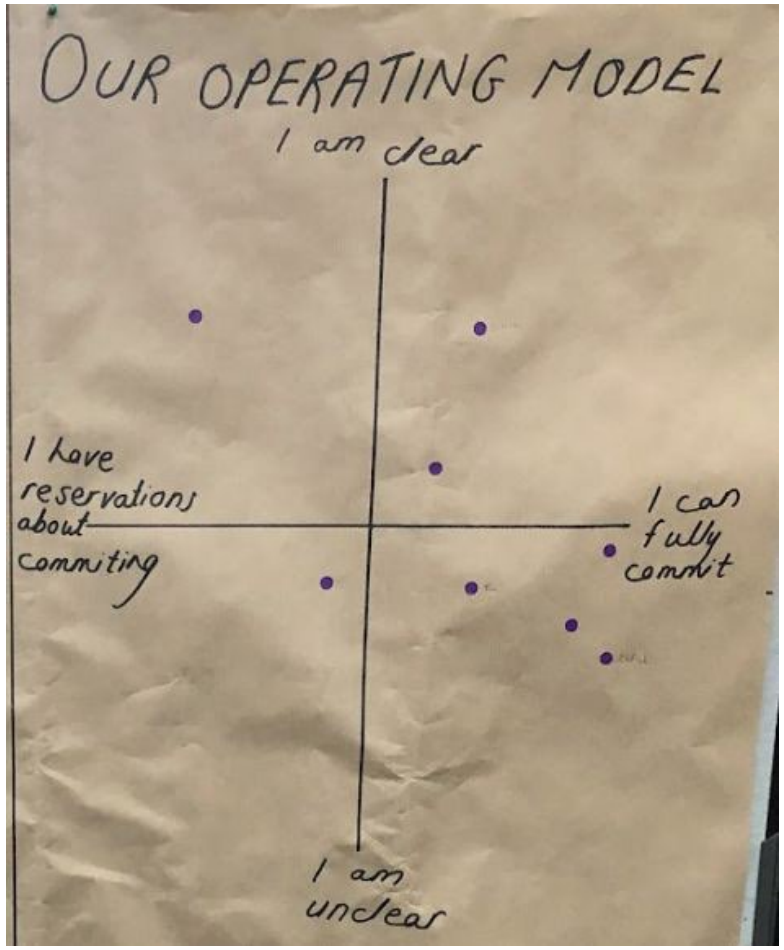
The day began with the SRO group turning attention to themselves - using a Personal Style Inventory exercise to explore individual working styles and what the profile of this leadership group means for how they lead together.



We reflected that:

- Understanding our styles is important to avoid assumptions/myths about how each other works
- The group is primarily a mix of driver and analytical/amiable, with nobody sitting firmly in the analytical space
- There is a need to translate this into how we work together going forward, being cognisant of our gaps. For example, asking the check-in question *'What really matters to you in this meeting?'*
- **Additionally, it would be helpful to understand each other's job roles and pressures - shifting from collaborative to system leadership**

Improving our operating model



Next we moved on to refining our operating model.

Our check-in exercise surfaced that despite positive energy and willingness amongst the group, there was confusion about what we mean by operating model and what the existing model was trying to capture/serve.

The group generated a set of specific asks for the next iteration of this plan, the detail of which can be found in on the next slide. In summary, we surfaced a need for something which bridges the gap between an operating model and the workplan.

We agreed that a successful iteration **needs to be used consistently throughout the system to ensure partnership working**. Additionally, the group needs to make a shared commitment to the final version.

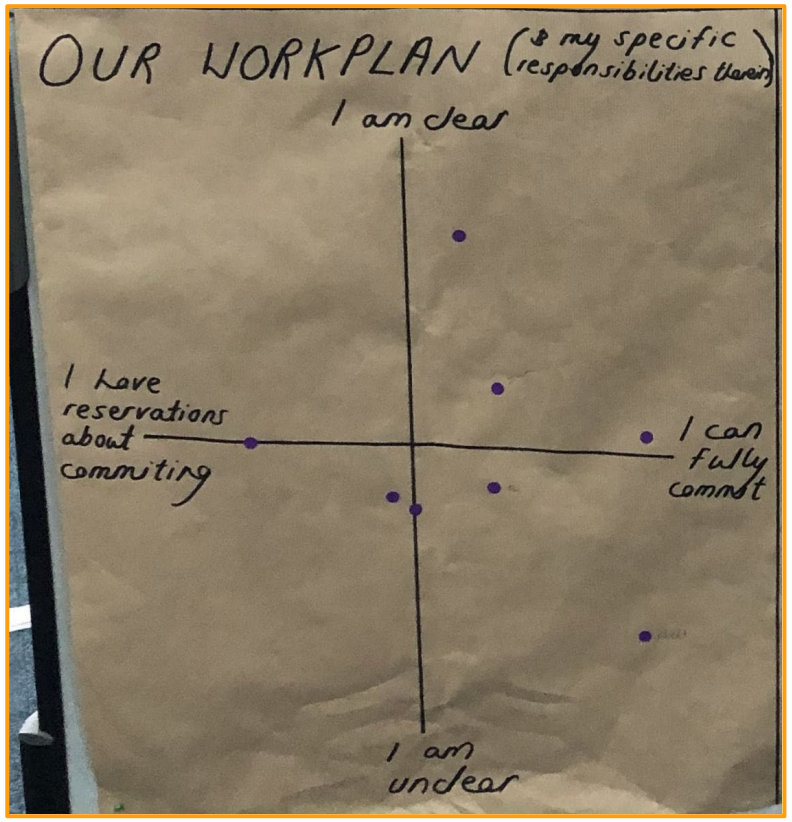
What we need from the next iteration of our operating model:

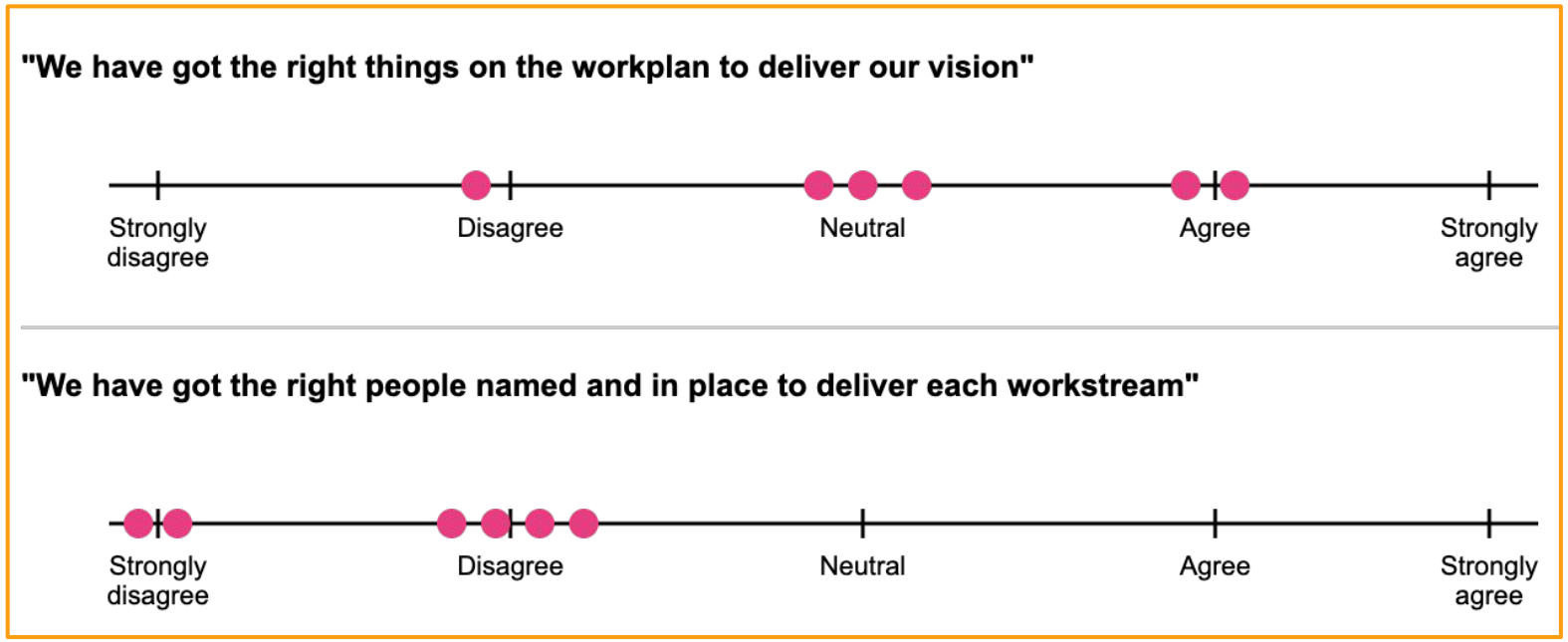
We need:

- To hold on to this as the basis of a ‘mapping’ tool but to acknowledge it is not an ‘operating model’
- A set of principles of what we’re trying to achieve (which we can share with our own organisations)
- It to show a generic resident/patient might flow backwards and forwards along this - from universal to high-end support
- It to show how primary care is the anchor, as it is consistent through different levels of resident involvement/need
- Thinking of the wider determinants cohort as well (e.g. unemployed people), as our current cohorts are health-defined
- More detail on leadership and accountability at different levels as the next level of detail
- More description which allows us as leaders to tell a coherent story about what it means for the system
- It split into prevention, proactive care and reactive care, showing the pathway through this continuum

Improving our workplan (1/2)

Similarly, the group agreed the workplan needs further iteration:





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Improving our workplan (2/2)

The discussion on developing the workplan covered:

- A lack of GP representation
- The difference between task and finish elements and ongoing workstreams
- The value/challenge of having multiple SROs for a single workstream
- The need for a finance workstream
- The need for UEC/reactive care - its absence risks reinforcing silos
- The need for a clear overview of how every part of the system fits into each workstream with a strong lead from each organisation.

Laura Jenner took an action away to update the workplan and review the membership of the INC committee, where the updated workplan will be approved to ensure primary care representation.

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The afternoon: SROs *and* operational/ programme leads

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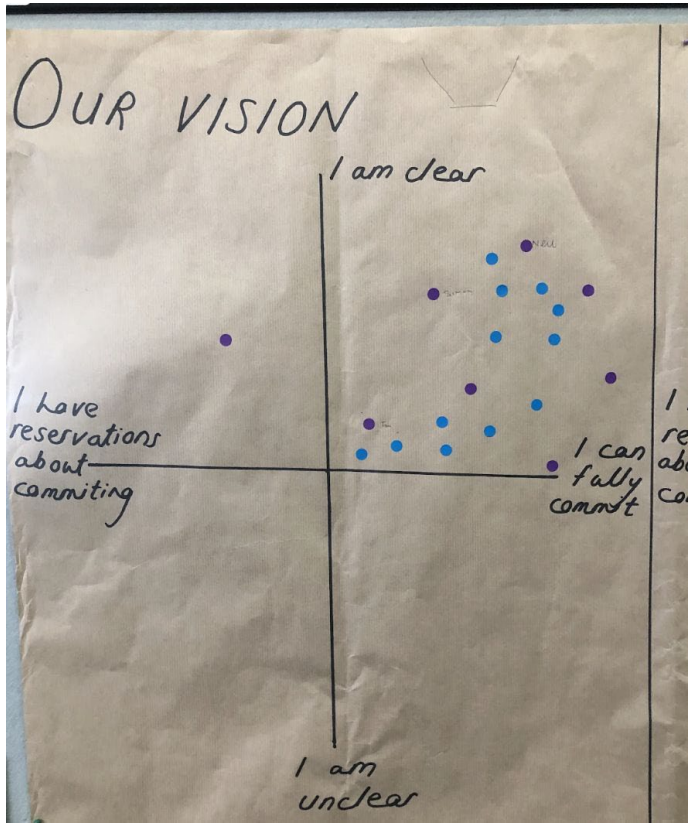
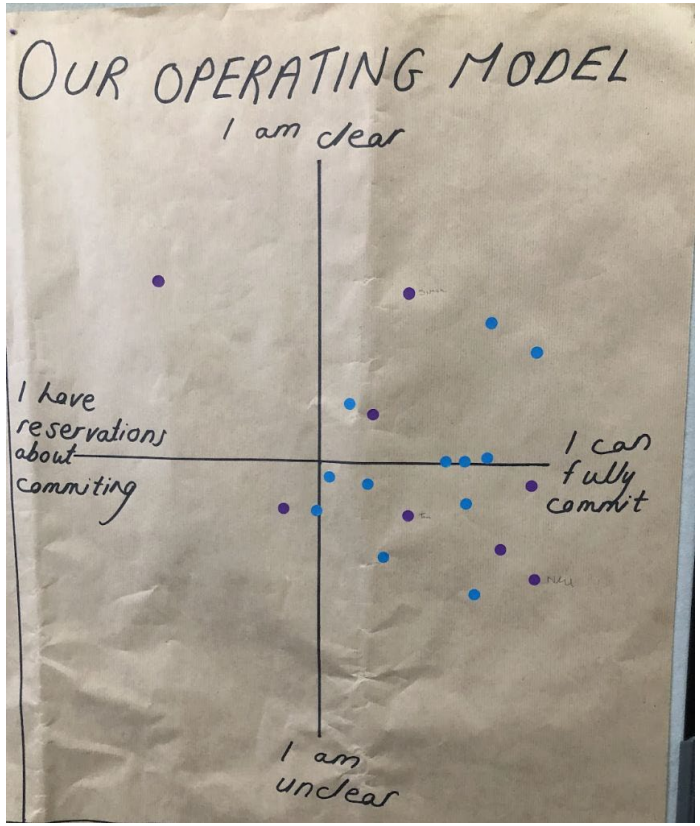
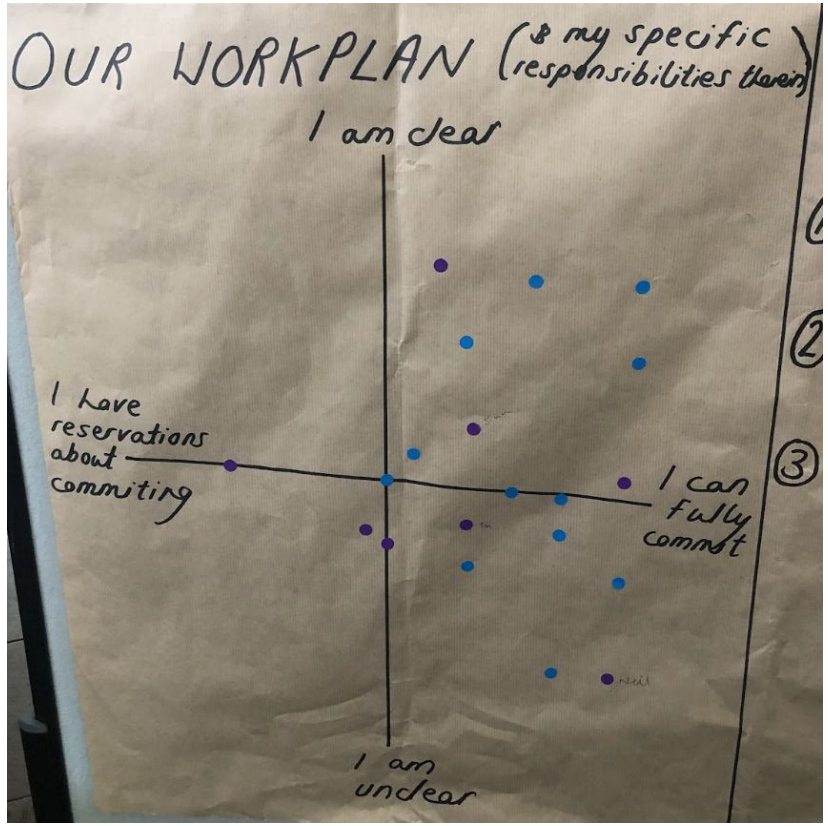
Clarity and commitment

We asked the operational/programme leads (blue dots) to do the same exercise as the SROs (purple dots), voting on their clarity on and commitment to the core elements of the programme. This supported the hypothesis that the vision is strong, but the operating model and workplan need to be iterated further.







What makes you proud?

We started the afternoon by sharing what makes us proud about the neighbourhood programme

- Mobilising the INTs
- The speed at which we've worked
- Lots of innovation, building on strong assets
- Health equity role
- FENOS
- Good buy-in for complex CYP INT
- The strong role of VCSE in capability building
- Strong start developing the primary/secondary care interface e.g. contact numbers accessible
- Sense everyone wants to do their best
- Clear sense of direction
- Lifestyle medicine service
- Shared problem solving
- The impact of the LCT INTs
- One voice for GPs

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Our questions of each other

In our two groups (SROs and programme/operational leads) we considered what single question we'd most like the other group to answer.

In discussing them as a whole group, we surfaced some questions we'd like to ask everyone/ourselves.

For SROs:

- How far are we looking to go with this?
- How do we genuinely go together?
- What is going to be different this time?

For programme/operational leads:

- What do you need from SROs to enable you to work effectively?
- What would 'different' look like?

