Lewisham Local Care Partners Strategic Board
Date: 25 July 2024, 14.00-15.45 hrs
Venue: MS Teams (meeting to be held in public)
Chair: Vanessa Smith

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, declarations of interest, apologies for absence & Minutes of the previous LCP meeting held on 30 May 2024 (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**				14.05-14.10 5 mins
3.	**PEL (Place Executive Lead) Report**	Enc 3	Ceri Jacob	To Note	14.10-14.20 10 mins
	Delivery (Lewisham priority 1)*				
4.	**Integrated community based care** • **Fuller review** • **Waldron**	Enc 4	Laura Jenner	For Discussion	14.20-14.45 25 mins
5.	**Older people's business case/Board and next steps**	Enc 5	Kenny Gregory	For Endorsement	14.45-15.05 20 mins
6.	**BCF (Better Care Fund) 2024/25**	Enc 6	Amanda Lloyd	For Endorsement	15.05-15.15 15 mins
	Break				15.15-15.20 5 mins
	Governance & Performance				
7.	**Risk Register**	Enc 7	Ceri Jacob	For Discussion	15.20-15.30 10 mins
8.	**Finance update**	Enc 8	Michael Cunningham	For Discussion	15.30-15.40 10 mins
	Place Based Leadership				

9.	**Any Other Business**		All		15.40-15.45 5 mins
					CLOSE
10.	**Date of next meeting (to be held in public):** • **Thursday 26 September 2024 at 14.00 hrs via Teams**				
	Papers for information				
11.	**Minutes/Updates from:** • **Primary Care Group Chairs Report (June 2024) (Enc 9 *plus appendices 1-5*)** • **Integrated Quality & Performance Group (IQ&AG) (08/03/2024) (Enc 10)**				

***Lewisham priority 1 – to strengthen the integration of primary and community-based care**

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 30 May 2024 at 14.00 hrs

via MS Teams

Present:

Tom Brown (TB) (Chair)	Executive Director for Community Services (DASS) LBL
Anne Hooper (AH)	Community Representative Lewisham
Dr Catherine Mbema (CMb)	Director of Public Health, LBL
Ceri Jacob (CJ)	Place Executive Lead (PEL) Lewisham
Dr Helen Tattersfield (HT)	GP, Primary Care Representative
Fiona Derbyshire (FD)	CEO Citizens Advice, Voluntary Sector Representative
Dr Prad Velayuthan (PV)	Chief Executive One Health Lewisham
Pinaki Ghoshal (PG)	Director of Children's Services, LBL
Vanessa Smith (VS)	Chief Nurse, SLaM
Barbara Gray (BG)	VCSE representative, KINARAA
Michael Kerin (MK)	Healthwatch representative

In attendance:

Lizzie Howe (LH)	Corporate Governance Lead, Lewisham, SEL ICS (Minutes)
Michael Cunningham (MC)	Associate Director Finance, SEL ICS

Laura Jenner (LJ)	Director of System Development, SEL ICS
Yvonne Davies (YD)	CBC Development Manager, SEL ICS
Charles Malcolm-Smith (CMS)	People & Provider Development Lead, SEL ICS
Folake Jacobs (FJ)	SEND Designated Clinical Officer
Chima Olugh (CO)	Neighbourhood Development Manager, SEL ICS
Corinne Moocarme (CM)	Assistant Director Community Support & Care, SEL ICS
Reinhild Onuoha (RO)	Head of Integrated SEND Services, CYP
Paul Creech (PC)	Senior Commissioner, CYP

Apologies for absence:

Neil Goulbourne
Kenny Gregory
Ashley O'Shaughnessy
Sabrina Dixon

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 14 March 2024** Tom Brown (Chair) welcomed everyone to the meeting. The meeting was agreed as quorate. TB advised attendees of the Housekeeping rules. Laura Jenner was introduced as new Director of System Development for the SEL ICS based in Lewisham. <u>Declaration of Interests</u> – There were no new or amended declarations of interest. Apologies for absence were noted as detailed above.	

	Minutes of the Lewisham LCP Strategic Board meeting held on 14 March 2024 – these were agreed as a correct record. Action log – updated. **The LCP Board approved the Minutes of the meeting held on 14 March 2024.**	
2.	**Questions from members of the public** The Board noted that no questions had been received in advance from members of the public for today's meeting.	
3.	**PEL (Place Executive Lead) report** Ceri Jacob presented the agenda item. The PEL report was taken as read. CJ thanked MK for his tenure as co-chair for the last year. Rotation of chair and co-chair noted. Vanessa Smith will now pick up tenure as co-chair with Tom Brown. The new Lewisham LCP Board ToRs (Terms of Reference) were ratified at the last (April 2024) ICB Board meeting. Waldron Health Centre development is part of a wider vision for community care and neighbourhood working. Work is underway to reconfigure the ground floor utilising funded secured from NHS England. There is a dedicated programme board and three task and finish groups. CJ requested LJ/CMS to provide a more detailed update at the next meeting *(LH noted for Forward Planner)*. A review of progress to date against the Fuller Report is being carried out and will be reported on at the next LHCP Strategic Board. This work aligns with work across SEL ICB to ensure progress is being made. TB queried the Waldron LIFT costs and if there was a way to incentivise greater utilisation of the centre? CJ advised the service	

	model review task and finish group is considering this as part of their work. The existing PFI agreement will end in the next few years. BG commented on contracts for organisations to deliver services, access to space and issues booking rooms. Reception and "pop up" space will be on the ground floor. Can space for black led VCSE organisations be accommodated? CJ advised space is available for free for VCSE groups, CMS to take away the suggestion with LJ. CMS commented that the Waldron has a community engagement workstream to ensure ground floor workspace does meet the needs of the community. He can add more detail in the report coming back to the Board. CJ noted that the LHCP Strategic Board is a sub-committee of the ICB Board and therefore any changes to the TORs need to be ratified by the ICB Board. The TORs can be kept under review to ensure recent changes, including inclusion of black led VCSE representation, has the anticipated impact. **The Lewisham LCP Board noted the PEL report.**	**CMS/LJ**
4.	**SEND assessment framework** Reinhild Onuoha and Paul Creech from the CYP (Children & Young People) team presented the agenda item. Slides shared on screen. Background to the paper given to the Board. RO presented first to the LCP Board. The new inspection framework is very different to the old one. It is a large inspection framework. Focus is very much on all partners involved and a strong focus on leadership. Inspection for Lewisham is imminent. Last inspection was undertaken using the old system. The 11 inspection questions/criteria were noted. New emphasis on children and communities. Areas of strength and improvement were noted. PC detailed the areas where there are strengths. Services across the ICB will be looked at. Expansion of special schools taking place. 99% Lewisham special schools have a good or outstanding	

	Ofsted rating. Lewisham All Age Autism Strategy and Support Service has been launched. Areas for improvement include EHCNA performance targets; work is underway for improvements. PC detailed the slide on leaders and strengths. More work can be done on engagement and the team is looking to work to reduce health inequalities. Multi-agency panels provide a good opportunity for joint working. LGT (Lewisham & Greenwich NHS Trust) children's community services rated as outstanding. <u>Improvement</u> Finalise development of SEND multi-agency dashboard Engagement and feedback with parents, carers and young people RO stated there were a lot of strong areas across the partnership. PG emphasised it is an area inspection not an LA (local authority) one. There will be a need to show the partnership approach. Number of children identified as special educational needs has increased significantly over the last few years both locally and nationally. CJ acknowledged all the work to ensure partners are around the table. With regards to workforce capacity and retention, how much is a Lewisham issue or a general one? PC noted that in health services, community paediatrics and SALT (Speech and Language Therapies) are under pressure. The Trust is trying to fill the gaps and recruit. It is a national problem and not just Lewisham. AH noted the addition of 280 places over next few years. RO said it would be over 300 places created over the last few years, but all places are taken. As soon as additional SEN capacity is created, it is filled. LBL offer more local choice and control and aim to keep children in the community.	

	SP said they should recognise the challenges of workforce when they do the inspection, queried non-doctors taking the roles and asked if there is supervision and someone to oversee them? RO noted that two neighbouring boroughs increased salaries but that it does not solve the issue and there is a desire to avoid a funding race across the boroughs. It is about what can be offered in Lewisham that is innovative and encourages people to work here. Supervision, working in a team with the doctors. Clinical supervision would be there. Can use other staff for drop in centre help and advice. **The LCP Board noted the SEND assessment framework.**	
5.	**Lewisham Five Year Forward View 2024/25 Refresh** Ceri Jacob presented the agenda item. Background to the item given. There was a national requirement for ICBs to update their 5 year forward view plans. As part of that, the six SEL Places have updated their local 5 year plans. There are no changes to the original proposal. The update provided some information on progress and priority actions for this year. On p. 35 Lewisham priority objectives were highlighted. BLACHIR incorporated as part of tackling health inequalities. On p.38 onwards some successes noted from 2023/24. Other parts of the report taken as read. Older People's proactive care programme should be finalised and approved by the end of June. UEC (Urgent & Emergency Care) programme should also be approved in the coming month. Integrated neighbourhood networks links to the Fuller work. As part of implementing the Fuller recommendation for same day urgent care, there is a need to reprocure the 111 service. This is driving the timeline for this area of the Fuller response. TB gave a reminder to attendees that the meeting was being held during a time of pre-election sensitivity (the period between notice of an election and the election itself).	

	HT commented on primary care inclusion, aims are good but solutions are in the Trust. Primary Care feels excluded. HT also commented on extra monies. CJ responded that primary care is recognised, e.g. hypertension. Will be others to follow linked to LTC (long term condition) management. Neighbourhoods build out from the PCNs. A number of areas such as older people and hypertension will need primary care if they are to be delivered. TB noted HT points. PG noted that there is not much emphasis on the anticipated impact and outcomes for residents. CJ said she was happy to look at this and see if this could be more clearly articulated. She reminded the group that this was not a new document and had been previously approved by the LHCP Strategic Board. MK mentioned that the public engagement section of the cover sheet said "N/A" but that there was a need for systematic public engagement and plans for feeding back to the public. CJ responded that the document was issued over a year ago and that there had been engagement then. This reviewed version had not fundamentally changed except to provide some updates on progress. AH noted the enablers; workforce, digital, estates and finance. People and communities are also an enabler in Lewisham. Need to reduce health inequalities. Missing an opportunity to show we really engage with communities. CJ advised she would look at that. VS said she felt this was an opportunity to strengthen expectation of mental health services and how they can contribute to the outcomes. CJ agreed to pick up with VS outside of the meeting. LJ said she would pick up with HT on her points. **The LCP Strategic Board endorsed the Lewisham Five Year Forward View 2024/25 refresh.**	

6.	**HIU (high intensity user) contract award notification** Yvonne Davies presented the agenda item and gave the background to the agenda item. Had previously been to a Part II LCP Board meeting to manage a COI (conflict of interest). The contract has been awarded to OHL and is now in the mobilisation phase with a go live date of 1 July. It is a two years 9 months contract. OHL are the incumbent provider. **The LCP Board noted the HIU (high intensity user) contract award notification.**	
7.	**Health & Wellbeing Charter** Charles Malcolm-Smith presented the agenda item and gave the background to the item. Noted the People's Partnership had reviewed this and the Healthier Communities Select Committee. It will be approved by the Health and Wellbeing Board prior to further engagement with the public. TB noted it was shaping into a very good document and commented on what professional access should look like. AH said it was a very good document. It had been to the Peoples Partnership three times and she hoped the HWB Board would approve it. CMb the HWB Board is due to be held on the 24 July. **The LCP Board endorsed the Health & Wellbeing Charter.**	
8.	**People's Partnership update** Anne Hooper presented the agenda item. The People's Partnership had been formed a year ago and is a long term endeavour. The partnership had reviewed their progress and what was being achieved in terms of engagement.	

	Highlights of the review included that, public engagement is complex and there is still have some way to go, that the work is valued, the importance of the VCSE. Also that work is not always co-ordinated and information is in organisational silos. Access to primary care remains a major issue for people although this does vary across the borough. It was noted that a lack of reimbursement is making it harder for people to engage. A draft action plan in Year 2 as to how the People's Partnership can respond to those issues and have a more co-ordinated approach has been developed. A hub and spoke model of engagement is proposed. Bring co-ordinated effort to engagement. Outcomes framework agreement needed. Feedback from primary care would be beneficial. Proposal is to continue discussions across the sector and communities and to bring an update back to a future Board meeting. SP commented on the will and integration going forward, how does primary care engage with this. Noted links with PCOG (Primary Care Operational Group) and the provider structures. AH advised that there was no primary care representative at the current time and agreed to discuss with SP outside of the meeting. CJ commented on the focus needing to be on system intentions and the Lewisham 5 priorities. PCN engagement is also important. CMb said it was a great report, noted the reimbursement comment, agreed policy across the organisations would be helpful. **The LCP Board noted the People's Partnership update.**	
9.	**Corporate Objectives** Laura Jenner & Chima Olugh presented the agenda item. LJ spoke about improving the uptake of immunisations, screening and SMI health checks and improvements for hypertension. Health checks have made good progress. Hypertension work is on-going. Screening	

	concentrated on breast and cervical cancer and campaigning work has been taking place. CO said achievement of the objectives is key as they lead to better patient outcomes and help them stay healthier for longer. On p.101 hypertension recently launched project working with 2 x PCN's, optimise blood pressure work locally. On p.102 serious mental illness, there is a joint plan with SLaM and the ICB. Local work with primary care colleagues and the health innovation network work is underway to look at the data for where elements sit if checks are undertaken elsewhere. Cancer screening work noted across the three different programmes. Figures for uptake are low at the moment. Outreach activities noted. Population health data mentioned to look at where uptake is low for certain conditions. CMb noted inequalities and screening and immunisations work. Difficult to get certain parts of the population to take the immunisations. Childhood immunisations for measles and whooping cough, there are cases at the moment. TB commented on trust in the community and the ongoing impact of work during COVID. Overlap in the populations not accessing immunisations or screening noted. HT wondered if the Peoples Partnership could help with this messaging. Local outbreak causes people to rethink the need for vaccinations. Needs to be dealt with nationally and in the media as well as through local work. PG said the data on childhood immunisations was quite startling. There is a poverty dimension to this as well. Lewisham indicators are on a downward trajectory compared to Greenwich. What is our plan? CMb trend for geographical spread, identical to covid 19 vaccination uptake. Tend to follow the Lambeth/Southwark pattern. Trust building is key. Need to get communities on board and to trust us. Really important backdrop. Links to the Peoples Partnership noted.	

	PG emphasised Greenwich trend, more than just the population compared to Lewisham. Any learning points for us. Noted it is not about access or sights where vaccinations take place. It is about engagement and trust. Social media conversations impact significantly on people's views and there is a need to develop a plan to counter this. An existential challenge to tackle the misunderstandings about vaccinations. Need to be honest about the risks, e.g. Measles and Mumps. CJ acknowledged it was difficult. Peer pressure, covid and non-vaccination, need peer championing. Access points are irrelevant if we do not tackle this and join the messages up. Staff, we are huge employers. Staff vaccination numbers are reducing. Schools can be used to tap into family members. MK agreed with CJ comments about engaging with a whole raft of community groups and interests. Campaigns cannot be done through one route. Professionals have played a part in building trust and community/religious leaders. Healthwatch keen to support efforts to reach out to parts of the community. Agreed on the staffing point and reinforcing the message on vaccinations. VS said there had been an impact on staff of Covid vaccinations being a condition of employment at one point. Challenges are not unique to mental health though. **The LCP Board noted the Corporate Objectives update.**	
10.	**Provider Selection Regime (PSR) update** Corinne Moocarme presented the agenda item. CM updated on changes to the procurement for health care services only. Change is to procurement regulations from 1 January 2024. Services must be of high quality and appropriate to our patients needs and comply with our legal obligations where direct award is used. The regulations relate to health and care services only.	

	Significantly different to previous regulations. Additional ways we can award contracts to providers but additional checks and balances and a threshold when the regime would apply. CM detailed the now four processes on p. 113. Governance requirements noted. Bidders can make representations if they are not chosen. A panel will be convened. ToR for existing groups will be amended. YD commented on the flowchart outputs both say no in the document. Arrow alignment noted. CM will advise KG to amend this. AH commented on evaluation criteria on what weighting is to be given, it is not stated? What value would be given to those engaging with the evaluation and taken into account. MK said the procurement process is not always clear where public engagement fits in and agreed with AH point about the weighting. Need to have openness and transparency on what it is. Award to existing people but ICB want greater VCSE provider involvement. How would that affect the flow chart? CM said could build that challenge in at the early stages. This would be at the SMT meeting stage. Evidence of having explored other routes for example. Want to avoid representations later on. All procurements are visible on the portal. BLACHIR meeting, discussions with BG about access to the portal for the VCSE sector. CJ emphasised quality and then access, can come up with a standard approach and take it to the People's Partnership. **The LCP Board noted the PSR (provider selection regime) update and agreed the changes to the LCP governance structure that oversees the procurement decision making process.**	**LJ**
11.	**Risk Register** Ceri Jacob presented the agenda item. New risks noted. Had looked at the differences across the six Places and also looked at alignment.	

	A new risk relating to Tower Hamlets LA placements to Pentland House noted. EHCP assessments score has improved. Mental health long term trajectory score has not improved. TB queried the mental health targets, any signs of improvements? CJ updated a range of work was underway working closely with SLaM (risk 334). CJ also updated on additional male ward beds in Lewisham. Community work underway as well. TB said he looked forward to more detail at a future meeting. CJ commented on risk rotation at the next Extended SMT. **The Board noted the Risk Register update**	
12.	**Finance update** MC presented the agenda item. MC updated on the outturn financial report for 2023/24. All figures are subject to audit, based on draft accounts at present. ICB delegated budget year-end position achieved an underspend of £36k compared to the target control total. This enabled the borough to meet its delegated budget responsibilities . Material cost pressures on prescribing and CHC were successfully managed in a very challenging year. However this was not achieved on a recurrent basis. Non recurrent measures for 2023/24 were relied on, and the £1.2m deficit underlying position needs to be addressed for 2024/25. ICB surplus of £46k, ICS deficit of £77.5m against a break even plan. £128m of non-recurrent flexibility applied. Key drivers are under delivery of efficiencies, industrial action and unplanned costs in using independent sector to clear waiting lists and back logs. LA Adults and Children's services overspend noted. 2024/25 budget is in the final stages of ICB governance. Challenging more than last financial year.	

	Current plan shows £146m over spend for 2024/25, NHSE expectation is we need to reduce that to under £100m. **The LCP Board noted the finance update.**	
13.	**Any Other Business** No items raised. Meeting closed 16.11 hrs.	
14.	**Date of next meeting.** Thursday 25 July 2024 at 14.00 hrs via Teams	
15.	**Minutes of previous meetings** TB noted the documents attached for information.	

Lewisham LCP Strategic Board Action Log 30 May 2024

Date of meeting & agenda item:	Action:	For:	Update:
30/05/2024 (3). PEL (Place Executive Lead) report	*Waldron - BG commented on contracts for organisations to deliver services access to space issue and booking rooms. Can space for black led VCSE organisations be accommodated. CMS to take away the suggestion with LJ.*	**CMS/LJ**	
30/05/2024 (10). Provider Selection Regime	*ToR for existing groups will be amended.*	**LJ**	

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 3
Enclosure 3

Title:	**PEL Report**
Meeting Date:	**25 July 2024**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

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

Summary of main points:

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

Tri-borough UEC Board
Lewisham LHCP have a well-established Urgent Emergency Care (UEC) Board that has representation from across the local system and is co-chaired by LGT and the LHCP. The Board has an agreed recovery plan that spans four main areas:

- Admission avoidance
- The front door of the Emergency Department
- Flow of patients through the hospital
- Discharge

Each of these areas is delivered through a dedicated working group that reports into the Lewisham LHCP UEC Board.

In consultation with colleagues from Bexley and Greenwich it has been agreed to merge the Lewisham UEC Board with the Bexley and Greenwich Board as this will allow increased sharing of good practice, reduced duplication of effort and governance and consistency in processes where this is felt to be beneficial to local people. The new tri-borough UEC Board will be chaired by the LGT CEO. The recovery plans of the three Places will reflect the four areas noted above. In Lewisham this means the four working groups will continue but the Lewisham UEC Board will cease to exist.

Community Dermatology Service
At the meeting of on 25 June 2024, the Lewisham LHCP Senior Management Team (SMT) approved direct award of the Community Dermatology Service to One Health Lewisham (OHL). The award was made under the Provider Selection Regime regulations and the decision was taken to ensure OHL were providing the

	service under a clear contract. The contract is fixed term until April 2025. During this time, the Lewisham LHCP will enter a formal process to procure a new Community Dermatology Service with a go live date of April 2025. **Lewisham LHCP 5 Priorities** In October 2022, Lewisham LHCP agreed 5 key strategic priorities. These were drawn from the priorities of local partner organisations and were identified as areas where most progress could be made by working collaboratively at a local Place level. The 5 priorities also fit within the priorities of the SEL ICS: • Collaborative working, encompassing neighbourhood development, UEC, mental health, older people and LTCs • Reducing health inequalities • CYP and Family Hubs • Workforce welfare and employment opportunities for local people • Financial sustainability Progress is overseen by the Place Executive Group (PEG) and updates are provided to the LCHP Strategic Board at least once a year. It has been agreed that in future to provide better oversight of progress against the priorities to the Board, agendas will be themed to reflect one of the 5 priority areas on a rolling basis. The aim is to provide a rounded view of work taking place to progress each priority and to provide an opportunity for challenge and support from local LHCP partners.
Potential Conflicts of Interest	**None**
Any impact on BLACHIR recommendations	The work of the UEC Board and the dermatology re-procurement will explicitly reference and take account of the Opportunities for Action identified in the BLACHIR report. The second LHCP priority is addressing health inequalities. The response to the BLACHIR report is integrated into this priority.

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

	Equality Impact	NA for this paper
	Financial Impact	NA for this paper
Other Engagement	Public Engagement	NA for this paper although engagement will take place at a programme level for each of the areas covered.
	Other Committee Discussion/ Engagement	NA
Recommendation:	The Board is asked to note this update.	

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 4
Enclosure 4

Title:	**Fuller updates including the Waldron project**
Meeting Date:	**25 July 2024**
Author:	Laura Jenner
Executive Lead:	Ceri Jacob

Purpose of paper:	The Report outlines the System Achievements with Implementing the Fuller Report and highlights the achievements within the Waldron space. The report highlights next steps needed to be taken.	Update / Information	*X*
		Discussion	
		Decision	

Summary of main points:

Introduction
The Fuller Report outlines key recommendations for transforming primary care and integrated community services. This report details the main recommendations of the Fuller Report and highlights how Lewisham is implementing these strategies to improve healthcare delivery and outcomes.

Main Recommendations of the Fuller Report
1. **Enhancing Access to Primary Care**
Recommendation: Improve access to primary care services, particularly urgent same-day care, to reduce pressure on emergency departments and ensure timely care for patients.

Lewisham's Implementation:
Lewisham has introduced a same-day urgent care approach to enhance access to general practice. This initiative ensures patients receive timely care, thereby reducing the burden on emergency services.

We have plans in place to further improve the offer and support people who attend Lewisham A&E who don't require emergency care to be redirected to more appropriate support (see slide 3, 4).

2. Implementing Integrated Neighbourhood Teams
Recommendation: Establish Integrated Neighbourhood Teams (INTs) to deliver coordinated, community-based care. These teams should include primary care, social care, mental health, and voluntary sector services.

Lewisham's Implementation:
Significant progress has been made to enhance the effectiveness of the Multi-Disciplinary Team (MDM) meetings, and the teams are actively working on

implementing proactive case finding. However, further efforts are needed to fully understand the system resources and commitment required to develop the teams beyond the MDT meetings.

3. Strengthening Long-Term Conditions (LTC) Pathways
Recommendation: Develop robust pathways for managing long-term conditions, ensuring continuity of care and proactive management of patients with chronic illnesses.

Lewisham's Implementation:
Lewisham is developing a robust, integrated pathway for Long-Term Conditions (LTC) within the Neighbourhood Model. This initiative ensures continuous and comprehensive care for patients with chronic conditions, enhancing their health outcomes and quality of life. Progress has already been made with a coordinated approach to diabetes care, and we are now expanding this model to address hypertension. This effort includes funding several Black-led voluntary organisations.

Additionally, we are collaborating with Health Inequalities Fellows to create proactive and strong pathways for cardiovascular disease (CVD), furthering our aim of reducing health inequalities in the community.

4. Fostering Strong Partnerships
Recommendation: Build strong partnerships across the healthcare system, including primary care, secondary care, social care, and the voluntary sector, to create a seamless care experience for patients.

Lewisham's Implementation:
Focussing on Neighbourhood Three to identify local challenges and adopting an integrated way of working to address these – taking the learning and scaling across the borough. Joint-funded two roles In Neighbourhood Three, Health Coach and Lead Social Prescriber, establishing a community café to provide the setting for proactive care.

Extending models of personalised care through the Social Prescribing Personal Health Budget scheme. This has provided training for Social Prescribing link workers and focuses on what matters most to the patient.

Working in close partnership with the local community to build a vibrant community space on the ground floor at the Waldron. Groups and activities have been running in the community space over the last 2 years, supported by the NLPCN Community Development Worker. Now creating a timetable of activities in the refurbished community space, to start from August.

Two new Waldron Navigator roles have been created (employed by NLPCN). They are the welcoming face of the Waldron, providing signposting to activities and supporting the coordination of activity in the new community space (see slides 6-11).

5. Developing Population Health Approaches
Recommendation: Implement population health management strategies to address health inequalities and improve health outcomes for the entire community.

	Lewisham's Implementation: Lewisham has actively built and developed its Population Health (POP Health) Team and approach. The team are supporting several proactive care projects in Lewisham including the Waldron project, which is outlined in the slides attached (see slides 20-34). **6. Utilising Programme Management Office (PMO) Approaches** Recommendation: Employ PMO approaches to manage and oversee the implementation of these changes effectively, ensuring accountability and continuous improvement. **Lewisham's Implementation:** Lewisham is building on the PMO approach in collaboration with Lewisham and Greenwich NHS Trust (LGT). This collaboration ensures that the implementation of new initiatives is well-coordinated, monitored, and refined over time.
Potential Conflicts of Interest	
Any impact on BLACHIR recommendations	

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

	Equality Impact	Completed
	Financial Impact	
Other Engagement	Public Engagement	The programme is being co-designed, and community-led, via several avenues: The People Partnership The Waldron community steering group The Health Inequalities Fellows programme
	Other Committee Discussion/ Engagement	

Recommendation:	Lewisham is actively implementing the key recommendations of the Fuller Report through various strategic initiatives. By enhancing access to primary care, establishing Integrated Neighbourhood Teams, strengthening LTC pathways, fostering strong partnerships, developing population health approaches, and utilizing PMO strategies, Lewisham is starting to make impact.

However, efforts are necessary to strengthen the Integrated Neighbourhood Teams (INT) beyond the MDM meetings and to enhance our Long-Term Condition (LTC) pathways. This will support individuals holistically and help reduce health inequalities in Lewisham. As the programme goes into its next phase, it is crucial to develop a benefits and savings framework, and elevate the work. This will enable partners across the system to understand the programme's impact comprehensively.

South East London Integrated Care System

NHS South East London

Lewisham Fuller Stocktake

DRAFT v0.12

18th June 2024 : Fuller Implementation Group

Fuller Programme Governance

- Strengthening the integration of primary and community-based care
- Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services
- Addressing inequalities throughout Lewisham health and care system
- Maximising our roles as Anchor Organisations, being compassionate employers and building a happier, healthier workforce
- Achieving financial sustainability

Action 1: Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices

→ Admission Avoidance Steering Group
→ SDUC working group
→ Bexley, Greenwich & Lewisham's Urgent Emergency Care Board

Action 3: Enable all PCNs to evolve into integrated neighbourhood teams,

Action 4: Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams

→ Integrated Neighbourhood Network Alliance
→ Long Conditions Forum

Action 5: Develop a primary care forum or network at system level

Action 12: Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods

→ Primary Care Operational Group

Action 6: Embed primary care workforce as an integral part of system thinking, planning and delivery.

→ Workforce Steering Group

→ Place Executive Group

Action 10: Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care

→ Estates Forum

Action 13. Work alongside local people and communities

→ The People's Partnership

→ Lewisham Health & Care Partnership

2024/25 Fuller Update: Progress against

Action 1: Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.

What was already in place

- GP Federation streaming and urgent care service at Lewisham Hospital UCC
- Urgent Community Response Service
- PCN Enhanced Access Service in place in line with national contract
- SELDOC managing OOH requests from 111
- ICB funded GP Home Visiting Service
- NHS ASK First App
- Delivering Integrated Hospital flow and discharge implemented through our system wide Home First Implementation Programme

Progress in 2023/24

- UHL Estates programme leading to full UTC implementation and procurement of UTC provider
- Same day urgent care approach (SDUC) agreed at Lewisham level by stakeholders
- Implementation of Single Point of Access with UCR and NHS@Home, improving interface between LGT and GP Federation.
- Care navigation and triage systems in general practice
- GP Home visiting service now funded by PCNs with specific focus on frailty
- Pharmacy First referral pathways to community pharmacy– Jan 24
- Direct access to urgent mental health support using 111*2
- SEL 111 re-procurement – develop local clinical assessment service in and out of hours
- Procurement of single APMS care home contract completed. Go-live 1/4/24
- Re-procurement of High Intensity User service. Go live 1/7/24
- Voluntary sector Bridge Café launched 1/9/22
- Rapid response service MH

2024/25 Fuller:

Action 1. Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.

lhcp Lewisham Health and Care Partnership

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Design a new integrated urgent care service model (including 111 and GP out of hours)	Ashley O'Shaughnessy Amanda Lloyd	September 2024	• Number of calls to 111 • Number of people booked into a GP appointment via 111 • Reduced numbers of type 3 to ED	• Current SEL 111 budget • EConsult software and hardware
Demand analysis and capacity modelling to enable 111 re-procurement	Amanda Lloyd Ashley O'Shaughnessy	September 2024	• ED attendance data • Primary care appointments • 111 data	
Refreshed public engagement /Primary care communication campaign to raise awareness of and attendance to new service model	Amanda Lloyd Helen Eldridge Ashley O'Shaughnessy	September-December 24 (subject to new service design and implementation)	• Type 3 attendances reducing • Primary care appointments booked via 111	• Will require additional resource to ensure a comprehensive campaign
Embed Pharmacy First referral pathways into community pharmacy.	Kapil Sadawana Erfan Kidia	April 2025	• Number of Community Pharmacy referrals • Number of people supported and diverted from a GP appointment • OTC ePACT data	• Rresources for training events/webinars on Pharmacy First. • Promotion of the Lewisham Pharmacy First and Pharmacy First Plus pathway • Embedding the Pharmacy First referral pathway into digital triage systems used by GP practices
Reduction type 3 attendance - Neighbourhood 2 pilot to explore Primary Care and Community opportunity	Ashley O' Shaughnessy Amanda Lloyd	April 2025	• Type 3 attendances performance reduced • Triage and navigation data –on how and where people are being diverted	• Investment into community services
Reduction of type 3 attendances –Agree and develop approach to reducing ED footfall from practices with high attends.	Amanda Lloyd Deeta Henry-Smith	September 2024	• ED attendance data • Increased No. of appts • To the Triage & Care Navigation • Increased number of people to HIU	

2024/25 Fuller Update: Progress against

Action 3: Enable all PCNs to evolve into integrated neighbourhood teams,

Population Health approach

To support the neighbourhood and Waldron work The PHM team have developed use case data statements to describe what stakeholders want to know and what action they will take. *E.g.; I want to know who is not having health checks and which of them are in the Core20PLUS x 3 and also have severe V5 levels. I will prioritize these people for health checks as the most in need. Our care coordinator will reach out and communicate to them based on their demographics to encourage them to attend and book an appointment to MOT them for a number of things at once*.

We have used a 3 step approach to support these statements:

1. Agreeing some conditions and risk groups to focus on
2. Adding on building blocks to process the question further – demographics / health inequalities & behaviour / encounters
3. Agreeing the output – what tools will be needed /operationalising how to use the data / tracking impact

Progress

- The PHM team have supported the Waldron Steering Group - to a deadline of 22nd May - to understand what data they need to provide a health needs assessment and inform how to best utilise the spaces in the Waldron and serve their population.

- To do this we have focused on risk groups and condition areas. Five conditions have been shortlisted.

- The aim is for services to work together better in the building – they don't necessarily need a clinical theme (or pop health data) to do that. Having a condition or risk group to focus on will help support this aim though.

- The Steering Group have a meeting on 19th June with the aim of working out how to take action from the data. The Steering Group will identify who can own and take forward actions from the data and who from the steering group is driving this / who the delivery owners are. The neighbourhood coordinators, MDMs and community development leads may be suitable delivery vehicles.

- Once this is agreed the PHM team can start to develop an agreed 1-3 areas in more detail. The PHM team can find the patients or hot spot geographical pockets as well as supporting the delivery owners on how to operationalise that data into everyday work and track the impact.

Next Steps

- Continue to support the Neighborhood One / Waldron working group to use the data to help design the intervention (see an example using Smokers for N1 on the next slide)
- As a blue print this could be rolled out to neighbourhoods 2,3,& 4 with additional conditions or risk groups considered.
- The CVD 4 condition work is already an agreed condition with delivery agreed through the Health Equity Fellows and CESEL.

2024/25 Fuller Update: Progress against

Action 3: Enable all PCNs to evolve into Integrated Neighbourhood Teams

Multidisciplinary Teams

Progress

Lewisham had a history of integrated neighbourhood working and as we delivered on the Fuller recommendations, we have a solid foundation on which to build.

Practice based MDMs:

- A comprehensive review of practice based multi-disciplinary meetings (MDMs) for complex patients was conducted in the second half of 2023. We are now implementing key findings: These include, adopting a more proactive approach to case finding and referrals, and placing greater focus on patient outcomes and measuring impact.
- Where gaps in membership or representation were identified, these have been followed up and largely resolved. There is ongoing work to develop a housing protocol which will address the unmet need around housing representation.
- Updates and recommendations were embedded in PMS contract and the Standard Operating Procedure for 24/25, with initial improvements to existing reporting mechanisms implemented.
- MDMs have helped to develop and improve working relationships across the borough by creating strong networks, they provide a solid foundation for further developing neighbourhood teams. The role of the neighbourhood coordinator has been central to the success of the MDMs, and they have established good relationships across organisations.
- In Q1 and Q3 of 2023 a total of 1203 cases were discussed at an MDM, however improved reporting and measuring outcomes are key priorities to progress.

Social prescribing:

- The on-going training, development and coordination across the PCN led social prescribing service has been a key focus. Improvements have also been made in raising awareness of the service and creating better links across the borough, including secondary care, to reduce demand in other areas across the system. Joy social prescribing platform was introduced in 2023 and provides easy and quick referrals in primary care to Social Prescribing Link workers.
- Opportunities to enhance and promote the creative health agenda have been successful and strong connections made with social prescribers. A personal health budget scheme has been piloted and extended.

Next Steps 2024:

- introduce a proactive system to improve MDM approach to case finding working closely with population health.
- Introduce key reporting outcomes for MDMs including the number of people being supported, changes made to care plans, preventions of hospital attendance etc.
- Work alongside the Mental Health Transformation programme to integrate Mental Health Community teams into Primary Care with mental health staff to attend MDTs and strengthen position within the INT.
- Introduce a new Integrated role which will provide holistic Frailty assessment and support, strengthening the offer in the neighbourhood.
- Continue to imbed the ARRS roles within the INT.
- Improve the joint working between District Nursing and the INT across the borough.
- Deliver on the actions identified in the MDM review including work to develop the housing protocol and improved governance and reporting.
- Understand the resource across the system to develop INTs to support residents in a holist and practice way

2024/25 Fuller Update: Progress against

Action 3: Enable all PCNs to evolve into Integrated Neighbourhood Teams

Health and Wellbeing hubs and Community Led interventions

Progress

- **Reimagining the Waldron:** The Waldron Health Centre in New Cross forms part of Lewisham's wider vision for fully integrated health & care services known as hubs. Working in close partnership with the local community we believe that the true potential of the Waldron can be unlocked to enhance health and wellbeing. Creating 5-day (the Waldron community space and some services are open 7 days) Health and Wellbeing hub with access to a wide range of healthily living and community support.

- **Neighbourhood Three pilot:** The Neighbourhood Three pilot is in progress with Sevenfields PCN, a N3 Stakeholder group has been convened to identify and deliver on local priorities based on data and engagement. The pilot also explores opportunities to break down organisational barriers and working across boundaries. The pilot is also joint funding two new roles, one to implement the community café to provide a setting for proactive care, and one lead social prescribing role

- **Hypertension:** A hypertension neighbourhood training model has been piloted to support non-clinical roles and community groups, and increase capacity and capabilities outside of traditional healthcare. The wider hypertension programme has been informed as a result of engagement, leading to a strong focus on community and Black led VCS organisations.

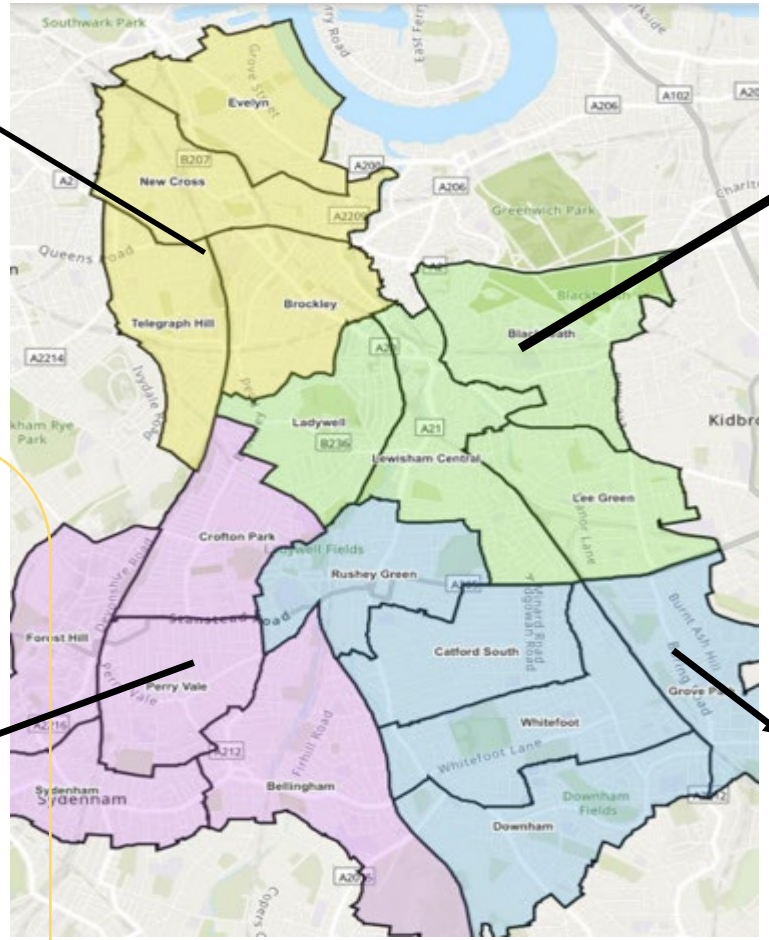
- **Health Equity Fellows:** are now embedded in each PCN and aligned to Health Inequalities Programme led by Public Health. The HEFs are partnering with community organisations and champions as well as PCN ARRS teams to support local priorities. Each PCN has taken a slightly different approach with many establishing health hubs. HEFs have created clinical, managerial and supervision capacity in primary care to prioritise health equity at a PCN level and begin to be embedded in the Neighbourhoods.

- **Other**: Population Health data has been used to target and invite people to immunisation education events, and a partnership wide immunisation group to support uptake held.
- Established the Prostate Cancer Support Role, delivered by Community Connections Lewisham. The role improves local pathways and is funded through SEL Health Inequality funding.

- **Next steps:**
- Implement the Hypertension business case workstreams with a key focus on working with VCSE group to reach most at risk population, aligning activity to the health equity fellow framework.
- Health equity fellow programme to be extended to include CVD.
- Continue development of the Waldron Health Centre redevelopment.
- LGT and North Lewisham PCN to develop a joint offer supporting people to manage diabetes.
- Launch the N3 community café and monitor impact.

Mapping partnership and innovation in the Neighbourhoods - examples

- Waldron Health Hub with NLPCN
- Multi Morbidity Clinics
- *North Lewisham Community forum brings the community together around a shared vision to address health inequalities in North Lewisham.*
- Lifestyle Medicine Clinic
- Mulberry, Young People's Mental Health Hub.



- Renal and Multi morbidities Pilot (TLCP PCN)
- Frailty Pilot (TLCP PCN)
- LTC Diabetes Framework with TLCP PCN

- APLOS/AfCD Community Health Project
- Health & wellbeing workshops
- Adolescent Mental Health clinic
- Primary Care Digital Hubs
- Caring Together in the Community, Modality partnered with Therapy 4 healing, a community led listening project
- Community Liver Clinic, early detection and diagnosis.
- Complementary Health Clinic, Modality and Therapy 4 Healing.
- PCN Lipid Hubs

- **Neighbourhood 3** - working together pilot (Sevenfields & Modality)
- SPIN fellow focusing on the core 20 plus 5 area of **early cancer diagnosis** with FIT screening uptake
- **outreach to the digitally excluded population** within the Sevenfields PCN area
- Community liver screening clinics run by Kings College Hospital from Goldsmiths community centre
- Community Hypertension Workshop with CESEL
- Outreach health checks, with health coaches and social prescribers.
- Mental Health Hub for Young People
- Goldsmith Community Café and health coach

lhcp Lewisham Health and Care Partnership

2024/25 Fuller:

Action 3. Enable all PCNs to evolve into Integrated Neighbourhood Teams

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Integrated Neighbourhood Programme Multi-Disciplinary Meeting Development Following Review of Practice based MDMs, Deliver on recommendations. Improve strategic oversight, operational processes and relationships. Establish model, for proactive and anticipatory approach and scale for MDMs e.g. adaptation of frailty dashboard and the CVD dashboard Link the HIU services to the MDMs to ensure people are being supported in an holist way	Fiona Kirkman Chima Olugh	December 2024 Sep 2024	• Enhanced reporting structures in place with ability to monitor performance • Cases of admission avoidance. • Identified options for measuring MDM outcomes (e.g. introduction of universal care plans) and on-going monitoring. No of people discussed and supported via the MDMs, No of people prevented from a hospital attendance • Number of care plans completed • Successful case finding tool • Monitoring patient cohort through MDMs • Number of people being supported by the HIU service and link to the MDM meeting	• Project lead required from end July 2024. • Resource required from CBC team. • Resource required from partners to develop a framework enabling commitment. • Resource required to review reports and on-going monitoring. • Population health team resource. • PCN resource to deliver pilot. • CCPL
Increase availability from Mental Health and the Voluntary sector	Fiona Kirkman	November 2024	• Update the DPIA to include several voluntary sector groups • Increase attendance from Primary Care mental Health and voluntary sector at the MDM meeting	• Implementation of the Mental Health community transformation programme

2024/25 Fuller:

Action 3. Enable all PCNs to evolve into Integrated Neighbourhood Teams

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Neighbourhood Three Partnership (learning from what works well and scaling up) **Neighbourhood Three Partnership** Joint funding ARRS roles (Health coach and lead Social Prescriber). Developing the N3 Steering Group Enable set up of health café, development of approach and evaluation.	Fiona Kirkman	August 2024	• Evaluation plan developed for health café and on-going review of agreed measures (e.g. at-risk individuals identified and invited, attendees at café) • Number of people proactively identified and referred to community café • Number of people attending the café and achieved agreed outcomes	• Funding secured for health café role. • Resource required from integrated neighbourhood programme.
Hypertension neighbourhood provision implementation Training within each neighbourhood to upskill non-clinical roles and community members to have effective conversations around hypertension, raise awareness of risk and signpost to seek further support. Incorporating recommendations from 'A Million Hearts and Minds-Kevin Fenton'. Funding to work directly with a VCSE organisation to prioritise those most at risk.	Johnathan Mclnerny	December 2024	• Numbers attended training • Improved confidence and knowledge measured through surveys • Increased opportunities for intervention. • Number of people supported to manage their Hypertension	• Funding secured through hypertension business case • Dependency on CESEL for delivery
Funding to support primary care to prioritise hypertension management.	Rachael Smith	August 2024	• Number of people identified via pop health • Number of people connect to attend the Waldron clinic space. • Increase numbers accessing smoking sensation services • Improve and increase early detection and treatment of CVD • Improved lipid management • Numbers of health checks completed • Number of medication reviews • Number of people connect with the community support	• Health checks, Smoking sensation, Pharmacy, LTC support all committing to work together in the Waldron space • The Health Inequalities funding – the Health Equity Fellows
Neighborhood One / Waldron working group to use the data to help design the intervention As a blue print that can be rolled out to neighborhoods 2,3,& 4 with additional conditions or risk groups considered. Using the pop health approach for CVD 4 condition and using the Health Equity Fellows and CESEL.as part of the delivery arm along with support from healthily living	Johnathan Mclerny Aaminah Verity	October 2024		

2024/25 Fuller:

Action 3. Enable all PCNs to evolve into Integrated Neighbourhood Teams

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Building Community Partnerships Improve integration, relationships and pathways. Develop Social Prescribing improvement plan. Joy Social Prescribing Platform, development of system and functionality. Linking data sets, improving quality of reporting Agree roll out to additional partners and development of new referral pathways.	Fiona Kirkman Fiona Kirkman Rachael Smith	December 2024 July 2024 tbc June 2024	Clearer pathways established for homecare provider across neighbourhoods Reduced number of issues on log for homecare providers Key metrics from Joy dashboard including: • Referrals to social prescribing. • Associated improved patient outcomes. • Reduced PT visits to primary care teams.	Resource from homecare provider teams to engage. IG support • Fuller coordination funding utilised. • Future funding to be secured. • Population Health analyst.
Using Neighbourhood data pack and delivery of deep dive engagement sessions within each neighbourhood to focus on local priorities and deliver on planned activity.	Rachael Smith, Fiona Kirkman	October 2024	• Agreed framework in place for regular data packs for each neighbourhood.	• Dependency on Population health for delivery • Resource required to plan and deliver engagement sessions
Co-designing Support Packs for Neighbourhoods, learning what works well with intention to scale up and interventions.	Fiona Kirkman,	September 2024	• Baseline measures identified for maturity of each Lewisham neighbourhood 'Team of Teams'	• Dependency on stakeholders capacity to engage, shape and develop collaboratively.
Development of the Waldron Community Space with stakeholders including the VCS to deliver on priorities for North Lewisham.	Fiona Kirkman	September 2024	• No of people attending the hub and accessing support • No of health checks provided	• VCSE Organisations providing activity. • 2 New ARRS Roles – Waldron Navigators for 24/5 • Community space provide free by ICB to VCS for use of space.

2024/25 Fuller Update: Progress against

Action 4: Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams

What was already in place

- Well Developed Governance structure in place to support the development of the Fuller recommendations
- The Peoples Partnership forum – Co-design with community
- Population Health Management programme in Lewisham – Neighbourhood Data packs produced for N3 and underway for N1 with N2 and N4 following. As stated earlier in this pack this will use a combination of demographics, health markers, conditions and encounters layered together to answer data statements that pull-out areas of interest to lead to action and consequence.
- Service design group – Waldron
- One public estate group
- Digital Delivery Group
- Clinical Effectiveness South East London programme underway

Progress in 2023/24

- Co-ordinated Protected Learning events for Primary Care Clinical and administration colleagues – CEPN
- Review N'hood programme of work and agree workstreams with key deliverables for the next year.
- Market place event planned for September 24 to highlight progress and continue to co-design models of care

2024/25 Fuller:

Action 4. Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Work with neighbourhoods to identify workforce, estates and digital development needs for effective neighbourhood working	Charles Malcolm-Smith	November 2024	• Enabler (workforce, estates and digital) development plan in place for each neighbourhood	
Engagement with the four Home Care providers to establish new ways of working under new contract arrangements.	tristan.brice	December 2025	• Feedback from the provider forum	
Local PMS premium incentivising General Practice engagement with MDTs (implemented)	Chima Olugh	October 2024	• Agreed number of people discussed • Agree targeted supported to prevent a hospital admission • Number of Care plans processed	
Implement the new Peoples partnership model (hub and spoke approach) joint working with Council Grant team and local VCSE organisations (see also Action 13)	Charles Malcolm-Smith	October 2024	• Model signed off at the LCP • Community plans from each N'hood	
Develop interoperability capabilities of Joy Platform	Rachael Smith	October 2024	• TBC	
Overarching vision for N'hoods and agree workstream including LTC and prevention support	Laura, Ashley, Fiona	September 2024	• Signed off workstreams • Signed off metrics for each workstream	

2024/25 Fuller Update: Progress against

Action 5. Develop a primary care forum or network at system level

What was already in place

- PCN Forum, bringing together PCN clinical directors, LMC, GP Federation and CCPL lead for primary care
- PCN, GP Federation and LMC representation confirmed on LCP Strategic Board
- Active Primary Care Nurses forum
- Active Practice Managers forum
- Primary Care represented on place-based boards but consideration needed as to how this effectively feeds into and out of the wider primary care system

Progress in 2023/24

- The PCN Forum has been reformed into the Lewisham Primary Care Leadership Forum (LPCLF) and has an independent chair who was formally recruited
- The group meets monthly and has a formal ToR, agendas and minutes/actions
- Membership of the LPCLF has been extended to local pharmacy (now standing members), dental and ophthalmic colleagues and contact has been made with key local stakeholders including LGT and SLAM
- The Forum interfaces with the South East London Primary Care Group (through common membership) to support a two way flow of information and discussion
- The forum has discussed key issues in 23/24 including the primary-secondary care interface, ARRS utilisation, sustainability of general practice and same day urgent care/111 re-procurement.
- The Forum has been instrumental in managing the transition of the ICB funded GP Home Visiting service to a service now funded by PCNs directly

2024/25 Fuller:

Action 5. Develop a primary care forum or network at system level

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Ongoing development of the PCLF including formal inclusion of dental and ophthalmic colleagues and consideration of now best to achieve a unified primary care voice for Lewisham	Ashley O'Shaughnessy	• Development throughout 24/25 • Formal inclusion of dental and ophthalmic colleagues by Q4 24/25	• Internal self-assessment	• Service Development Funding
Agree how best the PCLF links to ICB CCPLs both where CCPLs are working in primary care and where they are not	Ashley O'Shaughnessy /Charles Malcolm-Smith	Q2-3 24/25 (*following appointment into restructured CCPL roles*)	• Internal self-assessment	• None anticipated
Continue to socialise the existence of the PCLF so all system partners are aware and recognise this as the route to engage with primary care collectively	Ashley O'Shaughnessy	Throughout 24/25 – Review October 24	• Internal and external stakeholder assessment	• None anticipated
Ensure an effective interface between the PCLF and the SEL PLCG, particularly as the later considers transition to more formal primary care collaborative status	Ashley O'Shaughnessy	Throughout 24/25 – Review December 24	• Internal self-assessment	• None anticipated
Support effective two-way engagement and communication between the PCLF and constituent member organisations i.e. practices	Ashley O'Shaughnessy	Plan to be agreed by Q3 24/25	• Internal and external stakeholder assessment	• None anticipated

2024/25 Fuller Update: Progress against

Action 6: Embed primary care workforce as an integral part of system thinking, planning and delivery.

