

Integrated Care Board – Meeting in Public

12.30 to 16.10 on 16 July 2025

Committee room 1 Civic Centre
Churchill Court 2 Westmoreland Road BR1 1AS

Chair: Sir Richard Douglas Chair SEL ICB

Agenda

No.	Item	Paper	Presenter	Timing
Opening Business and Introduction				
1	Welcome • Apologies for absence • Declaration of Interest. • Minutes of previous meeting actions & matters arising	A B	RD	12.30
Borough Showcase				
2	Bromley – Borough Showcase	-	ABh	12.40
ICB Corporate Business				
3	ICB Annual Report 2024/25	C	TF	13.10
Report for Assurance and discussion of current issues				
4	Chief Executive Officer's report	D p40	AB	13.15
5	Overall Report of the ICB Committees and Provider Collaboratives	E p63	TF	13.30
6	Board Assurance Framework	F p98	TF	13.35
7	Finance Report including 2025/26 budgets	G p123	MF	13.45
8	Performance Report	H p168	SC	14.05
9	Quality and Safeguarding Report	I p189	GK	14.25
Delivering our Integrated Care Strategy				
10	Development of our South East London Neighbourhood Health service	J p198	CJ	14.45

11	Primary and Secondary Care Interface	K p241	TG UG	15.00
12	Review of Winter 2024/25 – Urgent and Emergency Care	L p253	SC	15.25
Closing Business				
13	Any other business	-	RD	15.50
14	Public Questions and Answers	-	RD	15.55
CLOSE 16.10				

Presenters

RD	Sir Richard Douglas	ICB Chair
AB	Andrew Bland	ICB CEO
ABh	Dr Angela Bhan	Bromley Place Executive Lead
SC	Sarah Cottingham	ICB Director of Planning and Deputy CEO
TF	Tosca Fairchild	ICB Chief of Staff
MF	Mike Fox	ICB CFO
TG	Dr Toby Garrood	ICB Medical Director
UG	Dr Upaasna Garbharran	ICB Deputy Medical Director
CJ	Ceri Jacob	Lewisham Place Executive Lead
GK	Gwen Kennedy	ICB Chief Nurse

NHS South East London Integrated Care Board
Register of Interests declared by Board members and attendees
Date: 16/07/2025

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Sir Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy 2. Trustee, Place2Be, an organisation providing mental health support in schools 3. Trustee, Demelza Hospice Care for Children, non-remunerated role. 4. Non Executive Member Department of Health and Social Care Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	March 2016 June 2022 August 2022 April 2024	Current Current Current Current
Andrew Bland	Chief Executive	1. Partner is an NHS Head of Primary Care for Ealing (a part of North West London ICB)	Indirect interest	1 April 2022	Current
Sarah Cottingham	Deputy Chief Executive and Director of Planning	None	-	-	-
Peter Matthew	Non executive director	None	n/a	n/a	n/a
Paul Najsarek	Non executive director	1. Advisor to Care Quality Commission on their approach to local authority assurance 2. Board member, The Health Foundation 3. Chair of North Central London ICB 4. Trustee of Waythrough 5. Director, Paul Policy Practice Ltd 6. Advisor to DA Languages Ltd 7. Lead inspector on best value inspection, Warrington Council	Non-financial professional interest Non-financial professional interest Financial interest Non-Financial professional interest Financial interest Non-Financial professional interest Non-Financial professional interest	1 April 2022 1 March 2023 7 Oct 2024 1 June 2024 24 Dec 2021 1 July 2024 1 May 2024	Current Current Current Current Current Current 31 Jan 2025
Anu Singh	Non executive director	1. Chair, Black Country Integrated Care Board 2. North London Mental Health Partnership 3. Non-executive director on Board of Birmingham and Solihull ICS. 4. Independent Chair of Lambeth Adult Safeguarding Board. 5. Member of the advisory committee on Fuel Poverty. 6. Non-executive director on the Parliamentary and Health Ombudsman.	Financial interest Financial interest Financial interest Financial interest Financial interest Financial interest	2020 March 2022 April 2021 2020 April 2020	Current Current Current Current Current
Dr. Angela Bhan	Place Executive Lead, Bromley	1. Undertake professional appraisals for consultants in public health professional public health appraiser for NHSE 2. Very occasional assessor for CESR applications for GMC, on behalf of Faculty of Public Health Faculty of Public Health 3. Professional Public health advise given when required London Borough of Bromley.	Non-Financial Professional Interest Financial Interest Non-Financial Professional Interest	July 2022 July 2022 July 2022	Current Current Current
David Bradley	Partner member, mental health	1. Unpaid advisor to Mindful Healthcare, a small start up providing digital therapy 2. Wife is an employee of NHS South West London ICS in a senior commissioning role 3. Chief Executive (employee) of South London and Maudsley NHS Foundation Trust	Non-financial profession interest Indirect interest Financial interest	April 2019 July 2019	Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Andrew Eyres	Place Executive Lead, Lambeth	1. Director of Lambeth Southwark and Lewisham LIFTco. representing the class B shares on behalf of Community Health Partnerships Ltd with the aim of inputting local knowledge to the LSL LIFTco, for the following LIFT companies: Building Better Health Lambeth Southwark Lewisham Limited, Building Better Health Lambeth, Southwark Lewisham (Holdco 2) Limited, Building Better Health Lambeth Southwark Lewisham (Holdco 3) Limited, Building Better Health Lambeth Southwark Lewisham (Fundco 2) Limited, Building Better Health Lambeth Southwark Lewisham (Fundco 3) Limited, Building Better Health LSL (Fundco Tranche 1) Limited, Building Better Health LSL (Fundco Holdco Tranche 1) ,Limited Building Better Health LSL Bid Cost Holdco Limited Building Better Health LSL Bid Cost Limited, Building Better Health - LSL (Holdco 4) Limited, Building Better Health - LSL (Fundco4),	Non-financial professional interest	1 April 2013	Current
Tosca Fairchild	Chief of Staff	1. Partner is a Consultant in Emergency Medicine. Potential to undertake locum work. 2. Bale Crocker Associates Consultancy – Client Executive 3. Non-Executive Director, Bolton NHS Foundation Trust	Non-Financial Professional Interest Financial Interest Financial Interest	01 May 2022 03 May 2022 01 Dec 2023	Current Current Current
Georgina Fekete	Non Executive Member	Nothing to declare.	-	-	-
Mike Fox	Chief Finance Officer	1. Director and Shareholder of Moorside Court Management Ltd 2. Spouse is employed by London Regional team of NHS England 3. Treasurer of the PTA fo Friends of Green Lane Primary	Financial interest Indirect interest Non-Financial Personal Interest	May 2007 June 2014 16 June 2023	Current Current Current
Dr. Toby Garrood	Medical Director	1. Serac Healthshare Shareholder 2. Guy's and St Thomas' NHS Foundation Trust Employed as a consultant rheumatologist 3. London Bridge Hospital Private medical practice 4. Guy's and St Thomas' NHS Foundation Trust In my role I have received research grant funding from Versus Arthritis, Pfizer, Gilead, Guy's and St Thomas' Charity and NHSx 5. British Society for Rheumatology Honorary Treasurer 6. UCB Speaking honorarium 7. Abbvie Speaking honorarium 8. Frensius-Kabi Sponsorship for educational meeting	Financial Interest Non-Financial Professional Interest Financial Interest Non-Financial Professional Interest Non-Financial Professional Interest Financial Interest Financial Interest Sponsorship	01/04/2020 07/10/2009 01/01/2012 01/01/2015 01/04/2020 01/07/2022 24/02/2023 30/03/2023	Current Current Current Current Current Current Current
Ceri Jacob	Place Executive Lead, Lewisham	None	n/a	n/a	n/a
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists 2. Fellow of the Royal College of Physicians (Edinburgh) 3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Non-financial professional interest Non-financial professional interest Financial interest	1994 2000 April 2019	Current Current Current
Darren Summers	Place Executive Lead, Southwark	1. Wife is Deputy Director of Financial reporting at North East London ICB 2. Member of Guys and St Thomas Trust Council of Governors	Indirect Interest Non-financial professional interest	09/06/2006 July 2024	Current Current
Gabi Darby	Chief Operating Officer	Nothing to declare			

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Ify Okocha	Partner member, Community	- Chief Executive (employee) of Oxleas NHS Foundation Trust - Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care - Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital - Fellow of the Royal College of Psychiatrists - Fellow of the Royal Society of Medicine - International Fellow of the American Psychiatric Association - Member of the British Association of Psychopharmacology - Member of the Faculty of Medical Leadership and Management - Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2021 1996 1992 1992 1992 1985 1985 1985 1985	Current Current Current Current Current Current Current Current Current
Diana Braithwaite	Place Executive Lead, Bexley	none			
Debbie Warren	Partner member, local authority	- Royal Borough of Greenwich salaried Chief Executive transacting financially with the SEL - Lead London Chief Executive on Finance, also contributing to the London Councils lobby on such matters including health.	Financial interest Non-financial professional interest	December 2018 (acting in role from July 2017) March 2020	Current Current
Dr. George Verghese	Partner member, primary care	- GP partner Waterloo Health Centre - Lambeth Together training and development hub director - Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	2010 2022 2019	Current Current Current
Ranjeet Kaile	Director of Communications and Engagement	Non-executive Trustee - People's Health Trust Charity	Non-financial professional interest	April 2024	-
Gwen Kennedy	Acting ICB Chief Nurse	Nothing to declare	-	-	-
Philippa Kirkpatrick	CDIO	Director – inactive company Philippa Kirkpatrick Ltd in use prior to start of ICB role	Financial Interest	April 2022	-
Crystal Akass	CPO	Nothing to declare	-	-	-
Holley Eden	Director of Delivery – Neighbourhood and Population Health	Nothing to declare	-	-	-

Integrated Care Board meeting in public

Minutes of the meeting on 16 April 2025

Board Room, Kings College Hospital, Denmark Hill London

Present:

Name	Title and organisation
Richard Douglas [Chair]	ICB Chair
Dr Angela Bhan	Bromley Place Executive Lead
Andrew Bland	ICB Chief Executive Officer
Diana Braithwaite	Bexley Place executive Lead
Andrew Eyres	Lambeth Place Executive Lead
Georgina Fekete	Non-Executive Member
David Maloney	For Chief Finance Officer
Paul Najsarek	Non-Executive Member
Dr Toby Garrood	ICB Joint Medical Director
Ceri Jacob	Lewisham Place Executive Lead
Prof Clive Kay	Partner Member Acute Care
Dr Elizabeth Aitken	Acting Chief Nurse
Peter Matthew	Non-Executive Member
Dr Ify Okocha	Partner Member Community Services
Anu Singh	Non-Executive Member
Darren Summers	Southwark Place Executive Lead
Dr George Verghese	Partner Member Primary Care

In attendance:

Ranjeet Kaile	Director of Communications and Engagement
Tosca Fairchild	Chief of Staff
Sarah Cottingham	Executive Director of Planning and Deputy CEO
Philippa Kirkpatrick	ICB Chief Digital Information Officer
Rebecca Jarvis (item 2)	Director of Partnership Delivery & Sustainability Southwark
Alison Gowland (item 2)	Senior Clinical Fellow
Sehrish Baloch (item 2)	Programme Lead

- | | |
|-----------|---|
| 1. | Welcome and Opening Business |
| 1.01 | Sir Richard Douglas welcomed all to the meeting and thanked King's College Hospital NHS FT for hosting the event. |
| 1.02 | Apologies were noted from Prof Ian Abbs, Ben Travis, Debbie Warren, David Bradley and Paul Larrisey |
| 1.03 | There were no additional declarations of interest in relation to matters in the meeting. |
| 1.04 | The minutes of the previous meeting were approved as a record of the meeting. |
| 1.05 | The action log was reviewed. |



2. Southwark Borough showcase

- 2.01 Rebecca Jarvis, Alison Gowland and Sehrish Baloch provided an update on work to managing frailty in Southwark, explaining that frailty was a priority in the Partnership Southwark Health and Care Plan and informed the development of Integrated Neighbourhood teams. Frailty was not an inevitable consequence of aging and, with support, the growing population of over 65-year-olds in Southwark would be able to live longer and better lives, avoiding the need for long term support or emergency care and associated costs.
- 2.02 A pilot in Faraday Ward had been expanded to include the Walworth Triangle, an area of c21,000 residents with widespread social and economic disadvantages. The pilot team comprised a range of organisations from pharmacy to social prescribing. Patients who could benefit were identified via EMIS (patient record) searches, multi-disciplinary team meetings and screening surveys. The patients were then offered a comprehensive geriatric assessment which would then be shared with the patient's GP to inform planning around the patient's priority needs and concerns. So far the pilot had undertaken 55 referrals and 38 home visits, and in 27% of cases had allowed needs to be met so that outpatient appointments could be cancelled.
- 2.03 Anu Singh noted the absence of social care and asked if there would be any support for those returning home who found services difficult to navigate. She asked what approach the pilot was intended to test as distinct from previous frailty work in Southwark. Alison Gowland noted that the involvement of intermediate care services in the team had been very useful in linking to social care. Rebecca Jarvis pointed out that the work related to the wider integrated neighbourhood teams approach and was being undertaken on a 'test and learn' basis. Much of the work had relied so far on the commitment of a few individuals and it was now important to translate this into business as usual.
- 2.04 Peter Matthew noted that social housing accounted for 45% of housing in Southwark and asked how the NHS was working with housing departments and tenancy officers who would have information about frail and vulnerable people. Rebecca Jarvis noted that there was similar work in Lambeth which focused more on how people living with frailty might be detected in other settings such as social housing, and there were plans in Southwark to meet with colleagues in a local housing estate to explore these opportunities and there had already been a social prescribing link worker contributing to the team.
- 2.05 Ceri Jacob welcomed the potential of work on frailty to reduce the gap between frailty services and end of life care. As the work continued some practical measures of progress would be important for example measuring how many people were able to stay in their own home rather than a care home.
- 2.06 Dr Toby Garrood asked whether an outcomes framework for the work had been developed and aligned with other frameworks across south east London and whether there was a common definition of the 'mild medium and severe' frailty.
- 2.07 Dr Ify Okocha noted the apparent focus on mild to moderate frailty and asked how the work would help ensure those with severe frailty were better managed in the community leading to a reduction of emergency hospital presentations as well as reduction in outpatient appointments. Alison Gowland noted that identification of those with severe frailty was challenging and that examples of ways to identify and interventions from elsewhere were being reviewed.



2.08	Prof Clive Kay noted that the excellent work delivered so far seemed to have a significant workforce requirement and asked if the pilot would evaluate how this would work over a greater scale, and whether this would increase the productivity of the whole system.
2.09	Paul Najsarek asked how the current pilot work would 'scale up' over. Sehrish Baloch noted that the initial plans to roll out to six practices had required some adjustment in recognition of the importance of establishing relationships and a feedback loop to local practices as part of the work. Alison Gowland added that there as a broad question about whether to deepen support for a particular cohort or expand existing provision across a wider area.
2.10	Dr George Verghese reflected on the financial reality of the NHS was obliged to consider whether the best value was being provided; for example did the work focus on the right population, with the right care model, and not create inequity between different areas. The focus would necessarily be broadening services to other areas rather than providing a higher level of service in a particular area. The Board would need to be able to demonstrate that it was able to shift resource away from hospital.
2.11	Darren Summers advised that the work was contributing to a south east London frailty framework expected to include more detail on how the success of the work would be measured, and recognised that sharing information for example from housing services with social care and health and that organising work into neighbourhoods and integrated neighbourhood teams was an opportunity to work in a different and more integrated way, but the lessons of the current work had shown that the development of relationships was key and took some time, although other learning such as how to access data could be applied more quickly at scale.
2.12	Andrew Bland pointed out that the Board had agreed a focus on frailty, children and young people and long-term conditions and that this work was still developing, and current pilots should be seen in the context of their operation within the constraints of the current system, but at the same time there was a desire to re-imagine the system itself which could involve larger scale changes to financial flows and contracting. He emphasised the importance of local neighbourhoods and making use of local community assets to build a sense of community ownership
2.13	Sir Richard Douglas agreed with the importance of building on current initiatives but also previous discussions about how the limitations of the current handling of costs between hospitals, community and primary care and the need to consider approaches for a future neighbourhood health context.
2.14	The Board noted the Southwark Borough showcase.
3.	Equality, Diversity and Inclusion reports
3.01	Tosca Fairchild presented the report detailing the ICB's Equality, Diversity and Inclusion work within the organisation, in providers and at Place. A range of activities demonstrated the boards commitment to reducing all inequalities extending beyond protected personal characteristics to include for example the social impact of deprivation and digital inclusion.
3.02	Statutory reports for the organisation showed increase in inequalities overall shown in the Public Sector Equalities Duty report. There had been an improvement in the



	Gender Pay Gap calculation, an improvement in the Equality Delivery system (completed this year with a focus on paediatric dentistry) from 'developing' to 'achieving'. A summary of the reports of the ICB as an organisation (including Workforce Standards in relation to Race Equality, Disability Equality and Sexual Orientation) showed some improvements and more work to do with actions outlined. All providers and the ICB had an anti-racism strategy. Equalities Objectives for 2025 had been set and the EDI team would work to support the actions, equality impact assessments on the ICBs work and work with the ICBs staff networks, whose contribution had been invaluable.
3.03	Peter Matthews noted the large amount of work and actions but asked how the Board would measure positive progress on EDI.
3.04	Anu Singh suggested that WRES data suggested actions taken to improve recruitment were not working, and asked what action should be taken in response.
3.05	Georgina Fekete asked what the Board itself might do to help progress, and if it would be possible to identify one action which would make the biggest difference.
3.06	Ranjeet Kaile pointed out a difficult context globally and nationally for EDI work and asked if this was having an effect.
3.07	Sir Richard Douglas emphasised the need to continue the Boards commitment to the work, and to track improvement using indicators such as the NHS Staff survey. All areas of the ICB's work should be underpinned by a consideration of the impact of inequalities and effort to reduce them.
3.08	Tosca Fairchild stated that the Board could help by continuing to support the work and show solidarity with those working on equality and diversity.
3.09	The Board noted the Equality, Diversity and Inclusion reports
4	2025/26 Operational Plan
4.01	Sarah Cottingham presented the 2025/26 system operating plan which comprised plans responding to specific national priorities from the ICB and the five major providers in south east London. In the plan, the system committed to break even financially and meet national performance standards in relation to A&E, referral to planned care, the cancer faster diagnosis standard and the 62-day target for the wait between urgent suspected cancer referral and the start of treatment (for pathways starting in south east London).
4.02	The financial plan depended on workforce plans including reduction of bank and agency rates and workforce reductions, and productivity improvements with the aim of delivering 72% of the opportunities identified for south east London by NHSE. The objectives were ambitious and associated with risk in relation to income, cost pressures and delivery of cost improvement programmes (CIPs), pathway flow, and the ability of a reduced workforce to deliver and monitor the changes needed. NHS England had provided feedback on the plan, asking for more reassurance on the identification of CIPs and mitigation of risks, as well as checking the underlying assumptions on workforce and productivity. It was not expected that this feedback would require the main commitments in the plan to change.
4.03	



4.04	Anu Singh asked about the additional assurance requested by NHS England given the ICB Board's previous approval. Sarah Cottingham pointed out that, in common with NHS England, partners across south east London would also wish to continue improve confidence in the delivery of the plans that had been submitted, identify detailed schemes and mitigate risks. Paul Najsarek alluded to the significant scale of the ICB's plans and associated risks and asked that the Board be kept informed of progress through the year as well as how it was achieving the 'three shifts' proposed for the NHS (shifting care from hospitals to communities; making better use of technology in health and care; and focusing on preventing sickness). Sarah Cottingham shared examples of productivity and efficiency work which would also contribute to the shifts; for example, work on community alternatives, urgent community response, virtual wards, and criteria to admit audits. Action
4.05	Georgina Fekete asked for an overall table of allocations to providers and boroughs, which differentiated acute, community and mental health spend and asked about the refresh of the joint forward plan. Action
4.06	Sarah Cottingham noted that the start budgets would provide details of the allocations, and this would be aligned with commitments made in the medium-term financial strategy. A light-touch refresh of Joint Forward Plans had been requested pending a more substantial refresh expected after the release of the NHS 10-year plan.
4.07	The Board noted the update on the 2025/26 Operational Plan.
5	Chief Executive Officers report
5.01	Andrew Bland referred to the report, highlighting to the Board the updates on the Primary Care Access Recovery Plan and the Mental Health Intensive & Assertive Outreach Review. The government had announced the abolition of NHS England and had asked for a 50% reduction in NHS provider corporate cost growth and a 50% reduction in the ICB running costs. By June 2025, all ICBs were asked to submit cost reduction plans. South East London ICB already had a lower cost per head of population than many other ICBs and therefore may not need to reduce by 50%. ICB staff had responded with professionalism and had been kept informed via well-attended staff briefings. An enhanced support offer for colleagues had been arranged including practical and wellbeing support.
5.02	Prof Clive Kay reflected on the challenging situation and welcomed work to support staff affected. Co-ordination seemed necessary to preserve system capacity for example by prevent all providers focussing on reducing the same function and wrongly assuming it could be supported elsewhere.
5.03	Andrew Bland noted that opportunities were being taken to share expertise across organisations such as the Chief People Officer role, the ICB recognised that many staff were jointly employed by Local councils and the ICB, and there may also be further opportunities to share resources not only with Providers and councils but neighbouring ICSs.
5.04	Sir Richard Douglas pointed out the difficulty of creating the incentive for participation in sharing arrangements for organisations needing to make their own savings even where sharing would be more cost effective.



5.05	Sarah Cottingham noted there were some areas where all parts of the system had a commitment and responsibilities such as safeguarding, as well as some areas where there may be duplicated resources working on similar areas for example on contracts where there might be opportunities to work across organisations.
5.06	Georgina Fekete emphasised the Boards recognition of the challenge faced by the organisation and its staff and desire to be kept informed and help where possible.
5.07	Ranjeet Kaile reported that staff seemed to appreciate the transparent nature of communications so far. The changes were an opportunity to continue to clarify how the ICB worked with its partners.
5.08	The board noted the CEO Report and the update on progress on the. Primary Care Access Recovery Plan and the Mental Health Intensive & Assertive Outreach Review.
6	Overall report of committee and provider collaborative
6.01	Tosca Fairchild referred to the report of the activities of committees and drew attention to the three decisions escalated to the board for its decision.
6.02	Andrew Eyres asked for a correction to the names of co-chairs of Lambeth LCP listed in the report.
6.03	The Board noted the report and • approved the revised Terms of Reference for the Greenwich Charitable Funds Committee. • approved the revised Scheme of Reservation and Delegation. • approved the revised Terms of Reference for the Integrated Performance Committee.
7	Board Assurance Framework
7.01	Tosca Fairchild presented the Board assurance framework noting that the risks had been subject to discussion in the executive committees of the Board. Since the report was produced any potential risks to the ICBs objectives associated with the national changes were being assessed and would be included if necessary. A system risk group helped to co-ordinate any risk across the system.
7.02	Georgina Fekete asked if risks associated with cost improvement plans and finance had been included. Sarah Cottingham noted that the risks at the time of report related to the 2024/25 and the risks associated with the 2025/26 plans would be assessed and escalated if necessary.
7.03	The Board approved the Board Assurance Framework
8	2024/25 Month 11 Finance report
8.01	David Maloney referred to the report setting out the position for the ICB and providers. The ICB had been asked to achieve a break-even position after factoring £100m deficit support funding. At Month 11 position the ICS was off-plan by £5m but continuing to forecast a break-even position by the year end. The most recent information indicated a small £0.5m surplus to plan would be achieved at year-end.



8.02	Sir Richard Douglas noted for clarity that the slight surplus was only achieved following the receipt of deficit support funding by the ICS.
8.03	Andrew Bland expressed thanks to the finance team and to teams across the system who had overcome a very significant challenge in successfully reaching the planned position.
8.04	The Board noted the 2024/25 Month 11 Finance report.
9	SEL System performance update
9.01	Sarah Cottingham referred to performance overview report, based on a detailed report considered by the ICB's executive committee, highlighting that: • Acute services continued to experience pressures over winter, exacerbated by some reductions in bed capacity due to infection prevention control issues but had delivered a stronger performance than for the same period of the previous year. • Cancer performance showed good progress on recovery around 28 day standard and faster diagnosis standard, with continuing challenges on the 62 day performance target. • Referral to treatment continued to be challenged in relation to 65-week waits but had made more positive progress on longer waits, partly due to community alternatives which had been commissioned. • Diagnostic services, a crucial enabler to cancer and referral to treatment work, also faced challenges but clear improvement plans were in place • Learning disability and mental health service performance included positive improvements in eating disorder referral metrics, but some challenge around other areas such as physical health checks. • Mental health crisis challenges - including long ED waits for those with mental health conditions - had been outlined in a separate section of the report and included work with both mental health and acute sector involvement to improve flow and reduce out-of-area placements. • The ICB was currently on track to meet learning disability in-patient targets and physical health checks for people with learning disability. • Waits for autism assessments were a key challenge but in mitigation work was progressing on a single point of access as well as an ongoing accreditation process for new providers under the right-to-choose arrangements. • Primary care data showed a large amount of activity, narrowly missing the two-week access target. • No significant changes to CHC 28-day assessment performance although some positive signs. • Urgent Community Response performance on 2-hour response and virtual ward activity was below plan but showing improvement each month. • Community waits continued to improve although there were hotspots in particular areas. Performance was still largely measured by process or access national targets, although the intention was to incorporate more population health and outcome data.
9.02	Prof Clive Kay suggested that as reporting moved focus to outcomes it should do so through the lens of health inequality.



9.03	Sir Richard Douglas noted a future board discussion planned on UEC and noted diagnostic performance and primary care as future areas the Board may wish to consider. Sarah Cottingham advised that providers faced a significant amount of scrutiny on diagnostic performance including weekly meetings.
9.04	Peter Matthew noted in relation to a discussion on primary care and its future the downstream effects should be considered, for example if patients were unable to book an appointment and attending emergency departments.
9.05	Andrew Bland agreed that 'missed opportunity' audits showed more detail about the choices made by those attending emergency departments suggested that uptake of alternatives such as community pharmacy could be improved.
9.06	Dr George Verghese suggested that there was work internally for primary care to adopt modern general practice but also noted that a narrative of access difficulties was not always borne out by the data. Sir Richard Douglas noted data on performance and differences would be useful as small areas of poorer performance may drive a perception of the whole.
9.07	Dr Ify Okocha noted that virtual wards should hold only those patients who otherwise would be in hospital, and it was important to ensure that the right clinicians were available for the patients needs. In addition to a single point of access there was a role for assessments in people's homes with a view to admission to a virtual ward if appropriate.
9.08	Sir Richard Douglas asked if there had been an evaluation of the effectiveness of virtual wards. Dr Toby Garrood noted that there had been an external evaluation showing that the wards were cost effective and able to help relieve pressure on ED but the data was being examined to better understand the acuity of patients being held in virtual wards.
9.09	The Board noted the SEL System performance update.
10	Quality and Safety Report Quarter 3
10.01	Dr Liz Aitken presented a quality and safety report for quarter 3 • Two 'never events' had been reported in relation to surgery, with investigations ongoing in the relevant trust's patient safety improvement plan focusing on improvements. • 74 Patient Safety Incident Investigations (PSIIs) had taken place with the key themes being delay in treatments and delayed diagnosis. • A pilot to implement the Patient Safety Incident Response Framework (PSIRF) in general practice had concluded its first year and would shortly report to inform the wider roll out. • A safeguarding leadership programme had been launched by the ICB working with the King's Fund and had been launched to provide opportunities for safeguarding practitioners to develop leadership skills. • The Local Maternity and Neonatal System (LMNS) had undertaken a deep dive into perinatal mortality, in response to a rise in figures across London. • Continuing care performance had improved and governance had been strengthened with a risk dashboard, refreshed policies and procedures and a handbook had been developed.



10.02	Paul Najsarak noted that the Audit committee had noted some delays in relation to actions recommended by internal audit in relation to continuing healthcare audits and asked about progress. Peter Matthew advised of an improved position which the Audit and Risk committee would continue to monitor.
10.03	Prof Clive Kay asked how the learning from 'Never Events' was being shared across the system, in a formal way which would be raised at executive level in other trusts. Dr Liz Aitken noted that regular forums such as the themes and concerns group were attended by provider representatives to share learning, and a series of quarterly more workshops was underway to explore how the learning was fed back in a more formal way.
10.04	The Board noted the Quality and Nursing Report for Quarter 3.
11	Development of Neighbourhoods and Integrated Neighbourhood teams in SEL
11.01	Ceri Jacob outlined progress on the neighbourhood health service following the Boards previous support for the direction of travel. The programme was now moving to implementation organised into five workstreams, overseen in each Place the local care partnership but supported by a south east London Neighbourhood-Based Care Board to co-ordinate, share best practice, and work with existing SEL committees and boards. Twenty-five neighbourhoods had now been identified across the six south east London boroughs and would work with three population groups: people with frailty, children and young people and people with three or more long term conditions. Work with these groups was thought to have the greatest potential for improvement in outcomes, in reduction of inequality and in positive impact on system financial sustainability. Boroughs were already undertaking actions and the board had previously heard some of the work in Bexley and Southwark on frailty. The ICB was working with London on work to identify 'Integrators' capable of supporting integrated neighbourhood working and teams in each place, with a suggestion from the NHS national team that there could be 'place providers' in the future. A draft set of function and form principles giving a guide to the requirements of these integrators had been produced. Risks included the context of structural changes and financial constraints for all providers and the ICB which would affect capacity, although the potential for the neighbourhoods to contribute to financial sustainability was being explored by the system sustainability plan.
11.02	Paul Najsarek asked what differences patients would see in the service they received as a result of the work, and if this could be measured and included in regular reporting. Ceri Jacob explained that whilst there would not be large changes in the next year as the programme was initialising, however with the development of frameworks local people should soon start to notice that health and care was more co-ordinated and proactive in the management of long-term conditions, as well as addressing wider social factors such as helping people who were unemployed due to health conditions.
11.03	Georgina Fekete asked how the outcomes created by the programme would be measured, including health improvement and cost savings. Ceri Jacob noted that frameworks being developed would set out a range of measures and outcomes by which progress would be measured, however the development of a Population Health Management function would be a key enabler to help measure this consistently, as this currently varied between places.



- 11.04 Anu Singh noted one of the risks identified that the NHS ten-year plan once released could suggest a significantly different approach. To mitigate this the programme would need to build in sufficient flexibility to align with national plans. Ceri Jacob noted the main risk was capacity in terms of people, relationship building however the restructure of ICBs was currently taking this into account and would involve working with provider partners.
- 11.05 Dr Angela Bhan advised that some impact was already being seen for example in Bromley 550 clinical patient assessments and 1000 follow-ups undertaken through an integrated care model over the last six months had improved frailty scores by 41% in addition to patients themselves reporting improvements in health and wellbeing. Integrated work with children and young people through hubs had led to 20% reduced attendance in primary care in the six months following triage and specialist care in the community.
- 11.06 Sir Richard Douglas proposed that it was important to identify and measure progress against specific improvements in outcomes for each of the three population groups, rather than benefits which might arise unintentionally or process measures only. Detail on the south east London frameworks in frailty and the other areas and how they would create consistency across the boroughs would also be useful.
- 11.07 Ceri Jacob confirmed that although boroughs plans may vary because of the different size of population groups in each borough, the aims of the frameworks would be the same for all boroughs, and would identify the outcomes by which success would be measured. Andrew Bland added that the frameworks should allow local flexibility on a 'comply or explain' basis but provide a common standard to help measure progress. The neighbourhood based care board could consider the desired outcomes and timescales working with non-executives, but there should also be consideration of wider outcomes such as reducing economic inactivity which would need to involve local government and other partners.
- 11.08 Sir Richard Douglas reflected that similar aims had been held by health and care systems held for some years, and the theoretical case for change was accepted. Practical success depended on all parties contributing and so he asked if the incentives for each organisation were sufficiently aligned for them to participate fully. Ceri Jacob noted that there was a marked change and increased enthusiasm from all partners to be involved in the work despite internal pressures in each organisation.
- 11.09 Dr Ify Okocha reinforced the importance of clear measurement of outcomes that must enable the reprioritisation of existing funds away from hospital and towards community approaches, in recognition that there was no additional money available to the system.
- 11.10 Dr George Verghese suggested that all partners would need to 'change together' and each recognise their responsibility for the work. The benefits of working through neighbourhoods would need articulating but also a definite and clear expectation for all partners, including secondary as well as primary and community care, and followed through in the way all funds were prioritised.
- 11.11 Philippa Kirkpatrick shared from insight from the Board tour of the hospital where secondary colleagues involved in projects to transfer activity to the community pointed out that success would lead to a perceived drop in their own work rate. The



	more the programme scaled up, the more important it would become to resolve perverse incentives of this kind. Sir Richard Douglas suggested that a consideration of incentives should form part of the next update on enablers.
11.12	Andrew Bland added that an 'integrator' would be a key feature of each Place, but would need to be identified based on local agreement about the current partner best placed to offer support to the system, rather than a procurement process to set up a new entity or tier in the structure. Therefore, early agreement on the leadership in each Place could accelerate the work, but conversely a competition or dispute about the appropriate integrator could delay progress by some years. The future integrator was also being considered as part of the process of ICB cost reductions.
11.13	The Board noted the update,
12	Winter Vaccinations Performance and Approach
12.01	Dr Angela Bhan presented work being done on vaccination programme focusing on flu, Covid and RSV vaccination. Vaccinations were a key preventative programme of work which was commissioned by NHS England and delivered in SEL London ICS by the SEL immunisation service with a co-ordinating SEL immunisation board, supported by operational sub-groups. It was important to recognise that interest in vaccinations amongst the public as well as in schools and general practice was varied, and data showed a general drop in uptake of vaccinations well as a worsening of inequality in the uptake for example poor vaccination rates for those living in less wealthy areas. SEL along with the rest of England appeared to be affected by 'vaccine fatigue'; an unwillingness to undergo continuing vaccinations. A strong engagement campaign and resources for learning had been put in place and continued to be refined through feedback- for example, a campaign highlighting the additional risk for people for example with diabetes had not been effective and so work was continuing with local people to build trust and attract ambassadors from within local communities. Some successful work included providing vaccinations at healthcare settings people attended for other reasons such as dialysis clinics, and a project started with the aim of calling pregnant women to talk about RSV vaccination had additionally resulted in an increase in flu and covid vaccinations.
12.02	Sir Richard Douglas welcomed the work being undertaken but asked what specific level of ambition was set in relation to improving uptake of vaccinations.
12.03	Tosca Fairchild pointed out that in vaccinations, as across many other areas of prevention, the Black community seemed from the evidence to be experiencing inequalities.
12.04	Prof Clive Kay commented on the adverse impact of the previous mandatory approach to Covid vaccination on take up by NHS staff and suggested that some retrospective review of the reasons why people were refusing vaccination would be necessary to guide the actions taken by the Board.
12.05	Darren Summers suggested it was clear that current communications were not working to increase vaccination, and the rates of Covid vaccination had tailed off dramatically. He asked whether the risks of not being vaccinated should be more clearly and bluntly set out in messaging.



12.06	Dr Toby Garrood asked what more secondary care could do to take the opportunity of people already attending a healthcare setting to administer vaccinations if necessary.
12.07	Ceri Jacob commented that the Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) research had shown the greater effectiveness of personal stories rather than numbers in improving uptake, and in recognition that more work was needed in relation to these inequalities Lewisham Place was working strategically with partners including the voluntary sector across the range of services beyond vaccines.
12.08	Dr George Verghese noted that the RSV vaccination work seemed to have been more successful in reducing respiratory illness and suggested the board may consider whether the best use of resources would be to maximise effort in such areas where there was the possibility of making progress.
12.09	Sir Richard Douglas proposed that a review of issues in access for Black African and Black Caribbean communities on a range of preventative areas should be brought to a future board seminar, and that the board be updated with details of the ambition in relation to the vaccination programme. Action
12.10	The Board noted the update.
13	Any Other Business
13.01	There was no other business.
14	Public Questions and Answers
14.01	<i>A member of the public asked how companies such as Heartstone Group could access opportunities for contracts to provide needed services to patients. Sarah Cottingham noted that an accreditation process was run by the ICB to support patients Right to Choose.</i>
14.02	<i>A member of the public asked in view of the abolition of NHS England and the reviewed importance of ICBs whether more information could be made available to the public on how they fitted in the overall governance structure.</i>
14.03	<i>A member of the public noted from the previous Board a reference to 4% savings being considered a safe level of savings and compared it to the current plans for 5% savings. Given the risks involved and the reference to quality impact assessments being made, the question was asked when these assessments would be published.</i>
14.04	Sir Richard Douglas clarified that cost improvement programmes were efficiencies rather than a 4% cut of services. Prof Clive Kay noted that the cost improvement programmes would present a challenging but that each trust would have a process in place to ensure that any programmes of efficiency were safe.
	Close



NHS South East London Integrated Care Board

ACTION LOG

REFERENCE	DATE ACTION AROSE	ACTION DESCRIPTION	STATUS	ACTION OWNER	DATE FOR COMPLETION	UPDATE/NOTES
ICB 011	16-Oct-24	Consideration of how regular reporting received by the board might allow them to monitor inequalities in relation to performance items	open	SC/AB	19-Mar-25	to be brought to September informal meeting
ICB 014	29-Jan-25	Executives to explore overall quantitative targets for reducing Mental Ill Health in south east London, and update on work to explore variation in numbers known to services in inner/outer London.	open	Executives	16-Apr-25	Ongoing via committees
ICB 016	29-Jan-25	Board to receive an update on UEC and system performance over winter 2024/25, to inform future planning with lessons learned.	to be closed	SC/AB	16-Apr-25	On the July agenda
ICB 018	29-Jan-25	For the ICB Audit committee to receive assurance on the governance in place in SEL organisations in relation to the Sexual safety and domestic violence charter.	open	PM	15-Oct-25	Audit committee has not yet had an opportunity to schedule this item.
ICB 019	16-Apr-25	To provide a breakdown of allocations to providers and boroughs, which differentiates acute, community and mental health spend	to be closed	MF	16-Jul-25	Start budgets for 2025/26 have been provided to the board as part of the finance papers.

ICB 020	16-Apr-25	To consider how the three shifts were being achieved throughout the year (shifting care from hospitals to communities; making better use of technology in health and care; and focusing on preventing sickness)	to be closed	AB/SC	ongoing to Mar 2026	We will be refreshing our medium-term strategy in the context of the national 10 year Plan for the NHS over the autumn period. This will include the development of strategic delivery plans and outcomes related to the three key shifts highlighted as vital in driving the overall ambition set out in the 10 year Plan – from acute to community based care, from cure to prevention and from analogue to digital. For 2025/26 we have tracked our investment plans for the year by area and against our medium term financial strategy, with a demonstrable increase in relative investment in community based care and inequalities. We will be tracking delivery of our agreed priorities and actions over the year as well.
ICB 021	16-Apr-25	To consider further to the presentation of progress on the vaccinations, what the ICB's level of ambition should be in relation to delivery.	open	ABh	16-Jul-25	The south east London Immunisation and Vaccination board has undertaken a discussion on what a realistic ambition may be in relation to increasing vaccination uptake.
ICB 022	16-Apr-25	Review of access issues faced by Black African and Caribbean communities in a range of health and disease prevention areas using	open	TG/TF	28-Jan-26	Ongoing expected to take 6 months
ICB 023	16-Apr-25	To consider the publication of Equality Impact Assessments (EIAs) in relation to Cost Improvement Programmes (CIPs) in south east London	to be closed		29-Jan-26	Providers include a comprehensive consideration of the impact of potential Cost Improvement Plans from an equity and quality perspective as part of their CIP planning process. These assessments are used to inform decisions on which CIPs will be taken forward as part of the annual operating plan, with an expectation that provider governance arrangements will ensure the proactive use of equity and quality assessments in decision making. In year monitoring and management of performance, quality and outcomes, including by the ICB, enables further assurance around the maintenance of standards in these areas and the identification of any issues. As part of the CIP process, we have also agreed that providers will specifically share with system partners any CIP proposals that have a potential impact on the wider system, to enable a collective discussion on understanding and mitigating associated risks.

ICB Board Meeting in Public

Title	2024/25 ICB Annual Report and Accounts					
Meeting date	16 July 2025	Agenda item Number	3	Paper Enclosure Ref	C	
Author	David Maloney, Director of Corporate Finance Julie Witherall, Director of Financial Management					
Executive lead	Mike Fox, Chief Finance Officer & Tosca Fairchild, Chief of Staff					
Paper is for:	Update	x	Discussion		Decision	
Purpose of paper	The purpose of the paper is to present to the Board at a meeting held in public the ICBs audited annual report and accounts for 2024/25.					
Summary of main points	The South East London ICB annual report and accounts for 2024/25 is presented to the Board in line with NHS England guidance, which requires presentation at a meeting held in public by 30 September 2025. The audited annual report and accounts were submitted to NHS England on Friday 20 June 2025, ahead of the deadline of Monday 23 June 2025, following the issue of an unqualified opinion by the ICBs external auditors. The annual accounts reported achievement of all the ICBs financial duties and targets for 2024/25 and were commended by the external auditors for their high quality. The annual report includes a new section on climate related disclosures which is required for this year, and the report will be used by NHS England as a principal source of assurance for the ICBs annual assessment. The ICB is required to publish the annual report and accounts on its website by 30 September 2025. A summary annual report for ease of reading will also be produced and published.					
Potential conflicts of Interest	Not applicable.					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Not applicable					
Financial Impact	The accounts report the financial performance of the ICB for the 2024/25 financial year.					
Public Patient Engagement	The annual report and accounts are required to be presented at a meeting held in public by the end of September 2025. This report presented at the Board meeting held in public meets this obligation.					
Committee engagement	The draft and audited annual report and accounts were reviewed and approved for submission by the ICB Audit & Risk Committee, in line with the ICB's scheme of reservation and delegation.					
Recommendation	Board members are asked to note the ICB 2024/25 annual report and accounts update.					

2024/25 Annual Accounts and Annual Report

NHS South East London Integrated Care Board
(ICB) 16 July 2025

1. Introduction

- 1.1. The purpose of this paper is to provide an update for the Board on the ICB annual accounts and annual report for the year ending 31 March 2025.

2. Submission of Annual Accounts and Annual Report

- 2.1. The final, audited ICB annual accounts and annual report, together with all required supporting documentation, was submitted to NHS England in advance of the national deadline of 9am on 23 June 2025.

3. Governance Arrangements (including the external audit) of the Annual Accounts and Annual Report

- 3.1. The annual accounts and annual report were presented to the ICB Audit & Risk Committee on 19 June 2025, for approval under delegation from the Board. The ICB's external auditors presented their Audit Findings Report and Annual Audit Report to the committee members at the same meeting, noting an exceptionally effective audit and high quality of accounts. An unmodified opinion to the accounts was proposed. On this basis, the Audit & Risk Committee approved the annual accounts and annual report.
- 3.2. The ICB has received an unqualified opinion on the annual accounts from its external auditors. Specifically:
 - An unqualified opinion on the financial statements
 - Regularity - the expenditure and income recorded in the financial statements had been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them
 - Nothing to report in respect of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources



- 3.3. There were two unadjusted audit differences in the ICB's annual accounts. The ICB estimated the costs of prescribing accruals for 2 months of the year and the actuals when received differed by £1.2m (overstatement) and similarly the ICB estimated additional accruals of £4.2m for prescribing and CHC accruals which the auditors determined were found to have no confirmed liability at the balance sheet date and agreed these transactions should be considered separately and not extrapolated. Management agreed with the audit team not to adjust for these as they were estimation errors which were not material on expenditure of circa £5bn. (Refer to ISA 260 Report).
- 3.4. Aside from the usual presentational changes agreed with our external auditors, the final audited annual accounts were consistent with the draft accounts submitted at the end of April 2025.

4. Financial Performance of the ICB

- 4.1. The ICB achieved all of its financial duties/targets for the financial year 2024/25. These are summarised below:
- An underspend against the overall resource limit of £87k
 - An underspend against the running cost allowance of £4.2m
 - Delivered all targets under the Better Payments Practice Code (BPPC)
 - Subject to the usual annual review, delivered its commitments under the Mental Health Investment Standard (MHIS)
 - Delivered its year-end cash book position, well within the target cash balance

5. Annual report

- 5.1. The annual report has been produced in accordance with NHS England and Treasury guidance. The contents have been sourced from departments across the ICB in order to reflect the breadth and depth of the collaborative work that has taken place across our six boroughs, whilst at the same time ensuring the annual report is more accessible and user friendly. A balance has been sought between providing the right level of detail and information to give readers a flavour of the ICB's activity and achievements in the year whilst also meeting the content requirements specified in the guidance from NHS England. Of note, following the phased approach from HM Treasury to incorporate recommended Task Force on Climate-related Financial Disclosures (TCFD) this year, a significant section on the ICBs approach to environmental sustainability and management of climate-related risk has been included for the first time in the 2024-25 annual report.
- 5.2. The report has been reviewed as part of the external audit process with no material matters of concern noted. The relevant information included in the remuneration and staff report sections has been fully audited, and this has been noted in the report.
- 5.3. As in previous years, the draft annual report (approved for submission by the ICB Audit & Risk Committee in April 2025), has been used by NHS England as part of the portfolio of evidence to complete the ICB's annual assessment of delivery against its statutory obligations. The outcome of this assessment is anticipated in late July.
- 5.4. In addition to the full annual report and accounts, published in line with guidance, a summary of highlights will be published for ease of reference, and is included as an appendix to this report.