For all:

- When are we going to start practicing system leadership, rather than collaborative leadership?
- What do we need from each other to be different - to work at pace, to build on success and to keep focus?
- **How am I going to be different this time?**

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Zooming in on our workstreams

A full write-up of the work we did together can be found in the appendix

We then moved on to do some detailed work on four workstreams:

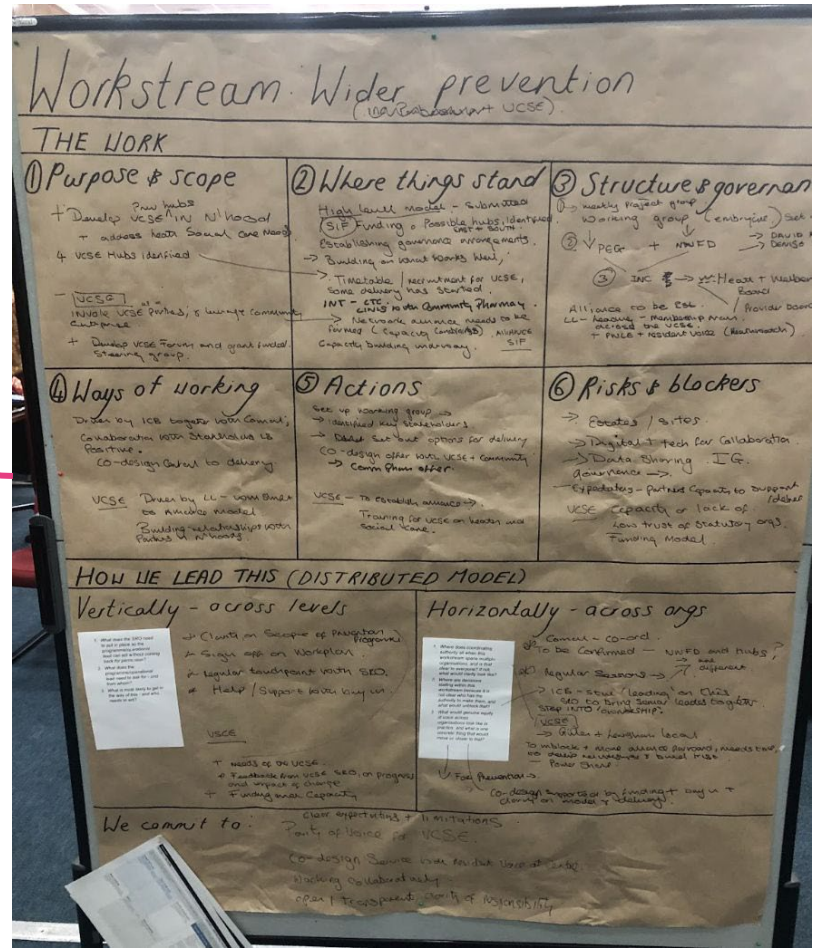
- Wider prevention
- Acute to community shift
- Frailty
- Complex CYP

Our conversations focused on both the work itself and how we realise distributed leadership, vertically across leadership levels and horizontally across organisations.

Two key themes emerged:

The need to build on rather than duplicate existing programmes and structures through mapping and gapping

The need to define and refine the purpose and scope of workstreams as the priority task (and the important role of the SRO in this)



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Feedback

What colleagues thought…

Top words used to describe the event:	Engaging Challenging Thought-provoking Productive Purposeful

100% **strongly agree or agree** that they would recommend an event like this to a colleague

You valued:	- Sharing success - Meeting colleagues face to face for the first time - Problem-solving together - Connecting with SROs

What could have been better:	- The group work was facilitated - Using Menti instead of brown paper - There was chocolate!

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Neighbourhood Workstreams Structure v.1.2

Workstreams	Focus	SRO	Programme Lead	Operational Leads	Clinical Leads
INTs: Multiple Long-Term Conditions (LTC)	• Proactive MDT support for patients with multiple LTCs • Population health segmentation & dashboards	Neil Goulbourne	Fiona Kirkman	Kath Howes, PCN CDs, INT Pharmacists, Abbie Greene	Camille Hirons, PCN CDs Ciara Doherty
INTs: Frailty	• Develop frailty model (incl. PAWS) • Proactive assessment & care planning • Strengthen MDT and community pathways	Helen Tattersfield	Jack Howell **Programme team:** Ada NWOKORO, Deeta Henry-Smith	Andrew Cook, Joan Hutton, Kath Howes Abbie Greene	Joanna Tayler-Gray Clinical Team : Jessica Gossage, GP lead to be confirmed
INTs: Complex CYP	• Design integrated CYP model for complex needs • Map services and pathways • Co-design with families	Tom Hasting	Stacy Jarrett	Primary Care, Dorett Davis, Paul Creech, VCSE representation	GP & Acute lead to be confirmed
Acute → Community Shift Left Shift	• Shift care from acute to community • Scope LTC services (diabetes, cardio, respiratory) • Redesign LTC pathways	Neil Goulbourne	Beckie Burn	Tom Hastings Gulen Petty	Riaz Jetha Belinda McCall
Wider Prevention	• Develop community prevention hubs in each neighbourhood • Address health and social care needs	Catherine Mbema	Fiona Kirkman	Jack Upton, Fiona Kirkman, Jacob Foreman, Naomi Sheeter, Sakthi Suriyaprakasam, Gulen Petty	Camille Hirons
Mental Health INT	• Expanded the INT by embedding mental health expertise new roles within Integrated Neighbourhood Teams, strengthening multidisciplinary working, improving access to early supporting the integration of mental and physical health care for residents with low mental health needs	Kate Lilywhite	Ellen McGale/ Phoebe Robinson	TBC	Anne Robinson (GP lead)
Enablers					
Digital	• Digital solutions and place wide plan for all partners • Data sharing and information governance	Holly Eden SEL lead	Rose Payne (SEL ICB)	Charles Malcolm Smith Jack Upton, Steven Thorndyke, Kate Lilywhite,	TBC
Estates & Community Hubs	• Develop neighbourhood hub sites and co-locate services • Implement Downham as a Neighbourhood health hub	Simon Parton	Kerry Bourne – primary care Jade Fortune	Ashley O'Shaughnessy Jess Haines Charles Malcolm-Smith James Lee	TBC
OD, Workforce and Leadership	• Foster a One-team, integrated workforce • Prioritise engagement & co-design • Quality Improvement	Denise Radley	Charles Malcolm-Smith, **Programme Team:** Beckie Burn, Ada Nwokoro	Laura Jenner Ashley O'Shaughnessy Workforce leads	TBC
Population Health & Benefits Modelling	• Proactive casefinding for eligible INT patients • Develop population health dashboards and reports	Neil Goulbourne	Rachael Smith	Pop health team, Laura Jenner SEL pop health	TBC
Comms & Engagement	• Internal comms: workstreams & vision • Resident updates on service and INT changes • Promote neighbourhood hub sites	Darren Summers	Laura Jenner,	Ada Nwokoro, Joe Tambini Claire Wilks	
Primary/ Secondary Care Interface	• Strengthen LGT–Primary Care collaboration • Develop new joint working solutions • Improve hospital–GP digital connectivity	Tom Hastings	Riaz Jetha	Cal Demby-Harris Ashley O'Shaughnessy	Belinda McCall Helen Tattersfield
Partnership Development					
Creating One Voice for Primary Care	• Establish cohesive Primary Care voice influencing decision-making and service design • Ensure primary care at all system level	Helen Tattersfield Simon Parton	Riaz Jetha,	Ashley O'Shaughnessy PCN, CDs	PCN, CDs
VCSE Development	• Involve VCS as equal INT partners and leverage community expertise • Develop VCS Forum and grant council	Gulen Petty	TBC		

South East London Integrated Care System

NHS South East London

Lewisham Health and Care Patnership Board

Title	**Proposed transfer of the Lewisham Neighbourhood Development Team to the Lewisham Integrator host - Lewisham and Greenwich NHS Trust**					
Meeting date	16 July 2026		Agenda item Number	*Leave*	Paper Enclosure Ref	*Leave*
Author	**Laura Jenner**					
Executive lead	**Ceri Jacob**					
Paper is for:	Update		Discussion	**x**	Decision	
Purpose of paper	To update the NBCB on proposals to transfer the Lewisham Place Neighbourhood Development Team to the Lewisham Integrator Host - Lewisham and Greenwich NHS Trust (LGT).					
Summary of main points	The purpose of this paper is to update the NBCB with Lewisham Place plans to transfer the SEL ICB Lewisham neighbourhood development functions and responsibilities to Lewisham & Greenwich NHS Trust (LGT). This includes the proposed transfer of associated responsibilities, budgets, and staff. Approval has been received from the ICB SMT to progress to more detailed work such as legal due diligence, examining delegation procedures, assessing financial impacts, and conducting necessary consultation about staff transfers. The NHS 10-year plan and the ICB blueprint set out an expectation that ICBs would establish a neighbourhood health (and care) service and that they would transfer certain functions, over time, to other NHS organisations. The London neighbourhood Target Operating Model set out the requirement for neighbourhood integrator organisations to be established. In Lewisham, the Integrator is a partnership between Primary Care, VCSE, SLaM, London Borough of Lewisham and Lewisham and Greenwich NHS Trust (LGT). LGT acts as the integrator host. Lewisham Place is progressing plans to transfer the Neighbourhood Development Team (encompassing primary care development) with a view to transferring in April 2027.					
Potential conflicts of Interest	Lewisham Place representatives on the NBCB are impacted by the proposed changes.					
Sharing and confidentiality	Not confidential.					
Relevant to these boroughs	Bexley		Bromley		Lewisham	**x**
	Greenwich		Lambeth		Southwark	

Equalities Impact	Not relevant for this paper
Financial Impact	Development budgets of c£2m for neighbourhood development and primary care development will transfer to the Integrator host.
Public Patient Engagement	Public and patient engagement is taking place in relation to services being delivered through the neighbourhood model but is not required for the function transfer. Workshop on the 15th July to work discuss the deligation in details and work through the KPIs
Committee engagement	Proposals approved for further detailed work at the ICB SMT on 11 June 2026.
Recommendation	The Committee are asked to note and discuss proposals set out in the paper.

Approval for the Transfer of Lewisham Neighbourhood Development to Lewisham & Greenwich NHS Trust

1. Purpose

The purpose of this paper is to update the NBCB with Lewisham Place plans to transfer the NHS South East London Integrated Care Board (SEL ICB) Lewisham neighbourhood development functions and responsibilities to Lewisham & Greenwich NHS Trust (LGT). This includes the proposed transfer of associated responsibilities, budgets, and staff. Approval has been received from the ICB SMT to progress to more detailed work such as legal due diligence, examining delegation procedures, assessing financial impacts, and conducting necessary consultation about staff transfers.

The following paper provides the background and context to the proposed change, an outline proposal for the transfer, the legal and governance framework considerations, proposal for governance oversight, the implementation approach and key milestones, draft risks and mitigations, and recommendations and next steps.

2. Background & Context

The proposed delegation is consistent with national and regional strategic plans, including:

- NHS 10-Year Health Plan for England sets the national direction to shift care from hospital to community, with a "neighbourhood health service" as a core model for more coordinated, preventative, and local care.
- The Model ICB Blueprint reframes ICBs primarily as strategic commissioners while signalling that a number of "delivery/enablement" functions should transfer out of ICBs over time. The Blueprint explicitly identifies neighbourhood partnership development and primary care operations & transformation (including medicines management and optimisation, estates, and workforce support) as functions expected to transfer to neighbourhood health providers.
- The Neighbourhood Health Framework strengthens expectations that neighbourhood health will be delivered jointly by the NHS, local authorities and partners, providing clearer national direction on implementation and reinforcing the "left shift" to community-based care and away from hospital settings.
- London Target Operating Model (TOM) (Neighbourhood Health Service for London) provides the London-wide operating model and roadmap for implementing neighbourhood health. The London TOM identified a need for an "integrator" to host integration "functions" required to enable primary, community, mental health, acute specialist, local authority, Voluntary, Community & Social Enterprise Sector (VCSE) and other partners to work together effectively at the neighbourhood level.

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In Lewisham, a Memorandum of Understanding (MoU) has been agreed that sets out the commitment from all Partners to develop the governance, operational frameworks, shared delivery and accountability for the integrator form and associated functions, as outlined in the TOM. The signatories to the MoU are:

- Lewisham Council: Adult Social Care, Children and Public Health
- Lewisham and Greenwich NHS Trust (LGT)
- Primary Care, initially through the Primary Care Leadership Forum
- South London and Maudsley NHS Foundation Trust (SLaM)
- Voluntary and Community Sector (VCS) Lewisham Local

The Integrator partnership in Lewisham will act as a strategic partnership, understanding the local population's needs and facilitating collaboration across health, social care, and community sectors to deliver person-centred, equitable, and proactive care at a neighbourhood level.

The structure of the proposed Lewisham Neighbourhood Development team is currently under consultation as part of the wider proposals for changes to the organisational structure of the SEL ICB. The proposals state that the Neighbourhood Development Team will work alongside the new Integrators to support the development, improvement, and delivery of a Neighbourhood Health Service at Place.

3. Proposal

It is proposed that, subject to detailed preparatory work, appropriate governance approvals, and staff consultation, the ICB will:

- Delegate authority for the management of the Lewisham Neighbourhood Development team and associated budgets to LGT.
    - LGT would function as the host organisation for these functions, including the employment of staff and administration of budgets, and would manage delivery against the priorities of SEL ICB and the Lewisham Integrator Partnership.
    - This model ensures that, whilst LGT provides operational infrastructure, decision-making remains collaborative across the Lewisham system, maintaining a strong place-based governance approach.
- Include neighbourhood and primary care development funding, as well as inequalities funding, within the scope of the proposed delegation.
- Agree to the governance model for oversight and assurance outlined in Section 5, including the integration of the Lewisham Health and Care Partnership and the Health and Wellbeing Board into a single strategic board to oversee the delivery of the Neighbourhood Health and Care Plan

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Strategic planning and commissioning for the local system will remain the responsibility of SEL ICB, including decisions relating to resource allocation and use of multi-neighbourhood models.

4. Legal & Governance Framework

To enable this delegation, a formal legal framework will be established. Initial legal advice has been obtained (see Annex 1) that advises that the delegation of functions by the ICB does not require a contract award and therefore would not be subject to any procurement process. The legal framework is expected to include:

- Clearly defined delegated authorities from the ICB to Lewisham & Greenwich NHS Trust (LGT).
- Joint governance arrangements between the ICB, LGT, and the Lewisham Integrator Partnership.
- A formal agreement, or suite of agreements, setting out roles, responsibilities, financial controls, and accountability mechanisms.

The governance model will ensure that:

- Decision-making authority rests with the Lewisham Integrator Partnership.
- LGT operates within the agreed scope in its role as host organisation.
- Robust financial management and performance oversight are maintained.

5. Oversight & Assurance

The proposed governance model (see figure1) includes the establishment of a new Joint Commissioning Group to provide a formal forum for commissioner decision-making, including oversight of delegated budgets, Section 75 arrangements, and relevant contractual approvals. This group will operate as a commissioner-only forum, ensuring clear accountability for commissioning functions. It will report jointly to the ICB and the Local Authority.

Strategic oversight of the wider system will be strengthened through the Health and Wellbeing Board, which will assume an enhanced role in overseeing place-based planning and integration, ensuring alignment between NHS and local authority priorities and supporting a more joined-up approach to improving population health outcomes. The existing Lewisham LCP Board will be merged with the HWBB.

A dedicated monitoring meeting will oversee delivery against the delegation agreement, agreed KPIs for the neighbourhood team, and associated budgets, with clear performance indicators in place and the ICB retaining the authority to revoke the delegation where these are not adhered to.

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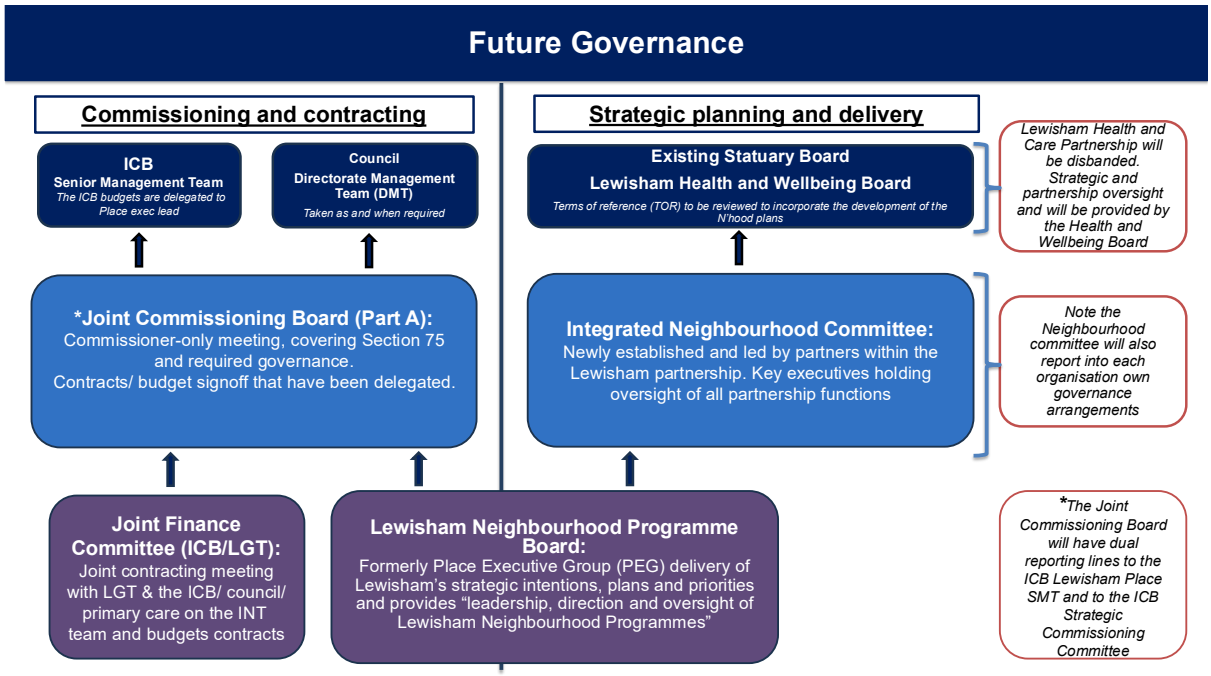
Figure 1



Please note the governance may change reflecting further changes to SEL/SWL governance

6. Implementation Approach

A project group will implement and monitor an overarching project plan for the transfer from the ICB to LGT. This group will provide updates to the ICB Transition Committee as required. Final approval for the transfer will be by the LGT Board, Local Authority (noting the neighbourhood development team includes shared posts) and the ICB Board following recommendation from the ICB Transition Committee.

Key provisional milestones include:

- Governance sign-off.
- Service specification defined and approved.
- Legal framework sign-off.
- Funding flow and envelope agreed.
- Staff consultation completed.
- Go-live and staff transfer.