What was already in place

Recruitment and utilisation of Additional Roles Reimbursement Scheme (ARRS) staff including pharmacists, social prescribers, care coordinators, mental health and first contact physiotherapists

CEPN Training Hub established

IT Facilitators across SEL who work with practices to improve coding and data mapping

Progress in 2023/24

Ongoing development of the ARRS Roles

General Practice excellence awards event – Dec 2023

2024/25 Fuller:

Action 6: Embed primary care workforce as an integral part of system thinking, planning and delivery.

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Develop consistent workforce data across all providers	Charles Malcom-Smith	Ongoing through 24/25		
Develop a more strategic approach to the utilisation, employment and support/development of ARRS staff with system partners	Laura and Ashley	Ongoing through 24/25	• Full utilisation of available ARRS budget • Improved recruitment and retention of ARRS staff	• ARRS funded directly by NHSE
Consider how community and primary care staff can work more effectively together within N'hood teams (Links to previous action) with system partners,	Ashley and Fiona	Ongoing through 24/25		
Primary care integrated in partnership workforce programme: community and primary care workforce career pathway and joint appointment initiatives for entry level, support roles	Charles Malcom-Smith	March 2025	• New roles and development plans in place for target workforce and specified roles	

2024/25 Fuller Update: Progress against

Action 10: Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care

What was already in place

- All PCNs have an established estates and clinical plan
- Lewisham Partnership Estates Group brings together system wide stakeholders and reports into the LHCP. Includes representatives from the Council, NHS providers, NHS property services and One Public estates
- Significant investment in the Waldron Health Centre to enable it to develop as a community hub

Progress in 2023/24

- Work is underway to develop the Waldron Community Hub in New Cross. To be opened in August 2024, providing remodelled health space and offering a venue for VCS and community groups to support local health priorities.
- Review underway of service model for the Waldron based on population health needs in North Lewisham
- Following a significant gap, Primary care representation on the Estates Group formally agreed through the PCLF

2024/25 Fuller:

Action 10: Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Develop an overarching estates plan for Lewisham	Charles Malcolm-Smith	December 2024	• Strategic plans in place for on-going estates development	
Conclusions and outcomes from Waldron Service Model Review	Charles Malcolm-Smith	October 2024	• Current and future services reflect population health needs and priorities	

2024/25 Fuller Update: Progress against

Action 12. Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods

What was already in place

- PMS premium services already offered to GMS practices to ensure equity
- Clinical Effectiveness South East London (CESEL) programme underway to support reduction in variation
- Borough wide GP Federation well established and two PCNs are also ‘super practices’, with merged core contracts
- Enhanced GP support to the Homeless population across Lewisham in place

Progress in 2023/24

- Discussions on the ongoing sustainability of primary care held through the PCLF.
- The PMS Premium has been reviewed and updated for 24/25 to ensure it continues to support LCP objectives.
- PCNs have been supported to update their development plans for 2023/24 including through the provision of consistent external consultancy/facilitation.
- GP Resilience programme for 23/24 successfully implemented with 8 practices awarded funding and an evaluation of the 22/23 programme undertaken
- The Lewisham Training Hub has been commissioned to work with practices to undertake the national Support Level Framework (SLF) assessment to review strengths and weaknesses and develop corresponding action plans
- Continue to fund and work with CESEL to embed agreed guidelines and pathways across general practice.
- A full general practice protected learning time (PLT) programme successfully delivered in 23/24 including 3 face to face sessions for all staff groups. Dates and themes for the 24/25 PLT programme have also been agreed and circulated to practices.

2024/25 Fuller:

Action 12. Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Continued support for PCN development and practice resilience	Ashley O'Shaughnessy	Q2-3	• PCN maturity matrix • Evaluation of resilience programme	• Service Development Funding
Continued implementation of the Support Level Framework assessment and delivery against associated action plans including feeding into the local and national General Practice Improvement Programme (GPIP)	Lewisham Training Hub	Ongoing through 24/25. Review Date December 24	• Number of SLF visits undertaken • Number of practices completing the GPIP	• Service Development Funding • Nationally funded GPIP programme
Implementation of PCN population health framework, starting with hypertension	Ashley O'Shaughnessy	Q2 24/25	• Reduction in variation in identified focus areas (blood pressure management for hypertension)	• Hypertension funding secured
Continued support to implement the Modern General Practice model to support improved patient experience and demand management	Ashley O'Shaughnessy	Ongoing through 24/25 Review date December 24	• GPPS / FFT / local patient surveys and feedback • PC Staff Survey	• Transformation and transition funding • Capacity and access improvement funding
Development and implementation of the Primary Care proposition (multi-morbidity) as part of the SEL wide work on this.	Ashley O'Shaughnessy	Q3-4 24/25	• TBC	• TBC
Continue discussions on the future of PC in Lewisham with PC leads within the context of Fuller and current pressures and future opportunities	Ashley O'Shaughnessy	Ongoing through 24/25 Review date September 24	• TBC	• TBC

2024/25 Fuller Update: Progress against

Action 13. Work alongside local people and communities

What was already in place

Strong stakeholder engagement in the redevelopment of the Waldron and the North Lewisham Community Forum.

Commitment from LCP board on approach to community engagement:

- **Support citizens and communities to exercise power** by creating the conditions where all individuals can contribute equally
- **Build trust** through purposeful and consistent efforts to foster relationships and act on feedback received
- **Provide people with opportunities** to participate by focusing on reducing current barriers (including around language, resources and cultures) to engagement
- **Work together** to achieve more with what we have recognising limits on the funding, time and capacity available

Agreement to establish People's Partnership group within governance structures of LCP to realise approach to community engagement, creating direct links with local communities and VCSE networks.

Progress in 2023/24

People's Partnership group has been established, chaired by LCP Board independent member. 73 people have attended representing either their own voice or the voices of communities and organisations in Lewisham.

Key areas of the LHCP strategic intentions have been discussed e.g., Improving access to Primary Care, LHCP System Intentions 24/25 and the Development of a Community Space in Lewisham Shopping Centre. The development of the Lewisham Health and Wellbeing Charter has been significantly influenced by the responses of people attending the LPP.

There has also been continuing local stakeholder engagement, working alongside North Lewisham PCN, in the development and refurbishment of the Waldron Health Centre to provide community space and access for VCS and local groups.

Other specific initiatives have been progressed with co-production with local populations, for instance on hypertension re-design and access to mental health services for young black men ('Should I really be here?).

2024/25 Fuller:

Action 13. Work alongside local people and communities

Team Priority What is the activity?	Lead Who will be responsible for it?	Target Date When will it be completed?	Metrics How will you evidence success?*	Additional resource / finance implications / source of funding if known
Develop a focused approach for the People's Partnership (eg alignment to health inequalities programme or primary care access)	Charles Malcolm-Smith	June 2024	• Demonstrable engagement with communities on service change and transformation • Increased numbers of citizen involvement and community organisations representing relevant populations	
Agree and co-develop an outcomes framework for feeding into the system the views of the People's Partnership	Charles Malcolm-Smith	October 2024		
Work with the VCSE sector (including Healthwatch) and the LHCP to identify who can best access and work with the people and communities identified noting £100k non-recurrent funding available for VCSE work.	Charles Malcolm-Smith	June 2024		
Engagement with stakeholder groups, including patients, residents and professionals to support neighbourhood Development. through new Peoples partnership model (hub and spoke approach) (see also Action 4)	Charles Malcolm-Smith	March 2025	• Community plans from each N'hood	

South East London Integrated Care System

NHS South East London

The Waldron programme

Waldron Programme Board

Ceri Jacob/Neil Goulbourne

- Overseeing the implementation of the refurbishment and any reconfiguration
- Agreeing the space provided for use by local residents and voluntary and community sector and promoting its use
- Monitor the progress of the building works
- Working together to fully utilise the building
- Ensuring expenditure remains within the available budget

Refurbishment Delivery Group

Linda Smith

- Manage delivery of refurbishment programme

Community Engagement Group

Fiona Kirkman

- On-going local stakeholder engagement to ensure that the centre can be an asset for the local community
- Supporting anchor organisation responsibilities by providing facilities for local community groups

Service Model Development Group

Tom Simpson

- Develop an overarching service model for the centre that meets the needs of the local population
- Review of existing service provision and gap analysis

Community Engagement- creating community space

- Groups and activities have been running in the community space over the last 2 years, supported by the NLPCN Community Development Worker.
- Creating a timetable of actives in the new space to start from August.
- New Waldron Navigator roles created and employed by NLPCN. The welcoming face of the Waldron, to support the coordination of activity.
- Mapping roles and responsibilities in the building, including repairs and security
- New Reception area, seating 'pods' and lighting
- New digital notice board and improved signage
- North Lewisham Community Forum artwork to be framed and displayed around the Waldron
- Installing a new hanging system for art displays
- Building creative health opportunities with local culture and arts organisations
- Lunchtime staff wellbeing session to be held in August

What's Next

- Further opportunities to co-create with our community
- Evaluating the impact and learning from what works
- Update Community Room prioritisation in line with Population Health data.
- Develop Digital platform, communications and What's on pages
- Planning with partners to establish Waldron Community Kitchen
- Creating a model for how the space be co-ordinated and managed in the long term
- Long term planning and sustainability

Ground floor at the Waldron – Creating the offer

Groups confirmed/returning to the Waldron	Groups interested in using the space	Groups/activities we would like to book
Red Ribbon Breast Cancer support group Ivorian UK diaspora LRMN CARERS Shine ur light UKAKAA DIAMOND ECOUTE LGBT BLACK GROUP (PROUD FEATHERS FOUNDATION) 360 lifestyle (Diabetes Support group) Brooke (waiting on funding decision)	Housing LEAN Citizens Advice Lewisham Mindful mums Befrienders We women circle Lifestyle medicine Sexual health (workshops on different issues Speech and language drop-in Family Hub EKLOEHOUN (self-help group)	Singing for health Art Sewing Health work shops Zumba Support groups Well-being events Nutrition and cooking preparation Exercise Breast feeding support group

Service Model Development Group

Waldron summary

The PHM team has been instrumental in assisting the Waldron Steering Group in identifying the necessary data for a comprehensive health needs assessment.

This will help optimize the use of spaces within the Waldron and better serve the community.

Our focus has been on risk groups and specific condition areas, from which five key areas have been identified.

Our goal is to enhance collaboration among the services within the building. We need to designate individuals who will take responsibility for implementing the data-driven actions and identify the driving forces within the steering group.

The PHM team will pinpoint patients or geographical hotspots and support delivery owners in integrating this data into their daily operations while monitoring the impact.

Neighbourhood coordinators, MDMs, and community development leads will be crucial in completing this puzzle

Input – process - output

The PHM team will work with you to help you refine your search by developing use case data statements.

e.g.; I want to know who is not having health checks and which of them are in the Core20PLUS x 3 and also have severe V5 levels.

Then describe what the action and delivery vehicle will be for the cohort.

e.g. I will prioritise these people for health checks as the most in need. Our care coordinator will reach out and communicate to them based on their demographics to encourage them to attend and book an appointment to MOT them for a number of things at once.

1. What is your clinical risk group or condition of interest (Input)?

The PHM team can build these risk groups and conditions by agreeing a collection of clinical codes with you.

We can do this in a few ways:

1. Utilise coding we have already built
2. By using ready-made QOF codes or SEL agreed codes that are available to us.
3. Start from scratch with coding that we agree jointly
4. We can replicate coding searches carried out by another borough or from another platform if commercially available (e.g. Ardens)
5. We can enhance 2 & 4 using our five-source data set (acute, community, Primary care, mental health and social care).

2. Choose some building blocks (process)

Select some or all of the building blocks to help you process your question further and find your priority cohort.

Inequalities, wider determinants of health and behavioural factors:

- Core20PLUS demographics (adults & Children)
- Core20PLUS 5 clinical areas (additional demographics)
- Protected characteristics LD/SMI
- Missing V5 data by certain cohorts (older ages and Core20PLUSx3)
- Has a carer/is a carer
- In receipt of social care y/n (adults and children)
- Vital 5 severity levels

Demographics and any nuances

- Granular ethnicity groups to address Blachir
- Younger more granular age range bandings (N1 specific)
- Agree a geography - registered and resident in? (N1 and/or NLPCN)

Service use or gaps in use:

- How do they use the system. Encounters (IP, OP, GP appointments, ED and Acute care, out of service).
- Rates and reasons for use and or admissions.
- Gaps in proactive care: health checks, imms & vaccines and screening.
- Trends and differences in access to services (clinics, appointments) treatments and outcomes among the sociodemographic

3. The output

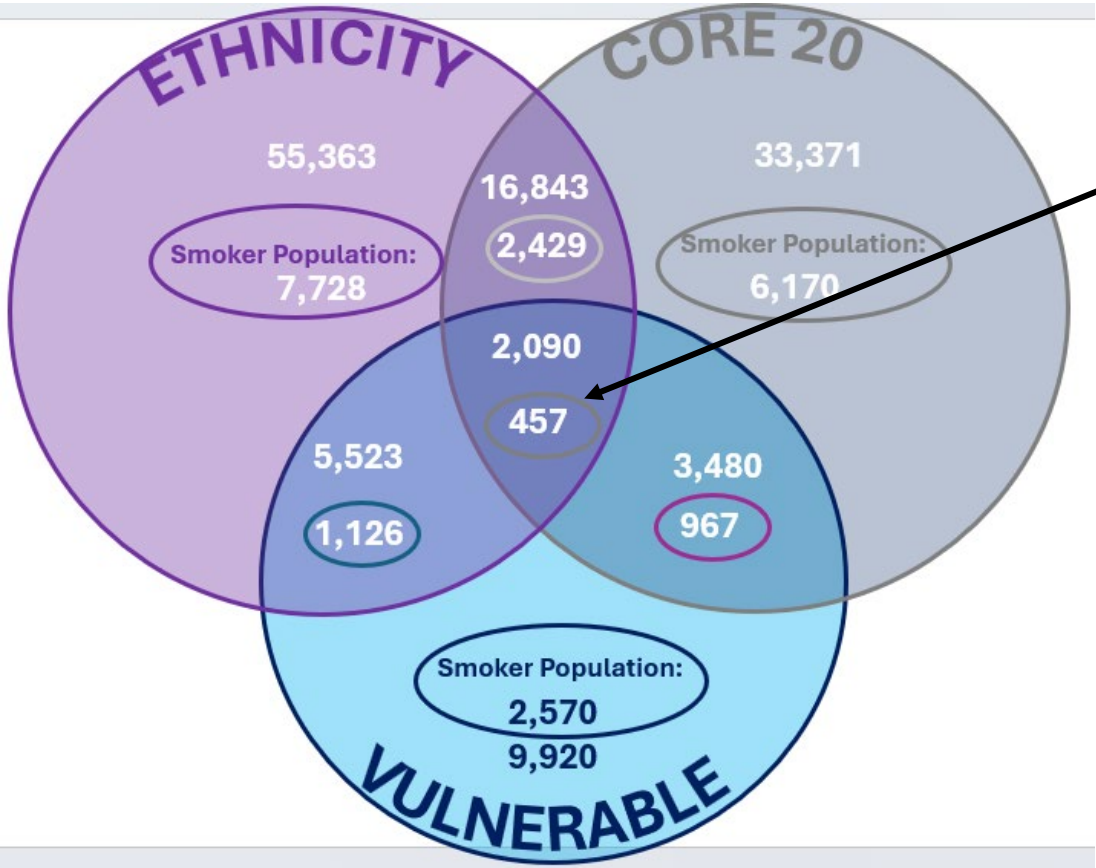
- Agree the best data tool(s) for your need. E.g.:
  - case finding list/geographical hotspotting/insight pack/dashboard
  - OR utilizing existing PHM tools e.g. Overlapping CVD conditions framework or the Older adults dashboard or the Vital 5 dashboard
- Operationalise the use of the tools into your BAU activities by mapping steps and agreeing codes for actions
- Track the impact for the prioritised patients using agreed codes

Steps 1-3 are the PHM approach for the Waldron and Neighbourhoods health needs assessment

Condition/ risk group	Use case data statements	Delivery vehicle	Ease/complexity of data	Stage of data build	Comments
CVD 4 conditions: AF/CKD/HT/ Diabetes	• What are demographics trends for higher BMIs • For HT those that are diagnosed, out of range but not optimised and in the C20Px3 • We would like to know the numbers of patients with cardiac events by age / Core20Px3, and not prescribed lipids post cardiac event • The numbers on dialysis by age / Core20Px3	• CESEL & HEFs – e.g. Camille Hirons, Kaluba Sianga, Sian Howell, Elaine Ainsworth. • Follow up meeting on 19th to agree mechanisms • PCNS and neighbourhoods could choose a pick list of one or more conditions from the areas of stratification: at risk of / undiagnosed / unoptimised	A complex search with multi definitions and codes across 4 conditions and 3 ranges of diagnosis	Definitions and codes for all 4 conditions and at risk of / undiagnosed / unoptimised are agreed. Aiming to be complete by August 2024 HT risk tool by end of July 2024	We could enhance the delivery arm further by linking into the Waldron services/social prescribing etc. which we can encourage through Kathryn Griffiths and Aaminah Verity so there is no danger this work is in silo from the rest of the Waldron and N/hood work. This is a well established piece of work that we can continue to push forward
Emergency contraception and ethnicity	Reviewing with Emily Mabonga Tuesday 18th	• Leadership and commitment through Emily Mabonga • Further clarity about other vehicles or ideas for delivery	• SRH analysts using SRH data along with some contraception data from PHM team • There is patient data matching to be done across the independent data sets	Nothing started but support from SRH analysts will help expedite the work.	
The core20PLUS families in North Lewisham	• What do we need to know about them that we don't know and how can The Waldron services coordinate collecting that data?' • "Public Health would like to know for the North Lewisham PCN population, are there any immunisations with particularly low uptake. This could be for adults or children and by any particular groups, nationality, ethnicity, faith group." • Uptake numbers for MMR and with the definition for Core20PLUS children. We could do by ethnicity, gender, language and for the core20PLUS definition is agreed.	TBC Initial conversations through the commissioners Simon Whitlock and Paul Creech but delivery arms would need to be agreed	Large data build spanning a number of areas Have a proxy search for the short term - any child whose parent is C20P. We need to develop the additional nuances LAT etc We could pull in social care data potentially Could pull in food bank data	We have HV checks set up already, and most other items would be covered by the building blocks	Mindful we don't to want to overlap with the Clyde work

Condition/ risk group	Use case data statements	Delivery vehicle	Ease/complexity of data	Stage of data build	Comments
Encounters and in hours and out of hours and perhaps missi ng health checks	• We would like to know the numbers who haven't had health checks by C20Px3 and the non C20P/rest of the population • "We would like to see an analysis of high and low intensity users - the interaction between GP in hours, PCN GP extended access PCNs, urgent care centre (GP but acute run) and ED attends by C20PLUS/not Core20PLUS " Do they not book in with their GP or are they using both in and OOH services • Also cut by age because we think older ages may not access extended access in the same way as younger age bandings." • What are the condition breakdowns of why they are accessing Out of hours? • Low conversion rates versus high conversion rates of ED attends to admission for: o high and low intensity users o By C20Px3 vs not C20P / age / gender / ethnicity / language / LTC count	TBC	• Large build spanning a number of areas	• Not started and the PHM team would need to do more work to build up the data here but a lot already in place.	• Interest from Neighbourhood coordinators and HEFs in this area • Could duplicate or work with OHL and some of the work Deeta Henry is doing.
Smokers	• "Public Health would like to know for the North Lewisham PCN population, are there higher rates of smoking in general or any particular population. • Could compliment the work we are doing with the national lung health checks team to support attendance at appointments starting in North Lewisham in July-August	• Matt Seal may be able to support TBC • Additional funding available	• Built but maybe gaps compared to the data source that the smoking cessation team use.	• Ready built but maybe be missing 'offered smoking cessation' as that data could be logged in a separate system	• It meets the core20PLUS focus for all 5 clinical areas. • Starting small could work well and the focus area is contained

Waldron example smokers



- The middle of the Venn diagram are those in all 3 factors for Core20PLUS and current smokers.
- The same has been applied for ethnicity, deprivation and vulnerability
- We could overlay other agreed building blocks such as pregnant/language/ethnicity bandings/not been referred to smoking cessation to filter down further
- And compare to smokers in the whole population compared to all the above demographics.

Generic delivery mechanisms N1/NLPCN might be:

- Referral into existing Waldron clinics and services
- Review of Waldron clinics to suit the needs of the priority population
- Locating voluntary sector and social prescribing services in the Waldron and neighbouring Deptford buildings to support the priority cohorts and an owner for referring on
- Referral pathways to Neighbourhood MDMs
- An integrated offer from CESEL and HEFs
- Identifying any new funding streams / HIN support / Business case development

Next Steps

The design group will continue to develop the delivery offer for individuals in the following areas:

- CVD conditions: AF, CKD, HT, and Diabetes
- Smokers

We will explore how current clinics and Primary Care Networks (PCNs) can collaborate to provide holistic support for people with CVD. Additionally, we will evaluate the feasibility of incorporating smoking cessation, weight management, and other healthy lifestyle services into the model.

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 5
Enclosure 5

Title:	**Business Case: Older People Transformation Programme: Proactive Care model / Older People Transformation Board ToR and next steps**
Meeting Date:	**25 July 2024**
Author:	Tristan Brice, Associate Director Community Support & Care
Executive Lead:	Ceri Jacob, Place Executive Lead Lewisham

Purpose of paper:	To update the Board on the business case outlining the agreed investment and expected deliverables of the Proactive Care model over a 15 month period.	Update / Information	
		Discussion	
		Decision	***X***
Summary of main points:	Highlighting key priorities within the Older Adults Transformation Programme. Proactive care team when fully operational is anticipated to result in a reduction of 2126 ED attendances (£1,328,219) per annum and 904 emergency admissions (£7,476,638) per annum. Consider an expansion of the Older Adult Transformation programme into a wider Ageing Well Strategic approach.		
Potential Conflicts of Interest	**N/A**		
Any impact on BLACHIR recommendations			

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

	Equality Impact	
	Financial Impact	
Other Engagement	Public Engagement	

	Other Committee Discussion/ Engagement	
Recommendation:	To note next steps. To agree the consideration of expansion of the OATP into an Ageing Well strategic approach.	

South East London Integrated Care System

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Business Case: Older People Transformation Programme: Proactive Care model / Older People Transformation Board ToR and next steps

18 July 2024

Overview

- Strategic House Model
- Why the need for a Proactive Care model?
- Learning from Frailty Pilot Evaluation Reports
- Business case proposal
- Staff compliment
- Implementation phase
- Full year effect
- Older Adults Transformation Programme Board: Terms of Reference
- Next steps

South East London Integrated Care System

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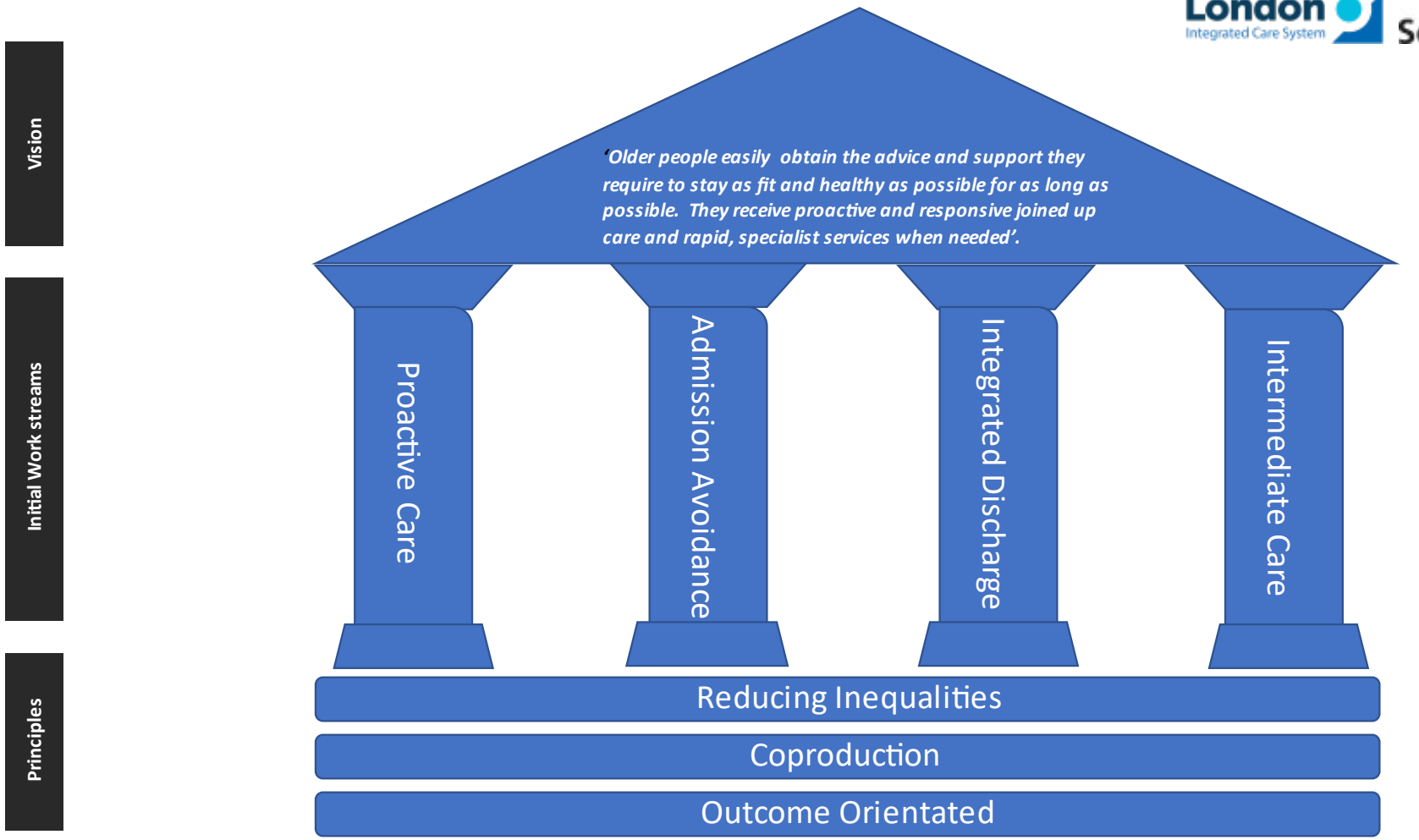
OUR STRATEGIC HOUSE MODEL

South East London Integrated Care System

NHS South East London



We are collaborative • We are caring • We are inclusive • We are innovative

Why the need for a Proactive Care model?

Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs.

The specific aims of proactive care are to improve health outcomes and patient experience by:

- Delaying the onset of health deterioration where possible
- Maintaining independent living
- Reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care'

Learning from Frailty Pilot Evaluation Reports

Lewisham

- 27% reduction in ED attendances when comparing the 6 months prior to the pilot intervention to the 6 months post intervention.
- 12% reduction in emergency admissions.

Greenwich

Patient cohort (ED attendances)	Number of admissions	Number of bed days
6 months Pre-Intervention	88/135	637
During intervention	67/135	443
6 months Post-Intervention	50/124	355

Patient cohort (Emergency Admissions)	Number of patients attending	Total number of visits
6 months Pre-Intervention	58/135	121
During intervention	35/135	65
6 months Post-Intervention	33/124	57

- Improved patient and family experience with:
- Members of the MDT found it a positive professional experience:

Business case proposal

The Business Case proposes investing approximately £500,000 over a 15-month period to implement a Proactive Care model that will:

- Improve quality of care received by adults aged 65+ and reduce Emergency Department attendances and Emergency Admissions from the predicted baseline by 4%
- Using the proactive frailty case-finding dashboard, promote a targeted approach when identifying patients who will benefit most from Proactive Care,
- Improve patient experience and impact.
- Improve professional experience.
- Contribute to improvement of the wider system affordability and sustainability.

Throughout the 15-month period, the service will be tracked continuously (appendix 2) to determine how effectively it is performing.

Staff compliment

- Geriatrician (0.2 wte)
- Band 8A (1.0 wte)
- Band 7 (1.0 wte)
- Band 6 (1.0 wte)
- Band 5 (1.0 wte)
- Apprentice (1.0 wte)

Implementation phase

South East London Integrated Care System

	Months 1 -3	Months 4 -6	Months 7 - 9	Month 10 – 12	Months 13 - 15
Investment	£99,310	£99,310	£99,310	£99,310	£99,310
10 CGAs completed per week when full team in post	65 CGAs completed	130 CGAs completed	130 CGAs completed	130 CGAs completed	130 CGAs completed
ED attendance reduction	0%	2% (266 ED attendances)	4% (531 ED attendances)	4% (531 ED attendances)	4% (531 ED attendances)
ED attendance reduction (£)	£0	£166,027	£332,055	£332,055	£332,055
Emergency Admission reduction	0%	1% (57 emergency admissions)	2% (113 emergency admissions)	4% (226 emergency admissions)	4% (226 emergency admissions)
Emergency Admission reduction (£)	£0	£467,290	£934,580	£1,869,160	£1,869,160
Referrals to community services	0	100	180	260	260

Full year effect

South East London Integrated Care System

	Q1	Q2	Q3	Q4	Full year once service is fully established
Investment	£99,310	£99,310	£99,310	£99,310	**£496,550**
10 CGAs completed per week when full team in post	130 CGAs completed	130 CGAs completed	130 CGAs completed	130 CGAs completed	**520 CGAs completed**
ED attendance reduction	4% (531 ED attendances)	4% (531 ED attendances)	4% (531 ED attendances)	4% (531 ED attendances)	**2126 ED attendances**
ED attendance reduction (£)	£332,056	£332,056	£332,055	£332,055	**£1,328,219**
Emergency Admission reduction	4% (226 emergency admissions)	4% (226 emergency admissions)	4% (226 emergency admissions)	4% (226 emergency admissions)	**904 emergency admissions**
Emergency Admission reduction (£)	£1,869,160	£1,869,160	£1,869,160	£1,869,160	**£7,476,638**
Referrals to community services	260	260	260	260	**1040 referrals to community services**

Older Adults Transformation Programme Board: Terms of Reference

Chair	Kenny Gregory/Dr Emma Nixon
Purpose	The purpose of this Programme Board group is to support the effective and efficient delivery of the integrated mental health service via the development of robust information sharing and electronic record keeping by 1) To provide system leadership to the Programme 2) To provide the overall governance and decision making framework for the Programme 3) To consider the recommendations made by the Programme Workstreams and Sub Groups 4) To consider and make recommendations to the statutory organisations for formal sign off by their respective Boards 5) To identify and utilise appropriate individuals, organisations and reference groups in support of the programme 6) To identify relevant funding streams to help in the development and delivery of the programme 7) To work within a remit aligned to the Health & Wellbeing strategy and ICP strategy **Key areas of work:** • Developing and determining our collective vision and principles of operation for Older Adults across the Health and Social Economy • Reviewing Population Health Management reports to identify and agree development priorities • Ensuring that Clinical and operational leadership are central to our development and prioritisation process • Ensuing the development and implementation of the Older Adults Transformation Programme/Plan • Providing a strategic steer on development of existing and new key workstreams • Mapping existing provision, programmes, projects and access and outcomes • Ensuring reduction in variation and duplication of effort across the older adults pathway • Understanding and addressing population needs in our planning building on BLACHIR and other insight projects (Demographics)
Membership & Attendance	• Clinical and Care Professionals Lead • LGT Geriatric Clinical Lead • LGT Community Geriatric Clinical Lead • Director of Adult Social Care Operations • LGT Community Services Lead • SLaM MOHA/Dementia Lead • Voluntary sector representative • PCN representative • Healthwatch • User and Carer champion
Standing Agenda	• Actions from previous meeting • Progress made against core workstreams and updates form individual T&F groups • Review of key risks, issues and relevant mitigations
Reporting	• **Inputs:** Action Log, Risk & Issue Log, relevant project plans and updates against planned activity. • **Outputs:** Agreed actions & decisions made.
	• Meetings will take place on a six weekly basis

Next steps

Date	Task(s)
August 2024	• Draft Engagement and Communication Plan • Confirm new service name / title (PAWS – Proactive Ageing Well Service) • Draft and Agree service mobilisation plan • Consider transition from a Transformation programme to an Ageing Well Strategic Approach in line with SEL ICS
September 2024	• Commence recruitment of team
October 2024	• Implementation of Case finding tool • Continue recruitment of team
November 2024	• Initiate monitoring / quantification of the impact on community services • Implementation of PHM Evaluation framework • Continue recruitment of team

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 6
Enclosure 6

Title:	Better Care Fund (BCF) Plan 2023 – 2025 Refresh submission 2024/25
Meeting Date:	25 July 2024
Author:	Amanda Lloyd, Assistant Director Service Development and UEC
Executive Lead:	Ceri Jacob

Purpose of paper:	To provide an update on the 24/25 Better Care Fund plan refresh, which was submitted to NHSE on 10th June 2024.	Update / Information	
		Discussion	
		Decision	*x*

Summary of main points:

1. Background

1.1 The Better Care Fund (BCF) policy framework and planning guidance for 2023 - 2025 were published on 4 April 2023. The 2-year plan was approved by the Lewisham Health and Wellbeing Board on 24th June 2023.

1.2 A BCF plan refresh for 2024/25 was required for submission to NHSE by 10th June 2024.

1.3 It is a requirement of BCF submission that the plan be approved by the Health and Wellbeing Board or under delegated authority from the Board.

1.4 The Health and Wellbeing Board has previously delegated authority to the S75 Agreement Management Group to manage delivery of the Better Care Fund and approve quarterly returns to NHS England. Plans and reports continue to be brought to HWB for oversight.

1.5 The dates for HWB meeting and BCF submission for 2024/25 did not coincide, sign off was delegated by the Mayor as Chair of HWBB to Cllr Paul Bell as Vice Chair who approved the plan for submission on 6th June 2024. The plan was submitted to NHSE on 10th June 2024.

1.6 The submission was brought to the S75 Agreement Management Group meeting on 13th June 2024 for information, and is going to Lewisham Health and Wellbeing Board on 24th July 2024 for ratification.

1.7 The plan is now subject to a national assurance process. South-East London Integrated Care Board (Lewisham) and the Council will be notified of the outcome of this process in due course.

2. Strategic Context

2.1 The Health and Social Care Act 2012 requires Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

2.2 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

2.3 The Better Care Fund (BCF) is a joint health and adult social care integration fund which supports local systems to deliver health and social care for adults in a way that supports person-centred care, sustainability and better outcomes for people and carers. The BCF is managed by Lewisham Council and SEL ICB (Lewisham). The strategic framework is set out in the national BCF policy framework and planning guidance.

3. BCF Plan 2023 – 25

3.1 On 4 April 2023, the Government published the Better Care Fund Policy Framework and Planning Requirements for 2023 - 2025. The documents set out the conditions and funding for the BCF and the requirements in terms of planned expenditure, objectives and metrics.

3.2 The stated aim of the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health and social care and housing services seamlessly around the person. This aim is underpinned by two core BCF objectives:

- To enable people to stay well, safe and independent at home for longer
- To provide the right care in the right place at the right time.

3.3 The BCF 2024/5 refresh plan has been developed by SEL ICB (Lewisham) and the Council.

3.4 During 2023/24 the previously non-recurrent Discharge Funding was rolled into the BCF but required to be reported monthly. Reporting for the Discharge Fund has now been aligned with BCF reporting and will be quarterly for 2024-25.

3.5 There is increasing scrutiny of BCF from central government and NHSE, and we can expect additional requests for information over the coming year, specifically in relation to scheme detail and outcomes. A report on the Enablement spend in 2023-24 will be brought to the next S75 Agreement Management Group and a schedule of scheme reviews will continue to be planned throughout the year.

4. Funding Contributions

4.1 The funding contributions to the BCF 2024/25 are set out below:

		Income	Expenditure
DFG		£1,656,817	£1,656,817
Minimum NHS Contribution		£28,995,029	£28,995,029
iBCF		£14,941,703	£14,941,703
Additional LA Contribution		£773,989	£773,989
Additional NHS Contribution		£0	£0
Local Authority Discharge Funding		£3,491,339	£3,491,339
ICB Discharge Funding		£2,882,622	£2,882,622
Total		**£52,741,499**	**£52,741,499**

4.2 The financial contributions to the BCF have been agreed by the ICB and Council and agreed through the ICB's and Council's formal budget setting processes.

4.3 The table below sets out the schemes that will receive funding from the BCF and the expenditure allocated to those schemes for 2024/25.

Schemes	***Areas of Expenditure***	***2024/25***
Assistive Technologies	Equipment and Telecare	£2,355,396
Bed based intermediate care services	Intermediate care with reablement	£312,000
Care Act Implementation Related Duties	IMHA - DOLS provision	£900,000
Carers Services	Support to unpaid carers	£658,646
Community Based Schemes	Community Secondary Mental Health, Community Rehab and enablement, Medicine Optimisation, Voluntary sector	£11,032,992
DFG	Adaptations to the home	£1,656,817
Enablers for integration	Population Health System	£2,241,086
	Connect Care	
	Integration programme and Alliance resource	
	Contingency	
High Impact Change Model for Managing Transfer of Care	Social Care Delivery	£6,203,052
	Hospital Discharge Provision	
	Continuing Health Care Assessments	
	Development of alternative care	
	Home First and D2A	
	Trusted assessors	
	Discharge Support	
Home Care or Domiciliary care	Demographic growth	£8,001,279
	Protection of current level of packages of care	
	Market stability	
Home based intermediate care services	Reablement at home	£400,000

Housing Related	Learning disability supported accommodation, step-down beds for hospital discharge	£446,000
Integrated Care Planning	Telephone Triage, Single Point of Access, Transition planning, Trusted Assessors, additional Winter Capacity for care planning, Social Care in ED	£6,115,502
Personalised Care at Home	Neighbourhood Community Teams	£5,593,453
	Primary care in community settings	
Prevention and Early Intervention	Community Falls Service	£1,337,439
	Sail Connections	
	Self-Management support	
	Social Prescribing	
Residential placements	Extra Care Provision	£4,283,781
	Transition support	
	Maintaining level of mental health provision	
	Residential care	
Workforce recruitment and retention	Hospital discharge provision	£1,204,056
	Arranging care	
Total		**£52,741,499**

5. National Conditions

5.1 The national conditions for the BCF plan are:

1) A jointly agreed plan between local health and adult social care, approved by the HWB
2) Implementing the BCF policy objectives to:
3) Enable people to stay safe, well and independent at home for longer and

    a) Provide the right care in the right place at the right time.
    b) Maintaining the NHS contribution to adult social care and investment in NHS commissioned out of hospital services.

The 2024/25 BCF plan refresh is required to demonstrate that these national conditions have been met.

The2024/25 BCF plan refresh is also required to include an updated intermediate care and short-term care capacity and demand plan, and discharge spending plan.

6. Metrics

6.1 The BCF policy framework sets national metrics (performance objectives) that must be included in BCF plans.

6.2 As per previous years, the same metrics are being asked for as part of the planning process although for 24/25, the ’91 day’ metric has been dropped as it is no longer collected in a way that facilitates its being used here. Other metrics are being considered by NHSE for future BCF reporting. The metrics included in the 24/25 refresh plan are as follows:

- **Avoidable Admissions** – For 24/25 we have set a target 3% reduction on Q1&2 actuals for 23/24. This may be challenged by NHSE as they are keen we include stretching targets. However, given we did not meet the target set for 23/24, a measured approach has been agreed for target-setting for 24/25. There are change plans in place, such as the focus on hypertension in the community, and reducing falls from extra-care and MH/LD care homes which are intended to reduce avoidable admissions, however, the impact of these initiatives will take time to have effect, and are unlikely to be felt quickly enough to significantly reduce hospital admissions in the next 9 months.
- **Discharge to Normal Place of Residence** – We met our target for 23/24 with an outturn of 95.3% and are proposing a target of 96.3% across the year for 24/25. This may be challenging as due to budget constraints we have had to cease additional provision of private therapies to bolster LGT provision, which had been commissioned by the ICB for the last two years. However, the BCF is putting significant investment into the Home First discharge improvement programme and we expect to see continued positive outcomes from this resulting in more people discharged to their own homes from hospital.
- **Emergency admissions due to falls in the 65+ population** – we exceeded our target for this metric in 23/24. Our target for 24/25 is the same as we achieved in 23/24. Lewisham has generally performed well on this metric, given good existing services with a joined-up approach, including Linkline, Falls Prevention team, and UCR falls pickup service. Given population growth and increased patient complexity, achieving this target may be challenging, but feels realistic given planned further efforts on falls prevention for 2024/25 and existing well embedded services.
- **Rate of permanent admissions to care homes**. We did not meet our target in 23/24 but the outturn position cannot be compared to the numbers we projected, as in-year inclusion of MH placements was added to the national reporting requirements, increasing the numbers being reported as entering care homes. For 24/25 BCF plan we are reporting the target set by Adult Social Care.

For further detail on the metrics, please see the BCF submission attached as Appendix A.

7. Governance

7.1 The BCF arrangements are underpinned by pooled funding arrangements with a section 75 agreement. A section 75 agreement is an agreement made under section 75 of the National Health Services Act 2006 between a local authority and an NHS body in England. It can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner.

7.2 The Section 75 Agreement Management Group (Adults) continues to oversee the 2023 -2025 BCF plan and expenditure.

Potential Conflicts of Interest	None

Any impact on BLACHIR recommendations	Tackling inequalities in health is one of the overarching purposes of integration. Each new or existing service funded by the BCF has regard to the need to reduce inequalities in access to care and outcomes of care. An equalities assessment/analysis is undertaken as part of the development of any new proposals to assess the impact of the new services on different communities and groups.		
Relevant to the following Boroughs	**Bexley**		**Bromley**
	Greenwich		**Lambeth**
	Lewisham	**x**	**Southwark**
	Equality Impact	Tackling inequalities in health is one of the overarching purposes of integration. Each new or existing service funded by the BCF has regard to the need to reduce inequalities in access to care and outcomes of care. An equalities assessment/analysis is undertaken as part of the development of any new proposals to assess the impact of the new services on different communities and groups.	
	Financial Impact	There are no financial implications arising from this report. Monitoring of the activity supported by the Better Care Fund continues to be undertaken by the Section 75 Agreement Management Group (Adults).	
Other Engagement	Public Engagement	Public engagement forms part of the design when considering new services funded through the Better Care Fund.	
	Other Committee Discussion/ Engagement	S75 Agreement Management Group, 13/6/24 Health and Wellbeing Board, 24/7/24	
Recommendation:	To note the submission made to NHSE		

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 7

Title:	**Lewisham Risk Register**
Meeting Date:	**Thursday 25 July 2024**
Author:	Cordelia Hughes
Executive Lead:	Ceri Jacob

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

Summary of main points:

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

Risk Type	Risk Description	Direction of Risk	*Risk Appetite Levels
Financial	**498.** Achievement of *Recurrent* Financial Balance 2024/25 Cost pressures are on an upward trend and are expected to continue into 2024/25. Material risk will not be able to achieve recurrent financial balance in 2024/25.	⟺	Open (10-12)
Financial	**549.** Achievement of *Non-Recurrent* Financial Balance 2024/25. Cost pressures are on an upward trend and expected to continue into the next financial year. The borough will not be able to achieve non recurrent financial balance in 2024/25.	⟺	Open (10-12)
Financial	**496.** Prescribing Budget Overspend. Risk that the prescribing budget 2024/25 may overspend.	⟺	Open (10-12)
Operational	**505.** The NHS@Home (virtual ward) Service – utilisation of the service is lower than planned for.	⟺	Eager (13-15)
Clinical, Quality and Safety	**528.** Access to Primary Care There is a risk that patients may experience an inequality (and inequity) in access to primary care services.	⟺	Cautious (7–9)
Clinical, Quality and Safety	**529.** Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population.	⟺	Cautious (7–9)
Strategic	**334.** Inability to deliver revised Mental Health Long Term Plan trajectories.	↓	Open (10-12)
Financial	**335.** Financial and staff resource risk in 2023/24 of high-cost packages through transition. This is a recurring annual risk.	⟺	Open (10-12)
Financial	**506.** The CHC outturn for adults will not deliver in line with budget.	⟺	Open (10-12)

Clinical, Quality and Safety	**527.** Intermediate Care Bed Provision. There is a risk that Lewisham will not have Intermediate Care Bed provision within the Borough.	↑	Cautious (7–9)
Governance	**347.** Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.	↔	Open (10-12)
Clinical, Quality and Safety	**526.** A large number of families (up to 200) have been relocated from Tower Hamlets to emergency temporary accommodation at Pentland House.	↔	Cautious (7–9)
Clinical, Quality and Safety	**377.** All Initial accommodation centres such as Stay City apartments Deptford Bridge have high levels of vulnerable Adults & Children and Young People asylum seekers residents.	↔	Cautious (7–9)
Governance	**359.** Failure to deliver on statutory timescales for completion of EHCP health assessments.	↑	Open (10-12)
Governance	**360.** Failure to deliver on statutory timescales for completion of ASD health assessments.	↔	Open (10-12)

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

↓ Risk has become worse.

↔ Risk has stayed the same.

↑ Risk is improving.

2.Process

Risks are discussed monthly with risk owners and reported at the bi-monthly 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.New Risks

A financial risk referring to - *Achievement of Non-Recurrent Financial Balance 2024/25* (risk 549) has been included which references that cost pressures are on an upward trend and are expected to continue into the next financial year. The borough will not be able to achieve non recurrent financial balance in 2024/25.

5.Key Themes:

The key themes from the risk register relate to finance/budgetary impact, 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	Yes		
	Other Committee Discussion/ Engagement	Risks are allocated each month for a deep dive at a weekly Senior Management Team meeting and monthly Extended SMT. In addition, the risk register is a standardised agenda item at the Lewisham Health & Care Partners Strategic Board.		
Recommendation:	The Lewisham Health & Care Partners Strategic Board are asked to note the upcoming changes to the risk process across SEL. The ICB Board will be taking more of an interest in the risk process as mentioned above for corporate and borough risks going forward and have asked for all high-level red risks to be reviewed at the Planning and Finance Committee along with the BAF. At local level risk owners with risks that are high-level (red) will meet with the Place Executive Lead and Borough Business Support Lead with their delivery plan to conduct a deep dive into risks and mitigations.			