6. Conclusion

- 6.1. SEL The final, audited versions of the annual accounts and annual report will be made available to view on the ICB's website in line with the 30 September 2025 deadline set by NHS England. The report will be available here:
<https://www.selondonics.org/icb/meetings-board-papers-reports/reports/>
- 6.2. The requirement to also present the annual report and accounts at a meeting of the ICB held in public by this date is being met through delivery of this report to the ICB Board.

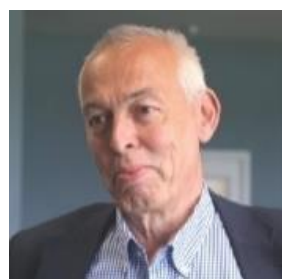
Annual Report - summary

Our Year 2024/25

Welcome to our Annual Report summary 2024/25

The purpose of the Annual Report is to show how we have discharged our functions and statutory duties in the last financial year.

Our operational performance improved in 2024/25 on most key metrics compared with the previous year. But it is still nowhere near where we would all wish it to be. Waiting times improved broadly in line with plans, but only 59% (54% in 2023/24) of patients are receiving elective care within 18 weeks with the NHS standard of 92%. 74% (72% in 2023/24) of patients waited four hours or less in A&E compared with the NHS standard of 95%. Our cancer work has focused on improving performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 as part of achieving the 80% ambition by March 2026, and improving performance against the 62-day referral/upgrade to treatment target to 70%. We are on track on both of these metrics. For mental health, we have seen consistent improvement in performance, particularly relating to children and young people and access to community services.



Sir Richard Douglas,
Chair



Andrew Bland
CEO

Our financial position remains difficult but is improving. As a health system, we spent a total of £4,886m in 2024-25. We are the most over-target system in the country in terms of our fair share of resources and received funding outside normal allocations of £100 million to cover the deficit at King's College Hospital NHS Foundation Trust. For these reasons, we cannot expect our financial issues to be resolved through additional income, as our allocation will grow at less than the average for the NHS for the foreseeable future. In 2024/25 we met all our financial duties but did this in a manner consistent with our long-term financial strategy of ensuring financial sustainability while re-balancing spending from physical to mental health, from hospital to community and from cure to prevention.

Both operational and financial performance were affected in 2024/25 by industrial action across the NHS and specifically in south east London by a cyberattack on our main pathology provider.

It is important that we do not just focus on in-year performance – important though this is – and this report also aims to show how we are working with our partners to improve health and care in the future through our Integrated Care Strategy and other work focused on long-term sustainability and transformation.

2025/26 will be a year of both continuity and change.

Continuity, as we press on with our programme of work to improve operational performance and financial sustainability supported by the government's three shifts: from hospital to community; cure to prevention and; analogue to digital.

Change, as we respond to the planned refocusing of ICBs and associated reductions in our management costs announced by the government.

In south east London, we believe we are well placed to respond to the challenges and opportunities created by these changes and look forward to continuing our work to improve the health and care of all our population.

Sir Richard Douglas, Chair
Andrew Bland, Chief Executive



Who we are

- NHS South East London Integrated Care Board was established on 1 July 2022.
- We are responsible for allocating public money and planning and delivering a wide range of health and care services.
- Part of the South East London Integrated Care System covering six local authorities, five trusts and 196 GP practices.
- Highly diverse population of two million people with significant health inequalities.
- Life expectancy can vary up to nine years between the most and least deprived areas of individual boroughs.



Our vision for future health

Our vision is to deliver against six core principles across five priority areas:



Our priorities					
Prevention and wellbeing 	Early years 	Children's and young people's mental health 	Adults' mental health 	Primary care and people with long-term conditions 	
Improving prevention of ill health and helping people in South East London to stay healthy and well.	Making sure that children get a good start in life and there is effective support for mothers, babies and families before birth and in the early years of life.	Improving children's and young people's mental health, making sure they have quick access to effective support for common mental health challenges.	Making sure adults have quick access to early support, to prevent mental health challenges from worsening.	Making sure people have convenient access to high-quality primary care, and improving support and care for people with long-term conditions.	

Delivering against our six core principles

1 Health and wellbeing



Being a system that is excellent at protecting health and wellbeing as well as treating illness, through investing in more joined-up and effective preventative health services and working in partnership to create healthier environments and support healthier living.

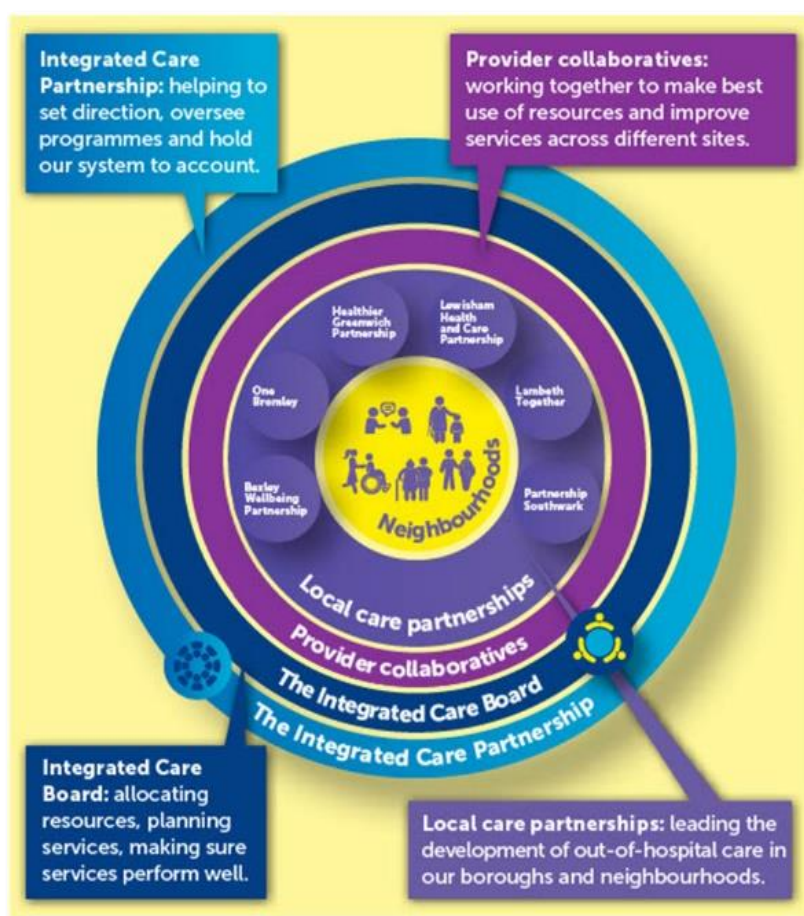
Our Integrated Care System is built on the principles of:

- partnership: working together
- subsidiarity: allowing local decisions and action
- accountability: being open and taking responsibility.

We have embedded a truly collaborative approach involving NHS organisations, local authorities, patient groups and the voluntary, community and social enterprise (VCSE) sector through a 'system of systems' approach.

This is driven at the highest level by the Integrated Care Partnership, a broad alliance of leaders who set strategic direction, provide leadership and support of key south east London-wide programmes. The ICP also ensure governance is in place to enable us to hold each other to account for the delivery of the ICB's priorities.

Our system approach is underpinned by the collaborative working that takes place at a local level through the borough-based Local Care Partnerships, which bring together NHS, Local Authority, other statutory and voluntary sector partners, to plan and deliver healthcare at a local level.



An illustration of our 'system of systems'





Making it as easy as possible for people to interact with our services, tackle long waiting times and offer more convenient and responsive care, delivering more care in or close to people’s homes and using the power of technology.

Service performance - how we did

Our headline performance is showing an improving trend upwards, but with ongoing work to do to achieve national standards in some areas.

<i>Requirement</i>	<i>Delivered</i>	<i>Mvmt to 2023/24</i>	<i>Target</i>
Cancer 28 day waits (faster diagnosis standard)	76.8%		75%
Dementia diagnosis	69.8%	↑	66.7%
CYP eating disorder wait times – urgent	100%		95%
Cancer 31-day decision to treat	92.2%	↑	96%
Cancer 62-day referral/upgrade to first treatment	66.8%	↑	85%
A&E four-hour performance	74.0%	↑	95%
Number of A&E 12 hour waits	2,184	↑	0
Elective referral to treatment within 18 weeks	58.7%	↑	92%

Note: Upward arrow indicates an increase / downward arrow a decrease – green arrow indicates this movement is an improvement, red arrow indicates the movement is an deterioration in performance.

These are examples of our performance against national standards. The full performance report is available in our full annual report.

We have achieved this in the context of:

- A national focus on reducing or eliminating long waits together with reducing overall waiting list size and improving productivity
- Industrial action and a cyberattack on a key supplier, which affected performance



We delivered on:

- Decreasing the number of people waiting 104, 78, 65 and 52 weeks for elective care.
- Improving length of stay and moving people through hospital.
- A continued focus on improving performance and moving people through hospitals through implementing system level urgent and emergency care recovery plans.
- Improving performance of cancer services against the 28 day faster diagnostic standard and 62-day referral / upgrade to treatment target.
- Consistently achieving the national dementia diagnosis rate target during 2024/25.
- Consistently meeting the target for children and young people accessing NHS-funded mental health services.
- Meeting the target for the number of people accessing specialist community mental health and maternal mental health services.
- Exceeding the target for the percentage of people with learning disability receiving an annual health check in 2024/25.
- Significantly delivering over target for the number of people accessing transformed community mental health services.
- Implementation of a SEL Autism Strategic Framework.
- Delivery of Oliver McGowan training across south east London.

We need to do more work on:

- Achieving the national standard targets for acute services.
- Eliminating 52, 65, 78 and 104 week waits from referral to treatment.
- Delivering a minimum of 95% of patients receiving a diagnostic test within six weeks.
- Tackling the high number of mental health attendances in SEL acute emergency departments.
- Improving inter-trust transfers and shared pathways flow.
- Achieving the planned improvement in the percentage of people with severe mental illness receiving an annual physical health check.

Moving care closer to home

We have continued to develop our Hospital@Home projects within our boroughs this year, supported by the six programmes in our digital, data and system intelligence strategy to drive digital innovation and use data-driven intelligence. Successes include:

- Increasing the number of our residents who are using the NHS app on a regular basis to over 1 million, representing over 60% of our population.
- Increasing digitalisation of virtual wards to keep people out of hospital unless necessary.



- Projects, in collaboration with local authority colleagues, to provide people with assistive technology to support living at home.
- Increasing access to the London Care Record to social care, care homes and community pharmacies, making an individual's record available (with permission) across health providers.
- Increasing cyber security and resilience.
- Transitioning GP pathology to a single ordering system.



Bringing together professions and services to deliver joined-up, team-based care, ensuring core teams of staff make shared decisions with people and their carers and deal with the issues that matter most to them.

Quality

Quality of care continues to be a focus, with the SEL quality team implementing weekly reviews of patient safety events, incidents and quality alerts. We analyse and discuss key themes at cross-organisational forums and formal committees.

- The south east London Local Maternity and Neonatal System operates as a collaborative network with membership from care providers, commissioners, service users and other key stakeholders, with the aim of overseeing and enhancing the quality, safety and transformation of services. This collaboration enables knowledge sharing and cross-system learning and implementation of improvements with an ultimate goal of reducing unwarranted variation in the care that women and birthing people receive in SEL.
- The SEL Infection Prevention and Control group meets monthly to provide a platform for organisations to share learning, identify risks and implement guidance in a consistent way across SEL sector care settings.
- The safeguarding team recognises, and complies with, its statutory responsibilities and has developed system-wide ways of working to share insight and learning.
- We led one of the transformational All Age Continuing Care (AACC) Pioneer projects, designed to support delivery of the national vision to support and embed positive cultural change to:
 - improve experience and transparency
 - reduce unwarranted variation across all forms of continuing care, children's and adults' joint funded packages of care, and adults' NHS-funded nursing care.



- We developed a digital capability assessment tool, now adopted and published as the national AACC Digital Capability Assessment Tool following regional and national endorsement.

Development of neighbourhood-based care

This will further contribute to a joined-up approach to meeting the health and care needs of local residents. All boroughs have now identified their local neighbourhood geographies and are working on developing their plans to use the neighbourhood-based approach to deliver better, more integrated and proactive care to residents.



Targeting resources at those most in need to tackle gaps in access, quality of care and health outcomes for different social groups.

Addressing health inequalities

This remains a golden thread within our system Joint Forward Plan (JFP). Embedded in the JFP is the delivery of the Core20PLUS5 framework for adults and children and young people (CYP), which includes:

- Improving access to early cancer diagnosis, working towards the national ambitions of diagnosing 75% of cases at stage 1 or 2 by 2028.
- Delivery of physical health checks for people with severe mental illness.
- Interventions and service improvements which optimise blood pressure and minimise the risk of myocardial infarction and stroke.
- Delivery of the national asthma bundle of care for CYP.
- Improving access to CYP mental health services.

In September 2024, we published our first [Health Inequalities Report](#) in response to NHS England's Statement on Information on Health Inequalities which places a duty on NHS organisations to report information on health inequalities.

To address some of the health inequalities identified in our data, we have:

- Carried out engagement and information sharing with communities where flu and Covid vaccination uptake is below average, leveraging grass roots community groups and the voluntary sector to maintain dialogue



- Acting on mental health detention data to provide earlier intervention and prevention in community mental health services for working age adults, invest in community services, and increase the focus on CYP mental health.

Digital Inclusion

Activity has been led by a dedicated resource, working to develop a digital inclusion strategy for the ICB, create a digital register of barriers to digital inclusion and the tools to support access to digital health. They have also been working closely with digital inclusion charities, social enterprises, NHS England, and other system partners to maximise digital access.

Access

Access to services has seen a general increase in performance in terms of reduced sizes of waiting lists, achievement of targets for people accessing services, and all age continuing care assessment targets. However, we acknowledge there remains more to be done in some service areas.



Supporting our staff to improve services and join up care, and to work in close partnership with local people, patients and service users to make full use of the strengths of our communities to improve health and wellbeing.

Working with people and our communities

This is an important priority for the ICS, utilising our Engagement Assurance Committee, comprising members of the public to form the majority membership and oversee engagement activity. Highlights of our work in the year include:

- Development of women's and girls' health hubs to provide more accessible integrated care to women and girls in the community.
- Engagement work to inform the redesign of the NHS 111 service in south east London.
- Supporting the national conversation on Change NHS to inform the development of the national 10-year plan.
- Ongoing development of the "Let's talk health and care in south east London" online platform.
- A review and refresh of the south east London People's Panel.



Our staff

We have supported our staff with a four-pillar organisational development workplan, looking at our culture, New Ways of Working, talent and development, and staff engagement and experience. In numbers:



Staff and teams across SEL have been publicly recognised throughout the year for their contributions to support the health and wellbeing of the people of south east London, through receipt of a variety of awards including:

- HSJ Award for NHS Communications initiative of the year
- LaingBuisson Award for best in primary care and diagnostics
- General Practice Awards “Pharmacy of the Year” award
- King’s Coronation Medal for work on emergency preparedness
- Our Chair, Richard Douglas, receiving a knighthood for services to the NHS
- Shortlisting for the driving efficiency through technology HSJ award

As the shape and size of the ICB changes in response to Government reforms, even greater emphasis is placed on supporting and developing our staff through a variety of ways including:

- Supporting mandatory and personal development training
- Delivering workshops to explore New Ways of Working
- Ensuring the ICB and wider SEL health system workforce receive Oliver McGowan training on learning disability and autism
- Providing pensions seminars
- Promoting inclusive recruitment training
- Recruiting and developing over 100 clinical and care professional leads.



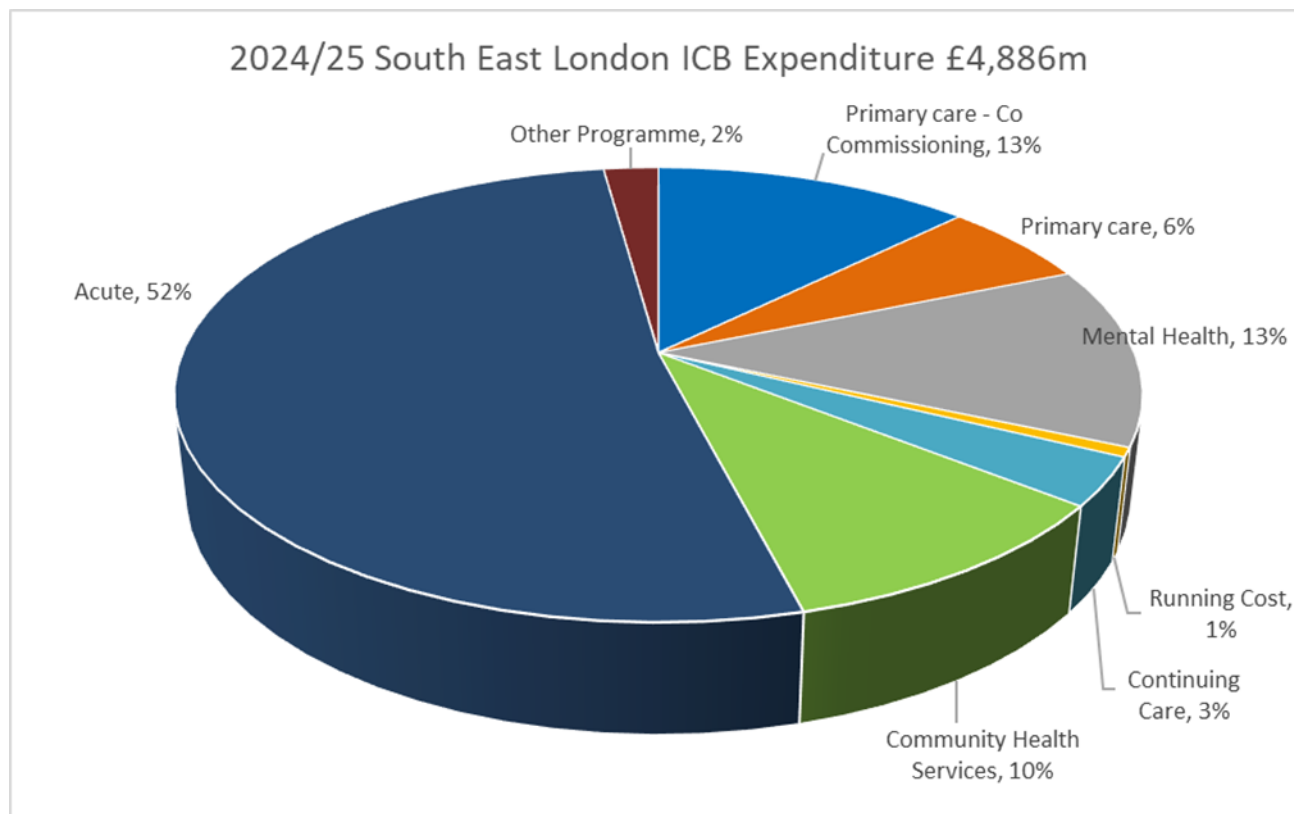


Delivering effective support for the health and wellbeing of the residents of south east London whilst staying within our financial means and reducing our environmental impact.

How we spent our money

We were given £4,486m in 2024/25 to fund the following services for our population:

- Hospital
- Community
- Primary care
- Mental health
- Community care
- Continuing care
- Running costs



We fund the prescribing costs of GP practices and hold delegated responsibility, from NHS England, for commissioning primary care, dental, pharmacy and ophthalmic services within south east London.

We use primary care co-commissioning funds to jointly plan and manage primary healthcare services to deliver more integrated and effective services.

Read our full accounts in our annual report at www.selondonics.org.uk

Caring for our environment

2024/25 was the third year of delivery for our three-year Green Plan, marking the first year that all 122 objectives of the plan were worked on. The plan has covered 11 areas of focus, being workforce and system leadership, air quality, travel and transport, estates and facilities, sustainable models of care, digital transformation, medicines, supply chain and procurement, food and nutrition, adaptation and green /blue space and biodiversity. Along with all other NHS organisations, we are now working on the next phase of the Green Plan.

There is more information in the full annual report on the achievements and our actions against Department of Health and Social Care Task Force on climate-related financial disclosures.



Corporate information

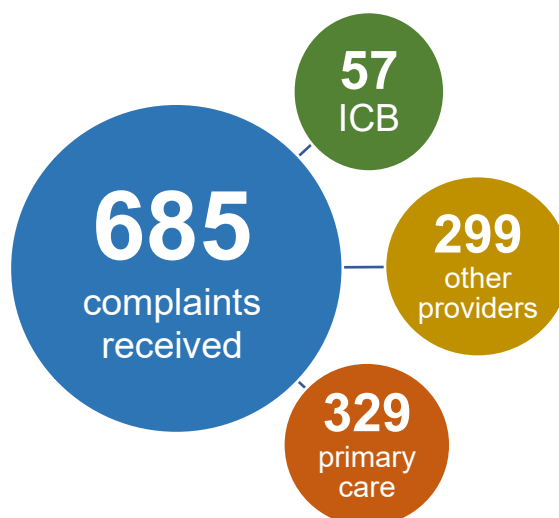
Complaints data

This is an important indicator, used to measure and assess our performance. Most commonly complained about areas are:

- Continuing healthcare
- Mental health commissioning

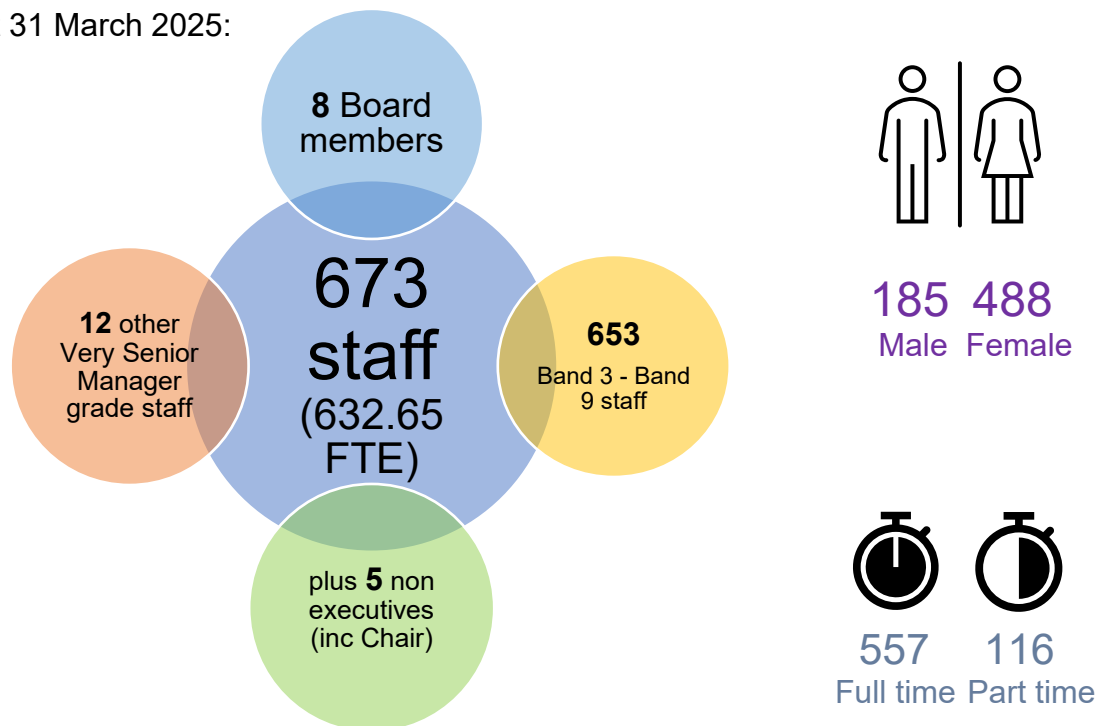
The themes in primary care related complaints are:

- Access and appointments
- Prescribing
- Aspects of clinical care and treatment
- Attitude of staff



Staff report

As at 31 March 2025:



Some other facts and figures:

- Average pay increase in year (NHS pay award and career progression pay increments): 5%
- Remuneration range: £24k - £249k
- 21% (116) of the workforce are on part-time contracts
- Total cost of wages: £41,699,458
- Absence rate: 2.71%

Risk management

Emergency planning: the Chief of Staff is our Accountable Emergency Officer. For 2024/25 we were assessed as providing a fully compliant level of assurance against NHS England core standards.

Counter fraud: the Chief Financial Officer is our executive lead for counter fraud and the Counter Fraud Champion. We met counter fraud standards for commissioners in 2024/25.



Key risks on our Board Assurance Framework where the current risk score exceeds the tolerance are detailed below:

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	543	ICS revenue financial plan 2024/25	12	25
Data and Information Management	435	SEL will not meet the AACC (All Age Continuing Care) Data Set submission due to variation in digitalisation across the six boroughs by the deadline of 1st April 2025.	9	12
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	384	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	12	16
	385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a consequence increase in waiting times for diagnosis and treatment.		16
	386	Ongoing pressures across SEL UEC services		16
	504	Cancer performance targets		16
Clinical, Quality and Safety	391	Increased waiting times for autism diagnostics assessments	9	16
	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics		12
	437	Disruption to IT/ Digital systems across provider settings due to external factors		15
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews		12
	528	Access to primary care services		12
	561	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations		12

Freedom to Speak Up: we have appointed a Freedom to Speak Up Guardian and Freedom to Speak Up Champions, managed under the executive leadership of the Chief of Staff and supported by a non-executive member. Five Freedom to Speak Up concerns were raised in the year.



Our full annual report is available [on our website](#).



Board meeting in Public

Title	Chief Executive Officer's Report					
Meeting date	16 April 2025	Agenda item Number	4	Paper Enclosure Ref	D	
Author	Andrew Bland, ICB Chief Executive Officer					
Executive lead	Andrew Bland, ICB Chief Executive Officer					
Paper is for:	Update	x	Discussion		Decision	
Purpose of paper	To receive the report from the Chief Executive Officer					
Summary of main points	This report updates the Board on matters of interest across NHS South East London since the last Board meeting on 16 April 2025					
Potential conflicts of Interest	None					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Equality Impact Assessments are considered where applicable					
Financial Impact	N/A					
Public Patient Engagement	Public engagement takes place where appropriate and this report is presented to the Board meeting in public and published on the ICB website					
Committee engagement	N/A					
Recommendation	That the Board receive the Chief Executive Officer's Report					

Chief Executive Officer's Report

NHS South East London Integrated Care Board (ICB) 16 July 2025

The report that follows provides an overview of the activities of the ICB and its partners across the Integrated Care System seeking to highlight those issues that the Executive Directors and their teams have been addressing over the last period and to record those developments of note in our system.

When taken together our board papers today outline current system pressures, an incredibly challenging set of plans for the year, alongside cost reductions in the management resources we have to address them. The scale and pace of these challenges requires fundamentally different responses across our partnership and heightens the need for the reform and transformation activities we also have on the agenda for our meeting. As we prepare of this Board meeting, we now do so with the recently launched NHS Ten Year Plan in mind.

Since the Board last met in public, our system has continued to work to deliver on the commitments we have made as a system in our operational plans for this year, with a particular focus on performance and quality improvement and taking action to deliver our financial plan and reduce our underlying financial deficit.

We have also been working to respond to new or emerging issues, with our developing neighbourhood care programme representing a key strategic opportunity and areas of focus over the last few months plus the work we are undertaking to respond to national organisational changes, with the model ICB changes representing the area of most direct impact on us as an ICB.

As ever it is clear that the challenges we face are system wide and impact all our partners. Likewise, that the solutions will only be found in our combined and co-ordinated efforts.



1. ICB Model Blueprint

- 1.1. South east London ICB (SEL ICB) continues to work up its management change proposals in response to the publication of the national model ICB blueprint that sets out the key role of ICBs in the future, with a focus on strategic commissioning to meet the health needs of the local population. The model ICB blueprint further sets out a range of current activities which will not fall to ICBs to deliver in the future with a need to transfer some services to other partners or to cease the activities where they result in system duplication. The national expectation is that ICB management costs reduce as a result of this re-focus with a national average reduction in cost of 50%. SEL ICB's reduction is a lower 35% reflecting its relatively low level of current spend per head of population.
- 1.2. SEL ICB's senior management team has been undertaking work over the last couple of months to take stock of the requirements and ambition set out in the model ICB blueprint, review our current function and form and consider the key changes required to effectively deliver the future role and meet the savings target that has been set. The review process has been undertaken through a series of rapid review sprints to enable the development of a target operating model against which more detailed proposals for change are being developed.
- 1.3. In addition, SEL ICB has been participating in work through which London's ICBs, working with London region colleagues, have shared learning on the interpretation of and thinking in relation to ICBs' future function and form as well as considering opportunities for collaborative approaches to some functions. This could be in relation to the provision of scarce skills and expertise or through the development of once for London policies and frameworks, providing economies of scale, increased efficiency and best value.
- 1.4. SEL ICB has also been working with provider partners to establish the level of interest in taking on those functions listed in the model ICB blueprint as subject to future transfer from ICBs to providers. Initial expressions of interest were received, followed by the provision of more detailed supporting information and joint discussions, with confirmed expressions of interest due to be received in July.
- 1.5. These three main strands of work are currently being brought together to enable the development of proposed functional and structural changes for the SEL ICB, upon which consultation will take place with staff over the summer months. It is hoped that SEL ICB will be consultation ready for early August, subject to any national requirements and authorisation required prior to doing so.
- 1.6. Staff have been regularly updated via all staff briefings, written Question and Answer feedback, HR advice and wider employee assistance and support. It is recognised however that the scale of the organisational change being enacted and the short timeframes to which the ICB is working is impacting on staff, who are facing significant uncertainty. The ICB is committed to doing everything possible to provide support to staff over the duration of the process.
- 1.7. The ICB has established a Transition Board that will oversee the programme of work, reporting to the Board and chaired by a Non-Executive Member of the Board.

2. The NHS 10-Year Plan

- 2.1. 'Fit for the Future: 10 Year Health Plan for England' was launched by the government on 3 July 2025. The Plan sets out a transformative vision for the National Health Service (NHS), with a focus on shifting from a reactive, hospital-centric model to a preventative, community based, and digitally driven healthcare system. Further core themes revolve around decentralising power to local providers and patients, harnessing technological advancements like genomics and Artificial Intelligence (AI), and ensuring long-term financial sustainability through re-allocated spending and new payment models, improving patient experience and outcomes and addressing health inequalities.
- 2.2. These changes will be driven through a first key shift from current approaches to a neighbourhood health service, providing localised, preventative and community based care that meets the needs of the population. The principle is that 'care should happen as locally as it can, digitally by default, in a patient's home, if possible, in a neighbourhood health centre when needed, in a hospital if necessary'.
- 2.3. A number of underpinning approaches are set out to enable this, including a shift in the pattern of NHS spending to invest in out of hospital care, enhanced GP access, an increased role for community pharmacy, improved dental care and the establishment of Neighbourhood Health Centres (NHCs), which will be established in every community, starting in areas with the lowest healthy life expectancy. These one stop shop facilities will be open at least 12 hours a day and 6 days a week, serving as bases for multidisciplinary teams.
- 2.4. There is a dual focus on patient empowerment, including increases in the provision of care plans, personalised health budgets and easier access to services through the NHS App. Alongside the 10 year plan, NHS England are inviting expressions of interest from places to join phase one of the National Neighbourhood Health Improvement Programme (NNHIP) which will pioneer the shift to the Neighbourhood Health Service. South East London ICB will be working across our six places to submit applications into this programme given our forward work in this area.
- 2.5. Prior to the publication of the 10 year plan, the London had articulated its approach to the development of the Neighbourhood Health Service through the publication of the [Case for Change](#) and a [London Target Operating Model for Neighbourhood Health](#). These have been developed in partnership between London's five Integrated Care Boards, NHS England London Region, and the wider London Health and Care Partnership (London Councils, Greater London Authority, UK Health Security Agency and the Officer for Health Improvement and Disparities in London), with support from Londonwide Local Medical Committees. What is outlined in these documents builds on the work that we have been doing in South East London to implement the Neighbourhood Health Service with clear alignment to the Integrated Neighbourhood Team framework that the Board signed off in January 2025.
- 2.6. SEL ICB's existing strategic plan (Joint Forward Plan) aligns well with the strategic ambition set out in the 10-year Plan, with significant work having been undertaken across south east London to take forward an integrated neighbourhood health and care model, including the development of three key integrated care pathways and teams, covering multiple long term conditions and comorbidities, frailty and children and young people. SEL ICB is also in the process of agreeing its borough-based



integrators who will take responsibility for convening and providing infrastructure support to provider partnerships at a neighbourhood level to deliver on SEL ICB's neighbourhood care plans.

- 2.7. The Plan places significant emphasis on moving from analogue to digital and leveraging technology for prediction, prevention, and personalised care as a second key shift. A new Single Patient Record (SPR) will be introduced, the NHS App will improve ease of access to services, the provision of information, clinically validated wearables will be increased plus the widespread use of genomics for key diseases like cardiovascular, renal, and diabetes. The Plan commits to developing AI to support diagnosis, the use of robotics and vaccine development. Again, these commitments chime with SEL ICB's existing system ambition, recognising that there is some way to go to realise the full opportunities offered by digital and technology.
- 2.8. The third key shift highlighted in the 10-year Plan relates to prevention and public health, secured through a huge cross-societal energy on prevention, involving collaboration with businesses, employers, investors, and local authorities. The Plan sets out a goal of a smoke-free generation for young people, action to tackle obesity, reduce alcohol consumption and improve environmental health. There is also a link to the neighbourhood health care and digital shift in enabling a greater focus on prevention, early detection and intervention. Again, the objectives in the 10-year plan resonate with SEL ICB's existing strategic ambition and its commitment to increasing investment and focus on prevention and targeted action to reduce inequalities. The organisation is currently developing a medium term prevention framework and will include the NHS 10-year Plan deliverables in thinking along with SEL ICB's own emphasis on tackling its biggest health related risks factors through primary and secondary prevention.
- 2.9. Finally, the NHS 10-year Plan sets out an extensive range of enablers, from workforce development to payment reform to drive financial sustainability and innovation, a shift to medium term planning, a new Patient Choice Charter and the development of a new NHS operating model and associated organisational and system architecture changes focussed upon securing a devolved, diverse, high performing and responsive NHS.
- 2.10. SEL ICB will need to systematically consider these enablers and what they mean for south east London, as a system, and the approach to strategic commissioning that will be taken as an ICB in response to them. The organisation will be refreshing its medium term strategic health and financial plans in the autumn and will be coming back to the Board to set out its approach to doing so, inclusive of reflecting the national 10-year Plan and the objectives set out in it.

3. Mental Health Assertive Outreach

- 3.1. Work continues to progress the actions that SEL ICB has agreed across its two mental health trusts following last year's review into intensive and assertive outreach services within community mental health services. Both mental health trusts have now presented updates on their internal work programmes at their respective public Board meetings.
- 3.2. A key finding from the review was caseload volumes at the two mental health trusts and a lack of alternative provision outside of secondary care to provide routine care for



people who are stable and on medication. In early July 2025, SEL ICB facilitated a workshop with key clinical leads from across the system to consider how delivery of care for people with severe and enduring mental illness could be considered as part of the development of neighbourhood-based care and thereby supporting secondary care services to further prioritise their resource for those who need more intensive or tailored care. This work is expected to take further shape over the next quarter.

- 3.3. SEL ICB remains aware of the national NHS England programme priorities and awaits publication of the proposed new core standards for community mental health services. The ICB is also working to complete a formal progress update and refreshed baseline review of the delivery of intensive and assertive outreach services by September 2025, in line with the national timetable. The findings of this updated review will be shared with the ICB Board in due course.

4. Equalities Update

Equalities Sub-Committee (ESC)

- 4.1. The ESC, chaired by the Chief of Staff and Equalities SRO, met in May and considered a range of topics including: the changing perceptions of equality, diversity and inclusion and how Creative Health can reduce health inequalities. This provided a timely opportunity to temperature check on Equality, Diversity & Inclusion (EDI), the future focus of the programme and leadership actions to take to support this work. Cross-sectional discussions also took place between Population Health Management, Engagement and EDI to ensure that there is awareness of programmes and collaborative working where relevant. The next ESC meeting will be held in July and will focus on Health Inequalities, Digital Inclusion and engagement with Black people and communities.

Equalities Forum

- 4.2. The latest Equalities Forum was held in June celebrating Pride Month. Speakers included Dr Layla McCay, Director of Policy at the NHS Confederation and Executive Lead of the Health and Care LGBTQ+ Leaders Network and Nathan Lewis, Programme and Partnerships Manager for the Black, Queer and Thriving programme at the south east London organisation Black Thrive. Dr Layla McCay shared her personal career journey and barriers which face LGBTQ+ staff and how to overcome them, including insights from her book *Breaking the Rainbow Ceiling*. Nathan Lewis spotlighted innovative work being carried out to understand the health and care experiences and needs of black and queer communities in south east London, with a focus on centring Black voices in policy and strategy development. The session provided a thought-provoking look into leadership, lived experience, and the intersectionality of race, sexuality, and health inequality. The next Equalities Forum in August will focus on South Asian Heritage Month.

EDI Consultation support offer

- 4.3. An exciting programme of wellbeing support and skills development is being offered by the Equality, Diversity and Inclusion team to support staff through the ICB Change Programme. Topics are wide-ranging and focus on practical application in work settings to ensure that a culture of equity and fairness, compassion and solidarity is

the bedrock of how staff navigate through this period. Sessions are being offered from June to October and cover: Workplace Adjustments, LGBTQ+ Allyship, Being Compassionate Through Change, Micro-incivilities and Bias in the Workplace, EDI Awareness and Equality Impact Assessment training. The sessions have had an excellent reception so far and the team continues to actively promote the offerings so that as many staff as possible will benefit.

5. Bexley Borough Update

Delivering the Bexley Joint Forward Integrated Plan

- 5.1. Bexley local health and care system is continuing to progress the development of Integrated Neighbourhoods to deliver better, more integrated and proactive care to residents. Adopting a population health management approach, the Bexley Wellbeing Partnership has identified Ageing Well/ Frailty as one of three priority areas aligned to the Bexley Joint Forward Integrated Plan and Local Health & Wellbeing Strategy. The aim is to shift from reactive care to a more preventative, personalised model of care that enables people to live healthier lives, maintain their independence for longer and improve long-term health outcomes.
- 5.2. In line with Bexley's commitment of promoting co-design and co-production of its integrated model of care, the Bexley Wellbeing Partnership held an 'Ageing Well' engagement event on Wednesday 4 June 2025. The event focused on three key 'asks' of attendees: Learn about the work that has happened so far; contribute to developing an ageing well model of care for Bexley; help us prioritise what we do first.
- 5.3. Over 60 people attended with broad representation from across the partnership. Over a quarter of attendees were Bexley residents who brought invaluable lived experience to the session, offering personal insights that highlighted everyday challenges, practical needs, and opportunities for meaningful change that might otherwise have been overlooked. Amongst the group were residents from sheltered accommodation, carers, members of a local South Asian Women's Group and a number of Community Champions – diverse and varied opinions helped reflect the spectrum of lived experience in Bexley.
- 5.4. The session included a consideration of a borough wide end-to-end model of care, exploring opportunities to support people to maintain their independence and started to describe what a proactive joined up model would look and feel like. Attendees also considered small-scale model of care proposals to test thinking, focussed on moderately frail individuals living in the Frogna Local Care Network.

Growing our Own

- 5.5. As part of SEL ICB's (Bexley) and London Borough of Bexley's strategy to address the shortage of Occupational Therapists (OTs) in Bexley, occupational therapists visited Blackfen All Girls Secondary School to take part in a careers' day event. The session was held on Tuesday 4 March 2025.
- 5.6. Students aged 13–16 years old showed a keen interest in the profession, with many excitedly visiting the stand to learn more about the essential work Occupational Therapists do. Occupational therapists were on hand to share their experiences and



offer insights into the everchanging role of an Occupational Therapist, answering all the questions put forward by the pupils.

- 5.7. One of the highlights of the day was when three enthusiastic young people in Year 9 signed up for their Year 10 work experience placements on the spot. The level of enthusiasm and interest has resulted in the Occupational Therapy team now having a waiting list of pupils eager to explore this career path further.
- 5.8. This careers' day was also a valuable opportunity to raise awareness of the NHS Learning Support Fund, which helps cover training costs for Allied Health Professional university courses. It was a good point of discussion, as many students were unaware of these funding opportunities. Their parents were especially pleased to receive this vital information.
- 5.9. Events like this are instrumental in raising awareness and interest and opening doors for young people to consider meaningful careers in Occupational Therapy, which is not often popularised. Bexley is keen to continue its outreach efforts in schools across the borough, helping to build a stronger, more sustainable future for Occupational Therapy services. The next push for school visits will take place after the summer holidays and look forward to more inspiring conversations regarding a career in Occupational Therapy.

Community Voice

- 5.10. The Bexley Community Voice Forum took place on Thursday 29 May 2025 at Erith Family Hub. This quarterly event is a collaboration between the Bexley Wellbeing Partnership and London Borough of Bexley's Staying Together team and is an opportunity for representatives from grassroots community and faith organisations to gain information and support from a variety of system partners, whilst feeding back issues from seldom heard groups.
- 5.11. On this occasion there was a presentation by the Libraries Team on services, a discussion around physical chastisement and an update on initiatives to support unpaid carers and involve community groups in Creative Health. It was also an opportunity for forum members to learn about the services based at the Erith Family Hub, which include health clinics run by the borough's 0-19 service, and Mindful Mums, a support service for pregnant mums and new parents to support emotional wellbeing.

6. Bromley Borough Update

Improved uptake of Learning Disabilities Health Checks in Bromley

- 6.1. Through the joint efforts of the Bromley Learning Disabilities (LD) Taskforce, Clinical Leads for Learning Disabilities and for Personalised Care, the Primary Care Network LD Champions, Bromley Mencap and Oxleas LD team, the Bromley uptake of Annual Health Checks by patients on the Learning Disabilities register reached 87% for 2024/25.
- 6.2. This achievement provides a particular cause for celebration as it exceeds last year's highest ever uptake. Increasing uptake of health checks will result in improved health



outcomes for some of Bromley's most vulnerable residents. Continued investment to this programme for 2025/26 aims to maintain and improve on this level of uptake, and to expand the project's focus to include increasing uptake of screening and preventive health services. The work seeks to reduce inequalities as uptake of these services in those with learning disability shows significant variation when compared to uptake amongst the wider patient population.

Integrated Neighbourhood Teams (INTs) roll out

- 6.3. Bromley's vision for INTs is to create better connection between services and for them to work closely with communities, integrating health, social, voluntary, and community organisations to improve health and wellbeing, in line with the One Bromley strategy.
- 6.4. The aim to more consistently provide holistic, person-centred care, focusing on prevention and delivering care closer to home within local communities. By doing so, the ambition is to simplify access to support, including from within communities themselves, for residents, leading to better health and wellbeing outcomes for the people of Bromley.
- 6.5. The One Bromley Executive has agreed a phased roll out of INTs across the borough, starting in South West Bromley, followed by North East, with North West and South East going live together. In line with local needs and national recommendations, the new model of care commences for individuals with three or more long-term conditions. Concurrently, there is a focus on frailty and children's health partnership models, which will integrate into the new INT footprints as they evolve. Bromley's system wide same-day care offer is also being systematically reviewed to align with INT working and the strategic principle of providing care closer to home.
- 6.6. The work is being supported by a new multi-agency sub-group: the INT Development Group, accountable to the One Bromley Executive. This sub-group is also aiding the development of One Bromley's plans for the Partnership's Executive to fulfil and support the Place integrator function.