This will be followed by a one-year period from April 2027, during which the delegated arrangements will operate in a controlled phase. A dedicated monitoring meeting will oversee delivery against the delegation agreement:

  - Test governance, decision-making and reporting, including operation of the Joint Commissioning Group and interfaces with the Health and Wellbeing Board and Integrator Partnership

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- Confirm financial flows, controls, and performance measures; identify and mitigate operational, workforce, contractual and delivery risks ahead of full implementation.

An initial review will take place after six months to confirm that the monitoring process is effective.

7. Risks & Mitigation

An initial risk assessment (see table 1) has identified the key risks to the successful transfer process. During due diligence, the following risks and their mitigations will be further detailed and monitored through the transfer programme's governance, with designated owners managing each risk.

Table 1

Risk	Potential impact	Mitigation / controls
Governance complexity	Delays to agreement/sign-off; reduced flexibility; unclear escalation.	Confirm decision rights, delegated authorities and escalation routes
Financial accountability	Lack of clarity on budget envelope and reporting; partners (including general practice) perceive loss of influence; risk of overspend or misallocation.	Agree budget scope and funding flows, define financial controls and reporting cadence and audit requirements
Organisational clarity	Roles/responsibilities unclear; slower decision-making.	Document roles and responsibilities, confirm interfaces with Integrator Partnership
Workforce transfer and consultation	Staff uncertainty, delays due to consultation requirements	Early HR/legal advice, agreed staff engagement and consultation plan
Information governance and data sharing	Delays or non-compliance relating to access to systems and sharing of personal/confidential data; operational disruption if system access is not in place.	Complete IG due diligence, agree data sharing and processing arrangements, ensure system access and information asset ownership are confirmed ahead of go-live

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Contracting and legal framework	Agreements not completed or not fit for purpose, unclear liabilities, delayed go-live.	legal review and timetable aligned to governance approvals

8. Summary

The proposal set out above supports national and London direction to strengthen neighbourhood health delivery, reflects the ICB Blueprint expectation that delivery/enablement functions transfer out of ICBs over time, and aims to provide clearer hosting arrangements while retaining collaborative place-based decision-making through the Lewisham Integrator Partnership and strengthened commissioner oversight.

Further detailed work will be carried out over the coming months with an aim of transferring the function in April 2027.

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Appendix 1

Pros and cons of contractual model versus delegation

	Contractual Model	Delegation
Legal basis	ICBs have general powers to enter into agreements under schedule 1B to the NHS Act 2006.	ICBs may delegate functions to "relevant bodies" including NHS Trusts and Foundation Trusts under section 65Z5 of the NHS Act 2006.
Procurement	Contract award will require ICB to undertake a procurement. Given the nature of the services in scope this may be under the Procurement Act rather than the PSR.	No requirement to carry out a procurement exercise in order to delegate functions to a provider.
Requirement for NHSE approval/support	No formal requirement for NHSE approval in respect of a contract award to a provider.	NHS England guidance "*Arrangements for delegation and joint exercise of statutory functions*" indicates that ICBs should not seek to use powers to delegate functions to NHS providers in financial year 2024/25. Proposals for such delegation will be subject to a risk based assurance review by NHS England. Guidance has not been updated for 2025/26.
Mechanism for transfer of staff	Contract award will amount to a "service provision change" under TUPE and will therefore	Delegation of functions from the ICB to the Trust will amount to a "business transfer" and/or "service

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	result in staff that are	

	assigned to the service transferring by operation of law.	provision change" under TUPE and will therefore result in staff that are assigned to the service transferring by operation of law.
Responsibility and Accountability	The Trust is responsible for providing the services that are specified in the contract. The ICB remains responsible and accountable for the exercise of its commissioning functions.	The Trust is responsible for the exercise of the delegated functions but the ICB remains accountable for those functions.
Liability	The Trust is liable under the contract for losses arising from its performance/non-performance of the specified services.	The Trust is liable for those functions that are delegated to it. Section 65Z5(6) of the NHS Act 2006 provides that any liabilities incurred in respect of the exercise by a body of any function that is delegated to it by virtue of this section are enforceable against that body (and no other person).
Financial arrangements	Under a contractual arrangement, the ICB would usually pay the Trust for the performance of services in accordance with the contract specification. However, the NHS England delegation guidance indicates that a	Where a function is delegated by the ICB to a Trust it can also delegate the budget associated with that function.

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	commissioner can lawfully give providers a wide degree	
	of latitude as to the services they provide under a contract, both in terms of which services are delivered and how they are delivered. The commissioner will still set the broad scope of what the provider is expected to achieve (clinical outcomes, for example) under a contract. A contract that confers discretion on a provider in respect of some or all services under the contract may be a useful alternative or precursor to delegation to trusts or foundation trusts under s65Z6 of the NHS Act 2006.	
Flexibility	Limited flexibility dependent on contractual terms and any variation provision in the contract. Contracting allows the ICB to maintain stricter control over specific service specifications.	Likely to be greater flexibility, particularly in respect of innovation and the redesign of services.
Nature of relationship	"Purchaser/Provider" contractual relationship.	Collaborative partnership with scope for integrated decision-making.

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Annex 2 budgets and staff budgets

BUDGETS

Please note this is subject to further consideration

Budget Description	**Total Revised Budget @ M10 2025/26**	**Budget 2026/27**	**Integrator**
Health Inequalities	764,000	725,800	725,800
VCSE Funding	100,000	100,000	100,000
Diabetes	155,000	225,000	225,000
LES PMF	3,708	3,708	3,708
LES Zoladex	38,316	38,316	38,316
INT Programme	295,000	192,000	192,000
Primary Care Training & Development	42,140	42,140	42,140
Protected Learning Time.	12,000	12,000	12,000
Growth Funding	16,192	20,514	20,514
Primary Care Transformation	675,000	675,000	675,000
Neighbourhood Funding-Multiple LTC (moved to PCD/non recurrent)	218,426	0	0
Neighbourhood Funding-Integrator Development (non-recurrent)	250,000	0	0
NR HEALTH INEQUALITIES - VITAL 5 PROOF OF CONCEPT - LEWISHAM (non-recurrent)	37,500	0	0
NR HEALTH INEQUALITIES - VITAL 5 CHECK - LEWISHAM (non-recurrent)	20,000	0	0
HEALTH INEQUALITIES - CARDIAC LOCAL SCHEME - LEWISHAM (non-recurrent)	21,763	0	0
Total			2,034,478

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PAY COSTS

Please note this is subject to further consideration

Job Title	WTE	AFC Band	Spine point at 01/04/2026	Structure No.	Actual Total Budget 2026/27	
Director of System Development	1.00	Band 9	XN1204	LE0	**82,266**	Director of Neighbourhood Development ICB 50% share (Council Employee)
Associate Director of Community Based Care & Primary Care	1.00	Band 8d	XN1106	LE1	**151,347**	Associate Director of CBC and Neighbourhood Development
Virtual Ward Delivery Manager	1.00	Band 8b		LE12	**98,998**	Virtual Ward & Home First Development Manager
Neighbourhood Development Manager	1.00	Band 8b	XN0903	LE15	**96,709**	Neighbourhood Development Manager
Head of LTC and Cancer Service Development	1.00	Band 8b	XN0906	LE25	**110,663**	Neighbourhood Change Manager
System Development Manager	1.00	Band 8a	XN0802	LE10	**84,994**	System Development Manager
CBC Development Manager	1.00	Band 8a	XN0806	LE21	**94,151**	CBC Development Manager *(Increased to 1.0 WTE in new structure)*
Population Health Analyst	0.70	Band 7	XN0705	LE23a	**54,428**	Population Health Analyst *(Increased to 0.7 wte in new structure)*
CBC System Development Facilitator	1.00	Band 7	XN0709	LE22	**84,121**	CBC System Development Facilitator
Business Support Lead - Lewisham	1.00	Band 6	XN0603	GBS7-e	**64,722**	Borough Business Support Lead
Business Support/PA - Lewisham	1.00	Band 5	XN0508	GBS8-e	**60,222**	Business Support/PA
	1.00	Band 8d			**0**	Associate Director for Population Health & Care *(no budget transfer as already 100% funded by integrator)*
					64,722	Change Manager *(This post is employed by OHL)*
					0	INT Delivery Lead (100% Council Funded) *(LBL will need to transfer the budget)*
				Total	**1,047,343**	

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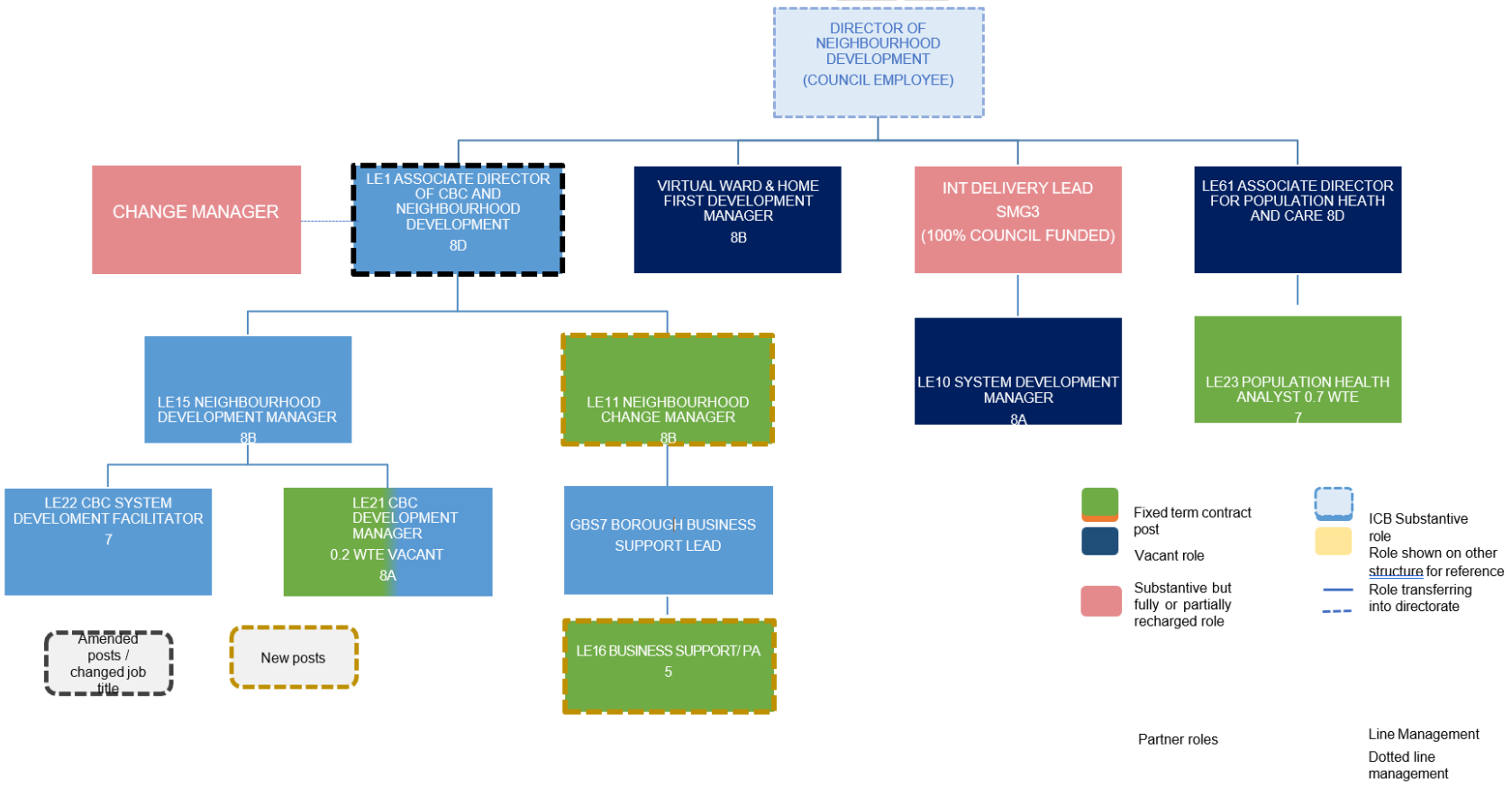
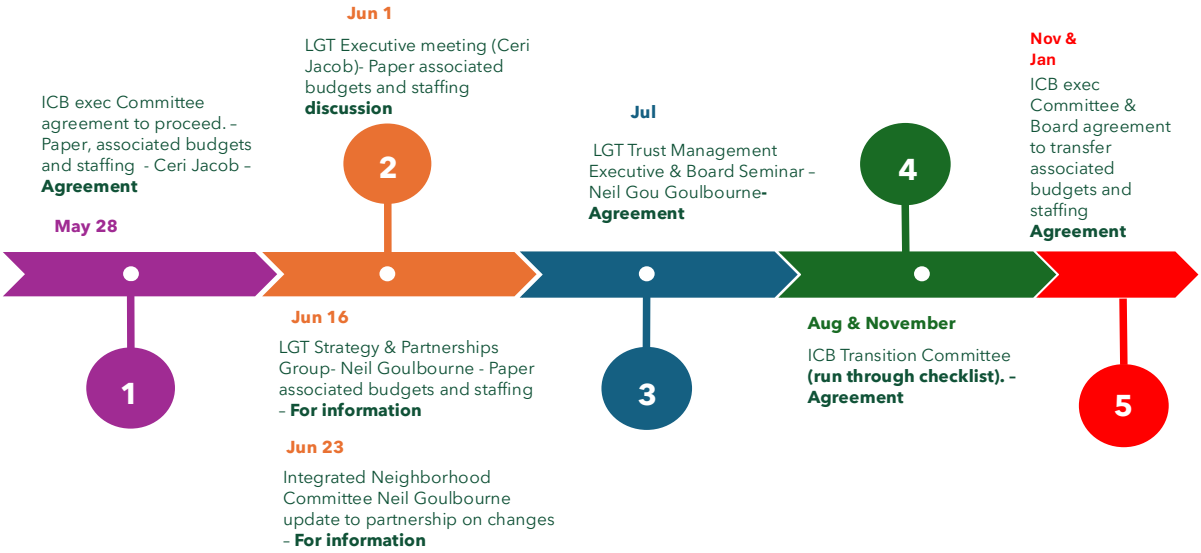
Annex 3 Lewisham Proposed Neighbourhood Structure Plan

Please note the structure is currently out for consultation and may have further changes



Governance timeline Sign off Delegation – ICB N'hood team and associated budgets (May –April 2027)



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South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 8
Enclosure 7

Title:	**Monthly Performance Report**
Meeting Date:	**23 July 2026**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

Purpose of paper:	To provide an update against key performance targets for Place.	Update / Information	x
		Discussion	x
		Decision	

Summary of main points:	SEL ICB Places are responsible for delivery against a number of performance targets as set out in the monthly performance report. These all impact on health inequalities in Lewisham. Improvements in performance are very difficult to achieve and maintain with any improvements seen tending to require a focus at a GP practice and local community level to have any lasting impact. Improvements between now and this time last year include: • Health checks for people with SMI increased from 54% to 61.8% • GP appointments per 1000 population increased from 307 to 361 • Control of hypertension to NICE guidelines increased from 62% to 64.7% • Breast cancer screening uptake increased from 58% to 60% (achieves the target) Focused work continues across all targets and the LCP Board is asked to identify which targets it would like to carry out a deep dive on in the next LCP Board.
Potential Conflicts of Interest	None
Any impact on BLACHIR recommendations	The LCP team is increasingly working with local and grass roots VCSE organisations, including black led VCSE organisations, to try and improve performance against the targets, noting the significant link with health inequalities. This work supports a number of BLACHIR Opportunities for Action.

	Bexley		**Bromley**

Relevant to the following Boroughs	Greenwich		Lambeth	
	Lewisham	✓	Southwark	
	Equality Impact	Not assessed as part of this paper, although initiatives are equality impact assessed.		
	Financial Impact	None that are relevant to this paper.		
Other Engagement	Public Engagement	Public engagement is through work with our local populations and VCSE groups on achievement of specific performance targets.		
	Other Committee Discussion/ Engagement	Lewisham LCP SMT.		
Recommendation:	The LCP Board is asked to note the latest performance report and to identify a deep dive area for the next LCP Board.			

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partnership
LCP performance data report

May 2026

South East London Integrated Care System

NHS South East London

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South East London Integrated Care System

Overview of report

NHS South East London

Summary:

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

Contents and structure of report:

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

Structure

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

Definitions:

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

South East London Integrated Care System

Lewisham performance overview

NHS South East London

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	Mar-26	National standard	66.7%	72.1%
IAPT discharge	↑	Mar-26	Operating plan	377	505
IAPT reliable improvement	↔	Mar-26	Operating plan	67.0%	69.0%
IAPT reliable recovery	↑	Mar-26	National standard	48.0%	51.0%
SMI Healthchecks*	↑	Q4	Local trajectory	75.0%	61.8%
PHBs	↑	Q4 - 25/26	LTP indicative trajectory	773	357
NHS CHC assessments in acute	↔	Q4 - 25/26	National standard	0.0%	0.0
CHC - Percentage assessments completed in 28 days	↓	Q4 - 25/26	National standard	80.0%	58.0%
CHC - Incomplete referrals over 12 weeks	↓	Q4 - 25/26	National standard	0	0
Children receiving MMR1 at 24 months	↑	Q3 - 25/26	PH efficiency standard	90.0%	84.9%
Children receiving MMR1 at 5 years	↓	Q3 - 25/26	PH efficiency standard	90.0%	86.0%
Children receiving MMR2 at 5 years	↓	Q3 - 25/26	PH efficiency standard	90.0%	72.4%
Children receiving DTaP/IPV/Hib % at 12 months	↑	Q3 - 25/26	PH efficiency standard	90.0%	89.6%
Children receiving DTaP/IPV/Hib % at 24 months	↓	Q3 - 25/26	PH efficiency standard	90.0%	88.4%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q3 - 25/26	PH efficiency standard	90.0%	65.8%
Children receiving DTaP/IPV/Hib % at 5 years	↓	Q3 - 25/26	PH efficiency standard	90.0%	89.0%
LD and Autism - Annual health checks*	↑	Mar-26	Local trajectory	1472	1584
Bowel Cancer Coverage (60-74)	↓	Apr-25	Corporate Objective	65.1%	64.1%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	68.0%	67.4%
Breast Cancer Coverage (50-70)	↑	Apr-25	Corporate Objective	59.6%	60.2%
Percentage of patients with hypertension treated to NICE guidance	↑	Q3 - 25/26	Corporate Objective	77.3%	64.7%
Flu vaccination rate over 65s	↑	Feb-26	Corporate Objective	61.0%	53.6%
Flu vaccination rate under 65s at risk	↑	Feb-26	Corporate Objective	34.3%	31.1%
Flu vaccination rate – children aged 2 and 3	↑	Feb-26	-	-	42.1%
Appointments seen within two weeks*	↓	Mar-26	-	-	85.4%
Appointments in general practice and primary care networks*	↑	Mar-26	Operating plan	-	128144
Appointments per 1,000 population*	↑	Mar-26	-	-	361.4

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

South East London Integrated Care System

NHS South East London

Performance data

South East London Integrated Care System

Dementia Diagnosis Rate

NHS South East London

SEL context and description of performance

- The national dementia diagnosis rate target is 66.7%. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. March 2026 performance was 71.6%.
- There is, though, variation between boroughs. Greenwich has not achieved the target during the previous 24 months.