Ref	Risk Type	Risk Title	Risk	Inherent Risk (L x I)	Residual Risk (L x I)	Target Risk (L x I)	Risk Appetite Level	Direction of Risk	Risk sponsor	Risk owner	Ongoing controls	Assurances	Impact of ongoing controls	Control gaps
Finance														
498	Financial	**Achievement of Recurrent Financial Balance 2024/25**	During 2023/24 Lewisham delivered efficiencies in excess of the targeted 4.5% (c.£4.2m) of the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and expected to continue into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m), it is unlikely these will be sufficient and available non recurrent measures are limited. There is therefore a material risk the borough will not be able to achieve recurrent financial balance in 2024/25.	5x3=15	5x3=15	2x2=4	Open (10–12)	⇔	Ceri Jacob	Michael Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. This includes for 2024/25 development of business cases to identify opportunities for system wide efficiencies and meetings with system partners have been arranged to discuss these proposals. 5. Review at LCP meetings with members on a bi-monthly basis. 6.System approach is being followed with LCP partners to align savings opportunities.	Monthly budget meetings. Monthly financial closedown process. Monthly financial reports for ICS and external reporting. Review financial position at CHC Executive meeting. Lewisham Senior Management Team Review.	The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed in new financial year. Regular borough financial focus group meetings with CFO and director of planning.	1. There are no currently identified control gaps.
549	Financial	**Achievement of Non Recurrent Financial Balance 2024/25**	During 2023/24 Lewisham delivered efficiencies in excess of the targeted 4.5% (c.£4.2m) of the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and are continuing into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m), it is unlikely these will be sufficient and available non recurrent measures are limited. There is therefore a risk the borough will not be able to achieve non recurrent financial balance in 2024/25.	3x3=9	3x2=6	3x2=6	Open (10–12)	⇔	Ceri Jacob	Michael Cunningham	1. A careful and detailed budget setting process has been conducted to identify target savings. 2. Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage. 3. The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4. The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. This includes for 2024/25 development of business cases to identify opportunities for system wide efficiencies and meetings with system partners have been arranged to discuss these proposals. 5. Review at LCP meetings with members on a bi-monthly basis. 6.System approach is being followed with LCP partners to align savings opportunities.	Monthly budget meetings. Monthly financial closedown process. Monthly financial reports for ICS and external reporting. Review financial position at CHC Executive meeting. Lewisham Senior Management Team Review.	The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed in new financial year. Regular borough financial focus group meetings with CFO and director of planning.	1. There are no currently identified control gaps.
Medicines Optimisation														
496	Financial	**Prescribing Budget Overspend**	There is a risk that the prescribing budget 2024/25 may overspend due to: 1- Medicines supplies and cost increases -NCSO/price concessions and Category M. 2- Lack of capacity to implement in year QIPP schemes by borough medicines optimisation teams following post MCR staffing changes may effect implementation of the QIPP scheme. 3- Entry of new drugs to the SEL formulary inc. those with NICE Technology Appraisal recommendations with increased cost pressure to prescribing budget. 4- Increased patient demand for self-care items, LTC and treatment to be prescribed rather than purchased as cost-of-living increases. 5- Prescribing budget although uplifted for 24/25 a gap remains with regards to forecast outturn and budget. 6- Priority shifts towards qualitative outcomes such as patient safety issues in Meds Management and supporting hospital avoidance or discharge. 7. Increase LTC prescribing	3x4=12	3x4=12	3x3=9	Open (10–12)	⇔	Ceri Jacob	Erfan Kidia	1. Monthly monitoring of spend (ePACT and PrescQIPP), and also Cat M and NCSO spend 2. Monthly meetings with finance colleagues reviewing PPA budgets to date 3. 2 weekly Place finance meetings 4. Borough QIPP plans, and incentive schemes developed, with following ongoing: -QIPP and Incentive scheme monitoring dashboards -Practice level budget deep dives with RAG and action plans -Face to face practice visits with targeted spend analysis and feedback. -Forum meetings providing information on QIPP status and recommending actions to optimise prescribing (i.e. Practice Managers forum) 5. SEL rebate schemes continue to be reviewed, evaluated and processed	Any actions with regard to the prescribing budget are completed by Erfan Kidia, to dates agreed with the Place Executive, Associate Director of Finance.	Cost and budget pressure	1. No gaps in control identified
Delivery / NHS @ Home (Virtual Ward)														
505	Operational	**NHS @ Home (Virtual Ward)**	The NHS@Home Service is now significantly busier than it was earlier in the year. The outstanding risk remains that few patients are actively being discharged from hospital earlier than they otherwise would be. This is because agreeing the acute clinical pathway is taking longer than expected, with limited clinical time available from LGT Clinicians.	3x3=9	2x2=4	1x2=2	Eager (13-15)	⇔	Amanda Lloyd	Amanda Lloyd	1.A robust service specification has been drawn up, with recurrent funding confirmed for Virtual Wards. 2.A series of workshops have been held to engage LGT Senior Colleagues. 3.Bi-weekly NHS@Home referral statistics are emailed to the LGT CEO and Divisional Director of Operations. 4.Daily in-reach is provided to the short-term medical assessment units and Emergency Department at UHL, to proactively identify suitable patients for the NHS@Home Service.	A follow up workshop is being planned for September 2024, which Ceri Jacob will chair, bringing together key stakeholders across the ICS, Local Authority, CHL and LGT.	The controls require active engagement from all LGT Stakeholders.	The above controls require active engagement from all LGT Stakeholders.
Primary Care / Community Based Care														
528	Clinical, Quality and Safety	**Access to Primary Care Services**	There is a risk that patients may experience an inequality (and inequity) in access to primary care services. The inequality in access may be caused by: 1.Patients not understanding the various routes to access primary care services and the appropriate alternatives that are available 2.GP Practices operating different access and triage models 3.Digital exclusion 4.Workforce challenges 5.Increasing demand It could lead to: Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls	4x4=16	4x3=12	4x2=8	Cautious (7 – 9)	⇔	Ceri Jacob	Ashley O'Shaughnessy	The current controls in place are: 1.Local implementation of the national "Delivery plan for recovering access to primary care" 2.The Modern General Practice model is being implemented across practices supported through the national transition and transformation funding. 3.All practices have telephone and digital access options in place to support and maximise patient access. 4.All 6 PCNs have developed and implemented Capacity and Access Improvement Plans for 23/24 which focus on patient experience, ease of access, demand management and appointment coding. 5.The PCN Additional Roles Recruitment Scheme is fully operational to support use of a diverse skill mix and provide additional workforce capacity. 6.The 7pcn Enhanced Access service is operational to provide additional capacity between 6.30pm and 8pm, Monday – Friday, and 9am - 5pm on Saturday. 7.Launch of the national Pharmacy First scheme to support the management of minor ailments and supply of prescription only medicines for specific conditions. 8.Community self-referral pathways have been developed to empower patients manage their own health. 9.Continued promotion of the NHS APP so patients can directly book appointments, request repeat prescriptions and access their own medical record. 10.Ongoing review of practice websites to ensure up to date and consistent to support patient navigation 11.Continued support for PCN digital inclusion hubs to support patients who are willing and able to maximise use of digital tools 12.Focused work on the primary/secondary care interface to free up capacity in General Practice 13. Oversight through the Lewisham Primary Care Group	As outlined in controls.	Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls	Need an effective public-facing communications and engagement plan to educate and inform the public on the new ways of working in general practice and wider primary care to improve understanding of services and manage expectations. Ongoing industrial action may have an impact on patient access.
529	Clinical, Quality and Safety	**Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population**	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	3x3=9	3x2=6	Cautious (7 – 9)	⇔	Ashley O'Shaughnessy	Mandyn Clarke	The current controls in place are: 1. All practices administer vaccinations and where clinically appropriate and operationally feasible, make co-administration of seasonal vaccinations the default model. 2. Practices have robust patient call and recall systems in place. 3. A national failsafe should ensure that unvaccinated individuals are flagged with registered practices. 4.Lewisham has a dedicated flu and immunisations coordinator who supports general practice. 5.The ICB works with the local authority (Public Health) to take responsibility for planning outreach services that meet the needs of underserved populations and address wider health inequalities. 6. There is vaccination delivery in convenient local places, with targeted outreach to support uptake in underserved populations. 7.A universal, core offer in a consistent location/setting to increase efficiency and capitalise on public understanding of 'where to go' for vaccinations. 8.Vulnerable populations, such as asylum seekers, refugees, and rough sleepers, are opportunistically offered vaccinations in different settings to ensure they are given the best chance of protection. 9.Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes ie MMR/Covid/polio. 10. Collaborative working with Population Health team to target smaller cohorts for flu vaccinations.	As outlined in controls.	Severe and harmful disease outbreaks. Increased pressure on Primary Care. Increased A&E attendances and emergency admissions. Poor patient outcomes, including disability and mortality.	Need a comprehensive LHCP approach to build vaccine confidence in groups who may not take up the offer of vaccination. LHCP approach to "making every contact count" especially through the offer of actual vaccination to eligible patients at every opportunity
Commissioning														
334	Strategic	**Inability to deliver revised Mental Health Long Term Plan trajectories**	There is a risk that Mental Health Long Term Plan trajectories cannot be met as a result of activity and financial pressures that are currently affecting SLaM. This is caused by increased demand, limited bed availability, insufficient workforce and insufficient digital solutions to meet a proportion of local demand. This will impact on the ICB's ability to meet statutory requirements and reduce health inequalities.	5x5=15	2x5=10	3x2=6	Open (10–12)	⇓	Kenny Gregory	Natalie Sutherland	1. Outcomes framework measure for Community Mental Health Transformation (CMHS) being produced across SEL ICB. 2.Place based assurance framework being updated to reflect new interventions and monitored through align as per MH Alliance Leadership Board. 3.Understand the needs of people not being admitted after attending A&E to understand what interventions could be accessed instead of A&E and gaps in the system. 4.Continue to implement the CMHS transformation plan and local priorities. 5.Quality Impact Assessments undertaken on all of the priority investments that have been proposed as result of mitigating financial pressures in SLaM and the ICS.	Alliance data/performance review process to be established to provide local oversight and improvement actions. SLaM Stocktake of CMHS through Quality Centre to understand impact of CMHS transformation.	Improvement against KPIs and better collaboration and integration across services (in line with provider alliance ambition).	1.Mitigation plans formulated for red rated measures i.e. Physical Health Checks for SMI. 2.Additional in-patient 16 bed male ward in Lewisham (trust wide resource) to help with bed capacity, as well as Bed management pilot in Lewisham to manage bed supply locally and not Trust wide. 3. Stocktake of CMHS to review effectiveness and implement recommendations, with aim to increase number of people supported in a primary care setting. 4. EOI for NHSE 2 year Community mental health pilot in N2. 5. Reiestablish alliance sub-groups for improved oversight and ownership i.e. Crisis Collaborative, Adult Transformation and assurance and outcomes forum to review system dashboard and other key system assurance processes
335	Financial	**Financial and staff resource risk of high cost packages through transition. This is a recurring annual risk.**	The financial risk identified in 2023/24 of new high cost LD packages through transition remains. There are a small number identified but at very high cost. These are young people with significant health needs requiring double handed and overnight waking care or with behaviour which is significant challenging in children's services. There is a potential impact of eligible patients leaving day schools in 24/25 which will represent (a) additional day time care costs previously met by education, or (b) 'hotel and support' costs additional to the costs of education if the person is placed in a residential college or (c) costs relating to full time residential care. This risk is SEL wide. These risks are reflected both in financial terms with cost of care potentially being in the hundreds of thousands of pounds a year. The complexity of health need also represents an increase in nurse time on complex case management.	4x4=16	4x3=12	4x3=12	Open (10–12)	⇔	Kenny Gregory	Tom Bird (Interim)	1. Head of CHC is attending quarterly Transition panels from a CHC perspective to support better understanding of demand and potential cost, supports improvement of <18 assessment in line with the Framework, increases possibility of deflecting unnecessarily high costs/ SEND decisions. Also to flag early warning signs for joint funding requests. Regular comms (1) from the CYP DSR meeting to the adult DSR meeting and (2) from the CYP CHC lead re children already joint funded and where likely demand for joint funding in adulthood is predictable. Quarterly flagging of transition you people not alerted through either process and a RCA of why those young people were not flagged to the adult CHC Team. 2. Quarterly review of ongoing requirement for joint funding funding of packages. 3. Adult Social Care are working with SENs to engage with them whenever they are considering a placement in a residential school or college.	Prioritising review of all new LD packages transferring from LBL to look for savings opportunities. Compliance with the Joint Funding Protocol. Weekly reporting through Funding & Governance Standing agenda item CHC Executive.	Mitigation of financial risk to Lewisham ICS/ ICB. Strengthened projection of future financial risk. Improved robustness and visibility of transitioning plans.	1. Quarterly projection of when younger SEN adults will leave day education and the potential impact on CHC budget to CHC Exec. (High cost) Joint Funded packages to be included as a standing agenda item at monthly Integrated Commissioning Budget Monitoring. Also to review at CHC Executive.
506	Financial	**The CHC outturn for Adults will not deliver in line with budget**	Pressure in adult spend is being driven by a number of variables: •Activity has grown, with new patient numbers increasing in all client groups, but most markedly in LD (an increase of 31%). Of these 13 patients, 3 were older patients who had deteriorated – the remainder are all late teens/early 20s transitioning from college/school to permanent placement/supported living. •There is pressure caused by costs of existing packages being driven up by inflationary uplifts and increases in NLW and LLW. AQP rate has increased by 4.1%. •CHC has continued to experience an increase in patient acuity in 2024/25 particularly in terms of POC at home an increase of 45 patients including several new tracheotomy patients. •There are a large number of delayed reviews which might have offered opportunities for savings through reduction in costs or eligibility decisions. •Delayed discharges from Neuro-Rehab Units continue to impact on CHC Budget.	5x4=20	4x3=12	4x3=12	Open (10–12)	⇔	Kenny Gregory	Corrine Moocarme	1. Review of CHC staffing requirements is underway to determine if additional staff are required to meet quality and savings targets. 2. Monthly budget review meetings. 3. Weekly review of CHC eligibility decisions and related cost of packages. 4. Monthly review of neuro specialist patients to manage associated trim point costs and escalating earlier where there are blockages to 5. discharge not in the control of the ICB	Prioritising review of all new LD packages transferring from LBL to look for savings opportunities Allocating SEL ICB review resource to prioritise remaining outstanding reviews Participating in wider SEL ICB CHC savings programme	Will not meet quality standards set by NHSE regarding 28 days target to complete DST.	Potential patient safety issues and increase in complaints because of reduction in packages.
527	Clinical, Quality and Safety	**Intermediate Care Bed Provision in Lewisham**	There is a risk that Lewisham will not have Intermediate Care Bed provision within the Borough. It is caused by: •The current provider not meeting contractual obligations and the contract is being terminated. •However, provider is currently performing against contractual conditions. •The current provider has submitted evidence to address areas of concern - to be reviewed by subject matter experts. •In the meantime, the current providers have been extended (by 6 months) to September 2025. Leading to: •No intermediate care bed provision in Lewisham. •Cohort of patients not being able to receive bed based rehabilitation locally. •Delay in patients being discharged from an acute bed when medically fit.	4x3=12	3x3=9	4x2=8	Cautious (7 – 9)	⇑	Kenny Gregory	Lorraine Sinnadrai	1.Quarterly contract monitoring in place. 2. Monthly meetings to address areas of concern identified as part of procurement. 3. Signed NHS Standard contract in place (01/04/24 – 31/03/25 with the option to extend by 6 months) which includes both organisations giving adequate notice if contract to be terminated. 4. Current provider has held a contract for 10 years+ and there have never been any major concerns / safeguarding issues / incidents to cause commissioners a significant cause of concern.	Service continuity for longer term absence. Reporting and escalation process for incidents and where governance sits within the organisation. How learning will be disseminated from incidents and complaints.	No intermediate care bed provision in Lewisham. Cohort of patients not being able to receive bed based rehabilitation locally. Delay in patients being discharged from an acute bed when medically fit.	Monthly meetings to be arranged with relevant SME's. Uncertainly of next steps following contract expiry, especially given the most recent 2 failed procurements.
Safeguarding														
347	Governance	**Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.**	Initial Health Assessment (IHA) – By law, Children Looked After require an IHA to be undertaken by a medical professional within 20 working days of the child entering care. The Lewisham CLA Health Team is able to see all CLA within 20 working days of notification. To give context, in 2023, 50% of IHA were completed outside the timescale (with a monthly range of 0-80%). Children not seen for their IHA may not have their health needs addressed in a timely manner and their carers are not enabled to promote their health appropriately.	4x3=12	3x3=9	2x3=6	Open (10–12)	⇔	Ceri Jacob	Christiane Nkouri/Margaret Mansfield	1.KPIs and provider data set in place. Provider data set includes IHAs undertaken outside of statutory timescales and IHAs on children placed in Lewisham by other local authorities. 2.The Designated Doctor, Medical Adviser and medical colleagues undertake IHAs. May 2024 - The Designated Doctor for Children Looked After who is involved in completion of Initial Health Assessment (IHA) is currently off sick until July 2024. The DD normally covers 12 IHA clinic sessions in a month and during the period of sickness, 9 out of 12 would be covered by other doctors leaving possibly 3 uncovered for the month. However, the provider reported plans to rearrange available doctor's diary to accommodate outstanding sessions. If this action is not achieved, the outcome would be delays in health service timely completion of IHA which could also impact on delay in children accessing any other health services for support where needed. 3.The Named Nurse supports CLA Admin with IHA data collection (although IHA are not a nursing remit). There is no Named Doctor in place to focus on this issue (The Designated Doctor does not have any time ringfenced for operational issues but uses some of the allocated DD time to support the Named Nurse). 4. Both Named and Specialist Nurse for CLA have regular discussions with Social Workers preparing forms for IHAs (at a drop-in). 5.Local Authority business support is expected to help with the timely preparation of IHA forms (completing demographic and contact details), provide a reminder to Social Workers regarding the completion of consent forms within 5 days of a child becoming looked after and sent those forms to the CLA health team. 6.Designated and Named Professionals are part of the Partnership CLA Steering Group for service improvement. 7.The quarterly Health and Social Care CLA Steering Group looks has a standing item looking at the issues affecting the timely completion of initial health assessments (includes children placed out of borough and those placed in Lewisham by other local authorities). 8.Health and CSC have developed a SOP for IHAs. 9.LAC health team plans to provide powerpoint slides reiterating good practices around IHA paperwork and consent. Slides to be included in new Social Worker starter pack. . 10.Director of Quality and Designated Professionals together with Commissioners are working on an updated service specification. 11.The NICE CLA benchmarking tool has been completed and shared with Commissioners and Directors (Quality and Place Directors).	Statutory guidance in place. Integrated Care Pathway with SOP for Social Workers (and Doctors) in place. IHAs are being completed but assessments are delayed as required forms (consent and demographic/contact details) are not being completed by Social Workers in a timely manner. Designated Doctor, Medical Adviser and other doctors continue completing IHAs as soon as consent is available. Health and Social Care CLA steering group continues monitoring.	IHAs are being completed but assessments are delayed as required forms (consent and demographic/contact details) are not being completed by Social Workers in a timely manner. Designated Doctor, Medical Adviser and other doctors continue completing IHAs as soon as consent is available. Health and Social Care CLA steering group continues monitoring.	1. Any gaps in service provision escalated to Lewisham Place Executive Director.
526	Clinical, Quality and Safety	**A large number of families (up to 200) have been relocated from Tower Hamlets to emergency temporary accommodation at Pentland House.**	There is a potential risk of failure to protect and safeguard the residents (adults and children) placed at Pentland House (temporary/emergency accommodation) due to a lack of health information available to form accurate assessments and provide appropriate support. Since Oct/Nov 2023, families were transferred to Pentland House accommodation. To date, information shared regarding families that have been placed in the accommodation has been limited and LBL CYP Joint Commissioning and LBL Housing are liaising with Tower Hamlets Housing Services to try to resolve this. Section 208 notice – housing legal requirements from Tower Hamlets to Lewisham is to provide data on all individuals including health. Emergency accommodation for Pentland House should only be for 56 days - this has now been breached. Families are also registered with Tower Hamlets (through choice) but the impact and risk is: pregnant females travelling across London for obstetric care, those fleeing domestic abuse, lack of advocacy generally within the location, those re-housed due to domestic / familial abuse and honour based violence abuse, nutritional concerns and limitations with security at Pentland House.	4x4=16	3x4=12	2x4=8	Cautious (7 – 9)	⇔	Ceri Jacob	Fiona Mitchell/Margaret Mansfield	Pregnancy Safeguarding Midwife LGT – liaising with Tower Hamlets vulnerable midwifery team. Specialist Health visiting service. Lewisham are attending weekly at Pentland House in relation to supporting mothers and young children. Liaising with AD of CBC, Lewisham – in relation to Enhanced Primary Care support / GP Access. ICB safeguarding and multi agencies have sent a letter to Tower Hamlets Children's Safeguarding team requesting an extraordinary safeguarding meeting, a response is expected by 24th May 2024.	Director of Housing, Fergus Downie in regards to legal element (S208) has escalated to the Director of Social Housing at Tower Hamlets under the housing and refugee resettlement S208 and in reference to no data has been provided on temporary accommodation residents residing at Pentland House accommodation and will make enquiries regarding advocacy support. Primary Care to escalate to Director at Tower Hamlets regarding the possibility of enhanced access to primary care support with consideration of costs to be absorbed Tower Hamlets. A meeting has been arranged. Joint Commissioning – 0-19 Health and Maternity to discuss gaps in service and risks. Paul Larrisey CN and Rebecca Saunders Safeguarding lead HoN briefed and Ceri Jacob PEL Lewisham who is escalating accordingly.	Unknown due to unknown demography of individuals residing.	None known at present
377	Clinical, Quality and Safety	**All Initial accommodation centres such as Lewisham Stay City apartments Deptford Bridge have high levels of vulnerable Adults & Children and Young People asylum seekers residents.**	Initial Accommodation Centres:- Stay City apartments Deptford Bridge has high levels of vulnerable adults, children and young people (asylum seekers) and to date no safeguarding adult referrals into MASH, ATHENA or PREVENT. Impact: data raises concerns that referral pathways are not being followed and nonconcordance with Lewisham local safeguarding referral pathway for adults. Risk is; large volume of adults, children young people deemed to be at risk. NOTE: Pentland House closed on 11th September 2023 - the rationale has not been shared.	3x3=9	3x3=9	1x1=1	Cautious (7 – 9)	⇔	Ceri Jacob	Fiona Mitchell	As of 11th September 2023, Pentland House has closed. Appropriately, 250 service users will be moved before this date and it is likely that the majority moved will take place prior to 31st August 2023. The Clear Springs Ready Safeguarding team visited Pentland House on 8th August 2023 to meet with those that have additional vulnerabilities to ensure they are profiled to appropriate accommodation. ICB and Lewisham's multi-agencies have met to discuss support of service users' and the transition to new locations. These include NGOs, Primary Care Sanctuaries and other agencies. In addition, a complaint will be raised with the Home Office and Clear Springs Ready homes in relation to system processes used during the closure. A meetings is being held to formulate a multi-agency response. ICB have reached a decision to not support complaint letter as better relationships developed with HO and Clear Springs Ready homes and agreement to refer safeguarding via local pathways in to adult and child MASH 09.04.24 Stay City Apartments remains open. Safeguarding assurance visit conducted with Lewisham ICB, Safeguarding adults and Children, AFRIL and Borough of Sanctuary with recommendations generated and working with Clear Spring Ready Homes and Home Office to progress. Unexpected death in Stay City Apartment - an Appreciative Inquiry has been conducted with multidisciplinary agencies including Home Office and Clear Springs Ready Homes, led by Lewisham ICB where learning outcomes will be discussed with all agencies. Case with Coroner and Police have closed case.	As outlined in controls.	Initial accommodation centres are not commissioned by the ICB but the Home Office. ICB has no contractual service agreement. However, primary care resources to centre supported by Lewisham ICB.	Initial accommodation centres not commissioned by ICB but Home Office. ICB has no contractual service agreement. However, enhanced primary care resources to centre supported by Lewisham ICB.
Children and Young People														

359	Governance	**Failure to deliver on statutory timescales for completion of EHCP health assessments**	Failure to deliver on statutory timescales for completion of Education Health Care Plan health assessments (EHCP). This is being driven by challenges in recruitment and capacity of community paediatricians and therapists. Significant increase in families requesting Special Educational Needs Assessment (SENA) Lewisham has one of the highest numbers for requests for Special Educational Needs Assessment. This will impact on the ICB's ability to meet statutory timescales for completion of EHCP assessments as it does not have the capacity to carry them out within the 22 weeks deadline.	4x4=16	3x4=12	2x3=6	Open (10 – 12)	⇧	Sara Rahman	Paul Creech	1.GPs are being rotated from Primary Care into community paediatrics to support some activity and free time for statutory CMPS work. There has been limited uptake from GPs so no further scope to expand. 2. Paediatric Nurse in place to support medical work which does not require a Paediatrician. 3. Trust are using American recruitment agent to recruit internationally. So far response has been limited but LGT are reviewing the applications. 4.Therapists continue to work weekends to clear the back-log of reviews. 5. Monthly Recovery meetings held with Head of Integrated SEN & LGT Manager to review EHCNA numbers. Detailed performance data identifies delays for assessments by teams to help determine areas to improve. 6.The DCO reviewing the joint working arrangements between health and SEND to streamline the process. EHCNA requests are triaged to reduce the number of new assessments necessary. 7. Trust are reviewing the requirement for all children to be seen by paeds and other professional to assist with carrying out health assessments. A formal proposal has been submitted and a meeting due in December with the Trust to confirm next steps and implementation (will need approval prior to implementation). 8. A group meeting is being held in January to approve implementation of the changes. A working group is in place to update on implementation of the pilot to change the pathway for ECHNAs and activity that have been identified as part of the improvement plan.	Monitoring ongoing to gauge impacts of controls. New Head of Integrated SEND is now in place and attending monitoring meetings.	Increase in EHCPs health assessments being completed on time.	1. Families not attending appointments., 2. Appointments changed. 3. Delayed paperwork (service user end). 4. Brexit has led to loss of staffing (therapists). 5. COVID has also had an impact on staffing levels. 6. Increase in EHCP requests.
360	Governance	**Failure to deliver on statutory timescales for completion of ASD health assessments.**	Failure to deliver on statutory timescales for completion of Autism Spectrum Disorder health assessments. There is an 18 month waiting list. This is being driven by challenges in recruitment of community paediatricians. Impact on ICB - referral to treatment timescale, reputational risk, financial risk - ICB to pay for private assessments.	4x3=12	3x3=9	2x3=6	Open (10 – 12)	⇔	Sara Rahman	Paul Creech	1.Quarterly review of ASD assessments with LCG, includes audit of initial assessments. 2.DCO commissioning reviewing existing autism support pathway to provide pre-diagnostic support. 3.GPs are being rotated from Primary Care into community paediatrics to free up capacity for ADOS assessments. Paediatric Nurse in place to support medical work. 4.International recruitment ongoing (x2 Paediatricians recruited). New adverts in place to attract more application being carefully considered to inspire applicants. No further recruitment - 2 vacancies at present and another round of recruitment due. In terms of capacity, clinical staff assessing ECHP will prioritise where possible ASD assessments too to assist with work demands. 5. A group meeting is being held in January to approve implementation of the changes. A working group is in place to update on implementation of the pilot to change the pathway for ECHNAs and activity that have been identified as part of the improvement plan.	Monitoring ongoing to gauge impacts of controls via Quarterly monitoring meetings.	Reduction in waiting times for assessments.	1. Availability of partners to undertake joint ASD assessments. COVID has increased childhood anxiety in some kids.

Key - Direction of Risk

⇩ Risk has become worse.

⇔ Risk has stayed the same

⇧ Risk is improving

Risk Register Summary (in accordance with Datix)

Lewisham Place Risk Register

Filter

0 (Pending)		15 Active		28 Inactive	
0 New	0 Escalated	13 Review due within 30 days	0 Review Overdue	28 Closed	0 Rejected

	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	**0**	**0**	**1**	**0**	**0**
Likely	**0**	**0**	**3**	**0**	**0**
Possible	**0**	**1**	**5**	**3**	**0**
Unlikely	**0**	**1**	**0**	**0**	**1**
Rare	**0**	**0**	**0**	**0**	**0**

Key

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

Key - Direction of Risk

Risk has become worse.

Risk has stayed the same

Risk is improving

Risk Scoring Matrix

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

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

Likelihood Matrix

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

Severity Matrix

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

South East London Integrated Care System

NHS South East London

NHS SEL ICB
Risk Appetite Statement 2023/24

SEL ICB Risk Appetite Statement 2023/24

The statement

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

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

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

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

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

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

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

South East London Integrated Care System

NHS South East London

ICB risk appetite level descriptions by type of risk

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

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

Selected ICB risk appetite level

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

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

Selected ICB risk appetite level

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

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

Selected ICB risk appetite level

South East London Integrated Care System

NHS South East London

Summary of SEL LCP risks

Prepared for the place executive leads (PELs), 29 April 2024

Version 3

Purpose

Purpose

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

2. Following review of the LCP risks by the PELs in November 2023, it was agreed to continue review of comparative LCP risks on a quarterly basis. This pack provides an updated set of LCP risks, as of **29 April 2024**.

3. The ICB assurance team have also been working with SEL risk owners to review their risks for 2024/25 – this has resulted in some areas of risks currently recorded on the SEL risk register to be considered for reallocation and inclusion onto the LCP risk registers (slides 10 - 12).

4. As the ICB begins to develop its system risk approach, LCP risks on slides 4 - 8 have been assigned* to one of two categories as below:

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

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

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

Contents

1. **Slides 4 - 5:** provide a summary of the risks which have been identified and recorded on more than one LCP risk register, with their residual risk score rating.

2. **Slides 6 - 8:** provide a summary of all risks identified and recorded on a single LCP risk register. The list of risks is varied and may be specific to a particular LCP, however these risk make a useful list of risk that in some cases **may also be applicable to other LCPs.** They should therefore be reviewed and considered for inclusion in local risks registers.

3. **Slide 9:** summarises the risks that were discussed at the PELs meeting on 5 February 2024, with an update on which LCP registers have those areas of risk recorded.

4. **Slides 10 - 12:** provide a summary of risks previously recorded on the SEL register, which should be considered by PELs and their SMTs for future inclusion on the LCP risk register.

5. **Slide 13:** provides a set of key questions for PELs, their SMTs and borough risk leads when completing risk reviews in the LCP.

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

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

Key:

- ● *To be shown on ICB BAF*
- ○ *Newly added risk*
- ▲ *References to 2023/24 to be updated to 2024/25*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

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

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

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Virtual wards will not be developed / optimised			9		4	
CYP diagnostic waiting times for autism and ADHD targets not being met		9 ○		6		8 ○
Financial risk associated with the legal challenge related to the integrated community equipment service (ICES)			6 ○			8
Financial pressure of mental health placements		9 ○				9

Key:

- *To be shown on ICB BAF*
- ○ *Newly added risk*
- △ *References to 2023/24 to be updated to 2024/25*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Risks recorded on one LCP risk register only (1 of 3)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Plans to support UEC will be unsuccessful	16 ●					
Primary Care Estate - Insecure lease arrangements	16 ●					
CHC packages leading to deprivation of liberty		8				
Lack of engagement with local communities			9			
Risk to development of iThrive and preventative system approach to children's MH and wellbeing			12			
Risk to the rollout of Family Hubs programme			9			
Risk to ensuring food and nutrition is included as part of all diet-rated disease care pathways			12			
Risk to implementation of Get Active physical activity and sports strategy			12			
Risk to delivery of performance targets delegated to place (these include IAPT access, SMI health checks, children immunisation and cancer screening)			12 ▲			
Clinical risk to CHC funded individual			12 ○			

Key:

● *To be shown on ICB BAF*

○ *Newly added risk*

↑ *Score increased*

↓ *Score decreased*

▢ *Primarily ICB risk*

▢ *Primarily System risk*

▲ *References to 2023/24 to be updated to 2024/25*

Risks recorded on one LCP risk register only (2 of 3)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Failure to safeguard adults due to pressures across partners				6		
Failure to prevent vaccine preventable diseases through less than optimal vaccination rates				12		
System wide pressures on LCP delivery plan				6		
Risk to continuity of service provision following expiry of leases for primary care sites				9		
Initial Health Assessments (IHAs) not completed for children Looked After within 20 days					9 ▲	
Safeguarding risks with high number of vulnerable adults/children in initial accommodation centres					9	
Risk to delivery of MH LTP trajectories					10	

Key:

- *To be shown on ICB BAF*
- *Newly added risk*
- ▲ *References to 2023/24 to be updated to 2024/25*
- ↑ *Score increased*
- ↓ *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Risks recorded on one LCP risk register only (3 of 3)

Risk summary	Residual Risk Score					
	Bex	Bro	Gre	Lam	Lew	Sou
Initial accommodation centres putting pressures on the local health system						↓ 6
Cost pressures due to rapid increase in patients seeking ADHD and Autism diagnostic services from independent sector providers						12
Service disruption due to delays opening of a health centre						12
MCR transition and implementation affecting BAU						12 ○

Key:

- *To be shown on ICB BAF*
- *Newly added risk*
- *References to 2023/24 to be updated to 2024/25*
- *Score increased*
- *Score decreased*
- *Primarily ICB risk*
- *Primarily System risk*

Risk areas discussed last quarter for potential inclusion on LCP registers

Following the comparative risk review by PELs on 5 February 2024, it was agreed that LCP and some SEL risks should be examined in further detail where there appeared to be a possible overlapping of accountability for an area of risk between LCPs and SEL (i.e. risks are included on the SEL register and LCP registers). It was noted that as per the Risk Management Framework, risk ownership should follow the delegation of responsibilities from the Board.

The table below summarises the areas of risks discussed, along with which LCPs have those areas of risks now recorded and which LCPs we await confirmation from.

Risk Summary		Risk area recorded on the following LCP registers:	Awaiting confirmation from:	Other comments
1	Financial and poor delivery risk associated with the community equipment services provider	Bromley, Greenwich, Lambeth, Southwark	Lewisham	Bexley review in Feb– not an area of risk for the LCP.
2	Patients fit for discharge unable to leave hospital due to pressures in community and social care services / loss of funding	Bexley, Greenwich, Southwark	Bromley, Lambeth, Lewisham	
3	CYP diagnostic waiting times for autism and ADHD targets not being met	Bromley, Lambeth, Southwark	Greenwich, Lewisham	Bexley review in Feb – not an area of risk for the the LCP

Risks confirmed and proposed for transfer from SEL to LCP risk registers (1 of 3)

Below are areas of risk that were either previously or are currently recorded on the SEL risk register. Following year-end review by the assurance team and SEL risk owners, these **areas of risk are proposed to transfer to LCP risk registers** given that responsibility for delivery is primarily delegated to LCPs.

<u>Action required</u>: LCPs to consider the below listed risk areas and to add an appropriate risk register entry as required.

Risk Summary		SEL risk description (risk now closed on SEL register and awaiting transfer to LCPs)
1	**Delivery of access to primary care appointments**	There is a risk of not being able achieve timely access to primary care services. This is caused by: a) constrained capacity due to workforce shortages, lack of digital enablement, inadequate estate or changes to commissioned services b) Increased demand due to population growth, increased acuity, backlog of care as a result of covid, pathway changes which increase activity and/or changes in patient expectations The impact on the ICB is its ability to meet statutory duties. Primary care is defined as “healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment”. This includes a wide range of services from general practice and pharmacy services, to NHS 111 and some urgent care services.
2	**Proportion of population vaccinated**	There is a risk that insufficient proportions of the population will be vaccinated making them vulnerable to the vaccine preventable diseases, and increasing the risk of outbreaks, thereby increasing levels of illness and risk of death in the population. Increases in infection levels may also impact on staff sickness and absence. The increase in levels of infectious disease may have consequences for other services, such as delay in routine procedures. There is also a risk that certain parts of the population, may suffer from illness disproportionally. This may because of a lack of access or culturally issues. These are two separate points and need to be on separate lines. This will impact on the ICB's ability to meet statutory requirements.

Risks confirmed and proposed for transfer from SEL to LCP risk registers (2 of 3)

Risk Summary		SEL risk description (risk recommended for closure on SEL register and transfer to LCPs)
3	**Delivering mental health access performance metric trajectories**	The NHS Long Term Plan sets out a series of ambitions for all mental health and learning disability/autism services to expand access to service provision. Expansion targets are in place for the whole country and there is a risk that due to workforce availability, capacity and competition, these access targets may not be delivered for 2023/24 There is a risk that services are unable to meet demand and waiting lists either grow or stagnate. Furthermore, as several of these access targets are part of our early intervention and prevention approach, there is a risk that this demand then presents through unplanned care routes impacting urgent and emergency care pathways, bed capacity and overall outcomes for service users.
4	**Delivering community-based mental health transformation programmes**	There is a risk that community transformation programmes across adults and children and young people's services are not delivered, which will lead to high demand for inpatient beds and ongoing crisis presentation. This is caued by competing priorities across the system, including front door crisis pressures, resources and time. This impacts on the ICB's ability to meet statutory obligations. Transforming and expanding mental health community service provision is key in supporting service users to stay well in their communities and maintain their independence, as well as reducing crisis presentations and admissions to inpatient beds.
5	**Reducing waiting times for mental health services**	As a result of the pandemic, there has been a significant increase in referrals to mental health services, specifically for adult ADHD services, community mental health services and children and young people’s mental health services (including eating disorders). There is a risk that despite achieving access rates for services, waiting times for first appointment and treatment remain high, impacting on acuity of presentations and overall recovery and outcomes for our population. Furthermore, there is a risk that this demand then presents through unplanned care routes impacting urgent and emergency care pathways, bed capacity and overall outcomes for service users.

Risks confirmed and proposed for transfer from SEL to LCP risk registers (3 of 3)

Risk Summary		SEL risk description (risk recommended for closure on SEL register and transfer to LCPs)
6	**There is the risk of reputational damage to SEL ICB due to the potential failure of a provider to meet statutory requirements, with an increase in numbers of patients presenting with safeguarding concerns not being addressed.**	There is the risk of reputational damage to SEL ICB due to the potential failure of a provider to meet statutory requirements, with an increase in numbers of patients presenting with safeguarding concerns not being addressed. This risk has been identified through a Safeguarding Learning Event held within the provider which highlighted their lack of knowledge in discharging their statutory safeguarding functions, as well as from other Child Safeguarding Practice Reviews and the Trust external review.
7	**Increased waiting times for Autism diagnostic assessments**	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory obligations. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.
8	**Reducing health inequalities**	The ICB is committed to reducing health inequalities through prevention and intervention programmes. There is a risk the programme of work is spread too thin to deliver measurable and tangible improvements in health inequalities resulting in communities continuing to experience inequalities in their outcomes and care.

Questions and points for consideration by PELs, LCP SMTs and risk leads

1. **Have all risks related to 2023/24 been closed or updated to reflect the new financial year?**

   Risks with references to 2023/24 have been indicated with the red triangle, and examples include:

   - financial balance in the borough
   - efficiency savings in the LCP
   - prescribing budget balance
   - CHC budget balance
   - Closure of risks relating to the 2023/24 LCP delivery plan commitments.

2. **Have all risks that threaten achievement of the activities / objectives / ambitions included in the LCP delivery plan for 2024/25 (year 2 of the plans) been considered and recorded on risk registers?**

3. **LCPs to consider whether:**
   - **there are local risks related to those areas of risk proposed to transfer from SEL ownership to LCPs (see pages 10 - 12)**
   - **areas of risk shown on slide 9 are applicable to their LCP (for those boroughs we await confirmation from).**

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 8
Enclosure 8

Title:	**Month 3 Finance Report 2024/25**
Meeting Date:	**25 July 2024**
Author:	Michael Cunningham
Executive Lead:	Ceri Jacob

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board on the ICB - Lewisham Place financial position at month 3 2024/25. A month 2 position is included for the wider ICB/ICS and LA, reflecting reporting timescales.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

Month 3 2024/25 – SEL ICB – Lewisham Place

At month 3, the borough is reporting an overspend year to date (YTD) of £392k but is retaining a forecast outturn (FOT) of breakeven. All budget areas individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing where there are material overspends.

It should be noted this in the first time in recent history that Lewisham place has reported an overspend and is reflective of the severity of the financial challenges faced locally. A breakeven FOT is currently maintained in anticipation that sufficient financial recovery measures will be identified and implemented in the remainder of the year.

Whilst some measures will be non-recurrent, these can only be used once. It is therefore vital that overspends are managed downwards as far as possible and other recurrent mitigations are applied to bring the place back to recurrent financial balance.

Further details of the financial position and the approach to financial recovery are included in this report.

Month 2 2024/25 – Lewisham Council

At month 2 Adult Social Care Services is forecasting an overspend of £6.0m and Children's Social Care Services is forecasting an overspend of £7.9m. Further details are provided in this report.

	Month 2 2024/25 – SEL ICB As at month 2, the ICB is reporting a year to date (YTD) underspend of £857k against its Revenue Resource Limit (RRL), which represents an overspend against plan of £2,506k, since the ICB has a planned surplus for 2024/25. As at month 2, and noting the risks outlined in this report, the ICB is forecasting that it will deliver a year-end position of break-even against plan. The detail of this position is shown as Appendix A to this report. **Month 2 2024/25 – SEL ICS** Appendix B shows the financial highlights for the ICS at month 2. The key elements are as follows: • Planned aggregate deficit of £100m. The Executive summary Appendix B shows the breakdown. • Efficiencies target £269.8m of which £228.1m is identified. At month 2 only 36.2% of this is rated as low risk of being delivered. • At month 2 the ICS is reporting a YTD deficit of £41.5m adverse to plan by £7.8m. The main driver of the month 2 position is under delivery against efficiency targets.
Potential Conflicts of Interest	Not applicable
Any impact on BLACHIR recommendations	Not applicable

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

	Equality Impact	Not applicable
	Financial Impact	The paper sets out the YTD financial position and forecast for 2024/25.
Other Engagement	Public Engagement	Not applicable
	Other Committee Discussion/ Engagement	The ICB Finance Report Appendix A is a standing item at the ICB Planning and Finance Committee.
Recommendation:	The Lewisham Health & Care Partners Strategic Board is asked to **note** the YTD financial position and forecast for 2024/25.	

NHS
South East London

Lewisham LCP Finance Report

Month 3 – 2024/25

ICB – Lewisham Delegated Budget – Month 3 2024-25

NHS South East London

Overall Position

- At month 3, the borough is reporting an overspend year to date (YTD) of £392k but is retaining a forecast outturn (FOT) of breakeven. All budget lines individually are showing breakeven or an underspend except for continuing care services (CHC) and prescribing.

- CHC shows a material overspend YTD of £1,310k and FOT of £5,239k (outturn 2023/24 £3,638k). The position is driven predominantly by the full year effect of activity pressures seen in the second half of last year c.£1,445k, a significant element relating to LD clients. The position also assumes price pressures of 4% for 2024/25 equivalent to £1,103k and emerging activity pressures in 2024/25, driven by palliative care clients and those in receipt of funded nursing care (FNC).

- The Place Executive Lead continues to lead weekly meetings of the Lewisham CHC team to ensure savings plans are being implemented and monitored, and a plan is in place to ensure client reviews are being undertaken in an optimal way. The team is also focussed on an ongoing cleanse of the client database to help assure reporting accuracy, and progress will be monitored through the weekly meetings.

- Prescribing shows an overspend YTD of £390k and FOT £1,547k. This is caused by an upward trend in April in some prescribing cost categories including appliances, central nervous system and Endocrine system prescribing costs. This cost behaviour will continue to be scrutinised through the Lewisham Financial Recovery Group and corrective interventions implemented where possible, recognising the volatility of prescribing data in the early part of the year.

- Whilst it is currently anticipated these pressures can be mitigated to achieve a breakeven position at the year end, this will involve a significant element of non-recurrent solutions being implemented and will be achieved at the opportunity cost of reduced investments in community and primary care services, and therefore consequential system implications.

- All currently identified mitigations have been applied in the reported financial position which is of concern, given that there will potentially be further activity pressures on CHC and prescribing as the year continues. The local authority has also indicated an intention to recover health contributions towards section 117 mental health clients which may have a material financial impact. A co-ordinated piece of work is underway to establish and verify the likely impact, the result of which is expected over the summer period.

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	325	219	106	1,298	876	422
Community Health Services	7,254	7,056	197	29,014	28,225	789
Mental Health Services	1,884	1,860	24	7,538	7,447	91
Continuing Care Services	5,764	7,074	(1,310)	23,056	28,295	(5,239)
Prescribing	10,648	11,038	(390)	42,591	44,137	(1,547)
Prescribing Reserves	0	0	0	0	0	0
Other Primary Care Services	377	270	107	1,508	1,080	428
Other Programme Services	838	6	832	3,354	(1,661)	5,015
Delegated Primary Care Services	14,246	14,246	0	62,008	62,008	0
Corporate Budgets	756	714	42	2,989	2,947	42
Total	**42,092**	**42,484**	**(392)**	**173,355**	**173,355**	**0**

- The Lewisham Financial Recovery Group (sub-group of SMT) continues to meet monthly, again chaired by the Place Executive Lead, and is focussed on identifying additional financial recovery actions across all budgets that can be taken to mitigate against the financial pressures faced by the borough.

- The borough efficiency target is £3,576k, is fully identified and forecast to deliver in full, but is insufficient on its own to mitigate the scale of financial pressures faced, and therefore additional financial recovery measures are urgently being pursued through the Lewisham Financial recovery Group.

Month 2 2024/25 – Lewisham Council

NHS South East London

Overall Position

2024/25 Efficiencies	Year-to-date Month 2 2024/25				Full-Year Forecast 2024/25		
	Plan	Actual	Variance		Plan	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	0.6	0.6	(0.0)		3.7	3.7	0.0
Childrens Care Services	0.5	0.44	(0.02)		0.91	0.88	(0.03)
Total	**1.1**	**1.0**	**(0.0)**		**4.6**	**4.6**	**(0.0)**

2024/25 LBL Managed Budgets	Year-to-date Month 2 2024/25				Full-Year Forecast 2024/25		
	Budget	Actual	Variance		Budget	Forecast	Variance
	£m	£m	£m		£m	£m	£m
Adult Care Services	12.9	13.9	(1.0)		77.3	83.3	(6.0)
Childrens Care Services	11.0	12.3	(1.3)		66.1	74.0	(7.9)
Total	**23.9**	**26.2**	**(2.3)**		**143.4**	**157.3**	**(13.9)**

Adults Commentary: The Adult Social Care & Health Directorate is forecasting a £6m overspend for 2024/25. The key cause of this pressure is the unusually high inflation requests from providers, largely due to the increase in London Living Wage, which is estimated to be £4m. This pressure is further exacerbated by the complexity of care requirements for discharged clients. Additionally, there is a steady increase in both the number of and cost of children transitioning to adulthood.
Work is ongoing to ensure early intervention and planning so that their care costs can be better managed.
The deep dive into ASC will look to re-assess the significant changes made post the Adults Transformation Programme in 201/22 and 2022/23 to see whether further cost reductions can be made to offset these pressures.
There is an ongoing challenge around collecting service user care costs where they are liable to pay for all or part of the care provided. Debt collection has been identified as a corporate priority and there is a specific project set up to ensure that these processes are improved.

1.1. **Children's Social Care:** The forecast is based on supporting a similar number of children at a comparable cost to 2023/24, which was £3.1m higher than the revised budget for 2024/25, with an additional in year pressures of £5m for additional Children Looked After (CLA) placements demand. This is based on a net additional impact of 10 CLA's at a rate of circa £10k per week for the duration of 2024/25. The forecast assumption is that any inflation uplifts can be met within the budget allocated for this as part of 2024/25 budget setting.

1.2. The directorate have been working towards more intervention and support strategies, this involves improved commissioning work with the PAN London Commissioning Alliance to secure more favourable rates and work undertaken to create alternative capacity such as the Amersham and Northover in house provision as well as further support offered to parents and young people. Further opportunities similar to this are being sought, however these are medium to long term solutions.

1.3. The service as part of the high cost panel review process, considers all young people with an endeavour to limit their stay in high cost provision and also where appropriate secure funding from partner organisations. The aim is to find alternative placements within a 3 to 4 month timeframe, however this is not always possible. Following amendments to the care planning placement and case review regulations, it has been illegal to place children under 16 years of age in unregulated placements. This is a significant driver behind the increased cost per child that the market are demanding and forecasting the expenditure on high cost (£7k a week plus) placements is extremely volatile, as there is huge uncertainty over their length of stay.

1.4. The CSC deep dive review has identified a number of key lines of enquiry, which is largely aligned with existing projects and programmes of improvement and which will be developed further to identify specific cost reduction measures.

Appendix A

SEL ICB Finance Report

Month 2 2024/25

Contents

NHS South East London

1. Executive Summary

NHS South East London

- This report sets out the month 2 financial position of the ICB. The financial reporting for month 2 is based upon the 2nd May plan submission. This included a planned year-end surplus of **£20,172k** for the ICB. This has been updated to a surplus of **£40,769k** in the plan submission made on 12th June.
- The ICB's financial allocation as at month 2 is **£4,472,839k.** In month, the ICB has received an additional allocation of £11,975k, which was in respect of the consultants pay award and will be paid to local providers.
- As at month 2, the ICB is reporting a year to date (YTD) overspend against plan of **£2,506k**. The full year element of the surplus to be directly achieved by the ICB is **£4,792k**, for which the YTD delivery **(circa £800k)** is reflected in the month 2 financial position. The remaining £15,380k of the surplus is being held by the ICB in its plan but will be delivered and reported within provider financial positions. This will generate a positive impact against provider plans, and net neutral across the ICS.
- Due to the usual two months arrears in receiving data from the PPA, the ICB does not have YTD actuals for 2425 prescribing spend is therefore reporting a breakeven position.
- The ICB is continuing to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's redundancy business case is now with the DHSC, and we are awaiting confirmation of its approval, so that notice can be given to staff. This delay is generating additional costs for the ICB both in respect of the ongoing cost (**£500k per month**) and the impact upon the final redundancy payments, given longer employment periods etc.
- The current expenditure run-rate for CHC services is above budget **(£958k)**, with places implementing efficiencies to mitigate this. Lewisham is particularly impacted **(£885k)**. This is as highlighted later in the report.
- At month 2, the delivery of the ICB's savings plan of **£25.4m** is on track.
- In reporting this month 2 position, the ICB has delivered the following financial duties:
    - A broadly balanced position on its management costs allocation – with vacancies currently offsetting the pay costs of ICB staff at risk. However, this is a non-recurrent benefit which will reduce as vacancies are recruited into;
    - 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, and noting the risks outlined in this report, the ICB is forecasting that it will deliver a year-end position of **break-even.**

2. Revenue Resource Limit

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	**147,630**	**249,631**	**177,025**	**214,455**	**170,943**	**167,786**	**3,333,394**	**4,460,864**
M2 Internal Adjustments								
Mental Health SDF	1,049	3,464	2,037	2,146	901	2,431	(12,028)	-
M2 Allocations								
Consultants pay award							11,975	**11,975**
M2 Budget	**148,679**	**253,095**	**179,062**	**216,601**	**171,844**	**170,217**	**3,333,341**	**4,472,839**

- The table sets out the Revenue Resource Limit at month 2.
- The start allocation of **£4,460,864k** is consistent with the Operating Plan submissions.
- During month 2, internal adjustments were actioned to ensure allocations were aligned to the correct agreed budgets. These had no overall impact on the overall allocation. The main adjustments related to the mental health SDF funding which was allocated to the places.
- In month, an additional allocation of **£11,975k** was received, giving the ICB a total allocation of **£4,472,839k** as at month 2**.** The additional allocation was in respect of the consultant pay award and this will be paid to local providers.
- Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

3. Key Financial Indicators

NHS South East London

Key Indicator Performance	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	745,473	747,979	4,527,672	4,527,672	
Operating Under Resource Revenue Limit	739,797	742,303	4,472,839	4,472,839	
Not to exceed Running Cost Allowance	5,252	5,313	31,509	31,509	
Month End Cash Position (expected to be below target)	4,063	237			
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%	99.8%			
Mental Health Investment Standard (Annual)			458,449	458,449	

- The above table sets out the ICB's performance against its main financial duties on both a year to date and forecast basis. As highlighted above in the Executive summary, the ICB is the ICB is reporting a year to date (YTD) **underspend of £857k against its revenue resource limit (RRL),** which represents an **overspend against plan of £2,506k**. The element of the surplus to be directly delivered by the ICB is £4,792k, which is reflected in the YTD financial position.
- The remaining £15,380k of the surplus is being held by the ICB in its plan but will be delivered and reported within provider financial positions. This will generate a positive impact against provider plans, and net neutral across the ICS.
- This position is consistent with the May 2024 plan submission. From month 3, the ICB will be reporting against the June submission of the plan which includes an ICB surplus of £40,769k.
- The ICB is reporting a broadly balanced position on its management costs allocation (overspend of £61k), with vacancies currently offsetting the pay costs of ICB staff at risk. However, this is a non-recurrent benefit which will reduce as vacancies are recruited into.
- All other financial duties have been delivered for the year to month 2 period.
- A **break-even position** is forecasted for the 2024/25 financial year.