Winter Planning Review

- 6.7. The 2024/25 One Bromley Winter Evaluation reviewed the system response to this year's winter pressures. The review was undertaken in four parts and culminated in a system workshop:
 - A performance review summarising trends and activity over winter
 - A qualitative review from system partner feedback on key strengths, challenges and recommendations for next winter
 - Clinical input through a clinical round table, CPAG input and GP feedback
 - Evaluation and learning from winter funded services
- 6.8. Some of the positive outcomes included:
 - 98% performance maintained for the Urgent Treatment Centre (UTC) throughout winter

- Positive feedback from GPs on improved 'Consultant Connect' pick up rates from previous years
- Noticeable increase in the use of Pharmacy First compared with the first 6 months of the year
- Focused work with Extra Care Housing saw a 21% reduction in London Ambulance Service conveyances compared to last winter
- Increased use of Universal care Plan (UCP) for care home residents with launch of Falls Bundle for care home residents
- The Voluntary sector post-discharge visits helped people be safely discharge from hospital. 765 Welfare calls took place through Take Home and Settle programme; 194 post discharge settling, with ongoing support to 79 patients vulnerable to re-admission due to home living environment factors
- Home-Based Rehab successfully increased its number of patients supported from 445 to 596 contracted slots over the 5-month period

6.9. Challenges included:

- High 'Did Not Attend' rates in some Primary Care Networks and lower weekend utilisation of the winter illness hubs
- Low redirection rates from UTC into Pharmacy First (IT related challenges)
- Use of Healthcare@Home for care residents did not improve throughout winter
- Acute Frailty Assessment Unit (AFAU) remained bedded for the majority of winter
- Issues with take home medication was a consistent challenge identified in post discharge welfare calls
- Lost capacity and under-utilised community provision in discharge pathways, partly because patients were not able to be discharged as planned
- The reach of the communication activity was restricted by limited capacity and some late starting national communications
- Challenges with Accident & Emergency presentations for non-medical reasons

Bromley Covid Spring Booster Campaign

- 6.10. The national Covid Spring Booster campaign commenced on 1 April 2025 and concluded on 17 June.
- 6.11. Despite the continued decline in demand for the Covid vaccination across the country, Bromley continues to have a good uptake, at the highest level across south east London. Amongst reasons for declining to come forward for their vaccine, patients are most often referring to a feeling of 'vaccine fatigue.'
- 6.12. The delivery and provision of Covid vaccination services continues to operate through a nationally coordinated arrangement. A number of Bromley GP practices provided vaccination services for this campaign, together with 27 Community Pharmacies. Bromley access therefore remained high, with services offered across the borough.

- 6.13. In addition to the core provision, targeted Community outreach clinics were organised by SEL ICB in Penge, the Crays and Mottingham areas, to provide greater access in communities with lower uptake. An invite-only event was also arranged for immunosuppressed patients at the One Bromley Wellbeing Hub. This was very positively received by patients, with all appointments successfully booked.
- 6.14. Due to the earlier scheduling of the Spring Booster this year, the 2024 data reflect the position at week 8 of the campaign to provide a more accurate year-on-year comparison.

Covid Spring Booster Uptake		
Cohort	2025 Uptake	2024 Uptake
75+	52.4%	57.5%
Immunosuppressed	22.3%	22.4%
Housebound	53.9%	51.5%
Older Adult Care Homes	73.8%	77.8%

7. Greenwich Borough Update

Neighbourhood Development

- 7.1. Greenwich's programme to deliver Neighbourhood Health Services is now fully underway, with three core strands established and developing plans through workshops, steering groups and feeding into Place governance. These are care models, workforce and population health and each has a senior sponsor leading the work. Enabler workstreams have also been established: digital, estates and communications, also with leads and gathering momentum.
- 7.2. Highlights include:
- a well-attended and productive workshop with the Local Care Partnership and a wider group of local experts and stakeholders to take forward all core strands of the Greenwich approach
 - Greenwich Wide Forum and Greenwich Community of Clinical Influence sessions with local GP and practice staff to discuss the role of general practice in Neighbourhoods
 - active participation at recent south east London (SEL) workshops to define and refine a consistent approach to Population Health Management in Neighbourhoods, and to develop the SEL Aging Well Framework
 - following the Greenwich Estates Strategy adoption locally, a workshop with all system Estates leads and wider stakeholders to identify and refine potential Neighbourhood Hub opportunities, with follow up workshops looking at Children's opportunities and the West Greenwich area; and
 - ongoing conversations with local system partners about how to maximise the opportunity of the Integrator role for Greenwich

Primary Care transformation

- 7.3. Greenwich recognises that general practices and community pharmacy will be crucial partners within the Neighbourhood healthcare model. A Primary Care OD plan is being developed to offer practices the opportunity to undertake training, business planning, staff engagement and other useful development approaches that will place all Greenwich practices in the best possible position for Neighbourhood delivery. The PMS Premium is also being reviewed with a view to directing a significant amount of the available funds into proactive care and case finding that will support the central aims of neighbourhoods, the 'shift left' and emphasis on prevention, as well as achieving system sustainability.
- 7.4. There are already several established and emerging projects with community pharmacies to provide care to residents closer to home and in places they are comfortable to access, with a direct impact on health inequalities. This will be deepened and spread through further engagement with pharmacies in the coming months, including inviting the Local Pharmaceutical Committee (LPC) to join the Healthier Greenwich Partnership.

Integrated Commissioning – Children and Young People Child Health Teams Pilot

- 7.5. The Local Child Health team continues to run within Greenwich West Primary Care Network with an additional Primary Care Network recently expressing an interest to expand the pilot to their area. Plans are underway to identify the relevant funding to enable this expansion to happen. As all the relevant templates are now built into EMIS and operational, the programme will be live on the south east London Data Dashboard by the middle of July. There is also a plan in place to enable future outcomes reporting in respect of the impact on A&E attendances and Primary Care presentations.

Integrated Commissioning – Adults

Adults' system leadership, staffing and team development including mobilisation of INTs and delivery of ICB changes

- 7.6. Teams across adults, public health, children and young people, and primary care have made progress collaborating and establishing new ways of working with partners. There is a commitment to this approach even in times of uncertainty and staff continue to deliver high quality work which is recognised as having impact now and in the future.
- 7.7. Plans are in place to ensure this continues this year including leadership development across teams and with partners. This includes consideration of how this work is extended across place partners, leveraging national and regional best and next practice, the art of the possible in transformation of health and care and procurement and enabling the delivery of strategic commissioning, which is consistent and ahead of the times, taking into consideration the proposed ICB changes, intentions in the 10-year plan, and political priorities around cooperation.



7.8. Greenwich is seen as leading nationally in its ways of working for some areas of adults commissioning which stands it in good stead for the intended changes ahead. Examples include:

- How the team has supported the development and early delivery of south east London Frameworks for Neighbourhoods and Frailty
- Joined up work across six Borough Integrated Commissioning team, which has included:
 - working on proposals for future Integrated Equipment Services
 - Continuing Healthcare
 - Accelerated Reform Fund Funded projects
 - Mental Health complex care and Section 117
 - INTs development
- sharing responsibilities with Greenwich leading on:
 - Wheelchairs
 - Ear Wax service commissioning; and
 - Learning disability sustainability market shaping work on behalf of south east London

7.9. Greenwich are a value-based leadership team and will ensure staffing impacts are minimised where possible and that staff wellbeing is supported through these challenging times. Weekly leadership briefings and support for staff continues, led by the Integrated Director of Commissioning for Adults for these staff teams and in collaboration with all place leaders alongside this for wider staff support.

7.10. Alongside the Local Authority Greenwich has recently developed a clear set of shared priorities which also includes linking these to the INTs' development programme so that all relevant work can be designed and delivered locally in a joined-up way and where commissioning priorities can be aligned this is being paid attention to.

Mental Health (MH) Review

7.11. We have recently embarked on a whole system review of mental health in Greenwich. We have brought together service, finance, outcome and workforce data to get a full understanding of the resources and where they are supporting residents, the impact, gaps and areas for improvement.

7.12. This review is aimed at enabling us to continue to achieve better outcomes for residents, better value for the money which aims to impact Greenwich residents including SEL ICB south east London commissioned services, enable transformation together where needed and ensure delivery on the commitments made after co-production of a vision for MH for Greenwich adults alongside the Voluntary & Community sector, Oxleas, Local Authority and other key partners.



- 7.13. This work will now inform continued work to develop INTs and ensure the shifts to community-based support are delivered and demand and resident needs met. As part of this work, Greenwich are looking at complex needs, links to south east London programmes such as South London Mental Health and Community Partnership (SLP) complex care, improved approaches to S117 and shaping and delivering on local market solutions such as the MH Alliance to continue to improve and transform community MH. This is an integrated whole place review including involvement of public health.

Digital Health & Care Service

- 7.14. Following contract award this service went live in April as planned. Staff have been trained and the impact of all the prior work to design the service across the local system as well as being connected to south east London is now becoming clear.
- 7.15. Initial findings indicate that the workforce has developed an increased understanding as a result of the approach used to support culture change efforts. Appropriate residents from various groups are being referred as intended, at key points in their health, care, and support journeys.
- 7.16. Early impact, costs, benefits and work with transformation partners is continuing to be looked at and Greenwich already being asked to share learning with the Department of Health and Social Care (DHSC) and others nationally and regionally as this is the first integrated service funded by pooled funds. The service was launched ahead of the 10-year plan for integrated neighbourhood health, supporting expected changes and promoting sustainable, proactive community care that benefits local people and staff.
- 7.17. This service has provided an excellent foundation to build on developing integrated neighbourhood team approaches ensuring Greenwich are able to better deliver preventative and proactive care. This includes both data, digital, workforce and transformation aspects.

Urgent and Emergency Care & Better Care Fund (BCF) Support Programme

- 7.18. Greenwich and Bexley have now concluded the work supported by the Better Care Fund (BCF) programme to review patient flow and discharge through the Queen Elizabeth Hospital in Woolwich. The BCF supports local health and social care systems to successfully deliver integration of services in a way that supports person-centred care, sustainability and better outcomes for people and carers. Leaders across health and social care in Greenwich and Bexley are now leading across the system as a group of collaborative leaders to deliver on these recommended changes across three key areas: discharge and flow; demand and capacity; and leadership.
- 7.19. Early success has been:
- joined up leadership and stewardship of the system and workforce around the changes needed
 - identifying where action is already underway
 - how to oversee the impact: and
 - identifying what new work is needed

- 7.20. The changes proposed will impact how this work is delivered but there is confidence that the right conditions are in place to allow this to happen. Risks will continue to be mitigated, and it is hoped the staffing changes expected will not adversely impact UEC progress.
- 7.21. There has also been success in securing Section 106 funds to develop the streaming space in the Urgent Treatment Centre (UTC) at Queen Elizabeth Hospital. It is intended that the final sign off by the Local Authority is completed soon so that works can conclude before winter. Alongside this, work continues with the UTC provider and other key partners to improve performance, and early impacts are being seen. This includes consideration of the contract and extension provisions and links to 111 developments.

MSK

- 7.24. The new service will be commissioned to be in place for April 2026. The tender process is nearing conclusion. Feedback will be provided to bidders in late summer. Preparations will then start to launch a more sustainable, improved service co-designed with local partners, following significant efforts and a successful Provider Selection Regime process for one of the top-value place-based services, supported by a strong team. Greenwich is now ensuring that the impacts of ICB changes do not present risks to commissioning or mobilisation of the new service in the expected timeframes.

Greenwich Charitable Funds

- 7.25. The [Greenwich Healthier Communities Fund](#) aims to prevent and respond to key health issues across Greenwich to ensure everyone has equal access to the health services and support they need, over the next 4 years. The Fund provides grants through various strands, all supporting work in Greenwich that aligns with the Health & Wellbeing Strategy.
- 7.26. Phase 1: Two strands of funding for VSCE organisations were launched in April 2024. The Enabling strand aims to increase an organisation's capacity building to better tackle health inequalities, whilst the Delivery strand aims to fund projects that prevent and respond to key health inequalities. The Enabling Strand has supported 31 organisations across three rounds, with a total of £245,726 awarded. The Delivery Stand has supported 48 organisations across two rounds, totalling £1,122,701.
- 7.27. Phase 2: After a period of development, with stakeholder input and grantee feedback, the Fund relaunched in April 2025 with an additional strand: Micro Grants. These fund the continuation or pilots of small projects, to encourage the trial of innovative projects on a smaller scale, before they are developed.
- 7.28. The Delivery Strand was also split into Small Awards and Medium Awards. Small awards funds projects up to £20,000 and medium awards up to £50,000. In round one, there have been 18 applications for Delivery Small Awards and 21 applications for Delivery Medium Awards, with funding decisions to be made over the next month.
- 7.29. Delivery Strand Medium Awards, final funding recommendations will be made by a community panel of key individuals who live or work in Greenwich, to ensure the Fund addresses key issues identified by the community.



- 7.30. For The Delivery Strand Medium awards, organisations were required to submit against a set of priority themes. Themes were selected based on the stakeholder and grantee input. The themes are:
- Improving Health Outcomes for People with Learning Disabilities and/or Autism
 - Tackling Isolation
 - Long-Term Health Conditions
 - Active Healthy Living for Children and Young People
- 7.31. The Delivery Strand Large Awards will launch in September 2025, awarding up to £200,000. Applicants must demonstrate how their project will align with a priority theme, as well as demonstrate collaborative working within the neighbourhoods in Greenwich.

8. Lambeth Borough Update

‘Our Health, Our Lambeth’

- 8.1. In May, the Lambeth Together Care Partnership (LTCP) Board approved [the second annual review of ‘Our Health, Our Lambeth’](#), Lambeth Together’s five-year Health and Care Plan. The refresh of the Health and Care Plan allowed partners to take stock of progress over the last two years and identify the key priorities that will enable Lambeth to successfully deliver improvements for residents and service users during 2025/26.
- 8.2. Throughout the year ahead, Lambeth will continue to develop the Neighbourhood Health Service model, bringing care closer to home and making it easier for people to get the care they need within their own communities through Integrated Neighbourhood Teams.
- 8.3. The Board reviewed the Lambeth Integrator Model and the Integrated Neighbourhood Team Delivery Plan for July to December 2025 at its July Board meeting. This builds on the national and south east London guidance on developing a neighbourhood health service, the London Target Operating Model for neighbourhoods, as well as the significant work that has been undertaken in Lambeth to develop a local model of support.
- 8.4. Over the coming months, Lambeth will continue to engage partners as this work develops and will commence a programme of public and community engagement in partnership with Healthwatch Lambeth to help shape the design of the overall neighbourhood approach.

Delivery Alliances

Neighbourhood and Wellbeing Delivery Alliance (NWDA)

- 8.5. The Neighbourhood and Wellbeing Delivery Alliance has been leading the development of neighbourhoods on behalf of Lambeth Together. Since the last Lambeth Together Care Partnership Board, Lambeth have formally proposed the integrator for the next 12 months as a partnership of Guy’s and St Thomas’ NHS

Foundation Trust with the Lambeth General Practice Provider Alliance (LGPPA). The NWDA have confirmed the area of focus for Integrated Neighbourhood Teams (INT's) in each of the five neighbourhoods. Over the next six months, detailed delivery plans will be developed with the leads of each neighbourhood and reviewed by the INT working group in January 2026 for implementation.

- 8.6. In addition, Lambeth are developing a proactive community-based integrated frailty care model focused on the most deprived areas in the borough, the Brixton and Herne Hill neighbourhood. To do this, the Alliance is:
- Developing a proactive in-reach and outreach model to identify people who are at risk of mild, moderate and severe frailty in the most deprived neighbourhood (this is a test and learn approach); and
 - Developing an outcome measure framework to enable the Alliance to understand the impact of the model that can be scaled across the borough.
- 8.7. The Alliance has also developed a "Frailty team" and recruited a dedicated Ageing Well Social Prescribing Link worker, and Frailty Nurse Practitioner, who are working alongside a GSTT Consultant Geriatrician. The Frailty team begun seeing moderate to severe frail patients from Minet Green Health Practice in March, alongside a GSTT Consultant Geriatrician. Over 26 patients have received a holistic frailty assessment, most of which were supported through a home visit. These patients are reviewed with the practice in a monthly multi-disciplinary team and the team are linking up with adult social care, occupational therapy and other teams where necessary / appropriate.

Living Well Network Delivery Alliance (LWNA)

- 8.8. An independent rapid review of the Lambeth Living Well Network Alliance took place at the beginning of 2025. The Alliance commissioned the review to ensure it remains effective and able to further improve Lambeth's mental health during its three-year contract extension to March 2028. All Alliance Partners welcomed the review and have committed to work together to continue to develop the Alliance to ensure it can sustain delivery of high-quality mental health care.
- 8.9. The review found that the Alliance has 'an enviable reputation inside and outside Lambeth' and having 'met much of its original cultural change purpose...is in need of a cultural reset to understand and meet the challenges of the current context'. The review recognised the pioneering work of the Alliance in integrating NHS clinical, social care and Voluntary, Community and Social Enterprise (VCSE) staff into neighbourhood-based Living Well Centres, improving the service offer to Lambeth residents living with a serious mental illness and simplifying access to support, personalising care and integrating service provision beyond clinical and social care into housing and employment support.

Children and Young People's Delivery Alliance

- 8.10. The Child Health Integrated Learning and Delivery System (CHILDS) framework continues to provide the foundation for developing Integrated Neighbourhood Teams for children and young people. CHILDS is a shared model of care built around common childhood conditions such as asthma, eczema and constipation, and supports more joined up, proactive working between services. It remains the core template for neighbourhood-based delivery, and work is now underway to identify the next

intervention that can be added to the CHILDS offer. This will help Lambeth to build on what is already in place and move closer to delivering on the integrated care ambitions.

- 8.11. In June, a new strand of CHILDS activity went live: a psychiatry led joint mental health case discussion model. This brings together mental health professionals, GPs, and a consultant psychiatrist to discuss more complex cases, particularly where children are experiencing emotional or mental health difficulties but do not meet the threshold for NHS mental health services, are waiting for diagnostic assessments, or need additional input from primary care. Initial feedback has been very positive. Although starting small, the model will be expanded across all five neighbourhoods in due course.

Working Together in the Community

Board on the Bus initiative

- 8.12. The Board listening programme is a year-round initiative that enables leaders to go out into the community to speak with residents about their healthcare needs and priorities. An important part of this is the Board on the Bus initiative. In May, Alice Jarvis and Dr Raj Mitra joined the bus at Lower Marsh market to hear residents' views, alongside Health Champions offering blood pressure checks and healthcare advice. Joining the team was Abudu Ziwa, a supported intern with the Lambeth Together team on a 10-week placement from Project SEARCH (School to Employment and Rehabilitation Centre Help), for 16–24-year-olds with Learning Disabilities and Autism.
- 8.13. In June, Patient and Public Voice Board Member, Eugenie Dadie, joined the bus at Brixton Library with the mental health support worker - a service available every Monday on the bus.

Lambeth Country Show 2025 – A big Lambeth Together Presence

- 8.14. Lambeth Together brought health and wellbeing advice and support right into the heart of the community at the Lambeth Country Show on 7 and 8 June.
- 8.15. Alongside the Health and Wellbeing Bus, the team engaged local residents, offering free Vital 5 health checks, expert advice, and practical resources to support healthier living. Local GPs, pharmacists and the Beacon Project delivered 185 blood pressure checks and onward signposting.
- 8.16. The Communications and Engagement team have created a video on the [Lambeth Together website](#), which captures the spirit of the event, and the impact of teams over a busy and productive weekend.

9. Lewisham Borough Update

Hypertension Project Recognised at HSJ Digital Awards

- 9.1. Lewisham's Hypertension Project won the 'Reducing Health Inequalities through Digital' category at the annual HSJ Digital Awards on 26 June 2025. This prestigious award recognises the innovative partnership between Suvera and the Lewisham place

team of SEL ICB, who worked together to deliver virtual hypertension clinics in TLCP and Modality Primary Care Networks (PCNs).

- 9.2. Over the course of the project, approximately 5,000 patients were invited to attend the virtual screening, with just over 80% then engaging in the programme. During a 6-month period, circa 7,400 successful consultations were held and over 15,000 blood pressure readings submitted. The number of Stage 3 Hypertensive patients fell from 55 to 28, normotensive patients increased from 1,617 to 1,987 and it is estimated that this project may have reduced the number of strokes by 40 and heart attacks by 25 in the long term.
- 9.3. It is particularly important to Lewisham residents, since the borough has some of the highest rates of uncontrolled hypertension in London, contributing significantly to health inequalities and cardiovascular disease risk. This initiative is already making a real difference by empowering patients and improving blood pressure control across the community.

Mayor of Lewisham Officially Launches the Waldron Health Centre and Community Hub

- 9.4. On Wednesday 18 June 2025, the Mayor of Lewisham, Brenda Dacres, joined guests from across the local health and care system and community, to officially launch The Waldron Health Centre and Community Hub. The event marked the completion of large-scale refurbishments, the opening of the Community Hub, and progress made so far in delivering enhanced health and care services to residents.
- 9.5. Over the last 18 months, the Waldron Health Centre has received an investment of £2.3m, under the NHS LIFT Programme, to improve the space and has undergone significant change to re-model and update the building. Improvements delivered include increased clinical and health space, improved facilities and a better integration of health services, and the provision of a Community Hub which has been made freely available for voluntary, community, and social enterprise (VCSE) groups to run health-supporting activities and engage with residents, based on local health and care priorities.
- 9.6. The development of the Community Hub is an important step in providing more holistic neighbourhood care in Lewisham. The space hosts a wide variety of community groups including: 360 Lifestyle, Bouake Diaspora, Broken Hearted Youth, community kitchen/coffee mornings, Empower Care, Imago Community, Lewisham Council – shared lives and fostering advice, Red Ribbon, DWP and Citizens Advice Lewisham.

The Integrator

- 9.7. Lewisham is developing a partnership arrangement founded on equality of voice in shared decision-making and strong collaboration. The partnership will ensure that general practice, the voluntary and community sector (VCS), South London and Maudsley NHS Foundation Trust (SLaM) and Lewisham Council each have an equal voice.
- 9.8. It is recognised that an NHS statutory body will need to act as the host organisation on behalf of the Integrator partners. At this stage, Lewisham and Greenwich NHS Trust (LGT) is the proposed host. Partners include:



- Lewisham Council Adult Social Care, Children and Public Health
- Lewisham and Greenwich Trust
- Primary Care
- South London and Maudsley NHS Foundation Trust (SLaM)
- Voluntary and Community Sector (VCS)

10. Southwark Borough Update

Partnership Southwark Strategic Board

- 10.1. The May meeting of the Partnership Southwark Strategic Board (PSSB) was held in the Walworth Living Room, a VCSE neighbourhood service provided by Pembroke House. The Board heard from the team at Pembroke House, who outlined the organisation's longstanding role in addressing local inequalities and fostering community wellbeing through integrated neighbourhood initiatives. The Board acknowledged the importance of such community spaces, particularly in combating social isolation and promoting holistic health.
- 10.2. The board received an update on the Integrated Neighbourhood Teams (INT) Programme, including details on the London Target Operating Model for INTs, the updated governance structure and an example of a 'Neighbourhood profile', which are in development. The progress updates shared were endorsed by the Board.
- 10.3. Colleagues from the Estates team followed with an Estates strategy update which explored how the Estates strategy fits with the Integrated Neighbourhood teams' priorities. The Board supported the vision of co-located services to enhance accessibility and community integration.
- 10.4. The Board also discussed the Integrated Assurance Report, which covers delegated performance, quality, safeguarding, risk and finance issues. Following concerns expressed about childhood immunisation rates, it was agreed to bring a deep dive report to the next meeting.

Integrated Neighbourhood Teams in Southwark

- 10.5. There has been good progress towards neighbourhood working in the last quarter which has involved significant engagement with key stakeholders to identify an appropriate 'integrator' to host the functions required to enable primary, community, mental health, acute specialist, local authority, VCSE and other partners to work together effectively at neighbourhood level. In June the Southwark Integrated Neighbourhood Team Programme Executive agreed to the recommendation for the formal appointment and approval of Guy's and St Thomas' NHS Foundation Trust (GSTT) in partnership with Improving Health Limited (South Southwark) and Quay Health Solutions (North Southwark), who are forming a joint venture as the integrator organisation for Southwark.
- 10.6. The development of an integrated frailty pathway in the Camberwell and Walworth Neighbourhood is expanding to more GP practices to develop improved ways of

identifying and supporting people who have severe, moderate or mild frailty. Early findings show this has kept care close to home, eased pressure on hospitals, and improved communication between GPs and hospital teams. Patients have also benefited from medication reviews and the opportunity to record their care preferences in case of future serious illness or incapacity.

Ofsted and Care Quality Commission thematic review of SEND children not in school

- 10.7. During May, Ofsted and the Care Quality Commission (CQC) carried out a thematic review in Southwark as part of the area SEND (Special Educational Needs and Disabilities) framework. The purpose of the visit was to better understand how health, Southwark council and the voluntary sector are working in partnership to meet the needs of children not in school across health, education and children's social care.
- 10.8. These visits provide insights which are used to promote improvements in the sector. Inspectors do not make judgements about individual areas during these visits, although they do share their findings in a national report which is due to be published in the Autumn of 2025. The visit took place over three weeks, with inspectors on site from 19-22 May. The inspectors provided feedback at the end of the visit and were impressed by the strength of the partnership, and the many examples of excellent practice in the school community and health and care services across the partnership. The inspectors also identified areas for continued development, including joint commissioning arrangements which is being addressed in development of a joint commissioning strategy for SEND in Southwark. Further information can be found about the thematic review here: [Thematic reviews of children not in school in local areas - GOV.UK](#)

Health Inequalities Impact report

- 10.9. The Health Innovation Network has completed an impact report on the Health Inequalities Fund initiatives that were funded in the 2024/25 financial year. This report focuses on ten initiatives in Southwark which have been directly supported by the 2024/5 Health Inequalities Fund, focused on improving outcomes for its residents, and especially for underserved communities.
- 10.10. These initiatives exhibit significant variation in scale and ambition. Six initiatives, funded in phase one from 2024 or prior, have demonstrated early impact, whilst four initiatives were more recently awarded funds as part of phase two. Whilst challenges exist in quantifying impact, qualitative data suggests benefits such as improved service access, community engagement, and health literacy. The Health Inequalities Fund has been pivotal in supporting grassroots organisations, facilitating the extension of essential services and enabling the delivery of targeted pilots and programmes. Despite uncertainties within the existing health and social care system, opportunities were raised to support future development of the fund. The full report can be found here: [Health Inequalities Fund Impact Report - Southwark - Health Innovation Network](#)

Southwark Health and Wellbeing Board

- 10.11. The Southwark Health and Wellbeing Board met on 19 June 2025. Key items of relevance to Partnership Southwark included:

- **Progress on “A Healthy Start in Life”.** The Board reviewed delivery against this strategic priority, including early years interventions, SEND support, parenting programmes, childhood immunisations, and mental health provision in schools.
- **Reflections from the “Health of the Borough” event.** Insights from the May 2025 event highlighted community-led health initiatives, persistent barriers to access, and opportunities to strengthen collaboration between statutory and voluntary sector partners.
- **Southwark Maternity Commission Action Plan.** The Board received an update on the implementation of the maternity action plan aimed at tackling inequalities in care. Presentations from residents with lived experience powerfully illustrated the urgency of the work.
- **Joint Strategic Needs Assessment (JSNA) 2025.** The annual JSNA report provided a borough-wide overview of health trends, including population growth, widening health inequalities, and priority areas for future needs assessments.
- **Better Care Fund (BCF) 2025/26 Approval.** The Board approved a pooled budget of £56 million between Southwark Council and the Integrated Care Board to support integrated, community-based health and care services. The associated plan includes targets to reduce delayed hospital discharges and avoidable admissions to hospital and care homes

Maternity Commission

- 10.12. A steering group has been established to oversee the ten recommendations of the Maternity Commission which were approved by the Health and Wellbeing Board in November 2024 following nine months of consultation with over 750 local residents, voluntary and community sector representatives, local maternity care service providers and local workforce.
- 10.13. The steering group, which was formed in April 2025 has developed an action plan which was reported to the Health and Wellbeing Board in June 2025. The action plan will be delivered over five years to September 2029 with a mid-year review in 2027 and aims to address the identified themes:
 - Tackling discrimination and better supporting women with specific needs
 - Ensuring women are listened to and supported to speak up, whatever their language or background
 - Providing women with the right information at the right time in the right way
 - Joining up council and NHS services better around women’s needs, and making sure care is consistent across borough borders
 - Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers
- 10.14. Early successes include:
 - Completion of a brief needs analysis by public health, using council data, which has highlighted disproportionalities in perinatal mental health needs, maternal obesity, hypertension, and gestational and Type 2 diabetes

- Identification of a good training and development offer available across a range of partners including psychological support to build resilience
- A range of community-based initiatives and targeted campaigns are in place
- A positive start to the pre-conception campaign being promoted through a number of Southwark locations and on-line

Mental Health Complex Care

- 10.15. Mental health for adults and children is a priority for Partnership Southwark and the cost pressure on the Complex Placements budget is an area of high risk.
- 10.16. Southwark has established a Complex Care steering group which is reviewing individual placements with support from colleagues in SLaM. This sits alongside work to ensure the complex care pathway reflects residents' voice and enables residents to live as independently as possible.
- 10.17. The programme includes reviewing future need and developing options to configure the local offer, reviewing future placement options and delegation, securing local supported living placements and developing and resourcing better personalised commissioning alongside the programme of targeted reviews.
- 10.18. The integrated commissioning team is also working with SLaM, Lambeth and Lewisham on a Complex Care Placements Recovery programme which is in its early stages.

LGBTQIA+ Needs Assessment

- 10.19. The LGBTQIA+ needs assessment has been developed collaboratively with residents, the community and voluntary sector, and partners to describe the health and wellbeing needs of LGBTQIA+ people in Southwark. The full report can be accessed here: [Joint Strategic Needs Assessment Programme | Southwark Council.](#)
- 10.20. This needs assessment highlights the current state of health inequalities faced by LGBTQIA+ residents in health services access, experience and outcomes, as well as broader sociocultural factors impacting health and wellbeing. The report shows consistent evidence that LGBTQIA+ people experience greater health inequalities when compared with cisgender and heterosexual people.
- 10.21. This needs assessment identifies five overarching themes in how public sector bodies, VCSE organisations and local services could improve, to better support the health and wellbeing of LGBTQIA+ residents in Southwark. Work is ongoing with partners across the system to progress many of these recommendations.

ICB Board Meeting in Public

Title	Overall Committees Report					
Meeting date	16 July 2025	Agenda item Number	5	Paper Enclosure Ref	E	
Author	Simon Beard, Associate Director for Corporate Operations					
Executive lead	Tosca Fairchild (Chief of Staff)					
Paper is for:	Update	x	Discussion		Decision	X
Purpose of paper	The purpose of the paper is to highlight to the Board any DECISIONS referred to the Board from ICB Committees, to provide INFORMATION on any decisions made under derogation by those committees, and to provide INFORMATION on activity of the committee meetings.					
Summary of main points	The Overall Committees paper provides an overview to the Board members of the activity and decision making that has taken place at the ICB committees which report directly to the Board in the period since the last Board meeting held in public. In particular the Board is asked to note: • Decisions referred to the Board for approval, detailed in section 4. • Decisions made by committees, under their own delegated authority. The Board is asked to consider the decisions referred for approval and to note the other activity that has taken place during the period.					
Potential conflicts of Interest	Where conflicts have been identified with any items discussed at a committee, action has been taken to mitigate the conflict in line with the ICBs Standards of Business Conduct policy.					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	No equality impacts identified					
Financial Impact	Any financial impacts are identified in the relevant papers.					
Public Patient Engagement	This paper is being presented to a Board meeting held in public for the purposes of transparency.					
Committee engagement	Discussions at other committees are detailed in the attached paper.					
Recommendation	The Board is asked to: • Approve the decisions recommended by its committees • Note the committee decisions and committee activities detailed.					



Overall Report of the ICB Committees

ICB Board 16 July 2025

1. Introduction

- 1.1 The purpose of this report is to provide a summary of the activity that has taken place within the Committees that report directly to the Board since the last meeting on 16 April 2025. In addition the ICS benefits from two provider collaboratives and one provider network and whilst no formal delegation has been made to them from the ICB this paper provides an update on their key activities over this same period.
- 1.2 The report highlights:
- Decisions recommended to the Board from Committees, in line with the ICBs Scheme of Reservation and Delegation.
 - A summary of items discussed at the Committees during the period being reported.
 - Report of activities taking place in the Local Care Partnerships of South East London.
 - Report of activities taking place in the South East London provider collaboratives and community services provider network.

2. Summary of Meetings

2.1 ICB Committees

	Committees								
	Integrated Performance Committee	Quality and Safeguarding Committee	Audit & Risk Committee	Remuneration Committee	Greenwich Charitable Funds Committee	Clinical and Care Professional Committee	People Committee	Digital Committee	Executive Committee
Meeting date	-	2 April 2025	24 April 2025	-	-	30 April 2025	24 March 2025	13 May 2025	2 April 2025
	-	-	19 June 2025	-	-	-	-	-	16 April 2025
	-	-	-	-	-	-	-	-	30 April 2025
	-	-	-	-	-	-	-	-	14 May 2025
	-	-	-	-	-	-	-	-	28 May 2025
									11 June 2025
									25 June 2025

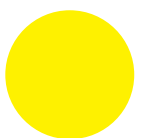
	Local Care Partnerships					
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Meeting date	27 March 2025	27 March 2025	23 April 2025	15 May 2025	27 March 2025	27 March 2025
	22 May 2025	19 June 2025	22 May 2025	-	22 May 2025	22 May 2025

To note, the March and May Integrated Performance Committees, and April Remuneration Committee did not take place. There have been no meetings of the Greenwich Charitable Funds Committee in the period.

3. Summary of the Principal Role of ICB Committees

Committee	Principal role of the committee	Chair
Integrated Performance Committee	Oversight and assurance of delivery of the ICS four aims through the objectives and deliverables set out in the range of ICP and ICB strategic plans. The Committee will monitor how delivery across different parts of the system contributes to the ICS's overall strategic work and direction, seeking to ensure efforts are aligned across the system.	Paul Najsarek, Non-Executive Member
Quality and Safeguarding Committee	Acts as a focal point for the collective oversight and strategic direction of safeguarding and quality matters across SEL Integrated Care System. Responsible for overseeing the delivery of high-quality care, ensuring compliance with safeguarding legislation, promoting the safety and wellbeing of vulnerable populations and fostering continuous improvement in health services. This is aimed at supporting improved health outcomes, reduced inequalities and enhanced patient experience.	Anu Singh, Non-Executive Member
Audit & Risk Committee	Responsible for delegated approval of annual accounts, providing an objective view of the ICB's compliance with statutory responsibilities, arranging appropriate audit, and oversight / assurance on the adequacy of governance, risk management and internal control processes across the ICB.	Peter Matthew, Non-Executive Member
Greenwich Charitable Funds Committee	Responsible for discharging its duties as a corporate trustee. Referred to as the Greenwich Healthier Communities Fund.	Peter Matthew, Non-Executive Member
Clinical and Care Professional Committee	Responsible for bringing together clinicians, care professionals and south east London residents to ensure the ICB has robust care, patient and public engagement, population health management, and leadership in place to shape and that the ICB's plans are demonstrably influenced by the outputs of its engagement work.	Dr Toby Garrood, Medical Director Paul Larrisey, Acting Chief Nursing Officer

People Committee	Responsible for the design, development and delivery of plans related to the health and care workforce in South East London. This includes meeting any national targets and ensuring sufficient and consistent strategies across the ICS for equality, diversity and inclusion and staff health and wellbeing.	Dr Ify Okocha, Partner Member
Digital Committee	The Digital Committee is constituted of members from across the SEL Integrated Care System partnership and provides leadership to the development of strategic priorities for digital and analytics, including ensuring digital capabilities are utilised to reduce inequalities.	David Bradley, Partner Member
Executive Committee	The Committee provides a platform for the executive directors of NHS South East London Integrated Care Board (SEL ICB) to discuss key issues relating to the strategy, operational delivery and performance of SEL ICB, and related Integrated Care System or wider issues upon which the executive team should be briefed or develop a proposed approach.	Andrew Bland, ICB Chief Executive
Local Care Partnerships	Responsible for convening local system partners to develop plans to meet the needs of the local population, reduce inequalities and optimise integration opportunities. The ICB will delegate responsibility for the delivery of specified out of hospital care objectives and outcomes, including the management of the associated budget. A representative from each LCP will be a member of the ICB.	Dr Sid Deshmukh (Bexley) Dr Andrew Parson & Cllr Colin Smith (co-chairs, Bromley) Dr Nayan Patel (Greenwich) Dr Di Aitken & Cllr Jim Dickson (co-chairs, Lambeth) Dr Jacqui McLeod (Lewisham) Dr Nancy Kuchemann & Cllr Evelyn Akoto (co-chairs, Southwark)



4. Recommendations to the Board for Decision / Approval

- 4.1 The ICB Board is asked to consider the revised Terms of Reference for the Clinical and Care Professional Committee included in Appendix A, which is recommended for approval by the Committee.
- 4.2 The ICB Board is asked to consider the 2025/26 start budgets for approval, as reviewed and recommended by the Executive Committee.
- 4.3 For transparency it is noted that the Board met on 18 June 2025 to be briefed on the ICB Reform programme, and at that meeting a draft terms of reference was approved for creation of a Transition Committee, as required in national guidance.

5. Decisions made by Committees or Sub-Committees Under Delegation

5.1 Below is a summary of decisions taken by committees under delegation from the Board.

No.	Committee name	Meeting date	Items for Board to note
1.	Executive Committee	16 April 2025	The Committee approved terms of reference for a group designed to develop a single population health and system intelligence function, making suggestions on membership.
2.	Audit & Risk Committee	24 April 2025	The 2025/26 internal audit programme was approved.
3.	Audit & Risk Committee	24 April 2025	The Committee reviewed and scrutinised the draft annual accounts and report, approving submission to NHS England.
4.	Executive Committee	30 April 2025	The Committee approved a recommendation from Bexley Wellbeing partnership in relation to appointment of a preferred provider and endorsed proceeding to contract discussions in relation to the Urgent Treatment (UTC) Service
5.	Executive Committee	30 April 2025	The Committee approved an approach and interim commissioning policy to implement the NICE technology assessment in relation to weight management drugs Mounjaro® (tirzepatide) and Wegovy® (semaglutide).

6.	Executive Committee	14 May 2025	The Committee approved corporate policies recommended by the Policy Review Group including new policies in relation to social media and a probationary policy.
7.	Executive Committee	14 May 2025	The Committee approved a Specialty Primary Care Guideline in relation to General Surgery.
8.	Executive Committee	28 May 2025	The Committee approved a SEL Local Resolution Policy, Procedure and Independent Review Panel Guidance in relation to continuing health care.
9.	Executive Committee	28 May 2025	The Committee approved a document setting out principles for colleagues working across the interface between primary and secondary care.
10.	Executive Committee	11 June 2025	The Committee approved updated policies in relation to Mental Capacity Act and DoLS, Managing Allegations Against Staff, and the Information Management policy.
11.	Executive Committee	11 June 2025	Approval was given for a proposal to provide continuous glucose monitoring devices for eligible patients with Type 2 diabetes, escalated from the Integrated Medicines Optimisation Committee due to exceeding the cost threshold.
12.	Audit & Risk Committee	19 June 2025	The Committee approved the submission of the audited annual report and accounts and the letter of representation by management.
13.	Executive Committee	25 June 2025	The Committee approved a proposal for use of ring-fenced dental budget to sustain levels of dental access in south east London and contribute to the commitment to restore pre-pandemic levels of activity.
14.	Executive Committee	25 June 2025	The Committee endorsed accreditation panel recommendations in relation to requests for a provider to be accredited against the service specification for ADHD services.
15.	Executive Committee	25 June 2025	The Committee endorsed the accreditation panel recommendation in relation to requests for a provider to be accredited against the service specification for consultant-led outpatient chronic pain services.

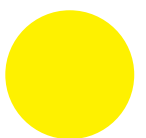
6. Agenda Items of Note

6.1 Below is a summary of other significant actions and items of note for Board information.

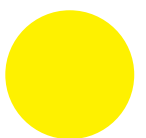
No.	Committee name	Meeting date	Items discussed
1.	People Committee	24 March 2025	• Government-mandated NHS directives: Members discussed the Government announcements regarding the planned abolition of NHS England, 50% reduction in running costs for ICBs and provider corporate growth reduction. Discussions focused on the impact on staff. • The Committee noted and discussed two specific social care risks: international recruitment challenges due to revoked licenses and policy changes restricting dependents and the impact of increased employer national insurance contributions on care providers. • Voice of social care and collaborative working: A spotlight presentation highlighted the significant demand for acute care from care homes in SEL, with over 6,000 individuals requiring support over nine months. Key challenges discussed included lack of access to information, communication barriers with ward staff and quality and safety concerns affecting collaborative working. • System leadership and Integrated Neighbourhood working: Members received an overview of plans for Integrated Neighbourhood Teams (INTs), focusing on three population groups: individuals with three or more long-term conditions, those experiencing frailty or approaching end of life and children with complex needs. The SEL System Leadership Academy progress was reviewed, with approximately 400 system leaders engaged. • Members received an update on the Oliver McGowan (OMG) mandatory training completion rates across SEL, which remain low at 20% for Tier 1 and 11% for Tier 2. Three delivery options for 2025/26 were discussed, with Option 3 (commissioning from an external provider) identified as the preferred approach. • An overview of the People Programme current year achievements was presented, highlighting reaching 738 individuals through EDI events, securing £500k savings through collaborative Employment Assistance Programme contracts

			and the SEL Health and Care Jobs Hub supporting over 700 individuals into employment.
2.	Quality & Safeguarding Committee	2 April 2025	• The Committee received update reports on quality and safety, the Local Maternity and Neonatal System report, All Age Continuing Care, Infection, Prevention and Control, Patient Experience, and Learning Disability, Autism and SEND. • The Quality Impact Assessment Policy was considered and agreed for recommendation to the Executive Committee and Policy Review Group for approval. • The Committee received a presentation on Patient Safety Incident Investigation (PSII), learning resulting from after action reviews, PSII and thematic reviews in the last reporting period. • The Committee was briefed on the quality oversight function in place for Specialised Commissioning, which was delegated to the ICB from 1 April 2025. • A comprehensive update on Safeguarding was delivered, covering training compliance, delivery of workstreams against the safeguarding workplan, safeguarding exceptions report, safeguarding statutory reviews, and development of the safeguarding competency strategy. • The quality, safety and safeguarding risk register was reviewed.
3.	Executive Committee	2 April 2025	• The Committee received an update on Electronic Patient Record system procurements at South London and Maudsley NHSFT and Lewisham and Greenwich NHST discussing the implications for the system and the benefits of alignment and interoperability. • The Committee received a report on Performance in the ICS. • A report on the financial position as at Month 11 was received, noting forecasted achievement of the ICB and ICS plans for 2024/25 but with a challenging plan for 2025/26. • The latest Board Assurance Framework was considered and recommended to the ICB Board. • Committee members received an update on the internal audit plan for the coming year, endorsing the plan and making suggestions on timing and handling of actions arising.

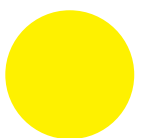
4.	Executive Committee	16 April 2025	• An update on the 25/26 operating plan was received, noting that the ICB had been required to provide further assurance in relation to Cost Improvement Plan (CIP) risks and productivity actions. • A presentation was delivered on efforts to increase usage of the NHS App in south east London, noting achievement of the 60% registrations target and a month-on-month improvement in use of other functionality.
5.	Audit & Risk Committee	24 April 2025	• Grant Thornton presented an update on the external audit plan for 2024/25, confirming the parameters of the audit and updating on completion of the Mental Health Investment Standard review. • The Committee received the internal audit progress paper and a separate paper on follow up of management actions. • The draft Head of Internal Audit Opinion was received from RSM and approved for inclusion in the draft annual report. • The 2025/26 internal audit programme was approved. • The Committee received an update report on progress against the anti-crime services annual workplan. • The Committee reviewed and scrutinised the draft annual accounts and report, approving submission to NHS England. • The Committee received a presentation on the latest Board Assurance Framework and work in relation to strategic system risks. • The Committee noted a report on tender waivers and confirmation no special payments, losses or write offs had been transacted in the reporting period.
6.	Clinical & Care Professional Committee	30 April 2025	• The Committee agreed a revised Terms of Reference for recommendation to the ICB Board for approval. • An update report on Engagement Assurance Committee activity was delivered. • The Committee received a briefing on neighbourhood working followed by a discussion on implications and next steps. • The System Sustainability Group delivered an update on progress. • The members discussed the work on the primary and secondary care interface consensus document, approving publication of the document.



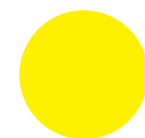
7.	Digital Committee	13 May 2025	• The meeting received a presentation on rollout of the eMental Health Act. • The Digital Capability Framework report was discussed, noting the risks and challenges with the supporting data. • The Committee were updated on the progress being made with Electronic Patient Record programmes in south east London. • Challenges with pathology order communications were discussed. • The meeting received a progress report on uptake of the NHS App in south east London, noting a 62% uptake rate as at the end of April 2025 and the ongoing campaigns to improve this rate in the next year. • The meeting discussed the piloting of ambient voice technology in mental health settings.
8.	Executive Committee	14 May 2025	• The Committee reviewed a monthly report on Performance in the ICS • Members conducted a deep dive into the corporate objective in relation to providing physical health checks for people with a serious mental illness, discussing progress as well as the impact of challenges and potential risks such as fragmentation of delivery, data sharing and recording, and changes to the primary care (QOF) incentive system. • The Committee endorsed the accreditation panel recommendation in relation to requests for a provider to be accredited against the service specification for consultant-led services in ENT • The Committee endorsed the accreditation panel recommendation in relation to requests for a provider to be accredited against the service specification for SEL Dermatology and Gynaecology. • Members noted budgets developed for 2025/26 and recommended them to the Board.
9.	Executive Committee	28 May 2025	• Received reflections from those involved on the process of provider accreditation required of ICBs. • Received an update on work with stakeholders across the system on the primary care- secondary care interface.