		Mar-26						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Dementia diagnosis rate*	66.7%	73.5%	73.1%	63.7%	73.2%	72.1%	70.8%	71.6%
Trend since last report	-	↑	↔	↔	↑	↑	↓	↑

South East London Integrated Care System

Talking Therapies

NHS South East London

SEL context and description of performance

- The NHS Talking Therapies metrics introduced in 2024/25 have continued into 2025/26. The targets are as follows:
  - Number of patients discharged having received at least 2 treatment appointments in the reporting period.
  - Reliable improvement rate for those completing a course of treatment.
  - Reliable recovery rate for those completing a course of treatment and meeting caseness.

	Mar-26						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	150	275	235	500	505	365	2045
Trajectory	176	248	295	533	377	360	2035
Trend since last reporting period	↑	↑	↓	↔	↑	↓	↑

		Mar-26						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	45.0%	53.0%	49.0%	54.0%	51.0%	49.0%	51.0%
Trend since last report	-	↓	↑	↑	↑	↑	↑	↑

		Mar-26						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	67.0%	71.0%	68.0%	74.0%	69.0%	67.0%	70.0%
Trend since last report	-	↓	↔	↑	↑	↔	↑	↑

South East London Integrated Care System

SMI Physical Health Checks

NHS South East London

SEL context and description of performance

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

	Q4 - 2025/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
SMI Healthchecks	65.9%	62.4%	59.6%	65.4%	61.8%	66.9%	63.7%
Indicative trajectory	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

***NOTE:** The above figures have been calculated based on published PCN performance for Q3: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

South East London Integrated Care System

Personal Health Budgets

NHS South East London

SEL context and description of performance

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

	Q4 - 2025/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Cumulative number of people with a personal health budget year to date	638	1307	685	436	357	403	3831
Indicative LTP trajectory	676	966	837	934	773	741	4926

South East London Integrated Care System

NHS Continuing Health Care

NHS South East London

SEL context and description of performance

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

		Q4 - 25/26						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
NHS CHC assessments in acute	0	0	0	0	0	0	0	0
Trend since last reporting period	-	↔	↔	↔	↔	↔	↔	↔

	Q4 - 25/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Percentage assessments completed in 28 days	79%	86%	95%	100%	58%	77%	83%
Trajectory	80%	80%	80%	80%	80%	80%	80%
Trend since last reporting period	↓	↓	↑	↑	↓	↓	↑

	Q4 - 25/26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Incomplete referrals over 12 weeks	0	0	0	0	0	0	0
Trajectory	0	0	0	0	0	0	0
Trend since last reporting period	↔	↔	↔	↔	↓	↔	↓

South East London Integrated Care System

Childhood immunisations (1 of 2)

NHS South East London

Description of metric and SEL context

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

		Q3 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 24 months	90%	86.0%	89.7%	84.7%	80.1%	84.9%	82.1%	84.6%	79.7%	87.8%
Trend since last reporting period	-	↑	↑	↑	↑	↑	↑	↑	↑	↓

		Q3 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 5 years	90%	91.5%	91.4%	86.3%	85.4%	86.0%	83.9%	87.4%	85.3%	92.3%
Trend since last reporting period	-	↑	↑	↑	↑	↓	↑	↑	↑	↑

		Q3 - 25/26								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR2 at 5 years	90%	78.2%	80.7%	69.7%	73.0%	72.4%	69.3%	73.9%	70.0%	83.8%
Trend since last reporting period	-	↑	↓	↓	↓	↓	↓	↑	↑	↑

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

South East London Integrated Care System

Childhood immunisations (2 of 2)

NHS South East London

Metric	Efficiency standard	Q3 - 25/26								
		Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	93.0%	93.4%	91.7%	88.6%	89.6%	89.1%	90.8%	85.9%	90.5%
Trend since last report	-	↑	↑	↑	↑	↑	↑	↑	↑	↑

Metric	Efficiency standard	Q3 - 25/26								
		Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	92.9%	92.6%	91.3%	88.1%	88.4%	88.5%	90.2%	87.4%	92.5%
Trend since last report	-	↑	↑	↑	↑	↓	↓	↑	↑	↑

Metric	Efficiency standard	Q3 - 25/26								
		Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	74.5%	72.2%	70.8%	67.2%	65.8%	60.7%	68.6%	65.7%	81.8%
Trend since last report	-	↑	↓	↑	↔	↓	↓	↑	↓	↔

Metric	Efficiency standard	Q3 - 25/26								
		Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	93.7%	92.4%	89.4%	87.0%	89.0%	86.3%	89.6%	87.4%	93.2%
Trend since last report	-	↑	↑	↑	↓	↓	↑	↑	↑	↑

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

South East London Integrated Care System

Learning disabilities and autism – annual health checks

NHS South East London

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective and a south east London trajectory for 2025/26 was submitted as part of the operational planning process.
- SEL achieved the 2025/26 plan with 7,771 health checks delivered against a plan of 6,825. All LCPs achieved their individual targets.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Mar-26						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
LD and Autism - Annual health checks	1021	1153	1440	1445	1584	1128	7771
Trajectory	908	938	1248	1279	1472	975	6825

South East London Integrated Care System

Cancer screening

NHS South East London

SEL context and description of performance

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

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

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

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

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

South East London Integrated Care System

Management of hypertension to NICE guidance

NHS South East London

SEL context and description of performance

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

	Mar-26 (Local data reporting)*						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	78%	76%	73%	73%	70%	74%	74%
Trajectory	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

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

	Q3-25/26 (using published CVD prevent reporting)**						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	72.7%	70.0%	67.1%	67.3%	64.7%	68.6%	68.5%
Trajectory	77.7%	78.1%	78.0%	78.0%	77.3%	77.9%	77.8%

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

South East London Integrated Care System

Adult flu immunisation (1 of 2)

NHS South East London

SEL context and description of performance

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

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

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

South East London Integrated Care System

Adult flu immunisation (2 of 2)

NHS South East London

Published February 2026 Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.5%	73.0%	62.1%	53.8%	53.6%	55.2%	62.7%
Local October trajectory	75.0%	75.0%	64.5%	60.0%	61.0%	62.6%	67.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	37.2%	40.4%	36.5%	31.5%	31.1%	34.1%	34.8%
Local October trajectory	42.0%	41.0%	36.9%	32.5%	34.3%	34.2%	36.3%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	37.3%	48.4%	38.0%	38.6%	42.1%	39.7%	40.9%

South East London Integrated Care System

Primary care access

NHS South East London

SEL context and description of performance

- The 2025/26 Priorities and Operational Planning guidance states that ICBs are expected to continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience.
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
  - Planned number of general practice appointments.
- Appointments totalled 850,382 in March against the operating plan of 844,075.

		Mar-26						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	-	88.6%	88.7%	92.1%	91.5%	85.4%	90.8%	89.7%

		Mar-26						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	844075	116383	159907	135754	182843	128144	127351	850382
Appointments per 1,000 population	-	452	447	412	410	361	356	404

South East London Integrated Care System

lhcp Lewisham Health and Care Partnership

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 9
Enclosure 8

Title:	**Lewisham Risk Register**
Meeting Date:	**Thursday 23 July 2026**
Author:	Jack Upton, System Development Manager
Executive Lead:	Ceri Jacob Place Executive Lead, Lewisham

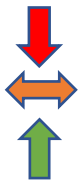
Purpose of paper:	The purpose of the paper is to provide an update to the Lewisham Health and Care Partnership Strategic Board regarding the Lewisham Risk Register.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

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

Risk Type	Risk Description	Direction of Risk	*Risk Appetite Levels
Financial	**592. Achievement of Recurrent Financial Balance 2026/27.** Lewisham borough anticipates achieving financial balance in 2026/27 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material one being an ability to fund mental health investment driven by the demand for and costs of ADHD assessments carried out in the independent sector. In addition, there are business as usual risks relating to activity pressures within continuing care and prescribing.	↔	Open (10-12)
Financial	**496. Prescribing Budget Overspend**. Risk that the prescribing budget 2026/27 may overspend.	↔	Open (10-12)
Strategic	**528. Access to Primary Care** There is a risk that patients may experience an inequality (and inequity) in access to primary care services.	↔	Cautious (7–9)
Strategic	**529. Increase in vaccine** preventable diseases due to not reaching herd immunity coverage across the population. ***Childhood Immunisations***	↔	Cautious (7–9)
Strategic	**561. Increase in vaccine** preventable diseases due to not reaching herd immunity coverage across the population. ***Seasonal Vaccinations***	↓	Cautious (7–9)
Strategic	**648. Uncontrolled mental health cost pressures restricting delivery of early-intervention, prevention and transformation programmes in Lewisham.**	↔	Open (10-12)
Financial	**506. The CHC outturn for Adults will not deliver in line with budget**	↔	Open (10-12)
Strategic	**644. Adults and CYP neurodevelopmental diagnostic pathways (Autism and ADHD).**	↔	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*** **– March 2026**

5.New/Closed Risks/Matrix Scores. There is a total of **8 risks** on the Lewisham risk register.

New, closed or reduced risks are detailed below:

New risks

0

Closed risks

TBC

Matrix Scores

TBC

All risks have been reviewed and updated with risk owners to reflect the new financial year 26/27.

An issues log monitors risks considered BAU and/or in development. Service areas have their own local risks to monitor.

6.Key Themes:

The key themes from the risk register relate to finance, budgetary and statutory impacts, workforce limitations, and quality of care around delivery of services.

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

South East London Integrated Care System

NHS South East London

Summary of SEL ICS BAF risks by theme

Prepared for the System Risk Group 14 April 2026

SEL ICS BAF risks – by theme: introduction

SEL ICS BAF risks by theme

- A SEL ICS wide system risk group collectively reviews risks from across the system partner BAFs, supporting collaboration in risk management across the ICS.
- The group have been reviewing the partner BAF risks through a comparative review, put together by the risk and assurance team. Following discussion in November 2024, it was agreed that the BAF risks should be grouped together by theme, and risks have been subsequently divided by the following main themes:
  - Finance and finance related
  - Sustainability and estates
  - Demand, capacity and operational performance
  - Quality of care
  - IT
  - Workforce

- **The system partner BAFs reviewed are:**
  - SEL Integrated Care Board (SEL ICB – March 2026*)
  - Guys and St Thomas' (GSTT – December 2025)
  - King's College Hospital (KCH – March 2026)
  - Lewisham and Greenwich Trust (LGT – March 2026*)
  - South London and Maudsley (SLaM – March 2026**)
  - Oxleas (March 2026)

  *subject to Board approval
  **subject to Board approval (including 3 pending risks not shown)

Key points to note:

- Risks that fall outside of the above categories, have not been included in the tables.
- Some risks have been included under more than one theme, where relevant.

South East London Integrated Care System

Finance and financial-related risks

NHS South East London

Risk summary	Residual risk score					
	SEL ICB	GSTT	KCH	LGT	SLaM	Oxleas
Revenue financial plan	9 (on CRR) ↓	12	25	20	16	4 ↓
Capital financial plan	closed			12		
Financial sustainability						16
ICS capital regime						8
Research & innovation opportunities		12	12			
Availability of capital departmental expenditure limit (CDEL) and ability to generate surpluses		8				
Risk to affordability of modernisation estates strategy – site opening delays, strategic estates disposal and double running costs					20	

Link to more detailed finance risk descriptions

South East London Integrated Care System

Environmental sustainability and estates risks

NHS South East London

Risk summary	Residual risk score					
Environmental sustainability	**SEL ICB**	**GSTT**	**KCH**	**LGT**	**SLaM**	**Oxleas**
Carbon zero / sustainability targets not achieved	3 (On CRR)					12

Estates	**SEL ICB**	**GSTT**	**KCH**	**LGT**	**SLaM**	**Oxleas**
Impact on operational and clinical activity / quality of care		16	16	15	12	8
Risk to modernising and maintaining existing estate					16	
Risk to affordability of modernisation estates strategy – site opening delays, strategic estates disposal and double running costs					20	
NDBH & PMCYP leaks: IHP build quality and leaks/mould issues at NDBH & PMCYP delay move-ins; ongoing financial, legal and reputational impact					20	

Link to more detailed: sustainability risk descriptions; estates risk descriptions

South East London Integrated Care System

Demand, capacity and operational performance risks

NHS South East London

Risk summary	Residual risk score					
	SEL ICB	GSTT	KCH	LGT	SLaM	Oxleas
Operational performance (insufficient activity and productivity in line with strategic plans) / demand and capacity inc. ED / Right Care	16	12	16	20	12	
Cancer performance targets	16			20		
Delivery of elective recovery and waiting times objectives.	16			20		
Competing priorities for non-admitted and admitted capacity, impacting elective recovery	16					
Waiting times for autism diagnostics assessments	16					
Bed management – quality and financial impact						12 ↓
Productivity: productivity levels may be insufficient to enable it to balance delivery of both its operational and financial responsibilities and therefore may impact delivery of its strategic priorities		20				

Link to more detailed demand and capacity risk descriptions

South East London Integrated Care System

Quality of care risks

NHS South East London

Risk summary	Residual risk score					
	SEL ICB	GSTT	KCH	LGT	SLaM	Oxleas
Failure to deliver safe, high-quality care to patients / have oversight of quality	9 (on CRR)	16 and 12	12	20	12	
Compassionate and culturally competent care to our patients and each other impacted			12			
Bed management – quality and financial impact						12 ↓

Link to more detailed quality of care risk descriptions

South East London Integrated Care System

IT and digital risks

NHS South East London

Risk summary	Residual risk score					
	SEL ICB	GSTT	KCH	LGT	SLaM	Oxleas
Cyber-attacks / IT system not adequately protected	12	20 ↑	20	15	16 ↑	15
Providers in our system significantly disrupted through the change initiatives being implemented by the NHS and healthcare and service providers.						
IT - Epic / Apollo benefits not realised		12				
Third party pathology service cyber incident					12	
Failure to anticipate the IT infrastructure demands				15		
Some post consultation messaging is not being returned to the GP practice from community pharmacy after a patient consultation.	16					

Link to more detailed IT risk descriptions

South East London Integrated Care System

Workforce risks

NHS South East London

Risk summary	Residual risk score					
	SEL ICB	GSTT	KCH	LGT	SLaM	Oxleas
Attracting, recruiting and retaining staff	12 (On CRR)			12	16	12
Maintaining staff health and wellbeing			12	12		9
Respect and compassion between staff and protection from violence/abuse				10		12
Lack of clinical and medical leadership				15		
Organisational change and transformation: effectively deliver multiple large-scale and complex transformation programmes / System sustainability – collaborating with stakeholders and partners		12	9	12		
High performing and future ready workforce		12	12			

Link to more detailed workforce risk descriptions

Appendix: Risk descriptions by theme

South East London Integrated Care System

Finance risks descriptions

NHS South East London

	Risk ID	Finance risks descriptions	Risk Score
ICB	606	The ICS does not deliver its deficit revenue financial plan for 2025/26.	9 ↓
GSTT	8	Unable to sustain financial efficiencies and secure sufficient income and/or capital for services, for high quality care and strategic agenda.	12
	12	Unable to maintain current levels of research ambition & partnerships and fail to attract sufficient investment/income to remain a research leader.	12
	9	The availability of CDEL and our ability to generate surpluses may restrict future investment in our strategic and operational objectives.	8
KCH	3	Unable to improve financial sustainability of services and not achieve financial plans, to deliver investment priorities & improve quality of services.	25
	5	If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre.	12
LGT	2a	Insufficient revenue funding through changes to national and local commissioning arrangements and is unable to identify planned levels of efficiency (with appropriate governance in place equals failure to remain financially sustainable.	20
	2b	Insufficient capital funding to enable investment in critical areas, leading to an inability to innovate or deliver strategic changes and a subsequent impact on the delivery of patient care and provision of an appropriate clinical/working environment.	12
SLaM	18	Underlying deficit, contributing to unsustainable financial position, putting the delivery of the wider trust strategy at risk.	16
	24	Capital & revenue costs risk affordability of Modernisation Estates strategy – site opening delays, strategic estates disposal and double running costs	20
Oxleas	1177	Risk to financial sustainability if required recurrent costs are not met with recurrent income.	16
	2627	2024/25 revenue and capital plan delivery	4 ↓
	2006	ICS capital regime limiting the ability to invest in maintaining and improving its estates and digital infrastructure and inhibiting the planning of longer-term capital investment needed to remodel and enable continuous improvement in service delivery.	8