4. Budget Overview

NHS South East London

	M2 YTD							
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	812	1,282	1,168	198	216	14	374,716	**378,406**
Community Health Services	3,513	14,538	6,311	4,352	4,597	5,770	41,699	**80,779**
Mental Health Services	1,716	2,434	1,396	3,806	1,262	1,684	85,671	**97,969**
Continuing Care Services	4,356	4,521	4,870	5,769	3,843	3,293	-	**26,653**
Prescribing	6,235	8,508	6,215	7,111	7,098	5,852	(70)	**40,950**
Other Primary Care Services	448	219	218	498	232	37	2,667	**4,318**
Other Programme Services	200	3	167	4	555	140	7,243	**8,311**
PROGRAMME WIDE PROJECTS	-	-	-	-	4	42	2,622	**2,668**
Delegated Primary Care Services	6,435	9,316	8,185	12,737	9,497	10,183	(323)	**56,030**
Delegated Primary Care Services DPO	-	-	-	-	-	-	34,891	**34,891**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	407	**407**
Corporate Budgets	469	555	576	587	504	517	5,206	**8,415**
Total Year to Date Budget	**24,184**	**41,377**	**29,105**	**35,063**	**27,809**	**27,531**	**554,728**	**739,797**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	812	1,282	1,182	198	187	14	374,715	**378,389**
Community Health Services	3,520	14,539	6,308	4,352	4,447	5,770	41,699	**80,635**
Mental Health Services	1,719	2,487	1,418	3,864	1,239	1,807	85,684	**98,219**
Continuing Care Services	4,347	4,633	4,978	5,699	4,727	3,227	-	**27,612**
Prescribing	6,235	8,508	6,215	7,111	7,098	5,852	(70)	**40,950**
Other Primary Care Services	448	219	218	498	161	37	2,667	**4,247**
Other Programme Services	200	3	35	4	(12)	140	7,242	**7,611**
PROGRAMME WIDE PROJECTS	-	-	-	-	4	42	4,789	**4,835**
Delegated Primary Care Services	6,435	9,316	8,185	12,737	9,497	10,183	(323)	**56,030**
Delegated Primary Care Services DPO	-	-	-	-	-	-	34,891	**34,891**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	1,421	**1,421**
Corporate Budgets	442	484	565	511	461	430	4,570	**7,462**
Total Year to Date Actual	**24,158**	**41,470**	**29,105**	**34,975**	**27,809**	**27,501**	**557,286**	**742,303**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCGs
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	(0)	1	(15)	(0)	30	0	0	**16**
Community Health Services	(7)	(0)	3	0	150	(0)	(1)	**145**
Mental Health Services	(3)	(53)	(22)	(58)	23	(123)	(13)	**(250)**
Continuing Care Services	9	(111)	(108)	70	(885)	66	-	**(958)**
Prescribing	-	-	-	-	-	-	-	**-**
Other Primary Care Services	-	-	-	-	71	-	-	**71**
Other Programme Services	-	-	132	-	567	-	1	**699**
PROGRAMME WIDE PROJECTS	-	-	-	-	-	0	(2,167)	**(2,167)**
Delegated Primary Care Services	-	-	0	-	-	-	(0)	**(0)**
Delegated Primary Care Services DPO	-	-	-	-	-	-	0	**0**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	(1,014)	**(1,014)**
Corporate Budgets	27	72	11	76	43	87	636	**953**
Total Year to Date Variance	**26**	**(92)**	**1**	**88**	**0**	**30**	**(2,558)**	**(2,506)**

- As at month 2, the ICB is reporting a year to date (YTD) underspend of **£857k** against RRL, which represents an overspend against plan of **£2,506k**. The full year element of the surplus to be directly achieved by the ICB is **£4,792k**, for which the YTD delivery is reflected in the month 2 financial position.
- Due to the usual two months arrears in receiving 2425 data from the PPA, the ICB is reporting a breakeven position on prescribing.
- There are two specific key risks to flag at month 2. The current expenditure run-rate for CHC services is above budget. Overspend at month 2 is **£958k**, of which the majority is in Lewisham **(£885k)**. In Lewisham programme budgets are being released to offset this. In all places, saving schemes being implemented to mitigate these and other pressures.
- In addition (and as described in earlier slides) the ICB is continuing to incur pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case is with the DHSC, and we are awaiting confirmation of its approval, so that notice can be given to staff. The ongoing additional cost is **£500k per month**.
- The Mental Health cost per case (CPC) budgets across the ICB are highlighting cost pressures and overall, the Mental Health budget is overspent by £250k at month 2. The CPC issue is differential across boroughs with Bromley and Southwark being the most impacted. Both boroughs are taking actions to mitigate this expenditure.
- Individual place financial positions will be provided from month 3, once the ICB starts to receive 2425 prescribing activity/cost information.

5. Prescribing – Overview

NHS South East London

- The YTD prescribing budget as at month 2 is **£40,950k**, with **£40,730k** budgeted to fund practice PPA expenditure. The table shows the PPA budgets at a place level. Due to the usual two months arrears in receiving data from the PPA, the ICB has no actual 2024/25 activity/cost information upon which to report expenditure at this stage of the year. A **break-even position** is therefore being reported.

M02 Prescribing	Total PMD (Excluding Cat M & NCSO)	Cat M & NCSO	Central Drugs	Flu Income	PY (Benefit)/Cost Pressure	Difference between PMD & IPP Report	Total 24/25 PPA Spend	YTD Budget	YTD Variance - (over)/under	Annual Budget (Includes Flu Income)	FOT Actual	FOT Variance - (over)/under
BEXLEY	6,200,836						6,200,836	6,200,836	0	37,205,018	37,205,018	0
BROMLEY	8,467,430						8,467,430	8,467,430	0	50,804,582	50,804,582	0
GREENWICH	6,166,667						6,166,667	6,166,667	0	37,000,001	37,000,001	0
LAMBETH	7,098,030						7,098,030	7,098,030	0	42,588,181	42,588,181	0
LEWISHAM	6,985,547						6,985,547	6,985,547	0	41,913,282	41,913,282	0
SOUTHWARK	5,792,012						5,792,012	5,792,012	0	34,752,075	34,752,075	0
SOUTH EAST LONDON	20,000						20,000	20,000.00	0	120,000	120,000	0
Grand Total	**40,730,523**	**0**	**0**	**0**	**0**	**0**	**40,730,523**	**40,730,523**	**0**	**244,383,139**	**244,383,139**	**0**

- An estimate of prescribing expenditure for February and March 2024 was accrued into the ICB's year-end 2023/24 financial position.
- We have now the final prescribing financial information for 2023/24. The actual expenditure was in line with the estimate made, meaning no adverse impact upon the ICB's financial position for 2024/25.
- The prescribing monthly run-rate for the last quarter of 2023/24 was circa £20,200k. Therefore, if prescribing expenditure continued at the same level for the first 2 months of this financial year, the YTD spend would be **£40,400k** against a budget of **£40,730k**, generating a broadly **balanced position** (underspend of £300k).

6. NHS Continuing Healthcare – Overview

NHS South East London

- The 2024/25 Continuing Care (CHC) budgets have been built from the 2023/24 budget and adjusted for reserves (£1.5m), underlying forecast outturn (£8.6m), price inflation (0.8%), activity growth (3.0%) and ICB allocation convergence adjustments (-1.09%). The overall budget as at month 2 is **£26,653k.**
- The overall CHC financial position as at month 02 is an **overspend of £958k**, with the underlying cost pressures variable across the places. The overspend in Bromley **(£111k)** is largely non-recurrent relating to the final settlement of a retrospective CHC case. The impact is the difference between the actual charge and the provision made. The overspends in Greenwich **(£108k)** and Lewisham **(£885k)** are primarily a result of pressures within fully funded, palliative, joint funded and funded nursing care (FNC) client settings. In both places, the overall financial positions are being managed through the release of programme reserves to deliver overall balance. In Lewisham, there are significant pressures generated by individual high-cost clients. The full year care packages of the 20 highest cost clients across both learning and physical disabilities (<65 age group for physical disabilities) is circa **£8,640k.** Weekly meetings chaired by the Place Executive Lead are held to review CHC activity. In addition, a cleanse of the CHC client database is being undertaken, plus the usual monthly reconciliations to invoices received.
- The remaining places are reporting small underspends.
- The ICB has a panel in place to review price increase requests above 1.8% from providers to both ensure equity across SE London and to mitigate large increases in cost. The panel meets every week to discuss and agree cost increase requests from the CHC care providers.
- All boroughs are reporting achievement of their 2024/25 CHC savings schemes.

7. Provider Position

NHS South East London

Overview:

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

- In year, the ICB is forecasting to spend circa **£3,086,358k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£695,199k**
    - Kings College Hospital **£744,271k**
    - Lewisham and Greenwich **£637,072k**
    - South London and the Maudsley **£313,891k**
    - Oxleas **£243,273k**

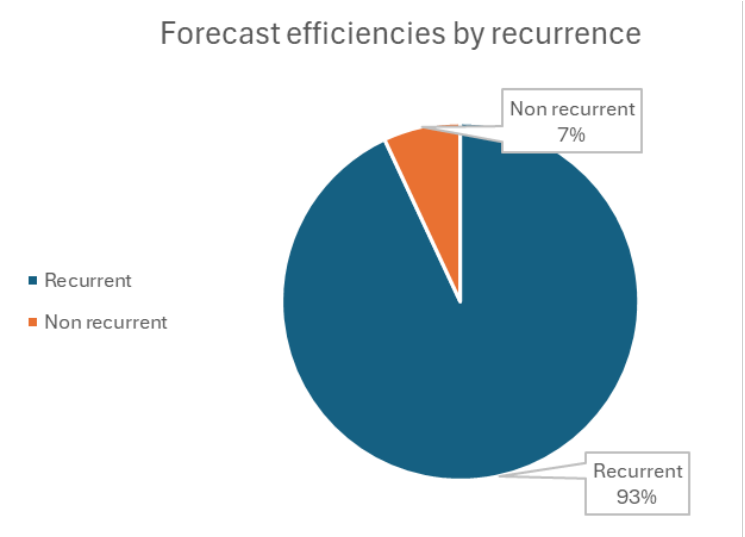
- In month, the ICB position is showing a break-even position on these NHS services and a break-even position has also been reflected as the forecast year-end position.

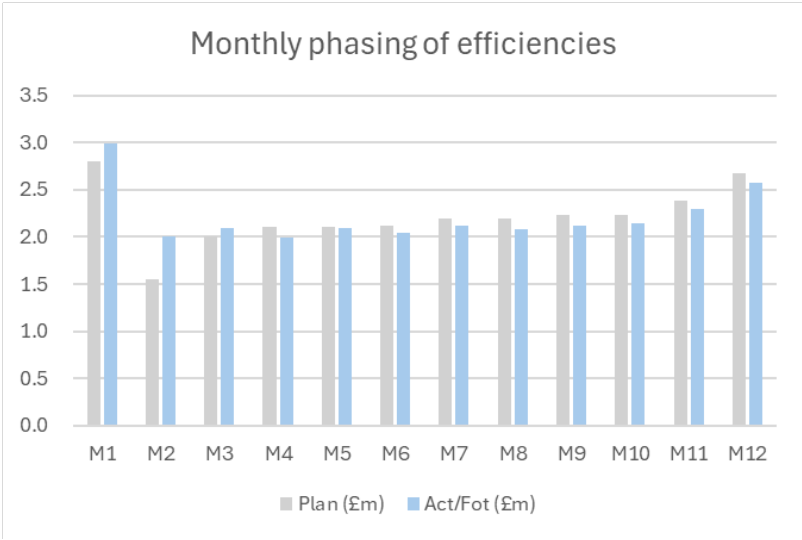
8. ICB Efficiency Schemes at as Month 2

NHS South East London

- The 6 places within the ICB have a total savings plan for 2024/25 of **£25.4m.** In common with the previous financial year, the key elements of the savings plans are in continuing healthcare (CHC) and prescribing.
- As at month 2, the table to the right sets out the YTD and forecast status of the ICB's efficiency schemes.
- **As at month 2, the ICB is reporting actual delivery in line with plan.** At this early stage in the financial year, the annual forecast is to slightly exceed the efficiency plan (by £1.2m), although this will need ongoing close monitoring.
- The current risk rating of the efficiency plan is also reported. At this stage in the year, **£1.5m** of the forecast outturn of **£26.6m** has been assessed by the places as **high risk.**
- Most of the savings **(93%)** are forecast to be delivered on a recurrent basis.

	M2 year-to-date			Full-year 2024/25			Full Year Forecast - Scheme Risk		
	Plan	Actual	Variance	Start Plan	Forecast	Variance	Low	Medium	High
ICB Boroughs	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	1.3	1.3	0.0	3.3	3.5	0.1	2.6	0.6	0.3
Bromley	0.8	0.8	0.0	6.3	6.4	0.1	4.1	2.4	0.0
Greenwich	0.6	0.5	(0.0)	3.5	4.2	0.7	0.6	3.5	0.0
Lambeth	0.6	0.6	(0.0)	5.2	5.2	(0.1)	0.0	5.2	0.0
Lewisham	0.5	0.5	0.0	3.2	3.6	0.4	2.9	0.7	0.0
Southwark	0.5	0.5	(0.0)	3.8	3.7	(0.0)	1.9	0.6	1.2
SEL ICB Total	**4.4**	**4.3**	**(0.0)**	**25.4**	**26.6**	**1.2**	**12.1**	**13.0**	**1.5**





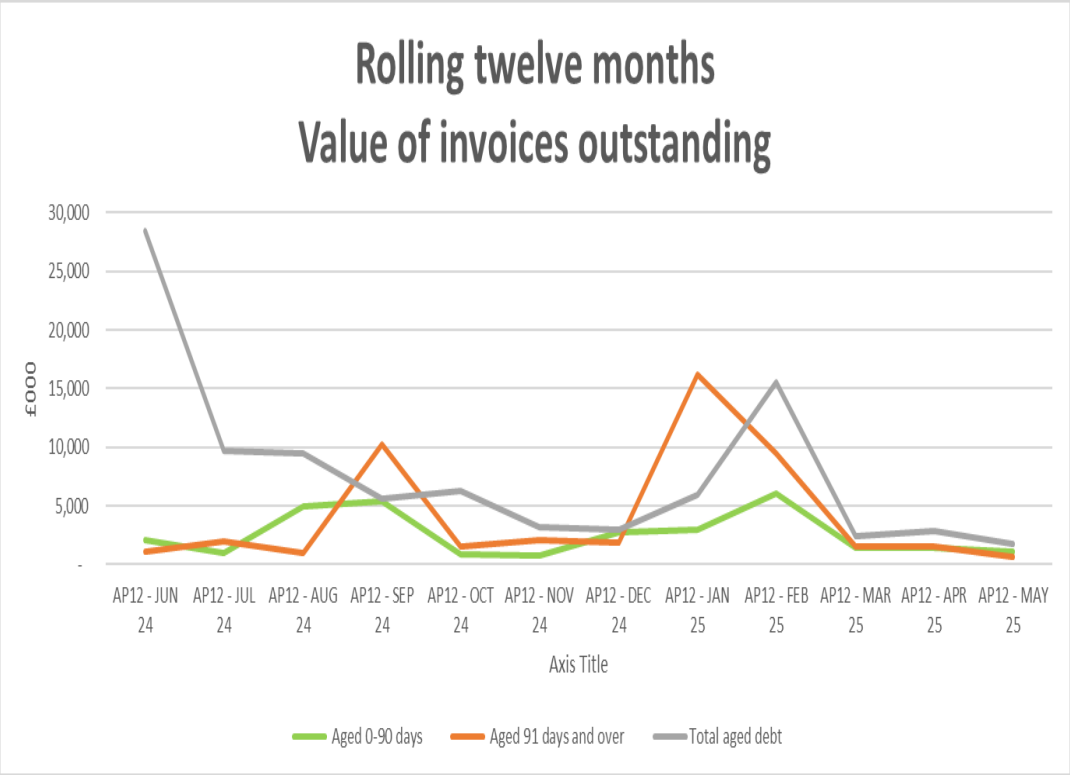
9. Corporate Costs – Programme and Running Costs

NHS South East London

Area		Year to Date		
	Annual Budget	Budget	Actual	Variance
	£	£	£	£
Boroughs				
Bexley	2,466,667	401,112	373,977	27,135
Bromley	3,073,060	530,677	458,950	71,727
Greenwich	3,030,610	529,101	518,324	10,778
Lambeth	3,202,049	551,175	475,201	75,974
Lewisham	2,773,243	468,207	424,835	43,372
Southwark	2,862,125	500,521	413,031	87,489
Subtotal	**17,407,754**	**2,980,793**	**2,664,318**	**316,475**
Central				
CESEL	437,482	72,914	30,978	41,935
Chief of Staff	2,912,328	485,388	433,646	51,742
Comms & Engagement	1,592,404	265,401	208,386	57,014
Digital	1,542,037	257,006	158,762	98,244
Digital - IM&T	2,965,644	494,274	430,555	63,718
Estates	615,590	102,598	124,667	(22,069)
Executive Team/GB	2,259,438	376,573	345,958	30,615
Finance	2,890,057	481,676	468,433	13,243
Medical Director - CCPL	1,566,501	256,584	214,162	42,421
Medical Director - ICS	235,647	39,274	56,172	(16,897)
Medicines Optimisation	3,714,176	619,029	555,872	63,157
Planning & Commissioning	7,761,074	1,293,512	1,079,809	213,703
Quality & Nursing	1,786,632	297,772	251,960	45,811
SEL Other (inc Apprenticeship Levy)	1,445,137	240,856	287,421	(46,564)
Subtotal	**31,724,147**	**5,282,857**	**4,646,782**	**636,075**
Total	**49,131,901**	**8,263,649**	**7,311,100**	**952,549**
Staff at risk			1,013,984	(1,013,984)
Grand Total	**49,131,901**	**8,263,649**	**8,325,084**	**(61,434)**

- The table below shows the YTD month 2 position on programme and running cost budgets.
- As described earlier in the report, the ICB is continuing to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs.
- The ICB's redundancy business case is now with the DHSC, and we are awaiting confirmation of its approval, so that notice can be given to staff. This delay is generating additional costs for the ICB both in respect of the ongoing cost **(circa £500k per month)** and the impact upon the final redundancy payments, given longer employment periods etc.
- The ICB is reporting a broadly balanced position on its corporate costs **(YTD overspend of £61k),** with vacancies **(82.5 WTE)** within directorates currently largely offsetting the pay costs of staff at risk.
- However, this is a non-recurrent benefit which will reduce as vacancies are recruited into.

10. Debtors Position



Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	166	43	0	776	122	0	1,107
Non-NHS	262	314	0	51	1	0	628
Unallocated	0	0	0	0	0	0	0
Total	**428**	**357**	**0**	**827**	**123**	**0**	**1,735**

- The ICB has an overall debt position of **£1.7m** at month 2. This is **£0.6m lower** compared to last month due to effective debt control plus fewer invoices being raised at this point in the financial year. Of the current debt, there is £123k of debt over 3 months old which is an improvement on previous months. **The largest debtor values this month are in the main with partner organisations and the ICB does not envisage any risk associated with settlement of these items.**
- The ICB has implemented a BAU approach to debt management, focusing on ensuring recovery of its larger debts, and in minimising debts over 3 months old. This will be especially important as we move to a new ISFE2 ledger at some point in the future. Regular meetings with SBS are assisting in the collection of debt, with a focus on debt over 90 days.
- The top 10 aged debtors are provided in the table below:

Number	Supplier Name	Total Value £000	Total Volume	Aged 0-90 days Value £000	Aged 91 days and over Value £000	Aged 0-90 days Volume	Aged 91 days and over Volume
1	NHS ENGLAND	585	3	585	-	3	
2	NHS SOUTH WEST LONDON ICB	321	5	199	122	3	2
3	CHIESI LTD	274	3	274	-	3	-
4	SOUTHWARK LONDON BOROUGH COUNCIL	154	5	154	-	5	-
5	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	117	4	117	-	4	-
6	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	52	1	52	-	1	-
7	KINGS COLLEGE HOSPITAL NHS TRUST	52	1	52	-	1	-
8	GREATER LONDON AUTHORITY	50	1	50	-	1	-
9	BEXLEY LONDON BOROUGH COUNCIL	34	5	34	-	5	-
10	BROMLEY EDUCATION AND TRAINING H	25	2	25	-	2	-

11. Cash Position

- The overall Maximum Cash Drawdown (MCD) as at month 2 was **£4,450,668k**. The maximum cash drawdown (MCD) after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing, community pharmacy and primary care dental expenditure) was **£3,725,923k**.
- As at month 2 the ICB had drawn down 16.3% of the available cash compared to the budget cash figure of 16.7%. The ICB has not needed to utilise the supplementary drawdown facility due to accurate cashflow forecasting.
- The cash key performance indicator (KPI) has been achieved in all months so far this year, showing continued successful management of the cash position by the ICB's Finance team. The actual cash balance at the end of Month 2 was **£237k (0.07% of cash limit)**, well within the target set by NHSE **(£4,063k, 1.25%). The ICB expects to utilise its cash limit in full by the year end.**
- ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. To date the ICB has met the BPPC targets each month, and it is expected that these targets will be met in full both each month and cumulatively at the end of the financial year.

ICB Annual Cash Drawdown Requirement for 2023/24	2024/25 AP2 - MAY 24	2024/25 AP1 - APR 24	2024/25 Month on month movement
	£000s	£000s	£000s
ICB ACDR	4,450,668	4,445,057	5,611
Capital allocation	0	0	0
Less:			
Cash drawn down	(665,000)	(340,000)	(325,000)
Prescription Pricing Authority	(44,844)	(22,301)	(22,543)
HOT	(303)	(133)	(171)
POD	(14,598)	(7,569)	(7,028)
Pay Award charges			0
PCSE POD charges adjustments			0
Pension Uplift			0
Remaining Cash limit	**3,725,923**	**4,075,054**	**(349,131)**

Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-24	340,000	0	340,000	8.30%	4,250	3,101	0.91%
May-24	325,000	0	665,000	16.30%	4,063	237	0.07%
Jun-24	365,000	0	1,030,000		4,563		
Jul-24			1,030,000				
Aug-24			1,030,000				
Sep-24			1,030,000				
Oct-24			1,030,000				
Nov-24			1,030,000				
Dec-24			1,030,000				
Jan-25			1,030,000				
Feb-25			1,030,000				
Mar-25							
	1,030,000	**0**					

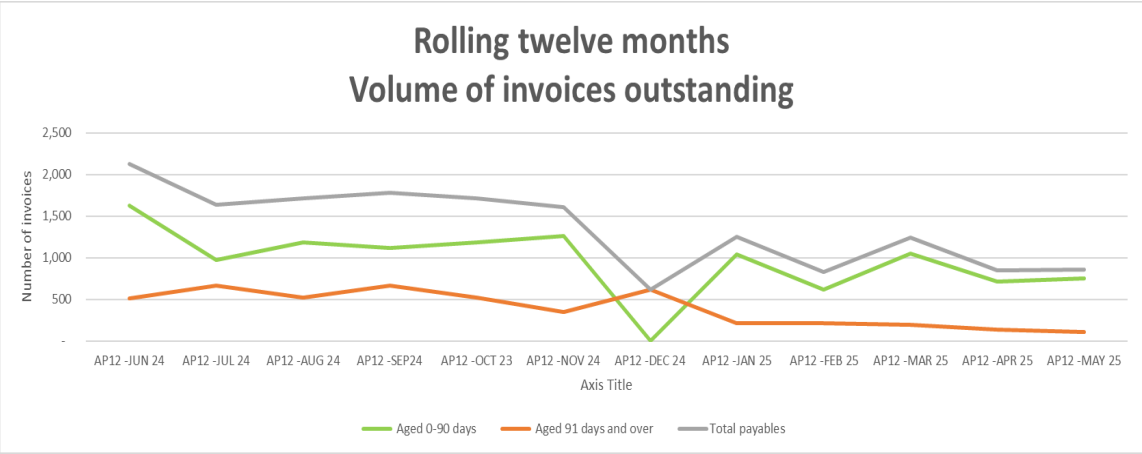
12. Aged Creditors

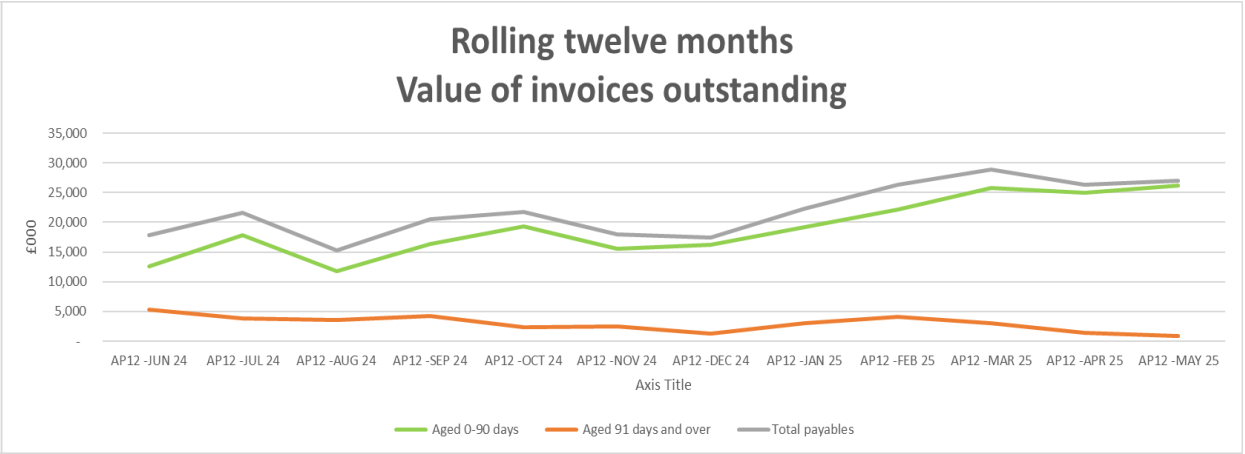
NHS South East London

- The ICB will be moving to a new ledger ISFE2 at some point during 2024/25 and so as with previous transitions, the ICB needs to reduce the volume and value of outstanding invoices on the ledger. The table below shows that there are currently outstanding invoices with a total value of circa £1.0m, which are over 90 days, the majority of which are from non-NHS organisations – largely CHC. The borough Finance leads, and the central Finance team are supporting budget holders to resolve queries with suppliers where required, so that invoices can be cleared.

- The graphs show that the volumes and values of items over 90 days are reducing. However, the value and volume of invoices under 90 days have increased slightly. As part of routine monthly reporting for 2024/25, high value invoices are being reviewed on a regular basis to establish if they can be settled quickly and budget holders are being reminded on a regular basis to review and clear their workflows.

Customer Group	Aged 0-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121-180 days £000	Aged 181+ days £000	Total £000
NHS	169	900	2,151	60	284	2	3,566
Non-NHS	14,120	4,323	4,481	154	230	188	23,496
Total	**14,289**	**5,223**	**6,632**	**214**	**514**	**190**	**27,062**





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

NHS South East London

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 23/24 outturn by a **minimum of the growth uplift of 4.22% as set out in the 12 June Operating Plan, a target of £458,449k.** This spend is subject to annual independent review. For Month 3 the MHIS target for 2024/25 will be increased to reflect the recently agreed consultant wage award.

- 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

- Slide 2 summarises the 2024/25 SEL ICB MHIS Plan. We will be reporting on MHIS delivery from Month 3

Risks to delivery

- We continue to see increasing spend on mental health, for example on S117 placements, and plans to mitigate this include improving joint funding panel arrangements and developing new services and pathways.
- There are pressures on learning disability placements budgets in some boroughs. Mitigating actions include review of LD cost per case activity across health and care to understand care package costs and range of providers, and planning for future patient discharges to agree funding approaches.
- ADHD is outside the MHIS definition and is therefore excluded from this reported position, however there is significant and increasing independent sector spend, with a forecast of at least £2m, along with an increasing number of independent sector providers result from Right to Choose referrals. We are currently working with local providers to consider how to maximise resources and capacity to reduce local waiting times.

13. Summary MHIS Position – Month 2 2024/25

NHS South East London

Mental Health (MH) Baseline Spend 2024/25		Total Plan 31/03/2025 Year Ending £'000	NHS Providers Plan 31/03/2025 Year Ending £'000	Non-NHS: Independent Sector (IS) Plan 31/03/2025 Year Ending £'000	Non-NHS: Voluntary Care Sector (VCS) Plan 31/03/2025 Year Ending £'000	Non-NHS: Other Non-NHS Plan 31/03/2025 Year Ending £'000	% of MHIS Spend Plan 31/03/2025 Year Ending %
Mental Health Investment Standard Categories:	**Category number**						
Children & Young People's Mental Health (excluding LD)	1	**43,216**	38,787	2,192	1,709	528	**9.4%**
Children & Young People's Eating Disorders	2	**2,754**	2,754	0	0	0	**0.6%**
Perinatal Mental Health (Community)	3	**9,455**	9,455	0	0	0	**2.1%**
Improved access to psychological therapies (adult and older adult)	4	**35,049**	28,590	0	0	6,459	**7.6%**
A and E and Ward Liaison mental health services (adult and older adult)	5	**18,804**	18,804	0	0	0	**4.1%**
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	**12,806**	12,806	0	0	0	**2.8%**
Adult community-based mental health crisis care (adult and older adult)	7	**35,007**	34,671	42	294	0	**7.6%**
Ambulance response services	8	**1,149**	1,149	0	0	0	**0.3%**
Community A – community services that are not bed-based / not placements	9a	**120,135**	107,711	1,259	9,494	1,671	**26.2%**
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	**25,120**	13,338	4,190	7,007	585	**5.5%**
Mental Health Placements in Hospitals	20	**4,351**	3,255	621	0	475	**0.9%**
Mental Health Act	10	**6,155**	0	4,937	0	1,218	**1.3%**
SMI Physical health checks	11	**843**	675	168	0	0	**0.2%**
Suicide Prevention	12	**0**	0	0	0	0	**0.0%**
Local NHS commissioned acute mental health and rehabilitation inpatient ser	13	**124,698**	124,698	0	0	0	**27.2%**
Adult and older adult acute mental health out of area placements	14	**9,475**	9,092	310	0	73	**2.1%**
Sub-total MHIS (exc. All-age Continuing Care, prescribing, LD & dementia)		**449,017**	**405,785**	**13,719**	**18,504**	**11,009**	**97.9%**
Other Mental Health Services:							
Mental health prescribing	16	**9,190**	0	0	0	9,190	**2.0%**
Mental health All-age Continuing Care	17	**242**	0	242	0	0	**0.1%**
Sub-total - MHIS (inc. All-age Continuing Care and prescribing)		**458,449**	**405,785**	**13,961**	**18,504**	**20,199**	**100.0%**
Learning Disability	18a	**13,144**	11,634	1,223	0	287	
Autism	18b	**3,766**	1,676	771	0	1,319	
Learning Disability & Autism - not separately identified	18c	**51,711**	4,759	23,789	1,369	21,794	
Sub-total - LD&A (not included in MHIS)	*i*	**68,621**	**18,069**	**25,783**	**1,369**	**23,400**	
Dementia	19	**14,527**	12,828	57	363	1,279	
Sub-total - Dementia (not included in MHIS)		**14,527**	**12,828**	**57**	**363**	**1,279**	
Total Mental Health Spend		**541,597**	**436,682**	**39,801**	**20,236**	**44,878**	

NHS
South East London

Appendix B

SEL ICS Financial Highlights

Month 2 2024/25

Executive summary

- NHSE reduced the reporting requirement at M2, recognising the replanning exercise which was happening in parallel.
- This report uses the resubmitted 12 June final plan. At M2 the forecast outturn is set at the resubmitted plan figures, per NHSE guidance.

Revenue

- The system is planning an aggregate deficit of (£100.0m). The 12 June plan submission shows an aggregate (£140.8m) deficit for providers offset by a £40.8m surplus in the ICB.
- The ICB £40.8m surplus consists of: a £4.8m stretch target for the ICB; £21.0m of agreed improvements to providers' positions; and an additional £15.0m stretch (King's), held in the ICB for planning purposes only.
- This plan includes a high level of risk, most significantly with trust plans targeting savings >4% of influenceable spend
- The recent Synnovis cyber attack and the planned junior doctors' strike are among other emerging material risks.
- At M2 the system is reporting a YTD deficit of (£41.5m), £7.8m adverse to the revised YTD plan of (£33.7m) deficit.

Efficiencies

- At M2 the system has **delivered £24.4m of efficiencies YTD, £9.3m behind plan.**

Capital

- The system capital plan is to spend the entire system allocation of £255.5m (inc. IFRS 16 uplift).

I&E summary

- The system is **planning an aggregate deficit of (£100.0m).** The 12 June submission shows an aggregate (£140.8m) deficit for providers offset by a £40.8m surplus in the ICB.
- The £40.8m surplus held in the ICB consists of: a £4.8m stretch target for the ICB; £21.0m of agreed improvements to providers' positions; and an additional £15.0m stretch required at King's, held in the ICB for planning purposes.
- At **M2 the system is reporting a YTD deficit of (£41.5m), £7.8m adverse to the revised YTD plan of (£33.7m) deficit.**
- The main driver of the YTD variance is under delivery against CIP targets, including unidentified CIPs. Trusts are required to share recovery action plans ahead of M3 reporting.
- The £15m KCH stretch has been profiled in the ICB plan as M12, hence it does not generate a variance in M2. Although the ICB FOT equals plan, as per NHSE guidance, there is no plan for the ICB to deliver the £15m KCH stretch assumption that, for system planning purposes only, shows against the ICB plan.

	M02 Year-to-date			2023/24 Out-turn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	*£m*	*£m*	*£m*	*£m*	*£m*
GSTT	(6.0)	(9.6)	(3.6)	0.0	0.0	0.0
KCH	(24.7)	(25.9)	(1.2)	(141.8)	(141.8)	0.0
LGT	(0.1)	(3.1)	(3.0)	0.0	0.0	0.0
Oxleas	0.2	0.2	(0.0)	1.0	1.0	0.0
SLaM	(3.9)	(3.9)	0.0	0.0	0.0	(0.0)
SEL Providers	**(34.5)**	**(42.3)**	**(7.8)**	**(140.8)**	**(140.8)**	**(0.0)**
SEL ICB	**0.8**	**0.9**	**0.1**	**40.8**	**40.8**	**0.0**
SEL ICS total	**(33.7)**	**(41.5)**	**(7.8)**	**(100.0)**	**(100.0)**	**(0.0)**

Risk

- The plan includes a high level of risk, most significantly, provider plans targeting savings >4% of influenceable spend, national delays to the MCR programme, non-SEL contract revenue.
- Subsequent emerging risks include the recent Synnovis cyber attack and the planned junior doctors' strike are among other material risks.
- Given these uncertainties the system has not made an assessment on the financial impact of the risks at M2 or forecast.

System capital expenditure

- **The total system capital allocation, before the impact of IFRS 16, for 2024/25 is £198.8m**, made up of £195.5m provider allocation and £3.3m ICB allocation. This allocation figure include the net impact of the £52.6m repayment of CDEL to NHS England and borrowing of £31.9m CDEL allocation from South West London ICS.
- The System has submitted a plan to spend its entire allocation. No forecasts were reported at M2 so the system is reporting forecast equal to the June 12 plan.
- At M2 the system has spent £17.5m YTD.

Capital spend against system capital allocation excl. IFRS 16

	Year to date (YTD)			Full-year (FY)		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
GSTT	8.3	8.3	0.0	92.4	92.4	0.0
KCH	0.2	0.2	0.0	45.0	45.0	0.0
LGT	6.2	6.2	0.0	36.9	36.9	0.0
Oxleas	1.4	1.4	0.0	12.0	12.0	0.0
SLAM	1.4	1.4	0.0	9.2	9.2	0.0
SEL Providers	**17.5**	**17.5**	**0.0**	**195.5**	**195.5**	**0.0**
SEL ICB	**0.0**	**0.0**	**0.0**	**3.3**	**3.3**	**0.0**
Total	**17.5**	**17.5**	**0.0**	**198.8**	**198.8**	**0.0**
Provider allocation				**195.5**		**0.0**
ICB allocation				**3.3**		**0.0**
System allocation				**198.8**		**0.0**

Impact of IFRS 16 on Capital Charge – excluded from system allocation at M2

	Impact of IFRS 16		
	Plan	Forecast	Variance
	£m	£m	£m
GSTT	32.4	32.4	0.0
KCH	5.4	5.4	0.0
LGT	8.0	8.0	0.0
Oxleas	5.2	5.2	0.0
SLAM	1.5	1.5	0.0
SEL Providers	**52.4**	**52.4**	**0.0**
SEL ICB			**0.0**
Total	**52.4**	**52.4**	**0.0**

Lewisham Local Care Partners Strategic Board

Cover Sheet

Item 11
Enclosure 9

Title:	**Lewisham Primary Care Group - Chairs Report**
Meeting Date:	25 July 2024
Author:	Chima Olugh, Neighbourhood Development Manager
Primary Care Group	Anne Hooper, Chair Primary Care Group
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 at the meetings of the Primary care Group.	Update / Information	X
		Discussion	
		Decision	

Summary of main points:	The following items were discussed and approved at the June 2024 Primary Care Group meeting: **Contractual** ▪ GP Practice Merger **Transformation** ▪ 2023/24 PCN Enhanced Access Report ▪ PCN Capacity & Access Improvement Plans and Payment **Quality** ▪ Care Quality Commission Inspection Updates a) SEL Special Allocation Scheme b) Modality Lewisham
Potential Conflicts of Interest	None identified
Any impact on BLACHIR recommendations	None identified

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact			
	Financial Impact	**Practice merger:** The estimated £20,000.00 associated with the merge of practice clinical and IT systems. Funded through the South East London GP IT budget. **PCN Capacity & Access Improvement Plans and Payment:** £412,865.87 of the Local Capacity & Access Improvement payment funding be paid to the PCNs. Funded through the delegated Primary Care budget.		
Other Engagement	Public Engagement	**Practice merger:** In preparation for the practice merger Burnt Ash Surgery and Downham Family Medical Practice engaged with their Patient Participation Groups. A patient survey was also conducted.		
	Other Committee Discussion/ Engagement	NA		
Recommendation:	This paper is for information. **The Lewisham Local Care Partnership Strategic Board is asked to note the updates from the Chairs Report.**			

1. Proposed Merger between Burnt Ash Surgery and Downham Family Medical Practice

1.1 Background

a) The ICB was informed of the proposed practice merger by the partners of Burnt Ash Surgery and Downham Family Medical Practice.

b) The main driving factor for the proposed merger is to support ongoing service provision at Burnt Ash Surgery following a significant contract change.

c) One of the GP partners applied to retire from the Burnt Ash Surgery partnership, with effect from 31st March 2024.

d) The partnership change means Burnt Ash Surgery only has a single GP partner.

e) This is a significant PMS contract change which has led to a 50% reduction in the responsible contract performers.

f) The remaining GP partner will continue to deliver the full range of services to registered patients, however the practice will be operating as a single hander with significant contractual instability and less resilience which puts safe patient service delivery at risk.

g) Both practices have agreed that a merger between them would be the best way forward in terms of increased resilience and support.

h) A merger will increase workforce resilience of Burnt Ash Surgery. It will support the expansion of leadership, clinical and non-clinical staff and provide better opportunities for peer clinical support, and upskilling of current staff.

i) The indicative date is 31st August 2024. The date is subject to confirmation by EMIS and will rely on the availability and lead times of EMIS and Primary Care Support England.

j) The new merged practice will be known as Ashdown Medical Group.

k) There are no planned site closures as a result of the merger, and no patients will be deregistered.

1.2 Financial Impact

a) The Integrated Care Board will not make any financial savings in relation to the premises budget.

b) The estimated £20,000.00 associated with the merge of practice clinical and IT systems.

c) There is likely to be some financial impact on the baseline allocations of Lewisham Alliance and Sevenfields PCN due to the change in PCN Core Network Practice membership.

d) Lewisham Alliance PCN is aware of the impact the merger will have on the Network Contract DES arrangements and has taken this into account for 2024/25 planning, including arrangements for the Additional Roles Reimbursement Scheme and Enhanced Access.

1.3 Recommendation

The Primary Care Group was recommended to approve:

a) The merger of the contracts and the patient lists of Burnt Ash Surgery and Downham Family Medical Practice.

b) The financial implications of c£20,000.00, associated with the merge of practice IT systems.

c) The change of Primary Care Network (PCN) membership for Burnt Ash Surgery from Sevenfields to Lewisham Alliance as a result of the merger and any associated changes in relation to the PCNs financial baseline allocations.

The Primary Care Group approved the recommendations.

1.4 Next Steps

a) The group will assure itself that any service change reflects the views and experience of Lewisham citizens, service users and member practices.

b) It will also provide support, oversight and monitor quality improvements associated with the merger.

1.5 Appendices

a) Appendix 1: Merger business case
b) Appendix 2: Practice merger analysis
c) Appendix 3: Practice improvement plan
d) Appendix 4: Equality and Health Inequalities Screening Tool.

2. 2023/24 PCN Enhanced Access Report

2.1 Background

a) Enhanced Access (EA) is a key component of the Primary Care Network (PCN) Network DES and refers to the delivery of core Primary Care Services within a PCN during 'Network Standard Hours' i.e. 18:30-20:00 on weekdays and 09:00 to 17:00 on Saturdays.
b) EA commenced on 1 October 2022 and replaced pre-existing arrangements for GP Extended Hours and Extended Access Hubs.
c) EA is delivered by Lewisham's 6 PCNs with an adjusted registered population of 351,371 for 2023/24 from 23 sites across as outlined below.

Aplos	Modality	Lewisham Alliance	The Lewisham Care Partnership (TLCP)	North Lewisham PCN (NLPCN)	Sevenfields
4 sites	3 sites	5 sites	5 sites	1 site	5 sites

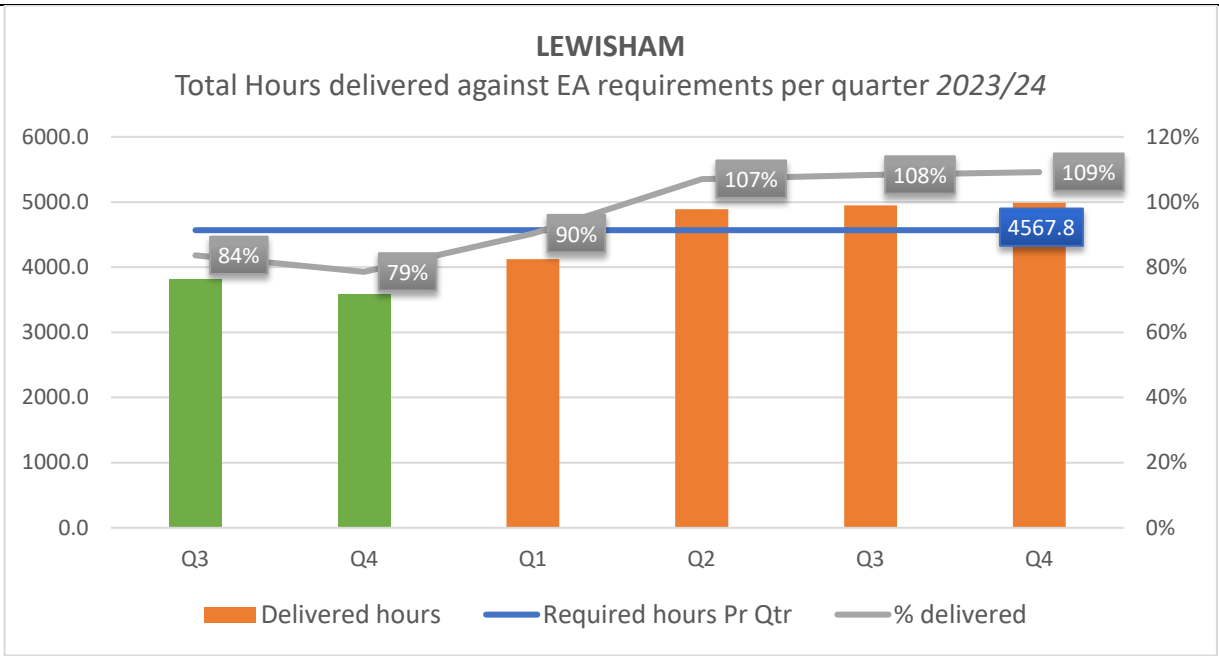
1. Sydenham Group Practice 2. The Vale MC 3. Wells Park Practice 4. Woolstone MC	1. The Jenner Practice 2. South Lewisham Group Practice 3. Bellingham Green surgery	1. Lee Road Surgery 2. Lewisham MC 3. Nightingale Surgery 4. Triangle Group Practice 5. Woodlands HC	1. Belmont Hill 2. Morden Hill 3. Hillyfields HC 4. Honor Oak 5. St Johns MC	1. Waldron HC	1. Downham FMP 2. Parkview Surgery 3. Burnt Ash Surgery 4. Novum 5. Torridon Road

d) PCNs are required to deliver or sub-contract EA in full, in accordance with the requirements of this Network Contract DES Specification and the sub-contracting requirements set out in their Core Network Practices' primary medical care services contracts.
e) PCNs are required to delivery approximately 18,271 hours of enhanced access per annum in line with the contract requirements and financial structure.
f) Quarterly reports are submitted to SEL ICB Lewisham to review delivery against contract requirements and identifying any operational changes to the plan, challenges experienced, and any commissioner support required.
g) Recovery plans are put into place each quarter for any PCNs that have not delivered the required capacity within the reporting period which outline how they propose to recoup any unmet hours in the following reporting period. It is expected that all PCNs will have delivered all required hours within a full year period.
h) It should be noted for the purpose of this report that data is based on a full 12 months of activity from 1st April 2023 – 31st March 2024 due to challenges experienced during the implementation phase as outlined in this document.

2.2 Summary of Findings

a) Overall, EA capacity across Lewisham is exceeding the specified EA requirements of 60 minutes per 1000 adjusted patients per annum offering 18,950/18,271 (104%) equating to approximately 67,451appointments per annum with an average hourly appointment offer of 3.6.

% hours offered against requirement	104%
% appointments booked	85%
% attendance rate	83%
% DNA (Did not attend)	16%
Total appointments offered	71278



b) It should however be noted that Q1 saw only 90% of hours being delivered. Subsequently, recovery plans were put into place for 5/6 PCNs and additional hours were delivered in remaining quarters to meet annual requirements.
c) There is variance between PCNs in relation to EA capacity with some offering more than the required hours and some not delivering the required hours.
d) Throughout the year 5/6 PCNs at some point undelivered the required hours within a given reporting quarter however all overdelivered by year end except for TLCP who under delivered at 92% of required capacity by year end.
e) There is evidence that there is significant 'spare' capacity withing EA provision e.g. In total across Lewisham approximately 10278 appointments (15%) per annum were not booked (2855 hours) equating to approximately 197 appointments / 54.9hours per week.
f) All PCNs are offering Face to Face (F2F) appointments in line with their plans.
g) Booking rates have fluctuated over the year with attendance rates remaining stable.
h) DNA rates are relatively high at an average of 16% across Lewisham.
i) There is significant variation PCNs with DNA rates ranging from 8% to 20%. Aplos DNA rates has remained stable with, 2 PCNs seeing an increase of approx. 11% each (Modality and Sevenfields) and 3 PCNs seeing an improvement in their DNA rates over time (Lewisham Alliance, NLPCN and TLCP).
j) All PCNs reported challenges in relation to work force and IT infrastructure especially during the first 6 months on implementation. Workforce remains the biggest challenge continually reported.
k) Patient engagement was undertaken as part of EA plan development however is not a requirement of the EA contract however PCNs are required to collate patient feedback in relation to access.
l) There is however evidence that patient information available on PCN and partner practice websites in relation to Enhanced Access is both variable in terms of the terminology used and also the information provided.

2.3 Next Steps and recommendations

ICB to share the report and findings with PCN Clinical Directors and managers.
All PCNs to be asked to

a) review and provide further assurance against the key Specification items and report back to the ICB, by October, with a progress update and plan for 'Full Delivery' against the key Service Specification requirements.
b) initiate a deep dive into their 'unbooked' capacity and identify trends/patterns in relation to appointment times and appointment type and provide assurance that the available capacity is best tailored to the needs and preferences of their population.
c) review DNA rates and ensure appropriate mitigations like SMS reminders are consistently deployed.
d) review messaging on member practice websites to ensure consistency of messaging re. EA and that EA forms part of planned Care Navigation training and wider Access and Recovery plans.
e) TLCP to provide assurance to ICB on EA delivery for 2024/25 in line with the Network DES specification requirements.