			The Committee endorsed accreditation panel recommendations in relation to requests for two providers to be accredited against service specification for ADHD services.
10.	Executive Committee	11 June 2025	- The Committee approved updated policies in relation to Mental Capacity Act and DoLS, Managing Allegations Against Staff, and the Information Management policy. - Approval was given for a proposal to provide continuous glucose monitoring devices for eligible patients with Type 2 diabetes, escalated from the Integrated Medicines Optimisation committee due to exceeding the cost threshold. - Committee members received an update on the progress with the ICB Change programme as well as updates on national guidance. - The Committee received a report of a recent Emergency Planning, Resilience and Response exercise ('Fracti'), noting the recommendations and learning. - The Committee received an update on Performance in the ICS
11.	Audit & Risk Committee	19 June 2025	- The Committee received and noted the 2024/25 annual report from the internal auditors. - The Committee accepted the external audit findings presented in the auditors annual report and audit outcomes report, which gave a very positive picture on the value for money audit and audit of the annual accounts for 2024/25. The external auditors confirmed an unmodified opinion for the accounts. - The Committee members approved submission of the audited annual report and accounts, as presented, and approved the letter of representation by management. - Discussion took place on forward planning for the committee agenda, with a proposal that ICB reform risks be included as a specific rolling agenda item.
12.	Executive Committee	25 June 2025	- An updated Board Assurance Framework was reviewed and recommended for presentation to the Board. - The Committee received an update on the development of neighbourhood health services.



			• An update on the financial position for month 2 2025/26 was presented.
--	--	--	--



Bexley Local Care Partnership – Bexley Health and Wellbeing Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Bexley Health and Wellbeing Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Bexley Health and Wellbeing Partnership under delegation from the Board:

No.	Meeting date	Agenda item	Items discussed
1.	27 March 2025	4. Integrated Joint Forward Plan 2025/26	The Bexley Wellbeing Partnership Committee received the refresh of Integrated Joint Forward Plan 2025/26. The plan sets out Bexley's medium-term objectives, outlining the development of service offers that meet the needs of the population in line with the Joint Local Health & Wellbeing Strategy. The Bexley Wellbeing Partnership Committee: • Approved the refreshed the Bexley Integrated Joint Forward Plan.
2.	27 March 2025	5. South East London Integrated Care System: Neighbourhoods & Integrated Neighbourhood Teams Framework	The Bexley Wellbeing Partnership Committee were asked to endorse the South East London Integrated Care System Neighbourhoods & Integrated Neighbourhood Teams Framework and the local approach to developing a neighbourhood health service. The Bexley Wellbeing Partnership Committee: • Endorsed the local health and care system's approach to neighbourhoods. • Approved the South East London Integrated Care System Neighbourhoods & Integrated Neighbourhood Teams Framework.
3.	27 March 2025	6. SEL Integrated Care System: Voluntary,	The Bexley Wellbeing Partnership Committee received an update on the SEL Integrated Care System's Voluntary, Community & Social Enterprise (VCSE) Charter. The Charter sets out how the system works with and supports the VCSE sector.

		Community & Social Enterprise Charter	The Bexley Wellbeing Partnership Committee: • Approved the adoption of the SEL VSCE Charter in Bexley. • Noted the London Borough of Bexley response to the Charter.
4.	27 March 2025	7. Better Care Fund 2025/26 Plan	The Bexley Wellbeing Partnership Committee received a draft of the Bexley Better Care Fund (BCF) 2025/26 Plan for approval. The Bexley Wellbeing Partnership Committee: • Commented on the draft Bexley BCF Plan for 2025/26. • Authorised the Place Executive Lead (Bexley, NHS South East London Integrated Care Board) on behalf of NHS South East London Integrated Care Board to review and agree the BCF Plan for 2025/26 with the Director of Adult Social Care & Health (London Borough of Bexley).
5.	22 May 2025	4. Community Champions Vision & Strategy	The Bexley Wellbeing Partnership Committee received a presentation of the Bexley Community Champions Vision & Strategy. The Community Champions Programme is recognised as a vital asset for the local health and care system and partners. The Bexley Wellbeing Partnership Committee: • Endorsed the Community Champions Vision & Strategy.
6.	22 May 2025	5. SEL Ageing Well Frailty Framework	The Bexley Wellbeing Partnership Committee were provided with an update on the development and adoption of the South East London (SEL) Integrated Care System's Ageing Well Framework. The Ageing Well Framework was developed between January and March 2025 involving multiple stakeholders and staff from each of the six boroughs across system partners, including residents. The Bexley Wellbeing Partnership Committee: • Endorsed the SEL Ageing Well Framework noting the alignment with Bexley's approach to developing an <i>integrated model of care</i> for Ageing Well/Frailty.
7.	22 May 2025	6. Lyndhurst Medical Centre – Contract Variation	The Bexley Wellbeing Partnership Committee received the report on the Lyndhurst Medical Centre Contract Variation. The purpose of the report was to approve a variation contract for the Lyndhurst Medical Centre to include Burstard Wood Surgery as a second (branch) site and transfer the registered patient list.

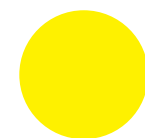
			The Bexley Wellbeing Partnership Committee: • Endorsed the recommendation.
--	--	--	---

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	27 March 2025	8. Tackling Health Inequalities: Progress Report	The Bexley Wellbeing Partnership Committee received an update on the progress of place-based health inequality projects funded by the Health Inequalities Fund entering their second year of delivery. The Bexley Wellbeing Partnership Committee: • Noted the update report on the progress.
2.	27 March 2025	10. <i>Let's talk:</i> Parenthood	• The Bexley Wellbeing Partnership Committee heard presentations on the support available to parents in the borough – particularly around mental wellbeing. The Committee heard from Bexley Maternity Voices Partnership and Mind in Bexley. The Committee heard about the 'Mindful Mums Project' and 'The Unlikely Mummy', a charity focussed on peer support for mothers struggling with their mental health.
3.	22 May 2025	7. Primary Care Quarterly Business Report (Q4 2024/25)	The Bexley Wellbeing Partnership Committee received the Quarterly Primary Care Delivery Sub-Committee Report (Q4 2024/25). The Bexley Wellbeing Partnership Committee: • Noted the report and the progress being made.
4.	22 May 2025	11. <i>Let's Talk:</i> The Power of Sport	• The Bexley Wellbeing Partnership Committee meeting was hosted by the Welling United Football Club (FC). The Committee heard presentations on how way being involved in sport and connected to a local sports club not only helps with physical, but also mental and social wellbeing. The Committee heard from the Welling United FC on joint efforts with the partnership on reaching working age men – by providing blood pressure checks on matchdays, encouraging take-up of Flu and COVID vaccinations

			for those eligible, and providing opportunities to talk about their mental wellbeing. The committee also heard from Oxleas NHS Foundation Trust about their project, which supports improving mental health through involvement in football and boxing. The committee also heard from the founder of the Bexley Walking Football Club.
--	--	--	---



Bromley Local Care Partnership – One Bromley

1. Recommendations to the Board for Decision/Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Bromley LCP Under Delegation

2.1 The following Contract Awards have been made by the Local Care Partnership under delegation:

- Bromley Mental Health and Wellbeing Hub
- Hospital Advocacy Service at the PRUH
- Rental of beds and mattresses
- Bromley Digital Locum Bank Service (2025-2027)
- Bromley Talking Therapies
- Community Headache Service
- Community Vasectomy Service
- Hospice Contract

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	27 March 2025	Item 6 – Neighbourhood Development Next Steps	• An update on development of Integrated Neighbourhood Teams (INTs) in Bromley was given, with broad discussion including topics such as reasoning for use of Delphi methodology, the integrator function, and the importance of communication.

			The Committee noted the South East London ICB Neighbourhood Framework, affirmed the importance of working together in INTs for and with our communities to tackle real world challenges and agreed to champion and discuss the approach in Bromley with their teams.
2.	27 March 2025	Item 7 – One Bromley End of Year Achievements 2024-25	The report was presented, with thanks given to all organisations for their contributions. The importance of celebrating achievements was noted, with a large amount of work driven forward in Bromley.
3.	27 March 2025	Item 8 - Partnership Report	The report on partnership working was received, highlighting that the Bromley SEL ICB team had moved into Bromley Civic Centre recently. Thanks were given to the local authority for hosting the team.
4.	27 March 2025	Item 9 - Month 10 SEL ICB Finance Report	- The SEL ICB and Bromley financial position as at Month 10 was discussed and noted. SEL ICB was forecasting that it would deliver a year end breakeven position. - The Bromley budget for 2025/26 was discussed and the report was noted.
5.	27 March 2025	Item 10 – Primary Care Group Report	The meeting focused on capacity and access in the primary care group, the transition transformation fund and ensuring support was given to practices and PCNs in delivering what is required.
6.	27 March 2025	Item 11 – Contracts and Procurement Group Report	Contracts were awarded as noted above. The list outlining contracts due to expire before May 2026 was highlighted.
7.	27 March 2025	Item 12 – Performance, Quality and Safeguarding Group Report	The LCP noted the meeting had focused on development of Integrated Neighbourhood teams from a performance, quality and safeguarding perspective. The Bromley Place Quality Summary Report, One Bromley Performance Report and Bromley Risk Register was discussed and noted. A safeguarding update was also presented.
8.	19 June 2025	Item 6 – Urgent and Emergency Care Recovery and Winter Planning Update	- The process undertaken to review last winter and to start to plan for this year was outlined. A rigorous evaluation was undertaken, which drew upon qualitative data and organisational feedback across the system. A workshop took place which was facilitated by the Bromley A&E Delivery Board and chaired by Dr Angela Bhan. - Twelve recommendations had been identified for action for next winter, these were noted. A winter planning paper would come to this meeting in the coming months.

9.	19 June 2025	Item 7 - Integrated Neighbourhood Teams Multiple Long-Term Conditions Focus	- The Bromley approach to rollout of Integrated INTs was outlined and discussed. - Questions included how this would be evaluated and how we could best communicate with staff and residents around this change. The Committee noted the latest developments in INTs and endorsed the cascade approach and multiple long-term condition focus agreed by the One Bromley Executive.
10.	19 June 2025	Item 8 - Communications and Engagement Annual Report	The paper covered the 2024-25 period and was taken as read. Key areas were highlighted including details of joint working and achievements across the system over the year. The report was noted.
11.	19 June 2025	Item 9 – Partnership Report	- The report was taken as read, with no further comments or questions received. - The report was noted.
12.	19 June 2025	Item 10 – Finance Month 12 Update	The Committee was advised the Integrated Commissioning Board (SEL ICB) had delivered all financial duties for 2024-25. The Bromley place budget was signed off in May and the borough is currently forecasting a breakeven position for the year.
13.	19 June 2025	Item 11 – Primary Care Group Report	- The meeting discussed a range of topics including the Primary Care Sustainability Programme, Bromley Education and Training Hub: 24/25 year-end report and 25/26 plans and digital change in primary care. - There were no comments or queries raised, and the report was noted.
14.	19 June 2025	Item 12 – Contracts and Procurement Group Report	Contracts have been awarded as noted above. The list outlining contracts due to expire before May 2026 was highlighted.
15.	19 June 2025	Item 13 – Performance, Quality and Safeguarding Group Report	The report outlined details of items discussed at the April and June meetings. These had included a detailed update on the Bromley Integrated Community Equipment Service, SEL System Quality Reports for Bromley and updates on the Bromley Risk Register. The report was noted.

Greenwich Local Care Partnership – Healthier Greenwich Partnership (HGP)

1. Recommendations to the Board for Decision / Approval

1.1 No items are recommended to the Board for decision or approval in the reporting period.

2. Decisions made by Healthier Greenwich Partnership LCP Under Delegation

2.1 Below is a summary of decisions taken by the Healthier Greenwich Partnership LCP under delegation from the Board:

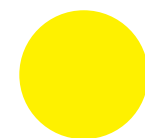
No.	Meeting date	Agenda item	Items for Board to note
1.	23 April 2025	Agenda item 8.2 Concept of an Integrator	The LCP members agreed that work on the Integrator model for Greenwich would commence, and that next steps would be discussed at the next quarterly meeting
2.	22 May 2025	Agenda item 3 Updated on Thamesmead APMS Contract Award	The LCP members approved that the procurement process for Thamesmead Medical Centre APMS contract be rewound to the point of contract award

3. Agenda Items of Note

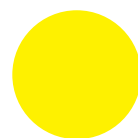
3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	23 April 2025	Agenda item 6. Chair Rotation	- The LCP members were advised that the Chair rotation as noted in the Terms of Reference, would take effect from May 2025 - The LCP members noted that the new Chair would be Kate Heaps, Chief Executive of Bexley and Greenwich Community Hospice

			An expression of gratitude on behalf of the partnership, residents and community was made to the outgoing Chair, Iain Dimond, by the LCP members
2.	23 April 2025	Agenda item 7. HGP Refresh and Joint Forward Plan	- The LCP members received a report and discussed the Joint Forward Plan, which included a reminder of the five pillars known as 'The Wells', highlighting high impact activities for 2025/2026 - The LCP members discussed how to progress collectively to ensure delivery of the plans - The LCP members noted that once the 10-year plan is published there may need to update the plan to make it more comprehensive
3.	23 April 2025	Agenda item 8.1 Neighbourhood Next Steps	- The LCP members received a report that detailed the neighbourhood geographies in Greenwich which included a population analysis for each area - The LCP members noted that there are some universal goals that apply to all neighbourhood - The LCP members were advised that there were some areas that would require more investigation before these were rolled out across the borough
4.	23 April 2025	Agenda item 8.2 Concept of an Integrator	- The LCP members had received a detailed paper prior to the meeting which detailed the functions of an integrator - The LCP members noted that there are some areas of duplication - The LCP members were advised that the announcement of 50% reduction in corporate costs which providers were also required to action would have an impact
5.	23 April 2025	Agenda item 9. Positive Partnership Story – Partnership working to improve acute flow during Super March	- The LCP members received a report on an initiative at Queen Elizabeth Hospital during March which involved several system partners - The LCP members noted that there was an improved 4-hour performance of 6.5% in comparison to March 2024 - The LCP members were advised that there was a significant amount of collaborative work between local partners which developed into building relationships that assisted with understanding and empathy and open communication on shared frustrations - The LCP members were advised about the trial of a Transference of Care Hub that held daily meetings where next actions in specific pathways were agreed



			The LCP members noted that the Transference of Care Hub was successful, and plans are being made to continue in a way that not only works but is beneficial
6.	23 April 2025	Agenda item 10. Healthier Greenwich Charitable Funds update – Funding Awards and Funding Themes	- The LCP members received an update on the distribution of funding awards and new funding themes - The LCP members noted that in the previous financial year 79 grants had been awarded with an overall value of £1.3 million - The LCP members were advised that themes aligned to inequalities had been developed for the delivery strand medium and large awards where applicants will have to clearly demonstrate how their project aligns with one of the themes to be considered for funding - The LCP members noted that the themes are relevant for the current financial year and the fund will then be paused, re-developed and new themes selected
7.	23 April 2025	Agenda item 11. Healthier Greenwich Partnership Report – Chief Operating Officer report	Members received the quarterly partnership report, which included updates from partners and the Healthier Greenwich Communities Fund
8.	23 April 2025	Agenda item 13. Risk update	The LCP Board reviewed the current Place based risk register, noting changes since the last update, and the work taking place at SEL level to consider system wide risk and agreed to accept the mitigations that have been put in place.



Lambeth Local Care Partnership – Lambeth Together

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lambeth Together Care Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Lambeth Together Care Partnership under delegation from the Board.

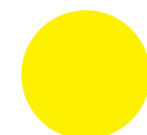
No.	Meeting date	Agenda item	Items for Board to note
1.	15 May 2025	Deep Dive: Homeless Health	Members of the Partnership Board: - Approved the Homeless Health programme progress report in line with 'Our Health Our Lambeth' activities and outcomes. - Endorsed recommissioning plans for the Vulnerable Adults housing pathway and rough sleeping outreach service.
2.	15 May 2025	Deep Dive - Sexual Health	Members of the Partnership Board: - Approved the progress report for the sexual health programme against 'Our Health, Our Lambeth' activities and outcomes. - Endorsed the promotion of local sexual health services, including the outreach service and Find Sexual Health online resource.
3.	15 May 2025	Lambeth Together Primary Care Commissioning Committee (PCCC)	Members of the Partnership Board noted the update on discussions held at the Primary Care Commissioning Committee on 19 March 2025 and ratified decisions made by the Committee at the meeting on 19 March 2025.
4.	15 May 2025	Business Planning: Second Annual Review Our Health Our Lambeth	Members of the Partnership Board: - Approved the second annual review of <i>Our Health, Our Lambeth</i> and the 2025/26 action plan. - Endorsed the final integrator model for Integrated Neighbourhood Teams (INTs) as agreed by the Neighbourhood and Wellbeing Delivery Alliance.

			Noted the 2025/26 SEL ICB (Lambeth) budget and 2025/26 Lambeth Council budget for health and social care and supported the expenditure plans.
--	--	--	---

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

1.	15 May 2025	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received an update on key developments since the last formal Lambeth Together Care Partnership Board meeting in Public on 6 March 2025, reporting on key issues, achievements and developments from across the Lambeth Together Partnership.
2.	15 May 2025	Lambeth Together Assurance Group (LTAG) Update	Members of the Partnership Board noted the update report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented at the Sub-Group on 18 March 2025, focused on outcomes that the partnership is aiming to achieve through delivery of the <i>Our Health, Our Lambeth</i> plan, with detailed updates by Lambeth partners leading work to understand impact of the activity and to track that outcomes are being achieved.



Lewisham Local Care Partnership – Lewisham Health & Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lewisham Health & Care Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Lewisham LCP under delegation from the Board.

No.	Meeting date	Agenda item	Items for Board to note
1.	27 March 2025	Item 4: Joint Forward Plan: Annual update	The Board were asked to give formal approval on the update of the Joint Forward Plan (JFP) , noting it had been endorsed by the Health and Wellbeing Board and was discussed at a recent LCP Strategic Board seminar.
2.	27 March 2025	Item 6: Neighbourhood health service	The Board were asked to approve the Neighbourhood health service: SEL Framework/Lewisham Integrated Neighbourhood Team Model of Care , noting the purpose was to develop a SEL Integrated Neighbourhood Team (INT) framework across all six Places in south east London , and followed the Fuller report in 2022 which recommended that all ICBs put in place a neighbourhood care model to deliver care in a more integrated manner.
3.	22 May 2025	Item 9: Primary Care Group - updated Terms of Reference	The Board were asked to give formal approval on the updated terms of reference (ToRs) for the Primary Care Group , recognising changes were made to the financial responsibilities around the signing off process and the provision for the chair of the Primary Care Leadership Forum to sit on the Group to strengthen the leadership of the Group and facilitate learning and sharing of information.

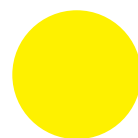
3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	27 March 2025	(3). PEL report	- The report included a brief on the NHS Changes recently announced. Planning Work was continuing to finalise plans for 2025/26, noting the 5% savings required from all LCPs for the coming year equated to £8,975k for Lewisham. This was the minimum required and further savings may be required to manage in year pressures. - Work to develop SEL Frameworks for LTC and Frailty collectively across the six SEL Places and SEL wide teams was discussed, to be delivered through neighbourhood working and the Integrated Neighbourhood Teams (INTs). A LTC framework had been previously agreed across the six Places and the focus was now on understanding gaps in provision against the framework for each Place and how these may be addressed within current funding envelopes.
2.	27 March 2025	(5). Community Development Projects and Funding/SDIP	Community Development Projects and Funding/SDIP; The transformation improvement funding for community services was discussed, describing the process that took place with joint working with providers such as Lewisham and Greenwich Trust, Local Authority, ICB and Primary Care, to ensure investment was targeted for maximum impact. The members were advised there is an additional recurrent fund of £200k to help the service with back logs, meaning teams could recruit to new posts to help with ongoing demand. In addition, funding had been allocated for bladder and bowel, new pharmacists and prescribers for the neighbourhood work to undertake multimorbidity assessments. Funding was also allocated for district nursing service.

3.	27 March 2025	(7). Primary Care Access Plan 24/25	• Primary Care Access Plan 24/25: The Primary Care Access plan in Lewisham was discussed, including the data trends and themes across certain areas, noting ongoing work to improve the primary and secondary care interface, including setting out the issues and putting in place actions to improve communication.
4.	27 March 2025	(8). Take Home and Settle (THAS) & Homeless support discharge services update	• A paper was presented for approval to award the Take Home and Settle (THAS) and Homeless Patients Legal Advocacy procurement contracts. These are the contracts who had been successful following the procurement process: • Homeless legal Advisory Service - there were 2 bidders in total, with 1 successful bidder reaching 81% and that was The Incumbent. • Take Home and Settle – there were 20 interested parties and a mix of bidders, 1 bidder scored 82.2% and that was the successful bidder - The Incumbent.
5.	27 March 2025	(9). Risk Register	• Risk Register update: the committee received an update on the Lewisham risk register, noting 15 total risks to date.
6.	27 March 2025	(10). Finance update	• Finance update: an update on the current delegated Lewisham Place financial position was delivered reporting an underspend of £86K at M10 and a break-even forecast outturn for 2024/25. This was a considerable improvement during the second half of the year and reflected ongoing work within CHC and prescribing. A savings plan, £3.6m (4%) of the budget excluding some budget areas were identified for 2024/25 and was delivering this in full.
7.	22 May 2025	(3). PEL Report	• NHS Reform: The Place Executive Lead updated the committee members on the national mandate to reduce ICB running costs and the engagement work underway with staff.
8.	22 May 2025	(4) Risk Register	• Risk Register update: an update was delivered on the local risk register, noting the challenge to achieve financial balance in year and new risks for the year including achievement of recurrent financial balance (592), achievement of efficiency savings

			(593) and temporary shortage of commissioned nursing capacity (594). The GP collective action risk was now closed.
9.	22 May 2025	(5) Finance update	• Finance update: The latest financial position was presented noting Lewisham achieved an underspend of £5K against a forecast break-even position under the delegated budget agreement, a significant achievement for Lewisham during the second half of the year.
10.	22 May 2025	(6) SEL Ageing Well Framework	• SEL Ageing Well Framework: The committee was updated on the progress made to engage with focused population groups, ensuring representation from across the system including our local populations.
11.	22 May 2025	(7) Plan to increase influenza vaccine 25/26	• Flu vaccination uptake and plans to improve and increase uptake for the upcoming flu season was briefed to the group, with plans including an aim to conduct engagement with our population and increase the number of community-based vaccination points.
12.	22 May 2025	(8). Briefing - Community Diagnostic Centres	• The Community Diagnostic Centres (CDC): The meeting was updated on the development of CDCs in South East London at two sites at Eltham Community Hospital and Queen Mary's Hospital in Sidcup.
13.	22 May 2025	(10). Programme Highlight Reports	• The key items of note from the Highlight reports presented at the monthly Place Executive Group meeting were discussed.



Southwark Local Care Partnership – Partnership Southwark

1. Recommendations to the Board for Decision / Approval

1.1 No items were referred to the Board for decision or approval in this period.

2. Decisions made by Partnership Southwark Under Delegation

2.1 Below is a summary of decisions taken by Partnership Southwark under delegation from the Board during the period.

No.	Meeting date	Agenda item	Items for Board to note
1.	27 March 2025	Item 3. Integrated Neighbourhood Teams	The board approved the SEL ICS Neighbourhood and Integrated Neighbourhood Teams framework and neighbourhood footprints for Integrated Neighbourhood Teams.

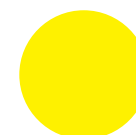
3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	27 March 2025	Item 2. Community Spotlight: Neighbourhood Care – Insights from the Walworth Triangle Frailty Pilot	The board received a presentation from Dr Nancy Kuchemann focussing on the learnings from the Frailty Pilot which she has been involved in through her GP role.

2.	27 March 2025	Item 5. Strategic Director for Health and Care and Place Executive Lead Report	The Strategic Director for Health and Care and Place Executive Lead presented the report to the board including: • The reduction in Integrated Care Board running costs • Community Southwark Impact report • Better Care Fund update • The Partnership Southwark Board development session on Environmentally Sustainable Healthcare • Southwark Health and Wellbeing Board update Reports from sub-groups of the board (Primary Care Group, Integrated Governance and Assurance and the Partnership Southwark Delivery Executive) were noted.
3.	27 March 2025	Item 6. Planning Update	• The board received an update on the financial plan for 2025/26 as well as other planning updates which included planning guidance, priorities and metrics.
4.	27 March 2025	Item 7. Integrated Assurance Report	• The board were presented with a draft of the new Integrated Assurance Report which aims to provide assurance to the board on the delivery of delegated ICB responsibilities. An executive summary of the report was provided, and the board discussed how this report can be further developed going forward. The board agreed to discuss a 'deep dive' into Immunisations and Vaccinations at a future board date.
5.	22 May 2025	Item 2. Community Spotlight: Showcasing the work of Pembroke House and Walworth Living Room	• The board received a talk from the team at Pembroke House/Walworth Living room which focussed on the importance of community spaces and sharing insights gathered from working with health partners. The board discussed the insights gained around the local community needs.
6.	22 May 2025	Item 3. Report from the Integrated Neighbourhood Teams Programme Board	• The board received a presentation covering updates from the Integrated Neighbourhood Teams Programme, including details on the London Target Operating Model for INTs and the updated governance structure.
7.	22 May 2025	Item 4. Estates Update	• The board received a presentation from Estates colleagues which explored how the Estates strategy fits with the Integrated Neighbourhood Teams priority. Board

			members and Estates colleagues discussed ways in which partners can best work together to tackle Estates related issues.
8.	22 May 2025	Item 6. Strategic Director for Health and Care and Place Executive Lead Report	The Strategic Director for Health and Care and Place Executive Lead presented the report to the board including: • The reduction in Integrated Care Board running costs • The Ofsted and CQC Thematic review of SEND children not in school • Maternity Commission update • Creative Health Southwark roundtable • Adult Mental Health Complex Care update • South East London ICB Board Presentation • ICB Health Inequalities Fund Impact report • Primary Care Contracts • An update on reporting from sub-groups Reports from sub-groups of the board (Primary Care Group, Integrated Governance and Assurance and the Partnership Southwark Delivery Executive) were noted.
9.	22 May 2025	Item 7. Integrated Assurance Report	• The board were presented an updated Integrated Assurance Report which aims to provide assurance to the board on the delivery of delegated ICB responsibilities. An executive summary of the report was provided and changes since the last board were highlighted.



Acute Provider Collaborative

1. Key decisions made by the Acute Provider Collaborative (APC)

1.1 Below is a summary of the decisions taken by the Acute Provider Collaborative for the period 1 April 2025 to 2 July 2025.

No.	Meeting date	Agenda item	Items for Board to note
1.	APC Executive 20 June 2025	APC resourcing 2025/26	The APC Executive approved a proposal to reduce the provider contribution element of APC income for 2025/26 by roughly 19% over the 2024/25 total with work under way to consider the impact of this on priorities and programme pace, as well as ways of streamlining governance.

2. Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note from the APC for the period 1 April 2025 to 2 July 2025, for Board information.

No.	Meeting	Agenda item	Items discussed
1.	APC Executive, 16 May 2025	APC surgical capacity at QMS	Queen Mary's Sidcup surgical capacity: agreed "twin track" approach to optimising utilisation at QMS in the short term while working up opportunities to optimise configuration in the medium to longer term – especially in the light of additional capacity coming on line.
2.	Multiple executive advisory groups – April to June 2025	Collaborative work with system sustainability group	Updates on ongoing Phase 1 service/specialty work to improve sustainability and address key challenges in orthopaedics, imaging, urogynaecology and breast services. Updates on ongoing Phase 2 work exploring wider opportunities.
3.	Multiple executive advisory groups – April to June 2025	Surgical centres task & finish group	Ongoing work to agree our collaborative approach to managing and optimising existing or future surgical centres (hubs) such as the Lewisham Surgical Centre, Guy's Surgical centre (e.g. role of host trust, workforce arrangements etc)

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

Below is a summary of decisions taken between 1 April and 30 June 2025, for the Boards awareness.

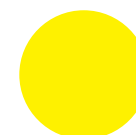
No.	Meeting date	Agenda item	Items for Board to note
1.	June 2025	NHS 111 for Mental Health	As part as strengthening of access for people with mental health concerns, SLP has commenced a programme of work to integrate 'NHS111 for Mental Health' with all- age mental health crisis lines operated by Oxleas, South London and Maudsley and South West London and St Georges. The objective of bringing these services together is to provide equity in access to a greater range of support options through one telephone call.

1. Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	June 2025	Secure mental health services	SLP has successfully mobilised a range of new services delivered through Oxleas, SL&M and SWLSTGs for adults with intellectual and neurodevelopmental disabilities who are known to mental health forensic services. Known as FIND (Forensic Intellectual and Neurodevelopmental Disabilities) these community-based services will provide care coordination and consultation to a range of partners across health and care.
2.	June 2025	Strategic commissioning	The strategic commissioning responsibilities for a range of mental health specialised services moved from NHSE to ICBs on 1 st April 2025. SLP, SEL ICB and SWL ICB

			have mobilised a new joint contracting management board to provide oversight and support for the continued success of four mental health provider collaboratives that cover secure care, CAMHS Tier 4, adult eating disorders, and perinatal inpatient services.
3.	June 2025	10 Year Health Plan	SLP's Partnership Committees-in-Common meets for a series of development sessions throughout the year and will be meeting on 23 July to consider the 10 Year Health Plan through the lens of partnership working and exploring further opportunities to drive greater value for our population through collaboration.



ICB Board Meeting in Public

Title	ICB Board Assurance Framework				
Meeting date	16 July 2025	Agenda item Number	7	Paper Enclosure Ref	G
Author	Kieran Swann (Associate Director of Assurance and Risk), Tara Patel (Head of Assurance - Risk)				
Executive lead	Tosca Fairchild (Chief of Staff)				
Paper is for:	Update		Discussion		Decision X
Purpose of paper	The latest Board Assurance Framework (BAF) sets out controls and assurances which show how risks are being appropriately managed as stipulated in the ICB's Risk Management Framework (RMF). The ICB Board is responsible for setting the strategic direction for risk management in the organisation and for formal approval of the BAF document. The Board agreed the scope of delegated activity to be undertaken by the Executive Committee (ExCo) and the six local care partnerships (LCPs) on its behalf in relation to risk management and has delegated the detailed oversight of risks to the ExCo. The RMF states that the Board should be kept apprised of significant risks facing the organisation and the actions taken on its behalf by the ExCo and other relevant committees to address them. The paper provides an update on ICB and ICS risk management activities and includes the latest version of the BAF, which was reviewed and endorsed by the ICB's Executive Committee on 25 June 2025.				
Summary of main points	Risk management update The ICB's risk and assurance team completed a comprehensive review of 116 risks across all SEL ICB directorate and LCPs to ensure alignment with 2025/26 priorities. Outdated risks were closed, new ones were added and escalated, and others were revalidated. The ICB's BAF remains aligned to system objectives through regular collaborative reviews, with peer learning now embedded via the SEL ICS System Risk Leadership Group. The team's approach was recently showcased at the KHP Advanced Safety and Quality Programme for future clinical leaders. ICB organisational change risks Four new risks linked to the ICB's management cost reduction programme covering change pace, business disruption, impact of change on staff, and disruption to developing programmes and long-term commitments have been added to the ICB's corporate risk register. Each of these risks is currently scored at 12 and will be monitored through the corporate risk process as this score currently sits below the BAF threshold.				

	Latest updates on BAF This paper presents the current version of the SEL ICB BAF, reflecting all risks above the ICB's agreed risk appetite threshold as of 16 June 2025. It has been endorsed by the ICB Executive Committee on 25 June 2025. The BAF includes 11 risks at SEL level and 2 LCP-level risks (Lewisham and Greenwich) which exceed agreed risk tolerance thresholds. There are no above-threshold risks for Bexley, Bromley, Lambeth, or Southwark LCPs. Key changes since the previous report: • Five new risks have been added to the BAF: • SEL 597 relating to the ICB falling victim to a cyber-attack (scored 12) • SEL 598 relating to patient records in some GP practices not being fully updated following a community pharmacy consultation (scored 16) • SEL 606 relating to ICS revenue financial plan (scored 25) • Lewisham 612 and Greenwich 619 relate to HealthIntent platform and funding position (both scored 16). • No existing risks escalated onto the BAF. • Two existing risks have de-escalated from the BAF: • Lewisham risk 528 relating to access to primary care services and Lewisham risk 561 relating to an increase in vaccine preventable diseases not reaching herd immunity across the population (seasonal vaccinations). Both risks were previously under the 'clinical, quality and safety' category. They have now been re-assigned to the "strategic" category, in alignment with the other LCP risks of the same nature. There has been no score change to these risks, which remain at 12. • Previous BAF risks that have been closed: • SEL 435 related to the ICB not meeting all age continuing care data set submission. SEL 543 related to SEL ICS revenue financial plan for 2024/25.																		
	Potential conflicts of Interest																		
	None identified																		
	<table> <tr> <td>Relevant to these boroughs</td><td>Bexley</td><td>X</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr> <tr> <td></td><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr> </table>						Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x		Greenwich	x	Lambeth	x	Southwark
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x													
	Greenwich	x	Lambeth	x	Southwark	x													
Equalities Impact																			
Not directly applicable to the production of this paper.																			



Financial Impact	Not directly applicable to the production of this paper.
Public Patient Engagement	Not directly applicable to the production of this paper.
Committee engagement	PELs Group, 2 June 2025 SEL ICS System Risk Leadership Group, 29 April 2025 SEL ICB Risk Forum, 13 May 2025 ICB Executive Committee, 25 June 2025
Recommendation	The Board is asked to review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 25 June 2025.



SEL ICB Board Assurance Framework July 2025

Prepared for SEL ICB Board, 16 July 2025

- **The ICB's risk appetite matrix allows the Board to set risk tolerance levels for various categories of risk across the organisation.** This approach is designed to promote and support local ownership of risk across the ICB's governance and delegation arrangements. It also means that the Board will receive a view on those risks that have been assessed as exceeding the tolerance levels set.
- **The ICB's Audit and Risk Committee is responsible for review and approval of the ICB's risk management arrangements on behalf of the Board.** The Audit and Risk Committee will consider an updated Risk Management Framework in July 2025 as per the agreed policy review schedule. Risk appetite thresholds are proposed to be retained at their current level across all risk categories.
- The **Board Assurance Framework (BAF)** document represents the full range of ICB risks that sit above the permitted level of risk tolerance.
- The ICB's **risk register includes system risks** which are material and are assessed as having some likelihood of impacting system objectives or the ability of the system to deliver business objectives.
- The ICB risk and assurance team continue to **collaborate with risk leaders from ICS NHS partner organisations on areas of common risk** impacting integrated care system objectives in south east London (**see slide 6**).

Review of Risks for 2025/26

- In April 2025, the ICB Risk and Assurance team led a comprehensive review process across all SEL and LCP risk registers.
- This process engaged all current ICB and 'place' risk owners and was run as a supportive 'check and challenge' type process.
- The review was designed to ensure all risks on SEL and place risk registers remain current, clearly owned, and are fit for purpose. To support this, the team circulated each borough/directorate's risk entries alongside targeted comments and queries to guide local review.

The objectives of the process were to:

- Support risk owners to revise and update risk and respond to all comments and challenges raised against each risk.
- Close risks no longer relevant for 2025/26.
- Identify and escalate any new or emerging risks.
- Revalidate all ongoing risks, confirming that controls, assurances, and gaps remain accurate and up to date, with outdated content removed or revised.

Summary outcome

- **116 risks were reviewed** across the SEL corporate risk register and LCP risk registers.
- **32 risks were closed** as they were no longer relevant or were fully mitigated.
- **61 risks were updated** for the new financial year, including risk description, controls, assurances and scores.
- **34 new risks** were added.

A. Place Executive Leads (PELs) meeting

- On **2 June 2025**, the **ICB Risk and Assurance team** attended the **PELs meeting** to lead a focused discussion on the **comparative review** of risks across the Local Care Partnerships (LCPs).
- This session covered:
 - **updates** that had been made to LCP risk registers as part of the review process.
 - areas of risk **still outstanding** or requiring **further clarification**.
 - risks linked to **LCP performance targets**.
 - risks alignment with borough-level **Joint Forward Plans**.
- **Key themes identified through the discussion included:**
 - The appropriate number of risks to include on an LCP risk register.
 - Whether delegated finance risks should be separately defined or remain part of the overarching financial balance risk.
 - How to reflect non-delivery of LCP performance targets within the risk framework.
 - Clarity on how Joint Forward Plan risks should be recorded.
 - Specific changes proposed to individual risks across the LCP registers.

B. SEL Executive Committee (ExCo)

- The ICB **Executive Committee met on 25 June 2025** to consider the draft BAF, as well as updates on 'place' risk registers, risk reviews for 2025/26, ICS partner BAF risks and the wider work of the ICS System Risk Leads group.
- The Executive Committee welcomed the latest iteration of the Board Assurance Framework and **endorsed its submission to the ICB Board**.
- The Executive Committee noted the risks that have been added to the corporate risk register relating to the **management cost reduction programme**.
- It was agreed that **Greenwich LCP will add a risk in relation to HealthelIntent platform and funding position**, as this is affecting both Lewisham and Greenwich boroughs. This risk has subsequently been added (risk 619) and is shown in the BAF being presented to the Board.

- In July 2024, the ICB Risk and Assurance team established the SEL ICS System Risk Leadership Group to improve coordination of risk management across acute, mental health, and system partners as well as the ICB.
- The group aims to strengthen collective oversight of system-wide risks and increase alignment against shared objectives (e.g. delivery of the ICS strategy, ICB Joint Forward Plan and other key system objectives or shared ambitions), moving away from siloed risk ownership.

Progress to date includes:

- The most recent session, held on 29 April 2025, focused on:
 - Reviewing and aligning risks across system partner BAFs
 - ‘Teach-in’ presentations and plenary sessions on:
 - Patient safety and system-wide risks by the ICB Associate Director of Quality and Patient Safety
 - Cyber and IT risks by the ICB Chief Information Security Officer.
- The group is gaining strong engagement and is now a regular forum for peer challenge, alignment and learning on risk. Its approach was shared externally by the ICB Risk and Assurance team as part of a session at the KHP Advanced Safety & Quality Programme for future clinical leaders, with a well-received presentation on *Integrated Care Systems Risks & Building a Culture of Risk Awareness* (St Thomas’, 6 June 2025).
- The next meeting of the ICS System Risk Leadership Group (8 July 2025) will focus on escalation processes and governance for programme-level risks, including CRRs/BAFs, and will feature a session on specialised commissioning risk led by the Associate Director of Delegation and Efficiencies, South London Office of Specialised Services (SLOSS).
- The SEL system BAF comparison pack continues to be shared regularly with the Executive Committee to inform system risk discussions.

- All risks on the SEL and LCP risk registers have been updated by designated risk owners working with their teams.
- **Appendix 1:** includes all the SEL risks which are above the tolerance levels (summarised on slides 12-13). **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 14). The **detailed descriptions of risks in the appendices**, include the following information:
 - risk owners and sponsors
 - the risk category that the risk falls into
 - the risk appetite for that category of risk
 - a description of the risk
 - controls that are in place to mitigate the risk
 - assurances
 - initial and residual risk scores

System versus ICB risks

- As the ICB develops its system risk approach, relevant risks in the appendices have been differentiated into 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 numbers 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 numbers have been highlighted in **blue**.
- A risk heatmap showing the likelihood and impact of the BAF risks, differentiated by these areas is included on **slide 15**.

The ICB Board:

- Is responsible for **setting the strategic direction for risk management and overseeing the arrangements for identifying and managing risk** across the organisation (including those exercised by joint committees or committees-in-common).
- Has a role in **agreeing the scope of delegated activity** to be undertaken by the Executive Committee (ExCo) on its behalf in relation to risk.
- The Board has delegated the detailed oversight of risks to the ExCo and is kept apprised of risk-related activity undertaken by relevant Board committees via committee reporting arrangements. The ICB **Board retains overall responsibility for formal approval of the ICB's BAF**.

Recommendation to the Board

- **Approve** the ICB BAF endorsed by the Executive Committee on 25 June 2025.

Key points to note:

- The risks included reflect the assessed position and risks were downloaded from **Datix on 16 June 2025**.
- The current version of the BAF includes **11 SEL risks above threshold and 2 LCP risks (Lewisham and Greenwich)**.
- There are **no risks above threshold** for **Bexley, Bromley, Lambeth and Southwark LCPs**.
- The report **incorporates recommendations provided at Executive Committee**, 25 June 2025.

Newly added BAF risks

- **5 new risks** with a score greater than the risk appetite thresholds have been **added** to the BAF:
 - **SEL risk 597** relates to SEL ICB falling victim to a cyber attack, affecting the operational running of the organisation. This falls under the data and information management category and has a current score of 12.
 - **SEL risk 598** relates to patient records in some GP practices not being fully updated after a community pharmacy consultation. This falls under the clinical, quality and safety category and has a current score of 16.
 - **SEL risk 606** relates to the ICS revenue financial plan for 2025/26. This falls under the finance category and has a current score of 25.
 - **Lewisham risk 612 and Greenwich risk 619** relate to HealtheIntent (HI) platform and funding position. Both risks fall under the clinical, quality and safety category and have a current score of 16.

Escalation and de-escalation of BAF risks

- **No existing risks escalated** onto the BAF.
- **Two existing risks** have **de-escalated** off the BAF:
 - **Lewisham risk 528** relating to access to primary care services and **Lewisham risk 561** relating to an increase in vaccine preventable diseases not reaching herd immunity across the population (seasonal vaccinations). Both risks were previously under the “clinical, quality and safety” category. They have now been re-assigned to the “strategic” category, in alignment with the other LCP risks of the same nature. There has been no score change to these risks, which remains at 12.

Previous BAF risks that have now been closed

2 risks that were previously on the BAF have now **closed**:

- **SEL risk 435** related to SEL ICB not meeting the AACC (All Age Continuing Care) Data Set submission due to variation in digitalisation across the six boroughs by the deadline of 1st April 2025 to coincide with month 1 of 25/26. This risk was closed following review because the AACCDs v2.0 reporting window period has now closed (1 April 2025) and SEL submission was completed. A new risk will be scoped to ensure that risks around data quality in the submission are measured/ captured.
- **SEL risk 543** related to SEL ICS revenue financial plan 2024/25. This risk has been closed with year end and a new risk (606), for 2025/26 has been opened.

Summary of SEL risks exceeding tolerance levels (1 of 2)

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	606	ICS revenue financial plan 2025/26.	12	25
Data and Information Management	597	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services	9	12
Clinical, Quality and Safety	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.		12
	437	Disruption to IT/Digital systems across provider settings due to external factors		15
	598	Digital Community Pharmacy programme		16

Summary of SEL risks exceeding tolerance levels (2 of 2)

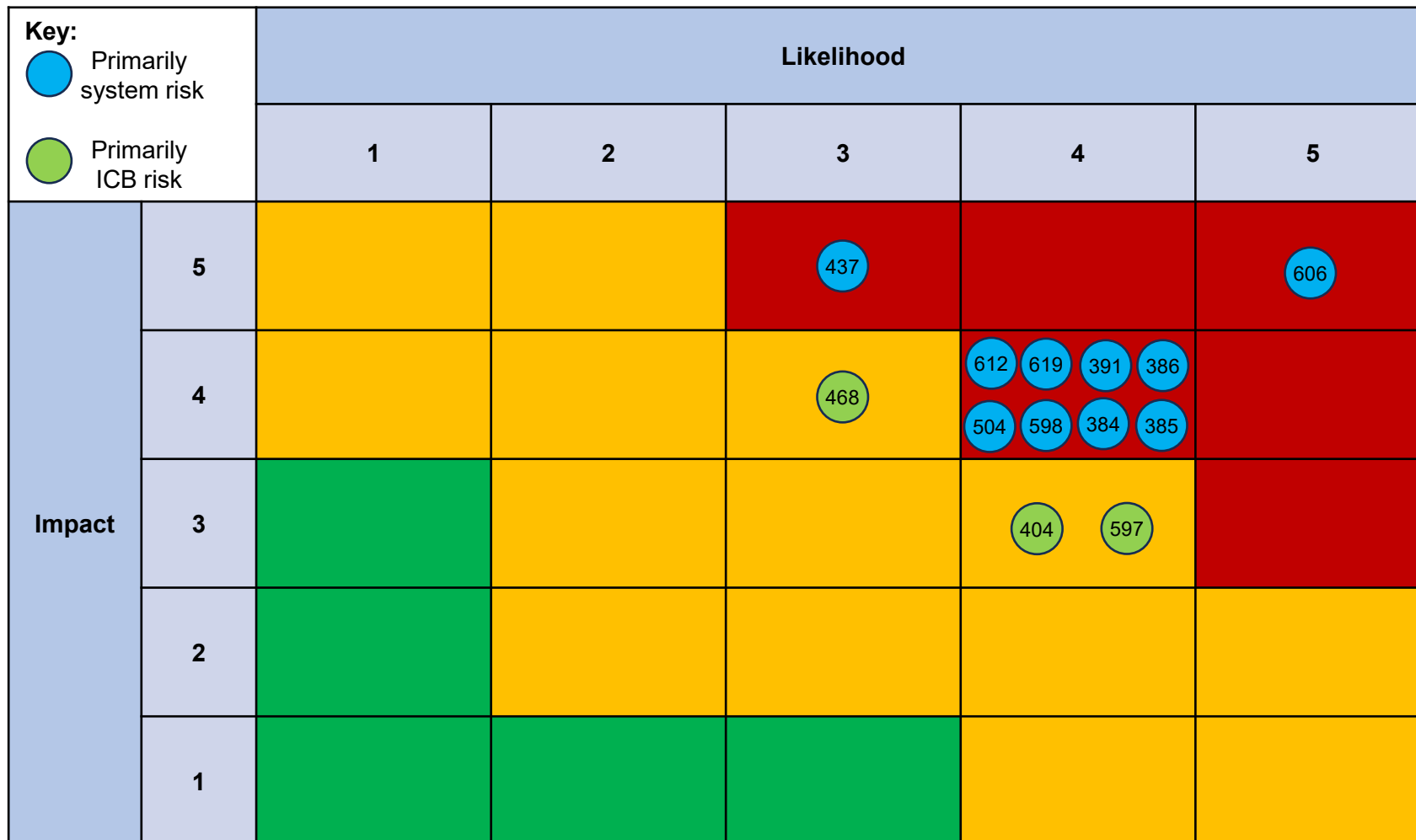
Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	384	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	12	16
	385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a consequent increase in waiting times for diagnosis and treatment, potentially impacting quality of care.		16
	386	Ongoing pressures across SEL UEC services.		16
	391	Increased waiting times for autism diagnostics assessments.		16
	504	Cancer performance targets.		16

Summary of LCP risks exceeding tolerance levels

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Clinical, quality and safety	Lewisham 612	HealthIntent (HI) Platform and Funding Position	9	16
	Greenwich 619	HealthIntent (HI) Platform and Funding Position		16

'Heat Map' of BAF risks

The heatmap below shows the likelihood and impact scores of the current BAF risks. They have also been differentiated by primarily ICB risks and primarily system risks.