South East London Integrated Care System

Sustainability risks and descriptions

NHS South East London

	Risk ID	Sustainability risk descriptions	Risk Score
ICB	397	ICB not able to achieve SEL ICS Green Plan targets (which aim to reduce the carbon footprint of the organisation by 2040 and not be enabled to measure detailed achievement of the targets set out in the plan. ICS Green plan includes targets specifically for the ICB (including Primary Care) but also the wider system. This risk affects both sets of targets.	3
Oxleas	1995	Trust may be unable to meet the NHS target of zero carbon emissions by 2032.	12

South East London Integrated Care System

Estates risks and descriptions

NHS South East London

	Risk ID	Estates risk descriptions	Risk Score
GSTT	3	The risk that estate infrastructure failures impact on operational and clinical activity. *Linked CRR risks: relate to clinical areas and other estate areas (fire safety, asbestos, water).*	16
KCH	4	Unable to maintain and develop the estate sufficiently, to deliver safe, high quality and sustainable services.	16
LGT	4b	Failure to anticipate estates infrastructure demands for intended improvements in quality, safety, patient experience.	15
SLaM	21	The Ladywell unit is close to reaching its useful life, affecting SLaM's ability to deliver quality care with safe and effective therapeutic services.	12
	22	Risk to improvement / maintenance of existing estates impacting business continuity, safety and patient care.	16
	24	Capital & revenue costs risk affordability of Modernisation Estates strategy – site opening delays, strategic estates disposal and double running costs	20
	25	NDBH & PMCYP leaks: IHP build quality and leaks/mould issues at NDBH & PMCYP delay move-ins; ongoing financial, legal and reputational impact	20
Oxleas	2006	ICS capital regime limiting the ability to invest in maintaining and improving its estates and digital infrastructure, as well as potentially inhibit the planning of longer-term capital investment needed to remodel and enable continuous improvement in service delivery.	8

South East London Integrated Care System

Demand and capacity risk descriptions

NHS South East London

	Risk ID	Demand and capacity risk descriptions	Risk Score
ICB	384	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	16
	385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a consequence increase in waiting times for diagnosis and treatment.	16
	386	Risk of not being to make improvements in waiting times, pathway flow and timely transfer of care as a result of demand and flow challenges across the system.	16
	504	The ICB does not meet the operational plan commitments it has made for 2024/25 with regards cancer access and wait times - including the Faster Diagnosis Standard and the 62-day treatment standard.	16
GSTT	1	The Trust's activity levels may not be sufficient to meet the trajectories in our operating plan, resulting in patients being unable to access our services in a timely manner and lead to continued or increased regulatory intervention.	12
	7	The Trust's productivity levels may be insufficient to enable it to balance delivery of both its operational and financial responsibilities and therefore may impact delivery of its strategic priorities.	20
KCH	8	If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	16
LGT	1a	Insufficient capacity to meet demand for emergency services patients may not receive the care they need on a timely basis.	20
	1b	Insufficient capacity to address elective waiting times.	20
	1c	Insufficient capacity to address cancer pathway waiting times.	20
SLaM	14	In the context of current capacity due to staffing levels and increasing demand across the system there is a risk of delay in delivery of Outstanding Care to patients which may impact on the ability of our patients to receive timely access to care and our staff to provide the right care at the right time in the right place.	12
Oxleas	2378	Risk to the quality of care provided to patients and to the financial stability of the trust if there are more than five people in the private beds.	12 ↓

South East London Integrated Care System

Quality of care risk descriptions

NHS South East London

	Risk ID	Quality of care risk descriptions	Risk Score
ICB	491	The ICB is unable to discharge its duty of having system oversight of quality and patient safety systems due to transition to the Learning from patient safety events (LFPSE) for reporting safety events which currently does not allow the ICB access to provider data which leaves the ICB 'blind' to information on LFPSE.	9
GSTT	2	The Trust may fail to deliver safe, high-quality care to patients across all sites and services.	16
	11	A lack of focus on optimising ways of working, an absence of clear frameworks, standards and processes, and insufficiently strong and visible leadership may impair organisational excellence, leading to a reduced ability to deliver high-quality patient care and delivery of the strategic priorities.	12
KCH	6	The Trust does not have adequate arrangements to support the delivery and oversight of high-quality care.	12
	2	Compassionate and culturally competent care to our patients and each other impacted.	12
LGT	1	Due to a demand on services, the Trust is unable to maintain safe, high-quality services for patients and local communities.	20
SLaM	14	In the context of current capacity due to staffing levels and increasing demand across the system there is a risk of delay in delivery of Outstanding Care to patients which may impact on the ability of our patients to receive timely access to care and our staff to provide the right care at the right time in the right place.	12
Oxleas	2378	Bed management – quality and financial impact	12 ↓

South East London Integrated Care System

IT risk descriptions

NHS South East London

	Risk ID	IT risk descriptions	Risk Score
ICB	651	Significant disruptions to the ICT and digital systems across out provider and/or supply settings.	12
GSTT	5	The Trust may not fully realise the opportunities to transform ways of working based on the EPIC EHR implementation and may not deliver the benefits set out in the business case	12
	4	Risk of cyber attack	20 ↑
KCH	9	Trust's IT infrastructure is not adequately protected and may be comprised.	20
LGT	4a	Risk of cyber attack.	15
	4c	Failure to anticipate the IT infrastructure demands and the intended improvements in quality, safety, patient experience and efficiency.	15
SLaM	19	Risk of cyber attack.	16 ↑
	23	Synnovis cyber attack affecting patient care.	12
Oxleas	1994	Risk of cyber attack.	15

South East London Integrated Care System

Workforce risk descriptions

NHS South East London

	Risk ID	Workforce risks descriptions	Risk Score
ICB	395	There is a risk that SEL ICS will not be able to deliver fully against the ambitions of the three pillars of National Long Term Workforce Plan and aligned five strategic priorities of the ICS People Strategy.	12
GSTT	6	Failure to effectively deliver multiple large-scale and complex transformation programmes concurrently, due to limitations in capacity, capability, governance, or stakeholder engagement. This could result in delays, increased costs, reduced quality of outcomes, and failure to achieve strategic objectives, ultimately affecting patient care and organisational sustainability.	12
	10	Insufficient workforce enablement, development and transformation impairs the Trust's ability to achieve the right people capacity, capability and change-ready organisational culture to meet the demands of healthcare now and into the future - ensuring safe, efficient and optimal care for patients and a healthy, high performing, and inclusive working environment for colleagues who provide it	12
KCH	1	If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	12
	2	If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	12
	7	If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.	9
LGT	3a	Insufficient support for staff health and wellbeing will lead to increased stress and sickness absence, poor staff engagement, increased recruitment/retention challenges and the detriment of staff morale	12
	3b	Lack of robust workforce plan and plans to secure a pipeline of clinical and non-clinical staff will lead to staff shortages and skill gaps.	12
	3c	Lack of clinical and medical engagement and effective clinical and medical leadership within the organisation, actions to address urgent issues are unlikely to be effective and the quality of care offered to patients may be placed at risk.	15
	3d	Measures to ensure respect and compassion between staff and to protect staff (and patients) from violence and aggression will impact staff wellbeing.	10
	5	If the Trust does not put in place appropriate governance structures to deliver agreed requirements it is likely to face increased regulatory scrutiny and enforcement actions. There is an increased risk given unknown nature and consequences of future performance regimes	15
SLaM	1	Risk that the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change.	16
Oxleas	1213	Risk that the trust cannot recruit and retain staff to a level which enables it to maintain optimum levels of substantive staff.	12
	1471	Staff may experience discrimination and abuse at work, based on their protected characteristics, impacting sickness absence, morale and retention.	9
	2301	Staff may experience violence, aggression or abuse from service users, carers or the public, leading to poor mental and physical health, trauma, low resilience, low productivity and potentially increased turnover.	12

	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 Financial Balance 2026/27**	Lewisham borough anticipates achieving financial balance in 2026/27 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material one being an ability to fund mental health investment driven by the demand for and costs of ADHD assessments carried out in the independent sector. In addition, there are business as usual risks relating to activity pressures within continuing care and prescribing.	3x3=9	3x3=9	3x2=6	Open (10–12)	⟺	Ceri Jacob	Chris Dalrow	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 5. Review at LCP meetings with members on a bi-monthly basis. 6.System approach is being followed with LCP partners to align savings opportunities. 7. The ICB is implementing an ADHD referrals triage system from November 2025.	1.Monthly budget meetings. 2.Monthly financial closedown process 3.Monthly financial reports for ICS and external reporting. 4.Review financial position at CHC Recovery meeting. 5.Lewisham Senior Management Team Review.	1.The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed. 2.Regular borough financial focus group meetings with CFO and Director of Planning.	There are no currently identified control gaps.
Medicines Optimisation															
2	496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2026/27 may overspend due to: 1. Medicine supplies and cost increases -NCSO/price concessions and Category M. 2. Reduced capacity to implement in year QIPP schemes by borough-medicines optimisation teams following NHS reform. 3. Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 5. Changes to disease pathways and guidance, recommending novel treatments earlier in the patient disease course, creating cost pressures 4. Increased patient demand for prescriptions including self-care items, LTC. 5. Prescribing budget although uplifted for 26/27, 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, PresoQIPP), inclusive of Cat M and NCSO spend. 2. Monthly budget finance meetings with finance colleagues reviewing PPA budgets to date. 3. Monthly savings meeting with SMT at Place to review prescribing spend and development of mitigations. 4. Bi-monthly MO/Finance SEL meetings tracking prescribing spend. 5. Borough QIPP plans, and incentive schemes developed, with following ongoing: - QIPP and Incentive scheme monitoring dashboards - Practice level budget deep dives with RAG and action plans - Face to face practice visits with targeted spend analysis and feedback. - Forum meetings providing information on QIPP status and recommending actions to optimise prescribing (i.e. Practice Managers forum, PLT, etc.)	1.Any actions with regard to the prescribing budget are completed by Erfan Kidia, to dates agreed with the Place Executive, Associate Director of Finance.	1. Cost and budget pressure.	No gaps in control identified.
Primary Care / Community Based Care															
3	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 in continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls.	4x4=16	3x3=9	4x2=8	Cautious (7 – 9)	⟺	Ceri Jacob	Ashley O'Shaughnessy	The current controls in place are: Priorities for 2026/27: 1. 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. All practices are now contractually required to keep their online consultation systems switched on throughout core hours (8:00 AM to 6:30 PM, Monday to Friday). 2. Explore possibility to re-run the public communications and engagement campaign to raise awareness with the public about how best to access primary care and other options e.g. the national Pharmacy First scheme and the local Pharmacy First PLUS scheme via community pharmacy, self-management resources, self-referral pathways and 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. 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. 6. Continue support for PCNs to maximise use of the increased flexibility within ARRS budgets. 7. Quarterly monitoring of PCN Enhanced Access delivery. 8. Continuation of the Digital Change Manager role to support digital tools in primary care and also to promote uptake of the NHS APP. 9. Work closely with Community Pharmacy South East London and Community Pharmacy Neighbourhood Leads to support access into Community Pharmacy. 10. Identify and review practice unwarranted variation in Same Day Urgent Care.	Assurances going forward are outlined in the controls section. Furthermore: Primary care access is reviewed regularly at the Primary Care Group. Discussions with the Primary Care Leaders at PCLF, PM forum and PLTs about the models of access and delivery. Regular reporting through SMT and the Local Care Partnership Strategic Board. A small Same Day Urgent Care working group has been established and meets frequently.	Highlight of progress made so far in 26/27 1. All practices have an Online consultation system available for patients to use to submit requests. As of 1 October 2025, all GP practices are contractually required to keep online consultation tools open for routine requests, medication queries, and administrative tasks during all core hours (8:00am-6:30pm). 2. All practices are required to ensure that any patient they identify as clinically urgent is dealt with on the same day. 3. All practices now use Cloud Based Telephony systems with features such as a queue position and call back functionality as well as real time data monitoring to support evidence-based service decisions. 4. There were a total of 128,000 patient appointments in March 2026 (up from 110,000 in April 2025) with about 36% seen on the same day and 32% seen within 7 days. 5. All PCNs meeting their contracted number of additional hours for Enhanced Access delivery. 6. All PCNs have been encouraged to constantly review their ARRS budgets and ensure full utilisation of roles and budgets. 7. Good progress made on the interface with Primary Care and Secondary Care. Examples of outputs so far include: Robust systems for the sharing of contact details between Primary / Secondary care colleagues to support improved communications, a formal "inappropriate request" process for GP practices to use where tasks are sent back from secondary care i.e. for onward referrals, creation of a "WhatsApp" group between Primary / Secondary care colleagues to quickly raise issues for resolution, podcasts with Primary / Secondary care colleagues to share learning and insight and help build relationships and trust and a joint grand round where clinicians will come together to discuss case studies based around the patient journey and experience. 8. An increase in NHS App utilisation. As of April 2026, 62% of the Lewisham population are registered to use the NHS App. Up from 60% in January 2026. 9. There has been continued promotion and use of community pharmacy for Pharmacy First for the 7 clinical conditions, blood pressure monitoring and the pharmacy contraceptive service. 10. Planned targeted visits to outlier practices regarding Same Day Urgent Care to review their data, identify challenges, gaps and/or issues and agree a plan to improve.	A robust and accurate, real-time access dashboard which triangulates and reflects data and intelligence from a range of sources across the system. This is in the design phase.
4	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)	⬇	Laura Jenner	Ashley O'Shaughnessy	The current controls in place are: 1.Practice level vaccination delivery remains in place across all GP practices, with co administration of eligible seasonal vaccinations offered as standard where clinically appropriate and operationally feasible. 2.Robust patient call/recall systems are operational across practices, ensuring timely invitations and follow up for eligible cohorts. 3.Dedicated Lewisham Flu and Immunisations Coordinator provides ongoing operational support to Primary Care, including data monitoring, troubleshooting, and quality improvement activity and liaison with practices and providers. 4.Continue to work jointly with Public Health to plan and deliver targeted outreach vaccination services for underserved communities, addressing wider health inequalities. 5.Convenient local vaccination sites and mobile/outreach models are maintained to widen access, particularly for groups with historically lower uptake a few outreach sites were mobilised as well as the Millwall Bus and 'big week' national Vaccination Bus, which yielded low or no activity. 6.A universal, consistent core vaccination offer is delivered in recognisable, stable settings to strengthen public understanding of where to attend for vaccinations. 7.Opportunistic vaccination remains embedded across relevant services, ensuring vulnerable cohorts (e.g., asylum seekers, refugees, rough sleepers) are offered protection at every contact. 8.Lewisham Immunisation Partnership Group provides strategic oversight, supported by targeted task and finish groups for specific programmes. 9.Robust communications plan was implemented, built around an overarching winter wellness theme. This included targeted social media activity, messaging through Lewisham Life and JCD boards, throughout Lewisham and information leaflets distributed widely across the community. 10.Lewisham Immunisation Strategy refresh is underway, led by Public Health. 11.Voluntary and Community Sector (VCS) organisations are commissioned to support community engagement around flu/winter wellness and promote vaccination uptake. Worked particularly well with insight reports submitted and will use as the basis for updated plans in future campaigns. 12.Vaccine confidence behavioural science training was provided to family hubs and VCS partners to support effective vaccine-confidence conversations. 13.Flu vaccination campaigns for staff, including Immunisation Champions, Flu Hubs and sign off, in place to answer patient questions and reduce misinformation barriers. 14. Collaboration with Southwark Health Bus continues, including vaccination provision at Millwall match days to access harder to reach groups. No vaccinations were given supporters were more engaged with BP checks and Vital 5 checks. As with The big week vaccination Bus based in central Lewisham and Deptford yielded most of it's engagement in vital 5 checks. 15.District Nursing Services were commissioned to deliver housebound vaccinations, ensuring equitable access for immobile and clinically vulnerable patients. The delivery program worked in collaboration with LGT and the newly appointed INT staff. Some challenges were met operationally but all involved worked hard to get through them. Questionnaire gone out to all involved to support debrief report.	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Future increased numbers in seasonal Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Future decrease in A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is vaccine hesitancy, fatigue and reluctance following covid 19 pandemic. Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 2.LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity.
5	529	Strategic	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Childhood Immunisation Programme**	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x4=12	3x4=12	3x3=9	Cautious (7 – 9)	⟺	Laura Jenner	Ashley O'Shaughnessy	The current controls in place are: 1.Robust practice level call and recall systems are in place across all GP practices to ensure timely invitation and follow up for all eligible children. 2.National failsafe mechanisms continue to identify unvaccinated children and flag them to their registered GP practice for follow up. 3.Dedicated Lewisham Flu & Immunisations Coordinator provides ongoing support to practices, with targeted focus on those with the lowest uptake and identified inequalities. 4.The ICB works jointly with Lewisham Public Health to design and deliver targeted outreach models for underserved and high risk population groups, addressing wider inequalities in immunisation uptake. 5.Local vaccination delivery points remain available at convenient community locations, with an increase in sites, by pharmacy being able to administer MMR. 6.A universal, age specific core vaccination offer is delivered in consistent, well communicated settings, improving public awareness of where to attend and at what age vaccines are due. 7.Opportunistic vaccination pathways continue across key services, ensuring children from vulnerable groups—such as asylum seekers, refugees, and those experiencing homelessness—are offered protection at every contact point. 8.Strategic oversight is provided through the Lewisham Immunisation Partnership Group, with programme specific task and finish groups (e.g., MMR/polio) coordinating focused improvement actions. 9.A co produced, system wide Childhood Immunisation Strategy—developed with parents, residents, system partners, and community organisations—is now in place. The strategy is outcomes based, aligned with the Lewisham Health & Wellbeing Strategy and SEL Immunisation Board's priorities. 10.Engagement support from the African Advocacy Group is in place from May 2025, strengthening culturally informed outreach and trusted community messaging. 11.Behavioural science training has been rolled out to family hubs, with planned engagement of nursery managers to expand confidence building conversations with parents. 12.The nationally revised childhood vaccination schedule launched July 2025 is being actively communicated across Lewisham to raise awareness among parents and professionals and support improved understanding and uptake. The MMRV vaccine, introduced in January 2026, has been accompanied by targeted communications to raise awareness of its impact on the childhood vaccination schedule and ensure parents and professionals understand the updated requirements. 3. Working with CHS Nurse Immunisation coordinators to improve immunisation recording at practice level. 14. SEL/place based focus on measles outbreaks. Comms sent to primary care awaiting system wide approach 1	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Increased numbers in childhood Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Decreased A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is also a clear lack of knowledge of the importance and effectiveness of vaccinations amongst young parents. 2.Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 3.LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity. 4.Limited influence over commissioning of vaccination programmes including routine childhood immunisations and school age vaccinations. These are commissioned regionally by NHSE&I. 5.Following a review of the immunisations survey that was shared with all practices, we are now taking steps to act on the suggestions received.
Commissioning															
6	648	Strategic	**Uncontrolled mental health cost pressures restricting delivery of early intervention, prevention and transformation programmes in Lewisham**	There is a risk that uncontrolled and rising mental health cost pressures in Lewisham - including ADHD Right to Choose activity, Section 117 placement costs and wider cost per case pressures — will significantly reduce the financial headroom and capacity required to deliver the Place based mental health transformation programme. Lewisham may be unable to sustain or expand early intervention and prevention offers, particularly those delivered through the VCSE sector, and programme management time may be diverted towards cost containment over wider system development and transformation objectives.	4x4=16	3x4=12	2x4=8	Open (10–12)	⟺	Kenny Gregory	Eileen McCrae	1. Enhanced financial monitoring of ADHD Right to Choose activity & setting of Indicative Activity Plans 2. Improved processes regarding S117 care package costs and strategic commissioning of blocks etc. 3. Alliance oversight of cost drivers and mitigations, with regular reporting through the Mental Health Alliance Finance Working Group 4. Prioritisation of transformation workstreams within available financial envelope, including oversight of VCSE grants and funded Prevention & Early Help projects	Monthly ICB finance reports and activity monitoring. Mental Health Alliance finance and performance oversight via Adults Working Group Section 117 joint review panels and QA processes - document to be finalised with financial split and process Finance & Contracting meetings reviewing actuals, forecasts and mitigation plans.	1. The strengthened financial oversight and joint review mechanisms provide earlier visibility of cost growth and enable targeted mitigation of high cost areas such as placements and ADHD Right to Choose activity. This supports improved forecasting and helps protect, where possible, priority elements of the transformation programme.	1. Structural inability to influence national cost drivers, including ADHD Right to Choose activity and mandated Section 117 responsibilities. 2. Insufficient financial flexibility to protect or expand early intervention and VCSE delivered prevention services during periods of rising spend and tightening national efficiency targets. 3. Impact of the NHS 5% efficiency requirement on provider uplift negotiations, potentially reducing baseline sustainability and exacerbating pressures across the local MH pathway. 4. Programme management capacity increasingly consumed by cost containment, reducing bandwidth for longer term transformation. 5. Data gaps and forecasting limitations, especially regarding demand growth, complex care activity and future pathway flows.
7	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 2025/26, 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 25/26 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 2025/26. The numbers that required tracheotomy care increased by 3. Numbers of newly eligible for CHC appear to have decreased in 2025/2026 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 AGP rate (2025/26). New rate is £1,247 per week. 1.5% uplift has been offered to Fairlie Group. Local Authority are recommending 5% uplift for Direct Payment rate. SEL ICB have been alerted to the Stoke Judgement and may need to change their approach to Uplift Offers to social care providers. Recovery Work We have made good progress in decreasing the number of delayed reviews, especially during the second half of 2025/26. However, opportunities for savings are still being delayed, however we have managed to take 3 clients off CHC which has been a saving. Also, the number of clients requiring 1-1 supervision in a placement has also been reduced. A further saving has been made due to the demise of a complex case. 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.	5x3=15	4x3=12	3x3=9	Open (10–12)	⟺	Kenny Gregory	Corinne Moncrieme	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.	1.Prioritising review of all new LD packages transferring from LBL to look for savings opportunities. 2. Prioritise outstanding reviews and ensure that annual reviews revert to BAU for CHC Nurse Assessors. 3.Participating in wider SEL ICB CHC savings programme.	1.Pressure from other CHC priorities (particularly appeals/ LRMs/ IRPs) continue to take significant management time and attention. 2.Allocation of Social Worker by LBL may still delay timely completion of DST.	1.Potential patient safety issues through the reduction in packages – all reductions are reviewed in dialogue with both patient and service provider. 2. Reputation of the ICB with Council/other partners – LBL regularly updated on progress against assessment, though there are several long term outstanding disputes. 3. Increase in complaints because of reduction in packages, or decision to remove CHC eligibility. 4. Assessing nurse to be clear about the rationale for the reduction in package or no longer eligible and this explanation to be put in writing at time decrease/change from CHC eligible is being enacted.M2.P2
Children and Young People															
8	644	Strategic	**Neurodevelopmental diagnostic pathways (Autism and ADHD) - Adults and CYP**	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	4x4=16	4x4=16	4x3=12	Open (10–12)	⟺	Simon Whitlock	Paul Cowan	ICB and system level controls 1.SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. 2.New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. 3.Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. 4.Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis 5.Place Executive Group meeting has oversight via SDIP with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. 6. Opportunity to join arrangements with other boroughs 7. SLAM is working with community and voluntary organisations to develop a dedicated ADHD pathway, with potential to support autism services. 8. Working with mental health school teams to support the identification of children for autism assessments.	Oversight through the Place Executive Board via SDIP with Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYP MH Delivery Group and borough governance.	1. Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. 2.Limited ability to influence activity and quality within private 'Right to Choose' pathways. 3. Data completeness and standardisation across providers and places not yet consistent. 4. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments. 5.Delivery of Autism wait times is being monitored by NHSE as part of the Trusts delivery plan and to bring down wait times to within 18 weeks. 6. Transformation work on the autism referral and assessment pathway to reduce waiting times and diversify the workforce to increase capacity.	1. Inconsistent and incomplete SEL BI reporting across places. However, this is not applicable via CYP Joint Commissioning due to local monitoring. 2. ADHD Limited independent verification of data accuracy and trajectory modelling.
Enablers															