The group will continue to monitor the effectiveness of the service.

The full PCN Enhanced Access 23/24 Report can be found in appendix 5.

3 PCN Capacity & Access Improvement Plans and Payment

3.1 The purpose of the Capacity & Access Improvement Plans (CAIP) is to support achievement of the Delivery Plan for Recovering Access to Primary Care, which has two core aims:
a) To tackle the 8am rush and reduce the number of people struggling to contact their practice.
b) For patients to know on the day they contact their practice how their request will be managed.

3.2 Funding to support and incentivise delivery of the plan consists of two parts:

a) **National Capacity and Access Support Payment:** 70% of funding will be unconditionally paid to PCNs in 12 equal payments over the 2023/24 financial year,

b) **Local Capacity and Access Improvement Payment:** part or all of 30% of the funding will be paid to PCNs based on commissioner assessment of a PCN's improvement in three key areas:
i) patient experience of contact;
ii) ease of access and demand management; and
iii) accuracy of recording in appointment books.

3.3 In order to make improvements in the key areas PCNs, with support from the Integrated Care Board (ICB) primary care team, developed CAIPs which were to be delivered between 1 August 2023 and 31 March 2024.

3.4 PCNs were required to complete an end of year reporting template and outline actions taken to deliver against their plans. The ICBs approach to the assessment aimed to:

a) provide a systematic approach to the assessment of PCN plans
b) ensure PCNs outlined delivery against their plans
c) understand any issues or challenges affecting progress
d) Capture best practice and any planned and/or unplanned improvements.

3.5 The ICB has completed its assessment and, based on information, evidence and data received, is assured that all 6 PCNs have fully delivered against their plans. Therefore, based on the assessment

and in line with the payment guidance, the ICB recommended £412,865.87 of the Local Capacity & Access Improvement payment funding be paid to the PCNs.

3.6 The Primary Care Group approved the release of the full 30% of funding (£412,865.87) to all 6 PCNs.

3.7 The payments will be made in line with the Capacity & Access Payment guidance issued by NHSE.

Below is a summary of the total PCN Capacity and Access Support Payment funding available to Lewisham PCNs in 2023/24 is £1,376,219.54.

PCN Name	Total	70%: National Capacity & Access Support Payment	30%: Local Capacity & Access Improvement Payment
Aplos Health	**£200,569.16**	£140,398.41	£60,170.75
Lewisham Alliance	**£209,314.46**	£146,520.12	£62,794.34
Modality Lewisham	**£153,362.70**	£107,353.89	£46,008.81
North Lewisham	**£358,790.36**	£251,153.25	£107,637.11
Sevenfields	**£257,046.26**	£179,932.38	£77,113.88
The Lewisham Care Partnership	**£197,136.60**	£137,995.62	£59,140.98
Overall total	**£1,376,219.54.**	**£822,955.26**	**£412,865.87**

4. Care Quality Commission Inspection Updates

The Primary Care Group received an update of actions taken by the ICB following its consideration of the issues identified by the Care Quality Commission in its inspection reports.

4.1 South East London Special Allocation Scheme

4.11 The South East London Special Allocation Scheme (SAS) was set up in order to meet commissioners' statutory responsibility to provide primary care services to patients who have been removed from their previous practices' registered lists as a result of violent or aggressive behaviour. The service is provided by the Lewisham GP Federation, One Health Lewisham (OHL) which delivers the service on behalf of the 6 boroughs of Bexley, Bromley, Greenwich, Lambeth, Southwark, and Lewisham.

4.12 It aims to ensure that any patient removed from their practice list has access to essential and additional medical services; and works with patients to reintegrate them, over time, back into mainstream general practice wherever possible.

4.13 The CQC carried out an announced comprehensive inspection of the SAS on 21 and 22 June 2023, and 11 July 2023. The report published on 20 November 2023 rated the service as 'Requires Improvement' overall. The following service domains were rated as Requires Improvement:

- Safe
- Well-led

4.14 The inspection mainly covered a range of SAS regulated activities provided by OHL. The inspection also included some other services provider by OHL such as respiratory and dermatology community services provided which are not part of the SAS provision.

4.15 Following the inspection, the CQC stated that lessons had been learned and improvements made by the provider. Most of the concerns were procedural and systems based rather than actual delivery of the service.

4.2 ICB Action

4.21 Commissioners and relevant subject matter experts have considered and reviewed the report and discussed the areas highlighted by the CQC.

4.22 The CQC did not request an action plan from the provider, which is unusual where a service is rated as requires improvement, however, the provider developed and submitted an action plan to the ICB which outlines how it has addressed the issues specified in the inspection report.

4.23 The action plan gave assurances that efforts had been made to address all areas in the report and robust systems were already in place to ensure patient care is both safe and well-led. The action plan has been reviewed by Lewisham subject matter experts who are assured that the provider has effective arrangements in place and has provided sufficient evidence of improvement where concerns were identified.

4.24 The Primary Care Group approved the recommendation that the ICB take no formal contractual action against the service.

4.3 Next Steps

4.31 As this is a SEL wide service, the paper, alongside the approved recommendation, will be shared with the other 5 boroughs to take through their local governance.

4.32 The ICB will formally write to the service to confirm that it is satisfied with the necessary actions that have been taken and that no formal contractual action will be pursued.

4.33 The ICB will arrange a follow up within 12 months to ensure the improved standards outlined in the action plan have been maintained.

4.34 Commissioners will provide an update to the Primary Care Group, which has oversight, in relation to the progress made and any other changes after the follow up.

The full inspection report can be found here; Urgent - 1-3055109492 Downham Health & Leisure Centre (20/11/2023) INS2-14450199381 (cqc.org.uk)

4.4 Modality Lewisham

4.41 Modality Lewisham was formed as a result of 3 practices which merged in 2022 to form a super practice, with a patient list size of 36,961. The practice is also a Primary Care Network (PCN).

4.42 The CQC carried out an announced comprehensive inspection of Modality Lewisham on 2 August 2023. The inspection was as a result of the recent merger. The report published on 20 December 2023 rated the practice as 'Requires Improvement' overall. The following service domains were rated Requires Improvement:

- Safe
- Responsive
- Well-led

4.43 The CQC identified areas of non-compliance with its standards, some of which also constitute regulatory breaches.

4.44 The practice responded promptly to concerns identified when CQC informed them of the areas where things could be improved.

4.5 ICB Action

4.51 Commissioners and relevant subject matter experts have considered and reviewed the report and discussed the areas of non-compliance with the practice and determined what actions have already been taken by the practice.

4.52 The practice has developed and submitted an action plan to the ICB which outlines how it has addressed the issues specified in the inspection report. The action plan gave assurances that efforts had been made to address all issues in the report. The action plan has been reviewed by subject matter experts who are assured that the provider has effective arrangements in place and has provided sufficient evidence of improvement where concerns were identified.

4.53 A member of the infection prevention and control specialist team has visited the practice to understand and confirm their infection prevention and control leadership and assurance arrangements. Audit reports have been completed for the 3 sites of the practice. No significant issues were highlighted during the visit.

4.54 The Primary Care Group approved the recommendation that the ICB take no formal contractual action against the practice.

4.6 Next Steps

4.61 The ICB will arrange a follow up within 12 months to ensure the improved standards outlined in the action plan have been maintained.

The full Modality Lewisham CQC inspection report can be found here;

The group continue to support and monitor quality improvement and effectiveness of primary care provision, including to inform continuous improvements.

Appendix 1: Merger business case
Appendix 2: Practice merger analysis
Appendix 3: Practice improvement plan
Appendix 4: Equality and Health Inequalities Screening Tool
Appendix 5: PCN Enhanced Access 23/24 Report.

Burnt Ash Surgery and Downham Family Medical Practice Proposed Merger Business Case

May 2024

Ashdown Medical Group

Putting your healthcare first. Making healthcare better together. A healthier you a healthier community.

Summary of current situation:

Burnt Ash Surgery is facing a significant operational challenge following the decision of a GP partner to retire from the partnership, effective 31st March 2024. This departure will reduce the number of responsible contract performers by 50%, leaving the practice with only one GP partner and thus converting it into a single-handed practice.

Risks and Challenges:

- **Compromised Patient Care:** Only one GP partner increases the likelihood of decision fatigue, leading to potential harm and suboptimal care.
- **Increased Wait Times:** Fewer GPs will likely result in longer wait times for appointments, which can lead to dissatisfaction and decreased patient trust in the practice's ability to provide timely care.
- **Clinician Burnout:** The remaining GP partner will face increased workloads, raising the risk of burnout. This can further degrade the quality of care and threaten the well-being of the clinician.
- **Workforce and Resilience Threat:** The practice's workforce and resilience are significantly threatened with the strain on the single-handed GP partner which may eventually disrupt continuity of care for patients.

To mitigate these risks and ensure the continued provision of high-quality care, a merger with a Downham Family Medcial Practice is proposed to offer the following benefits:

- **Enhanced Clinical Capacity:** By joining forces with another practice, Burnt Ash Surgery can immediately increase its pool of GPs, ensuring that patient care remains safe and effective.
- **Improved Appointment Availability:** A larger team of healthcare professionals will reduce wait times for patient appointments, improving patient satisfaction and access to care.
- **Balanced Workload:** Distributing the patient load among more GPs will prevent clinician burnout, fostering a healthier work environment and better patient outcomes.
- **Strengthened Workforce and Resilience:** The merger will create a more robust practice, capable of handling workforce fluctuations without compromising patient care. This resilience will safeguard against the risk of having to return the contract to the ICB.

Merging Burnt Ash Surgery with Downham Family Medical Practice is a strategic move to address the impending challenges following the retirement of a GP partner. This merger will enhance clinical capacity, improve patient care and appointment availability, prevent clinician burnout, and strengthen the overall resilience of the practice. By taking this proactive step, we can ensure the long-term sustainability and effectiveness of Burnt Ash Surgery in serving its patient community.

Background (1/3)

- In May 2021, Dr Leonardo Antony, Senior Partner, Burnt Ash Surgery gave notice of his plan to retire in September 2021 after over 20 years of service.
- In June 2021, it was agreed that both Burnt Ash Surgery (G85027) and Downham Family Medical Practice (G85057) would share Practice Manager services provided by Louise Hassan after a vacancy became available at Downham.
- In July 2021, both practices employed an Operations Lead to support the Practice Manager.
- On 1st September 2021, Dr Antony retired from Burnt Ash Surgery. Dr Alexandra Baker joined the Partnership and engaged with plans for the merger.
- In July 2022, Dr Baker confirmed her decision to cease seeing patients at Burnt Ash Surgery and no longer wished to proceed with the merged Partnership. Since this time, Dr Nadine Lawrence has been working collaboratively with GPs from Downham Family Medical Practice to maintain the standard of care to the patients.
- In June 2022, Dr Nadine Lawrence joined the Downham Family Medical Practice Partnership.
- On 25th May 2024, Dr Baker signed a PMS contract variation form confirming her resignation from the Burnt Ash Surgery contract effective 31st March 2024. Burnt Ash Surgery will effectively become a single-handed practice. The merger will ensure the practice's continued resilience and sustainability.
- Although Dr Lawrence will continue to deliver the full range of services to registered patients, the practice will be operating as a single hander with significant contractual instability, less resilience and at risk of continuing to deliver safe patient services.

Background (2/3)

- At the end of April 2021 Burnt Ash Surgery and Downham Family Medical Practice had preliminary discussions regarding the proposed merger and it was agreed by all that it should proceed.
- Following these discussions, the proposal was raised with Ashley O'Shaughnessy, Associate Director of Primary Care in Lewisham who was supportive subject to the correct route being followed. It was also suggested that Nightingale Surgery, also based within the Lee Health Centre, should be offered the opportunity join the merger. This offer was made but has since been turned down by Nightingale Surgery.

Background (3/3)

- Partners of the two practices have been meeting regularly as part of the merger process planning since April 2021.

- Both Practices have been sharing their values and commitment to high quality clinical care over the past two years and now believe a full merger will help to provided improved access and choice for patients.

- Planning talks have been held with Chima Olugh, Primary Care Commissioning Manager in Lewisham.

- Patient engagement* with patients has been completed. Merger update/Q&A meeting was held on Monday 10th June at Downham Family Medical Practice. Both Patient Participation Group's have been provided with regular merger updates at the meetings and minutes sent via email.

**Stakeholder engagement is set out from page 19 & in appendix 1.*

The Proposal (1/2)

- **This business case is intended to outline the case for the merger between Burnt Ash Surgery and Downham Family Medical Practice for your consideration.**
- The business case sets out an indicative three-month lead-in time;

  - The registered patient list of Burnt Ash Surgery PMS contract is to be merged with the Downham Family Medical Practice PMS contract registered patient list by the end of July 2024 (indicative date, awaiting confirmation from EMIS).
  - Both practices will remain open and operational from both existing sites.
  - New telephony services have been implemented at both practices to ensure a positive patient experience and have now been upgraded to provide a patient call back service.
  - We will plan the merger of both practice's EMIS systems over a weekend so as not to cause any disruption to patients.

The Proposal (2/2)

- The Merger will create a single registered patient list of c. 13,500, retaining the ODS code of G85057.
- Both practices will form Ashdown Medical Group.
- Dedicated leadership and managerial workforce model has been in place since June 2021.
- Burnt Ash Surgery has been accepted to join Sevenfields Primary Care Network (PCN). Lewisham Alliance PCN have been working with Sevenfields PCN during 23/24 to ensure funding is re-allocated and took the PCN change into account for 2023/24 planning.
- Prior to the EMIS merge, patients will be allocated Burnt Ash or Downham Family as their Usual GP. This will ensure all staff are notified of where the patient received care prior to the merger. New patients registering at either site will be allocated the appropriate Usual GP. This system will highlight which neighbourhood the patient falls into eliminating any confusion when accessing community services and multi-disciplinary care.

Practice Overview (1/3)

	Downham Family Medical Practice	Burnt Ash Surgery
Address of Practice	7-9 Moorside Road, Bromley, BR1 5EP	2 Handen Road, Lee, SE12 8NP
Contract Type	PMS	PMS
Registered List size Raw/weighted	6,756 / 6121	6300 / 6630
Opening Hours	Monday to Friday 8.00 – 18.30 Saturdays 9.00 – 17.00	Monday, to Friday 08.00 – 18.30 Saturdays 9.00 – 13.00
Partners	Dr Ola Fagbohungbe, Dr Anwuli Bosah, Dr Nadine Lawrence	Dr Nadine Lawrence
Staff	2 PAs: 2 FTE, 3 Nurses: 1.6 FTE, 1 long term locum GP; 0.4 WTE 1 Pharmacist: 0.4 1 Trainee HCA; 0.2 FTE 1 Practice Manager: 0.5 FTE, 1 Operations Manager; 0.5 TE, 1 Operations Lead: 0.8 FTE 1 Prescribing Clerk: 0.5 FTE, 6 Receptionists/administrators: 5.2 FTE	1 Salaried GP: 0.6 WTE, 2 long term locum GPs; 1 WTE, 1 PAs: 1 FTE, 1 Pharmacist; 0.4 FTE 3 Nurses: 2 WTE, 1 Practice Manager: 0.5 FTE, 1 Operations Manager: 0.5 FTE, 1 Prescribing Clerk: 0.5 FTE, 7 Receptionists/administrators: 5.2 FTE **Recruiting: 1 FTE GP – starting Aug 24**
Languages spoken by staff	English, Nigerian, Georgian	English, Russian, Romanian, Nigerian
Clinical system	EMIS Web	EMIS Web
QOF points 2022/2023	569.98/635	477.54/635
CQC Rating	Requires Improvement – Action plan complete, no further action needed	Good
Locality working inc. PCN	Sevenfields PCN	Lewisham Alliance PCN – Accepted into Sevenfields PCN
Services offered	GP Extended Access Services, Core Services, Sexual Health and Family Planning, Zoladex, Phlebotomy	GP Extended Access Services, Core Services, Sexual Health and Family Planning, Zoladex, Phlebotomy

Practice Overview (2/3)

The merger aims to enhance operational efficiency, improve patient care, and ensure the long-term sustainability of both practices.

In June 2022, Downham Family Medical Practice underwent a CQC inspection, which identified several areas requiring improvement. Specifically, the inspection highlighted the need for enhanced processes in appraisals, recruitment, safety alerts, and monitoring processes. The practice lacked the resources and management support to efficiently address the areas identified in the CQC inspection.

This merger will bring several key benefits, including shared management and resources to address challenges and ensure ongoing resilience.

Improved Operational Efficiency:

- Shared management has enabled streamlined and enhanced processes for conducting appraisals and recruitment, ensuring the practices meet required standards.
- Implementation of standardised procedures will lead to more efficient and effective operations across both practices.

Enhanced Patient Safety and Care:

- Shared resources will ensure timely processing of safety alerts and significant events, thereby improving patient safety.
- Coordinated efforts will allow for better monitoring and response to potential risks, leading to improved overall care quality.

Practice Overview (3/3)

Collaborative Resource Utilisation:

- The practices have employed a shared Clinical Pharmacist to support GPs, ensuring patients receive appropriate health and medication monitoring.
- Working at scale has enabled the employment of a Prescription Clerk to support the Pharmacist, ensuring the smooth running of the prescription process and blood test monitoring.

The merger of Burnt Ash Surgery with Downham Family Medical Practice is a strategic move to address current challenges and enhance the quality of care provided to patients. By sharing management resources, utilising collaborative resources such as a Pharmacist and prescription clerk, and implementing more efficient processes, the merged practices will be better equipped to meet regulatory requirements and ensure long-term sustainability.

Proceeding with the merger will combine the strengths of both practices, ensuring continued high-quality patient care and operational efficiency.

Premises Overview

	Downham Family Medical Practice	Burnt Ash Surgery
Type of Property	Purpose built – within Health Centre Built in 1980's	Purpose built – within Health Centre Built in 1960's
Landlord	NHS Properties	Lewisham & Greenwich Trust
Leasehold/Freehold	Leasehold	Leasehold
Disabled Access	Yes – Practice on ground level. Disabled toilet on site	Yes – Practice on ground level. Disabled toilet on site
Disabled Parking	Yes	Yes
IPC Issues	None	Issue raised with L&GT regarding some outstanding repairs to clinical rooms and Legionella assessment overdue. Working with ICS Estates to escalate and ensure works are carried out.
Clinical Rooms	7	7
Admin Rooms	3	3
Conference Room	Yes	Shared within Health Centre
Patient Waiting Room	Yes	Yes

Rationale for Merger (1/2)

GP Partner

In May 2021, Burnt Ash Surgery's Senior Partner gave notice of retirement and the part-time salaried GP also resigned with immediate effect due to personal commitments.

At the end of August 2021, Dr Antony retired from Burnt Ash Surgery.

Downham Family Medical Practice that has 3 GP Partners, including a Senior Partner with over 25yrs experience which will provide the support needed for Burnt Ash Surgery.

Management Services

In May 2021, Downham Family Medical Practice had a Practice Manager vacancy that could not be filled.

Louise Hassan, previous Practice Manager agreed to return and provide managerial support to both practices.

It was agreed that the practices would work collaboratively to share managerial and administration support. Both the Practice Manager and Operational Leads have been working across both sites since June 2021.

Staff Turnover

Lack of good managerial leadership at Downham Family Medical Practice prior to the collaborative working, had an effect on reception and administration staff turnover.

Burnt Ash Surgery went through changes with nursing staff due to various staff's personal reasons which left the practice having to rely on support from locums. Difficulty recruiting clinical and non-clinical staff, working together will provide joint resources.

Rationale for Merger (2/2)

The proposal is underpinned by key strategic and local drivers that will improve access, patient experience and safety, and build workforce resilience.

Strategic Drivers: Alignment with GPFV and NHS LTP

The combined practice list size of circa 13,000 patients will ensure an at scale working service model.

It aligns with the NHS Long Term Plan and the GP Forward View for larger practices working together to deal with the pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.

It also aligns with the ICBs strategy of working at scale with fewer contracts.

Improved long term viability of the practice with improved financial stability and more resilience.

Local Drivers: At scale resources and improved patient experience

With the practice working at scale it will;
Help improve patient access as patients will have a choice of two different practice sites to attend for their primary medical needs.

Ensure patients have access to a wider range of healthcare professionals who will work across all the sites and provide a variety of services.

Increase resilience due to a more integrated workforce.

Increase management resource and the longer term viability of the practice.

Benefits of the Merger – Staff (1/2)

Benefit	Rationale
Pooled resources and processes	Merging the two practices will increase current capacity as sharing clinical and allied professionals, services can be targeted to meet needs of our population. More leadership (clinical and non-clinical) and management capacity will be provided to support practice staff and support the practice with service transformation and oversee the day-to-day operations.
Improved workforce and wellbeing	The merged practice will create and maintain a happy, healthy, and attractive workplace for its staff. It will also allow for better networking opportunities for staff. Improved cover for all staff leave/absences by other team members which will reduce the need to use locum cover.
Enhanced business continuity	In any unforeseen circumstances, staff can continue to work from one or other site without any major disruption to the services provided.
Future recruitment and retention	The new infrastructure will offer more peer support, learning and development opportunities as well as career progression.
Stability and efficiency	Increase stability and succession planning in partnership, allowing shared expertise and more flexibility and eliminating the requirement for one practice to become a single hander.

Benefits of the Merger – Staff (2/2)

Benefit	Rationale
Governance and management processes	Larger clinical and non-clinical team to provide the support to strengthen clinical governance and performance with improved methods and best practice resulting in more effective and efficient processes across both sites.
Student support	Improve medical student and student nurse placement experience and to enhance development on both sites as training practices.
Training and retention of clinical staff	GP trainees and PA students are trained and supported within both practices. Two PAs trained within Downham Family have now taken permanent roles at Burnt Ash Surgery. Both surgeries are training practices.
Improved Patient Experience	The practices will make use of the experience and strengths from each practice to improve patient care. Training will be put in place for all reception staff to ensure consistent and empathetic service is provided on both sites. There will be a more diverse clinical workforce in terms of skill mix and gender.

Benefits of the Merger – Patients

Benefit	Rationale
Improved Patient Access	Improved access to services, more flexibility in appointments across the wider workforce and shorter waiting times made possible from improved efficiencies. Both practices use the Anima triage tool system, providing the benefits of triaging at scale. The system allows for efficient utilisation of the three Physician Associates across both sites, enhancing the management of patient care and triage. Shared administrative functions reduce the burden on individual practitioners, allowing them to focus more on patient care.
Convenient and multiple access methods	There will be more opportunities for service expansion, with the two sites, allowing greater choice of where patients can be seen for appointments. Access to more enhanced services such as minor surgery, micro suction and increased LARC appointments.
Continuity of Care	This will be achieved by ensuring every patient has a Named & Accountable GP. The staff will work as a broader team inclusive of allied healthcare professionals. Increased clinical cover for sickness absences.
Improved patient care	Both practices working within the same PCN will offer patients access to other healthcare providers to support holistic and social needs in the community. Opportunity to increase services through local working, innovation and service redesign. Both practices being part of Sevenfields PCN will provide better access to Social Prescribing, more Pharmacist appointments, Specialist Diabetic Nurse clinics, LARC PCN service, Health and Lifestyle Coaches and outdoor gym facilities. Well run PPG's within the PCN will inform patients of other lifestyle activities in the borough.

Proposed Time Line for Merger

Burnt Ash Surgery and Downham Family Medical Practice to merge EMIS/DXS/DOCMAN and telephony by the end of July 2024.

- Practice Manager is meeting bi-weekly with the ICB and IT to ensure IT requirements are met prior to the merger which will include server audits and PC equipment refresh
- Plans to liaise with PCSE once the merger has been endorsed by Lewisham Care Partnership Board.
- Business case was endorsed by the Primary Care Group in September 2022.

Financial Implications

Costs associated with the merger are shown below:

Task	Estimated Cost	Comment
Costs associated with notifying patients of the merger.	N/A	There is no charge for PCSE to send 2nd Class Postage letter notifications to patients.
Clinical system merger costs including EMIS and Docman and London Shared Services.	£20,000.00	The practice would look to the ICB to support it financially with the integration costs

Stakeholder Engagement

Pre-merger Stakeholder Engagement (1/2)

Stakeholder	Purpose	Method
Patients	• To ensure all patients are aware of the changes, the rationale and the benefits of the merger (to minimise service disruption). Initial discussions were held with the PPG groups in June 2022. Online survey was completed in 2022 and responses collated and assessed. • An update on the merger was presented at both PPG meetings in April & May 2024 and received a positive response. • PPG Attendance: Burnt Ash Surgery – April 24; 4 attendees. Downham Family – May 24; 4 attendees. All members of the PPG were updated on the merger plans and provided positive feedback. Burnt Ash Surgery PPG members expressed strong appreciation for Dr. Lawrence's resilience over the past two years and emphasised the importance of her receiving support. *All PPG members are sent a copy of the minutes of the meetings.* • June 2024, website announcements have been uploaded to provide an update on the merger plans and notify patients that the practice will be holding a Q&A meeting on 10th June at Downham Family Medical Practice. • Feedback forms are available in the practices and on the websites. A link to the form was also attached to SMS messages inviting patient to the Q&A meeting. Feedback is still being collected.	❑ Face to face meetings with PPGs – Downham Family 12th April 2024 Burnt Ash Surgery 15th April 2024. ❑ Engagement with Healthwatch. ❑ Online survey completed in June 2022. ❑ Posters and leaflets in the practices (updated regularly) ❑ Fully trained reception staff to answer patient queries . ❑ Feedback forms are available via MS forms link and in paper format in practice ❑ Q&A meeting for patients will take place on Monday 10th June 2024 6-8pm.

Pre-merger Stakeholder Engagement (2/2)

Stakeholder	Purpose	Method
	• Queries coming into the practice email address are responded to on the same day. • The main concern highlighted by the feedback to date, relates to travelling to other sites and the access to GP appointments. We have reassured the patients that they can still be seen at the practice of their choice, the additional site is only offered as an option. A new full time salaried GP is also starting in August and will work across both sites to increase clinical appointments. • Letters have been sent to housebound and vulnerable patients to update them on the merger plans. • LD patients have been sent an Easy to Read letter to explain the merger and what this will mean for them.	❑ Collect and display patient feeback in practice and on websites ❑ Revise Q&A information sheet based on additional feedback ❑ Schedule a follow up Q&A meeting 3-6 months post-merger to address issues/concerns ❑ Create easy-to-read handouts in the practice and ensure they are given to patients as needed.
Staff	To ensure all staff are aware of the changes, the rationale and the benefits. Provide reassurance.	❑ Face to face meetings – Update on merger plans will be provided at the next PLT and through monthly practice meetings. ❑ Staff FAQs

Pre-merger Stakeholder Engagement (2/2)

Stakeholder	Purpose	Method
PCN colleagues	To ensure PCN colleagues, shared PCN staff and community pharmacies are aware of the changes.	❑ Face to face meetings ❑ Virtual meetings ❑ Leaflets to Pharmacies /Pharmacy First ❑ Update automatic response on practice generic websites ❑ Update Jayex board/calling screen ❑ Message on telephone welcome message
Other services	To ensure Healthwatch are provided with regular updates and asked to re-attend the practices regularly post-merger.	

Key Messages (1/2)

Messaging to patients

Key facts:

Burnt Ash Surgery and Downham Family Medical Practice are planning to merge to form a single patient list.

Changes and improvements:

Both practices will remain open on their current site and form Ashdown Medical Group sharing their values and commitment to high quality patient care.

There will be no staff redundancies and all staff will remain in practice. This new model will offer:

- Improvements to the overall range and quality of services to patients - *There will be no detrimental effect to the care that you receive*
- Improved access to services - *There will be no reduction in services at either practice*
- Improved access to more clinical staff for patients - *You can continue to see the same clinician that you see at the moment however the merger affords extended availability to healthcare professionals of different gender, medical knowledge and specialised clinics*
- Improved patient choice and increased GP and nurse availability - *You will have a wider choice of which clinician to see and working collaboratively will also provide support for across both sites during periods of staff absence, allowing for a more consistent level of care*

If you have any other questions, please visit your surgery website for a list of FAQs or email Louise Hassan at selicb.g85057@nhs.net

Key Messages (2/2)

Messaging to PCN's

With the re-start of the merger process in 2024, the Lewisham Alliance PCN CD has been updated.

Other members of the PCN were informed of the merger.

Sevenfields PCN and Lewisham Alliance have been regularly updated with information regarding the merger plans.

Messaging to other stakeholders:

"Burnt Ash Surgery and Downham Family Medical Practice are proposing a merger to form a single patient list. The practices will form Ashdown Medical Group pooling their management and clinical teams to offer greater resilience and a wider choice of services to our patients. Both Practices have been sharing their values and commitment to high quality clinical care over the past year and now believe a full merger will help to provided improved access and choice for patients."

Online Survey Results (1/3)

Conducted in 2022.

550 responses were received from the online Survey:

539 (99.26%) were patients at the practices

- 306 (56.15%) Burnt Ash
- 234 (42.94%) Downham Family Medical Practice
- 3 (0.92%) not a patient at either practice

The trend is that patients would rather stay at the surgery they are currently registered at. Further engagement will reassure patients that this will be possible and they will be given the option of which practice they would like an appointment with.

Patients comments suggest that they are unable to travel to the other practice due to being elderly, infirm or not having means of travel.

The triaging system in place will enable patients to talk to clinicians from either site without any impact on the patient. Patients will then be offered an appointment at their requested practice if needed.

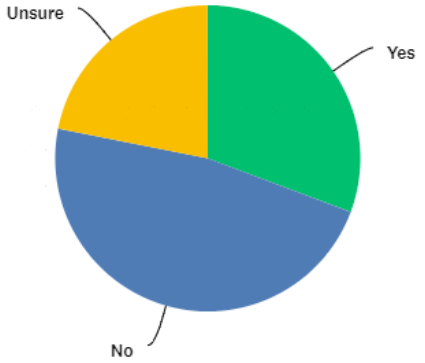
57.51% of patients commented they would not like to accept an appointment at a different site, patient engagement to date has reassured patients that they will be able to continue to attend their preferred practice and would only be asked to attend a different site in the circumstances of an emergency such as having to trigger our business continuity plan.

31.14% of patients are happy to travel and **14.29%** were unsure.

Patients are concerned that the level of care will be affected. Further engagement will give clarity how the merger will offer better cover for clinicians due to illness or leave, expand clinical skills and knowledge across both sites and improvement on staff retention which will provide improved access to appointments. Following the merger both sites will be able to offer expanded services, including dedicated LARC, minor surgery and micro suction services. This will improve the quality of services provided by Ashdown Medical Group.

Would you be prepared to go to another of our practices to receivespecialist care;

Answered: 544 Skipped: 6

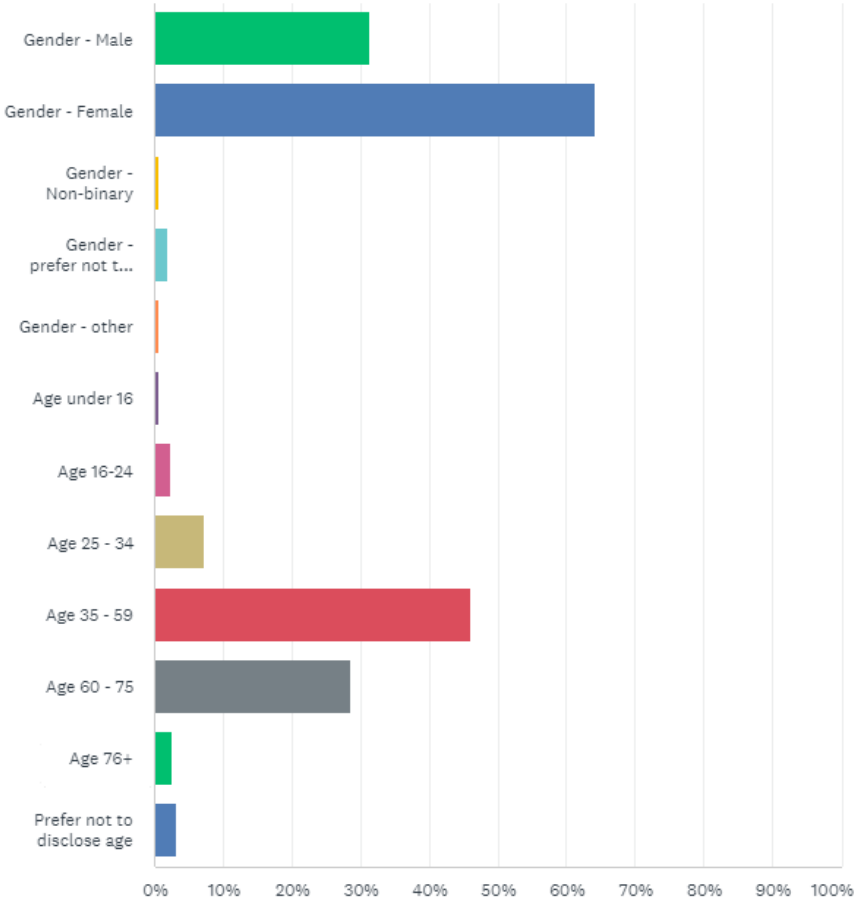


ANSWER CHOICES	RESPONSES	
Yes	30.70%	167
No	47.43%	258
Unsure	21.88%	119
TOTAL		544

Online Survey Results (2/3)

Equality Monitoring Questions

Answered: 544 Skipped: 6



ANSWER CHOICES	RESPONSES	
Gender - Male	31.43%	171
Gender - Female	64.15%	349
Gender - Non-binary	0.74%	4
Gender - prefer not to say	1.84%	10
Gender - other	0.55%	3
Age under 16	0.74%	4
Age 16-24	2.39%	13
Age 25 - 34	7.17%	39
Age 35 - 59	46.14%	251
Age 60 - 75	28.49%	155
Age 76+	2.57%	14
Prefer not to disclose age	3.13%	17
Total Respondents: 544		

Online Survey Results (3/3)

- Acknowledging and address the concerns of patients:
- A message will be displayed on the websites thanking patients for taking part in our survey and advising that:
- A further FAQs session has taken place to address the issues raised by the patients
  - Further patient feedback is being collated.
- Letters with the FAQs have been sent to housebound and vulnerable patients to provide updates.
- PPG involvement will be encouraged to provide the practices with an understanding of the issues patient may be concerned about.
- A further survey will be sent out after the merger to gauge the level of service and ensure this is improving.
- Messages will be displayed in reception areas, websites and calling screens to inform patients that following the merger we will continue to operate and deliver services at the two surgeries and patients do not need to travel between the sites. New services will follow the patients rather than patients following the service. Minor surgery clinics, LARC services and Diabetic Nurse Specialist clinics will be delivered at both practices. This will be advantageous to the patients as they will continue to receive undisruptive services.

Engagement following approval (1/3)

We have laid out our planned approach to stakeholder engagement if merger is agreed

Stakeholder	Purpose	Method
Patients	To ensure all patients are aware of the approved merger, understand the benefits and are notified of any anticipated short term service disruption. The practice will learn from other practice mergers in the borough and ensure patients are fully prepared.	Consultations, including face-to-face patient engagement meetings with an option to join virtually, were held at each site in 2022. Both Patient Participation Groups (PPGs) were informed of the delay in the merger due to a Partnership issue. In April 2024, both PPGs were updated that plans for the merger would now proceed.
	Address patients concerns highlighted during the pre-merger engagement sessions and agree on how some of these can be resolved.	Ashdown Medical Group will publish a report to address concerns or queries and publish on websites, notice boards in reception areas and to the PPG groups.

Engagement following approval (2/3)

Stakeholder	Purpose	Method
Staff	Key updates to be discussed at clinical and administration meetings to provide staff with key updates, minutes of meetings to be emailed to all staff.	Virtual or F2F meetings
PCN Colleagues	Inform key PCN colleagues (PCN CDs and managers) of updates on the merger planning	Virtual Monthly meetings

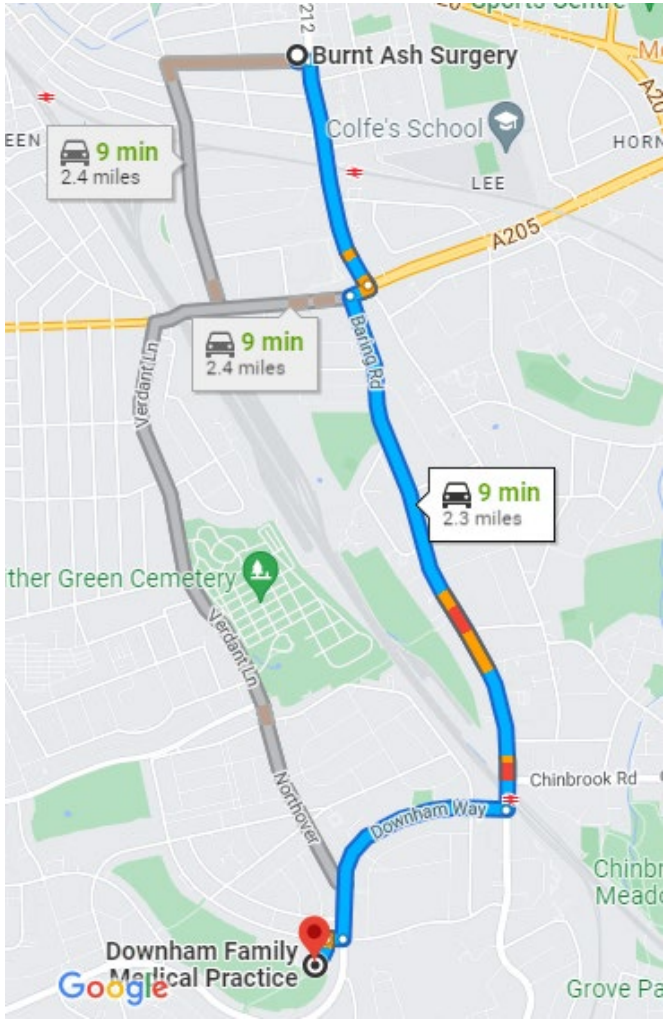
Engagement following approval (3/3)

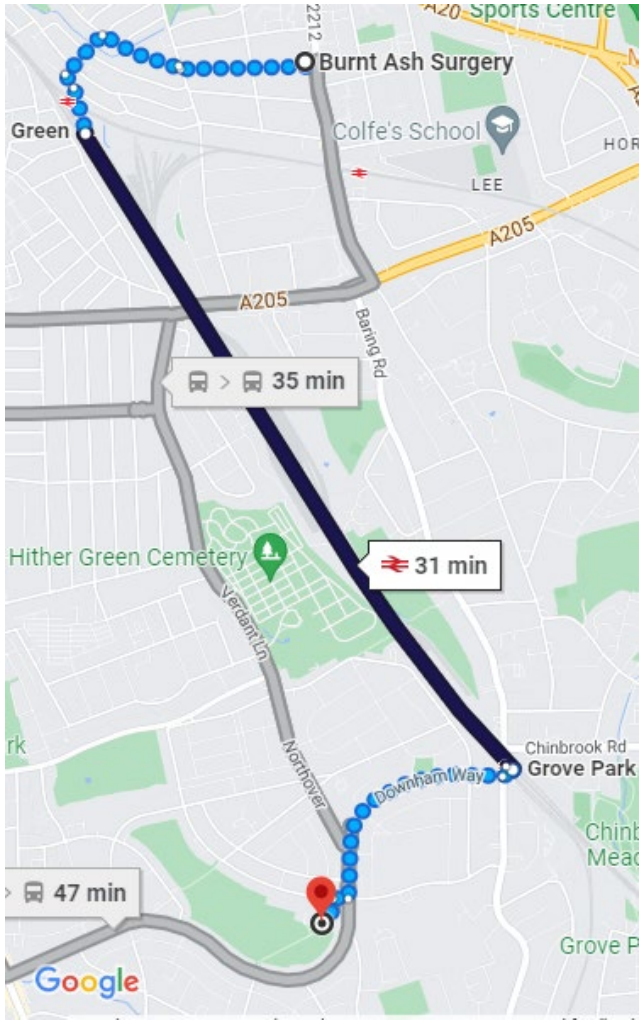
- The practices will work with the primary care team to ensure all stakeholders are informed of the proposal.
- Including SELDOC, local acute and community care providers (LGT), SLAM, 111, Lewisham Healthier Select Committee, Local MPs, Local Councillors and Lewisham Local Medical Committee.
- Following approval Ashdown Medical Group will promote patient feedback via AccuRx text messaging, online and in practice feedback forms to actively monitor the service provided by the practices.
- All vulnerable patients will be contacted nearer to the merger date to ensure they understand what the merger means for them and how they will be supported by Ashdown Medical Group.
- Easy-to-read letters will be sent to all learning disability patients.

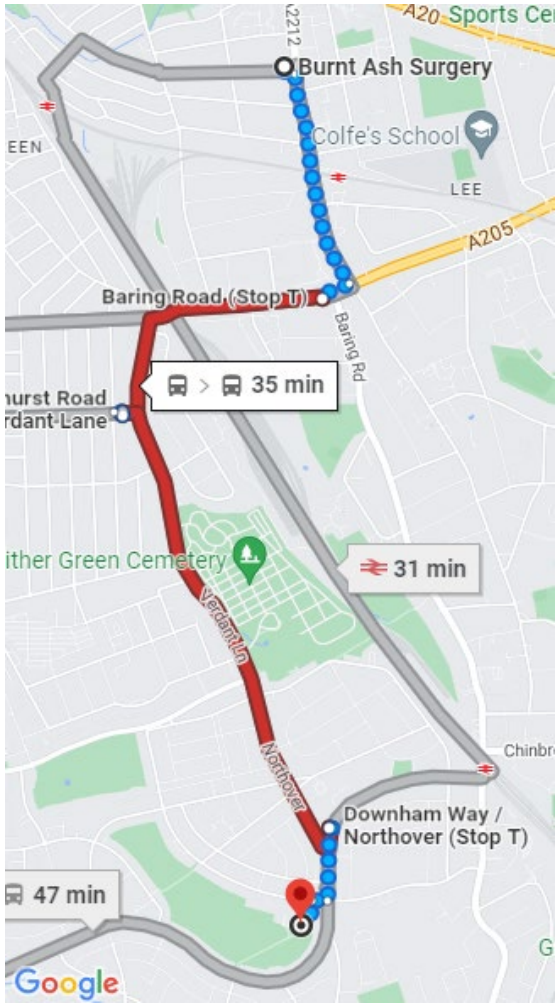
Key Facts of the Merger

Newly merged practice contract code	G85057
Practices to form:	Ashdown Medical Group
Intended contract merger date:	31/07/2024
Intended clinical system merger date :	To be confirmed (over a weekend in early – Mid July 2024)
Changes to existing premises:	There are no planned premises closures
Changes to telephony:	Both practices use the same icloud telephony system which can be easily linked. Both practice telephone numbers will remain active
Planned changes to opening hours:	No change
Distance between practices:	1.73 miles between practices. Practice boundaries overlap
Travel options between practices:	It is an 8 – 10 minute drive between practices and both sites have free parking options with blue badge/disabled parking Bus routes – 202 and 284 / 273 and 284 / 273 and 124 /202 and 181

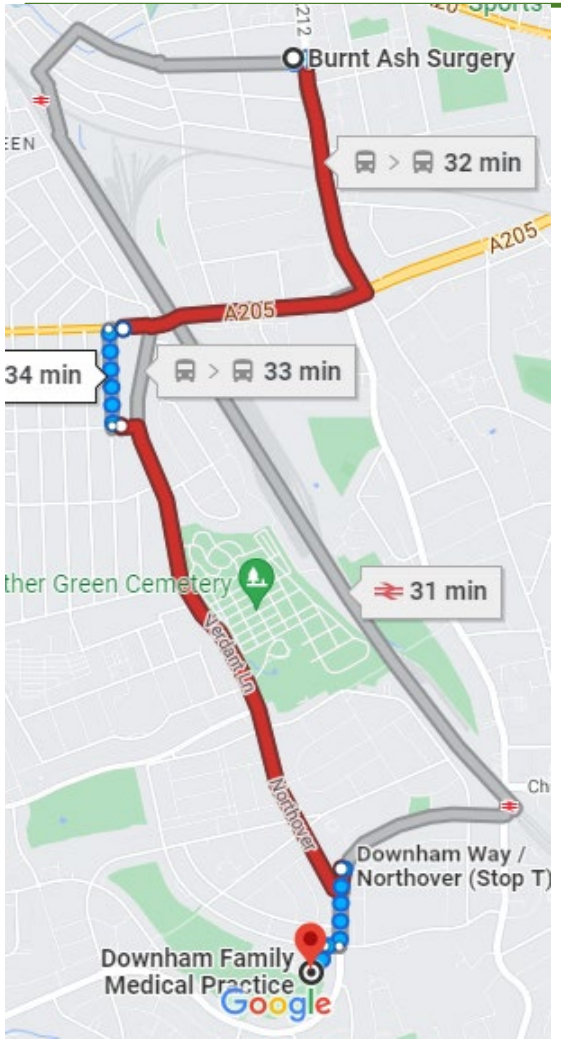
Travel Routes (1/2)

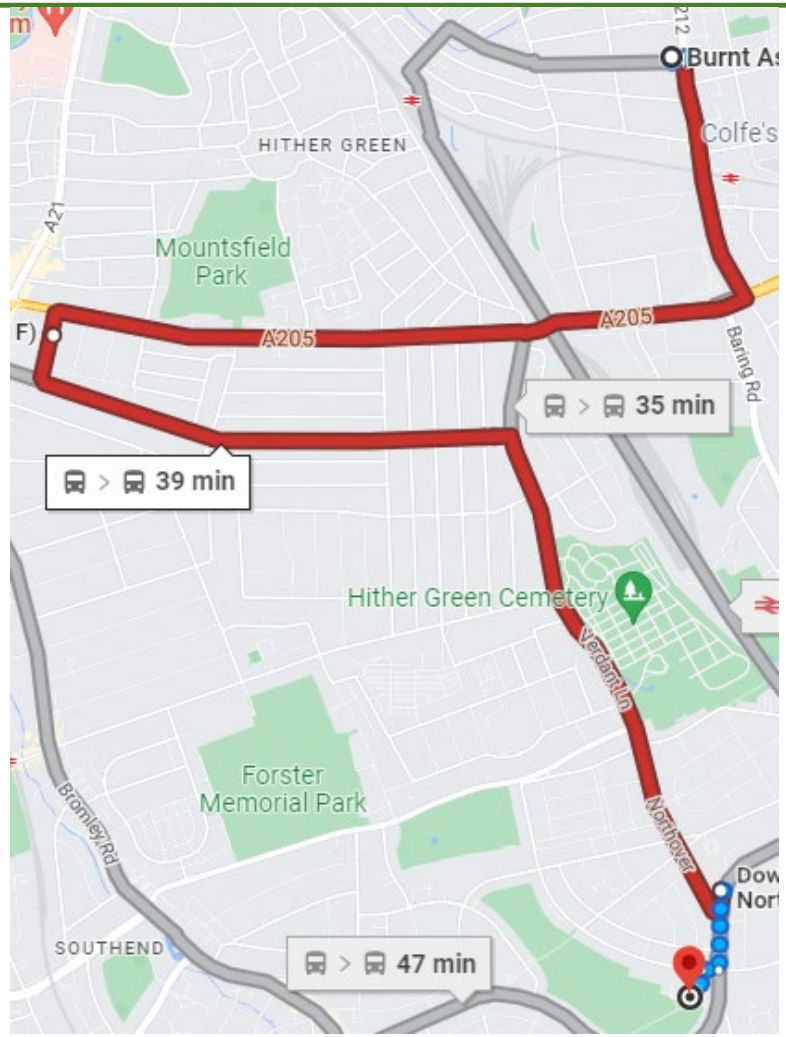






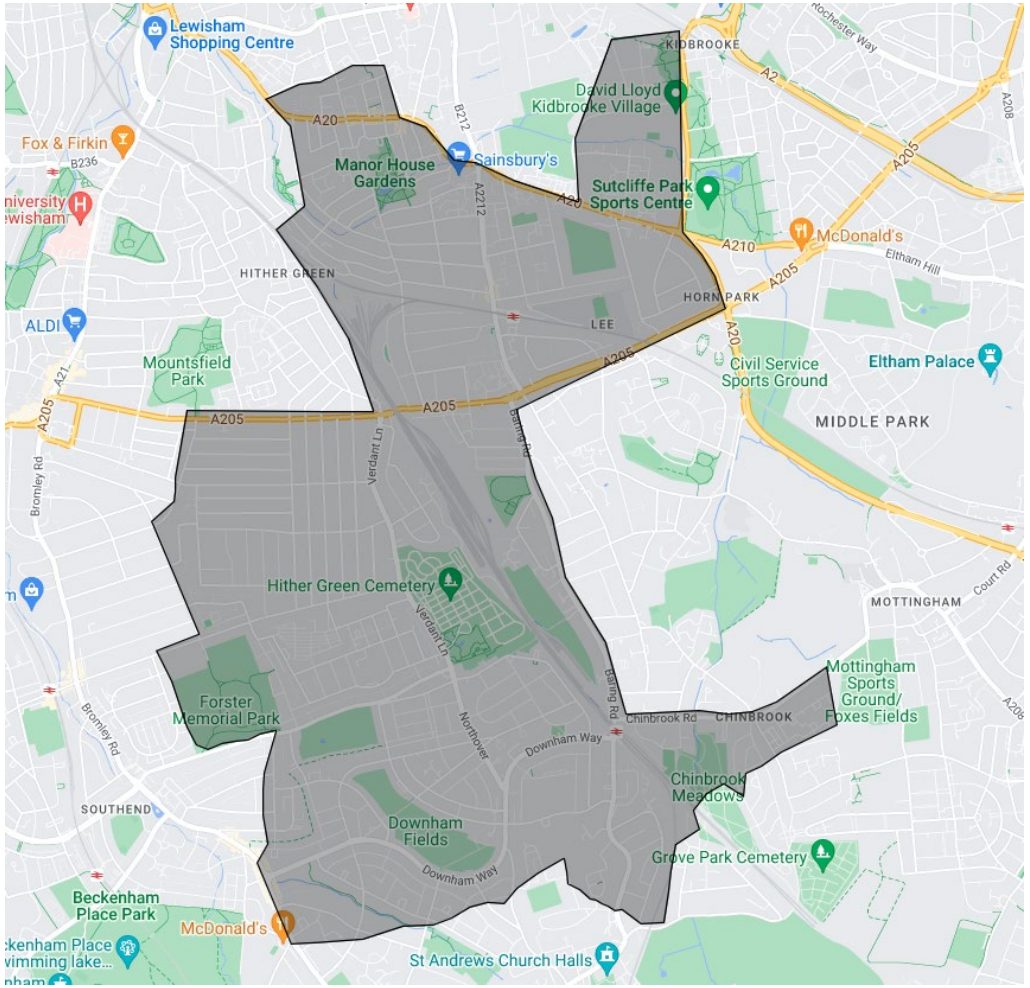
Travel Routes (2/2)