ID	Summary risk descriptions
384	Elective care transformation programmes
385	Elective recoveries across the ICB/its providers
386	Ongoing pressures across SEL UEC services
391	Increased waiting times for autism diagnostics assessments
404	ICB oversight of new & emerging HCID & pandemics
437	Disruption to IT / digital systems
468	Variation in performance with funded nursing care
504	Cancer performance targets
597	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services
598	Digital Community Pharmacy programme
606	ICS Revenue financial plan 2025/26
612	HealthIntent (HI) Platform and Funding Position
619	HealthIntent (HI) Platform and Funding Position

Appendices: risk scoring matrices

Risk scoring matrices (1 of 3)

The matrices below are taken from the ICB's Risk Management Framework and represent the possible combined risk scores based on a measurement of both the likelihood (probability) and severity (impact) of risk issues. A combination of likelihood and severity score provides the combine risk score.

Likelihood x Severity = Risk Score

			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

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%

Risk scoring matrices (2 of 3)

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
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data [Information Management Risks]	Damage to an individual's reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team's reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

Severity (Impact) Score	1	2	3	4	5
Descriptor	Negligible	Minor	Moderate	Major	Catastrophic
Complaints / Claims	Locally resolved complaint Risk of claim remote	Justified complaint peripheral to clinical care e.g. civil action with or without defence. Claim(s) less than £10k	Below excess claim. Justified complaint involving lack of appropriate care. Claim(s) between £10k and £100k	Claim above excess level. Claim(s) between £100k and £1 million. Multiple justified complaints	Multiple claims or single major claim >£1 million. Significant financial loss >£1 million
HR / Organisational Development Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces service quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objectives / service due to lack of staff Ongoing unsafe staffing levels or incompetence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Financial (damage / loss / fraud) [Financial Risks]	Negligible organisational / financial loss (£< 1000)	Negligible organisational / financial loss (£1000- £10000)	Organisational / financial loss (£10000 -100000)	Organisational / financial loss (£100000 - £1m)	Organisational / financial loss (£>1million)
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards Reduced performance rating if unresolved	Reduced rating Challenging recommendations Non-compliance with core standards Prohibition notice served.	Enforcement action Low rating Critical report. Major non-compliance with core standards. Improvement notice	Prosecution. Zero rating. Severely critical report. Complete systems change required.

Appendix 1. SEL risks greater than risk appetite thresholds

Risk ID	Risk Title	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
384	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	Harriet Agegepong	Sarah Cottingham	Strategic commitments and delivery priorities, implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	There is a risk of non delivery in a range of elective care transformation programmes (theatre, admitted, non admitted) led by the Acute Provider Collaborative. This is caused by the limited bandwidth of clinical and operational teams due to: Multiple asks of the same clinical and operational teams (e.g. a single specialty is asked to introduce a range of initiatives simultaneously). This could result in confusion over priorities, teams being overwhelmed or lacking the resource and support required to secure impactful and sustainable delivery. Inadequate capacity for clinical and other leads to engage and co-design initiatives with partners across primary and secondary care, leading to lack of awareness, buy-in and adherence to new pathways/ways of working with consequent inconsistency and inefficiency of care pathways. Insufficient oversight and awareness of the range of asks on teams (e.g. elective, cancer, urgent care), and what support might be needed to enable delivery. This will impact on the ICB's ability to meet statutory obligations and will impact on the waiting times for services that residents receive, with resulting potential impacts on patient experience, quality of life and outcomes alongside broader socioeconomic impact. It will also impact delivery of optimal care for those with long-term conditions if patients requiring treatment cannot be seen in a timely way in the most appropriate setting.	3	4	12	4	4	16	Acute Provider Collaborative governance has been reviewed to ensure that there are clear structures in place between clinical networks, cross-cutting workstreams and the APC Executive. These structures ensure that there is clarity on responsibility and accountability, and better oversight of the range of programmes underway (elective elective and non-elective and ability to prioritise/deprioritise work as pressures increase). Significant regional and national oversight of elective transformation programmes and associated performance. Clinical leadership capacity has been increased with each specialty network having a secondary care clinical lead in place, and primary and community leads also being appointed. These leads have protected time to develop initiatives, and to engage with clinicians across the ICB. This will be kept under regular review to ensure that sufficient clinical capacity is in place, and that it can be supplemented as necessary. This risk has been increased in Jun/24 as a result of the Synovis incident at GSTT & KCH. The system oversight of this incident is managed by the ICB, the acute trusts are involved directly in these meetings. The impact is shared across APC partners where relevant so there is a system understanding of the impact and risks. The impact of Synovis is an agenda item at APC Ops & Strategy meeting to enable an understanding of direct impacts and mitigations on elective recovery & waiting time objectives.	No gaps	Minutes of APC Executive meetings, and key workstreams (e.g. Non-Admitted, Theatre), noting ICB participation in the APC-led workstreams. In addition regular performance reporting across key standards and metrics. Regional review and enhanced assurance measures as part of national system oversight framework for changed providers and services, including for SEL on elective delivery. Joint work and approaches across the ICB and APC, providing ICB visibility of actions and progress. Operational Plan commitments and agreed actions in elective recovery plan. Regular reporting and review against these - including monthly ICB/provider performance meetings plus monthly System Focus Meetings with the regional team, and a range of other Regional meetings.	No gaps
385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICBs providers, with a consequent increase in waiting times for diagnosis and treatment.	Harriet Agegepong	Sarah Cottingham	Strategic commitments and delivery priorities, implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	There is a risk of decreased capacity available for elective work which could lead to a consequent reduction in elective activity and ability to meet targets to reduce patients waiting a very long time for appointment / treatment. This is caused by competing pressures in the system e.g. urgent and cancer demand in relation to finite available capacity and resource. This will impact on the ICB's ability to meet statutory obligations and targets set out in the 2025 operational plan, and will further impact on the length of time patients are required to wait for these services, affecting patient experience, plus potentially quality of life, clinical and psychosocial outcomes as a result of suboptimal waits.	3	4	12	4	4	16	In year plan refresh and winter plans (planning templates and recovery narratives) - inclusive of Internal Board sign off and external/regulatory assurance and sign off. Regular review including through System Focus Meetings with the regional team, Minutes of APC Meetings - particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery, noting ICB participation and representation as part of ICB governance. Regional assurance and review elective meetings. APC system level and internal trust work to theatre productivity to maximise activity that is carried out in the capacity available for non-urgent elective work and to optimise the use of day case and outpatient procedure capacity. All areas are regularly monitored and reviewed. APC work on non-admitted care and specialist advice. Annual work on winter planning to minimise disruption on elective care by planning for likely increases in non-elective activity over the winter period and wider transformation work in UEC. PIFU and use of community services to make best use of outpatient capacity available. This risk has been increased in Jun/24 as a result of the Synovis incident at GSTT & KCH. The system oversight of this incident is managed by the ICB, the acute trusts are involved directly in these meetings. The impact is shared across APC partners where relevant so there is a system understanding of the impact and risks. The impact of Synovis is an agenda item at APC Ops & Strategy meeting to enable an understanding of direct impacts and mitigations on elective recovery & waiting time objectives.	No gaps	Operational plan for 2024/25, in year plan refresh and winter plans (planning templates and recovery narratives) - inclusive of Internal Board sign off and external/regulatory assurance and sign off. Regular review including through System Focus Meetings with the regional team. Minutes of APC Meetings - particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery, noting ICB participation and representation as part of ICB governance. Regional assurance and review elective meetings, including Tier 2 (GT, KCH). Assurance also monitored through monthly Performance Report to the APC Ops & Strategy Group, fortnightly reports to the Operational Delivery Group, Weekly updated SEL NHSE dashboards. And monthly Trust specific Performance Meetings by the ICB Acute Performance Team. Notes and actions written for all NHSE, APC and ICB meetings.	No gaps
386	Ongoing pressures across SEL UEC services	Kelly Hudson and Sara White	Sarah Cottingham	Strategic commitments and delivery priorities, implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	There is a risk of making limited improvements in waiting times, pathway flow and timely transfer of care as a result of demand and flow challenges across the system. This impacts the ICB's ability to meet operational plan commitments and impact on the service users affected by these services, affecting patient experience. Increased waits - for ambulance support, in the Emergency Department or for transfer of care (e.g. from a physical to a mental health facility) increases the risk of poorer clinical outcomes. Cyber attacks in 2024 have had system-wide impact and have exacerbated existing issues and complicated efforts to alternative services, which, in turn, impacts on system recovery of UEC performance. Whilst the system has largely recovered operationally from the last attack, the risk of future attacks remain.	4	4	16	4	4	16	Robust daily intensive system support in place, led and coordinated by the SEL ICB System Control Centre, to review, manage and smooth pressures across the system, agree mutual aid and support site safety, SCC operates 24/7 providing in and out of hours system support. Operational plan for 2025/26 includes a number of performance improvement initiatives. Focused work on care pathway changes (aligned to recommended best practice) including those out of hospital (community offer), increasing direct access to same day urgent and emergency care and increasing UEC access for mental health crisis. Protocols and escalation arrangements to support the effective management of pressures, focussed particularly on admission avoidance and supported and timely discharge. Established urgent community response and virtual ward offer. Ongoing management of impact for UEC via recovery process including monthly recovery meetings with UEC SRDs and local UEC leads in place and acute.	None	The daily SCC provide immediate system support to retain site safety across all SEL sites, with SEL SCC meeting the required national specification. SEL operational plan for 2025/26 is again being assured by means of the SEL UEC Recovery Plans and monthly review meetings with each local system. Each local system will manage their recovery plan through their local UEC Board with SEL UEC Board having oversight of performance against trajectory. Monthly call with UEC local system leaders to review current performance issues. Further assurance through London UEC and MH UEC Boards.	None - no known at time of reporting
391	Increased waiting times for Autism diagnostic assessments	Carol-Anne Murray	Paul Lintsey	Clinical, Quality and Safety	7 - 9	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contrasted activity leads 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 and increased spend due to non-contrasted activity. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.	3	4	12	4	4	16	Implementation of services for backlog clearance by October to reduce the waiting time by end of March 2025 including development of services to meet the demand and maintain waiting times within 6 months. Clinical and care professional leaders recruited to focus on autism across all ages, particularly post-diagnostic support for autism only diagnoses and on the development of ASD community support. All age autism strategy approved and launched, with non-recurrent funding (£240k) provide to each borough LA (£25k) to align with strategic framework. Core offer for CYP Autism assessment developed and agreed with stakeholder. Set up of Community of practice to share best practice and find solutions to ongoing issues. Exploring options for assessment of 18/17 to 19 year olds before adulthood to prevent longer waits in adult services - Pidding SEL CYP Neurodivergent Hub for diagnostic assessments and medication pathways. Implementation and sharing of learning from projected piloted using non-recurrent funding in 23/24 with each borough.	No gaps	SEL LDA Strategic Executive Group Agenda and Minutes List the assurance evidence. SEL LDA Operational Board Agenda and Minutes. To be relaunched during 2025/26. Minutes from the quarterly Joint Region and System LDA Health Partnership meeting.	No gaps on assurances
404	New and emerging High Consequence Infections Diseases (HCID) & pandemics	Simon Beard	Tosca Fairchild	Clinical, Quality and Safety	7 - 9	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more areas. This could cause disruption to the operations of the ICB with staff and the reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	4	4	16	4	3	12	Staff are offered flu and covid-19 vaccines to mitigate as far as possible the impact on the workforce. HCID & pandemic plan is in place. Annual plan in place for SEL system. Collaboration with organisations across the system through forums such as Borough Resilience Forums enables the ICB to horizon scan for potential emerging HCID issues and put mitigating actions in place early to minimise impact to the workforce and ICB operations. Hybrid working arrangements are in place, supported by cloud-based access to IT systems, which enables the ICB to reduce face to face interactions between staff should this be necessary as a measure to reduce spread of infections. The ICB has an established process for considering staff redeployment to focus on business critical services. Employee assistance is available - e.g. mental health first aiders, occupational health and employee assistance programme. During the 2024-25 year there are plans to run tabletop and workbook exercises with the primary care teams and GPs to test and exercise the ICB plans for HCIDs. A national exercise - Op Pegasus - is planned to be run in 2025 to test plans.	UK HSA have published updated communicable disease outbreak management guidance which will be used in London to develop a pan London MoU for managing multiple infectious disease outbreaks. Once completed, the ICB HCD response plan will need to be reviewed for alignment. SEL ICB Head of EPRR and the Bromley PEL Angela Bhan, have been involved in the initial scoping discussion for the pan London MoU and are engaged in the ongoing development work.	SEL ICB - System approach utilised and implemented for HCIDs. EPRR Practitioners network is in place enabling early sharing of information/ horizon scanning in relation to HCIDs, which will ensure organisations can take early mitigating actions. HCID plan reviewed and updated in 2024. Refreshed plan has been endorsed by ICB AEO and approved for publication by ICB Executive Committee. SEL ICB Head of EPRR and the Bromley PEL Angela Bhan, have been involved in the initial scoping discussion for the pan London MoU and are engaged in the ongoing development work.	No gaps in assurance
437	DIGITAL - Disruption to IT/Digital systems	Philippa Kirkpatrick, Michael Knight	Andrew Bland	Clinical, Quality and Safety	7 - 9	There is a risk of significant disruptions to the IT and digital systems across our provider settings. This may be caused by external factors such as cyber attacks directly on our computer systems or servers, or those managed by our supply chain providers. It may also be caused by extreme weather conditions, fire or other events that result in system unavailability. The consequences of this risk occurring is significant disruption to the provision of clinical services, lack of access to historical information and lack of access to systems that support patient management such as waiting lists. In some events, patient and administrative data may be taken (see risk 10). These occurrences could result in patient harm or death, and may lead to significant financial loss. It could also lead to adverse public reaction and reputation damage.	2	5	10	3	5	16	Individual organisations accountable to their own boards to demonstrate sustainability of their digital and IT infrastructure, and actions put in place to move to create third party hosting rather than relying on on-premise data centre. GPT services are mostly 3rd party managed cloud-based solutions. GP services are required to have business continuity, including for their IT services, built into their contracts. A paper on the 2022 cyber and resilience incidents provided to the Board in July 2023, including lessons learnt and actions taken following the incident. Capturing lessons learnt from the Synovis incident under way. A senior Chief Information Security Officer for the ICB has been recruited. This role is responsible for identifying risks and will support partnership working to mitigate those risks. An external cyber and resilience maturity assessment has been completed by EY. Management responses to the review have been agreed by the Board and progress of agreed actions are being tracked by the Digital Board and the Audit and Risk Committee. MFA provides a second line of defence with regard to accessing systems where a password has been breached. All trusts in our system are now required to be compliant with MFA as per the national policy, and we are undertaking standards based configuration reviews before the end of the financial year to identify residual risks associated to local implementation. Organisations that handle personal identifiable data must complete the annual Data Security and Protection Toolkit, which includes assurance against Business continuity and resilience planning, information technology security, data management and due diligence with supply chain/third-party suppliers. A deep due review of essential services and the associated supply chain has started, to help identify specific risks and support mitigation of specific risks within the supply chain. The Board has approved the SEL ICB Cyber Security and Technology Resilience Strategy.	The quantum of funding required to mitigate risks to an acceptable level has not yet been determined. It will be necessary to do this as part of the strategy development and provide advice to the Board if there are gaps in funding on controls following this process. There is currently no central tracking of MFA status of all organisations in our system. This is best managed through commissioning arrangements where expectations and reporting on this can be established. The ICB Cyber Strategy will need to address this. Some components within technology platforms are aged, which impacts the extent to which desired controls can be applied to mitigate the likelihood of a cyber security incident. The supply chain supporting SEL is vast and diverse. Assurance of suppliers at point of procurement needs, but ongoing assurance is not consistently undertaken. Platforms and systems are not consistently configured in line with recognised frameworks to optimise security. There are gaps in identification and monitoring of assets, in particular those not supported by IT teams. There is currently limited reporting of system wide cyber security status at committees. This is due for implementation in Q1 2025/26.	The Digital Board is responsible for overseeing the cyber status of our system. They are able to do this as they are guided by the external EY review, as well as an expert community of practice that has been established. Board cyber training held on 26 January 2024 to support members understand risks and mitigations. An external review was conducted by EY into the cyber and resilience maturity of Trusts and Arrangements in our system. A management response to the review has been agreed by the Board and agreed actions will be tracked by the Digital Board and the Audit and Risk Committee. Annual Completion of DSPT	No gaps
468	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	Jane Waite	Paul Lintsey	Clinical, Quality and Safety	7 - 9	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews. This is due to a significant number of reviews over the required time frames (National Standard). This is impacting on the ICB's ability to meet statutory requirements. This is a clinical risk which impacts on financial control across the system and patient experience.	4	4	16	3	4	12	This risk is monitored at the NHSE assurance meeting monthly. The SEL Head of CHC/CYPCC governance assurance and QIPP has oversight of this risk. There is a monthly assurance pack produced which goes to the CHC review meetings. The CHC monthly assurance report tracks FNC reviews. There are monthly meetings held at place level where this risk is discussed. There are individual borough plans setting out how boroughs will clear the overdue reviews.	M37 M49	There are minimal vacancies across the place based teams. Individual borough plans in place and teams are working towards reducing the backlogs.	Place CHC leads have been asked to provide individual borough trajectories where necessary. The CHC monthly performance report shows that overdue FNC reviews have been increasing overall
504	Cancer Performance	Carl Genister	Sarah Cottingham	Strategic commitments and delivery priorities, implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	This is a risk that the ICB does not meet the operational plan commitments it has made for 2025/26 with regards cancer access and wait times - including the Faster Diagnosis Standard and the 62-day treatment standard. Failure to meet agreed access and waiting times standards exacerbates the risk of poorer clinical outcomes due to diagnosis and treatment delays.	4	4	16	4	4	16	The 2025/26 operational plan includes agreed system-wide commitments to improve cancer performance, specifically access and waiting time standards, including the Faster Diagnosis Standard (FDS) and the 62-day treatment standard. Cancer performance has improved consistently across the system over the last financial year, however, the system has committed to further speeding targets for 2025/26. Cancer planning was embedded within broader operational and capacity planning to ensure requirements were modelled and prioritised appropriately. These plans underwent internal assurance and were also subject to external assurance through both regional and national processes. Ongoing oversight is maintained through the South East London (SEL) ICB Cancer Executive, with additional scrutiny through regional performance meetings. While GSTT Cancer remains under Tier 1 of the regional System Oversight Framework support process, neither GSTT nor LGT are currently subject to formal support measures. Quality and safety are monitored through continuous surveillance, including harm reviews for patients affected by delays. The system is on track to meet the Faster Diagnosis Standard, although meeting the 62-day standard remains more challenging.	No current gaps in controls identified.	Governance and Oversight: Robust governance structures are in place at both provider and system level, with regular reporting through minutes, papers, and performance dashboards. Progress is monitored against agreed trajectories and recovery plan milestones. System Collaboration: The ICB Planned Care and Cancer teams work closely with providers and the Cancer Alliance to support planning, delivery, and performance improvement. External Review and Assurance: Cancer plans are reviewed through regular Tier 1 meetings with NHS England (London Region), where the ICB participates in performance discussions and receives external scrutiny. Plan Assurance: Operational plans have been assured to confirm they address all necessary elements; however, delivery remains challenging due to the complexity of cancer pathways across multiple providers and specialities. Targeted support is in place to strengthen delivery capability where required.	No current gaps in assurance identified.
597	IGIT (SEL CORP) Cyber Security or Technology Resilience issue causing disruption to the operation of essential services	Pin Bhandal	Philippa Kirkpatrick and Michael Knight	Data and Information Management	7 - 9	There is a risk that NHS SEL ICB could fall victim of a cyber attack. This could include unauthorised access to sensitive and/or patient identifiable data which could be illegally obtained, corrupted, encrypted and held to ransom. This could be due to gaps in security controls or human factors including phishing or social engineering. This could cause severely disrupt the day to day running of NHS SEL corporate systems and potentially affect clinical care systems, such as Continuing Health Care Systems. It may result in the loss or breach of personal data which could lead to the potential for financial and reputational damage, in addition to potential fines by the Information Commissioner.	4	3	12	4	3	12	Governance - Relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk. There is a well established assurance plan, including external assurance, and risk management framework that supports our risk management approach. Supply Chain - Processes to risk assess the supply chain are in place and there is an understanding of how suppliers may impact the delivery of our essential functions. Asset Management - assets that underpin our essential services are identified, prioritised and have clear ownership assigned. Supply Chain - Processes to risk assess the supply chain are in place and there is an understanding of how suppliers may impact the delivery of our essential functions. Policy, Process and Procedures - Most policies, processes and procedures are clearly defined, integrate with broader organisational process and are well understood by users. Identity and Access Control - processes to verify, authenticate and authorise users are in place. Multi Factor Authentication is widely adopted. Processes to verify, authenticate and authorise users are in place. Multi Factor Authentication is widely adopted. Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity. Systems are designed to ensure appropriate levels of resilience and recovery plans are in place. Plans are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles. Monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures.	There are opportunities to further improve maturity of risk management practices by broadening the use of threat intelligence. There are opportunities to improve the depth of analysis regarding our supply chain and establish more stringent controls within the supply chain. There are opportunities to further improve the design and implementation of some policies, processes and procedures. There are opportunities to further improve technical controls. There are opportunities to further enhance our monitoring capability	Secure design and development practices, including security requirements and targets. Supply Chain Security, including Vendor/supplier use of standards. Application of Cloud security principles. Risk Management. User Training. Classification - CE+. Compliance - Secure Email Standard DCB 1986. Patching and maintenance. Internal Audit. Configuration mgmt. and change control. Security monitoring. Business Continuity and Disaster Recovery Exercises. Security Incident Management Processes	Data Security and Protection Toolkit Compliance - 2024/25
598	DIGITAL - Digital Community Pharmacy programme	Sharon Sheldon / Clare Fennie	Ananya Datta	Clinical, Quality and Safety	7 - 9	There is risk that some post event messaging is not being returned to the GP practice from community pharmacy after a patient consultation. This is due to GP Connect update record not turned on for all SEL practices and PharmOutcomes software used by Pharmacies requiring an email and email verification for the GP practice. The impact is that the GP record does not have the full detail of patient consultations where this has not been sent by the community pharmacy and poses a patient safety risk.	5	4	20	4	4	16	Liaising with GP practices to carry out task for programme of work - Regular monitoring and escalation to Primary Care Leads and supplier reviews, GP Practices contractually required to undertake programme of work.	None	Encouraging GP practice engagement. Contractually required by GP practices with switch on GP Connect. Raising issues to Local Pharmaceutical Committee and NHS England of any issues. Ongoing liaising between supplier, pharmaceuticals and GP practices	Currently no gaps recorded

Risk ID	Risk Title	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
005	ICS revenue financial plan 2025/26	David Makoney	Mike Fox	Finance	10 - 12	There is a risk that Risk that ICS does not deliver its deficit revenue financial plan for 2025/26, due to: inability to deliver required level of targeted savings. Uncertainty over closing £5m gap between plan and control total. Under-delivery against elective recovery commitments. inability to recover income in line with planning guidance.	5	5	25	5	5	25	Break-even plan for 2025/26 agreed by ICS Executive and ICS ESG, subject to non recurrent deficit support funding of £75m from NHSE. Component parts of ICS plan to be agreed by SEL organisation Boards. Monthly review and reporting to ICB Executive and SEL System Sustainability Group on delivery against financial plans and risk of organisational efficiency plans. Over-sight of revenue financial position and efficiency by SEL CFO group meeting fortnightly. Agency limit and monitoring of spend reported routinely each month. External review of SEL run rate and performance working with NHSE. Organisational control mechanisms. Monitoring of financial risks by SEL CFO group. Funding received from NHSE. KCH NOF 4 status. Quarterly review and reporting to ICB Integrated Performance Committee on delivery against financial plans and risk of organisational efficiency plans. Formal CFO in year review of trust year end forecasts and risks to delivery. Monitoring of risks and potential mitigations to achieve plan. Contracts agreed. Budgets agreed.	Identified CPs and CP forecasts do not currently meet targets.	Non recurrent deficit funding received from NHSE, enabling a breakeven plan. Budgets agreed. SEL CFO group meeting fortnightly. ESG meeting monthly. Internal control totals agreed.	CP plans do not meet targets. Monthly run rate forecasts do not yet show required improvement. Assurance on delivery of FYE of 2024/25 CP schemes

Appendix 2. LCP risks greater than risk appetite thresholds

Risk ID	Risk Title	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gap in Control Summary	Assurance in Place	Gap in Assurance
612	Healthierent (H) Platform and Funding Position	Rachael Smith	Laura Jenner	Clinical, Quality and Safety	7 - 9	The current Memorandum of Understanding (MOU) for funding the Healthierent (H) platform, provided by Lewisham and Greenwich Place ICsBs, is set to expire at the end of March 2026. It is unlikely that LGT would be able to continue funding the platform independently beyond that point. The H contract itself runs until March 2027, in parallel with the Orside Millennium contract. As such, a decision needs to be made regarding the future of the H platform, with the following options available: Healthierent is a digital platform which allows healthcare professionals to provide more proactive care to residents and communities. Options for H Platform Contract: 1.Terminate at March 2026. Give six months' notice to Orside by the end of September 2025. Platform would cease in March 2026. 2.Extend Beyond March 2026 (Temporarily). Continue for a TBC defined period beyond March 2026. Six months' notice can technically be served at any point during the contract period. 3.Maintain H Platform Contract End (March 2027). No early termination; platform remains active through the full contract term. If Termination Notice is served a plan will be needed to: •Phase, archive, or store the existing work at the end of the notice period •Or transfer some or all of the work and data to another environment where delivery can continue.	4	4	16	4	4	16	We are setting out the data and platform requirements for PHM, the timelines and the decommissioning plans. We will set out the initial view of our requirements, indicative timelines, and a draft decommissioning plan during June 2025. We are engaging with the SEL PHM team to explore and gather options for meeting our requirements through alternative solutions and to understand the gaps. E.g. LGS, SEL, B Team. During July to September 2025 - this period will be used to assess the available options, consider the implications, and ultimately decide whether to give notice on the Healthierent contract by the end of September 2025.	There is a lack of information available across London and SEL on what the options are for meeting our requirements. There is a lack of information available across London and SEL on what the options are for meeting our requirements	Timelines and initial meetings in place	Case finding to support MDMs, INTs, PAW, and other delivery arms will be significantly compromised if we are unable to continue or replicate the work currently being undertaken to generate and maintain cohort lists
619	Healthierent (H) Platform and Funding Position	Rachael Smith	Gabi Darby	Clinical, Quality and Safety	7 - 9	The current Memorandum of Understanding (MOU) for funding the Healthierent (H) platform, provided by Lewisham and Greenwich Place ICsBs, is set to expire at the end of March 2026. It is unlikely that LGT would be able to continue funding the platform independently beyond that point. The H contract itself runs until March 2027, in parallel with the Orside Millennium contract. As such, a decision needs to be made regarding the future of the H platform, with the following options available: Healthierent is a digital platform which allows healthcare professionals to provide more proactive care to residents and communities. Options for H Platform Contract: 1.Terminate at March 2026. Give six months' notice to Orside by the end of September 2025. Platform would cease in March 2026. 2.Extend Beyond March 2026 (Temporarily). Continue for a TBC defined period beyond March 2026. Six months' notice can technically be served at any point during the contract period. 3.Maintain H Platform Contract End (March 2027). No early termination; platform remains active through the full contract term. If Termination Notice is served a plan will be needed to: •Phase, archive, or store the existing work at the end of the notice period •Or transfer some or all of the work and data to another environment where delivery can continue.	4	4	16	4	4	16	We are setting out the data and platform requirements for PHM, the timelines and the decommissioning plans. We will set out the initial view of our requirements, indicative timelines, and a draft decommissioning plan during June 2025. We are engaging with the SEL PHM team to explore and gather options for meeting our requirements through alternative solutions and to understand the gaps. E.g. LGS, SEL, B Team. During July to September 2025 - this period will be used to assess the available options, consider the implications, and ultimately decide whether to give notice on the Healthierent contract by the end of September 2025.	There is a lack of information available across London and SEL on what the options are for meeting our requirements. There is a lack of information available across London and SEL on what the options are for meeting our requirements	Timelines and initial meetings in place	Case finding to support MDMs, INTs, PAW, and other delivery arms will be significantly compromised if we are unable to continue or replicate the work currently being undertaken to generate and maintain cohort lists

ICB Board meeting in public

Title	2024/25 Month 2 ICB and ICS Financial update					
Meeting date	16 July 2025	Agenda item Number			Paper Enclosure Ref	
Author	ICB Finance Team					
Executive lead	Mike Fox, ICB CFO					
Paper is for:	Update	x	Discussion	x	Decision	
Purpose of paper	To provide an update to the Board of the financial position of the ICB and ICS as at month 2.					
Summary of main points	The South East London ICS has an agreed financial plan for 2025/26 of a break-even position. This is inclusive of non-recurrent deficit support funding of £75.0m, for which the allocation for quarter 1 of £18.75m has been received. As at month 2, the key headlines are: • The ICB is reporting a year to date break-even position. • The ICS is reporting a year to date deficit of £21.1m against a planned deficit of £14.2m, an adverse variance of £6.9m. All organisations with the exception of the ICB and Oxleas are off plan at month 2. • The ICS has delivered £35.2m of efficiencies against a plan of £41.8m, slippage of £6.6m. £19.3m of the savings delivered YTD have been on a non-recurrent basis. • Unidentified efficiencies as at month 2 are £31.7m, circa 9% of the overall savings plan. The Board is also asked to note the final start budgets for the ICB and how this compares to our original MTFS assumptions. This shows that inline with our MTFS the ICB is allocating a greater proportion of its resources to non-acute services in 2025/26.					
Potential conflicts of Interest	Not applicable					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Not applicable					
Financial Impact	As set out in the attached finance report.					
Public Patient Engagement	Not applicable					
Committee engagement	ICB committees receive regular updates on the financial position.					
Recommendation	The Board are asked to <u>note</u> the report					

SEL ICB Finance Report

Month 2 2025/26

- 1. Key Financial Indicators**
- 2. Executive Summary**
- 3. Revenue Resource Limit (RRL)**
- 4. Budget Overview**
- 5. NHS Continuing Healthcare**
- 6. Provider Position**
- 7. ICB Efficiency Schemes**
- 8. Corporate Costs**
- 9. Debtors Position**
- 10. Cash Position**
- 11. Creditors Position**
- 12. Metrics Report**
- 13. MHIS performance**

Appendices

- 1. Bexley Place Position**
- 2. Bromley Place Position**
- 3. Greenwich Place Position**
- 4. Lambeth Place Position**
- 5. Lewisham Place Position**
- 6. Southwark Place Position**

1. Key Financial Indicators

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

Key Indicator Performance

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

2. Executive Summary

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

3. Revenue Resource Limit (RRL)

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

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

4. Budget Overview

	M02 YTD							
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	838	1,353	1,152	81	226	43	546,300	549,994
Community Health Services	4,235	15,767	6,731	4,978	5,677	6,295	46,670	90,354
Mental Health Services	1,775	2,438	1,459	3,956	1,329	1,777	106,654	119,387
Continuing Care Services	4,452	4,689	5,051	5,985	4,236	3,420	-	27,833
Prescribing	6,288	8,459	6,180	7,069	7,060	5,819	(72)	40,802
Other Primary Care Services	250	338	322	659	341	167	2,299	4,375
Other Programme Services	204	-	299	-	-	99	4,558	5,160
Programme Wide Projects	-	-	-	-	4	43	1,085	1,133
Delegated Primary Care Services	8,179	11,718	10,464	15,900	11,967	12,784	(338)	70,674
Delegated Primary Care Services DPO	-	-	-	-	-	-	36,729	36,729
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	491	585	577	758	529	667	6,587	10,194
Total Year to Date Budget	26,712	45,347	32,234	39,386	31,370	31,112	750,473	956,635
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	838	1,353	1,152	81	226	43	546,283	549,976
Community Health Services	4,235	15,767	6,731	4,978	5,081	6,108	46,671	89,571
Mental Health Services	1,786	2,627	1,815	4,048	1,452	2,054	106,698	120,480
Continuing Care Services	4,452	4,776	5,327	5,985	4,714	3,337	-	28,590
Prescribing	6,288	8,459	6,180	7,069	7,060	5,819	(72)	40,802
Other Primary Care Services	250	338	322	659	344	167	2,299	4,379
Other Programme Services	204	-	-	-	-	99	4,170	4,473
Programme Wide Projects	-	-	-	-	4	36	1,085	1,125
Delegated Primary Care Services	8,179	11,718	10,464	15,900	11,967	12,784	(338)	70,674
Delegated Primary Care Services DPO	-	-	-	-	-	-	36,729	36,729
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	454	507	573	743	498	632	6,428	9,836
Total Year to Date Actual	26,686	45,545	32,562	39,464	31,346	31,078	749,954	956,635
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	(0)	0	0	(0)	(0)	0	18	18
Community Health Services	(0)	0	0	0	597	187	(0)	783
Mental Health Services	(11)	(189)	(357)	(92)	(123)	(278)	(44)	(1,093)
Continuing Care Services	0	(86)	(275)	0	(477)	83	-	(756)
Prescribing	-	-	-	-	-	-	-	-
Other Primary Care Services	(0)	(0)	0	(0)	(4)	(0)	0	(4)
Other Programme Services	-	-	299	-	-	-	387	687
Programme Wide Projects	-	-	-	-	-	7	0	7
Delegated Primary Care Services	-	-	-	-	-	0	-	0
Delegated Primary Care Services DPO	-	-	-	-	-	-	(0)	(0)
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	37	77	4	15	31	35	159	358
Total Year to Date Variance	27	(198)	(329)	(78)	24	35	520	0

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

5. NHS Continuing Healthcare

- As of Month 2, the CHC budget reflects an overall overspend of **£756k**. Cost pressures vary across boroughs: **Lewisham, Bromley, and Greenwich** are reporting overspends, while **Bexley and Lambeth** are break-even, and **Southwark** shows an underspend of **£83k**.
- **Lewisham** is the largest contributor to the overspend at **£477k**, primarily driven by high costs among palliative care clients. The reported figure includes **£176k** for anticipated provider price increases.
- **Bromley** is reporting an **£86k overspend**, largely due to a provision of **£131k** for potential future price increases agreed with providers.
- **Greenwich** has an overspend of **£275k**, mainly attributed to a **£179k** provision for provider price increases and costs associated with Funded Nursing Care (FNC) clients.
- To manage provider price uplifts, an **ICB panel** has been established to review all price increase requests exceeding **1.5%**, meeting weekly to ensure consistency across the ICB, and to contain cost escalation. All borough financial positions include a provision for a **4% inflationary uplift**.
- On savings delivery, all boroughs have identified and made progress against their CHC savings plans, with **one borough exceeding its target**. However, increasing levels of activity and the prevalence of high-cost patients continue to create ongoing financial pressures on the CHC budget.

6. Provider Position

Overview:

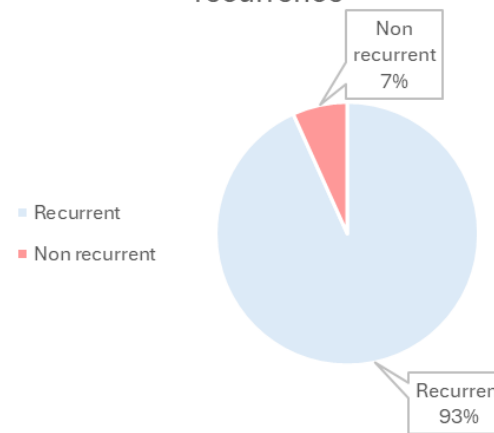
- This is the most material area of ICB spend and relates to contractual expenditure with NHS and Non-NHS acute, community and mental health providers, much of which is within block contracts.
- In year, the ICB is forecasting to spend circa **£4,275,527k** of its total allocation on NHS block contracts, with payments to our local providers as follows:
 - Guys and St Thomas **£1,075,902k**
 - Kings College Hospital **£1,162,501k**
 - Lewisham and Greenwich **£747,918k**
 - South London and the Maudsley **£365,160k**
 - Oxleas **£325,176k**
- In month, the ICB position is showing a break-even position on these NHS services, and a break-even position has also been reflected as the forecast year-end position.

7. ICB Efficiency Schemes at as Month 2

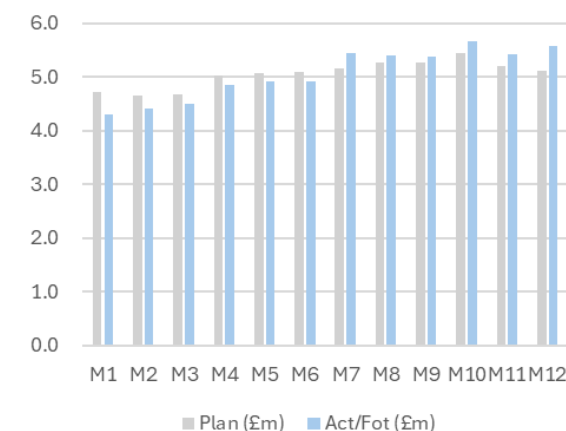
- The 6 places within the ICB have a total savings plan for 2025/26 of **£60.7m**. In common with the previous financial year, the key elements of the savings plans are in prescribing, continuing healthcare (CHC) and community services.
- The table to the right sets out the YTD and forecast status of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

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

Forecast efficiencies by recurrence



Monthly phasing of efficiencies

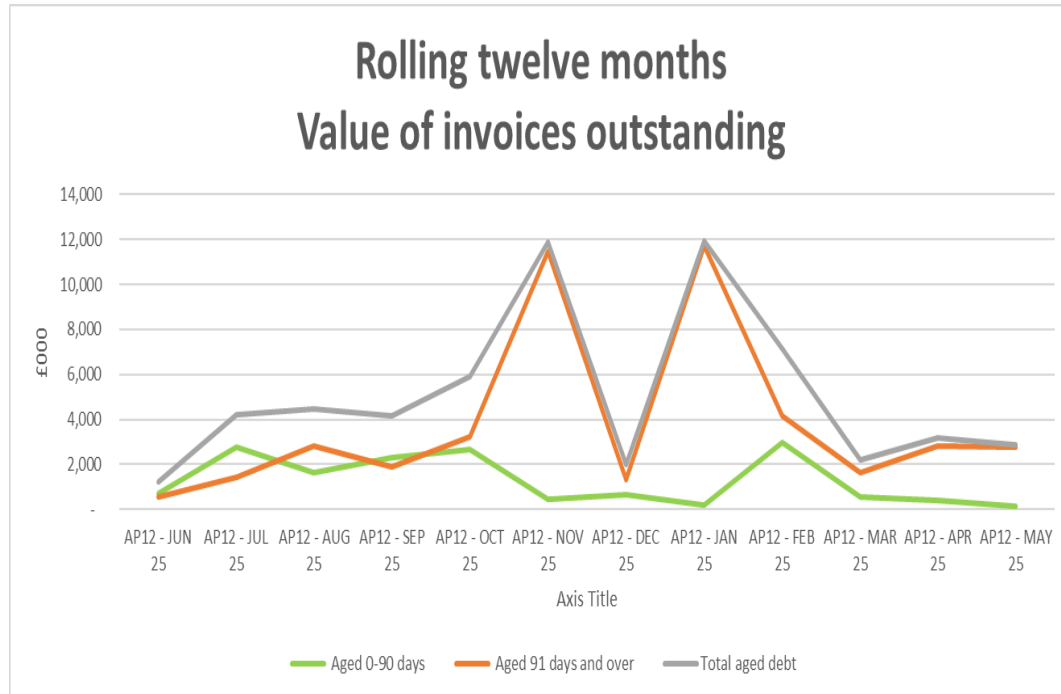


8. Corporate Costs – Programme and Running Costs

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

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

9. Debtors Position



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

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

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

10. Cash Position

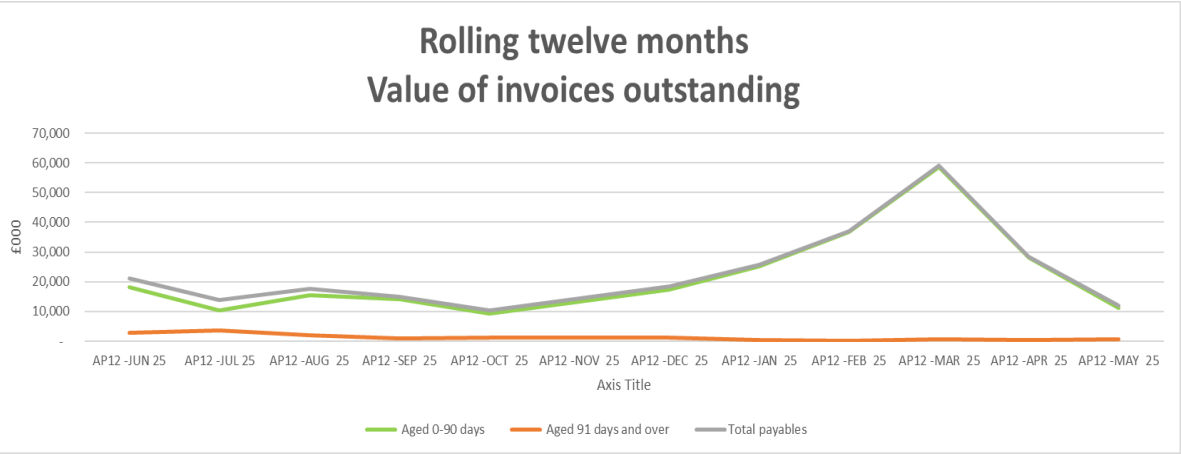
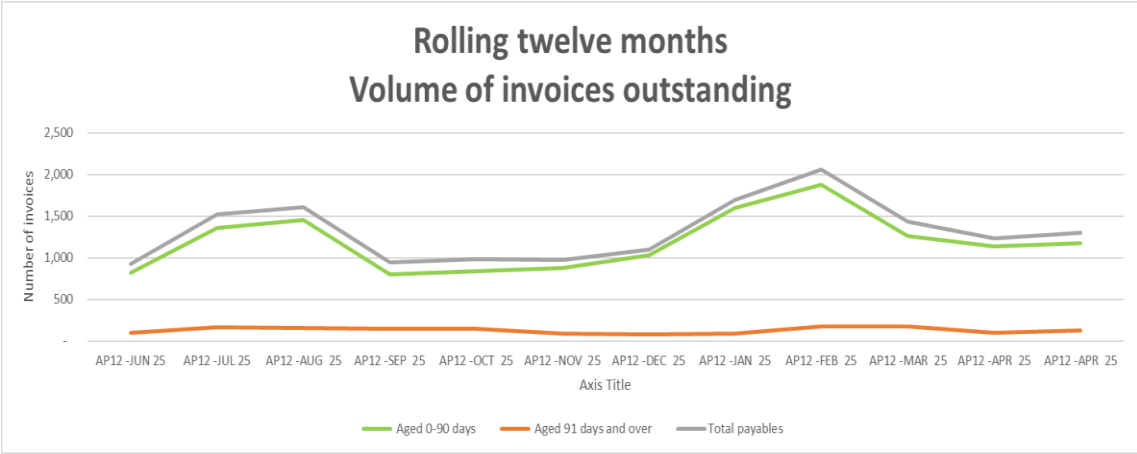
- The Maximum Cash Drawdown (MCD) as at month 2 was **£5,691,833k**. The MCD available as at month 2, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing, community pharmacy and primary care dental expenditure) was **£4,717,883k**.
-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

ICB	2025/26 AP2 - MAY 25	2025/26 AP1 - APR 25	2025/26 Month on month movement	Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR cumulative %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Annual Cash Draw down Requirement for 2023/24	£000s	£000s	£000s								
ICB ACDR	5,691,833	5,607,194	84,639	Apr-25	435,000	20,000	455,000	8.70%	5,438	50	0.01%
Capital allocation			0	May-25	455,000	0	910,000	17.10%	5,688	2,164	0.48%
Less:				Jun-25	440,000	0	1,350,000		5,500		
Cash drawn down	(910,000)	(455,000)	(455,000)	Jul-25							
Dental	(16,520)	(8,469)	(8,050)	Aug-25							
HOT	(379)	(188)	(191)	Sep-25							
Prescription Pricing Authority	(47,052)	(22,867)	(24,184)	Oct-25							
Pay Award charges			0	Nov-25							
PCSE POD charges adjustments			0	Dec-25							
Pension Uplift			0	Jan-26							
				Feb-26							
				Mar-26							
Remaining Cash limit	4,717,883	5,120,669	(402,786)		1,330,000	20,000					

11. Aged Creditors

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

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



12. Metrics Report

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

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

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

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

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

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2024/25 outturn by a **minimum of the growth uplift of 4.37%, a target of £534,854k**. This spend is subject to annual independent review.
- There are two changes in the MHIS target for 2025/26.
 - the MHIS target now includes £42,754k of Service Development Funding (SDF) transferred into the ICB baseline
 - there is now a separate MHIS target for Delegated Specialised Commissioning of £89,325k where responsibility has been transferred to the ICB from NHSE for services delivered through contracts managed by the South London Partnership (the Mental Health Provider Collaborative)
- MHIS excludes:
 - spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
 - out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
 - spend on SDF and other non-recurrent allocations, noting that the majority of SDF funding has been transferred into the ICB baseline.
- The 2025/26 planned spend exceeds the MHIS target as result of funding to support financial recovery and further investment in areas formerly funded through SDF and forming part of ICB core allocations.
- As at Month 2 we are forecasting MHIS delivery of **£544,483k**, exceeding the target by **£9,629k** (1.80%). This is made up of planned over-delivery as described above.