1	**611- 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	*1.Lack of clarity of optimal solution.* *2.Lack of identified funding to procure optimal digital solution.*	*Medium*	Medium Impact Issue	19/05/2026	Charles Malcolm-Smith	Open

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

	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 Financial Balance 2026/27**	Lewisham borough anticipates achieving financial balance in 2026/27 but has identified numerous risks that have potential to jeopardise a balanced financial position, the material one being an ability to fund mental health investment driven by the demand for and costs of ADHD assessments carried out in the independent sector. In addition, there are business as usual risks relating to activity pressures within continuing care and prescribing.	3x3=9	3x3=9	3x2=6	Open (10–12)	⟺	Cerri Jacobs	Chris Dancer	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. 5. Review at LCP meetings with members on a bi-monthly basis. 6.System approach is being followed with LCP partners to align savings opportunities. 7. The ICB is implementing an ADHD referrals triage system from November 2025.	1.Monthly budget meetings. 2.Monthly financial closedown process 3.Monthly financial reports for ICS and external reporting. 4.Review financial position at CHC Recovery meeting. 5.Lewisham Senior Management Team Review.	1.The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed. 2.Regular borough financial focus group meetings with CFO and Director of Planning.	There are no currently identified control gaps.
Medicines Optimisation															
2	496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2026/27 may overspend due to: 1. Medicine supplies and cost increases -NCSOI/price concessions and Category M. 2. Reduced capacity to implement in year QIPP schemes by borough medicines optimisation teams following NHS reform. 3. Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 5. Changes to disease pathways and guidance, recommending novel treatments earlier in the patient disease course, creating cost pressures 4. Increased patient demand for prescriptions including self-care items, LTC. 5. Prescribing budget although uplifted for 26/27, a gap remains with regards to forecast outturn and budget. 6. Priority shifts towards qualitative outcomes such as patient safety issues in Meds Management and supporting prevention, hospital avoidance or discharge. 7. Shift in prescribing from acute to community setting which places a pressure on primary care prescribing.	3x4=12	3x4=12	3x3=9	Open (10–12)	⟺	Laura Jenner	Erfan Kidia	1. Monthly monitoring of spend (ePACT, PrescQIPP), inclusive of Cat M and NCSO spend. 2. Monthly budget finance meetings with finance colleagues reviewing PPA budgets to date. 3. Monthly savings meeting with SMT at Place to review prescribing spend and development of mitigations. 4. Bi-monthly MG/Finance SEL meetings tracking prescribing spend. 5. Borough QIPP plans, and incentive schemes developed, with following ongoing: QIPP and Incentive scheme monitoring dashboards - Practice level budget deep dives with RAG and action plans - Face to face practice visits with targeted spend analysis and feedback. - Forum meetings providing information on QIPP status and recommending actions to optimise prescribing (i.e. Practice Managers forum, PLT, etc.)	1.Any actions with regard to the prescribing budget are completed by Erfan Kidia, to dates agreed with the Place Executive, Associate Director of Finance.	1. Cost and budget pressure.	No gaps in control identified.
Primary Care / Community Based Care															
3	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 in continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls.	4x4=16	3x3=9	4x2=8	Cautious (7 – 9)	⟺	Cerri Jacobs	Ashley O'Donoghue-Brown	The current controls in place are: Priorities for 2026/27: 1. 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. All practices are now contractually required to keep their online consultation systems switched on throughout core hours (8:00 AM to 6:30 PM, Monday to Friday). 2. Explore possibility to re-run the public communications and engagement campaign to raise awareness with the public about how best to access primary care and other options e.g. the national Pharmacy First scheme and the local Pharmacy First PLUS scheme via community pharmacy, self-management resources, self-referral pathways and 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. 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. 6. Continue support for PCNs to maximise use of the increased flexibility within ARRS budgets. 7. Quarterly monitoring of PCN Enhanced Access delivery. 8. Continuation of the Digital Change Manager role to support digital tools in primary care and also to promote uptake of the NHS APP. 9. Work closely with Community Pharmacy South East London and Community Pharmacy Neighbourhood Leads to support access into Community Pharmacy. 10. Identify and review practice unwarranted variation in Same Day Urgent Care.	Assurances going forward are outlined in the controls section. Furthermore: Primary care access is reviewed regularly at the Primary Care Group. Discussions with the Primary Care Leaders at PCLF, PM forum and PLTs about the models of access and delivery. Regular reporting through SMT and the Local Care Partnership Strategic Board. A small Same Day Urgent Care working group has been established and meets frequently.	Highlight of progress made so far in 26/27 1. All practices have an Online consultation system available for patients to use to submit requests. As of 1 October 2025, all GP practices are contractually required to keep online consultation tools open for routine requests, medication queries, and administrative tasks during all core hours (8:00am-6:30pm). 2. All practices are required to ensure that any patient they identify as clinically urgent is dealt with on the same day. 3. All practices now use Cloud Based Telephony systems with features such as a queue position and call back functionality as well as real time data monitoring to support evidence-based service decisions. 4. There were a total of 128,000 patient appointments in March 2026 (up from 110,000 in April 2025) with about 36% seen on the same day and 32% seen within 7 days 5. All PCNs meeting their contracted number of additional hours for Enhanced Access delivery. 6. All PCNs have been encouraged to constantly review their ARRS budgets and ensure full utilisation of roles and budgets. 7. Good progress made on the interface with Primary Care and Secondary Care. Examples of outputs so far include: Robust systems for the sharing of contact details between Primary / Secondary care colleagues to support improved communications, a formal "inappropriate request" process for GP practices to use where tasks are sent back from secondary care i.e. for onward referrals, creation of a "WhatsApp" group between Primary / Secondary care colleagues to quickly raise issues for resolution, podcasts with Primary / Secondary care colleagues to share learning and insight and help build relationships and trust and a joint grand round where clinicians will come together to discuss case studies based around the patient journey and experience. 8. An increase in NHS App utilisation. As of April 2026, 62% of the Lewisham population are registered to use the NHS App. Up from 60% in January 2026. 9. There has been continued promotion and use of community pharmacy for Pharmacy First for the 7 clinical conditions, blood pressure monitoring and the pharmacy contraceptive service. 10. Planned targeted visits to outlier practices regarding Same Day Urgent Care to review their data, identify challenges, gaps and/or issues and agree a plan to improve.	A robust and accurate, real-time access dashboard which triangulates and reflects data and intelligence from a range of sources across the system. This is in the design phase.
4	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)	↓	Laura Jenner	Ashley O'Donoghue-Brown	The current controls in place are: 1.Practice level vaccination delivery remains in place across all GP practices, with co administration of eligible seasonal vaccinations offered as standard where clinically appropriate and operationally feasible. 2.Robust patient call/recall systems are operational across practices, ensuring timely invitations and follow up for eligible cohorts. 3.Dedicated Lewisham Flu and Immunisations Coordinator provides ongoing operational support to Primary Care, including data monitoring, troubleshooting, and quality improvement activity and liaison with practices and public health. 4.Continue to work jointly with Public Health to plan and deliver targeted outreach vaccination services for underserved communities, addressing wider health inequalities. 5.Convenient local vaccination sites and mobile/outreach models are maintained to widen access, particularly for groups with historically lower uptake a few outreach sites were mobilised as well as the Millwall Bus and 'big green' national Vaccination Bus, which yielded low or no activity. 6.Communications and engagement campaigns are planned to raise recognisable, stable settings to strengthen public understanding of where to attend for vaccinations. 7.Opportunistic vaccination remains embedded across relevant services, ensuring eligible cohorts (e.g., asylum seekers, refugees, rough sleepers) are offered protection at every contact. 8.Lewisham Immunisation Partnership Group provides strategic oversight, supported by targeted task and finish groups for specific programmes. 9.Robust communications plan was implemented, built around an overarching winter wellness theme. This included targeted social media activity, messaging through Lewisham Life and JCD boards, throughout Lewisham and information leaflets distributed widely across the community. 10.Lewisham Immunisation Strategy refresh is underway, led by Public Health. 11.Voluntary and Community Sector (VCS) organisations are commissioned to support community engagement around flu/winter wellness and promote vaccination uptake. Worked particularly well with insight reports submitted and will use as the basis for updated plans in future campaigns. 12.Vaccine confidence behavioural science training was provided to family hubs and VCS partners to support effective vaccine-confidence conversations. 13.A vaccination chatbot/helpline pilot has been commissioned and is final stages of sign off, in place to answer patient questions and reduce misinformation barriers. 14. Collaboration with Southwark Health Bus continues, including vaccination provision at Millwall match days to access harder to reach groups. No vaccinations were given supporters were more engaged with BP checks and Vital 5 checks. As with The big week vaccination Bus based in central Lewisham and Deptford yielded most of it's engagement is vital 5 checks. 15.District Nursing Services were commissioned to deliver housebound vaccinations, ensuring equitable access for immobile and clinically vulnerable patients. The delivery program worked in collaboration with LGT and the newly appointed INT staff. Some challenges were met operationally but all involved worked hard to get through them. Questionnaire gone out to all involved to support debrief report.	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Future increased numbers in seasonal Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Future decrease in A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is vaccine hesitancy, fatigue and reluctance following covid 19 pandemic. Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 2.LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity.
5	529	Strategic	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Childhood Immunisation Programme**	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3x4=12	3x4=12	3x3=9	Cautious (7 – 9)	⟺	Laura Jenner	Ashley O'Donoghue-Brown	The current controls in place are: 1.Robust practice level call and recall systems are in place across all GP practices to ensure timely invitation and follow up for all eligible children. 2.National failsafe mechanisms continue to identify unvaccinated children and flag them to their registered GP practice for follow up. 3.Dedicated Lewisham Flu & Immunisations Coordinator provides ongoing support to practices, with targeted focus on those with the lowest uptake and identified inequalities. 4.The ICB works jointly with Lewisham Public Health to design and deliver targeted outreach models for underserved and high risk population groups, addressing wider inequalities in immunisation uptake. 5.Local vaccination delivery points remain available at convenient community locations, with an increase in sites, by pharmacy being able to administer MMR. 6.A universal, age specific core vaccination offer is delivered in consistent, well communicated settings, improving public awareness of where to attend and at what age vaccines are due. 7.Opportunistic vaccination pathways continue across key services, ensuring children from vulnerable groups—such as asylum seekers, refugees, and those experiencing homelessness—are offered protection at every contact point. 8.Strategic oversight is provided through the Lewisham Immunisation Partnership Group, with programme specific task and finish groups (e.g., MMR/polio) coordinating focused improvement actions. 9.A co produced, system wide Childhood Immunisation Strategy—developed with parents, residents, system partners, and community organisations—is now in place. The strategy is outcomes based, aligned with the Lewisham Health & Wellbeing Strategy and SEL Immunisation Board's priorities. 10.Engagement support from the African Advocacy Group is in place from May 2025, strengthening culturally informed outreach and trusted community messaging. 11.Behavioural science training has been rolled out to family hubs, with planned engagement of nursery managers to expand confidence building conversations with parents. 12.The nationally revised childhood vaccination schedule launched July 2025 is being actively communicated across Lewisham to raise awareness among parents and professionals and support improved understanding and uptake. The MMRV vaccine, introduced in January 2026, has been accompanied by targeted communications to raise awareness of its impact on the childhood vaccination schedule and ensure parents and professionals understand the updated requirements. 13. Working with CHIS Nurse Immunisation coordinators to improve immunisation recording at practice level. 14. SEL/place based focus on measles outbreaks. Comms sent to primary care awaiting system wide approach 1	1.Appropriate governance in place which includes a stakeholder group and a working group. Lewisham representation at SEL immunisation and Vaccination board. Continued Joint working between primary care and public health.	1.Increased numbers in childhood Imms reported. 2.Reduction in severe and harmful disease outbreaks. 3.Help relieve some of the pressure on Primary Care. 4.Decreased A&E attendances and emergency admissions. 5.Help improve patient outcomes, including disability and mortality.	1.There is also a clear lack of knowledge of the importance and effectiveness of vaccinations amongst young parents. 2.Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. 3.LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity. 4.Limited influence over commissioning of vaccination programmes including routine childhood immunisations and school age vaccinations. These are commissioned regionally by NHSE&I. 5.Following a review of the immunisations survey that was shared with all practices, we are now taking steps to act on the suggestions received.
Commissioning															
6	648	Strategic	**Uncontrolled mental health cost pressures restricting delivery of early intervention, prevention and transformation programmes in Lewisham**	There is a risk that uncontrolled and rising mental health cost pressures in Lewisham - including ADHD Right to Choose activity, Section 117 placement costs and wider cost per case pressures — will significantly reduce the financial headroom and capacity required to deliver the Place based mental health transformation programme. Lewisham may be unable to sustain or expand early intervention and prevention offers, particularly those delivered through the VCSE sector, and programme management time may be diverted towards cost containment over wider system development and transformation objectives.	4x4=16	3x4=12	2x4=8	Open (10–12)	⟺	Kenny Gregory	Elton McCoke	1. Enhanced financial monitoring of ADHD Right to Choose activity & setting of Indicative Activity Plans 2. Improved processes regarding S117 care package costs and strategic commissioning of blocks etc 3. Alliance oversight of cost drivers and mitigations, with regular reporting through the Mental Health Alliance Finance Working Group 4. Prioritisation of transformation workstreams within available financial envelope, including oversight of VCSE grants and funded Prevention & Early Help projects	Monthly ICB finance reports and activity monitoring. Mental Health Alliance finance and performance oversight via Adults Working Group Section 117 joint review panels and QA processes - document to be finalised with financial split and process Finance & Contracting meetings reviewing actuals, forecasts and mitigation plans.	1. The strengthened financial oversight and joint review mechanisms provide earlier visibility of cost growth and enable targeted mitigation of high cost areas such as placements and ADHD Right to Choose activity. This supports improved forecasting and helps protect, where possible, priority elements of the transformation programme.	1. Structural inability to influence national cost drivers, including ADHD Right to Cboose activity and mandated Section 117 responsibilities. 2. Insufficient financial flexibility to protect or expand early intervention and VCSE delivered prevention services during periods of rising spend and tightening national efficiency targets. 3. Impact of the NHS 5% efficiency requirement on provider uplift negotiations, potentially reducing baseline sustainability and exacerbating pressures across the local MH pathway. 4. Programme management capacity increasingly consumed by cost containment, reducing bandwidth for longer term transformation. 5. Data gaps and forecasting limitations, especially regarding demand growth, complex care activity and future pathway flows.
7	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 2025/26, 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 25/26 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 2025/26. The numbers that required tracheotomy care increased by 3. Numbers of newly eligible for CHC appear to have decreased in 2025/2026 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 Fairfie Group. Local Authority are recommending 5% uplift for Direct Payment rate. SEL ICB have been alerted to the Stoke Judgement and may need to change their approach to Uplift Offers to social care providers. Recovery Work We have made good progress in decreasing the number of delayed reviews, especially during the second half of 2025/26. However, opportunities for savings are still being delayed, however we have managed to take 3 clients off CHC which has been a saving. Also, the number of clients requiring 1-1 supervision in a placement has also been reduced. A further saving has been made due to the demise of a complex case. 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.	5x3=15	4x3=12	3x3=9	Open (10–12)	⟺	Kenny Gregory	Corinne Moore	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 Fairfie/ 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.	1.Prioritising review of all new LD packages transferring from LBL to look for savings opportunities. 2. Prioritise outstanding reviews and ensure that annual reviews revert to BAU for CHC Nurse Assessors. 3.Participating in wider SEL ICB CHC savings programme.	1.Pressure from other CHC priorities (particularly appeals/ LRMs/ IRPs) continue to take significant management time and attention. 2.Allocation of Social Worker by LBL may still delay timely completion of DST.	1.Potential patient safety issues through the reduction in packages – all reductions are reviewed in dialogue with both patient and service provider. 2. Reputation of the ICB with Council/other partners – LBL regularly updated on progress against assessment, though there are several long term outstanding disputes. 3. Increase in complaints because of reduction in packages, or decision to remove CHC eligibility. 4. Assessing nurse to be clear about the rationale for the reduction in package or no longer eligible and this explanation to be put in writing at time decrease/change from CHC eligible is being enacted.M2:P2
Children and Young People															
8	644	Strategic	**Neurodevelopmental diagnostic pathways (Autism and ADHD) - Adults and CYP**	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	4x4=16	4x4=16	4x3=12	Open (10–12)	⟺	Simon Whitlock	Paul Creech	ICB and system level controls 1.SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL borough/ places. 2.New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. 3. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. 4.Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis 5.Place Executive Group meeting has oversight via SDIP with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. 6. Opportunity to join arrangements with other boroughs 7. SLAM is working with community and voluntary organisations to develop a dedicated ADHD pathway, with potential to support autism services. 8. Working with mental health school teams to support the identification of children for autism assessments.	Oversight through the Place Executive Board via SDIP with Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYP MH Delivery Group and borough governance.	1. Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. 2.Limited ability to influence activity and quality within private 'Right to Choose' pathways. 3. Data completeness and standardisation across providers and places not yet consistent. 4. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments. 5.Delivery of Autism wait times is being monitored by NHSE as part of the Trusts delivery plan and to bring down wait times to within 18 weeks. 6. Transformation work on the autism referral and assessment pathway to reduce waiting times and diversify the workforce to increase capacity.	1. Inconsistent and incomplete SEL BI reporting across places. However, this is not applicable via CYP Joint Commissioning due to local monitoring. 2. ADHD Limited independent verification of data accuracy and trajectory modelling.
Enablers															