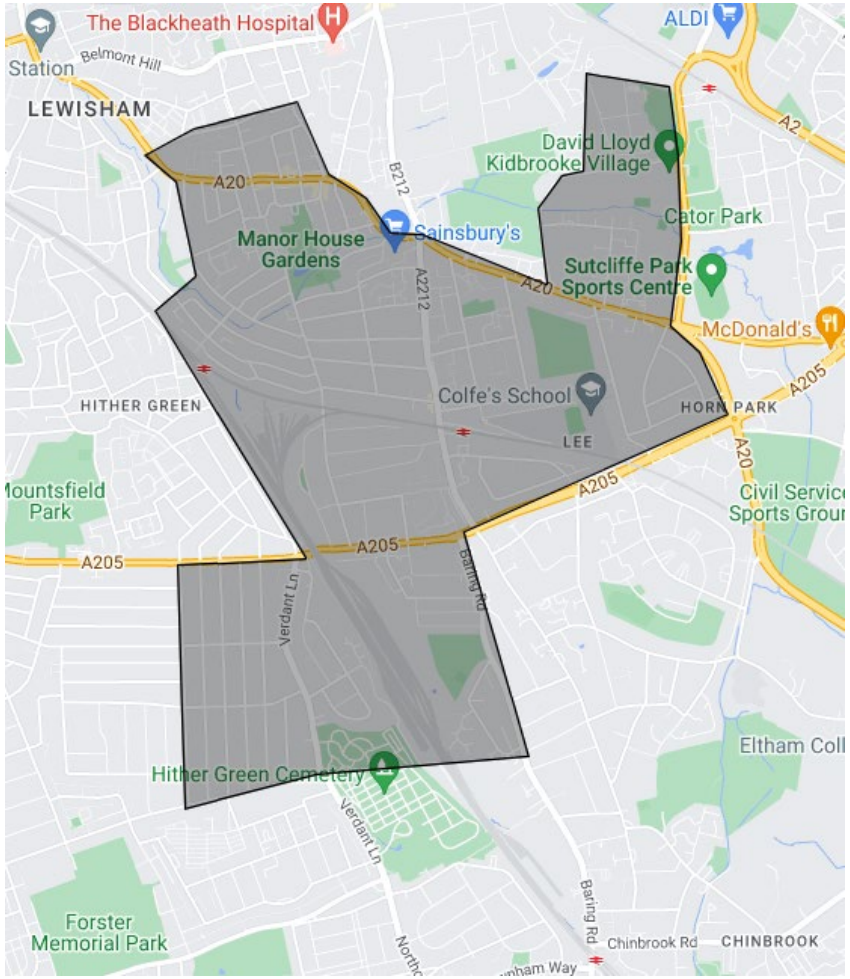
Practice Catchment Areas

Downham Family Medical Practice

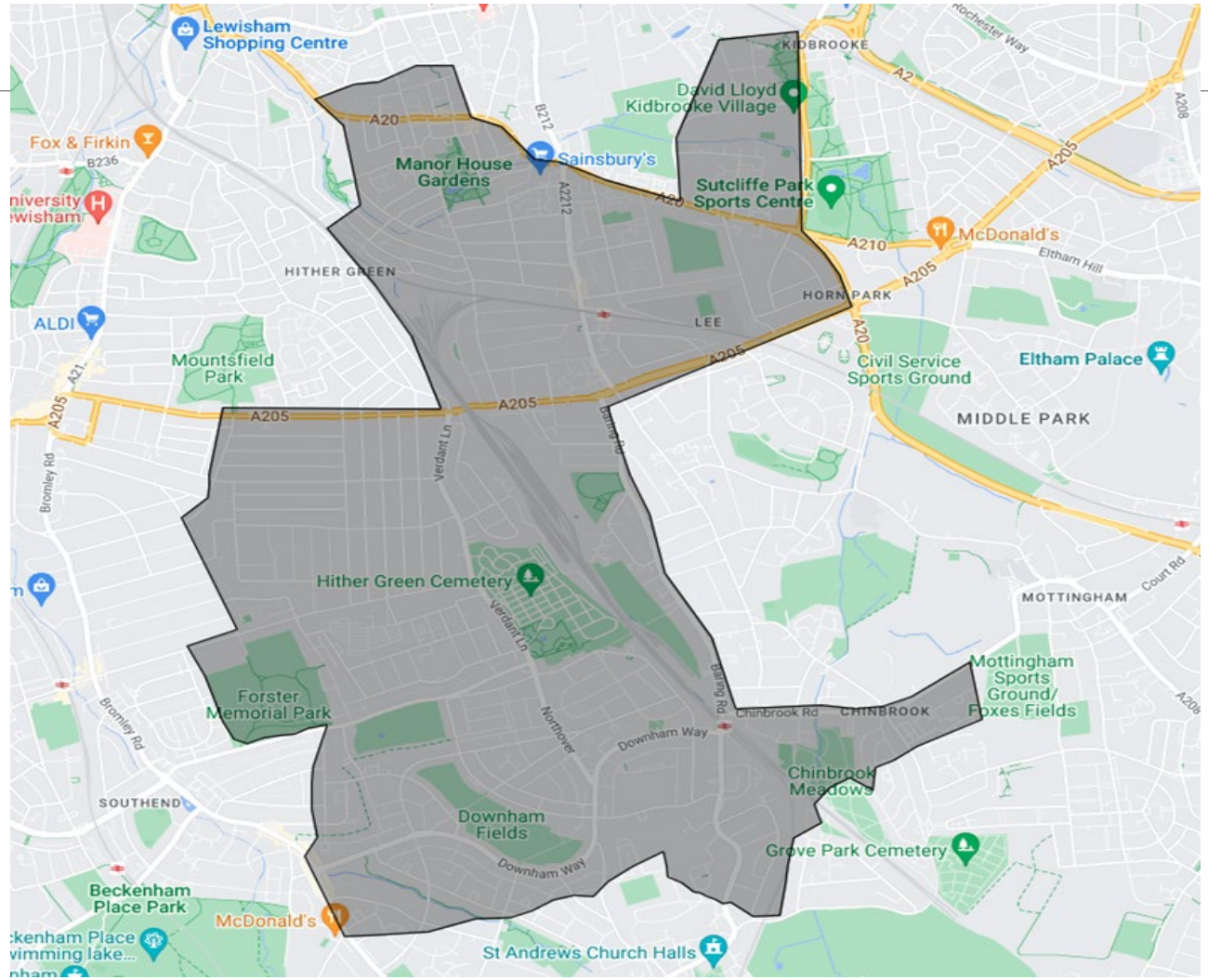


The catchment area for Downham Family Medical Practice has recently been expanded to incorporate the catchment area of Burnt Ash Surgery. This combined area will now serve as the catchment area for the merged practices (Ashdown Medical Group).

Burnt Ash Surgery

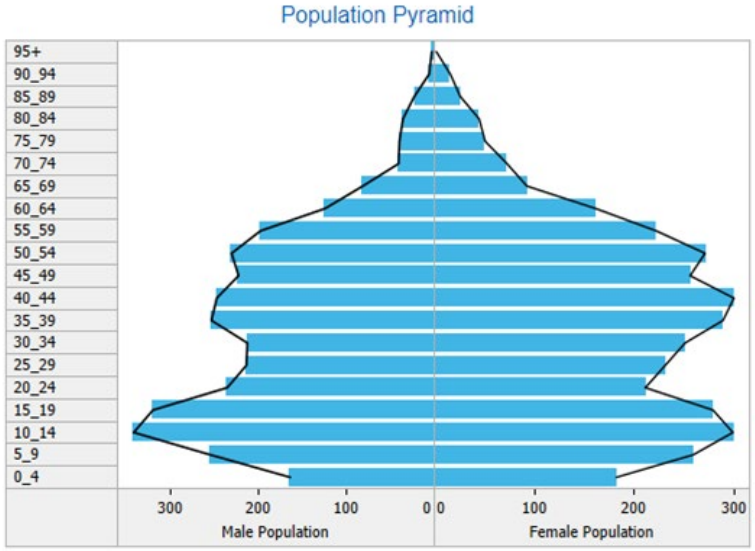


Ashdown Medical Group Catchment Area



Practice Demographics Comparison (1/2)

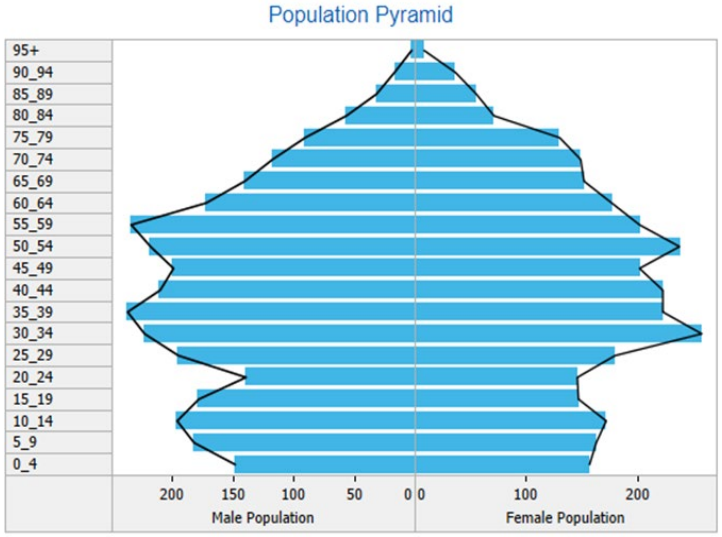
Downham Family Medical Practice



Practice Profile

Contract Type: PMS
Dispensing Practice: No
List Adjusted IMD: 32.75
List Adjusted IDACI: 0.27
List Adjusted ADAOPI: 0.26
%BME: 50.40
Practice List Size: 6,798
Weighted List Size: 6,058
Practice Rurality: Urban
Total GP FTE: 2.91
Other Direct Patient FTE: 3.12

Burnt Ash Surgery



Practice Profile

Contract Type: PMS
Dispensing Practice: No
List Adjusted IMD: 21.36
List Adjusted IDACI: 0.17
List Adjusted ADAOPI: 0.18
%BME: 38.70
Practice List Size: 6,092
Weighted List Size: 6,393
Practice Rurality: Urban
Total GP FTE: 2.56
Other Direct Patient FTE: 2.64

Practice Demographics Comparison (2/2)

- The overlapping catchment areas means the practice's demographics are not too dissimilar. Downham has a higher population of BAME and younger patients, while Burnt Ash has a higher population of older patients. As all clinicians understand the different demands of these demographics and the services provided in both practices will be mirrored, we do not envisage any impact on the services provided.
- The GPs in the practices have experience of working in different areas of Lewisham and have the knowledge and skill sets to adapt to varying demographics.
- Both practices have a highly dynamic population which keeps evolving and the merger between the practices will be advantageous to two practice populations. Patients who move property but stay within the Ashdown Medical Group catchment area will be able to remain with the practice they are currently registered with. This will be advantageous to patients who have comorbidity and value continuity of care.
- Nursing staff are currently working across both sites and are being introduced to the different ethnic make up and deprivation indicies. Physician Associate employed at Burnt Ash Surgery spent some of their training at Downham Family Medical Practice and are therefore aware of the needs of patients at both sites.
- Joint clinical meetings involving both practices will be used as a platform to share information and concerns regarding patients with specific needs, health issues and difficult to reach patients. Sevenfields Care Co-ordinators will support recalls for these patients.
- Following the merger, clinicians from both practices will attend the necessary MDM meetings to ensure they fully understand the needs of the vulnerable patients on both practice lists.

Risk Analysis – Risk Identification and Management (1/3)

A SWOT Analysis of the merger between the two practices was carried out to identify potential risks and provide solutions for such risks. The risks identified are linked to the weaknesses and threats in our SWOT analysis

Internal	**Strengths** • Improved sustainability in providing services • Improved access to services at multiple sites for patients • Economies of scale through ability to increase volume and type of services offered to patients • Ability to offer increased/extended patient access • Ability to bulk buy and reduce costs • Ability to share facilities and premises • Improved working at scale and sharing administrative work • Improved staff retention • Ability to offer greater clinical expertise and skills	**Weaknesses** • Each Practice will sacrifice an element of their independence as both practices have different processes and cultures • Staff of both practices will have to be integrated and have to learn to work in collaboration
External	**Opportunities** • Opportunity to offer greater training functions to develop more skilled workforce • Potential to reduce workload pressures • Greater chance of successfully bidding for contracts • Opportunity to become a pro-active practice	**Threats** • The liabilities which belong to each practice may pose an issue unless positive action is taken to mitigate the liabilities or ring fence them • Cost and time constraints may pose difficulties during initial stage of merger

Risk Analysis – Risk Identification and Management (2/3)

MITIGATING AGAINST POTENTIAL RISKS

Potential risk can arise either before or after the merger and it is important that such risks are identified and solutions proffered.

Risk Analysis and Management

1. **Lack of Due Diligence :** Due diligence is extremely important for both practices in order to learn as much as possible about the practice's financials, contracts, patients, demographics, and other pertinent information in order to avoid getting caught up in obligations they are not ready to assume such as litigation issues and complicated tax matters.

   Both Practices have engaged the services of foremost law firm – Hempsons Solicitors and Independent Medical Accountants for a thorough legal and financial due diligence. Both practices were happy to proceed with the merger following successful outcome of the due diligence reports.

2. **Miscalculating Synergies between the two Practices :** It is easy to be overly optimistic about the gains of a merger and underestimate how long synergies takes to come to fruition.

Risk Analysis – Risk Identification and Management (3/3)

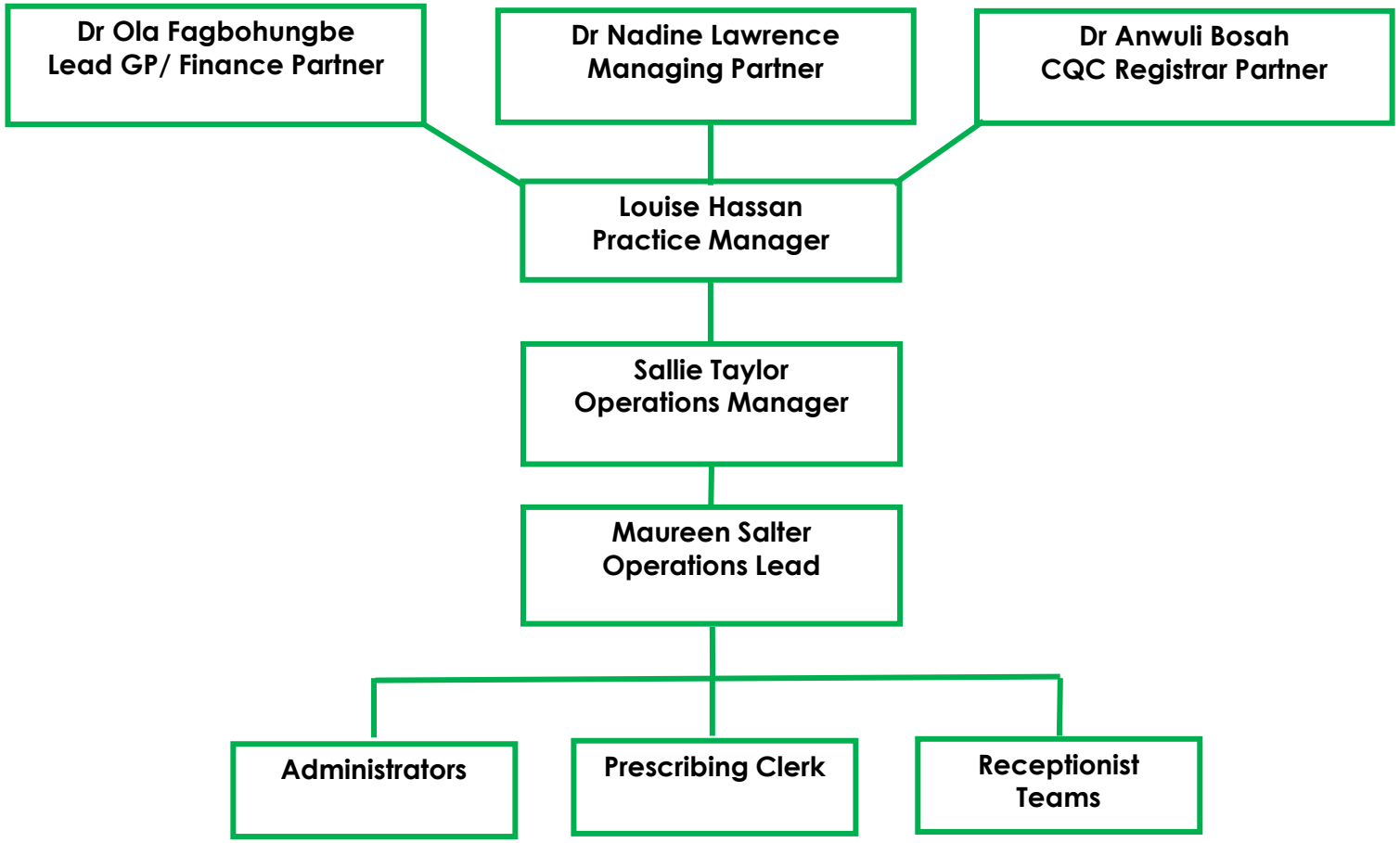
Following the due diligence process and regular partners meetings, we have been working collaboratively on consolidating workforces and operational processes in order to achieve the overall aim of ensuring that the combined practices are more valuable than they are individually.

3. **Integration Issues :** Significant integration issues can crop up after a merger. A merger is a major organisational change with a potential to alter many of the underlying processes behind how both practices operate. Different cultures may also pose a challenge.

   As the partners of the two practices have been meeting regularly and created a single management operational framework, managed by a single Practice Manager and supported by two Operational Leads, we have been learning and improving on the practices cultural and operational differences and streamlining our processes further by ensuring that staff on both sides, work across both practices.

   The two practices share the same values and ethos and are similar in so many respects. Both practices have been working collaboratively, working together under the same management and administration structure for the past 12 months. The Partners and staff are already bonding well both professionally and socially. There were shared events at Christmas and a summer social took place recently.

Ashdown Management Structure



Ashdown Medical Group Recruitment

Downham Family Medical Practice Current Staff	Burnt Ash Surgery Current Staff	Recruitment for Ashdown Medical Group
2 x GP Partners 2.0 FTE	1 x GP Partners - 1.0 FTE	
No salaried GPs 1 x long term locum 0.6 FTE	1 x Salaried GP 0.6 FTE 1 x GP 0.75 FTE. Currently a locum and joining the practice in August 2024 1 x long term locum 0.25 FTE	1 x locum GP and joining the practice in May 0.5 FTE 1 x salaried GP joining the practices in August 2024 1.0 FTE
1 x Clinical Pharmacist 0.4 FTE	1 x Clinical Pharmacist 0.4 FTE	No further recruitment needed
2 x Physician Associate 1.0 FTE	1 x Physician Associates 1 FTE	No further recruitment needed
1 x Nurse Prescriber currently 0.36 FTE. Up to 1.0 FTE from October/November 2022. 1 x Practice Nurse 0.7 FTE 1 x GP Academic Nurse 0.5 FTE. To be offered F/T employment in February 2023.	1 x Nurse Associate 1.0 FTE 1 x Practice Nurse specialising in Sexual Health 0.6 FTE	No further recruitment needed
Management/Administration Shared staff		
1 x Practice Manager 1.0 FTE 1 x Operations Manager 1.0 FTE 1 x Operations Lead 0.8 FTE		No further recruitment needed
Administration and Reception staff 5.2 FTE	Administration and Reception staff 5.2 FTE	1 x Receptionist/administrator 1.0 FTE – recruiting in process

Appendix 1: Engagement Plan

Ashdown Medical Group: Engagement Plan (1/3)

Required Action	Outcome	Remaining Action	Status	Complete By
Liaise with PPG Groups	Ensure PPG members are made aware of plans to merge, given opportunity to feedback and kept updated of developments.	Keep PPG members informed of ongoing progress and key dates and the practices to receive feedback.	Complete	31st May 2024
Set up and carry out Patient Engagement Survey	Engage with patients via online survey (Survey Monkey) sent to all over 16's with a mobile number. Letters sent to all patients without a mobile number. Set up dedicated email for responses.	Feedback at the next patient engagement and produce further FAQs to address concerns raised.	Complete	
Patient engagement via paper questionnaires	Engage with patients who are not digitally enabled by distributing paper questionnaires at the practices.	Keep staff updated with plans and ensure they are comfortable to answer any patient queries.	Complete	
Put proposed merger details and FAQs on websites	Ensure patients are informed of proposed merger and what it will mean for patients	Keep website updated with progress and development, once merger date is closer advise of patient drop in sessions.	Complete	

Ashdown Medical Group: Engagement Plan (2/3)

Required Action	Outcome	Remaining Action	Status
Proposed merger information in practice reception areas – posters, leaflets and FAQs	Ensure patients are informed of proposed merger and have an opportunity to speak with the clinicians or administration staff about concerns.		Complete
Liaise with Health Watch Lewisham on patient engagement	Health Watch are currently visiting the practices on a regular basis and will be able to engage with patient groups to ensure they are aware of the proposed merger and feedback concerns.		Complete
Active engagement with local practices, PCN, local pharmacies, support organisations and other key stakeholders.	Contact: SELDOC, local practices, One Health Lewisham, SLAM, PCSE, Local acute and community care providers, LMC to consider effects of the merger and ways to minimise disruption.	Discuss at MDM and safeguarding meetings to ensure social services, district nurses and health visitors are aware.	Complete
Set up dedicated email address	Have a point of contact for all patients or service providers who have questions about the merger		Complete

Ashdown Medical Group: Engagement Plan (3/3)

Required Action	Outcome	Remaining Action	Status	Complete By
Planned F2F and virtual engagement sessions following merger approval.	F2F meeting with virtual link to engage with patients.	Dates to be set for each site once merger date approved.	Not started	July 2024
Collate findings and concerns from engagement and agree actions to address.	Identify common themes and provide reassurance to patients. Continue to review patient engagement after merger to address concerns.	Common themes to be identified – addressed at the planned engagement meetings and published on websites.	Not started	30th June 2024
Identify and contact vulnerable patients from both practices to provide support with the merger where necessary.	Write letters or make telephone calls to identified patients informing them of the merger and reassure them of support they will continue to receive.	Letters and calls to be made once merger date approved.	Not started	July 2024

Appendix 2:
2023 GP Survey Results

Burnt Ash Surgery

Lee Health Centre, 2 Handen Road, Lee, SE12 8NP

Practice Summary (PowerPoint)

Practice overview | Patient experience | Compare practice ►

Where patient experience **is highest** compared with the ICS result

- **63%** of respondents find it easy to get through to this GP practice by phone
  ICS result: 48% | National result: 50%
- **87%** of respondents find the receptionists at this GP practice helpful
  ICS result: 80% | National result: 82%
- **98%** of respondents were given a time for their last general practice appointment
  ICS result: 92% | National result: 91%

Where patient experience **is lowest** compared with the ICS result

- **56%** of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  ICS result: 59% | National result: 59%
- **49%** of respondents are satisfied with the general practice appointment times available
  ICS result: 50% | National result: 53%

Comparisons with the local ICS or national results are indicative only and may not be statistically significant.

422 Surveys sent out

129 Surveys sent back

31% Completion rate

Downham Family Medical Practice

Downham Family Med Pract, 7-9 Moorside Road, Downham, BR1 5EP

Practice Summary (PowerPoint)

Practice overview | Patient experience | Compare practice ►

Where patient experience **is highest** compared with the ICS result

- **79%** of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  ICS result: 59% | National result: 59%
- **65%** of respondents are satisfied with the general practice appointment times available
  ICS result: 50% | National result: 53%
- **63%** of respondents describe their experience of making an appointment as good
  ICS result: 50% | National result: 54%

Where patient experience **is lowest** compared with the ICS result

- **72%** of respondents say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment
  ICS result: 81% | National result: 84%
- **87%** of respondents had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment
  ICS result: 92% | National result: 93%
- **28%** of respondents usually get to see or speak to their preferred GP when they would like to
  ICS result: 33% | National result: 35%

Comparisons with the local ICS or national results are indicative only and may not be statistically significant.

701
Surveys sent out

107
Surveys sent back

15%
Completion rate

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who find it easy to get through to this GP practice by phone Show breakdown ⊕	63% ICS result: 48% National result: 50%	60% ICS result: 48% National result: 50%
% of patients who find the receptionists at this GP practice helpful Show breakdown ⊕	87% ICS result: 80% National result: 82%	89% ICS result: 80% National result: 82%
% of patients who are satisfied with the general practice appointment times available Show breakdown ⊕	49% ICS result: 50% National result: 53%	65% ICS result: 50% National result: 53%
% of patients who usually get to see or speak to their preferred GP when they would like to Show breakdown ⊕	34% ICS result: 33% National result: 35%	28% ICS result: 33% National result: 35%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
Making an appointment		
% of patients who were offered a choice of appointment when they last tried to make a general practice appointment Show breakdown ⊕	56% ICS result: 59% National result: 59%	79% ICS result: 59% National result: 59%
% of patients who were satisfied with the appointment they were offered Show breakdown ⊕	71% ICS result: 66% National result: 72%	74% ICS result: 66% National result: 72%
% of patients who took the appointment they were offered Show breakdown ⊕	99% ICS result: 95% National result: 96%	96% ICS result: 95% National result: 96%
% of patients who describe their experience of making an appointment as good	53% ICS result: 50% National result: 54%	63% ICS result: 50% National result: 54%

Your local GP services

	Burnt Ash Surgery ⊗	Downham Family Medical Practice ⊗

Your last appointment

% of patients who were given a time for their last general practice appointment Show breakdown ⊕	98% ICS result: 92% National result: 91%	99% ICS result: 92% National result: 91%
% of patients who say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment Show breakdown ⊕	85% ICS result: 81% National result: 84%	86% ICS result: 81% National result: 84%
% of patients who say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment Show breakdown ⊕	84% ICS result: 83% National result: 85%	84% ICS result: 83% National result: 85%

Your local GP services

	Burnt Ash Surgery ⊗	Downham Family Medical Practice ⊗
% of patients who say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment Show breakdown ⊕	84% ICS result: 81% National result: 84%	72% ICS result: 81% National result: 84%
% of patients who felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment Show breakdown ⊕	82% ICS result: 79% National result: 81%	86% ICS result: 79% National result: 81%
% of patients who were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment Show breakdown ⊕	93% ICS result: 89% National result: 90%	88% ICS result: 89% National result: 90%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice
% of patients who had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment Show breakdown ⊕	93% ICS result: 92% National result: 93%	87% ICS result: 92% National result: 93%
% of patients who felt their needs were met during their last general practice appointment Show breakdown ⊕	92% ICS result: 90% National result: 91%	85% ICS result: 90% National result: 91%

Your local GP services

	Burnt Ash Surgery	Downham Family Medical Practice

Your health

% of patients who say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s) Show breakdown ⊕	66% ICS result: 60% National result: 65%	64% ICS result: 60% National result: 65%

Overall experience

% of patients who describe their overall experience of this GP practice as good Show breakdown ⊕	71% ICS result: 67% National result: 71%	78% ICS result: 67% National result: 71%

GP Survey Comparison

- Both practice results show that patients are generally happy with the care they have received from the healthcare provider and patients felt involved in the decisions made about their care. Patients at both practices feel that they have confidence and trust in the healthcare professional they saw.
- Results show that patients find the receptionists very helpful at both practices. Although the percentages in this area were higher than national results patients have scored both sites lower for their experience of making an appointment. Ashdown Medical Group has recently moved over to a total triage system which should improve the results in next year's survey.
- Both practices show higher than national average for getting through to the practice. Both sites now have a cloud telephony system in place which enables the incoming calls to be answered from either site and the new call back service will be active by the end of June 2024. Ashdown Medical Group aim to make access via the telephones easier by promoting the NHS App and Anima triage App.
- Results for both practices were below national average with regards to patients usually getting to see their preferred GP. This has been due to both practices needing to utilise locum cover. Burnt Ash Surgery now has a highly regarded Lewisham GP working 3 days a week who will be permanent by the end of August 2024 as well as an additional long term locum who started in May 2024. This will provide more continuity of care across both sites.
- The merger aims to improve access to appointments and patient satisfaction with the appointments offered. There will be greater choice of GP provision offering patients the option to book with a wider choice of GP as well as the improved skill mix with different GP specialisms across the sites. Ashdown Medical Group has employed a Practice Pharmacist to increase the number of appointments offered and free up GP appointments to allocate to more complex healthcare. A full time Nurse Associate at Burnt Ash, trained in Phlebotomy, will support Physician Associates with diabetic care as well as providing support to the Practice Nurses allowing more appointments to be booked for LTCs. Reception staff have been given Care Navigation training to ensure patients are signposted to other relevant services such as Pharmacy First and PCN healthcare providers which will in turn provide more appointments in practice.

Appendix 3: Improvement Plan

Improvement Plan (1/4)

The merger of the two contracts provides an opportunity to review and improve some key areas through benefit of shared learning. As outlined in the Business Case there are some areas where the variation in performance can be improved.

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
1.	Patient Engagement	Practice has conducted engagement in 2022 and 2024.	To continue regular and meaningful patient engagement post-merger.	Feedback forms are in practice, on websites and have been sent to patients - to be collected until end of June. Data will be collated, analysed and reported on. Results to be displayed in practice and on websites. Survey to be sent to patients 6 months post merger to provide continuous improvements and address any concerns. PPG meetings are held every 6 weeks to provide regular updates. Notice boards and websites will be updated regularly.	Ongoing	Louise Hassan	31.07.2024
2.	Mental Health	<u>Burnt Ash Surgery</u> ○ Level 2 Trigger - Mental Health Comprehensive Care Plan – 44%. ○ Level 2 Trigger - SMI Alcohol Record – 26%. ○ Level 1 Trigger - SMI BP Record – 70%. <u>Downham Medical Family Practice</u> ○ Level 1 Trigger - Mental Health Comprehensive Care Plan – 85%. ○ Level 1 Trigger - SMI Alcohol Record – 83%.	○ Allocate clinics for reviews in practice with Physician Associates. ○ Utilise allocated clinics within the PCN. ○ Utilise support from PCN MHP. ○ New PCN Youth Clinic will provide extra support to 13-24yr olds. ○ Dedicated recall team across both sites. ○ PCN care Coordinators support with recall 2 days a week. ○ Care coordinators completeing an audit of MH patients who did not attend a review last year to ensure up to date contact details	Continue to improve engagement with patients on MH register and ensure that every contact counts. Updating registration details to improve engagement. Align targets across both practices.	Ongoing	Dr Bosah / Physician Associates	31.03.2025

Improvement Plan (2/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
3.	Cervical Screening Age 25 - 49	Burnt Ash Surgery ○ Level 1 Trigger – 71%. Downham Medical Family Practice ○ Level 1 Trigger – 71%.	○ Appoint a nurse to Lead to work closely with recall team and trainee HCA. ○ Identify reasons for low achievement – GPN Academic nurse is providing this during fellowship. ○ Increase admin hours for call/recall / failsafe procedures. ○ Utilise Enhance Access nursing appointments to improve access.	Meet the QoF target for age 25 - 49yrs	Ongoing	Nursing Team	31.03.2025
4.	Cervical Screening Age 50 - 64	Burnt Ash Surgery ○ Level 1 Trigger – 77%. Downham Medical Family Practice Level 1 Trigger – 80%.	○ Appoint a nurse to Lead to work closely with recall team and trainee HCA. ○ Identify reasons for low achievement – GPN Academic nurse is providing this during fellowship. ○ Increase admin hours for call/recall / failsafe procedures. ○ Utilise Enhance Access nursing appointments to improve access.	Meet the QoF target for age 25 - 49yrs	Ongoing	Lead Nurse and recall teams	31.03.2025

Improvement Plan (3/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
5.	Child Imms DTaP/IPV/Hib/Hep B (age 1 year)	Burnt Ash Surgery ○ Level 1 Trigger - 92%. Downham Medical Family Practice ○ Level 1 Trigger – 86%.	○ Robust recall team administrators ○ Dedicated PCN Care Coordinator support to contact hard to reach patients ○ Nurses to call parents reluctant to give child vaccines to educate the importance of immunisations ○ Promote communication on immunisations ○ Utilise the PCN Enhanced Access Immunisation Clinics to improve access.	Improve uptake to achieve better QoF target. Educate parents	Ongoing	Lead Nurse and recall teams	31.03.2025
6.	Child Imms Hib/MenC booster	Burnt Ash Surgery ○ Level 1 Trigger – 84%. Downham Medical Family Practice ○ Level 1 Trigger – 70%.	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025
7.	Child Imms MMR (age 2 years)	Burnt Ash Surgery ○ Level 1 Trigger - 80%. Downham Family Medical Practice ○ Level 1 Trigger – 73%	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025

Improvement Plan (4/4)

No.	Improvement Area	Baseline Measurement	Action Due	Expected Outputs	Status	Person Responsible	Action By
8.	Child Imms PCV Booster	Burnt Ash Surgery o Level 1 Trigger - 82%. Downham Family Medical Practice o Level 1 Trigger – 61%.	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025
9.	2023/24 Q4 PMS Premium Contract Management Tool	Burnt Ash Surgery Childhood Obesity (% had weight, height measurement check & BMI centile calculated) – 54.5%.	Dedicated call and recall team Make every nurse contact count Educate healthy eating habits in practice Work with the PCN to promote healthy eating campaigns and workshops at the PCN community Café	Meet QoF Target	Ongoing	Lead Nurse And GPs	31.03.2025

South East London Integrated Care System

NHS South East London

Practice Merger Analysis

Proposed Merger between Burnt Ash Surgery (G85027) and Downham Family Medical Practice (G85057)

Borough	Lewisham		
Practice Details	Practice Names	Burnt Ash Surgery	Downham Family Medical Practice
	Contract Types	PMS – no end date	PMS – no end date
	Site Addresses	Lee Health Centre, 2 Handen Rd, SE12 8NP	7-9 Moorside Rd, Bromley BR1 5EP
	List Sizes Apr 24	Raw: 6383 Weighted: 6719.80	Raw: 6805 Weighted: 6183.40
	No of Partners	One	Three
	Current CQC Rating	Good	Requires Improvement
	PCN Details	Lewisham Alliance PCN. 6 practices. Raw list size as at 01/01/2024 is 56,558.	Sevenfields PCN. 6 practices. Raw list size as at 01/01/2024 is 65,202.

Recommended action for the Group

The Primary Care Group is asked to approve:

a) The merger of the contracts and the patient lists of Burnt Ash Surgery and Downham Family Medical Practice.

b) The financial implications of c£20,000.00, associated with the merge of practice clinical and IT systems.

c) The change of Primary Care Network (PCN) membership for Burnt Ash Surgery from Sevenfields to Lewisham Alliance as a result of the merger and any associated changes in relation to the PCNs financial baseline allocations.

Summary Outline

- The main driving factor for the proposed merger is to support ongoing service provision at Burnt Ash Surgery following a significant contract change.
- One of the GP partners applied to retire from the Burnt Ash Surgery partnership, with effect from 31st March 2024.
- The partnership change means Burnt Ash Surgery only has a single GP partner.
- This is a significant PMS contract change which has led to a 50% reduction in the responsible contract performers.

- Although the remaining GP partner will continue to deliver the full range of services to registered patients, the practice will be operating as a single hander with significant contractual instability and less resilience which puts safe patient service delivery at risk.

- Furthermore, on 30th June 2022 Downham Family Medical Practice was inspected by the Care Quality Commission, the subsequent report published in November 2022 rated the practice as Requires Improvement overall.

- Downham Family Medical Practice and Burnt Ash Surgery have used the sequence of events as an opportunity to explore ways to secure a sustainable, safe and resilient service with the ability to extend service provision for patients.

- Both practices have agreed that a merger between them would be the best way forward in terms of increased resilience and support.

- The merger will increase workforce resilience of Burnt Ash Surgery. It will support the expansion of leadership, clinical and non-clinical staff and provide better opportunities for peer clinical support, and upskilling of current staff.

- An arrangement has been reached where Burnt Ash Surgery and Downham Family Medical Practice now share practice manager services, leadership, and other key managerial workforce.

- A merger will ensure long term sustainability and the ability to streamline processes between the practices.

- The proposal is for the registered patient list of both practices to be merged on 31st August 2024.

- The merger date is indicative as it is subject to confirmation by EMIS following approval and will rely on the availability and lead times of EMIS and PCSE.

- The signatories of both practices' contracts will be the signatories of the single, merged contract under the ODS code of G85057 which is the current code for Downham Family Medical Practice.

- There are no planned site closures as a result of the merger, and no patients will be deregistered.

- The new merged practice will be known as Ashdown Medical Group.

- Burnt Ash Surgery will in operate as a branch site of Ashdown Medical Group.

- The practices belong to different PCNs. Burnt Ash Surgery is a member of Lewisham Alliance PCN while Downham Family Medical Practice is a member of Sevenfields PCN.

- If approved the merged practice will be a member of Sevenfields PCN.

- Lewisham Alliance PCN is aware of the impact the merger will have on the Network Contract DES arrangements and has taken this into account for 2024/25 planning, including arrangements for the Additional Roles Reimbursement Scheme and Enhanced Access.

- The South East London Integrated Care Board Information Technology team will support the sites throughout the merger process.
- Considerable patient and stakeholder engagement has been carried out, in 2022 and recently, and there is an engagement plan which outlines further planned engagement.
- There are a number of alternative practices within a 1 mile radius for patients to choose to register with should they wish to not remain registered with the practice.
- Patients will be supported to reregister, should they not wish to remain registered with the practice.
- Local practices have open lists so patients can register wherever they chose so far as they live within the practice catchment area.
- The Integrated Care Board will not make any financial savings in relation to the premises budget, but it will improve the long-term viability of the practice and financial stability.
- The proposal to merge the two contracts aligns with the South East London strategy of working at scale.

Background of each of the Practices

Burnt Ash Surgery and Downham Family Medical Practice hold separate PMS contracts which they wish to merge. The merger date is indicative and subject to confirmation by EMIS following approval.

Burnt Ash Surgery

- Burnt Ash Surgery is a 1960's purpose built building located within Lee Health Centre which is owned by Lewisham & Greenwich Trust.
- It is co-located with another practice, Nightingale Surgery.
- The building is Disability Discrimination Act (DDA) and infection control compliant.

Downham Family Medical Practice

- Downham Family Medical Practice is located in a 1980's purpose built building located within Downham Health and Leisure Centre.
- Similar to Burnt Ash Surgery, it is co-located with another practice, ICO Health Group.
- The building is DDA and infection control compliant.

Merged Practice

- The merger will create a single registered patient list of circa 13,000 and retain the ODS code of G85057.
- Both practices use the same telephony system which can be easily linked following the merger.
- They also use Accurx for messaging, clinics, online consultation and triage.
- Both practice telephone numbers will remain active to ensure patients are able to contact the practices for patient care.
- Burnt Ash Surgery and Downham Family Medical Practice boundaries overlap, and the merged practice will retain the existing practice boundaries.
- The distance between the two practices is 1.73 miles, this is an 8 – 10 minute drive by car. Both sites have free parking options with blue badge/disabled parking.
- The practices are served by the 202, 284, 273, 124 and 181 buses.

Practice Performance

The practice has developed an improvement plan which outlines how it intends to address any areas where there are issues.

Table 1 illustrates the clinical indicators and practice achievement.

Table 1 - Clinical Indicators

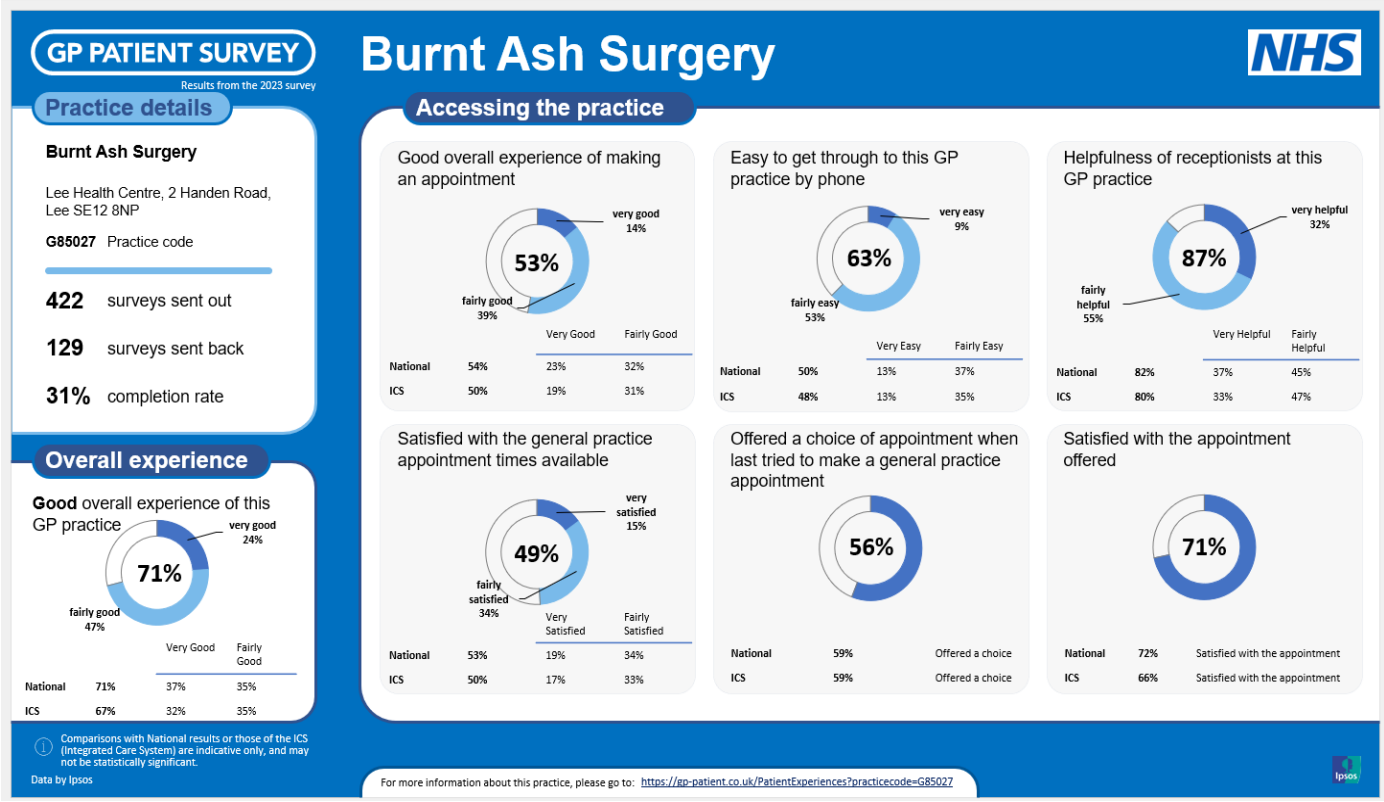
PH Indicators	Time Period	BAS	DMFP
% Child Imms DTaP/IPV/Hib/HepB (age 1 year)	2022/23	92%	86%
% Child Imms Hib/MenC booster	2022/23	84%	70%
% Child Imms MMR (Age 2 yrs)	2022/23	80%	73%
% Child Imms PCV Booster	2022/23	82%	61%
Cervical Screening Age 25 to 49	2023/24 Q2	71%	71%
Cervical Screening Age 50 to 64	2023/24 Q2	77%	80%

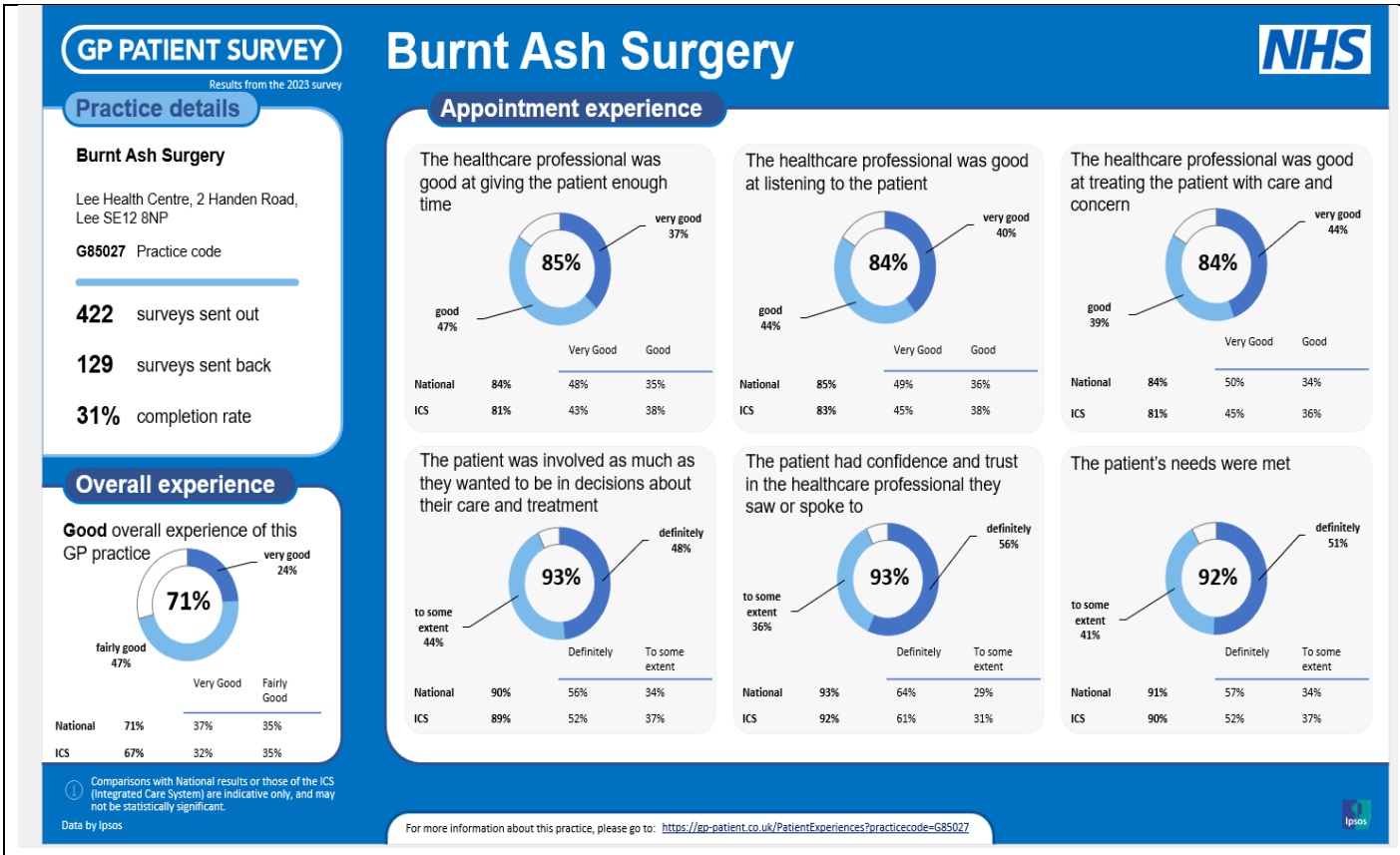
Practice Achievements from latest available data as of June 2024

Burnt Ash Surgery
13 Level 1 Triggers
4 Level 2 Trigger

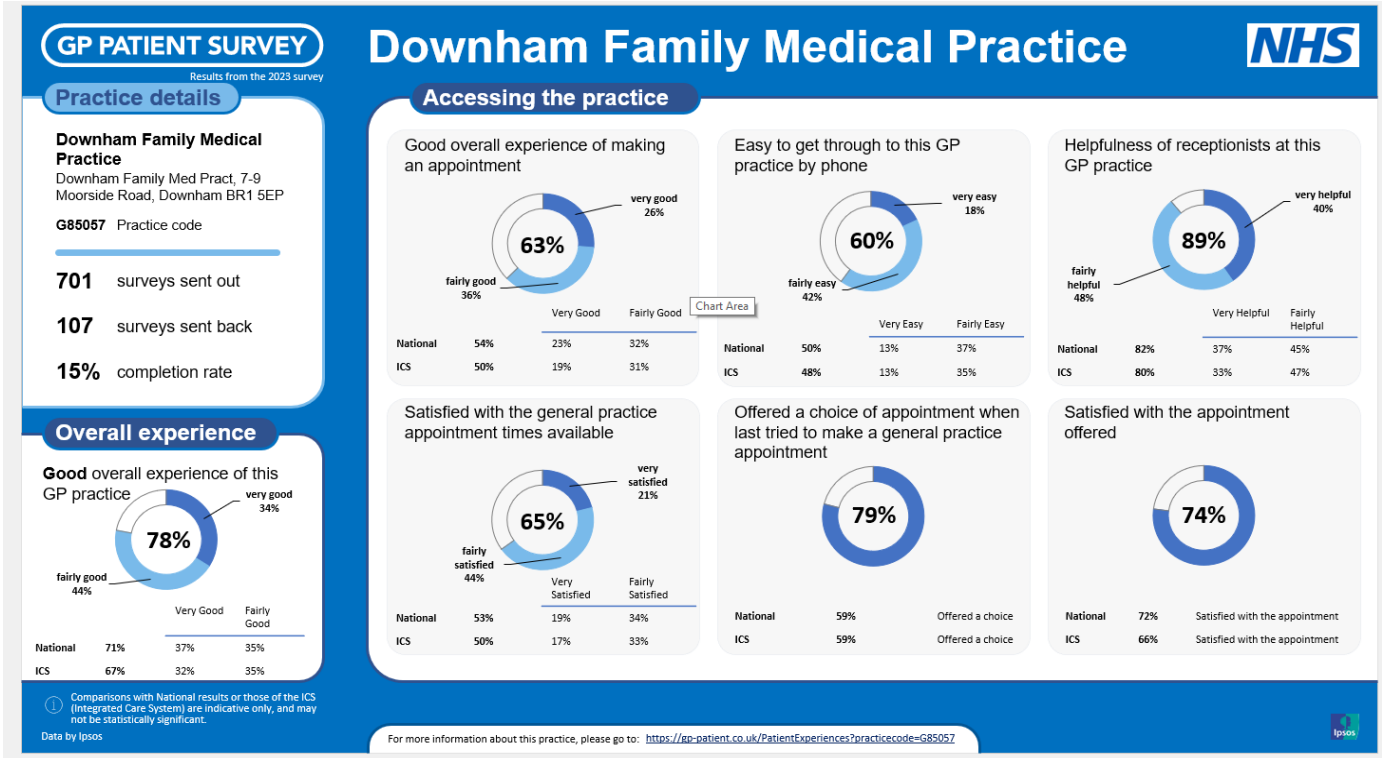
Downham Family Medical Practice
7 Level 1 Triggers
3 Level 2 Trigger

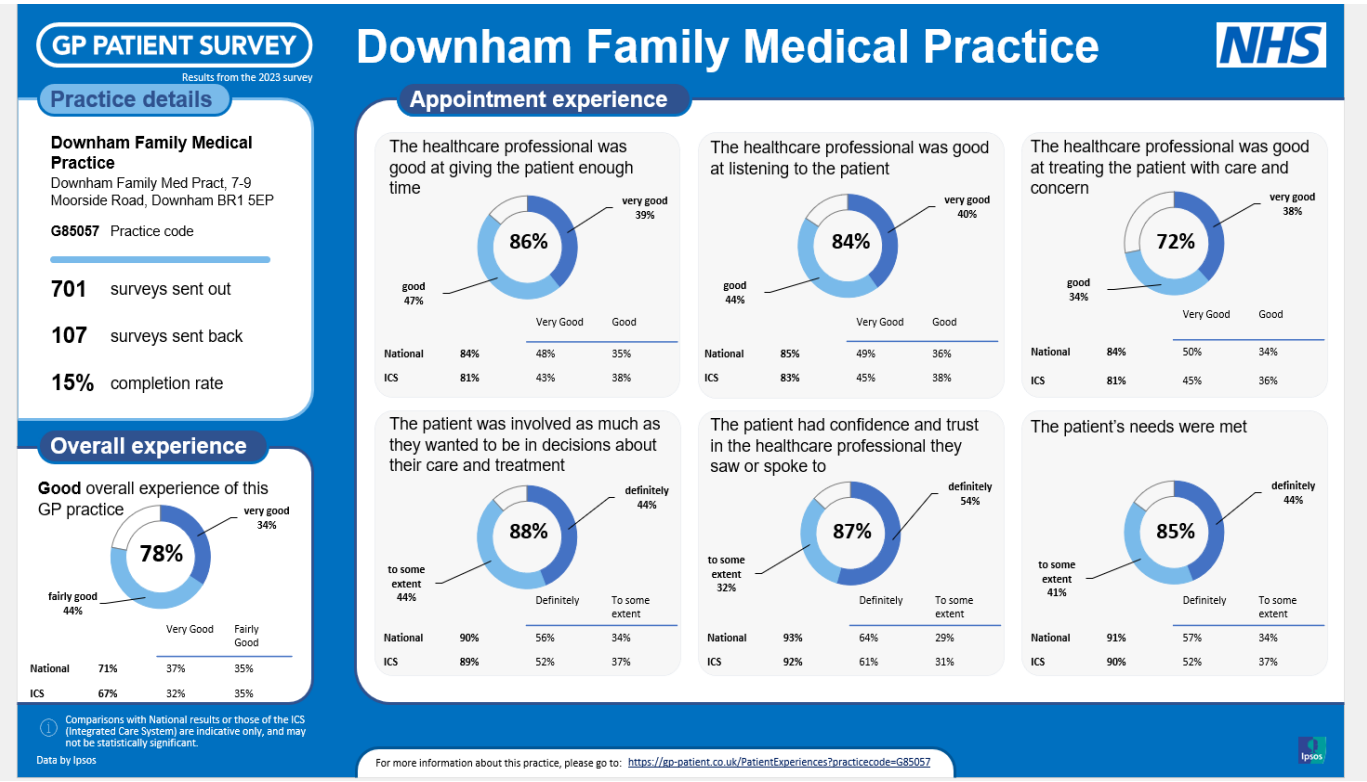
Patient Experience Performance (based on the 2023 GP Patient Survey)
Burnt Ash Surgery ratings in relation to patient experience are mainly above the Integrated Care System (ICS) average.