SEL ICB Finance Report

Updates from Boroughs

Month 2

Appendix 1 – Bexley

Overall Position

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

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

Appendix 2 – Bromley

Overall Position

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

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

Appendix 3 – Greenwich

Overall Position

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

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

Overall Position

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

- The borough is reporting an overall £78k year to date overspend position and a forecast breakeven position at Month 02 (May 2025). The reported forecast position includes £337k overspend on Mental Health Services (including Learning Disabilities) and £337k underspend on Continuing Health Care (CHC) Services.
- The underlying key risks within the 2025-26 Lambeth's finance position remain associated with demand driven budgets (Audiology, Interpreting Service, Cardiovascular Diagnostic Service, Mental Health including Learning Disability Services, Continuing Health Care Services and Prescribing).
- Mental Health budget year to date and forecast overspend is driven by increased ADHD spend, Mental Health and Learning Disabilities (LD) placement expenditure, and mitigated by constraining investments. Borough Commissioners leading on efficiency and productivity schemes including right sizing projects with providers to enable service users to live more independently though either stepping down restrictive levels of care or moving to more independent settings.
- Delegated Primary Care Services is reporting a breakeven position against in year budget at month 2, noting previous year (2024-25) overspend position is driven by locum reimbursements, retainer scheme and list size growth.
- The Continuing Healthcare budget is forecasting £337k underspend as the CHC team continues to deliver on reviewing high-cost packages and out of area placements. Work is ongoing to establish better value costs. The number of active CHC and FNC clients at M02 is 532.
- Prescribing actual data is provided two months in arrears and the borough is reporting a breakeven position against in year budget at month 2.
- The borough 2025-26 minimum (5%) efficiency and productivity target is £11.3m and has a savings plan of £12.6m. In addition to the embedded efficiency (£5.6m) as part of the budget setting process, the borough has saving plans for Continuing Healthcare (£1.9m), Prescribing (£1.1m) and Mental Health Services Learning Disability Services (1.2m). The borough efficiency and productivity target is forecast to deliver in full.

Appendix 5 - Lewisham

Overall Position

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

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

Overall Position

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

- The borough is reporting an underspend of £35k as at the end of May 25. Key areas of risk continue to be mental health, delegated primary care and prescribing with underspends in corporate budgets and continuing care absorbing some of overspends.
- For Mental Health we are reporting a year to date overspend of £278k and a forecast overspend of £1.5m. This is driven mainly by overspends in Right to Choose adult ADHD/Autism pathways and placements. Our forecast overspend of £1.5m is largely due to overspend (£1m) on Right to Choose adult ADHD/ASD. Placements costs for Learning disability continues to be a cost pressures. There is a risk of increased pressure in tri-partite Children and Young People mental health costs. The borough has been reviewing placements spend as part of its recovery plan started in 2024/25. A structured process of reviews with support from clinical leads has been implemented as part of our savings plans for 2025/26..
- Prescribing actual data is provided two months in arrears and the borough is reporting a breakeven position against in year budget at month 2. It is important to note that in 2/25 the borough overspent by £1.4m on prescribing. Medicine Optimisation team continue to monitor prescribing spend and also delivering savings plans on prescribing,
- Corporate budgets are £35k underspent as at month 2 due to vacancies.
- All other budget lines are at breakeven or showing relatively small underspends. Continuing Care whilst showing a small underspend is another risk area in 24/25 as AQP rate increases are likely to impact and will need to be managed within a budgeted uplift of 2.4%.
- Borough has an efficiency target of 5% which on applicable budgets amounts to £8.8m. Within this figure prescribing savings total £3.6m and most of these phased to deliver after quarter 1. As at month 2 the borough is reporting a small under delivery against plan and forecast savings in line with plan.
- The year end forecast position is breakeven overall with overspends expected in mental health budgets and underspend in continuing care and community health services. It is too early in the year to accurately assess the year end position for Prescribing and Delegated Primary Care and therefore these areas are reported as breakeven for month 2.

South East London ICS Finance Report – Month 2

Executive Summary

- This report sets out the month 2 financial position of the ICS.
- The ICS financial plan is to deliver a break-even position. This is after the receipt of non-recurrent deficit support funding of **£75.0m**. The Q1 allocation of which (£18.75m) was received in month 2.
- At month 2, the ICS is reporting a YTD deficit of **(£21.1m)**, **£6.9m** adverse to plan. The main driver is the slippage in efficiency programmes (**£6.6m**).
- As at month 2, each of the individual organisations is forecasting a break-even year-end position – this is in line with the overall ICS financial plan submitted on 30 April.
- The total system capital allocation for 2025/26 is **£227.5m**, including IFRS 16 impacts. This comprises a £223.5m provider allocation and a £4.0m ICB primary care allocation. Additionally, there is funding for national programmes of £64.5m for estates CIR, national standards funding and mental health ROAP. This brings the system capital allocation to circa **£292.1m**.
- The allocation includes a **£31.9m** CDEL loan from SWL ICB, with repayment linked to the Lambeth Hospital site disposal agreed in principle with SWL ICB and SLaM, for deferral to 2026/27.
- At month 2, the system is forecasting a **£3.0m overspend** on its capital allocation, for which mitigating actions will be needed.

I&E summary

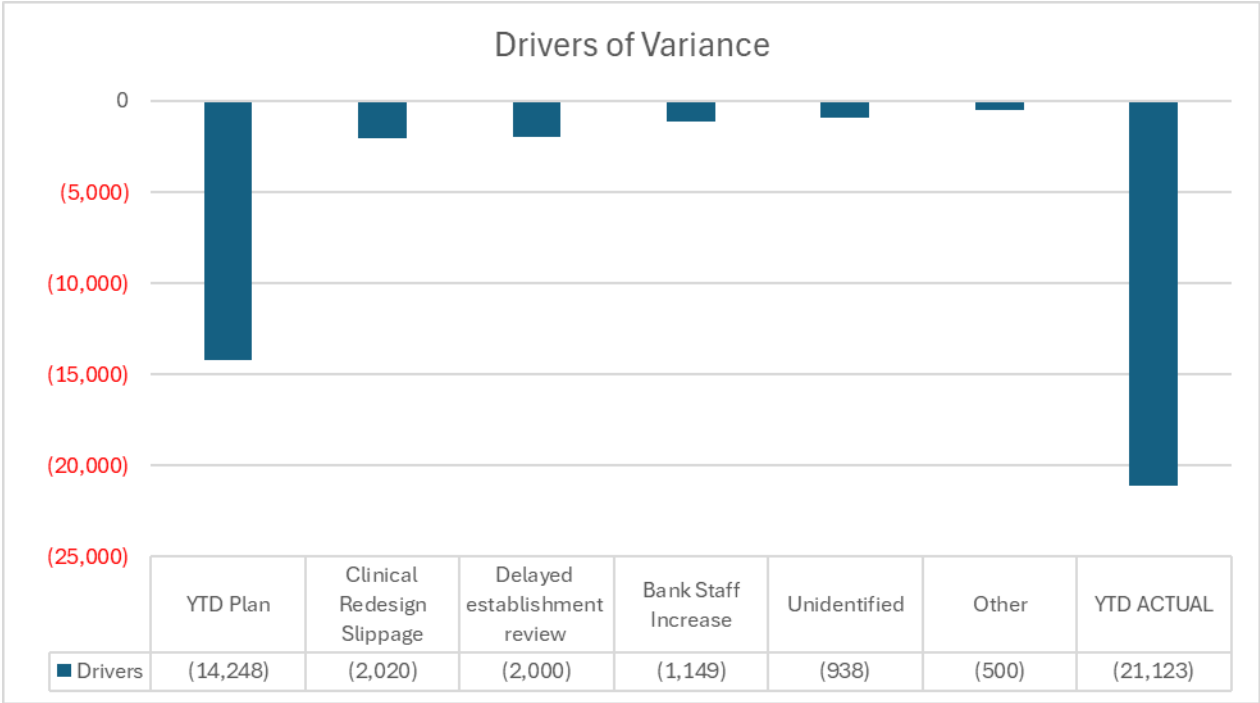
Organisation	Surplus/ (Deficit) - Adjusted Financial Position							
	Plan incl. DSF YTD	Actual YTD	Variance YTD	Variance YTD	Plan inc DSF FOT	Actual FOT	Variance FOT	Variance FOT
	£000	£000	£000	% of Income	£000	£000	£000	%
GSTT	(15,322)	(17,388)	(2,066)	(0.4%)	0	0	0	0.0%
LGT	514	(1,216)	(1,730)	(0.5%)	0	0	0	0.0%
Kings	0	(1,224)	(1,224)	(0.8%)	0	0	0	0.0%
Oxleas	(0)	(5)	(5)	(0.0%)	0	1	1	0.0%
SLAM	560	(1,290)	(1,850)	(1.6%)	0	0	0	0.0%
Provider	(14,248)	(21,123)	(6,875)	(0.6%)	0	1	1	0.0%
SE London ICB	(0)	0	0	0.0%	0	0	0	0.0%
Total ICS	(14,248)	(21,123)	(6,875)	0.0%	0	1	1	0.0%

- At month 2, SEL ICS is reporting a YTD deficit of (£21.1m), **£6.9m adverse** to plan. The main driver is **the slippage in efficiency programmes (£6.6m)**. All organisations, except for Oxleas and the ICB, are reporting off-plan at month 2.
- The month 2 slippage in efficiency is expected to recover, with each organisation forecasting that it will deliver its efficiency plan in full.
- At month 2, the ICS system forecast remains at a break-even financial position.**

Analysis of month 2 YTD position

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

- Delayed delivery of clinical service re-design schemes at SLaM of £2m.
- Slippage in establishment reviews and corporate services transformation schemes of £2m; KCH- £1.2m and LGT- £0.8m.
- Increase in bank staff activity against savings plan of £1.15m evenly split at both SLaM and LGT.
- £0.94m unidentified schemes at LGT.
- ICB (0.5m) due to slippage in the adult CHC schemes and primary care schemes which are expected to recover within the financial year.



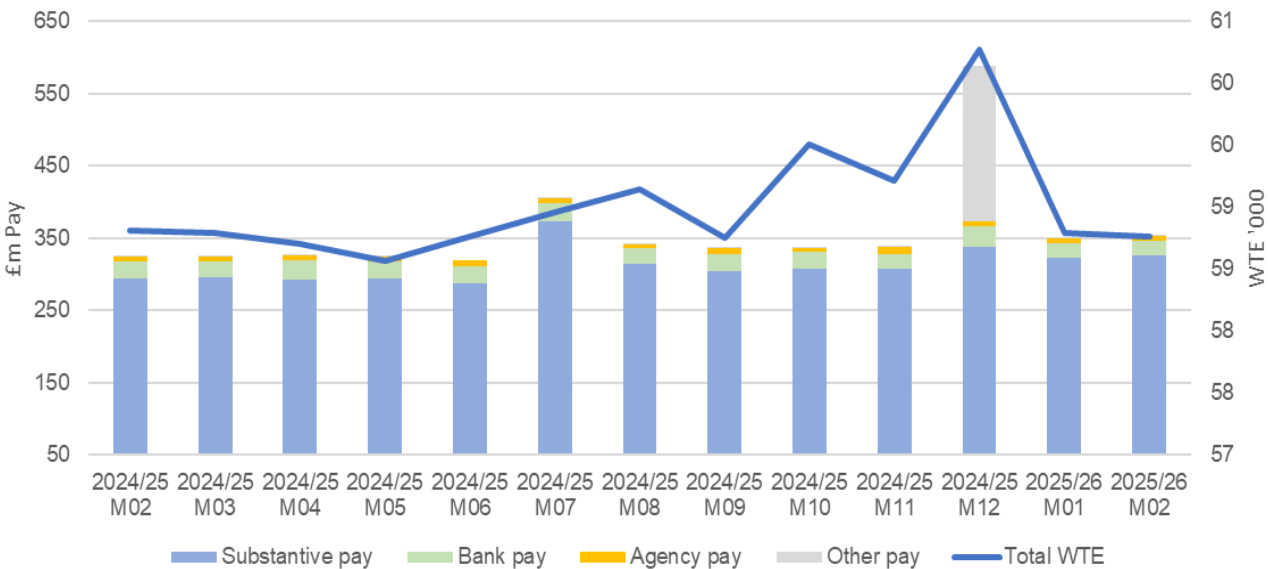
Provider run-rate analysis

Key data category	Last 5 months					Current month				Year-to-date				Analysis			
	2024/25 M09	2024/25 M10	2024/25 M11	2024/25 M12	2025/26 M01	Month 2 (in-month)				Month 2 (YTD)				Change from last month		Year-on-year change	
	Actual £m	Actual £m	Actual £m	Actual £m	Actual £m	Last year £m	Plan £m	Actual £m	Variance £m	Last year £m	Plan £m	Actual £m	Variance £m	£m	%	£m	%
Income	574.4	588.0	615.8	926.5	580.5	538.8	578.3	584.9	6.6	1,072.5	1,154.4	1,165.4	11.1	4.4	0.8%	93.0	8.7%
Pay	(337.6)	(336.5)	(338.2)	(588.4)	(349.1)	(325.2)	(348.8)	(352.7)	(3.9)	(650.9)	(697.4)	(701.8)	(4.4)	(3.5)	1.0%	(50.9)	7.8%
Non-Pay	(228.0)	(238.6)	(234.7)	(305.4)	(238.3)	(230.2)	(228.9)	(233.0)	(4.2)	(458.4)	(455.6)	(471.3)	(15.7)	5.2	(2.2%)	(12.9)	2.8%
Non Operating Items	(6.2)	(8.0)	(5.7)	(5.3)	(6.9)	(6.3)	(7.8)	(6.6)	1.3	(13.3)	(15.5)	(13.4)	2.1	0.3	(4.7%)	(0.2)	1.2%
Surplus/(Deficit)	2.6	4.8	37.3	27.4	(13.8)	(22.9)	(7.1)	(7.3)	(0.2)	(50.1)	(14.2)	(21.1)	(6.9)	6.4		29.0	

- Providers delivered a marginal **run-rate deficit** of £0.2m in month 2, an **improvement** from a £13.8m deficit in month 1. This is driven by the following:
 - YTD **non-pay** is up 2.8% year on year, and the in-month actuals are 2.2% **lower than month 1**. **Improvements** are mainly at GSTT (£5m) and KCH (£3m), offset by an increase of £3m at SLaM.
 - YTD **income** is up 8.7% year on year and an **increase** of £4.4m (0.8%) in **income compared to month 1**, mainly at KCH (£3m) and SLaM (£1.4m)
 - YTD **pay** is up 7.8% year on year and **1% higher than last month** (£3.5m). This is in line with the national pay inflation assumption and is reflected mainly at GSTT (£1.9m) and (£1.6m) KCH.

Pay run-rate and WTE analysis

- Month 2 pay is £3.5m (0.5%) 1% higher than month 1. This is mainly driven by a £4.2m (1.3%) increase in substantive staff.
- **There are 0.1% (34) fewer WTE in Month 2 than Month 1, mainly due to reduction in Bank staff.**
- Compared to 2024/25, the system has seen a 26.3% reduction in agency average WTEs YTD. This is a reduction of 275 average WTEs, resulting in reduction in **agency spend of £4.2m (27.0%) year-on-year.**



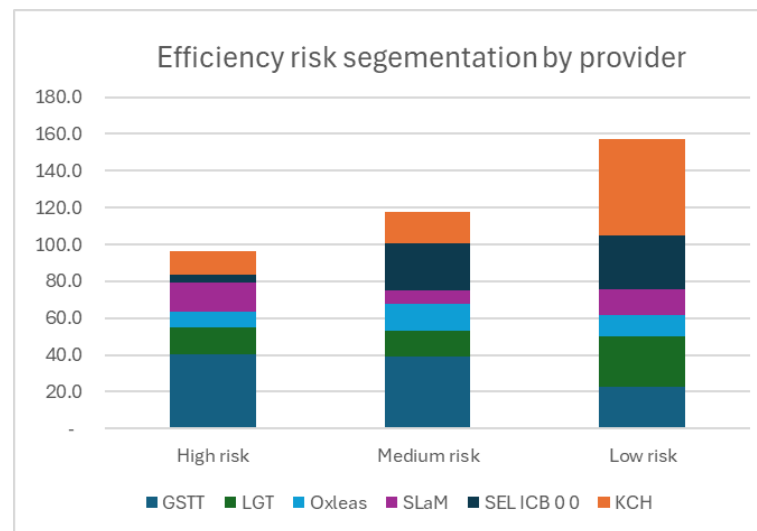
	Last 5 months					Current month				Year-to-date				Analysis			
	2024/25 M09	2024/25 M10	2024/25 M11	2024/25 M12	2025/26 M01	Month 2 (in-month)				Month 2 (YTD)				Change from last month		Year-on-year change	
	Actual £m	Actual £m	Actual £m	Actual £m	Actual £m	Last year £m	Plan £m	Actual £m	Variance £m	Last year £m	Plan £m	Actual £m	Variance £m	£/WTE	%	£/WTE	%
Substantive	304.9	308.2	307.4	338.2	322.1	294.8	322.4	326.2	3,799	590.2	644.8	648.3	3,487	4.2	1.3%	58.1	9.8%
Bank	22.8	23.2	20.6	27.7	21.3	22.4	20.7	20.4	(281)	44.9	41.5	41.7	283	(0.8)	(4.0%)	(3.1)	(7.0%)
Agency	8.5	4.1	9.0	7.5	5.6	8.0	5.4	5.8	450	15.7	10.8	11.5	697	0.2	3.6%	(4.2)	(27.0%)
Other	1.5	1.0	1.1	215.0	0.2	0.1	0.2	0.2	(50)	0.1	0.4	0.3	(108)	0.0	5.8%	0.2	149.7%
Total Pay	337.6	336.5	338.2	588.4	349.1	325.2	348.8	352.7	3,919	650.9	697.4	701.8	4,358	3.5	1.0%	50.9	7.8%
Substantive	53,319	53,585	53,548	53,962	53,708	52,867	53,535	53,727	192	52,921	53,572	53,718	146	19	0.0%	797	1.5%
Bank	4,457	5,038	4,734	5,342	4,328	4,948	4,572	4,250	(322)	4,864	4,570	4,289	(281)	(78)	(1.8%)	(575)	(11.8%)
Agency	974	885	933	968	760	1,001	796	784	(11)	1,047	805	772	(33)	25	3.2%	(275)	(26.3%)
Total WTE	58,750	59,508	59,215	60,272	58,796	58,815	58,903	58,762	(141)	58,832	58,947	58,779	(169)	(34)	(0.1%)	(54)	(0.1%)

Month 11 YTD WTE = the average of months 1 to 10 WTE inclusive.

Efficiency delivery and maturity

- At Month 2, the system delivered £35.2m of efficiencies year-to-date, which is £6.6m (15.8%) behind the plan of £41.8m.
- Non-recurrent schemes account for £19.3m, representing 54.8% of the year-to-date delivery.
- Despite the YTD shortfall, the system is forecasting a slight full-year over-delivery, with provider organisations forecasting full of programme delivery.
- 42% of the efficiency plan are assessed as low risk (£157.5m), a £37.2m (10%) improvement from Month 1.
- A notable shift is the reduction in unidentified efficiencies from £56.6m in Month 1 to £31.7m in Month 2, mainly at GSTT, LGT and SLaM.
- This has contributed to a 26% reduction in the high-risk category, decreasing from £130.8m in Month 1 to £96.6m.

	Year-to-date					Full-year Forecast		
	Plan	Actual	Variance	Recurrent	Non-recurrent	Plan	Forecast	Variance
Organisation	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	4.1	4.2	0.1	3.3	0.9	102.1	102.1	0.0
KCH	7.1	5.9	(1.2)	5.9	0.0	82.4	82.4	(0.0)
LGT	9.6	7.9	(1.7)	3.1	4.8	56.5	56.5	0.0
Oxleas	5.7	5.7	0.0	0.1	5.6	33.9	33.9	0.0
SLaM	6.2	2.9	(3.3)	2.9	0.0	37.1	37.1	0.0
Provider total	32.6	26.5	(6.1)	15.2	11.3	312.1	312.1	0.0
SEL ICB total	9.2	8.7	(0.5)	0.7	8.0	59.7	60.8	1.1
System total	41.8	35.2	(6.6)	15.9	19.3	371.8	372.9	1.1



Organisation	Plan	Identified	Unidentified	High risk	Medium risk	Low risk
	£m	£m	£m	£m	£m	£m
GSTT	102.1	70.4	31.7	40.3	39.0	22.8
KCH	82.4	82.4	-	12.8	17.0	52.6
LGT	56.5	56.5	-	14.7	14.3	27.4
Oxleas	33.9	33.9	-	8.4	14.4	11.2
SLaM	37.1	37.1	-	15.7	7.4	14.0
SEL Providers	312.1	280.3	31.7	91.9	92.2	128.0
SEL ICB	59.7	60.8	-	4.7	25.5	29.5
System Total	371.8	341.1	31.7	96.6	117.6	157.5

System capital expenditure

Capital spend against system capital allocation

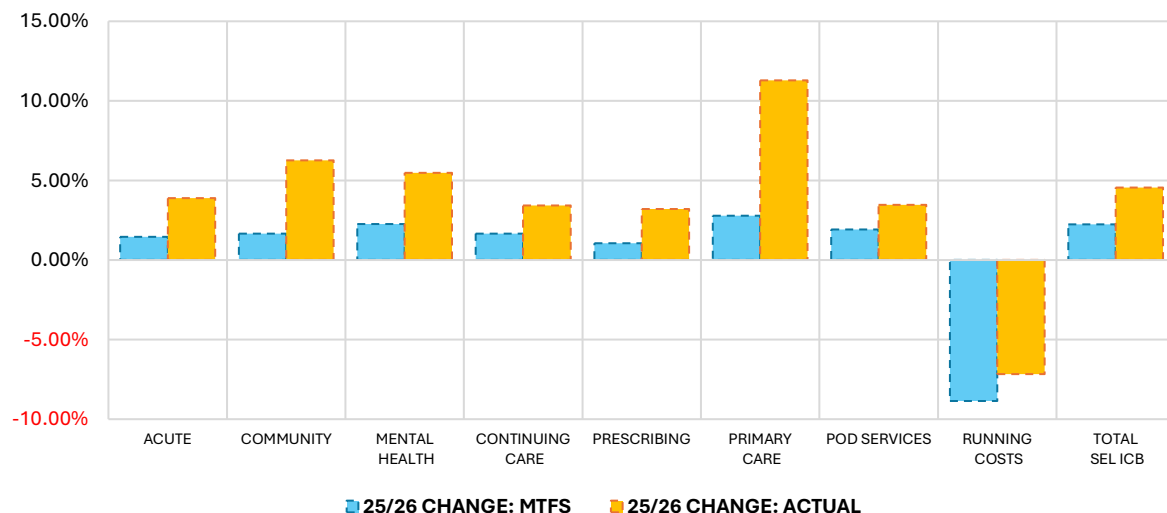
Organisation	Year-to-date					Full Year				
	Allocation	Other	Total Plan	Actual	Variance	Allocation	Other	Total Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	14.0	3.7	17.7	7.7	10.0	110.3	24.2	134.5	134.5	0.0
Kings	3.1	0.8	3.9	3.2	0.7	36.9	11.8	48.7	48.9	(0.3)
LGT	4.4	2.2	6.6	8.7	(2.1)	26.3	17.9	44.3	47.0	(2.7)
Oxleas	4.3	0.0	4.3	4.3	(0.0)	15.0	2.5	17.5	17.5	0.0
SLaM	4.2	1.3	5.5	0.7	4.8	35.1	8.1	43.2	43.2	0.0
Provider total	30.0	8.1	38.0	24.6	13.4	223.6	64.5	288.1	291.1	(3.0)
ICB	0.0	0.0	0.0	0.0	0.0	4.0	0.0	4.0	4.0	0.0
Total	30.0	8.1	38.0	24.6	13.4	227.5	64.5	292.1	295.0	(3.0)

- The total system capital allocation for 2025/26 is £227.5m, including IFRS 16 impacts. This comprises a £223.5m provider allocation and a £4m ICB primary care allocation.
- The provider total includes a £31.9m CDEL loan from SWL ICB, with repayment linked to the Lambeth Hospital site disposal agreed in principle with SWL ICB and SLaM, for deferral to 2026/27.
- There are other national programme funding of £64.5m for estates CIR, national standards funding and mental health ROAP. This is over and above the system allocation bringing the system capital allocation to circa **£292.1m**.
- At month 2, the system has spent £24.6m YTD, £13.4m less than plan, mainly due to phasing of the national programme projects.
- At month 2, the **system is forecasting an over-spend on its allocation by £3.0m**, for which mitigating actions will be needed.

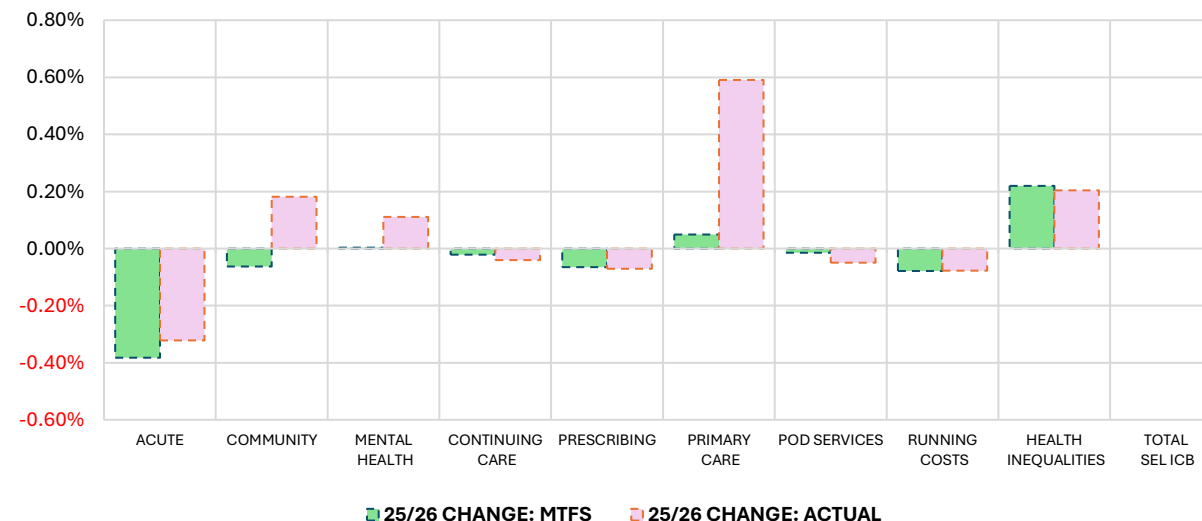
MTFS QUESTIONS – JULY 2025

2025/26 CHANGE IN SPEND: MTFS & ACTUAL PLANS

2025/26 CHANGE IN FUNDING: MTFS & 25/26 BUDGETS



SHARES OF TOTAL SEL ICB SPEND 24/25 - 25/26: MTFS AND 25/26 BUDGETS

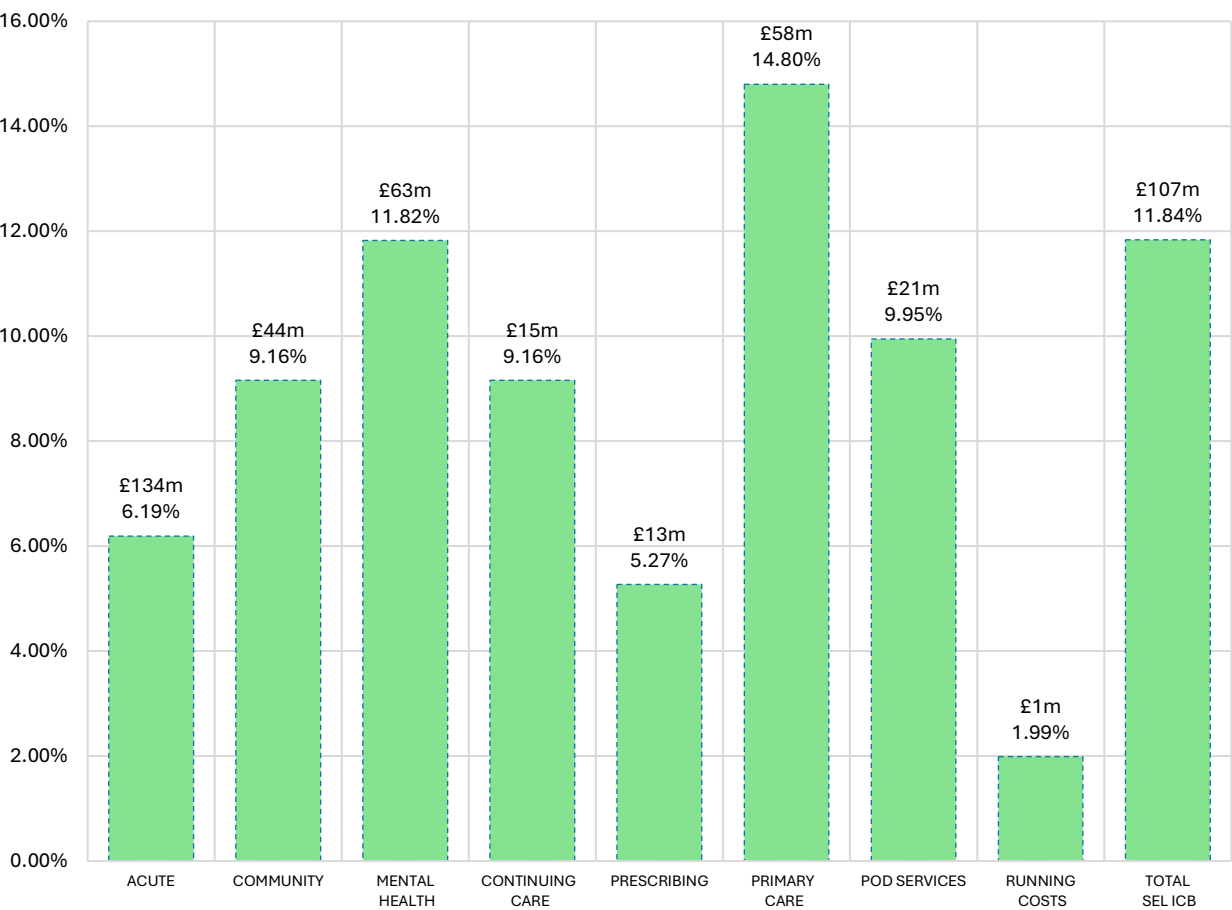


- The charts above compare MTFS change in spend assumptions **for 2025/26 only** to actual plan changes for 25/26. The chart on the left shows total changes in recurrent spend and the chart on the right the changes to the shares of total ICB spend.
- Actual growth uplifts reflect national requirements for:**
 - Mental health in line with the Mental Health Investment Standard.
 - Delegated primary care as per ringfenced allocation.
 - ICB running costs – reflecting the further reduction in funding in 2025/26 to meet the 30% reduction target and the inclusion of the delegated specialised commissioning allowance.
- Local uplifts for:** Continuing healthcare (CHC), Primary care prescribing and Community services to reflect tariff increases, embedded efficiency, convergence and growth.
- While actual uplifts are different from that planned, in particular due to changes in convergence, growth, tariff and additional Additional Roles Reimbursement Scheme (ARRS) primary care funding, financial plans continue to follow the direction set out in the ICB's Medium Term Financial Strategy (MTFS) and national allocations/financial guidance. This is shown most clearly in the chart on the right where we can see a shift in proportionate spend to out of hospital areas of spend.
- The ICB will be updating its MTFS over the Summer and Autumn in response to the NHS ten year plan and in particular to update for the **3 shifts: from hospital to community; from analogue to digital and from sickness to prevention**. Our existing MTFS would support these shifts but updates will be required as more details of the national direction and resource assumptions emerge.

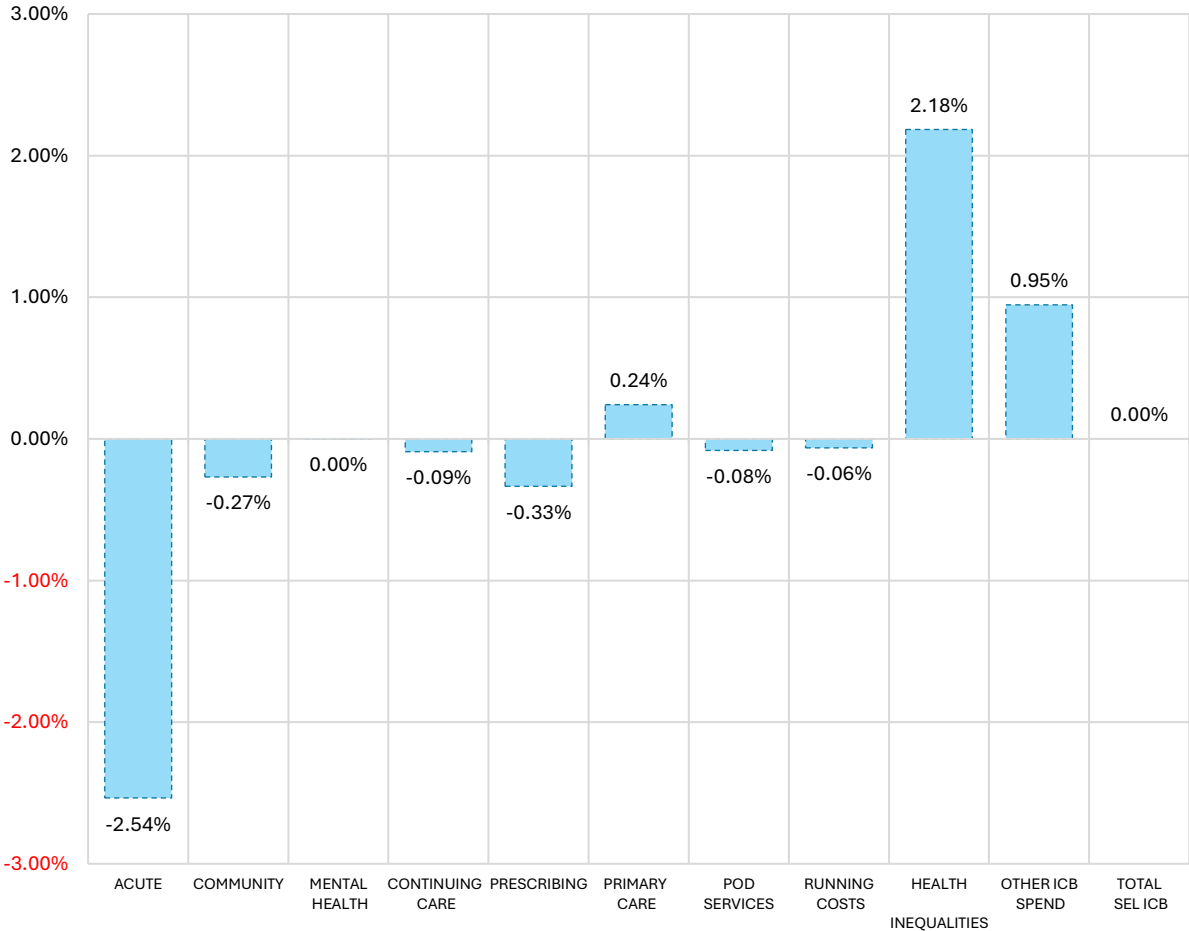
RECAP - MTFS: PLANNED CHANGE IN SPEND: 25/26 - 29/30

- Our MTFS proposed investment approach results in a **changes in the balance of spend across the ICB** as set out in the table below, with a shift in total share of spend from the acute sector towards community, mental health, primary care and health inequalities & prevention, in line with our strategic and Medium-Term Financial Strategy (MTFS) objectives and aspirations.

TOTAL % CHANGE IN INVESTMENT 2025/26 - 2029/30



CHANGES IN SHARES OF TOTAL SEL ICB SPEND 2024/25 - 2029/30



SEL INTEGRATED CARE BOARD 2025/26 START BUDGETS

APRIL 2025

- This paper sets out SEL ICB's budget setting approach and start budgets for 2025/26 across all areas of ICB spend.
- The ICB's budget setting process includes agreement of budgets held at both Place and SEL level, inclusive of the funding that has been made available to SEL's NHS Providers as part of the planning process. The paper sets out high level budgets which are supported by granular details as agreed with budget holders and with Providers of healthcare.
- The headline uplift to the ICB's core allocation in 2025/26 is 3.85% in cash terms, which includes inflation, investment growth, convergence and other efficiency assumptions. This compared to a core allocation uplift of 3.08% in 2024/25.
- This paper provides details of our financial planning assumptions including investment and savings, both in total, and by area.
- It does not include the delegated funds from specialised commissioning as these do not form part of the formal ICB start plan. However, this funding will transfer to the ICB in Q1 2025/26.
- It should be noted that final ICB movements to financial positions to bring the South East London Integrated Care System to a start financial plan have now been agreed. The ICS plan is to breakeven inclusive of the utilisation of the nationally provided system deficit support funding of £75m. In order to reach this position, several budgets and non recurrent sources will be released to support our SEL Provider positions, recognising the need to secure a system as well as an ICB financial plan for 2025/26.
- All five local SEL Providers and SEL ICB are planning a breakeven financial plan for 2025/26, inclusive of the utilisation of the system deficit funding. This position is reflected in the SEL Operational Plan submissions on the 30th April 2025. King's College Hospital will be in receipt of the full deficit support funding in 2025/26.
- Although the ICS plan is set to breakeven, there are still significant risks that require close management during the year, such as managing out of sector approaches to various NHS payment scheme rules and mechanisms; delivery of challenging performance targets; managing in-year price and activity pressures for areas such as prescribing and continuing care; and continued focus on increased productivity. Every effort needs to be made individually and collectively to de-risk positions and develop mitigation strategies.
- The ICS plan also includes material Cost Improvement Plan (CIP) assumptions, and again it will be important that we work as individual organisations, and collectively, to maximise the in-year and full year effect CIPs, secured on a recurrent basis, as part of our agreed commitment to improving our underlying position and securing a sustainable financial position for our system.

The ICB's 2025/26 start budgets are broadly based on the same assumptions shared on the 14th February 2025 in start envelopes:

- Financial plans continue to follow the direction set out in the ICB's Medium Term Financial Strategy (MTFS) and national allocations/financial guidance.
 - Total ICB available funding as per the **previously published ICB allocations for 2025/26**, and inclusive of any subsequent amendments made through the planning process.
 - **Starting position**
 - Brought forward 2024/25 recurrent budgets, including additional pay award funding.
 - Reversal of 24/25 non-recurrent system support and other non-recurrent support.
 - **Net Inflation uplift** of 2.15%, inclusive of 2.0% embedded efficiency.
 - **Convergence** applied at -0.53% across all budgets.
 - **Growth uplifts in line with national requirements for:**
 - Mental health in line with the Mental Health Investment Standard.
 - Delegated primary care as per ringfenced allocation.
 - ICB running costs – reflecting the further reduction in funding in 2025/26 to meet the 30% reduction target and the inclusion of the delegated specialised commissioning allowance.
 - Local uplifts for: Continuing healthcare (CHC), Primary care prescribing and Community services to reflect tariff increases, embedded efficiency, convergence and growth.
 - **Investment of £25m in our Population & Sustainability Fund.** This was previously £30m. This has been split as follows:
 1. Non-Recurrent funding of £5m in 2025/26 to support financial sustainability pump-priming, recognising investments will be agreed with system partners. This has reduced from the initial £10m in recognition of the challenging overall financial position of the ICS and the level of support required to our local Providers.
 2. Recurrent underlying position support for KCH of £10m to reflect the impact of historic claims and challenge adjustments within the KCH contract envelope that are no longer considered valid. This funding has been made available upon the agreement of system plans and it is reflected in a matching improvement in the Trust's bottom line position.
 3. Recurrent investment of £10m in mental health services for Lambeth and Southwark to reflect the historical under-investment in mental health services when compared to population need. This funding has been made available to South London and the Maudsley upon the agreement of system plans, and it is reflected in a matching improvement in the Trust's bottom line position.
 - **Cost pressures** to be managed within overall 2025/26 envelopes.
 - **Remaining growth** - Distributed to local acute providers. Note that 1/3rd of local acute growth (£6.26m) has been retained to fund agreed system priorities (e.g. neuro-rehab) and will be subsequently included in envelopes in-year, noting all system investment priorities will be agreed jointly with providers taking due account of the wider context.

- **Elective Recovery Fund (ERF)** – At this stage, ERF funding is included based on a rollover of start 2024/25 funding, in year pay award adjustments and a further £46.2m to reflect in-year performance in 2024/25 with a national reduction applied. National Approaches to the working of elective funding in 25/26 are still unclear but we have worked on the basis that funding should be agreed upfront in contracts and will revisit during the year if required.
 - **Specialised commissioning funding is currently excluded.** Ongoing work in collaboration with NHS England London Region has been undertaken during the planning round and specific Provider values are now known and factored into broader ICS plans. ICB allocations do not yet include specialised commissioning funding, but this is expected to be amended in M02/May.
 - The system's **deficit repayment** requirement of £16.057m has been dealt with outside of this planning process and it is assumed that the ICB will mitigate this through a review of non-recurrent balance sheet flexibilities to manage this on behalf of the system in 2025/26.
- **PRODUCTIVITY & EFFICIENCY:**
 - National guidance has clear productivity & efficiency expectations of systems, in particular:
 - A 2% reduction in the 2024/25 cost base for the 2025/26 plan (a national 1% requirement for all systems plus a further stretch for deficit systems).
 - A minimum 5% efficiency requirement.
 - A 30% reduction in agency costs.
 - A 10% reduction in bank costs.
 - Aa above a **minimum efficiency requirement of 5.0% has been applied across all budgets.** This will be met through a combination of :
 - 2.0% embedded within Tariff/ inflation uplifts
 - Savings/efficiencies to offset the convergence adjustment
 - Business as usual cash releasing efficiencies and improved productivity and efficiency.
 - System wide sustainability initiatives.