1	**611- 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	*1.Lack of clarity of optimal solution.* *2.Lack of identified funding to procure optimal digital solution.*	*Medium*	Medium Impact Issue	19/05/2026	Charles Malcolm-Smith	Open

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

lhcp Lewisham Health and Care Partnership

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 10
Enclosure 9

Title:	**Month 03 Finance Report 2026/27**
Meeting Date:	**23rd July 2026**
Author:	Chris Dance
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board on the ICB - Lewisham Place financial outturn position at month 3 2026/27. A month 2 position is also included for the wider ICB and Lewisham Council.	Update / Information	✓
		Discussion	
		Decision	

Summary of main points:

Month 03 2026/27 – SEL ICB – Lewisham Place

At month 03, the borough reported a breakeven position against the year to date & annual (forecast) plan. There are pressures reported for Mental Health Services, and Continuing Care offset by favourable variances (against budget) within Community services where delivery of cumulative efficiencies across the borough are reported.

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

Month 02 2026/27 – Lewisham Council

The month 02 outturn is included in this report. Adult Social Care shows an adverse variance to budget of £0.4m year to date. Children and Young People shows an adverse variance to budget of £0.3m year to date. Further details are included in this report.

Month 2 2026/27 – SEL ICB

The ICB is reporting a breakeven position against the revenue resource limit (RRL) and against a breakeven plan.

Further details of the ICB position are shown within Appendix A 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 03 2026/27.		
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 3 reported financial position for 2026/27.			

NHS
South East London

Lewisham LCP Finance Report

Month 03 – 2026/27

Month 03 2026/27 - ICB (Lewisham)

NHS South East London

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	668	167	167	0	668	0
Community Health Services	31,921	7,980	7,668	312	30,848	1,073
Mental Health Services	10,585	2,646	2,805	(159)	11,041	(456)
Continuing Care Services	25,374	6,344	6,498	(154)	25,992	(617)
Prescribing	47,267	11,586	10,668	918	46,349	918
Prescribing Reserves (Non PPA)	0	0	918	(918)	918	(918)
Other Primary Care Services	1,835	459	459	0	1,835	0
Other Programme Services	0	0	0	0	0	0
Programme Wide Projects	26	6	6	0	26	0
Corporate Budgets	3,466	866	866	0	3,466	0
Sub-Total	**121,141**	**30,054**	**30,055**	**(1)**	**121,142**	**(0)**

At month 3, the overall Lewisham financial position is aligned to the year-to-date plan, with a forecast breakeven position.

The Prescribing position is aligned to plan noting a 2-month lag in PPA dataset reporting. The aggregation of PPA budgets is approved in principle and will reflect in the subsequent months report to align with final ratification of agreement. The non PPA budgets will be retained in Place subject to further discussions.

Mental Health is reporting a £159k adverse variance attributable to cost per case placement costs, subject to ongoing internal validation to ensure robustness of reporting numbers. The ADHD/ASD referrals is assumed aligned to plan in absence of sufficient invoicing for the 2026/27 financial year. This remains a key financial risk & will be closely monitored throughout the financial year.

CHC is reporting a £154k adverse variance due to a reported uptake within fast-track placements. The details will be reviewed within the monthly budget meeting to ensure the costs are appropriately validated.

Community services is £312k favourable to the year-to-date plan and reflects the delivery of planned savings in line with plan and in support of the overall financial position.

Month 02 2026-27 – Lewisham Council

NHS South East London

2026/27 Efficiencies	Year-to-date Month 2 2026/27			Full-Year Forecast 2026/27		
	Plan	Forecast	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Adult Care Services	1.1	0.8	(0.3)	6.8	4.8	(2.0)
Children and Young People	1.4	1.4	0.0	8.2	8.2	0.0
Total	**2.5**	**2.2**	**(0.3)**	**15.0**	**13.0**	**(2.0)**

2026/27 LBL Managed Budgets	Year-to-date Month 2 2026/27			Full-Year Forecast 2026/27		
	Budget	Forecast	Variance	Budget	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Adult Care Services	20.0	20.5	(0.4)	120.1	122.8	(2.7)
Children and Young People	19.4	19.7	(0.3)	116.1	117.9	(1.8)
Total	**39.4**	**40.1**	**(0.8)**	**236.2**	**240.7**	**(4.5)**

Adult Social Care and Health: currently projected to have a £2.7m overspend. The service are showing pressure on packages and placements budgets which is currently being off-set by growth of £6.5m that was given in the 2026/27 budget setting process. However, this is based on current numbers and does not include any headroom for growth. This pressure on statutory Adult Social Care services provided under the Care Act 2014 is being observed across London boroughs and nationwide. The 2026/27 full year forecast overspend at Period 2 includes an anticipated pressure of £0.7m related to increase of the bad debt provision. The service are also showing a red risk on a saving of £2m entitled Budget Review & Efficiencies – Cost Reductions Through Prevention & Technology. Therefore, this is shown as pressure in the 2026/27 out-turn until mitigating savings are found

Children and Young People: is reporting a £1.8m overspend. The division has also seen an increased number accessing the service under Section 17, particularly around accommodation costs. The department is also working through implementation of the national Families First for Children, social care reforms which aims to rebalance the system towards earlier help and reduce reliance on high-cost statutory interventions over time. There is a risk around the placement sufficiency savings of £6.29m..

Appendix A

SEL ICB Finance Summary

Month 02 2026/27

Contents

NHS South East London

1. Key Financial Indicators
2. Executive Summary
3. Revenue Resource Limit (RRL)
4. Budget Overview
5. NHS Continuing Healthcare
6. MHIS performance

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 02, 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.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year-end.**
- The ICB is showing a **break-even** position for YTD and forecast out-turn position against the **running cost allowance (RCA)**. Any YTD underspends against running cost and programme corporate budgets are being used to mitigate the reduction to the ICB's overall allocation **(£21,400k)** in respect of the Change Programme.
- The ICB is reporting that YTD its efficiencies plan is on track and the forecast is for the annual plan to be delivered.
- **All financial duties have been delivered for the year to month 02 period.**

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	989,201	989,201	5,950,393	5,950,393	
Operating Under Resource Revenue Limit	989,201	989,201	5,950,393	5,950,393	
Not to exceed Running Cost Allowance	5,342	5,342	31,717	31,717	
Month End Cash Position (expected to be below target)	5,563	3,231			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	100.0%			
95% of non-NHS creditor payments within 30 days	95.0%	99.7%			
Mental Health Investment Standard (Annual)			560,171	561,171	

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 **£5,950,393k**. In month, the ICB has received an additional **£48,587k** 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.**
- Due to the routine time lag, the ICB has not yet received any 2627 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **break-even position YTD across PPA and non PPA**. Once information is available the usual slide will be presented.
- Given that reporting for dental, ophthalmic and community pharmacy is subject to same time lag, a YTD breakeven position is reported. Again, when information is available, the usual slide will be included within the monthly reporting pack.
- The CHC financial position is **£126k overspent** at month 2. The boroughs which are most impacted are Lewisham and Bexley, further work will be undertaken to validate the clients in month to ensure the reporting is correct and any mitigations can be identified. The YTD position for **Mental Health services** is an overall **overspend of £974k.** This is generated by pressures on cost per case services and Right to Choose costs with all boroughs impacted. **ADHD and ASD assessments** continue to be a significant financial pressure for all boroughs. Additional analysis of these MH pressures is being undertaken in month as well as identifying potential mitigations against these pressures. Work is due to be undertaken around the ASD and ADHD pathways, and progress regarding this work will be followed up on and reported back in future reports.
- Two places are reporting a small overspends YTD at month 2 – **Bromley (£161k – driven by MH CPC and Right to Choose overspends) and Greenwich (£122k – driven by MH CPC and Right to Choose overspends), with a break-even position being forecast by all.** All Places have been tasked to identify additional mitigations to offset financial risks.
- In reporting this month 2 position, the ICB has delivered the following financial duties:
  - An **overall break-even** YTD financial position.
  - Breakeven against its management costs allocation. YTD underspends **(£1,680k)** are being used to offset the allocation reduction **(£21,400k)** due to the national assumption that staff restructures arising from the Change Programme were implemented by 1st April 2026 which is not true for the ICB. The redundancy costs of the programme were included as either provisions (Voluntary Redundancy Scheme 2 and any compulsory Redundancies) or accruals (Voluntary Redundancy Scheme 1) in the ICB's 2025/26 annual accounts, so will not be a charge against the 2026/27 position.
  - 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 forecasting an overall **break-even position** against its annual financial plan.

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 (as per submitted plan)	**109,388**	**208,005**	**130,682**	**145,879**	**119,148**	**113,778**	**5,074,926**	**5,901,806**
M2 Internal Adjustments								
Planning Adjustments to Boroughs	538	527	837	788	312		-3,004	**0**
Transfer to Lewisham for S117 cost pressures					1,600		-1,600	**0**
M2 Allocations								
Indicative budget still pending at M2 (SDF)							(9,967)	**(9,967)**
Cost increase on ICB programme funded expenditure (Recurrent)	121	566	173	30	42	60	22,966	**23,958**
DDRB - Cost increase on ICB programme funded expenditure (Recurrent)	84	390	119	20	29	42	15,832	**16,516**
Cost increase on ICB specialised commissioning funded expenditure (Recurrent)							6,035	**6,035**
DDRB - cost increase on Specialised Commissioning expenditure (Recurrent)							3,966	**3,966**
Non-recurrent support for NHS providers (host basis)							2,887	**2,887**
DDRB - Non-recurrent support for NHS providers (host basis)							1,895	**1,895**
Additional FNC allocation							1,165	**1,165**
Childrens Hospice Grant allocations 2026/27							840	**840**
Cost increase on ICB primary care funded expenditure							412	**412**
Running Costs Allowance Pay Award Impact							320	**320**
Various Minor Allocations under £250k							560	**560**
M2 Budget	**110,132**	**209,488**	**131,811**	**146,717**	**121,131**	**113,880**	**5,117,233**	**5,950,393**

- The table sets out the Revenue Resource Limit (RRL) at month 2.
- The start allocation of **£5,901,806k** is consistent with the Operating Plan submissions.
- In month, the ICB has received an additional **£48,587k** of allocations, giving a total allocation of **£5,950,393k** at month 2**.**
- Indicative SDF funding of **£9,967k** which was included in the planning submission is still pending as at month 2.
- Additional allocations received in month 2 included funding to cover the impact of 2026/27 pay awards for the ICB and ICS partners totalling **£55,989k**, an additional FNC allocation of **£1,165k,** Children's Hospice Grant funding of **£840k**, and other smaller adjustments totalling **£560k.**
- 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	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget									
Acute Services	113	1,129	993	79	111	12	559,972	-	**562,409**
Community Health Services	4,390	16,406	6,121	5,319	5,320	6,125	54,276	-	**97,958**
Mental Health Services	1,904	2,668	1,883	4,175	1,764	2,076	112,515	874	**127,858**
Continuing Care Services	4,440	4,927	5,348	5,928	4,229	3,436	-	-	**28,307**
Prescribing	6,327	8,298	6,375	7,129	7,517	6,031	-	553	**42,230**
Other Primary Care Services	264	356	319	664	306	137	-	2,621	**4,667**
Other Programme Services	83	-	-	-	-	121	3,220	1,151	**4,574**
Programme Wide Projects	-	-	-	-	4	-	-	637	**642**
Delegated Primary Care Services	8,259	11,830	10,568	16,043	12,080	12,901	-	440	**72,120**
Delegated Primary Care Services DPO	-	-	-	-	-	-	11,248	26,009	**37,257**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-	**-**
Corporate Budgets	530	733	623	813	578	750	-	7,153	**11,179**
Total Year to Date Budget	**26,309**	**46,347**	**32,230**	**40,150**	**31,909**	**31,588**	**741,231**	**39,438**	**989,201**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual									
Acute Services	113	1,129	993	79	111	12	559,797	-	**562,234**
Community Health Services	4,074	16,249	6,076	5,319	5,245	6,125	54,299	-	**97,388**
Mental Health Services	1,996	2,985	2,046	4,335	1,794	2,144	112,665	867	**128,833**
Continuing Care Services	4,746	4,927	5,351	5,768	4,274	3,368	-	-	**28,434**
Prescribing	6,327	8,298	6,375	7,129	7,517	6,031	-	553	**42,230**
Other Primary Care Services	264	356	319	664	306	137	-	2,621	**4,667**
Other Programme Services	-	-	-	-	-	121	3,220	875	**4,215**
Programme Wide Projects	-	-	-	-	4	-	-	637	**642**
Delegated Primary Care Services	8,259	11,830	10,568	16,043	12,080	12,901	-	440	**72,120**
Delegated Primary Care Services DPO	-	-	-	-	-	-	11,251	26,009	**37,260**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-	**-**
Corporate Budgets	530	733	623	813	578	750	-	7,153	**11,179**
Total Year to Date Actual	**26,308**	**46,508**	**32,352**	**40,150**	**31,908**	**31,588**	**741,232**	**39,156**	**989,201**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance									
Acute Services	0	(0)	(0)	0	0	0	175	-	**175**
Community Health Services	316	157	45	(0)	75	(0)	(23)	-	**570**
Mental Health Services	(93)	(318)	(163)	(160)	(30)	(68)	(149)	6	**(974)**
Continuing Care Services	(306)	(0)	(4)	160	(45)	68	-	-	**(126)**
Prescribing	-	-	-	-	-	-	-	-	**-**
Other Primary Care Services	0	0	(0)	0	0	-	-	(0)	**0**
Other Programme Services	83	-	-	-	-	-	(0)	275	**359**
Programme Wide Projects	-	-	-	-	-	-	-	(0)	**(0)**
Delegated Primary Care Services	-	-	-	-	-	0	-	-	**0**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(3)	-	**(3)**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-	**-**
Corporate Budgets	(0)	0	0	(0)	0	0	-	0	**0**
Total Year to Date Variance	**1**	**(161)**	**(122)**	**(0)**	**0**	**0**	**(0)**	**282**	**(0)**