Downham Family Medical Practice ratings in relation to patient experience are also mainly above the ICS average.





CQC Ratings

- Burnt Ash Surgery had a full CQC inspection in November 2016 and the report published in March 2017. The practice was rated 'Good' overall.

- Downham Family Medical Practice had its last full inspection in June 2022.

The report published in November 2022 rated the practices as requires improvement overall.
The practice developed an action to address areas of concern highlighted in the inspection report.
The ICB is assured that all areas of concern have been addressed.

Information about local demography

Burnt Ash Surgery

Population

- Burnt Ash Surgery is situated in the Lee Green ward.
- Lee Green has an estimated population of 16,080 residents.
- Among its residents, 48.8% identify as female, and 51.2% as male.
- Unfortunately, ONS population statistics do not include estimates for nonbinary gender identities.
- The average age in Lee Green is 37, compared to 36 in Lewisham as a whole, and 37 in London. This makes it one of the oldest wards in the borough.

Diversity: Ethnicity

- 54.1% of Lee Green residents have an ethnicity of White British (White English, Welsh, Scottish, or Northern Irish).

- Among those not White British, the three most common ethnicities are White Other (10.0%), Black Caribbean (7.5%), and Black African (6.1%).

Diversity: Country of birth

- 68.4% of Lee Green residents were born in England, compared to 64.0% in Lewisham as a whole.
- Among those not born in England, the three most common countries of birth are Jamaica (2.4%), Nigeria (2.2%), and Ireland (1.6%).

Diversity: Languages

- 85.2% of Lee Green residents speak English as their primary language, compared to 83.5% in Lewisham as a whole.
- Of the remaining residents, 12.3% can speak English well or very well.
- Among those not speaking English as their main language, the three most widely spoken languages are Polish (1.4%), Tamil (1.2%), and French (1.1%).

Deprivation

- Of the eight LSOAs in Lee Green, zero rank in the bottom 20% of the country (decile 1 or 2).

Fuel Poverty

- In the eight LSOAs in Lee Green, proportion of households' fuel poor ranges from 12% to 18%.

Health and life expectancy

- The average life expectancy at birth for females in Lee Green is 85.2 years compared to England average of 83.2.
- The average life expectancy at birth for males in Lee Green is 78.9 years compared to England average of 79.6.

Downham Family Medical Practice

Population

- Downham has an estimated population of 18,224 residents, which makes it one of the larger constituencies in the borough (rank 5 of 19 wards).
- Among its residents, 52.3% identify as female, and 47.7% as male.
- The average age in Downham is 36, compared to 36 in Lewisham as a whole, and 37 in London.
- This makes it one of the oldest wards in the borough.

Diversity: Ethnicity

- 51.1% of Downham residents have an ethnicity of White British (White English, Welsh, Scottish, or Northern Irish), compared to 41.5% in Lewisham as a whole.
- Among those not White British, the three most common ethnicities are Black African (10.9%), Black Caribbean (9.5%), and White Other (6.0%).

Diversity: Country of birth

- 74.6% of Downham residents were born in England, compared to 64.0% in Lewisham as a whole, 61.1% in London, and 83.5% in England.
- Among those not born in England, the three most common countries of birth are Nigeria (3.1%), Jamaica (2.9%), and Sri Lanka (2.0%).

Diversity: Languages

- 88.5% of Downham residents speak English as their primary language, compared to 83.5% in Lewisham as a whole, 77.9% in London, and 92.0% in England.
- Of the remaining residents, 9.4% can speak English well or very well.

- Among those not speaking English as their main language, the three most widely spoken languages are Tamil (2.2%), Turkish (1.1%), and Polish (0.9%).

Deprivation

- Of the 12 LSOAs in Downham, seven rank in the bottom 20% of the country (decile 1 or 2).

Fuel Poverty

- In the 12 LSOAs in Downham, proportion of household's fuel poor ranges from 14% to 30.2%.

Health and life expectancy

- The average life expectancy at birth for females in Downham is 83.8 years compared to England average of 83.2.
- The average life expectancy at birth for males in Downham is 77.4 years compared to England average of 79.6.

Capacity and Quality of Local Practices

Although there will be no site closures, the ICB undertook a quality and capacity review of local practices', within a 1 mile radius, to understand the impact on local practices should patients decide not to remain registered following the merger. See table 2 below.

The ICB will monitor the numbers of patients that choose not to remain registered with the practice and ensure they are supported to register with a suitable practice of their choice.

South East London Integrated Care System

NHS South East London

Table 2

Practice Name	Woodlands Health Centre	Lee Road Surgery	The Lewisham Care Partnership	Everest Health Partnership	Manor Brook Medical Centre	Nightingale Surgery	Lewisham Medical Centre
Distance in Miles	0.5	0.6	0.9	0.4	0.4	0	0.4
Borough	**Lewisham**	**Lewisham**	**Lewisham**	**Greenwich**	**Greenwich**	**Lewisham**	**Lewisham**
List open for registration	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Known capacity issues?	No	No	No	No	No	No	No
Selected for resilience programme support in 2023/24.	No	Yes	Yes	N/A	N/A	No	No
CQC overall rating	Good	Good	Good	Good	Good	Good	Good

Potential Conflicts of Interest and mitigations	None identified. Any conflict of interest would be managed according to the ICBs Standards of Business Conduct and Conflict of Interest Management Policy.
Impacts of this proposal	
Key risks & mitigations (and/or BAF reference)	Should the merger not be approved; ▪ Safe clinical care of patients at Burnt Ash Surgery could be compromised where it continues to operate as a single handed practice. ▪ Fewer GPs providing care for patients would increase the risk of harm and suboptimal care through decision fatigue. ▪ There is a possibility that wait times for GP appointments at Burnt Ash Surgery would increase. ▪ There is a possibility of clinician fatigue and burn out. ▪ Burnt Ash Surgery would face a significant threat to its workforce and its resilience and might ultimately have to hand back its PMS contract to the ICB. A decision would then need to be made to ensure the 6,144 patients register with another practice(s), which would lead to issues of continuity of care for patients. ▪ The proposed merger ensures there is clear continuity of care for patients who choose to remain registered under the merged list.
Equalities legislation impact	▪ The ICB has conducted an Equality Impact Assessment which confirms there will be no adverse equality impact on the protected characteristic groups. ▪ There will be no reduction of services following the merger. ▪ There will be no reduction in the merged practice's catchment area. ▪ Patients currently registered with both practices will remain patients of the newly merged practice unless they chose to reregister with another local practice of their choice. Patients will be supported in this regard. ▪ Both practices are DDA compliant. ▪ Both practices have engaged with patients to ensure they understand the pending changes in order to manage expectations.
Financial impact	▪ The estimated cost of the clinical system merger is approximately £20,000.00, which will be funded through the ICB GP IT budget. ▪ The ICB will not realise any financial savings in relation to the premises budget as there are no site closures, it will however improve the long-term viability of Burnt Ash Surgery and ensure financial stability.
Impact on patients/service users	Refer to the key risks & mitigations and Equalities legislation impact sections, detailed above.

Impact on other practices and PCNs	▪ Change in Core Network Practice members - in accordance with section 6.8 of the guidance. ▪ The two practices are members of different PCNs and if the merger is approved the merged practice will be a member of Sevenfields PCN. This has already been agreed with the PCN. ▪ Lewisham Alliance PCN is aware of the impact the merger might have and are taking this into account as part of its 2024/25 planning.
Estates impact	There will be no reduction in sites, as outlined in the business case. Lee Health Centre which is where Burnt Ash Surgery is based requires capital investment to make it fit for purpose and ensure CQC compliance standards are met.
Workforce impact	Table 3 below shows the current workforce for each practice. Patients will have access to a wide range of healthcare professionals who can provide quality patient care and enhance the patient experience journey.

Table 3

Practice Overview (1/3)

	Downham Family Medical Practice	Burnt Ash Surgery
Address of Practice	7-9 Moorside Road, Bromley, BR1 5EP	2 Handen Road, Lee, SE12 8NP
Contract Type	PMS	PMS
Registered List size Raw/weighted	6,756 / 6121	6300 / 6630
Opening Hours	Monday to Friday 8.00 – 18.30 Saturdays 9.00 – 17.00	Monday, to Friday 08.00 – 18.30 Saturdays 9.00 – 13.00
Partners	Dr Ola Fagbohungbe, Dr Anwuli Bosah, Dr Nadine Lawrence	Dr Nadine Lawrence
Staff	2 PAs: 2 FTE, 3 Nurses: 1.6 FTE, 1 long term locum GP; 0.4 WTE 1 Pharmacist: 0.4 1 Trainee HCA; 0.2 FTE 1 Practice Manager: 0.5 FTE, 1 Operations Manager; 0.5 TE, 1 Operations Lead: 0.8 FTE 1 Prescribing Clerk: 0.5 FTE, 6 Receptionists/administrators: 5.2 FTE	1 Salaried GP: 0.6 WTE, 2 long term locum GPs; 1 WTE, 1 PAs: 1 FTE, 1 Pharmacist; 0.4 FTE 3 Nurses: 2 WTE, 1 Practice Manager: 0.5 FTE, 1 Operations Manager: 0.5 FTE, 1 Prescribing Clerk: 0.5 FTE, 7 Receptionists/administrators: 5.2 FTE
Languages spoken by staff	English, Nigerian, Georgian	English, Russian, Romanian, Nigerian
Clinical system	EMIS Web	EMIS Web
QOF points 2023/2024	500/567	475/567
CQC Rating	Requires Improvement – Action plan complete, no further action needed	Good
Locality working inc. PCN	Sevenfields PCN	Lewisham Alliance PCN – Accepted into Sevenfields PCN
Services offered	GP Extended Access Services, Core Services, Sexual Health and Family Planning, Zoladex, Phlebotomy	GP Extended Access Services, Core Services, Sexual Health and Family Planning, Zoladex, Phlebotomy

Improve quality/ safety	▪ The merger of the two contracts will provide an opportunity to review and improve some key areas through the benefit of shared learning. As outlined in the business case there are some areas where the variation in performance can be improved as identified by the practices and the ICB. ▪ The improvement plan aligns with the improvements identified as part of a review of performance data relating to both practices. The improvement plan will be contractualised and monitored by the ICB to support its successful implementation and execution.
Support integration	▪ The merger will help bring together high quality general practice and ensure service continuity. ▪ It will also ensure the Burnt Ash site remains resilient and robust, with the ability to respond to new innovations and service delivery. ▪ Both practices share the same values and ethos and believe in delivery of best medical care in a timely fashion and offering the best patient experience.
Does the recommendation align with the boroughs primary care strategy	▪ The proposed merger is in line with the ICBs strategic priorities, forward planning, and developments of the PCNs and working at scale. ▪ Furthermore, it aligns with the NHS Long Term Plan for larger practices working together to deal with the pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.
Wider support for this proposal	
Patient Engagement	**Conducted in 2024:** ▪ Website announcements were uploaded to provide an update on the merger plans and notify patients of engagement sessions. ▪ In April and May both practices have held face to face meetings with their Patient Participation Groups. ▪ In June a joint question and answer meeting was held for patients. ▪ Feedback forms are available in the practices and on the websites. ▪ A link to the feedback form was also attached to SMS messages sent to patients informing them of the question and answer session. ▪ Feedback forms are available via MS forms link and in paper format in practice. ▪ Fully trained reception staff to answer patient queries. ▪ Patient feedback is still being collected. **Conducted in 2022:** Both practices met face to face with their PPGs, heavy users of practice services and vulnerable patient groups to gauge feedback as part of the pre-engagement process.

	As a result of the PPG meetings patients were provided with access to an online survey (either directly online or via a paper form) which was used to gather opinions and understand any concerns and put mitigations in place. A summary of the online results is included in the business case. ▪ 550 responses were received. ▪ 539 (99.26%) were patients at the two practices. Results indicate that; ▪ Patients would like to stay registered at their surgery site. Further engagement will be used to reassure patients that this will be possible, and they will be given the option of which site they would like to attend their appointment. ▪ Patient engagement to date has reassured patients that they will be able to continue to attend their preferred site. ▪ Patients would prefer not to travel to the other practice site due to being elderly, infirm or not having means of travel. The triage system in place will enable patients to talk to clinicians from either site without any impact on patient care. ▪ An estimated 31.14% of patients are happy to travel between sites. ▪ Further engagement will give clarity on how the merger will offer better cover for clinicians due to illness or leave, expand clinical skills and knowledge across both sites and improve staff retention. ▪ Across both sites there has been engagement with patients using platforms such as social media, practice websites, FAQs and emails. ▪ The practice plans to continue its engagement and highlight how concerns are being addressed, in the short, medium and long term. ▪ If the merger is agreed, the practice will hold face-to-face and online drop-in sessions with patients at each site to further address any concerns.
Other Committee Discussion/ Borough Engagement	The Lewisham Primary Care Group formally discussed the merger proposals at its August 2022 meeting and feedback from the group was incorporated into the final business case. The updated merger proposals were formally endorsed at the September 2022 Primary Care Group meeting.
Stakeholder engagement, including PCN, LMC, Health Watch, Scrutiny committee, MP's, Councillors,	▪ Both practices have signed up to the Network Contract Directed Enhanced Service 2024/25. ▪ Lewisham PCNs and the GP Federation have been informed of the merger plans. ▪ The original merger proposals were also supported by the Lewisham Local Medical Committee ▪ The original merger proposals were also supported by Healthwatch Lewisham.
Public Engagement	Further engagement will take place as appropriate following approval and after the merger.

Practice Improvement Plan

The merger of the two contracts provides an opportunity to review and improve some key areas through benefit of shared learning. As outlined in the Business Case there are some areas where the variation in performance can be improved.

No.	**Improvement Area**	**Baseline Measurement**	**Action Due**	**Expected Outputs**	**Status**	**Person Responsible**	**Action By**
1.	Patient Engagement	Practice has conducted engagement in 2022 and 2024.	○ To continue regular and meaningful patient engagement post-merger.	Feedback forms are in practice, on websites and have been sent to patients - to be collected until end of June. Data will be collated, analysed and reported on. Results to be displayed in practice and on websites. Survey to be sent to patients 6 months post merger to provide continuous improvements and address any concerns. PPG meetings are held every 6 weeks to provide regular updates. Notice boards and websites will be updated regularly.	Ongoing	Louise Hassan	31.07.2024
2.	Mental Health	<u>Burnt Ash Surgery</u> ○ Level 2 Trigger - Mental Health Comprehensive Care Plan – 44%. ○ Level 2 Trigger - SMI Alcohol Record – 26%. ○ Level 1 Trigger - SMI BP Record – 70%. <u>Downham Medical Family Practice</u>	○ Allocate clinics for reviews in practice with Physician Associates. ○ Utilise allocated clinics within the PCN. ○ Utilise support from PCN MHP. ○ New PCN Youth Clinic will provide extra support to 13-24yr olds.	Continue to improve engagement with patients on MH register and ensure that every contact counts. Updating registration details to improve engagement. Align targets across both practices.	Ongoing	Dr Bosah / Physician Associates	31.03.2025

		○ Level 1 Trigger - Mental Health Comprehensive Care Plan – 85%. ○ Level 1 Trigger - SMI Alcohol Record – 83%. ○ Level 1 Trigger - SMI BP Record – 88%.	○ Dedicated recall team across both sites. ○ PCN care Coordinators support with recall 2 days a week. ○ Care coordinators completeing an audit of MH patients who did not attend a review last year to ensure up to date contact details				
3.	Cervical Screening Age 25 - 49	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger – 71%. <u>Downham Medical Family Practice</u> ○ Level 1 Trigger – 71%.	○ Appoint a nurse to Lead to work closely with recall team and trainee HCA. ○ Identify reasons for low achievement – GPN Academic nurse is providing this during fellowship. ○ Increase admin hours for call/recall / failsafe procedures. ○ Utilise Enhance Access nursing appointments to improve access.	Meet the QoF target for age 25 - 49yrs	Ongoing	Nursing Team	31.03.2025
4.	Cervical Screening Age 50 - 64	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger – 77%. <u>Downham Medical Family Practice</u> Level 1 Trigger – 80%.	○ Appoint a nurse to Lead to work closely with recall team and trainee HCA. ○ Identify reasons for low achievement – GPN Academic nurse is providing this during fellowship.	Meet the QoF target for age 25 - 49yrs	Ongoing	Lead Nurse and recall teams	31.03.2025

			○ Increase admin hours for call/recall / failsafe procedures. ○ Utilise Enhance Access nursing appointments to improve access.				
5.	Child Imms DTaP/IPV /Hib/HepB (age 1 year)	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger - 92%. <u>Downham Medical Family Practice</u> ○ Level 1 Trigger – 86%.	○ Robust recall team administrators ○ Dedicated PCN Care Coordinator support to contact hard to reach patients ○ Nurses to call parents reluctant to give child vaccines to educate the importance of immunisations ○ Promote communication on immunisations ○ Utilise the PCN Enhanced Access Immunisation Clinics to improve access	Improve uptake to achieve better QoF target. Educate parents	Ongoing	Lead Nurse and recall teams	31.03.2025
6.	Child Imms Hib/MenC booster	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger – 84%. <u>Downham Medical Family Practice</u> ○ Level 1 Trigger – 70%.	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025
7.	Child Imms MMR (age 2 years)	<u>Burnt Ash Surgery</u> ○ Level 1 Trigger - 80%. <u>Downham Family Medical Practice</u> ○ Level 1 Trigger – 73%	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025

8.	Child Imms PCV Booster	Burnt Ash Surgery ○ Level 1 Trigger - 82%. Downham Family Medical Practice ○ Level 1 Trigger – 61%.	As above	As above	Ongoing	Lead Nurse and recall teams	31.03.2025
9.	2023/24 Q4 PMS Premium Contract Management Tool	Burnt Ash Surgery Childhood Obesity (% had weight, height measurement check & BMI centile calculated) – 54.5%.	Dedicated call and recall team Make every nurse contact count Educate healthy eating habits in practice Work with the PCN to promote healthy eating campaigns and workshops at the PCN community Café	Meet QoF Target	Ongoing	Lead Nurse And GPs	31.03.205

Equality and Health Inequalities Screening Tool

A. General Information	
Date of Assessment	3 June 2024
Assessor Name(s) & Job Title(s)	Chima Olugh. Neighbourhood Development Manager
Organisation	NHS South East London Integrated Care Board (Lewisham).
Name of the policy, function, service development	The separate PMS contracts of **Burnt Ash Surgery and Downham Family Medical Practice** will be merged into one single PMS contract and form Ashdown Medical Group.
Aim/Purpose of the policy, function, service development	The purpose of this Equality and Health Inequalities Screening Tool is to ensure that during and after the process of the contract merger, registered patients continue to have unrestricted access to Primary Medical Services. The new merged practice will be known as Ashdown Medical Group. The two GP practices which will make up Ashdown Medical Group are; 1) Burnt Ash Surgery - G85027 – 6,383 patients. 2) Downham Family Medical Practice – G85057 – 6,805 patients. **The indicative timeline for the merger is 31st August 2024.** The merged contracts will create a single registered patient list of circa 13,000, retaining the ODS code of G85057 which is the current Downham Family Medical Practice contract. Burnt Ash Surgery will operate as branch site. If the merger is approved the practice will be part of Sevenfields PCN. Lewisham Alliance PCN is aware of the impact the merger will have on the Network Contract DES arrangements and has taken this into account for 2024/25 planning, including arrangements for the Additional Roles Reimbursement Scheme and PCN Enhanced Access. **The reason for the merger** The main driving factor for the proposed merger is to support ongoing service provision at Burnt Ash Surgery following the significant contract change.

	One of the GP partners applied to retire from the Burnt Ash Surgery partnership, with effect from 31st March 2024. The partnership change means the practice has a single partner. This is a significant PMS contract change which has led to a 50% reduction in the responsible contract performers. Although the remaining partner will continue to deliver the full range of services to registered patients, the practice will be operating as a single hander with significant contractual instability, less resilient and at risk of continuing to deliver safe patient services. Both practices have been sharing their values and commitment to high quality clinical care over the past 3 years and agree a merger will help to provide improved access, choice, and quality for patients. **Benefits of the merger** The merger will increase workforce resilience of Burnt Ash Surgery. It will support the expansion of leadership, clinical and non-clinical staff and provide better opportunities for peer clinical support, and upskilling of current staff. <u>Improved patient experience</u> The merged practice will make use of the experience and strengths from each practice to improve patient care. Training will be put in place for all reception staff to ensure consistent and empathetic service is provided across both sites. There will also be a more diverse clinical workforce in terms of skill and gender mix. <u>Improved Patient Access</u> Improved access to services, more flexibility in appointments across the wider workforce, sites and shorter waiting times made possible from improved efficiencies. <u>Continuity of Care</u> This will be achieved by ensuring every patient has a Named & Accountable GP. The staff will work as a broader team inclusive of allied healthcare professionals. Increased clinical cover for sickness absences. **Patient and stakeholder Engagement** <u>How patients will be informed of the merger if approved</u>

	To ensure all patients are aware of the changes, the rationale and the benefits of the merger (to minimise service disruption) the practice has carried out the following: Face to face meetings with PPGs of both practices. Engagement with Healthwatch. An online patient survey. Text messages sent to all patients with a recent mobile telephone number known to the practice. Posters and leaflets have been put up in both practices. Merger information on the websites of both practices. Feedback forms are available via a MS forms link and in paper format in practice Reception staff have been trained to answer patient queries. <u>How the practices will respond to the issues raised through the patient engagement process</u> ▪ Ashdown Medical Group will produce and publicise a FAQs document to address the issues raised by its patients. ▪ Ashdown Medical Group acknowledge that some patients are concerned that the merger might affect access to services. Ashdown Medical Group will ensure that staffing and services will not be reduced if the merger is approved. ▪ Ashdown Medical Group will keep patient engagement under review as part of its engagement plan.
Intended Outcomes	The merger does not involve any site closures. <u>Intended outcomes of the merger include:</u> ▪ Increased resilience and strength to secure the future of both practices and wider primary care across Sevenfields PCN and Lewisham. ▪ An increase in capacity by sharing clinical and allied professionals. ▪ More leadership (clinical and non-clinical) and management capacity to support our practice staff and support the practice with the service transformation. ▪ Improved quality and continuity of care for patients with healthcare professionals. ▪ Improved access to services, more appointments and shorter waiting times. ▪ Patients will be able to book appointments at their preferred site.

	▪ Ensure patients have access to a wider range of healthcare professionals who will work across all the sites and provide a variety of services.
Who will be affected by the merger	Circa 27 practice staff and of 13,000 patients.

Consideration for the nine protected characteristics and how the merger impacts any of them. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

B. The Public Sector Equality Duty	
Could the merger help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?	**Not applicable**
Could the merger undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics?	**No**
Could the merger help to advance equality of opportunity? If yes, for which of the nine protected characteristics?	**Yes (all 9)**
Could the merger undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?	**No**
Could the merger help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?	**No**
Could the merger undermine the fostering of good relations between groups who share protected characteristics. If yes, for which of the nine protected characteristics?	**No**

If you answered 'No' to any of the above, give your reasons why

It is anticipated that there will be no adverse equality impact upon the nine protected characteristic groups noted above, as any affected group will have the option to continue to register with Ashdown Medical Group.

The practice will ensure that information on transportation routes between the different sites, and neighbouring practices that are within a one-mile radius is made available.

C. The duty to have regard to reduce health inequalities	
Could the merger reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?	**Yes (all 9)**
Could the merger reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?	**No**

If you answered 'yes' to any of the above, give your reasons why

The practice merger will provide an opportunity to understand patients' access needs better.

D. Please indicate if a Full Equality and Health Inequalities is recommended			**No**
Project Lead: Chima Olugh, Neighbourhood Development Manager. NHS South East London Integrated Care Board.	Date completed: 3/06/2024		

The signed and completed Equality and Health Inequalities Screening Tool should be attached as an appendix to the policy or function/service development documentation as evidence of completion and proof of review.

South East London Integrated Care System

NHS South East London

2023/24 report

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Date: 30/05/2024
Version: 1.0

Document Control:

Version	Date	Author / Amended by	Submitted to	Notes
1.0		Yvonne Davies	**Ashley O'Shaughnessy**	

Introduction

The purpose of this paper is to provide a high-level summary on the delivery of GP Enhanced Access (EA) across Lewisham for 1st April 2023-31st March 2024.

Executive Summary

Background

Enhanced Access (EA) is a key component of the Primary Care Network (PCN) Network DES and refers to the delivery of core Primary Care Services within a PCN during 'Network Standard Hours' i.e. 18:30-20:00 on weekdays and 09:00 to 17:00 on Saturdays.

EA commenced from 1 October 2022 and replaced pre-existing arrangements for GP Extended Hours and Extended Access Hubs.

Lewisham has 6 Primary Care Networks (PCNs) with an adjusted registered population of 351,371 for 2023/24.

PCNs are required to deliver or sub-contract EA in full, in accordance with the requirements of this Network Contract DES Specification and the sub-contracting requirements set out in their Core Network Practices' primary medical care services contracts.

PCNs are required to delivery approximately 18271 hours of enhanced access per annum in line with the contract requirements and financial structure.

Quarterly reports are submitted to SEL ICB Lewisham to review delivery against contract requirements and identifying any operational changes to the plan, challenges experienced, and any commissioner support required.

Recovery plans are put into place each quarter for any PCNs that have not delivered the required capacity within the reporting period which outline how they propose to recoup any unmet hours in the following reporting period. It is expected that all PCNs will have delivered all required hours within a full year period.

It should be noted for the purpose of this report that data is based on a full 12 months of activity from 1st April 2023 – 31st March 2024 due to challenges experienced during the implementation phase as outlined in this document.

The 6 PCNs are

- Aplos
- Lewisham Alliance
- Modality
- North Lewisham (NLPCN)
- The Lewisham Care Partnership (TLCP)
- Sevenfields

Summary of Key findings

Overall, EA capacity across Lewisham is exceeding the specified EA requirements of 60minutes per 1000 adjusted patients per annum offering 18950/18271 (104%) equating to approximately 67451appointments per annum with an average hourly appointment offer of 3.6.

% hours offered against requirement	104%
% appointments booked	85%
% attendance rate	83%
% DNA (Did not attend)	16%
Total appointments offered	71278

It should however be noted that Q1 saw only 90% of hours being delivered. Subsequently, recovery plans were put into place for 5/6 PCNs and additional hours were delivered in remaining quarters to meet annual requirements.

There is variance between PCNs in relation to EA capacity with some offering more than the required hours and some not delivering the required hours.

Throughout the year 5/6 PCNs at some point undelivered the required hours within a given reporting quarter however all overdelivered by year end except for TLCP who under delivered at 92% of required capacity by year end.

There is evidence that there is significant 'spare' capacity withing EA provision e.g. In total across Lewisham approximately 10278 appointments (15%) per annum were not booked (2855 hours) equating to approximately 197 appointments / 54.9hours per week.

All PCNs are offering Face to Face (F2F) appointments in line with their plans.

Booking rates have fluctuated over the year with attendance rates remaining stable.

DNA rates are relatively high at an average of 16% across Lewisham.

There is significant variation PCNs with DNA rates ranging from 8% to 20%. Aplos DNA rates has remained stable with, 2 PCNs seeing an increase of approx. 11% each (Modality and Sevenfields) and 3 PCNs seeing an improvement in their DNA rates over time (Lewisham Alliance, NLPCN and TLCP).

All PCNs reported challenges in relation to work force and IT infrastructure especially during the first 6 months on implementation. Workforce remains the biggest challenge continually reported.

Patient engagement was undertaken as part of EA plan development however is not a requirement of the EA contract however PCNs are required to collate patient feedback in relation to access.

There is however evidence that patient information available on PCN and partner practice websites in relation to Enhanced Access is both variable in terms of the terminology used and the information provided.

Proposed next steps for 2024/25

- ICB to share the report and findings with PCN Clinical Directors and managers.
- All PCNs to be asked to
    - review and provide further assurance against the key Specification items outlined in section **0** (delivery assessment against Network Contract DES specification) and to report back to the October Primary Care Operational Group (PCOG) with a progress update and plan for 'Full Delivery' against the key Service Specification requirements.
    - initiate a deep dive into their 'unbooked' capacity and identify trends/patterns in relation to appointment times and appointment type and provide assurance that the available capacity is best tailored to the needs and preferences of their population.
    - review DNA rates and ensure appropriate mitigations like SMS reminders are consistently deployed.
    - review messaging on member practice websites to ensure consistency of messaging re. EA and that EA forms part of planned Care Navigation training and wider Access and Recovery plans.
- TLCP to provide assurance to ICB on EA delivery against core requirements for 2024/25.

Service Outline and contractual arrangements.

Contract arrangements.

Enhanced Access (EA) is a key component of the Primary Care Network (PCN) Network DES and refers to the delivery of core Primary Care Services within a PCN during 'Network Standard Hours' i.e. 18:30-20:00 on weekdays and 09:00 to 17:00 on Saturdays.

EA commenced from 1 October 2022 and replaced pre-existing arrangements for GP Extended Hours and Extended Access Hubs.

All Lewisham PCNs submitted EA proposals outlining their intention to either fully deliver EA capacity or implement subcontract arrangements.

All practices opted to fully deliver EA capacity for their registered patient population however it should be noted that there are subcontract arrangements in place between Lewisham Alliance and Sevenfields PCNs with regards to Burnt Ash Surgery as follows:

- Sevenfields will deliver EA for Burnt Ash Surgery on behalf of Lewisham Alliance.
- Lewisham Alliance will receive funding for EA for Burnt Ash Surgery and will transfer fundings to Sevenfields for services provided under a memorandum of understanding arrangement.
- EA activity reporting and core requirements i.e. hours required to be offered, will be updated to reflect arrangements in relation to Burnt Ash Surgery.

All plans were formally approved by the ICB, and service delivery commenced on 1st October 2022

Enhanced Access sites

EA is delivered from 23 sites across the 6 PCNs as outlined below.

Aplos	Modality	Lewisham Alliance	The Lewisham Care Partnership (TLCP)	North Lewisham PCN (NLPCN)	Sevenfields
4 sites	3 sites	5 sites	5 sites	1 site	5 sites
1. Sydenham Group Practice 2. The Vale MC 3. Wells Park Practice 4. Woolstone MC	1. The Jenner Practice 2. South Lewisham Group Practice 3. Bellingham Green surgery	1. Lee Road Surgery 2. Lewisham MC 3. Nightingale Surgery 4. Triangle Group Practice 5. Woodlands HC	1. Belmont Hill 2. Morden Hill 3. Hillyfields HC 4. Honor Oak 5. St Johns MC	1. Waldron HC	1. Downham FMP 2. Parkview Surgery 3. Burnt Ash Surgery 4. Novum 5. Torridon Road

Funding arrangements

Total EA payment for Lewisham since October 2022 is approximately £3.32m.

Payment is calculated per registered population (prp) size per annum based on a payment of £3.76 for Oct'22-Mar'23 and £7.578 for Apr'23-Mar'24.

The following table outlines EA costs between Oct'22 – Mar'24.

	Registered patient list size	2022/23 @ £3.760 *(6 months)*	2023/24 @ £7.578 *(12 months)*	Total Oct'22- Mar'24
Aplos	50777	£ 95,460.76	£ 384,788.11	£ 480,248.87
Modality	38826	£ 72,992.88	£ 294,223.43	£ 367,216.31
Lew Alliance	46678*	£ 99,623.08	£ 353,725.88	£ 453,348.96
TLCP	52869	£ 99,393.72	£ 400,641.28	£ 500,035.00
NLPCN	90833	£ 170,766.04	£ 688,332.47	£ 859,098.51
Sevenfields	71388**	£ 122,341.00	£ 540,978.26	£ 663,319.26
Total Year	**351371**	**£660,577.48**	**£ 2,662,689.44**	**£ 3,323,266.92**

**Lewisham Alliance excludes Burnt Ash adjusted list size*
***Sevenfields includes Burnt Ash adjusted list size*

Enhanced Access core requirements

Lewisham is required to deliver a minimum of 4568 hours per quarter (approx. 18,271 hrs per annum) as outlined below for the Lewisham adjusted registered patient population.

	Weighted list size (as of 1/1/23)	Local Adjustment weighted list size if applicable	Weighted list size (as of 1/1/23) per 1000	Additional hours to be delivered per quarter	Hrs to be delivered per annum
Aplos	50777.0	5077	50.8	660.1	2640.4
Lew Alliance	52991.0	46678*	46.7	606.8	2427.3
Modality	38826.0	38826	38.8	504.7	2019.0
TLCP	52869.0	52869	52.9	687.3	2749.2
NLPCN	90833.0	90833	90.8	1180.8	4723.3
Sevenfields	65075.0	71388**	71.4	928.0	3712.2
Total Year	**351371**	**351371**	**351**	**4568**	**18271.3**

**Lewisham Alliance excludes Burnt Ash adjusted list size*
***Sevenfields includes Burnt Ash adjusted list size*

Reporting requirements

PCNs are required to submit quarterly reports to SEL ICB to outline service provision delivered as follows:

- **Service Activity** (total hrs offered, appts booked/delivered/ DNA) broken down by clinician type (GP, nurse, ARRs, Other and appointment type (Face to Face, telephone, remote).
- **Operational and Quality issues**
- **Change requests** (changes to service delivery)
- **Commissioner support required.**

Recovery plans are put in place for PCNs that do not deliver the core hour offer within the reporting period. PCNs will be required to make up hours within the reporting period.

Quarterly updates are reported to the Lewisham Primary Care Operational Group for review.

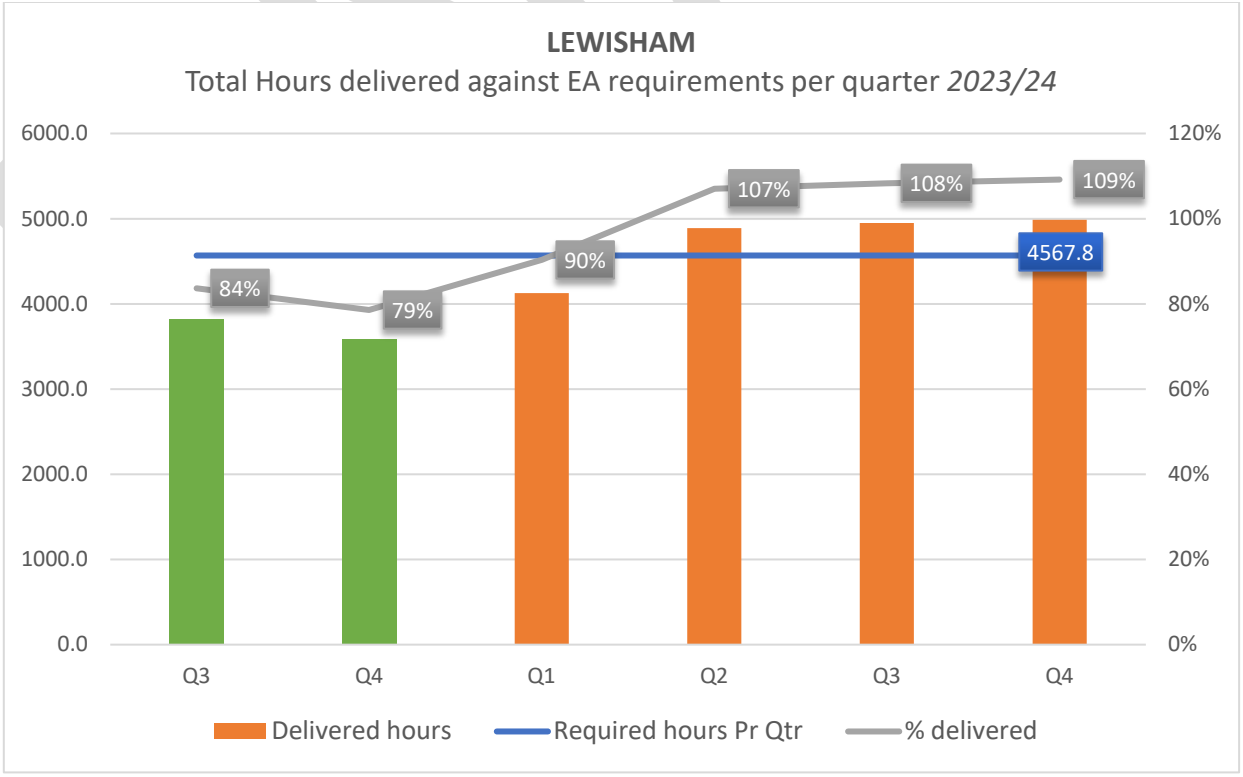
Service Delivery

Overall Performance / Key Performance Indicators (KPIs)

Activity and performance data used for this report is for the period 1st April 2023- 31st March 2024.

EA capacity is being provided in line with the specified EA requirements of 60minutes per 1000 adjusted patients with PCNs delivering an annual average of 104% of required hours per annum. This is a significant increase from the first 6 months of service delivery (Oct'22-Mar'23) that saw only 81% of required hours being offered.

The following graph shows the quarterly offer across Lewisham for EA. It is clear to see the quarterly increase since the service commenced in October 2022.

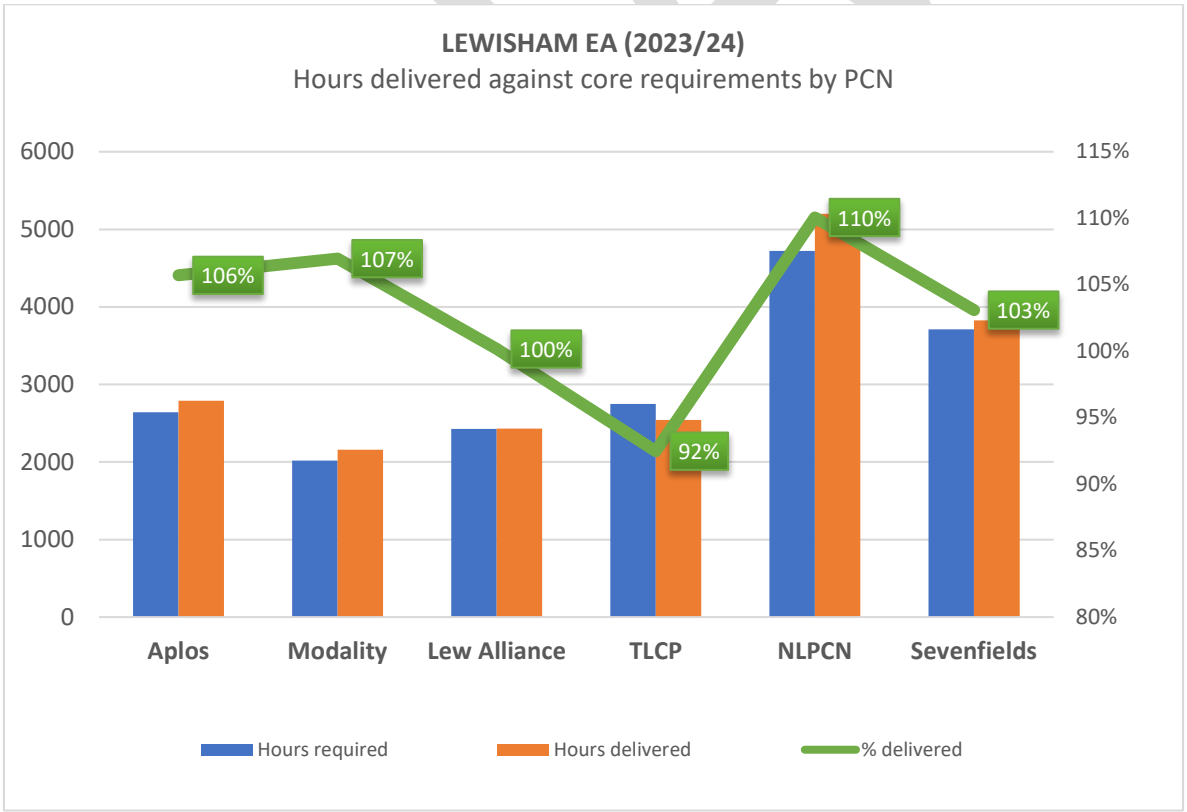


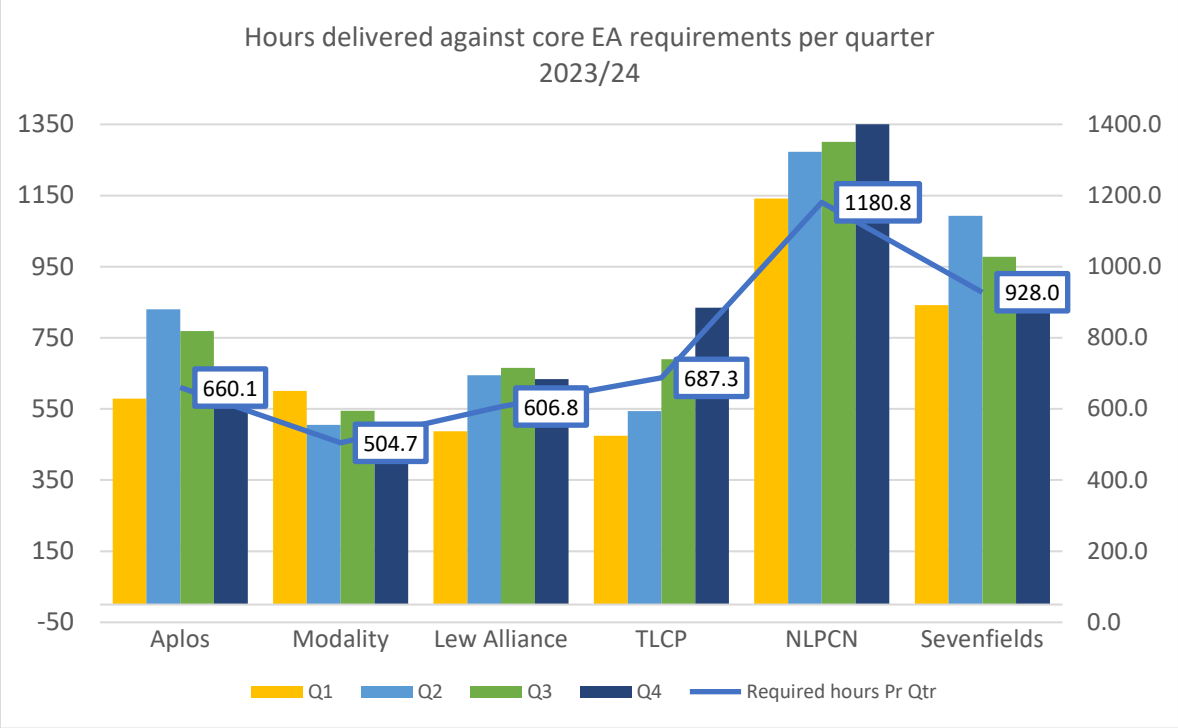
LEWISHAM	Q1	Q2	Q3	Q4	TOTAL

Core requirements	Hours offered	**4126**	**4889**	**4948**	**4987**	**18950**
	Hours required	4567.8	4567.8	4567.8	4567.8	**18271**
	% Delivery rate	90%	107%	108%	109%	104%
Appointment offer	Total appointments offered	**13196**	**17937**	**20816**	**15502**	**67451**
	Ave appts per hour offered	**3.2**	**3.7**	**4.2**	**3.1**	**3.6**
	% prebook able appts	84%	87%	81%	87%	**87%**
	% Same day/urgent appts	11%	9%	16%	13%	**13%**
Performance	Total Appointments booked	12004	15029	16372	13768	**57173**
	Total Appointments attended	9789	12761	13354	11343	**47247**
	Booked rate (% of offered appointments)	91%	84%	79%	89%	**85%**
	Attendance Rate (%)	82%	85%	82%	82%	**83%**
	DNA rate	14%	14%	18%	18%	**16%**
Recovery plans	Plans implemented (to recoup hours)	5	1	0	0	6

The following demonstrates this activity by PCN for the full year i.e. hours delivered (offered) by PCN per annum practice against hours required.

All PCNs except 1 (TLCP), met and exceeded their requirements.





The following provides a high-level summary of key findings.