SEL ICB START ALLOCATION

SEL ICB 2025/26 ALLOCATION	CORE	DELEGATED PRIMARY CARE	POD	RUNNING COSTS	TOTAL [EXCL. SPEC COMM]
	£'000	£'000	£'000	£'000	£'000
RECURRENT ALLOCATIONS					
2024/25 Adjusted Recurrent Baseline	£3,800,574	£377,040	£212,314	£31,509	£4,421,437
Growth before convergence	£166,085	£11,651	£7,367	£2,974	£182,129
Convergence	£19,833	£1,943	£0	£0	£21,777
Net Growth	£146,252	£9,707	£7,367	£2,974	£160,352
Growth before convergence %	4.37%	3.09%	3.47%	-7.16%	4.12%
Convergence %	-0.52%	-0.52%	0.00%	0.00%	-0.49%
Net Growth %	3.85%	2.57%	3.47%	-7.16%	3.63%
2025/26 Recurrent Allocation	£3,946,826	£386,747	£219,681	£28,535	£4,581,789
RECURRENT ALLOCATIONS					
Roll out of OCT	£245				£245
Corneal Tissue	£244				£244
Running cost allowance (delegation staff transfer funding – population basis)				£1,993	£1,993
Additional BCF	£590				£590
Management of obesity	£676				£676
Primary Care Medical		£36,678			£36,678
Primary Care Medical		£615			£615
2025/26 Recurrent Allocations	£777	£37,293	£0	£1,993	£40,063
CONFIRMATION OF EXISTING ALLOCATIONS [NOT NEW FUNDING]					
Discharge	£16,246				£16,246
Covid-19 testing	£2,962				£2,962
Central technology licence arrangement adjustment	£1,212				£1,212
Charge exempt overseas visitor adjustment	£1,912				£1,912
2025/26 Confirmation of Existing Allocations	£19,908	£0	£0	£0	£19,908
NON-RECURRENT & OTHER ALLOCATIONS					
Transfers from Service Development Fund	£62,919				£62,919
Service Development Fund Retained	£15,331				£15,331
Community Diagnostic Centres [CDC]	£12,130				£12,130
Elective Recovery Funding: Core	£92,792				£92,792
Elective Recovery Funding: Additional	£56,386				£56,386
Pay: Other income support	£4,641				£4,641
Corneal transplant					£0
Community LFD testing			£227		£227
SES Optom			£420		£420
SES Dental Checks			£45		£45
Delegated Running Costs					£0
HCDD adjustment					£0
MH Delegated					£0
Depreciation/amortisation - Additional Ringfenced [Indicative]	£20,290				£20,290
2025/26 Non-Recurrent and Other Allocations	£264,489	£0	£692	£0	£265,181
TOTAL ALLOCATION	£4,232,000	£424,040	£220,373	£30,528	£4,906,941
BUSINESS RULES					
2025/26 historical deficit repayment	£16,058				£16,058
Support funding (to cover plan limit)	£74,986				£74,986
TOTAL AFTER BUSINESS RULES	£4,290,928	£424,040	£220,373	£30,528	£4,965,869

- Initial 2025/26 allocations were published on 30th January, which set out headline growth funding.
- Subsequent amendments to the allocations have been received ahead of the formal plan submission. The most significant of which related to the inclusion of baseline funding relating to ARRS, within delegated primary care.
- It should be noted that delegated specialised services allocation is not included in start ICB plans. However, this is expected to be received in M2/May and will be factored into ICB budgets thereafter. On-going work has been undertaken throughout the planning round between ICB/ICS and NHSE to understand and agree the approach to allocating funding across contracts.
- The SEL system received, as expected, £75m of support funding. This is compared to £100m received in 2024/25.
- There is also the requirement to pay back £16.1m of the system's deficit in 2025/26.

Note: Historical Deficit Repayment Breakdown:	ICB core programme allocation - recurrent	Agreed historical CCG net cumulative position	Validated system overspend 2022/23	Validated system overspend 2023/24	Total overspend to be repaid	Repayment of prior year deficits in 2025/26
SEL	£3,946,826	£8,933	£113	£57,219	£48,173	£16,058

Note: Deficit Support Funding Breakdown:	2024/25 planning deficit	Deficit reduction efficiencies	Stretch deficit reduction	Regional reserve distribution	Planning expectation (Deficit limit)	Support Funding
SEL	£99,989	£23,838	£19,948	£18,782	£74,986	£74,986

START BUDGETS BY PLACE & SEL DIRECTORATE

Budgets have been set within the overall allocation by directorate and by place as per the table below:

	Place						Sub Total - Place Held	South East London	Total
Row Labels	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark			
Acute Services - Local	£5,025,674	£8,118,696	£6,911,975	£487,919	£732,190	£257,476	£21,533,929		£21,533,929
Community Health Services - Local	£25,325,520	£94,495,585	£40,162,404	£29,580,425	£27,252,307	£37,560,988	£254,377,229	£0	£254,377,229
Mental Health Services - Local	£10,614,022	£14,576,954	£8,600,210	£23,542,157	£7,489,444	£10,507,088	£75,329,875	£2,494,355	£77,824,230
Continuing Care Services	£27,397,975	£28,867,365	£31,121,805	£37,067,906	£24,673,346	£21,696,289	£170,824,687		£170,824,687
Prescribing	£39,133,917	£52,641,720	£38,453,780	£43,997,617	£43,628,804	£36,208,053	£254,063,891	-£430,943	£253,632,948
Primary Care Services	£2,045,121	£2,025,614	£2,342,049	£5,341,005	£1,795,356	£1,220,599	£14,769,744	£16,949,480	£31,719,224
Other Programme Services					£25,500	£259,000	£284,500	£23,855,914	£24,140,414
Other Commissioned Services	£781,594	£1,062,850	£1,144,388	£1,057,756	£1,098,264	£1,034,592	£6,179,444	£3,382,822	£9,562,266
Primary Care Co-Commissioning	£49,075,923	£70,309,820	£62,781,562	£95,399,081	£71,799,817	£76,701,747	£426,067,950	-£2,027,950	£424,040,000
Delegated Primary Care Services - DOP							£0	£158,302,000	£158,302,000
Running Costs	£1,014,970	£1,824,626	£1,313,679	£1,232,132	£1,523,197	£1,778,353	£8,686,956	£21,841,044	£30,528,000
Programme Reserves & Contingencies	£1,225,157	£0	£1,795,000	£0	£9,625,555	£593,171	£13,238,884	-£2,723,896	£10,514,988
Acute Services - PCD								£2,590,224,984	£2,590,224,984
Community Health Services - PCD								£280,106,987	£280,106,987
Delegated Primary Care Services - DOP - PCD								£62,072,202	£62,072,202
Mental Health Services - PCD								£545,618,911	£545,618,911
Other Commissioned Services - PCD								£20,846,000	£20,846,000
Total	£161,639,872	£273,923,230	£194,626,853	£237,705,999	£189,643,779	£187,817,357	£1,245,357,090	£3,720,511,911	£4,965,869,000

SOURCE & APPLICATION OF ADDITIONAL FUNDS

ICB ADDITIONAL INCOME	2025/26	25/26 ALLOCATION NOTES
	£'000	
ICB GROWTH		
GROWTH	£187,939	4.37%
DELEGATED PC FUNDING	£11,650	3.09%
PHARMACEUTICAL, GENERAL OPHTHALMIC SERVICES AND DENTISTRY (POD)	£7,368	3.47%
SPECIALISED COMMISSIONING	£23,366	4.97%
RUNNING COSTS	-£4,041	-7.16%
CORE CONVERGENCE	-£19,833	-0.54%
DELEGATED PRIMARY CARE CONVERGENCE	-£1,943	-0.52%
DOPS CONVERGENCE	£0	0.00%
SPECIALISED COMMISSIONING CONVERGENCE	-£3,210	-0.50% excl MH & HCDD
NET GROWTH	£201,296	
NON-RECURRENT		
ERF INCOME CHANGE	£4,829	
TOTAL INCOME CHANGE	£206,125	

- A revised source & application of funds has been set out based on confirmed 25/26 allocations.
- This is additional growth and additional expenditure. Growth is offset in our financial envelopes by the convergence factor which has been applied across all budgets.

ICB ADDITIONAL EXPENDITURE	2025/26	ALLOCATION NOTES
	£'000	
INFLATION/ TARIFF		
TARIFF UPLIFT	£215,047	4.15% (3.65% for prescribing)
TARIFF EFFICIENCY	-£104,229	-2.00%
INFLATION/ TARIFF	£110,818	
POPULATION & SYSTEM SUSTAINABILITY		
HEALTH INEQUALITIES & PREVENTION	£10,000	
SUSTAINABILITY PUMP PRIMING	£5,000	
UNDERLYING POSITION SUPPORT	£10,000	
POPULATION & SYSTEM SUSTAINABILITY	£25,000	
GROWTH (AFTER TARIFF, BEFORE CONVERGENCE)		
DELEGATED PRIMARY CARE	£3,544	as per ringfenced allocation
PRIMARY CARE PRESCRIBING	£4,915	2.00%
CONTINUING CARE	£3,303	2.00%
NON-LOCAL ACUTE UPLIFTS	£4,267	1.00%
COMMUNITY	£9,823	2.00%
MENTAL HEALTH	£12,220	2.22%
OTHER DIRECT COMM'ING (ODC)	£2,803	as per ringfenced allocation
OTHER PRIMARY CARE	£275	0.50%
LOCAL ACUTE PROVIDERS	£18,781	balancing figure
BCF	£2,000	estimate
OTHER PROGRAMME	£167	0.50%
GROWTH (BEFORE CONVERGENCE)	£67,098	
SPECIALISED COMMISSIONING		
SPECIALISED COMMISSIONING UPLIFT OVER 2024/25	£23,366	includes tariff
NON-RECURRENT	£23,366	
NON-RECURRENT		
ERF INCOME CHANGE	£4,829	reconciliation required
NON-RECURRENT	£4,829	
CONVERGENCE		
CORE CONVERGENCE	-£19,833	across all appropriate ICB budgets
DELEGATED PRIMARY CARE CONVERGENCE	-£1,943	-0.5%
DOPS CONVERGENCE	£0	0.0%
SPECIALISED COMMISSIONING CONVERGENCE	-£3,210	-0.50% excl MH & HCDD
CONVERGENCE	-£24,986	
TOTAL EXPENDITURE	£206,125	
SURPLUS/ -DEFICIT	£0	

2025/26 budget setting continues to follow the direction set out in the draft Medium Term Financial Strategy (MTFS), which has been updated to reflect national allocations, planning guidance and agreed local adjustments. Budgeting for Place held budgets is taking place alongside budget setting across all SEL ICB areas of spend.

- High level budgets across the ICB were initially shared on the 14th February 2025. These include overall indicative Place budgets, together with further details by expenditure area (e.g., mental health, community, continuing healthcare, primary care, prescribing, running costs). **This formed an overall Place control total to enable balanced detailed budgets to be set.**
- 2025/26 high level (and the later detailed) budgets were built using carry forward 2024/25 recurrent budgets, as at month 8, as a starting baseline. **A clear audit trail to 2025/26 budgets was maintained** through the detailed budget setting process inclusive of: Inflation uplifts, savings/ efficiencies, cost pressures, investments, and a rebasing of budgets to reflect outturn.
- Places were able to agree **budgets virements** between expenditure areas but on the basis that the ICB will need to operate within guiding commitments and local approaches including:
 - Delivery of the **Mental Health Investment Standard**
 - Running cost ceilings**
 - Earmarking of **delegated primary care**
 - Adherence to and delivery of agreed commitments made within the MTFS with regards to allocative approaches**
 - Any changes to indicative provider envelopes are collectively agreed, appropriately recognising the knock-on impact on provider and ICB financial positions
- The expectation was that **cost pressures e.g., underlying demand, inflationary/price pressures and new treatments were met within overall budgets** and funded through local prioritisation exercises, which would then be reflected through the detailed budget setting exercise.
- Through collaboration with Place ADOFs [Associate Directors of Finance], between the 14th February 2025 and the submission of the 2nd ICB operating plan on the 30th April 2025, the high-level **Place budgets have been through a detailed process of review and refinement.** Furthermore, budgets have also been adjusted to reflect specific allocation changes e.g., BCF, delegated primary care and SDF transfers to ICB core programme baselines. The table below summarises the movements made to locally held Place budgets.

	14th Feb [Initial]	Changes	28th March [1st Plan]	Changes	30th April [2nd Plan]
Bexley	£155,009,534	£112,837	£155,122,371	£6,517,500	£161,639,872
Bromley	£262,587,785	£204,710	£262,792,495	£11,130,735	£273,923,230
Greenwich	£185,476,180	£101,173	£185,577,353	£9,049,500	£194,626,853
Lambeth	£226,386,907	£146,166	£226,533,073	£11,172,927	£237,705,999
Lewisham	£179,499,766	£148,738	£179,648,504	£9,995,275	£189,643,779
Southwark	£177,431,310	£232,817	£177,664,128	£10,153,229	£187,817,357
Total Place	£1,186,391,482	£946,441	£1,187,337,923	£58,019,166	£1,245,357,090

- The ICB has needed to demonstrate delivery of **at least 5% productivity and efficiency savings**, in line with national expectations of the ICB and all providers within the system, plus manage all cost pressures and investments within the budget uplifts set. We also need to continue to secure a collective assurance around value, impact and investment across all areas of ICB spend – with a specific focus on **return on investment and benefits realisation.**

2024/25 SDF FUNDING

- SEL ICB has received Service Development Funding (SDF) non-recurrently on an annual basis since 2020/21 to fund NHS Long Term Plan deliverables. The total value of SDF funding for 2024/25 [based on M08 allocations] was £102.594m, as set out in the table. This funding is ringfenced for specific schemes. SDF has increased differentially by area over the period with mental health being the largest single area at 46.8% of the current total value.

2025/26 FORMER SDF FUNDING

- For 2025/26 many SDF bundles will move into ICB core programme allocations. [See Annex A](#). Where funding has been transferred into ICB core programme allocations - this is no longer ringfenced and there are no additional performance requirements beyond those set out in the 2025/26 priorities and operational planning guidance. For SEL, the former SDF allocation is £62.530m, this was subsequently adjusted to **£62.920m** for two specific programmes [£218k CYP and £172k Prevention – CVD and Stroke].
- It should be noted that the funding transfer was reduced by £4.782m (7.5%) in overall terms compared to 24/25 values.
- Given the significant financial challenge the system faced in 2025/26; the requirement to manage the funding top slice; and in the context of national expectations, the ICB reviewed its SDF allocation to ensure that services being delivered offer value for money on what is a substantial level of investment. A view was taken on the following:
 - schemes that should continue,
 - schemes that needed to be refocussed to drive increased return on investment
 - schemes that should be stopped due to their low priority for our system or failure to add value

2025/26 CONTINUED SDF FUNDING

- Several areas of retained ICB SDF allocations have now been issued. Where funding remains in SDF allocations, ICBs must spend it on the purpose for which it has been allocated. Where SDF funding is not spent on its intended purpose this will be subject to removal from system positions.
- Further allocations are likely to be confirmed in-year and the ICB will be required to report spend against these monthly.

2025/26 FORMER SDF FUNDING	M08 24/25 NR Received		In core 2025/26 baseline
	£'000s	% Share	£'000s
Community Health Services	£2,673	2.61%	£2,674
Cancer	£12,841	12.52%	0
CYP	£741	0.72%	£445
Diagnostics	£4,562	4.45%	£0
Innovation	£30	0.03%	£0
IT & Tech	£1,220	1.19%	£0
LD & Autism	£4,554	4.44%	£4,174
Maternity	£2,494	2.43%	£2,494
Mental Health	£48,011	46.80%	£44,610
Other SDF	£2,982	2.91%	£1,717
People	£185	0.18%	£0
Prevention & Long Term Conditions	£3,358	3.27%	£2,928
Primary Care	£18,943	18.46%	£4,515
Total	£102,594		£63,557
Pay uplift			£161
Long Covid CYP			£80
Total per SDF in core baseline guidance			£63,799
Additional SDF allocations for 24/25 pay settlement			£2,197
Reductions applied to SDF			-£4,782
Adjusted total - in 24/25 terms			£61,214
CUF at 2.2%			£1,316
SDF transferring to core allocations			£62,530

2025/26 CONTINUED SDF FUNDING	24/25 £'000	25/26 £'000	Change £'000
Cancer Alliance Core Funding	£8,927	£6,633	-£2,294
Cancer Alliance Targeted Funding	£4,306	£4,515	£209
Complications of Excess Weight	£0	£301	£301
Individual Placement Support (IPS)	£780	£1,574	£794
Children's Hospices	£807	£823	£16
Hybrid Closed Loop	£207	£1,455	£1,248
REN Programme	£30	£30	£0
Total	£15,057	£15,331	£274

ANNEX A/1: SDF TRANSFERS TO ICB CORE PROGRAMME

SDF Detailed Overview
As at 30th April 2025

		Included in Provider Envelopes - For 27th March 2025 Planning Submission															
		GSTT	KCH	LGT	OXLEAS	SLAM	SUB TOTAL	OTHER PCD	PLACE	RETAINED CENTRALLY	TOTAL	BEX	BROM	GWH	LAM	LEW	SWK
SDF Category	Sub Category	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Community Health Services	Community Transformation Team						£0			£196	£196						
	End of Life						£0			£286	£286						
	Community Transformation						£0		£1,128		£1,128	£264	£283	£162	£131	£155	£133
Community Health Services Total		£0	£0	£0	£0	£0	£0	£0	£1,128	£482	£1,610	£264	£283	£162	£131	£155	£133
CYP	CEW Clinics						£0				£0						
	SPOT/PEWS	£6	£11	£11	£0	£0	£28				£28						
	Epilepsy	£115					£115				£115						
	Asthma Programme						£0	£64			£64						
	Mental Health Champions	£16	£32	£32			£80				£80						
	Diabetes						£0	£10			£10						
	Youth Support Workers						£0	£46			£46						
	Integration						£0	£70			£70						
	Infrastructure						£0	£22			£22						
CYP Transformation						£0	£218			£218							
CYP Total		£137	£43	£43	£0	£0	£223	£430	£0	£0	£653	£0	£0	£0	£0	£0	£0
LD & Autism	Community				£681	£582	£1,263			£1,452	£2,715						
	Key Workers						£0			£1,180	£1,180						
	Autism						£0			£137	£137						
	Hearing Screening						£0			£31	£31						
LD & Autism Total		£0	£0	£0	£681	£582	£1,263	£0	£0	£2,801	£4,064	£0	£0	£0	£0	£0	£0
Maternity	LMNS Project Managers						£0	£280			£280						
	Clinical Leadership						£0	£65			£65						
	Obstetric Workforce	£103	£103	£103			£308			£0	£308						
	Pelvic Health	£143	£136	£170			£449			£0	£449						
	Maternal Medicine Network	£321					£321			£0	£321						
	Preterm Birth	£15	£15	£15			£45			£0	£45						
	Equality & Equity						£0	£67			£67						
	Ockenden Workforce II	£151	£245	£213			£609			£0	£609						
	Maternal Mental Health Services		£87	£37			£124			£0	£124						
Maternity Transformation						£0	£160			£160							
Maternity Total		£734	£585	£538	£0	£0	£1,857	£572	£0	£0	£2,429	£0	£0	£0	£0	£0	£0

ANNEX A/2: SDF TRANSFERS TO ICB CORE PROGRAMME

SDF Detailed Overview
As at 30th April 2025

Included in Provider Envelopes - For 27th March 2025 Planning Submission																	
SDF Category	Sub Category	GSTT	KCH	LGT	OXLEAS	SLAM	SUB TOTAL	OTHER PCD	PLACE	RETAINED CENTRALLY	TOTAL	BEX	BROM	GWH	LAM	LEW	SWK
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mental Health	MH CYP - CYP community, Crisis and Eating Disorders				£2,609	£2,449	£5,058	£1,086	£2,027		£8,171	£179	£451	£286	£411	£357	£343
	MH CYP - CYP ED (Additional)				£0	£593	£593	£138	£0		£731	£0	£0	£0	£0	£0	£0
	MH CYP - Perinatal - Maternal Mental Health Services (MMHS) - KCH/LGT		£85	£30	£0	£0	£115	£0	£0		£115	£0	£0	£0	£0	£0	£0
	MH CYP - Young Adults				£0	£0	£0	£0	£0		£0	£0	£0	£0	£0	£0	£0
	MH Schools Teams - MHST 18/19 Trailblazers (MHST18/19)				£0	£0	£0	£0	£1,021		£1,021	£0	£1,021	£0	£0	£0	£0
	MH Schools Teams - MHST 19/20 sites wave 1&2 (MHST19/20)				£1,021	£1,067	£2,088	£0	£0		£2,088	£0	£0	£0	£0	£0	£0
	MH Schools Teams - MHST 20/21 sites wave 3&4 (MHST20/21)				£1,021	£893	£1,914	£0	£174		£2,088	£0	£0	£0	£174	£0	£0
	MH Schools Teams - MHST 21/22 sites wave 5&6 (MHST21/22)				£499	£521	£1,020	£0	£1,020		£2,040	£0	£499	£0	£0	£0	£521
	MH Schools Teams - MHST 21/22 sites wave 7&8 (MHST22/23)				£495	£516	£1,011	£0	£516		£1,527	£0	£0	£0	£0	£0	£516
	MH Schools Teams - MHST 21/22 sites wave 9&10 (MHST22/23)				£0	£354	£354	£0	£354		£708	£0	£0	£0	£0	£0	£354
	MH Schools Teams - MHST 21/22 sites wave 12 (MHST22/23)				£143	£149	£292	£16	£0		£308	£0	£0	£0	£0	£0	£0
	MH Adult Crisis - Adult Mental Health Crisis (AMH Crisis)				£1,314	£1,450	£2,764	£0	£0		£2,764	£0	£0	£0	£0	£0	£0
	MH Adult Crisis - Adult Mental Health Liaison (Crisis/Liaison)				£334	£502	£836	£0	£0		£836	£0	£0	£0	£0	£0	£0
	MH Adult Crisis - Suicide Prevention				£0	£392	£392	£0	£0		£392	£0	£0	£0	£0	£0	£0
	MH Adult Crisis - Suicide Bereavement				£0	£94	£94	£0	£0		£94	£0	£0	£0	£0	£0	£0
	MH Adult Community - Adult Mental Health Community (AMH Community)				£3,471	£6,406	£9,877	£444	£6,226		£16,547	£772	£1,303	£1,589	£1,328	£508	£726
	MH Adult Community - SMI SMI Outreach				£0	£0	£0	£0	£0		£0	£0	£0	£0	£0	£0	£0
	MH Adult Community - Individual Placement Support (IPS)				£0	£75	£75	£0	£157		£232	£15	£52	£71	£19	£0	£0
	MH Adult Community - Rough Sleeping existing sites				£0	£285	£285	£0	£38		£323	£0	£0	£0	£38	£0	£0
	MHLDA inpatient quality transformation				£724	£1,086	£1,810	£0	£0		£1,810	£0	£0	£0	£0	£0	£0
	MHLDA inpatient quality transformation - Lewisham Pilot				£0	£2,767	£2,767	£0	£0		£2,767	£0	£0	£0	£0	£0	£0
Mental Health Total		£0	£85	£30	£11,631	£19,599	£31,345	£1,684	£11,533	£0	£44,562	£966	£3,326	£1,946	£1,970	£865	£2,460
Other SDF	Medical Examiners	£550	£754	£500			£1,804				£1,804						
Other SDF Total		£550	£754	£500	£0	£0	£1,804	£0	£0	£0	£1,804	£0	£0	£0	£0	£0	£0
Prevention & Long Term Conditions	Tobacco Maternity	£131	£124	£124			£379	£0			£379						
	Tobacco Inpatients (Physical/MH)	£148	£170	£166	£60	£103	£647	£0			£647						
	Leadership System Delivery Architecture Funding						£0	£95			£95						
	Leadership Leadership						£0	£95			£95						
	Respiratory Pulmonary Rehab	£49	£0	£132	£143	£0	£324	£160			£484						
	Cardiac Rehabilitation						£0	£294			£294						
	Stroke Rehabilitation						£0	£158			£158						
	Alcohol Transition Funding		£141	£144			£285	£0			£285						
	Diabetes Clinical Leadership						£0	£0			£0						
	Diabetes T2 Diabetes Path to Remission						£0	£0			£0						
	Diabetes Transition & Young Adult Care Pilots		£170				£170	£0			£170						
	Diabetes T2DAY - T2 Diabetes						£0	£239			£239						
	Long COVID CYP Long Covid						£0	£84			£84						
	CVD Prevention Leadership, Stroke Pathway Improvement/Thrombectomy						£0	£172			£172						
Prevention & LTC Total		£328	£605	£567	£203	£103	£1,805	£1,296	£0	£0	£3,101	£0	£0	£0	£0	£0	£0
Primary Care	Primary Care Transformation						£0		£3,952		£3,952	£460	£680	£580	£855	£675	£702
	GPIT - Infrastructure and Resilience						£0			£444	£444						
	GPIT -Digital Tools						£0			£301	£301						
Primary Care Total		£0	£0	£0	£0	£0	£0	£0	£3,952	£745	£4,697	£460	£680	£580	£855	£675	£702
Total		£1,749	£2,072	£1,678	£12,515	£20,284	£38,297	£3,981	£16,613	£4,028	£62,920	£1,690	£4,289	£2,688	£2,956	£1,695	£3,295

Notes where changes are expected in Q1 2025/26

ICB Board Meeting in Public

Title	SEL System Performance update					
Meeting date	16 July 2025	Agenda item Number		8	Paper Enclosure Ref	H
Author	ICB Risk and Assurance and Performance teams					
Executive lead	Sarah Cottingham, Deputy CEO, Executive Director of Planning					
Paper is for:	Update	X	Discussion	X	Decision	
Purpose of paper	The report provides the Board with a summary of current system performance across a range of national performance metrics. It is intended to ensure Board members are appraised of progress against key operational planning commitments for 2025/26 and understand the areas of challenge, risk and improvement focus. The report supports the Board’s oversight of assurance and delivery by setting out the latest available data and together with a summary analysis across a range of key performance areas, including urgent and emergency care, cancer, referral to treatment, diagnostics, primary care, mental health, community services and continuing healthcare. Where performance is below trajectory, the paper outlines the agreed recovery actions and improvement trajectories.					
Summary of main points	The report shows encouraging progress in a number of areas. SEL met the new national target for 12-hour A&E waits in May 2025 and continues to deliver above plan against the Faster Diagnosis Standard for cancer. GP appointment volumes remain above plan, with good uptake of <i>Pharmacy First</i> clinical conditions and hypertension services in community pharmacy. The inpatient and health check targets for people with a learning disability and autistic people have also been met. At the same time, significant pressures remain. These include in urgent and emergency care, mental health crisis presentations and demand for admissions, waits for community paediatrics and diagnostics. Referral to treatment long (65 week +) waits have begun to increase, and some challenges persist in securing mental health access targets and continuing healthcare reviews. The paper outlines the recovery actions underway across these areas and notes changes to future reporting to reflect updated 2025/26 operational plan requirements.					
Potential conflicts of Interest	None identified					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Not directly applicable to the production of this paper.					
Financial Impact	Not directly applicable to the production of this paper.					

Public Patient Engagement	Not directly applicable to the production of this paper.
Committee engagement	ICB Executive Committee, 25 June 2025
Recommendation	The Board is asked to note the update and consider any implications for system assurance and delivery oversight.



SEL System Performance Summary July 2025

SEL ICB Board - 16 July 2025

Contents

1. <u>Summary of year-to-date position - July 2025</u>	3
2. <u>Urgent & emergency care</u>	6
3. <u>Cancer</u>	7
4. <u>Referral to treatment</u>	8
5. <u>Diagnostics</u>	10
6. <u>Mental health</u>	11
7. <u>Mental health crisis and flow</u>	12
8. <u>Primary care access</u>	13
9. <u>Community Pharmacy</u>	15
10. <u>Urgent community response and community waits</u>	16
11. <u>Virtual ward</u>	17
12. <u>Continuing healthcare</u>	18
13. <u>Learning disability and autism</u>	19

Summary of YTD position – July 2025 (1 of 3):

Area	YTD summary and key issues
Urgent & Emergency Care (UEC)	- Performance across 25/26 has remained broadly in line with improvement trajectories, with delivery of the new 12-hour wait standard and some gains in handover delays. - SEL trusts combined view of 4-hour performance in May was 72.4% (based on SitRep data), which met the month 2 trajectory for combined trust performance. - SEL 'footprint' performance, which includes activity from stand alone Urgent Treatment Centres, was 76.8%. - The new target for the percentage of 12-hour delays (from arrival) was met in May 2025. - Demand, capacity and flow challenges continue across physical and mental health, with on going improvement work across the care pathway. This includes embedding discharge and admission avoidance models. There has been an increased recent focus on reducing the number of delayed days post-discharge ready date (DRD). - New UEC operations planning metrics for discharge will be added to this report next month.
Cancer	Delivery of plans across cancer pathways have shown resilience year to date, with consistent achievement of delivery against the Faster Diagnostic Standard with the system having an agreed a trajectory to reach 80% by year end. The treatment backlog position is also currently stable. However, 62-day performance remains below standard, and the system focus continues to be around pathway efficiency, inter-trust transfers, treatment capacity and targeted support and focus on challenged specialties e.g. urology and breast.
Referral to Treatment Times (RTT)	While there has been significant focus on RTT performance, including a renewed emphasis and focus on the implementation of transformation initiatives, 65-week-waits have recently risen following a period of downward movement at the end of 24/25. Urology, ENT and gynaecology are the challenged specialties for long waiters and remain priority areas for recovery. Progress in outpatient transformation and demand management is expected to support system performance improvement in the second half of 25/26.
Diagnostics	Diagnostic performance remains an area of significant system challenge. Year-to-date performance has been affected by sustained pressure on key modalities such as non-obstetric ultrasound and echocardiography. Recovery plans, including insourcing and regional demand and capacity reviews, are in progress as part of the ICS system sustainability programme, and are expected to support improvement later in the financial year.

Summary of YTD position – July 2025 (2 of 3):

Area	YTD summary and key issues
Primary care access	- Appointment levels have exceeded plan year-to-date with the growing adoption of digital services and enhanced access models. Appointments totalled 741,850 in April 2025 against an operating plan target of 636,239. - Borough-level improvement plans are now in place, and all boroughs are engaged in actions to better understand and target support for practices showing variation in access levels. Capacity pressures and rising demand continue to impact patient experience in some areas.
Mental health including crisis and flow	- Mental health services continue to experience significant year-to-date pressure, particularly across crisis pathways. Crisis services have seen high levels of Emergency Department (ED) presentations and delays, with out-of-area placements remaining above plan. All providers are delivering internal flow improvement plans, and system-wide work is underway to reduce ED delays and support timely discharge. Data quality improvements and updated trajectories are in place as part of 2025/26 plans. - Urgent Children and Young People (CYP) eating disorder targets have been met alongside perinatal access and talking therapy recovery rate targets. However, challenges remain in routine CYP access, physical health checks for people with Serious Mental Illness (SMI), and overall adult community mental health demand. - Mental health metrics will be revised slightly in next month's report to ensure all key operational planning metrics are reflected in this report.
Continuing healthcare (CHC)	- CHC performance improved across 2024/25 and into 2025/26, with delivery of the national 28-day standard in most months and a reduction in backlogs for reviews. However, fast-track and Funded Nursing Care (FNC) reviews remain under pressure in some boroughs. Teams continue to deliver against agreed trajectories and are working to embed more robust quality and assurance processes. - May 2025 performance (local reporting) against the number of referrals completed within the 28-day timeframe is 81% which remains above the national target of 80%. The number of overdue CHC referrals and CHC reviews decreased. Overall CHC data completeness achieved was 84.4% in March 2025. This has now been replaced by the All Age Continuing Care dataset.
Learning disability and autism	- SEL met the year-end target for inpatient numbers and exceeded the annual health check target for 2024/25. - There are new definitions for the inpatient target in 2025/26, focused on reducing reliance on mental health inpatient care for adults with a learning disability and for autistic adults. The new definition distinguishes between adults with a learning disability and autistic adults. Plans are in place to meet the new target for the current year. - Increasing demand for autism assessments remains a system-wide challenge. Work is progressing on diagnostic pathway redesign, community development and Right to Choose accreditation of new providers to support further improvement in 2025/26.

Summary of YTD position – July 2025 (3 of 3):

Area	YTD summary and key issues
Community pharmacy: pharmacy first clinical consultations, hypertension and oral contraception	• Take-up of Pharmacy First, hypertension and contraception services has been strong across most boroughs, with 90% of SEL community pharmacies providing all three services as of May 2025. Since the start of the <i>Pharmacy First</i> service across community pharmacy in SEL in February 2024, there have been approximately 86k consultations for the seven clinical conditions, approximately 171k for hypertension consultations (blood pressure and ambulatory monitoring), and 17k oral contraception consultations (both initiation and ongoing supply) up to May 2025. • Ongoing work is focused on improving referral pathways and data quality.
Community waits and urgent community response (UCT)	• Long community waits, particularly in paediatric therapies and adult podiatry, remain a significant challenge. Demand continues to exceed capacity in key services, and system-wide recovery planning is underway to support backlog reduction and improved reporting. • UCR performance has been variable across the year but continues to meet response standards in most boroughs.
Virtual ward	• Virtual ward capacity has exceeded plan year to date, though utilisation has varied due to data and operational challenges. Service reviews and re-procurements are underway to support future development. SEL continues to work with national and regional teams to strengthen virtual ward integration and maximise their role in urgent care and long-term condition management. • The virtual ward service delivered by Bromley Healthcare has been identified as an example of excellence and will be presented to the national <i>Virtual Wards Summit</i> in Manchester on 17 June 2025.

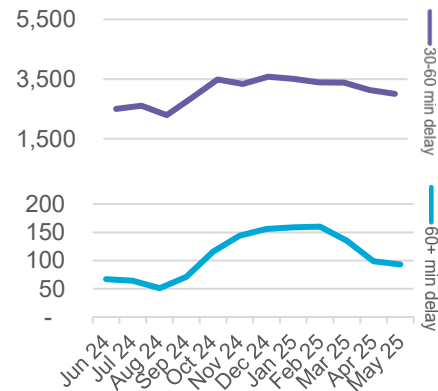
Urgent & Emergency Care

Notes and Issues

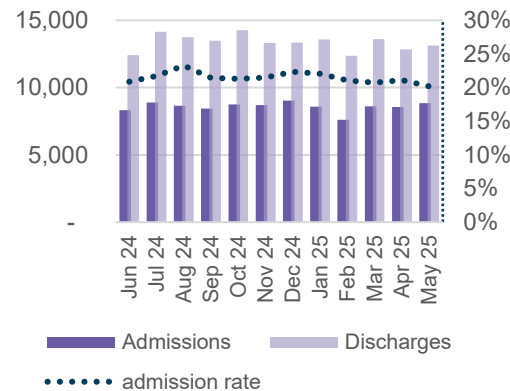
- ED performance – May SitRep data showed performance of 72.40% across the three acute Trusts. Published performance for SEL in May 2025 (including standalone UTC activity) was **76.8%**, a small deterioration on the 75.5% reported in April.
- The system continues to see surges in mental health demand, leading to some long delays.
- Ambulance handover delays decreased in May, but the number remain high due to overall demand and flow pressures. However the number of 30-60 minute delays and the number of 60+ minute delays decreased again in April.
- Bed occupancy levels decreased with overall occupancy of just below 94%.
- The new target for the percentage of 12 hours waits (from arrival) was met in May.
- New discharge targets will be added to this report next month.



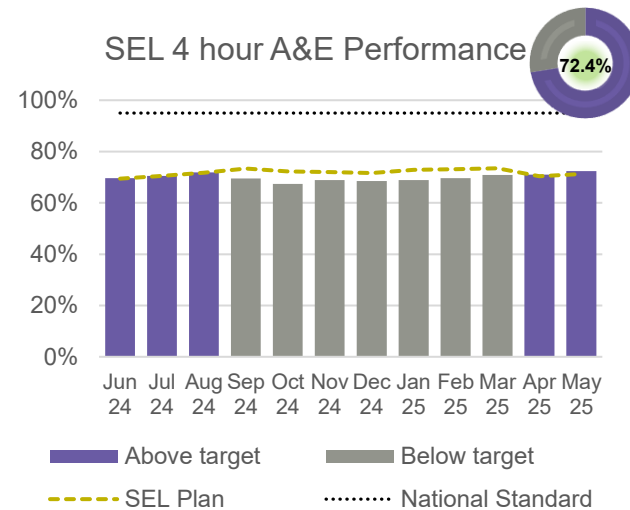
Handover Delays



Emergency admissions & Discharge



SEL 4 hour A&E Performance



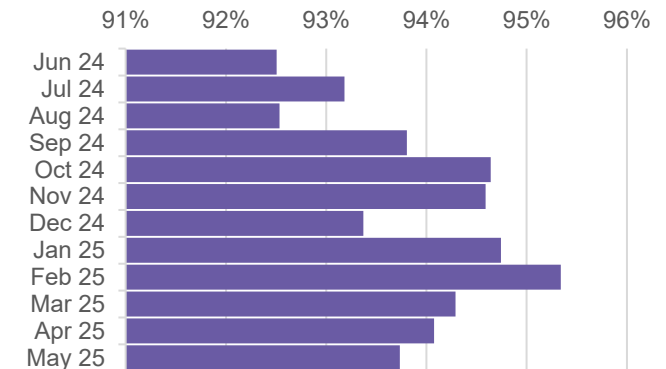
Recovery Actions

- Local systems/providers are implementing plans for 2025/26 to help deliver agreed improvement trajectories. Improvement actions continue to focus on:
 - Front door management – use of alternatives to ED, ED triage and streaming, redirection, use of admission avoidance, MH crisis pathway, hospital handovers.
 - Implementation of 'Criteria to Admit' (CTA) across all sites.
 - In hospital management – same day emergency care, length of stay improvement.
- Regional/national focus on reducing delays beyond discharge ready date (DRD) – plus local discharge improvement actions.
- Development of data/performance dashboard to support UEC recovery and new areas of focus highlighted in the new national Urgent & Emergency Care Plan (release in June).

G&A Occupancy rate

93.7% of G&A beds are currently occupied

84% at GSTT
98% at KCH
97% at LGT

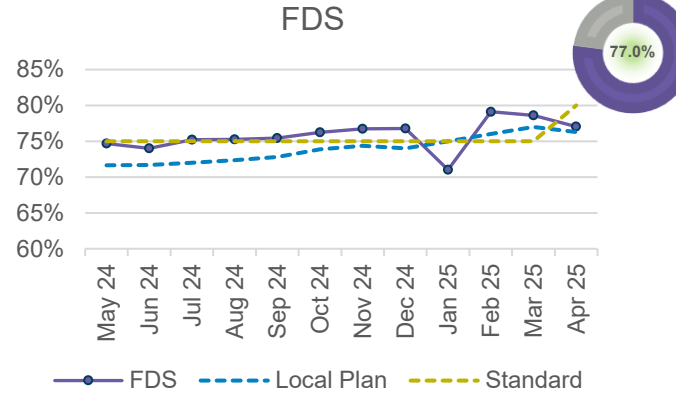


Cancer

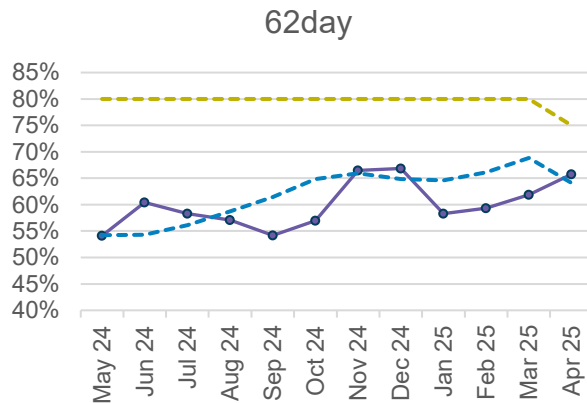
—●— Actual
—●— Standard Target
—●— Operational Plan

Notes and Issues

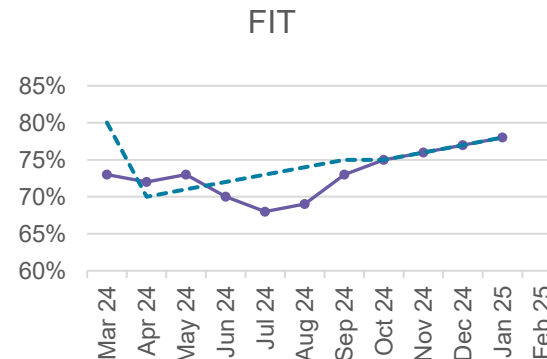
- Faster Diagnosis Standard (FDS) performance remains robust at a system level, trajectories have been agreed to meet the national aim of reaching 80% by year end.
- 62-day performance remains a challenge for the system but has shown consistent improvement since January 2025. Timely and effective Inter-Trust Transfer are critical to improving performance, along with treatment capacity. Focussed support is being provided to address service or provider level specialty challenges, with a focus on urology and breast services. There may be a performance impact over the coming months which may vary by trust.
- Backlog position has remained low although is now not formally monitored.
- The system continues to perform well on the Faecal Immunochemical Test (FIT) targets.



Faster Diagnosis Standard (Standard Target 80%)
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days



(Standard Target 75%)
% of patients with first treatment within 62 days of urgent GP referral
From Oct 23 metric changed to 62 Day (Combined). This merges the urgent, screening and consultant upgrade standards that were in effect before.

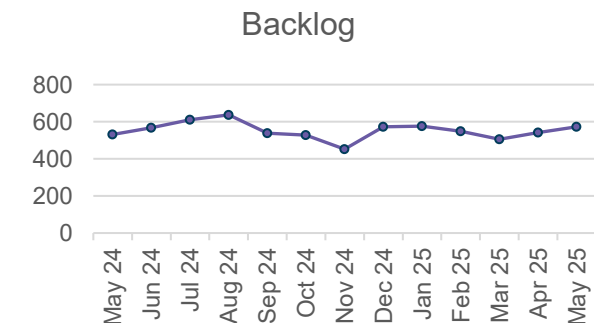


Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a **faecal immunochemical test** result, with the result recorded either in the twenty-one days leading up to the referral, or in the fourteen days after the referral

Recovery Actions

- Streamline cancer pathways and optimise diagnostics.
- Ensure timely communication of diagnoses and cancer rule-outs within 28 days.
- Promote utilisation of rapid diagnostic clinics, FIT testing, teledermatology, and personalised stratified follow-up.
- Improve early diagnosis, patient experience, and resource utilisation.
- Proactively mitigate potential risks related to workforce, technology systems, and industrial action.
- Participate in national trials and programs to contribute to advancements in cancer detection and management.
- Allocate identified funding to support key actions.
- Waiting list validation and review including clinical review.
- Increased theatre capacity
- Cancer recognised as priority pathway within capacity planning.

Please note that this is the only metric on this page that is not included in the Systems operational plan for 25/26. We have included this for information purposes at this time.

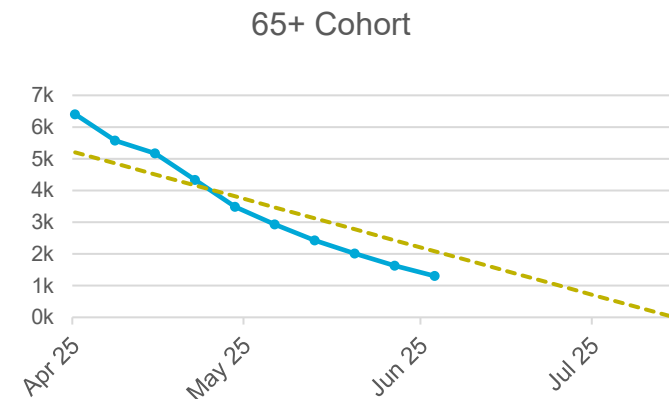


Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period

Referral to Treatment (RTT): Long Waiters

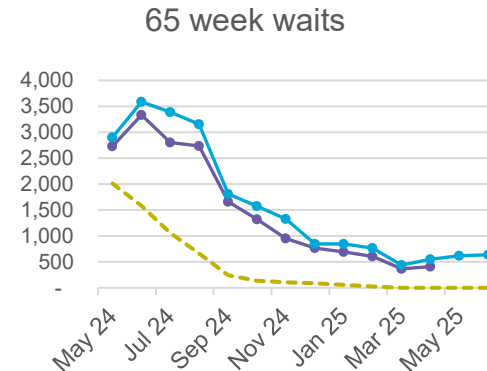
Notes and Issues

- The focus for 2025/26 is on delivering on the 65 week wait reduction in addition to wider RTT metrics on 18-week performance.
- Since the declining levels of 65+ ww at end of 2024/25 there has been an uptick in the number of long waiters. This has enhanced the focus in SEL on system and process changes needed to optimise the management of long waiters.
- Urology, ENT and gynaecology are the most challenged specialties for 65+ ww.
- 52+ ww as a percentage of overall waiting list size is another new metric introduced for 2025/26.