- As at month 2, the ICB is reporting a YTD **break-even position**, albeit with **pressures in specific budgets.** The main area of financial pressure is in **mental health services.**
- Due to the routine time lag, the ICB has not yet received any 2627 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a breakeven position YTD across PPA and non PPA budgets.
- The **CHC** financial position is **£126k** overspent at month 2. The boroughs which are most impacted are Lewisham and Bexley, further work will be undertaken to validate the clients in month to ensure the reporting is correct and any mitigations can be identified.
- The YTD position for **Mental Health services** is an overall overspend of **£974k**. This is generated by pressures on cost per case services and Right to Choose costs with all boroughs impacted. **ADHD and ASD assessments** continue to be a significant financial pressure for all boroughs. Additional analysis of these MH pressures is being undertaken in month, as well as identifying potential mitigations.
- The ICB is now settling the Voluntary Redundancy 1 claims which are being charged against year end accruals and shortly costs for the Voluntary Redundancy 2 scheme will be coming through which will be offset against a year end provision, so neither of these schemes will impact upon the 2026/27 financial position.
- Two places are reporting a small overspends YTD at month 2 – **Bromley (£161k – driven by MH CPC and Right to Choose overspends) and Greenwich (£122k – driven by MH CPC and Right to Choose overspends)**, with a break-even position being forecast by all. All places have been tasked to identify additional mitigations to offset any financial risks, to ensure delivery of their financial plans.

5. NHS Continuing Healthcare

NHS South East London

- As of Month 02, the Continuing Healthcare (CHC) budget is reporting an overall year-to-date **overspend of £126k**, although cost pressures continue to vary across boroughs. **Bexley and Lewisham** are currently reporting **modest overspends**.
- **Bexley** is the largest contributor to the overall overspend, with a year-to-date variance of **£306k above budget and a forecast outturn overspend of £500k**. This is primarily driven by **high-cost palliative care and Personal Health Budget (PHB) clients** and includes a **£763k full-year contingency within the reported position** for anticipated provider price increases. **Lewisham** is reporting an **overspend of £44k**, mainly attributable to **Funded Nursing Care**.
- Places continue to review client packages to ensure correct packages of care are in place and to ensure equity and value for money.
- To support consistent management of provider price uplifts, an ICB-wide panel has been established to review all requests exceeding 1.5%. The uplift panel meets weekly to review and agree provider requests.
- In summary, the boroughs are currently forecasting delivery of their annual plans. However, given the nature of CHC costs, it is still too early to forecast with certainty. Overall, there are no significant changes in the financial position compared with the previous financial year.

6. Mental Health Investment Standard (MHIS) – 2026/27

NHS South East London

Mental Health Investment Standard (excluding LD and Dementia) and Delegated Specialised Commissioning Mental Health Investment Standard:		2_1Achieve01	2_1PLAN%01	2_1AuditedPY	2_1TARGET01	2_1ACT02	2_1VAR%01	2_1VAR02	2_1Achieve02	2_1POP01	2_1Achieve03	2_1SCMHISAuditedPY	2_1TARGET02	2_1ACT03	2_1SCMHISVAR%01	2_1SCMHISVAR02	2_1SCMHISAchieve02	2_1COMM01
		MHIS Achieved per plans submitted 31/03/2026	2026/27 allocation growth	2025/26 Outturn	Target MHIS spend 2026/27	FOT 2026/27	Excess / Shortfall in 2026/27 MHIS Delivery %	Excess / Shortfall in 2026/27 MHIS Delivery	MHIS Achieved in 2026/27?	Projected Population 2026/27	SCMHIS Achieved per plans submitted 31/03/2026	2025/26 SCMHIS Outturn	Target SCMHIS spend 2026/27	SCMHIS FOT 2026/27	Excess / Shortfall in 2026/27 SCMHIS Delivery %	Excess / Shortfall in 2026/27 SCMHIS Delivery	SCMHIS Achieved in 2026/27?	Commentary for Variances
	Expected Sign	Desc 31/03/2027 Year Ending TEXT	Plan 31/03/2027 Year Ending %	Actual 31/03/2026 Year Ending £'000	Target 31/03/2027 Year Ending £'000	Forecast 31/03/2027 Year Ending £'000	Actual 31/03/2027 Year Ending %	Actual 31/03/2027 Year Ending £'000	Desc 31/03/2027 Year Ending TEXT	YTD 31/03/2027 Year Ending Number	Desc 31/03/2027 Year Ending TEXT	Actual 31/03/2026 Year Ending £'000	Target 31/03/2027 Year Ending £'000	Forecast 31/03/2027 Year Ending £'000	Actual 31/03/2027 Year Ending %	Actual 31/03/2027 Year Ending £'000	Desc 31/03/2027 Year Ending TEXT	Desc 31/03/2027 Year Ending TEXT
MHIS Achievement	+/-	Yes	2.03%	550,303	560,171	**561,171**	**0.18%**	**1,000**	Yes	2,757,608	Yes	91,032	92,573	**92,587**	**0.01%**	**13**	Yes	

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2025/26 outturn by a **minimum of the growth uplift of 2.03%.** The spend will be subject to independent review as part of the annual accounts audits effective from the year 2025/26 where the audit has just concluded.

- There are two elements to the MHIS target for 2026/27, as there were in the previous year:
  - The core MHIS target of £560,171; and
  - Plus, there is a separate MHIS target for Delegated Specialised Commissioning of £92,573k 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.

- **As at Month 2 we are forecasting core MHIS delivery of £561,171k, exceeding the target by circa £1,000k (0.18%) plus Specialised Commissioning MHIS delivery of £92,587k, exceeding the target by £14k. This is summarised in the above table, with further details available in the Month 2 IFR submitted to NHS England.**

6. Mental Health Investment Standard (MHIS) – 2026/27

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.

- 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, continued, significant and increasing independent sector spend on both ADHD and ASD services. A referral management centre was set up in year in 2025/26, however, the impact of this is to be assessed. A SE London wide piece of work on ADHD and ASD assessments is to be undertaken in 2026/27, with the scope still in discussion.

  The following actions which began last year are continuing to be undertaken:

  - 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.

Key:	Action progressing as planned	Minor delay or dependency requiring monitoring	Closed: Action completed and evidenced	Delayed/Significant Risk

Ref	Meeting Date	Item	Action / Decision	Owner	Current Status	Update / Next Steps	Due Date
LNPB-006	06/07/2026	Workstreams Structure	**MH:** Add Lesa Bartlett as Operational lead **Enablers - (Digital, Estates and Community Hub):** Review to ensure right people are involved from system partners. **Partnership Development (Creating One Voice for Primary Care):** Mauro Campus as Operational lead and Waqas as Clinical lead. Add OHL (Waqas to provide names).	Ada Nwokoro	In progress	Liaise with population health team for data to facilitate identification of prioirty cohorts+K1:P2	Aug-26
LNPB-007	06/07/2026	Frailty INT	**Frailty Pilot:** Update on winter plan for the pilot	Jack Howel	In progress	06/07/26: Incorporate end of life and winter plan in the frailty pilot plan.	Aug-26
LNPB-009	06/07/2026	Complex CYP	Liaise with population health team for data to facilitate identification of prioirty cohorts	Stacey Jarrett & Rachael Smith	In progress		Oct-26
PEG	02/02/2026	Communication & Visibility	Add neighbourhood programme visibility actions to forward planner (communications)	Ada Nwokoro	In Progress	06/07/26: Draft Communications Plan to be presented a next meeting Alignment with communications plan in development	03/08/2026
PEG	02/02/2026	Programme Planning	Develop 6–12-month forward programme plan	Ada Nwokoro	In Progress	Draft programme roadmap being prepared for Board review	03/08/2026
PEG	02/02/2026	OD Provider for Neighbourhoods	Share final specification for OD programme	Charles Malcolm-Smith	Closed	Final specification circulated via email dated 03/02/2026	08/02/2026
PEG	02/02/2026	Frailty Programme	Continue discussions regarding governance arrangements	Deeta Henry-Smith / Rochelle Scott	Closed	06/07/26: Closed from the tracker – now monitored through the Programme Board rolling agenda. Governance proposals to return to Board for review	06/04/2026
PEG	02/02/2026	Programme Membership	Update Board membership to include additional programme representatives	Ada Nwokoro Lauren Woolhead	Closed	06/07/26: Closed. Membership reviewed by Programmeb Board Chair. Final list will be shared by next meeting.	06/04/2026
LNPB-004	11/05/2026	INT – Frailty	Develop programme scope, milestones, and implementation timeline	Jack Howell	Closed	06/07/26: Closed from the tracker – now monitored through the Programme Board rolling agenda. Initial timeline in development for presentation to Board	Jun-26
LNPB-005	11/05/2026	INT – LTC	Include performance targets within reporting dashboard	Fiona Kirkman	Closed	06/07/26: Closed from the tracker – now monitored through the Programme Board rolling agenda. KPI measures being aligned with programme reporting framework	Jun-26
LNPB-001	11/05/2026	Change of PEG	Transforming the PEG to Neighbourhoolds Programme Board	Beckie Burn / Laura Jenner	Closed	Agreed	
LNPB-002	11/05/2026	Neighbourhoods Programme	Consider use of the Work Well Programme to support employees within neighbourhood	Charles Malcolm-Smith	Closed	06/07/26:Close - Presented	Jun-26
LNPB-003	11/05/2026	INT Workstreams	Clarify responsibilities and expectations for operational, clinical and programme leadership roles across workstreams	Beckie Burn / Laura Jenner	Closed	06/07/26: On the agenda 11/05/26: Draft role expectations being developed for review at next meeting	Jun-26
PEG	02/02/2026	UEC Improvement Programme	Share presentation slides and continue engagement discussions with Primary Care representatives	Rochelle Scott Ashley O'Shaughnessy Laura Jenner	Ongoing	06/07/26: Close from tracker. The UEC work is feeding into the Frailty workstream and may also contribute to the Left Shift workstream. Discussions progressing outside formal LNPB meetings	Jun-26

South East London Integrated Care System

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Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 13
Enclosure 10

Title:	**Primary Care Group Chairs Report**
Meeting Date:	23 July 2026
Author:	Chima Olugh, Neighbourhood Development Manager
Executive Lead:	Ceri Jacob, Place Executive Lead

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

Summary of main points:

The following item were discussed at the May and July 2026 Primary Care Group meetings:

1. General Practice Variation and Resilience.

General practice across South East London is under sustained pressure from rising demand, constrained workforce capacity and challenges within the GP partnership model.

There is significant variation across practices in access, experience and outcomes, with a need to better distinguish warranted variation linked to population need from unwarranted variation requiring action.

SEL ICB has developed a structured methodology and tiered sustainability support model to identify variation, align support and apply contractual levers proportionately where required.

2. Primary care service development funding 2026/27.

The 2026/27, Lewisham's Primary Care Service Development Funding allocation was proposed to be used for a combination of borough-specific priorities and South East London-wide initiatives where collaboration is expected to reduce duplication, improve consistency and secure better value for money.

The total allocation for Lewisham is £675,000.00.

The proposals are expected to contribute to reducing health inequalities by supporting digital inclusion, improving consistency across primary care services,

	strengthening social prescribing coordination, and enabling more targeted support for practices and communities with identified needs. The proposals are also intended to support improved access, better integration and more proactive community-based care. **3. 2026 GP Patient Survey Results – SEL Integrated Care System.** The GP Patient Survey (GPPS) is an annual England-wide survey, providing data about patients' experiences of their GP practices. The survey covers a range of topics and provides a snapshot of patient experience at a given time.
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	Noe

Recommendation:	The Lewisham Local Care Partners Strategic Board is asked to note the report.

1. General Practice Variation and Resilience

- The Group received a paper on **General Practice Variation and Resilience** that was taken to the SEL Integrated Care Board.
- The paper outlined variation within access, experience and outcomes across general practice, drivers for variation and broader sustainability challenges and the proposed SEL-wide support and oversight model.

- General practice across South East London is under sustained pressure from rising demand, constrained workforce capacity and challenges within the GP partnership model.

- There is significant variation across practices in access, experience and outcomes, with a need to better distinguish warranted variation linked to population need from unwarranted variation requiring action.

- SEL ICB has developed a structured methodology and tiered sustainability support model to identify variation, align support and apply contractual levers proportionately where required.

- Even with sustained action to reduce unwarranted variation, demand for general practice services is rising at a greater rate than capacity increases. As demand for care grows, the ICB needs to consider how to support an effective balance between convenient access and continuity of care within general practice.

- This will require the ICB to think about general practice access through a broader lens that considers utilisation, effectiveness and equity. It may also require bravery to explore alternative access models for people with lower health need who value convenience and speed over continuity of care.

- his work needs to be taken forward through a multi-disciplinary approach that brings together place leadership, strategic commissioning expertise, end to end care pathway specialism and primary care leadership.

2. Primary care service development funding 2026/27

- The Group was asked to endorse the proposed use of the 2026/27 Primary Care Service Development Funding (SDF) allocation and the intended focus on transformation, sustainability, integration, workforce resilience, digital enablement and reducing unwarranted variation across Lewisham primary care.

- For 2026/27, Lewisham's Primary Care Service Development Funding allocation is £675,000. The proposed programme commits almost the full allocation to a combination of borough-specific priorities and South East London-wide initiatives where collaboration is expected to reduce duplication, improve consistency and secure better value for money. A small residual balance remains unallocated to allow for final adjustments as proposals are confirmed through governance.

- The proposed areas of investment include continued digital transformation support, practice sustainability, flexible staffing arrangements, clinical leadership, social prescribing, neighbourhood management capacity, Fractional Exhaled Nitric Oxide coordination, and system-wide workforce development.

- Together, these proposals are designed to support general practice to meet current contractual requirements, improve service resilience, strengthen the role of primary care within Integrated Neighbourhood Teams, and support a more consistent patient experience across Lewisham.

- Key investment themes include maintaining dedicated digital change capacity to help practices embed digital tools and improve access routes; supporting borough and South East London-wide digital assurance and data capability; providing universal and targeted support to practices where operational,

workforce, access or quality risks are identified; and continuing flexible staffing arrangements to support workforce resilience and continuity of patient care.

- The funding will also support the further development of neighbourhood working, including scoping proposed neighbourhood management roles and strengthening communication and coordination between primary care, community services, social care, public health and voluntary sector partners. These proposals will be developed through partner engagement before any final implementation decisions are made.

- Clinical leadership remains a central priority. The proposed allocation would support dedicated primary care clinical leadership for neighbourhood development, Integrated Neighbourhood Team delivery, primary and secondary care interface work, pathway development, and wider transformation priorities. The programme also includes support for leadership development and the continued strengthening of a coherent primary care voice across Lewisham.

- The proposals are expected to contribute to reducing health inequalities by supporting digital inclusion, improving consistency across primary care services, strengthening social prescribing coordination, and enabling more targeted support for practices and communities with identified needs.

- The proposals are also intended to support improved access, better integration and more proactive community-based care.

- All allocations will be subject to proportionate governance and assurance.

The Group endorsed the plans for the use of the Primary Care SDF allocation for 2026/27.

3. 2026 GP Patient Survey Results – SEL Integrated Care System.

- The GP Patient Survey (GPPS) is an annual England-wide survey, providing data about patients' experiences of their GP practices. The survey covers a range of topics and provides a snapshot of patient experience at a given time.

- In SEL Integrated Care System, 113,295 questionnaires were sent out, and 20,437 were returned completed. This represents a response rate of 18%.

- A detailed summary of the 2026 SEL ICS survey results can be found here - **GP patient survey 2026**

South East London Integrated Care System

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Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 13
Enclosure 10

Title:	**Lewisham Medicines Optimisation and Prescribing (LMOP) Chair's Report**
Meeting Date:	**23 July 2026**
Author:	Dr Taj Singhrao & Helen Magnusen Baker
Executive Lead:	Ceri Jacob, Place Executive Lead (Lewisham)

Purpose of paper:	To provide the Board with an update on key activities of LMOP	Update / Information	*x*
		Discussion	
		Decision	
Summary of main points:	• LIMOS Annual Report • Generic Dapagliflozin Local Enhanced scheme launch • MOT Prescribing budget • 102% achievement of QIPP at Month 11 2025/26 • Lidocaine Deprescribing resources approved		
Potential Conflicts of Interest	**None**		
Any impact on BLACHIR recommendations	**None**		

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

	Equality Impact	N/A
	Financial Impact	N/A
Other Engagement	Public Engagement	Lewisham Healthwatch invited to meeting
	Other Committee Discussion/ Engagement	N/A

Recommendation:	To note this report.