Core requirements	• EA capacity is offering 104% capacity against the core requirements (18950 /18271). • 5/6 PCN met or exceeded their annual requirements for hours offered except TLCP who delivered at annual rate of 92% despite over delivering in Q3 & Q4. • **3.6** appointments an hour is offered on average (ranging from 3.1 in Q4 (lowest) to 4.2 in Q3 (highest). Again, there is variation between PCNs with NLPCN offering approximately 5.3 appointments per hour compared to Aplos that offer approximately 2.2 appointments per hour. The remaining PCNs offer between 3.3 and 3.9 appointments per hour. • Across Lewisham approximately 87% of appointments offered are prebook able with 13% being offered as same day/urgent appointments. • TLCP and Modality are the only PCNs that do not offer same day/urgent appointments. • The remaining PCNs offer between 68-85% prebookable and 15-32% same day/urgent. • Only 2 PCNs (Modality and NLPCN) offer appointments to 111. The other PCNs have reported IT infrastructure/challenges as a reason why EA appointments are not available to 111 bookings.

Appointment Utilisation	• **85%** average booking rate (decrease from 91% in Q1 to 85% in Q4) • **83%** average attendance rate has remained static at 82% in Q1, Q3 and Q4 increasing to 85% in Q2). • Average DNA rate of 16% which has increased from 14% in Q1-2 to 18% in Q3-4. • There is significant variation PCNs with DNA rates ranging from 8% to 20%. • Aplos DNA rate has remained stable with, 2 PCNs seeing an increase of approx. 11% each (Modality and Sevenfields) and 2 PCNs seeing an improvement in their DNA rates over time (NLPCN and TLCP).
Appointments attended by clinician type	• GPs have the highest booking rate and attendance rate despite nurses having the most appointments offered. • Nurses have the highest DNA rate representing 47% of all DNA appointments.
Appointments attended by appointment type	• Face to face (F2F) appointments is the most offered (79%) and most attended appointment type (74%) followed by nurses (19% offered / 21% attended). • Average DNA rate = 16% for Lewisham however fluctuates between PCNs ranging from
Recovery plans	• A total of 6 recovery plans were implemented during the year. • 5 recovery plans were put into place during Q1 to recoup unmet hours in Q3-4 of 2022/23. • Only 1 recovery plan was required during Q2-3. • 2 PCNs did not meet the required hours for Q4 however exceeded their annual requirement so fulfilled their core requirements. • All PCNs except 1 were able to meet the additional hours required for the year. • This demonstrates the challenges that PCNs experienced during mobilisation of the service during the first 6 months and how PCNs have been able to overcome initial challenges to meet core requirements.

Clinician Type

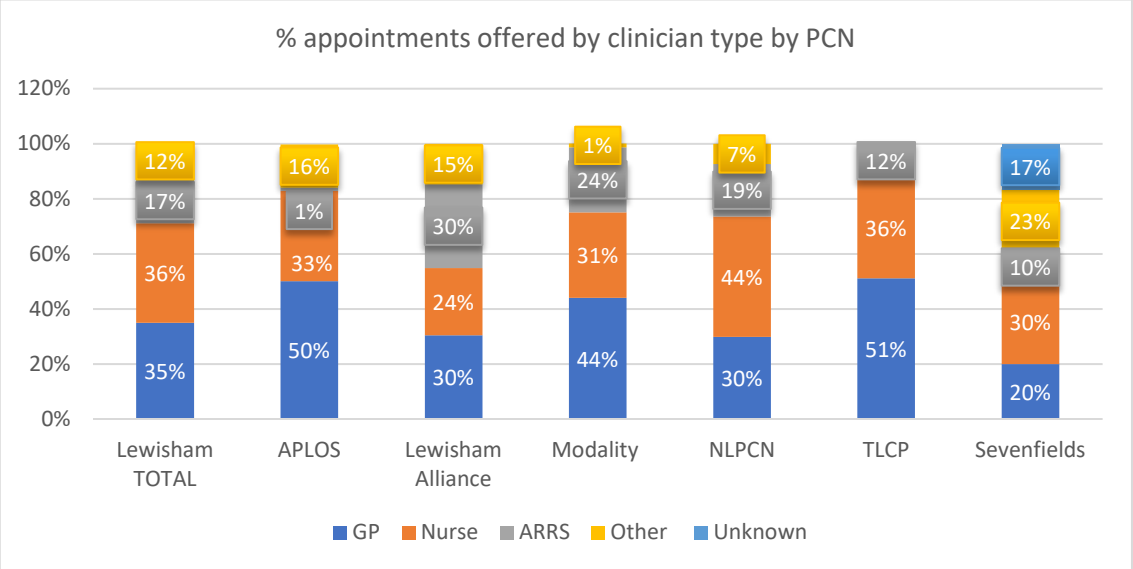
All PCNs offered a multidisciplinary team offer of clinician types including GPs, Nurses, ARRs roles and other Health Care Professionals (HCPs).

When looking individually at each appointment by clinician type

- Gp appointments have the highest booking (93%) and utilisation rate (91%) and the lowest DNA rate (9%).
- Nurse appointments have a 78% booking rate of total appointments offered and a utilisation rate of 82% of total appointments booked. High DNA rate (18%).
- ARRs appointments have a 66% booking rate, 81% attendance rate and 19% DNA rate and is the least utilised appointment type by clinician.

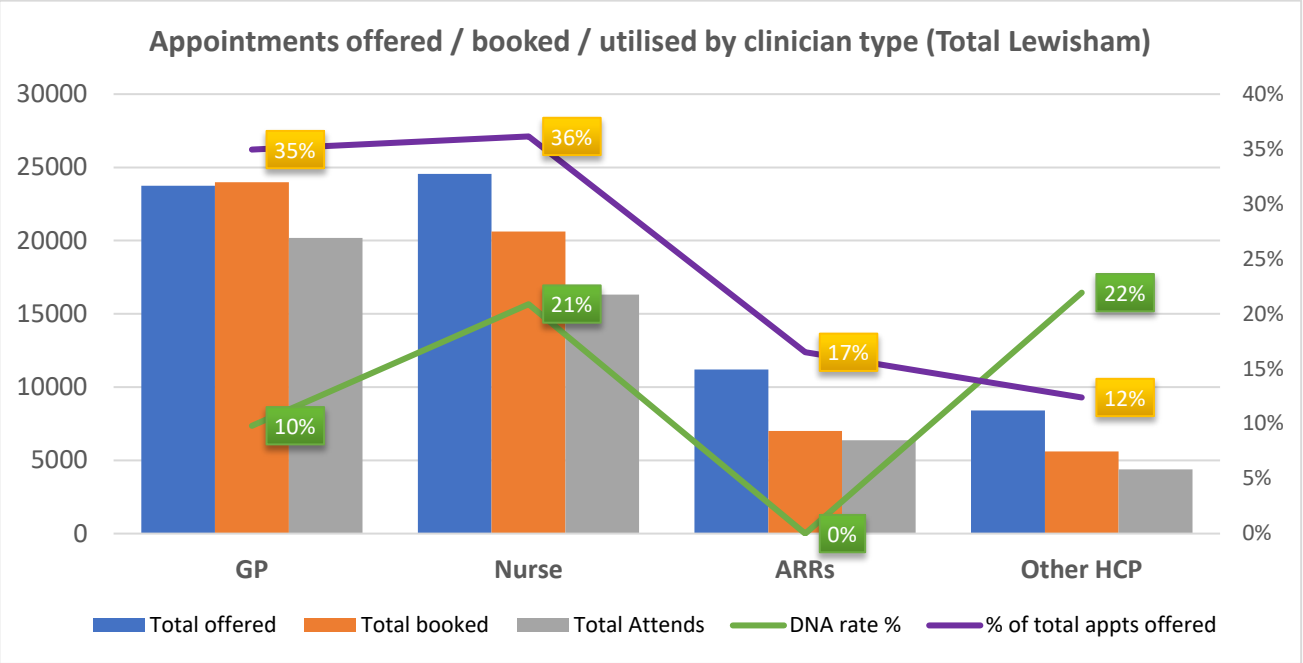
There was variation between PCNs in the number of appointments offered by clinician type.

- Aplos and TLCP offered the most GP appointments (approximately 50%) followed by nurse appointments.
- SevenFields offered the least GP appointments (20%), but the most appointments for 'other clinician', however 17% of appointments offered were recorded as unknown clinician type. 30% of appointments were for nurses followed by other clinician type.
- NLCPN was the only PCN that offered more nurse appointments than any other clinician type.
- Lewisham Alliance offered the most ARRs appointments (30%)



GP appointments accounted for the most booked, attended and DNA rates despite being the 2nd highest clinician appointment type offered. The following table shows total rates across Lewisham for each clinician type.

	Most Offered	Most Booked	Most Attended	DNA
GP	35%	**40%**	**43%**	**47%**
Nurse	**36%**	36%	34%	26%
ARRs	17%	17%	12%	14%
Other HCP	12%	7%	9%	13%

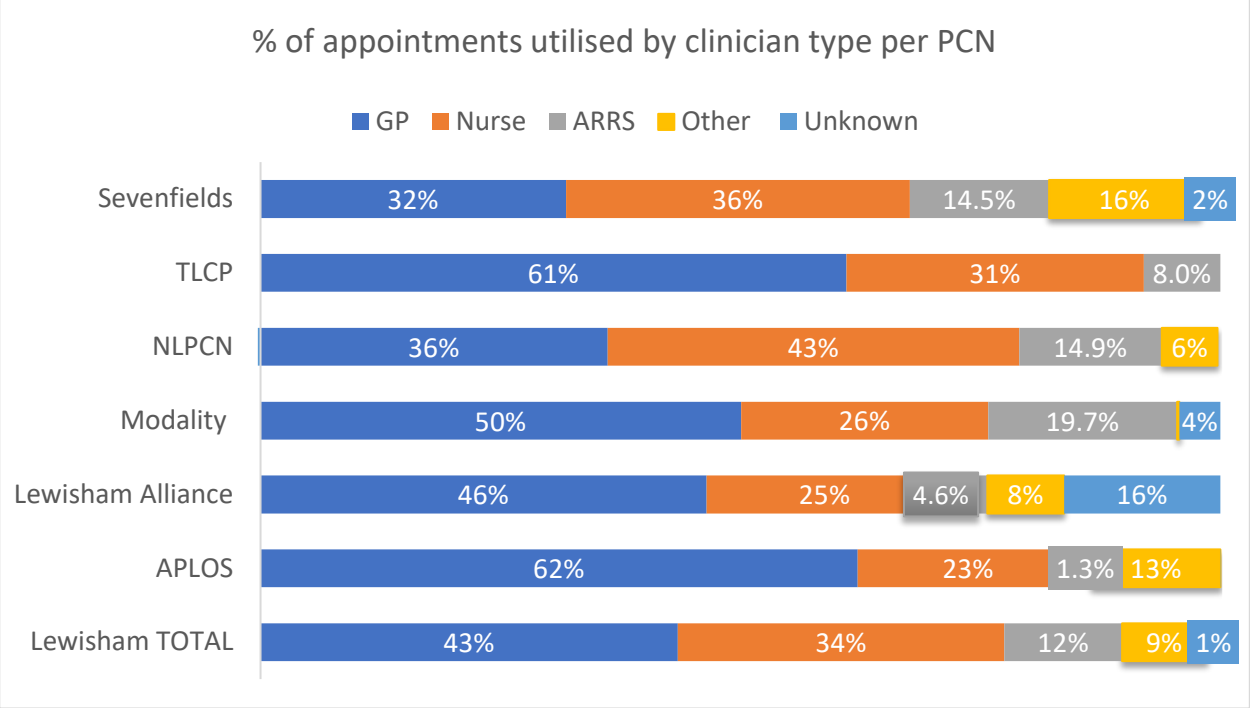


There is variation across PCNs for appointments offered, booked and utilised.

- Aplos and TLCP had the highest attends for GP appointments (62% & 61%). The lowest GP attends are for Sevenfields (32%) and NLPCN (36%).
- NLPCN saw the highest number of attends
- NLPCN saw the lowest F2F attends (36%) but highest nurse appointments (41%).
- Aplos and Modality were the only 2 PCNs with ARRs appointments.

The following table and graph show attendance rates by clinician type per PCN

	Lewisham TOTAL	APLOS	Lewisham Alliance	Modality	NLPCN	TLCP	Sevenfields
GP	43%	62%	46%	50%	36%	61%	32%
Nurse	34%	23%	25%	26%	43%	31%	36%
ARRS	12%	1.3%	4.6%	19.7%	14.9%	8.0%	14.5%
Other	9%	13%	8%	0%	6%	0%	16%
Unknown	1%	0%	16%	4%	0%	0%	2%
	100%	100%	100%	100%	100%	100%	100%



Appointment Type

74% of all appointments attended were for Face to face (F2F) appointments compared to Telephone (23%) and other e.g. online (2%). 1% recorded as unknown.

There is variation across PCNs.

- NLPCN saw the highest F2F attends at 85% with the least telephone (18%).
- Aplos saw the least F2F (62%) but the highest telephone (37%).
- Sevenfields offered the most online appointments (5%) with only 1 other PCN (NLPCN) offering online appointments
- Lewisham Alliance had the biggest recorded 'unknown' appointment type at 16%.

When looking individually at each appointment type

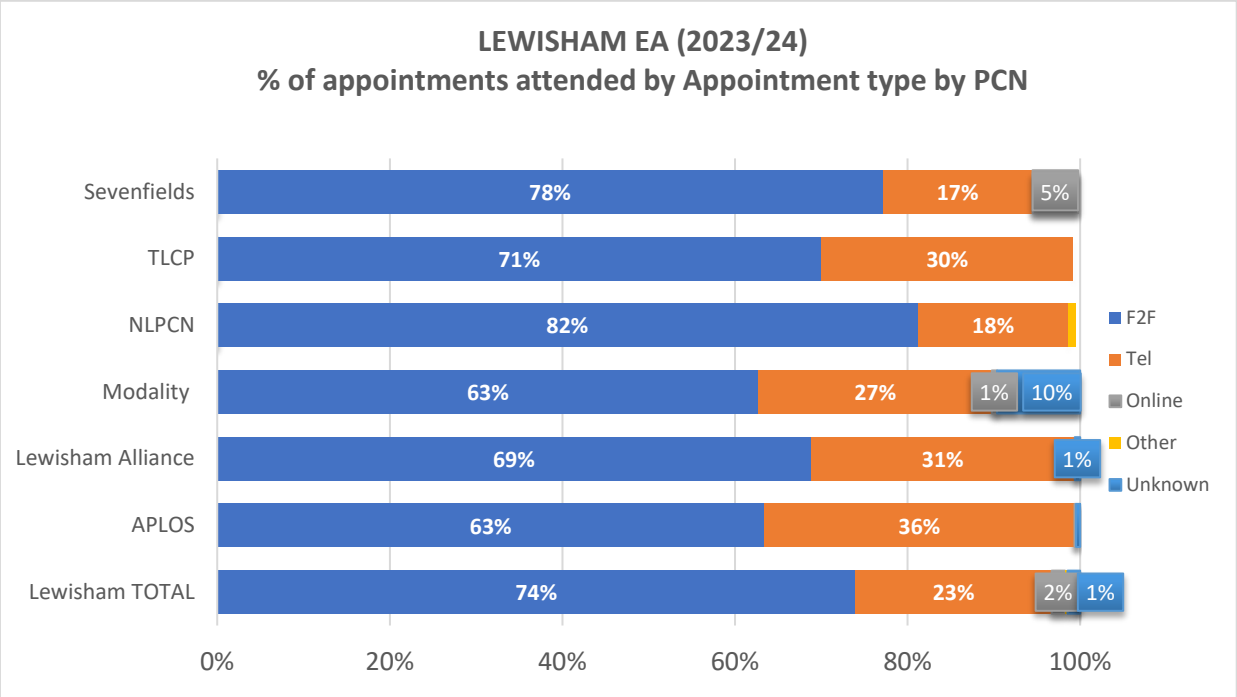
- Telephone appointments have the highest booking rate (82%) and highest attendance rate (90%) and a 10% DNA rate.

- F2F has an 80% booking rate and 85% utilisation rate and the highest DNA rate (15%).

- A large proportion (13%) of activity is for 'other' appointment types which are either online i.e. video or recorded as unknown and have the lowest booking and utilisation rate but the highest DNA rate.

The following summarises attended (utilised) appointment by type across Lewisham and by PCN.

		Lewisham TOTAL	APLOS	Lewisham Alliance	Modality	NLPCN	TLCP	Sevenfields
% Appt type	F2F	74%	63%	69%	63%	82%	71%	78%
	Tel	23%	36%	31%	27%	18%	30%	17%
	Online	2%	0%	0%	1%	0%	0%	5%
	Other	0%	0%	0%	0%	1%	0%	0%
	Unknown	1%	0%	1%	10%	0%	-1%	0%



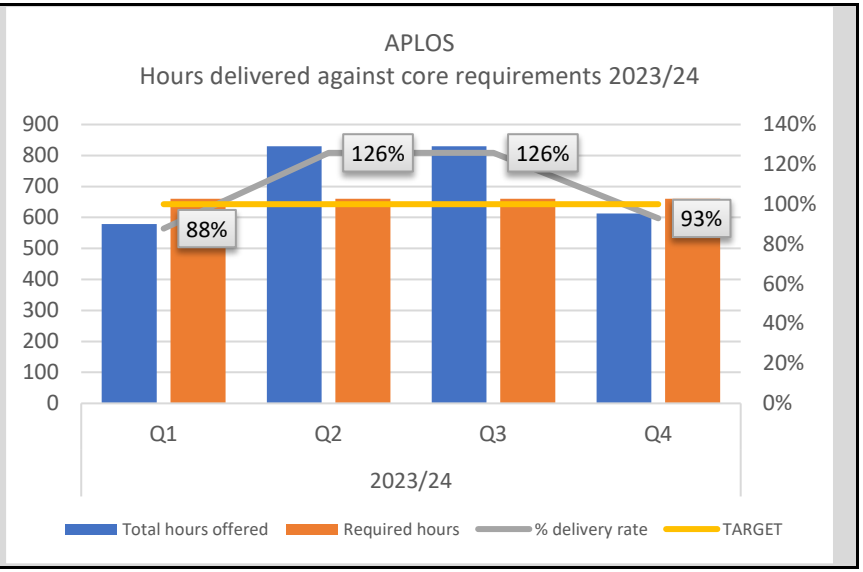
The tables below provide a summary of activity at PCN level.

South East London Integrated Care System

NHS South East London

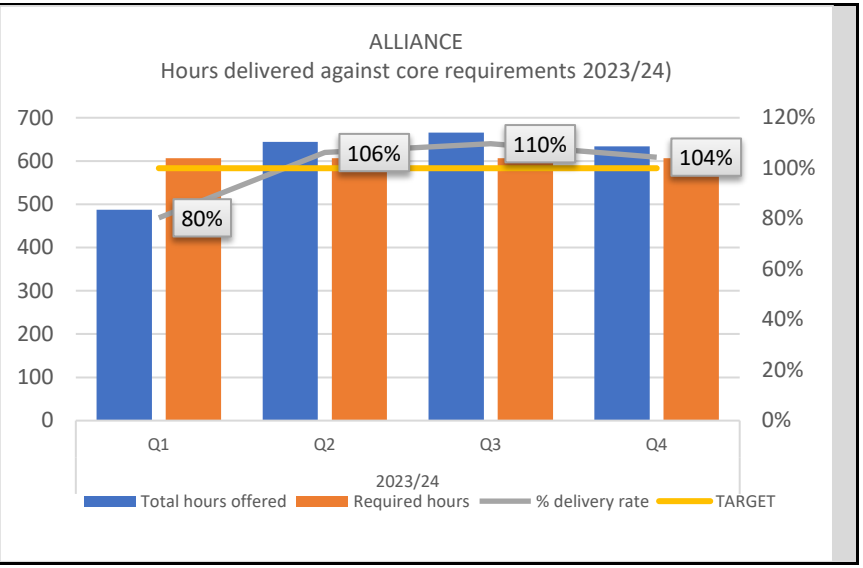
APLOS

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	**579**	**830**	**769**	**613**	**2791**
	Hours required	660.1	660.1	660.1	660.1	2640.4
	% Delivery rate	88%	126%	116%	93%	106%
Appointment Delivery	Total appointments offered	**845**	**2490**	**1604**	**1222**	**6161**
	Ave appts per hour offered	**1.5**	**3.0**	**2.1**	**2.0**	**2.2**
	% prebook able appts	100%	100%	100%	100%	100%
	% Same day/urgent appts	0%	0%	0%	0%	0%
Performance	Total Appointments booked	703	2221	1434	1127	5485
	Total Appointments attended	642	2043	1282	1051	5018
	Booked rate (% of offered appointments)	83%	89%	89%	92%	89%
	Attendance Rate (%)	91%	92%	89%	93%	91%
	DNA rate	7%	7%	11%	7%	8%
Recovery plans	Plans implemented (to recoup hours)	1	0	0	0	1



LEWISHAM ALLIANCE

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	**488**	**645**	**666**	**634**	**2431**
	Hours required	606.8	606.8	606.8	606.8	**2427.3**
	% Delivery rate	80%	106%	110%	104%	**100%**
Appointment Delivery	Total appointments offered	**1940**	**1847**	**2427**	**1811**	**8025**
	Ave appts per hour offered	**4.0**	**2.9**	**3.6**	**2.9**	**3.3**
	% prebook able appts	70%	68%	74%	65%	**70%**
	% Same day/urgent appts	30%	32%	26%	35%	**30%**
Performance	Total Appointments booked	1406	1348	1532	1396	**5682**
	Total Appointments attended	1151	1100	1142	1109	**4502**
	Booked rate (% of offered appointments)	63%	77%	79%	71%	**71%**
	Attendance Rate (%)	82%	82%	75%	79%	**79%**
	DNA rate	25%	21%	14%	21%	**21%**
Recovery plans	Plans implemented (to recoup hours)	1	0	0	0	1

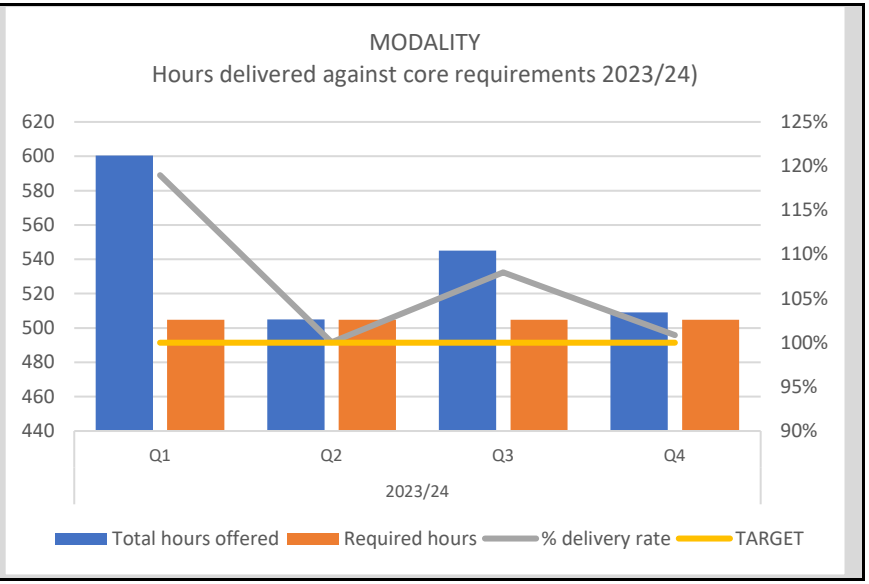


South East London Integrated Care System

NHS South East London

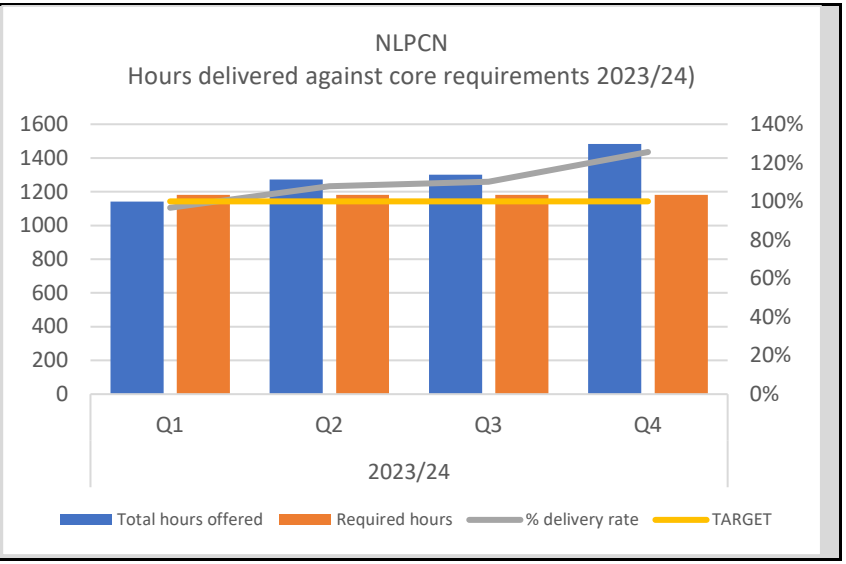
MODALITY

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	**601**	**505**	**545**	**509**	**2160**
	Hours required	504.7	504.7	504.7	504.7	2019.0
	% Delivery rate	119%	100%	108%	101%	107%
Appointment Delivery	Total appointments offered	**1619**	**1993**	**2282**	**1918**	**7812**
	Ave appts per hour offered	**2.7**	**3.9**	**4.2**	**3.8**	**3.6**
	% prebook able appts	100%	100%	100%	100%	**100%**
	% Same day/urgent appts	0%	0%	0%	0%	**0%**
Performance	Total Appointments booked	1504	1570	1822	1643	**6539**
	Total Appointments attended	1425	1363	1553	1373	**5714**
	Booked rate (% of offered appointments)	93%	79%	80%	86%	**84%**
	Attendance Rate (%)	95%	87%	85%	84%	**87%**
	DNA rate	5%	6%	15%	16%	**11%**
Recovery plans	Plans implemented (to recoup hours)	0	0	0	0	0



NORTH LEWISHAM

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	**1142**	**1273**	**1301**	**1483**	**5198**
	Hours required	1180.8	1180.8	1180.8	1180.8	4723.3
	% Delivery rate	97%	108%	110%	126%	110%
Appointment Delivery	Total appointments offered	**4203**	**4553**	**5341**	**5060**	**19157**
	Ave appts per hour offered	**3.7**	**3.6**	**4.1**	**3.4**	**3.7**
	% prebook able appts	85%	85%	68%	74%	77%
	% Same day/urgent appts	15%	15%	32%	26%	23%
Performance	Total Appointments booked	3889	4243	4010	4738	**16880**
	Total Appointments attended	2777	3259	3117	3881	**13034**
	Booked rate (% of offered appointments)	93%	93%	75%	94%	88%
	Attendance Rate (%)	71%	77%	78%	82%	77%
	DNA rate	22%	18%	16%	19%	19%
Recovery plans	Plans implemented (to recoup hours)					1

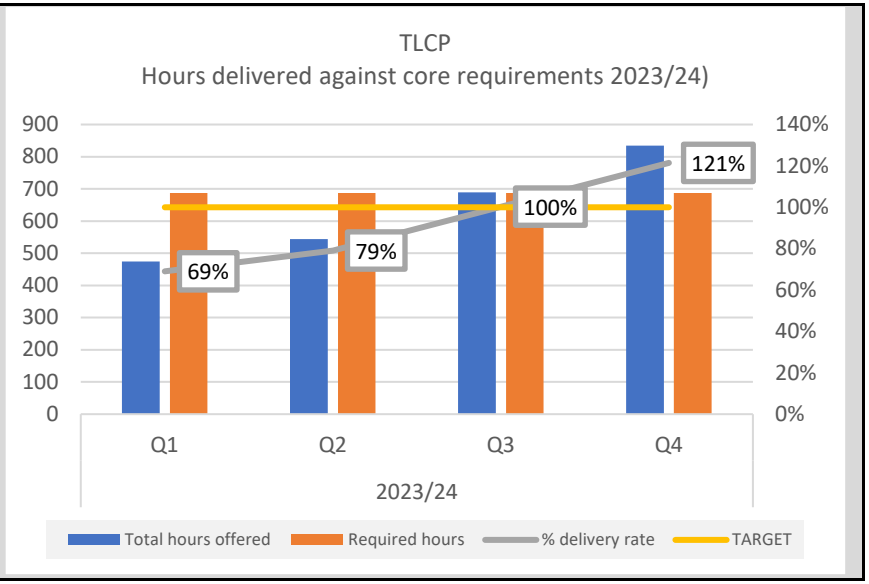


South East London Integrated Care System

NHS South East London

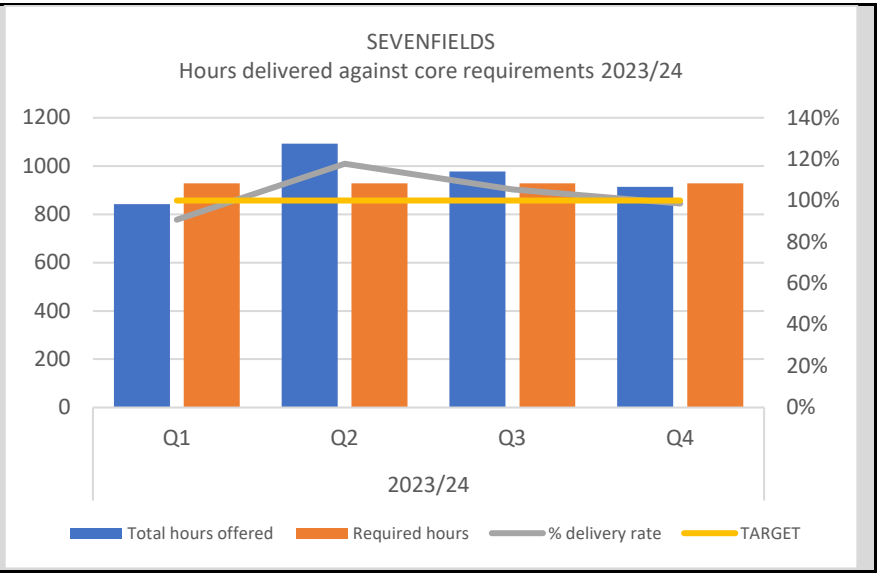
TLCP

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	475	544	690	835	**2542**
	Hours required	687.3	687.3	687.3	687.3	**2749.2**
	% Delivery rate	69%	79%	100%	121%	**92%**
Appointment Delivery	Total appointments offered	1775	2153	3086	2793	**9807**
	Ave appts per hour offered	**3.7**	**4.0**	**4.5**	**3.3**	**3.9**
	% prebook able appts	1.0	1.0	1.0	1.0	**100%**
	% Same day/urgent appts	0%	0%	0%	0%	**0%**
Performance	Total Appointments booked	1636	2037	2822	2514	**9009**
	Total Appointments attended	1437	1826	2530	2260	**8053**
	Booked rate (% of offered appointments)	92%	95%	91%	90%	**92%**
	Attendance Rate (%)	88%	90%	90%	90%	**89%**
	DNA rate	12%	10%	10%	10%	**11%**
Recovery plans	Plans implemented (to recoup hours)	1	1	0	0	**1**



SEVENFIELDS

		Q1	Q2	Q3	Q4	TOTAL
Core requirements	Hours offered	**842**	**1093**	**978**	**914**	**3827**
	Hours required	928.0	928.0	928.0	928.0	**3712.2**
	% Delivery rate	91%	118%	105%	98%	**103%**
Appointment Delivery	Total appointments offered	**3656**	**5994**	**7054**	**3612**	**20316**
	Ave appts per hour offered	**4.3**	**5.5**	**7.2**	**4.0**	**5.3**
	% prebook able appts	68%	77%	71%	71%	**72%**
	% Same day/urgent appts	9%	5%	15%	4%	**9%**
Performance	Total Appointments booked	2866	3610	4752	2350	**13578**
	Total Appointments attended	2357	3170	3730	1669	**10926**
	Booked rate (% of offered appointments)	78%	60%	67%	65%	**67%**
	Attendance Rate (%)	82%	88%	78%	71%	**80%**
	DNA rate	18%	12%	22%	29%	**20%**
Recovery plans	Plans implemented (to recoup hours)	1	0	0	0	**1**



Operational Challenges

Following the start of EA on 1st October 2022, PCNs reported several mobilisation issues and ongoing challenges with service delivery as outlined below.

ICT	• Initial IT set up issues with EMIS, docman, ERS, Apex etc. • No access to T-quest for blood results • Wi-Fi connection issues at larger health centres (ongoing)
Reporting	• Data inconsistencies and reliability of setting up PCNs dashboard. • Manual reporting required which has been labour intensive across all sites due to IT challenges resulting in inconsistent data reporting (Q3-4 2022/23)
Workforce	All PCNs have reported issues in the following areas; • Workforce shortage / Shortage of locum GPs available including challenges in recruiting workforce especially for weekends or short shifts. • IT infrastructure. Initial IT set up issues with EMIS, docman, ERS, Apex etc and WiFi connection issues at larger health centres.
Operational	• No blood collections on a Saturday • Underutilisation of some clinician appointments i.e. nurses. PCNs flexed and adapted offers where applicable.
Estates	• Planned refurbishment of sites, reduction in location offer likely.

Service User Feedback / Access to EA

Service User (patient) engagement was undertaken as part of EA plan development however is not a requirement of the EA contract. PCNs are however required to collate patient feedback in relation to access to general practice but does not specify feedback directly relating to EA services.

The core contract does require PCNs to ensure that they effectively communicate with patients about EA and the services it offers and how it can be accessed.

A review of materials made available to patients by the PCNs was not assessed as part of this review however the following provides a high-level summary of the PCNs and partner practice webpages it is evident that there are inconsistencies in the terminology and level of information available to Lewisham patients.

The below summarises some of these findings.

Aplos	https://www.aploshealth.co.uk/

	• There is reference to Extended Hours service however links to One Health Lewisham webpage OHL no longer provide this service. ***Webpage needs updating.*** • Weblinks on individual partner practice webpages do however reference Aplos Enhanced Access across all partner practices. • 3 of the 4 practice webpages are easy to navigate in terms of locating information about Direct Access.
Lewisham Alliance	• No PCN webpage available • 4/5 partner practice webpages did not reference EA. Those that did have information missing / incomplete. • ***Webpage needs updating.***
Modality	https://www.modalitypartnership.nhs.uk/primary-care • Links on Modality Partnership website still links One health Lewisham webpage for GPEA which is no longer available to access as they no longer deliver it. ***Webpage needs updating.*** • Webpage difficult to navigate and challenging to find clear information regarding GP Enhanced Access Services
North Lewisham PCN	https://www.northlewishampcn.nhs.uk/about-us/our-services/ • EA is mentioned on webpage however link to more information does not work. ***Webpage needs updating.*** • Individual practices do reference EA and how to access them however there is lack of consistency in the information provided.
TLCP	https://www.thelewishamcarepartnership.co.uk/ • Unable to locate any information about Enhanced Access under Services provided or appointments sections. ***Webpage needs updating.*** • Only 1 webpage (St Johns) clearly stated enhanced access. The others went to the core TLCP webpage.
Sevenfields	https://www.sevenfieldspcn.nhs.uk/ • Only reference to EA is in relation to a privacy notice with regards to EA but no direct information on how to access EA. ***Webpage needs updating.*** • 6/8 practice webpages reference EA however inconsistencies in information available and terminology used. Some links are not working.

Delivery Assessment

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1963_i_Network-Contract-DES-Specification_171022.pdf (page 49)

Core Requirement	Assessed Delivery Status (i.e. Full, Partial, Undelivered)	Assurance / Mitigations
All appointment slots available to all PCN patients	Partial	There is reasonable assurance that EA appointments are available to all PCN patients although the offer available to patients' at PCN / practice level is variable which is likely to result in differing experiences of access for patients. It is difficult to understand about patients awareness of Enhanced Access services available due to patient engagement not being a direct requirement of the contract.

Appointments available for any general practice services and services pursuant to the Network Contract DES that are provided to patients	Partial	There is evidence of this being met however clarity over certain service types required from PCNs as not collated as part of this review.
Bookable appointments that may be made in advance or on the same day by the PCNs core Network Practices, regardless of the access route that patients may contact their practice.	Partial	There is variation in the offer available by PCNs with only 2 PCNs offering same day/urgent EA appointments resulting in potentially differing experiences and access for patients.
Appointments delivered by a multi-disciplinary team of healthcare professionals employed or engaged by the PCNs core Network practices, including GPs, nurses and Additional roles (ARRs) and other professionals employed or engaged by the PCN to assist in the provision of health services.	Full	There is assurance that appointments are being made available with a wide range of health care professionals with approximately 68% being seen by a GP or nurse, 30% ARRs and 2% other HCP. There is however variance in the offer provided by PCNs and therefore differing experiences in access for patients.
A minimum or 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours calculated using the following formula; Additional minutes*= (the PCN adjusted population** ÷ 1000) x 60 convert to hours and minutes and round, either up or down to the nearest quarter hour.	Partial	There is reasonable assurance that the number of appointments/ hours/ minutes being offered by the PCNs. Only 1 PCN, TLCP, did not meet their annual requirement of offering their core annual hours required. It is anticipated that this will be met within Q1 & Q2 2024/25.
Where a PCN cancels any EA appointments or where appointments cannot be offered (for example, but not limited to, a bank holiday) the PCN must make up the cancelled time by offering additional appointments within a two- week period, unless an alternative time period is agreed with the commissioner.	Partial	As above. There is insufficient evidence that the deficits are routinely made up within a two-week period however there is evidence that unmet hours are routinely made-up within the agreed reporting period e.g. quarterly.
A PCN's Core Network Practices must actively communicate availability of these enhanced access appointments to their patients, including informing patients how they can be accessed, what and when specific services are available (for example vaccinations and immunisations, screening, health checks, PCN services etc) and what and when different members of the MDT are available, through promotion and publication through multiple routes. This may include the NHS website (nhs.uk), the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments	Partial	Due to EA patient engagement not forming part of the core EA requirement there is insufficient evidence about the level of awareness of EA within the Lewisham population. There is however evidence of inconsistencies in both terminology used and information available on both PCN and partner practice websites.
PCNs must offer a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimises inequalities in access across the patient population;	Partial	There is evidence that all PCNs are offering a combination of appointment types offering a variety of access routes for patients with Face to Face and telephone being the majority offer. Evidence of Online/ Video consultation available however is variable across PCNs.

PCNs will ensure that their appointment system used for Enhanced Access can be identified so that appointment data for that PCN can be incorporated into the General Practice Appointment Data (GPAD) set. Where a commissioner requests further information regarding the PCN's Enhanced Access service appointment data, the PCN will provide such requested information as soon as reasonably practicable and in any event within 30 days of the date the request was made	Partial	Confirmation required from PCNs with regards to the status of incorporating into GPAD. There is evidence that all PCNs are able to clearly identify and report in EA activity however IT issues have made this challenging.

Next Steps

Overall appointment capacity is being provided in line with the 60 minutes per 1000 adjusted patients per week however there is clear evidence of

- Additional EA capacity available which is not being utilised.
- variation between PCNs in relation to the offer available to patients i.e. by clinician type, by appointment type and booking, attendance and DNA rates.
- Uncertainty around patients' awareness of EA services and how the service model is flexed to meet patients needs.
- Uncertainty around PCNs recovery processes for recouping any unmet capacity.

The following recommendations are therefore proposed:

i. Commissioners will continue to monitor EA activity quarterly, working with PCNs to address any operational challenges being experienced by PCN.

ii. All PCNs to be asked to review and provide further assurance against the key Specification items outlined in section 4.2 Delivery Assessment and to report back to the October Primary Care Operational Group (PCOG) with a progress update and plan for 'Full Delivery' against the key Service Specification requirements.

iii. TLCP to review their delivery of EA hours to ensure that they are offering 100% of required hours and provide further assurance that any deficits in appointments will be routinely made up within the specified 2-week window or quarterly reporting period.

iv. All PCNs to be asked to initiate a deep dive into their 'unbooked' capacity and identify trends/patterns in relation to appointment times and appointment type and provide assurance that the available capacity is best tailored to the needs and preferences of their population.

v. All PCNs to be asked to review DNA rates and ensure appropriate mitigations like SMS reminders are consistently deployed.

vi. PCNs to be asked to review messaging on member practice websites to ensure consistency of messaging re. EA and that EA forms part of planned Care Navigation training and wider Access and Recovery plans.

Notes and actions from Lewisham IQAG 8 March 2024 - APPROVED 28 June 2024

Discussion	Actions
Attendees: Louise Crosby (chair) (LC) Lizzie Howe (notes) (LH) Ceri Jacob (CJ) Caroline Walker (CW) Dr Faruk Majid (FM) Joanna Peck (JA) Carolyn Denne (CD) Ashley O'Shaughnessy (AOS) Matt Agbolegbe (MA) SlaM Iain McDiarmid (IMcD) Helen Woolford (HW) Kerry Lonergan (KL) Corinne Moocarme (AM) Apologies for absence: Neil Goulbourne Ian Ross Joan Hutton Dr Taj Singhrao Sarah Davis	
1. Notes of previous meeting	Agreed as a correct record
2. **Action Log** LC requested Interface work as a standing agenda item (CW to note for Forward Planner.	No outstanding actions.

CW noted the Harms Review information had been circulated to the group.	
3. **LCP Performance Data**. LH shared the document on screen. CW noted red areas on the performance overview. LC said PHB needs a review and discussion next time (CW to note for Forward Planner). KL commented on the red scores in relation to children having first immunisations. There is a lag of data reporting, lot of work underway aiming to increase uptake. NHSE data is the previous 2 quarters. AOS noted the data lag issue. Hopefully higher numbers by the end of March 2024. A number of clinics are taking place. Cervical screening engagement session at Lewisham shopping centre tomorrow by a practice nurse. CD commented on Dementia diagnosis and the Tristan Brice presentation last time showed the whole picture. He mentioned circulating a draft dashboard, has it been sent? Also, hypertension work. LC noted patients being sent to A&E with hypertension. FM said hypertension had been an issue for a number of years. Lewisham hospital emergency guidelines state patient must be referred to the ED. Need to look at how we manage this as a system. Discussion amongst the group about ways of going forward with regards to the performance data.	CW to check with TB.

4. NHS Patient Safety Incident Response Framework (PSIRF) CW led the agenda item. This is underpinned by the patient safety strategy. Have been some early adopters. Key areas of the report highlighted. This is a contractual requirement for all services provided by/for the NHS. Have submitted our own PSIRF plan to NHSE. Had a stakeholder event for our GPs. LC keen to understand how we learn across organisations. AOS said this is a good topic to get everybody together and a good opportunity. Can address any barriers or challenges. HW spoke about sharing information and looking at what works well. LFPSE (beta version) noted.	
5. Feedback from <u>ICB Quality & Performance/ ICB System Quality Group</u> No update for this meeting due to the cycle of the meetings. **Themes and concerns group update.** CW updated on the key highlights. Slides 2-4 in the pack gave an overview of the group and ToR. Flow chart for the governance, will be a multi-disciplinary group. Group have a focus on investigative incidents. PII not SI's going forward. Slides 10-14 updates on actions providers have taken to mitigate risks. Slides 15-17 never events update. Review last year, actions to convene some T&F groups. Triangulation of information noted. Slides 22-23 safeguarding summary. Slides 25-31	

end of year thematic review by the CQC looking at themes and trends. Would like to bring this to the PCOG for the GPs to see it. HW mentioned good to see Tor with regards to relevant providers? Are they invited in at certain points? CW advised too early to tell. The idea is to invite the provider who the themes and trends are relating to, will evolve over time. HW queried how does shared learning come back if not there? CW said the triangulation would be with her. HW noted framework consultation feedback. MA said the framework is to pull learning from boroughs etc to the ICB. CW is still talking to providers and NHSE about access to LFPSE. MA noted important to keep the discussion. CW advised JD's for new organisation have patient safety heavily embedded. LC felt a whole meeting on this would be beneficial. We need to consider how we would do that. CD noted patient safety week next week. In terms of membership and the ToR, healthwatch is there, how else is the focus on patient experience? CW advised this will be considered. <u>CCPL</u> FM updated CCPL roles are changing as part of the MCR. Attendance at meetings will change. Not a specific quality lead CCPL going forward. Looking at what are the other determinants why patients are attending GP surgeries. As a system would be useful to have a discussion around this. Look again at this as a system issue. CW happy to support bringing an item back to this meeting for discussion. LC agreed, next meeting suggested. FM agreed. CW to note for Forward Planner.	

6. Quality Alerts/PII Noted change in terminology from SI to PII. CW gave the background to the new PII around patient harm or potential patient harm. Providers are transitioning to the new PII system. Cases being reported on STEIS are decreasing at the moment due to the new system. 6 x PII on system currently under review, will share learning at a future meeting. LC commented on QA access, massive issue and challenge for the NHS, industrial action effect noted as well. Communication to patients and GPs commented on. New trends and lack of oversight in the beginning but will have internal knowledge. HW commented on importance of looking at all data in a wider sense. This is about learning and improvement. CW said still a little bit of uncertainty how things will look. Themes and concerns group has been set up as part of our PSIRF transition.	
7. Radiology CW led the agenda item and gave the background to the issues. Several QA's had been submitted without response. Deep dive taken place. Report taken as read, CW noted the key highlights. These will be useful to keep a focus on the key issues and improvements. Significant increase in number of QA raised for Radiology. QA process is not mandatory, grateful when these are submitted. In 2022 55 alerts, 70 in 2023. Lewisham specific data noted. Highest reporting borough for this particular problem. 55 x QA Jan 2021- Feb 2024 raised. Overview of QA gradings given.	

Delayed test results, were 14 in that period. LC noted the difference in numbers compared to other boroughs, impact on patients acknowledged. Helpful to share separately to those in the meeting. IT team input noted. Do need to monitor this. CW advised she has spoken to Tom Hastings. CW suggested looking at this again in 6-12 months' time. Had been issues with IT and reports being sent back to GP surgeries. LC performance manage internally as well to CW. Noted Tom will be aware of this. AOS broader issues noted, PLT session recently plug for QA's and their importance given. Intranet site to be launched, would be good to have where to report QA prominent on this. JP acknowledged the importance of those conversations. Work on clinical reporting system being looked at. LC to CW please send presentation separately. Agreed Tom to be copied in as well. CW queried the Intranet AOS who advised it will be SEL wide with borough specific areas. CW noted the barriers and challenges, Tom's input has been instrumental. Had suggested a T&F group. Have also shared some of the learning from the Radiology QA's as well. LC noted the importance of T&F groups. CW mentioned it might be important to have a standing agenda item. CD said it was a really helpful example of bringing together data and probing what is happening and the learning. Also important for primary	CW

care as well. Not just about Radiology in isolation. LC said this was an important point. FM noted important to have the right people together to discuss these issues. LC advised would liaise with colleagues and would be best to consider the right people to be involved. CW had discussed previously with AOS. AOS advised previous meetings were chaired by FM, FLAG etc. over the years with various members.	
8. Reflective session LC spoke about the achievements and priorities for the next year. A doing group rather than a monitoring group. Liaison between Trust and primary care noted. CJ noted the original list. Priorities identified were quite specific, detailed and evolving. Reports from CW have been useful. Need to close off things and ensure actions do not get lost. LC suggested we chose our priorities on the data we see regularly, maybe three to be chosen. Need clear ownership. CJ spoke about digital exclusion. LC stated the need to be clear who else is doing what comment, monitor that and see if we have a role. Feedback is needed, albeit intermittently. LC queried others views? HW noted it does take a while to get going as a new group, plenty of topics for us to focus on. Set a couple of priorities, frequency of meetings as a doing group or T&F groups to feed into this group. IMc commented on how best to engage with the group as integrated commissioners.	

CW keen to have sub groups which feed into this group. Interface item shows this. There are a lot of pockets of work being undertaken. FM spoke about Ian Ross' informal mapping exercise on primary care quality aspects, essential if we are understand how to distribute time. CJ spoke about the focus on acute and primary care, mental health should be considered and community side, LA side as well. Ramifications for other parts of the system. LC agreed. Interface work is a key piece of work acknowledged LC. Significant improvements if we improve relationships. Mental health chosen as an area of focus. Deep dive community care over a period of months. CW said it was an opportunity for this group to feed back to the System Quality group. Have been looking at community care over the last two months. Report will be shared at a later date. Quarterly reports by July to be shared. CJ mentioned the All Age Mental Health Alliance, joined up conversation about concerns and what we can look at here. Community had been the focus of the last LCP Board seminar session. LC summed up. Do feel the group has evolved. Better conversations and refined data is being looked at. Mental health and then a focus on community services suggested. CD commented on SLaM work and the community model for Lewisham. Issues around anti-racist practice and working with BAME communities. Mental health issues for patients but are living well at the moment but no current care under the GP or SLaM and also the broader picture as well.	

CM agreed with CD, lot of work still to be done around carers, peer review next week in preparation for a CQC inspection. Accelerated reform fund SEL ICB bid is around carers, working with carers to facilitate discharge etc. other things have been short term or pilots. Community services and care homes lots of reports being pulled together and deep dives. There is working taking place around quality. CW said this was interesting and helpful to know. Care Home Liaison Lead in Bromley, have been working with her. Will discuss with CM offline. CM said we do need to have challenge as part of any discussions. CD advised can send through some information on carers and examples of what other areas are doing. LC agreed to continue with the interface work as well as carers and support. Also, community overview and any potential improvements. CM to provide detailed information on care homes. CW will prepare an agenda for next pre-meet with LC.	
9. Forward Planner Noted no comments.	
10. Escalations None to note.	
11. AOB/Date of next meeting No items raised.	

Notes and actions from Lewisham IQAG 8 March 2024 - APPROVED 28 June 2024

LC closed the meeting at 12.45 hrs. <u>Date of next meeting:</u> Friday 10 May 2024 at 11.00-13.00 hrs via Teams	