65+ Cohort

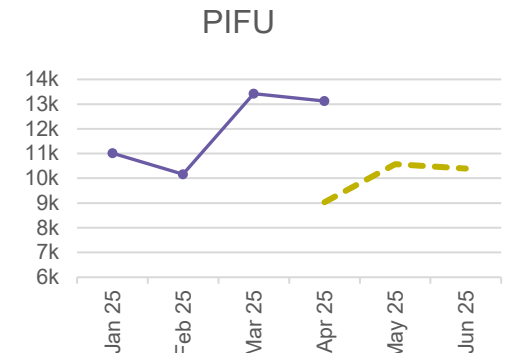
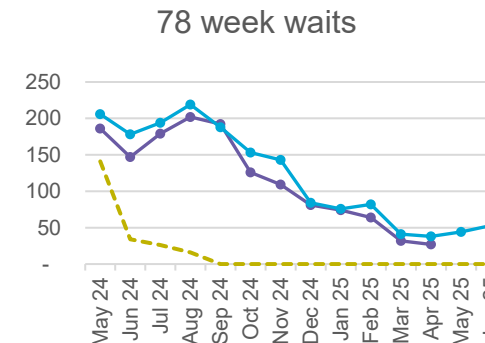
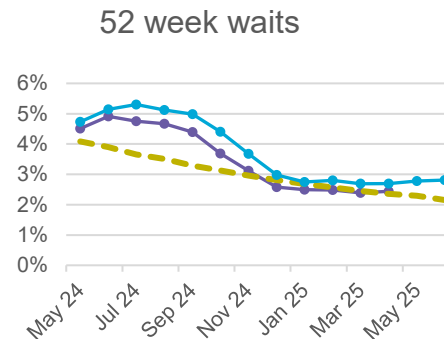
(total pathways which will already have, or will breach 65+ weeks by 30/06/2025 if not seen)



There are currently **639** patients at SEL trusts who have been waiting more than 65 weeks

Recovery Actions

- Waiting list validation including the sprint programme which includes additional funding for trusts who can validate waiting lists at levels above those achieved in prior years.
- Introduction of straight to test and patient initiated follow up (PIFU) to release more capacity for first outpatient appointment.
- Addressing cross-site disparity in waiting times by equalising waits.
- Adoption of nationally recommended (GIRFT) Further Faster pathway.
- Additional capacity through outsourcing and insourcing.

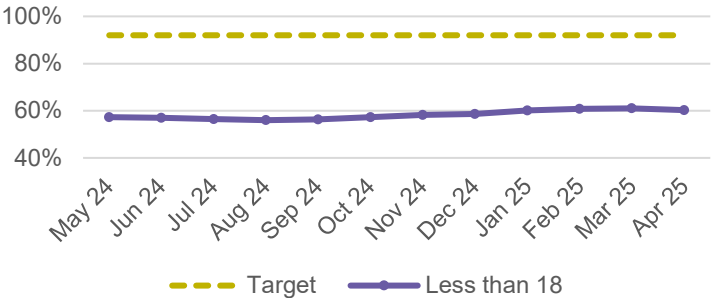


RTT Patients still waiting Apr 25				
	52+	65+	78+	104+
This month	6,430	406	27	1
Plan	✓ 6,553	✗ -	✗ 0	✗ 0
Last month	▼ -9 (-0.1%)	▲ 40 (9.9%)	▼ -5 (-18.5%)	▼ -1 (-100.0%)
Latest week	7,395	639	53	1

Notes and Issues

- 18+ weeks performance and time to 1st appointment are new metrics for 2025/26. The national expectation is 65% and 72% respectively however trust specific targets are based on improvement of 5 percentage points from the Nov 2024 position.
- The SEL operational plans included trajectories for the delivery of the trust specific targets for the above metric.
- Although not a specific operational plan metric, a reduction in total waiting list size is also being monitored nationally.
- Advice and Guidance (A&G) through electronic referral is performing well with high diversion rates and timely responses, increasing provision is a priority. Consultant Connect A&G call answer rate and diversion rates are however comparatively low.
- There is a focus on triage to improve provision and ensure sustainable services, whilst understanding opportunity for appropriate diversion improvement.

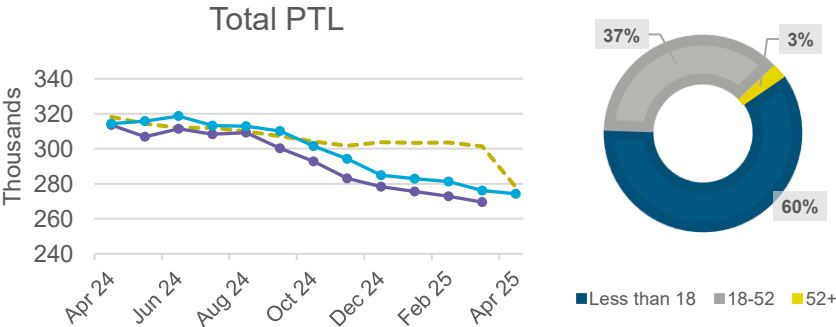
18 week Performance



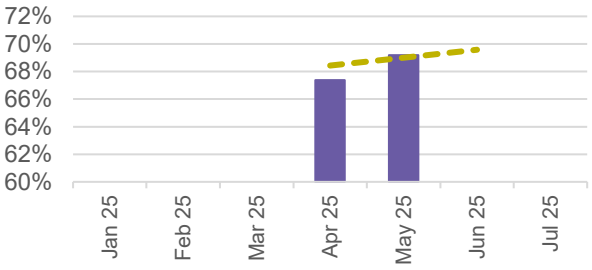
RTT Patients still waiting Apr 25			
	Total	<18 ww	18 week perf
This month	263,513	158,744	60.24%
Plan	✓ 314,402		✗ 92%
Last month	▼ -6010 (-2.3%)	▼ -5695 (-3.6%)	▼ -0.8% (-1.3%)
Latest week	263,181	158,682	60.29%

Recovery Actions

- Waiting list validation including the sprint program which includes additional funding for trusts validating at above previous years levels.
- Improved use of advice services and a priority focus on increasing and improving triage as the most EBI for demand management.
- Outpatient transformation including straight to test to improve waiting times at the beginning of RTT pathways.
- Focus over Quarters 1 and 2 on A&G, triage, booking processes Do Not Attend rates and scaling PIFU.



Time to 1st Appointment

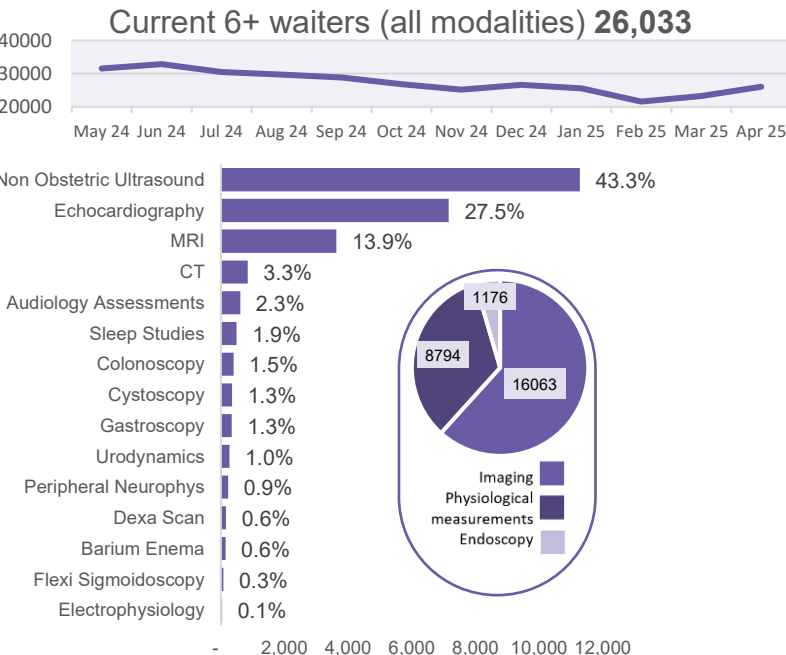


DEMAND MANAGEMENT METRICS				
	Current	Mar-25	National	RAG
eRS Advice & Guidance				
Provision	41%	39%	nk	
Turn Around Time	0-2 Days	3-7 Days	0-2 Days	
Diversion Rate	77%	78%	65%	
Consultant Connect				
Provision	65	69	n/a	
Answer Rate (calls)	51%	43%	64%	
Answer Rate (messages)	99%	99%	99%	
Diversion Rate (calls)	20%	20%	61%	
Diversion Rate (messages)	67%	68%	50%	
Referral Triage				
Provision	36.1%	33.7%	tbc	
Turn Around Time	3-7 Days	0-2 Days	tbc	
Diversion Rate	13%	13%	14%	

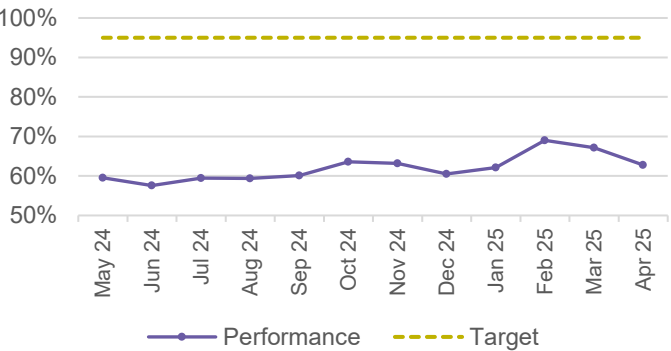
Diagnostics

Notes and Issues

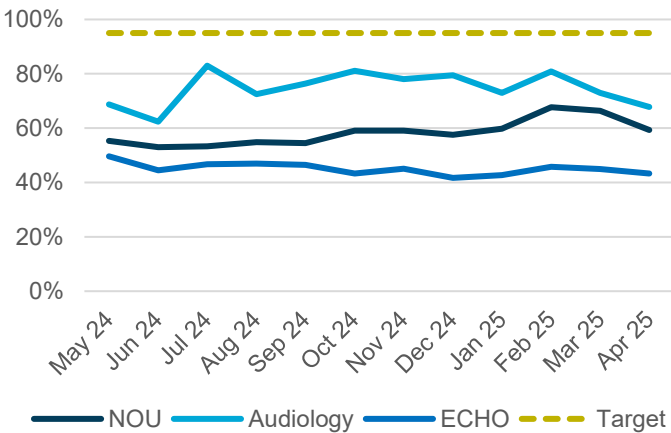
- No new targets were set for diagnostics for 2025/26, however the expectation is that improvements in waiting times will be required to support the delivery of RTT and cancer.
- SEL's current performance is challenged in terms of access and waiting times and focused recovery actions are underway.
- Key modalities that are challenged include Non-Obstetric Ultra Sound (NOUS), echocardiology and audiology (partly due to a change in policy on how patient pathways are managed)
- There has also been a challenge with long waiters (13-week plus waiters), which has been improving but with more work to be done.



Performance against 95% target (all modalities)



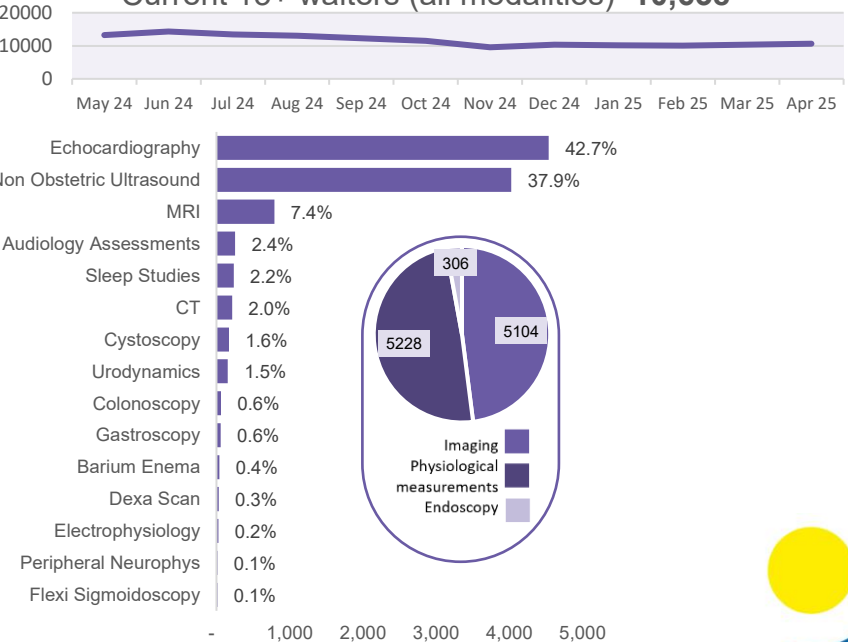
Performance against 95% target (key modalities)



Recovery Actions

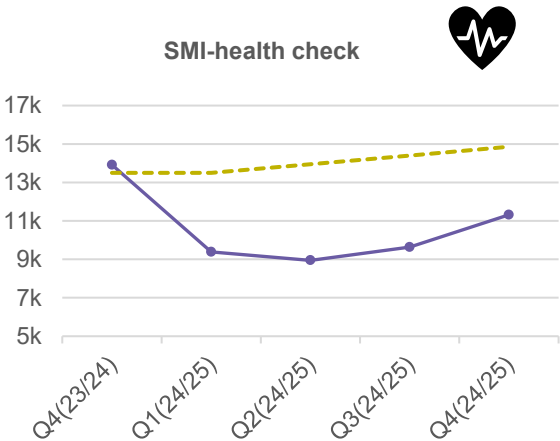
- Clinical and administrative validation of the overall diagnostic waiting list.
- Implementing a clinical decision support tool to assist with demand management.
- Additional capacity, through maximising on site capacity, insourcing and outsourcing.
- As part of the operational planning process local trajectories for further reducing 13-week waiters were agreed.
- The Acute Provider Collaborative is leading SEL wide demand and capacity reviews for imaging as part of their work on system sustainability, echos will be included in this work.

Current 13+ waiters (all modalities) 10,638



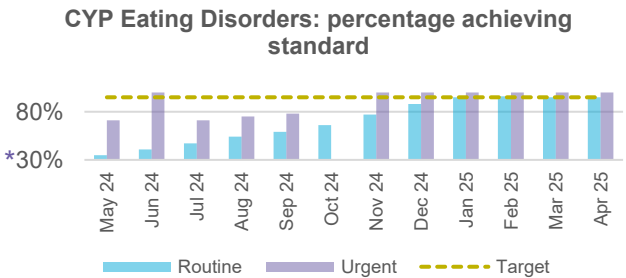
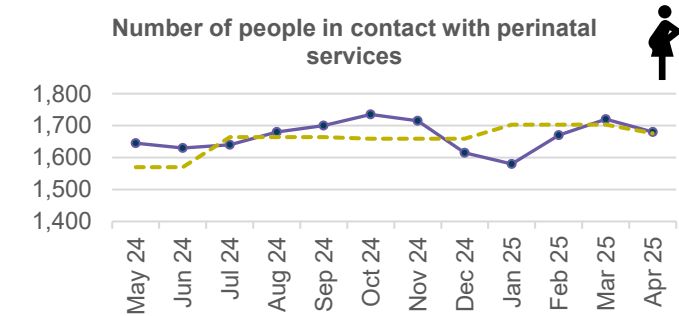
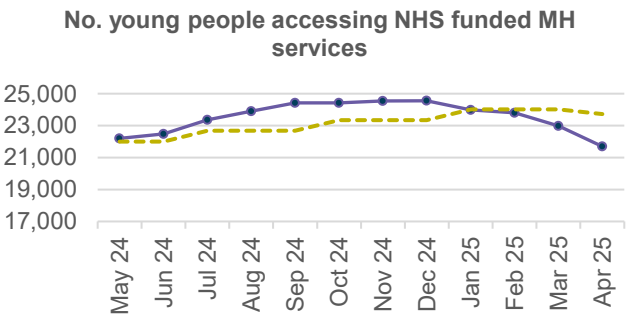
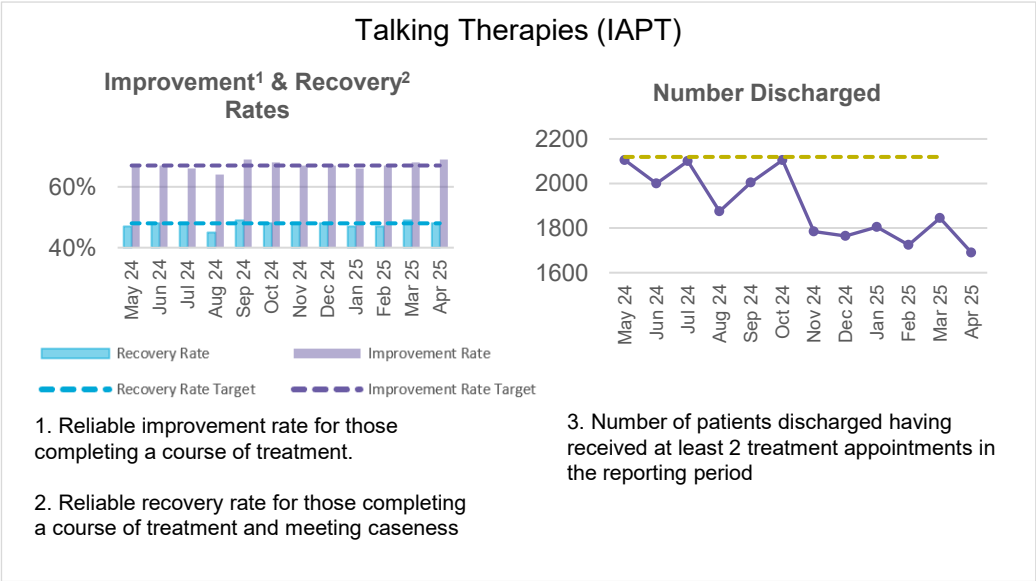
Notes and Issues

- The waiting times target for urgent CYP eating disorder was met again in April. The target was narrowly missed for routine waits.
- CYP access performance fell below target in April, performance is expected to improve over the next few months as data issues are rectified.
- SEL Talking Therapy performance remains below trajectory for the number of patients completing a course of treatment. The reliable recovery and improvement rate targets were both met in April.
- Perinatal access performance in May was in line with trajectory although numbers accessing the service need to increase for SEL to achieve the Q1 target of 1720.
- The number of physical health checks for people with SMI, which is a corporate objective, remained significantly below trajectory at the end of 2024/25 with 9,630 health checked undertaken vs. a plan of 14,405.
- New metrics will be added to this report next month.



Recovery Actions

- Continued support available to ensure all providers can submit data.
- Data Quality Improvement Plans in place to support data quality improvement.
- Local improvement plans in place to increase the number of Physical Health Checks undertaken for people with SMI.
- Work continues to explore deterioration in Talking Therapy performance, the drivers for the deterioration are multifactorial and different for each of the providers.
- Trajectories have been agreed for all mental health targets as part of the 2025/26 planning process, with regular review to agree improvement actions.

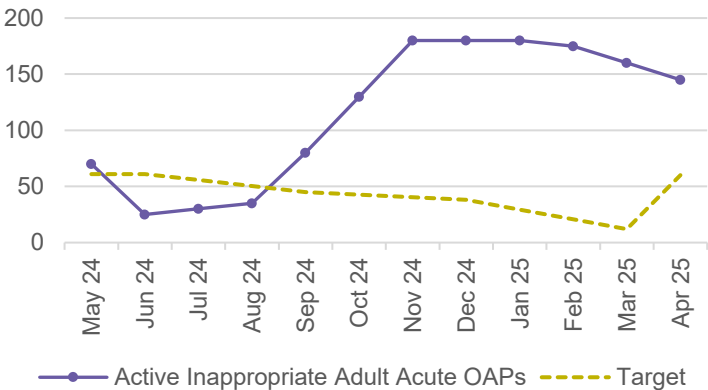


Mental Health (MH) Crisis & Flow

Notes and Issues

- Mental Health emergency pressures continue with challenges with regards crisis presentations to our Emergency Department and demand for admissions.
- A&E data shows that the proportion of MH presentations in ED was just over 3.5%. 54% of MH patients waited more than 6 hours in ED and 31% more than 12 hours, and several +72 hour waits.
- A&E breaches are disproportionately high for MH patients, SEL's operational plan for 2025/26 gives a commitment to reducing the number of breaches. Recovery actions to support delivery.
- The number of inappropriate out of area placements has reduced in April but remains above trajectory. National data submission challenges continue to affect the accuracy of OAP reporting.

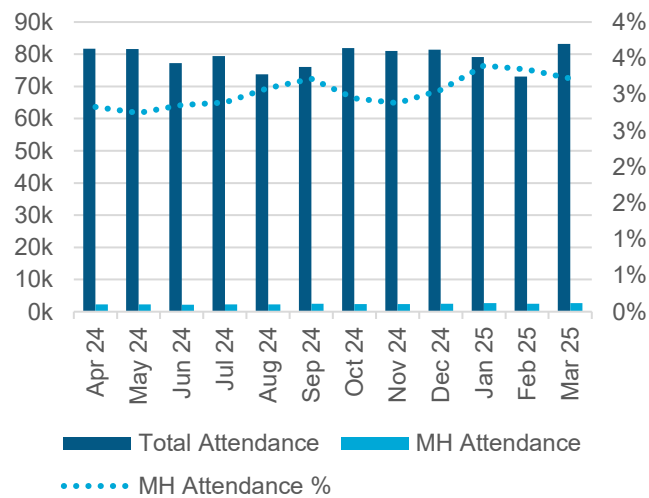
Active Inappropriate Adult Acute OAPs



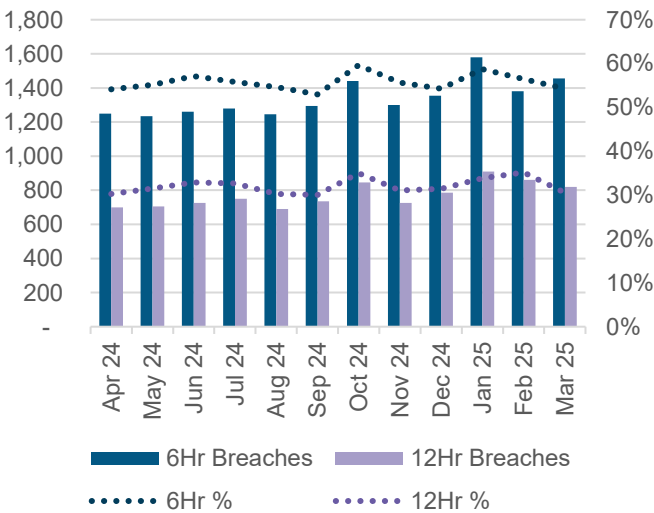
Recovery Actions

- Recovery actions in place to support a reduction in the number of long delays in ED for MH patients.
- Mental health providers continue to deliver their internal flow improvement plans, focusing on reducing length of stay, purposeful admission, stepping down patients and providing alternatives to admissions where appropriate.
- Continued focus from all system partners on expediting discharges for those patients that are clinically ready for discharge to support inpatient flow.
- Work to ensure OAPs data is submitted correctly by all providers.

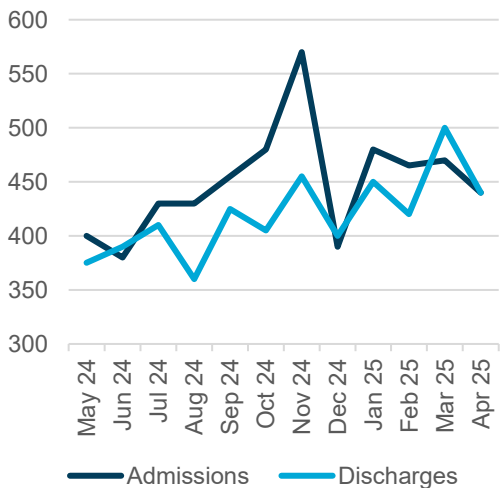
A&E Attendance



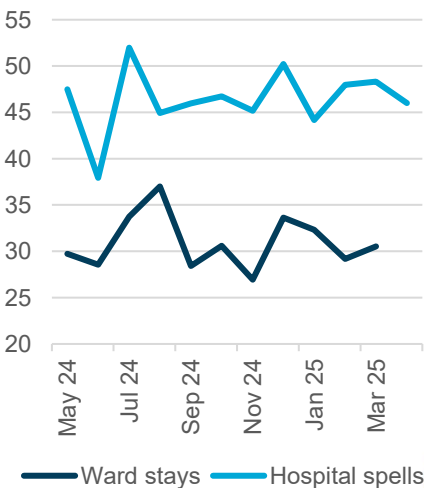
A&E Breaches



Admission & Discharge



Length of Stay



Primary care access (1 of 2)

Notes and Issues

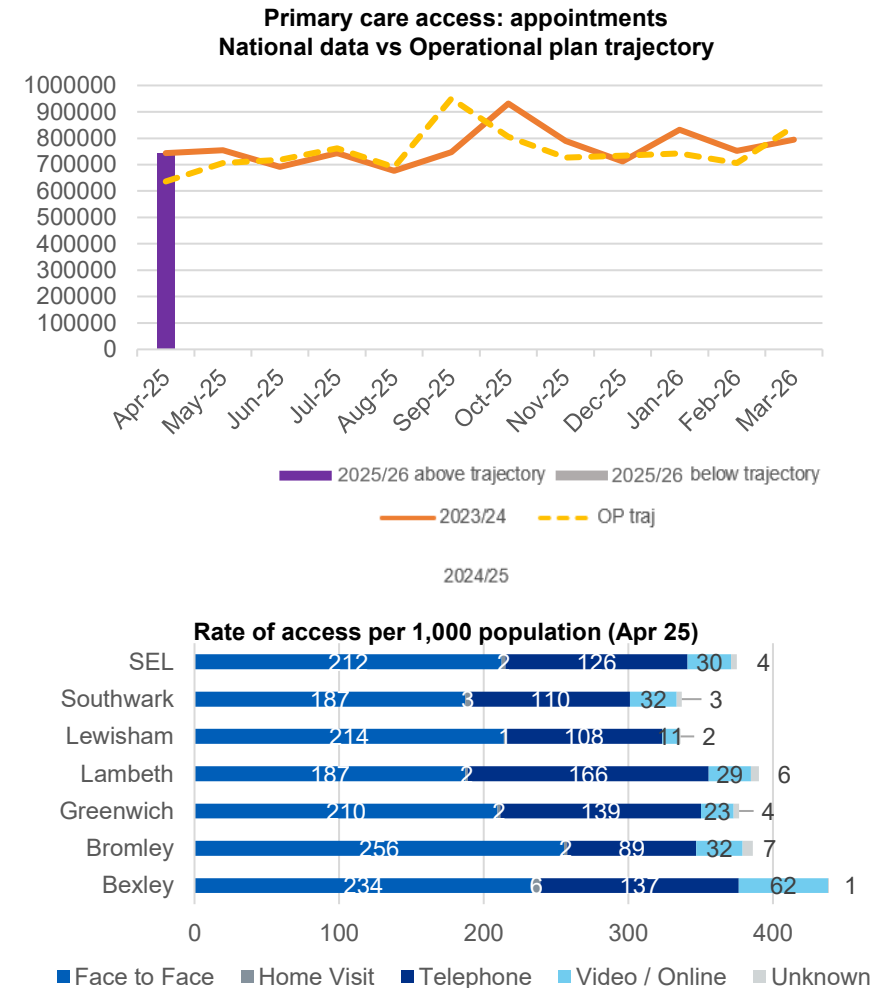
- Appointments have returned to pre-pandemic levels, as has the level of face-to-face care offered. However, capacity in general practice is increasingly constrained with increasing patient demand which will impact on patients' experience of access.
- Appointments totalled 741,850 in April against the operating plan target of 636,239, noting variation by month.

General Practice Action Plan

- SEL ICB has developed its action plan to improve general practice in line with NHS England's requirement for all ICBs to have such plans in place by June 2025. While the plan has been completed, it is currently pending final sign-off by NHS England.
- The plan sets out a coordinated approach to contract oversight, commissioning, transformation, and addressing unwarranted variation. It is designed to support the delivery of Modern General Practice, ensuring targeted support is provided to practices based on their ability to offer timely access and deliver a positive patient experience

Recovery Actions

- Work across our six borough Local Care Partnerships to develop schemes to encourage more staff into primary care and support retention and maximise the use of investment in additional roles.
- The ICB has purchased software for analytics at practice, PCN and federation level providing a better understanding of capacity and demand, population health insight, future forecasting of demand and trend analysis.
- Commenced a campaign to help residents understand how general practice works and the different roles of staff.



Note on data source: All charts use the nationally published PCN level GPAD data to calculate borough level reporting: [Appointments in General Practice - NHS England Digital](#)

Primary care access: LCP updates (2 of 2)

Bexley

- Linking with the South East London Primary Care Workforce Academy and Bexley Training Hub to recruit suitable practices for participation in the 25/26 General Practice Improvement Programme (GPIP) practice level support (PLS) offer from 'Qualitas'.
- Collating practice level information regarding GP and nursing workforce, together with other soft intelligence and insights in support of an SEL action plan to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in 25/26.

Bromley

- Ongoing work with practices and PCNs to ensure GPAD mapping by practices is correctly coded. This work to link to the CATS dashboard and the requirement to review areas of variance. This will look at percentage of appointments over 14 days and appointment numbers per 1000. This will involve working with practices and PCN DTLs to give specific data-related support.
- Ongoing work with BETH and GP Fellow to ensure support is provided to identified practices. This involves engaging with practices planning changes to OC availability in order these align to October 2025 contractual obligation. Utilising our GP Fellow to support some practices and working with others using alternative options of support to ensure that practices can deliver the contractual requirements and are using a total triage model by 1st October..
- Ongoing work with PCNs to optimise use of ARRS and GP ARRS roles. With PCNs, reviewing enhanced access capacity and use of this provision to best effect for patient access.

Greenwich

- Greenwich exceeded the 60% SEL target for NHS App 2024/25, a strong upward trend of over 0.5% a month with a total of 170,00 registrations and over half registered users turning on notifications.
- 100% practice websites are compliant with the national GP website benchmarking and improvement tool criteria
- PCNs have self-declared with ICB validation achievement of CAIP criteria for 24-25. Three PCNs have not met criteria 2 online consultations available through core hours and are being supported with national and local support offers to achieve this by 1 October 2025.

Lambeth

- The borough-level target for appointments (1.5%) has been exceeded.
- A comprehensive roadmap has been developed in collaboration with clinical cabinet, focusing on strengthening the general practice programme including the development of a GP provider alliance.
- General practice leads have been identified for each of the five Lambeth Neighbourhoods.

Lewisham

- Deep dive review of General Practice Appointment Data with LSE to validate accuracy, particular in terms of inclusion of online consultation activity has now commenced.
- Ongoing promotion of NHS APP including targeted support for practices who have merged and lost significant registrations as part of the process.
- SDUC programme underway including review of links between PC assess and A&E/111 use.

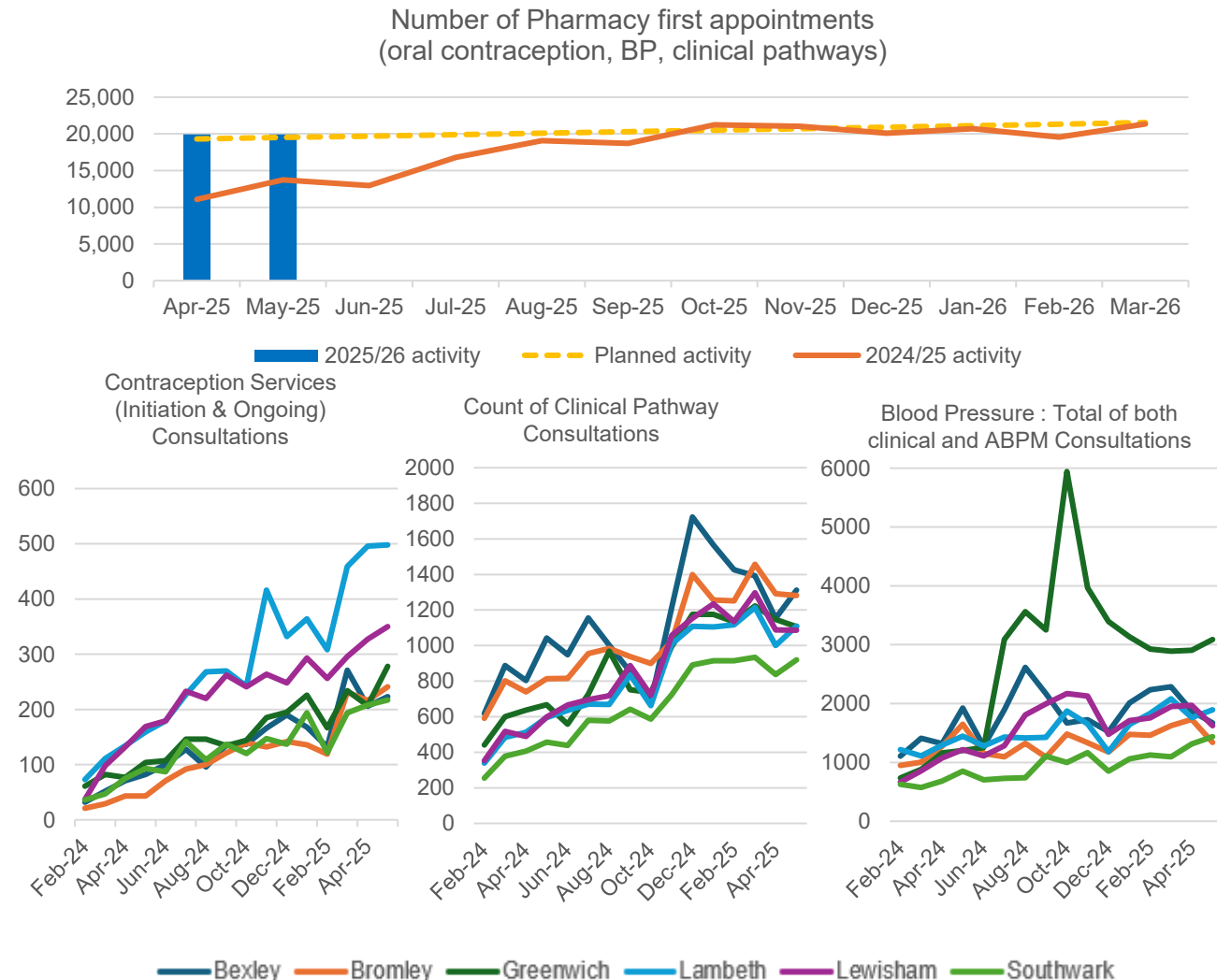
Southwark

- Following ongoing work to improve Southwark practice websites, all practices were asked to implement the required enhancements by 30th May 2025 to ensure compliance with PCARP requirements. As of now, 30 out of the 32 practices are fully compliant with the national PCARP website criteria, with the remaining two actively working towards compliance. Examples of compliant websites have been shared, along with support offered to any practices experiencing difficulties.
- CAIP 25/26 – A template for the 25/26 CAIP has been created and was agreed upon by the SEL Primary Care Leads during the SEL Primary Care Executive Meeting on Wednesday, 11th June. This is to ensure a consistent approach across SEL. Southwark has shared the template, along with key milestones, with the PCNs. Additionally, the central team has established a working group to explore the risk stratification domain and determine the most suitable approach for SEL.

Community Pharmacy: Pharmacy First Clinical Consultations, Hypertension and Oral Contraception

Notes and Issues

- As of June 2025, pharmacies must be registered to provide all three services to qualify for threshold payments
- Number of Pharmacies achieving threshold payments for Clinical Pathway Conditions in last 3 months out of 323 SEL Pharmacies: March 150, April 133, May 130, for which the threshold was 30 clinical pathway consultations for these months.
- Of all Pharmacy First Clinical Pathway consultations approx. 5% are referred from GP. 86% are self-referred.
- Pharmacy First clinical pathways consultations total per 100,000, a relatively low rate compared to the London average.
- Oral Contraception: gradual increase in consultations in community pharmacy for both initiations and ongoing supply.
- Hypertension: Total consultations appear to have plateaued slightly in recent months but with positive overall consultation rates.
- Issues regarding post event messaging (PEM) and coding have been identified and are being reviewed.



Note: all data/charts based on latest unpublished management information in line with the 2025/26 priorities and operational planning guidance technical definitions.

Recovery Actions

- Digital team supporting in contacting pharmacies who are not registered, supported by Medicines Optimisation (MO) team and SEL Local Pharmaceutical Committee (LPC).
- Sharing of resources, webinars and toolkit roll out for practices and pharmacies to improve referrals to community pharmacy for all three services.
- Improving data sharing across teams, to drive referrals from practices.
- Digital resources being promoted to increase uptake for contraception consultations in community pharmacy e.g. AccuRx messaging from GP practices.
- Working with National and Regional teams to manage issues around PEM and pregnancy miscoding.
- Working closely with SEL LPC to support services in community pharmacy.
- Refresh of CPNL programme, part of which role will be supporting in driving services available in community pharmacy.
- Encouraging sharing learning from each other, most boroughs having Pharmacy Network Meetings.

UCR and community waits

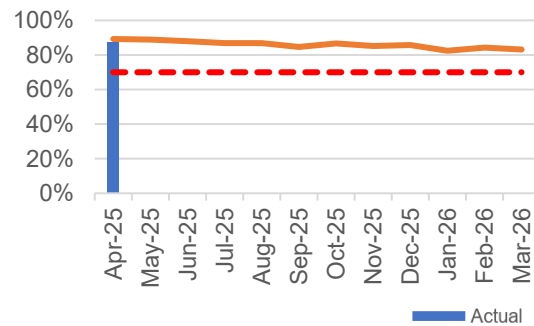
Notes and Issues

- April UCR performance data gives a partial picture for SEL as not all activity was captured in month one reporting.
- Combined performance of SEL providers exceeded the 2-hour and 2-day response standards. Services in Bexley and Bromley achieving the highest levels of compliance.
- The total number of patients reported on the Community Services waiting list for services in scope in SEL was 32,413 - an increase of 1,557 on the previous month. This was across all waiting list intervals (except 1-2 weeks which saw a reduction).
- Of the total number of patients waiting, 18,396 (57%) have been waiting less than 12 weeks for a first appointment. This is a deterioration on March performance of 59%. Services contributing most to overall wait numbers are: MSK, Podiatry & Podiatric Surgery, Rehab, LTC Nursing (Continence) and Respiratory (COPD) services in Adult Services and Community Paediatrics, Therapies (SLT) and Audiology in Children's Services.

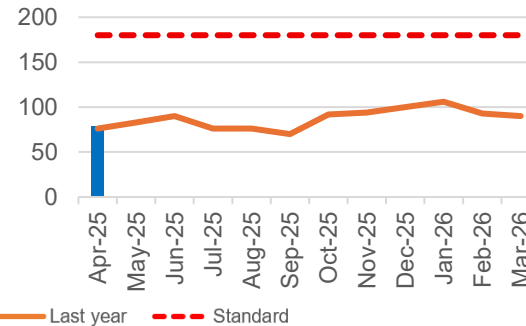
Long waiters:

- Of the 2,543 patients waiting 52-104 weeks 2,530 (99.5%) were in Community Paediatrics, with small numbers across a range of other services. 88 patients were waiting over 104 weeks.
- Paediatrics waits have increased across all providers, due to increased demand/referrals.

Combined SEL Trust level UCR performance (Published data)**



Standardised rate of referral per 100,000 population



**Latest month is provisional data which excludes GSTT

Community waits >52 weeks***



***April 24 to Feb 25 data excludes GSTT

Borough level UCR performance – April 2025 (local data)

Borough	2hr referrals		2-day referrals	
	No.	%	No.	%
Bexley	99	91%	166	100%
Bromley	279	91%	9	100%
Greenwich	84	100%	39	49%
Lambeth	-	-	-	-
Lewisham	87	98%	34	79%
Southwark	-	-	-	-
SEL	584	94%	248	85%

SEL Waiting List Breakdown (April 25)

Weeks	Number of waiters
0-1 weeks	2,784
>1-2 weeks	1,771
>2-4 weeks	3,574
>4-12 weeks	10,267
>12-18 weeks	3,864
>18-52 weeks	7,522
>52-104 weeks	2,543
>104 weeks	88

Recovery Actions

UCR:

- Data reporting improvement plans for challenged providers.
- The ICB is currently reviewing all of the UCR services to look at opportunities to maximise referrals to the services, with providers indicating that capacity is aligned to current levels of demand.
- Exploration of digital options and tools to support greater efficiency and productivity of staff in UCR teams.

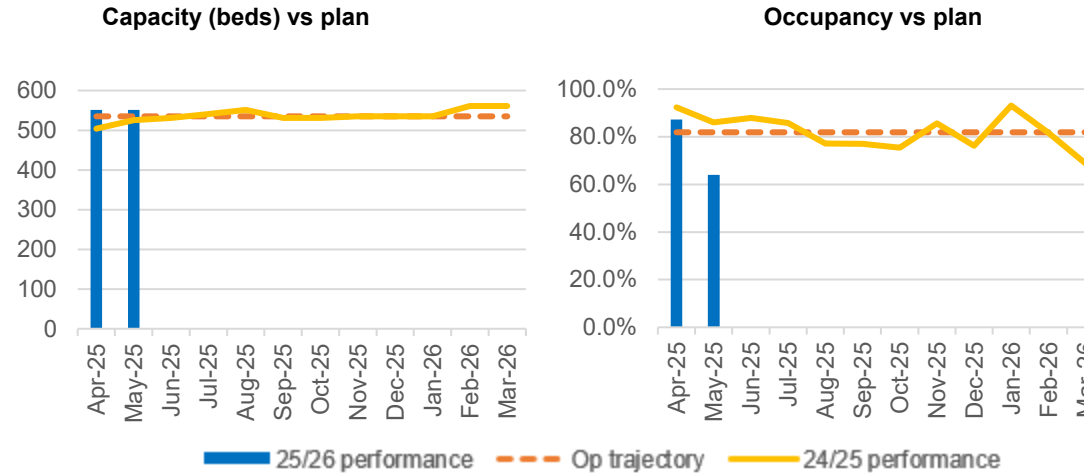
Community wait list:

- Recovery actions to improve waiting times across challenged specialties with a key focus on community paediatric improvement planning and action to bring performance back into line with trajectory.

Virtual wards

Notes and Issues

- The SEL virtual wards capacity was above plan at 551 beds against a target of 535.
- The monthly average utilisation for south east London did not meet the target of 82%, noting missing data distorts the reported position. Actions agreed to ensure future submissions are completed ahead of data filing deadlines.
- Lewisham is in the process of re-procuring their VW service. This has been split into two lots:
 - Lot 1 – NHS @Home Service: the provider will be expected to deliver a hybrid clinical Hospital at Home service model that ensures the provision of high levels of patient care for up to 8 days, and concurrent patients should not remain on the ward unless clear evidence of an acute deterioration during their stay.
 - Lot 2. NHS Virtual + Health Monitoring: a digitally enabled, integrated care model designed to support patients with long-term conditions. Patients will be onboarded for 4-8 weeks in total and provided with health monitoring technology and a clinical team to provide education and management.



Average of snapshots May 2025

May-25	Av. Capacity	Average Utilisation
SEL actuals	551	64%
SEL Plan	535	82%

*Occupancy data missing from all submissions during May 2025

**Occupancy data missing from one (of three) submissions during May 2025

2025/26 Plans and Actions

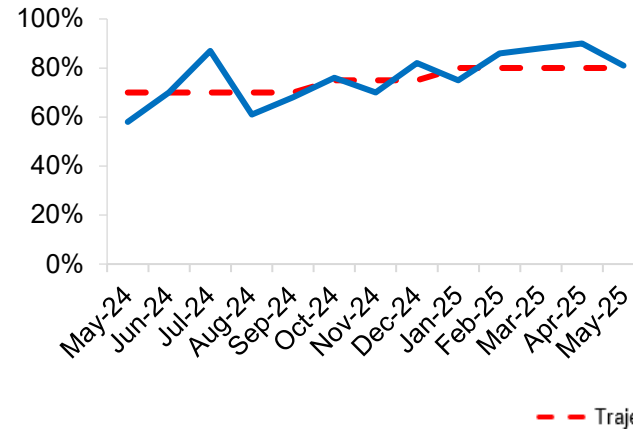
- NHSE National team has shared their priorities for Virtual Wards and UCR services with ICBs. This includes; reviewing frameworks and guidance on VW, UCR and single point of access to develop a more integrated overarching framework.
- Systems will be supported to promote/secure collaboration and integrated approaches across VW, Care Homes and UCR services.
- A review of all VW services has commenced. Each service will be reviewed and visited to ensure an understanding of the different service delivery models, workforce skill set, challenges and opportunities for transformation.
- A set of strategic workshops will support the development of an overall SEL vision for integrated services including Single Point of Access into an Integrated Urgent Care coordination hub.
- Lewisham and Greenwich have proceeded with individual procurements for remote monitoring services. The remaining SEL boroughs are still considering the value in moving forward with a joint procurement.
- They also plan to support systems to promote collaboration with VW and care homes into UCR services.

NHS Continuing Healthcare

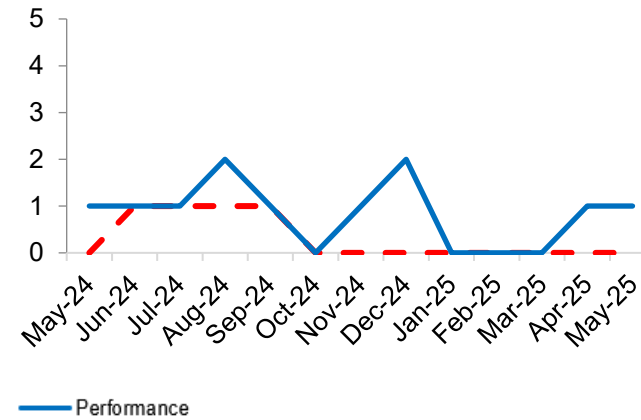
Notes and Issues

- 28 day performance**
May performance (local reporting) against the number of referrals completed within the 28-day timeframe is 81%. This is a decrease from April performance of 90% but remains above the national target of 80%.
- Incomplete referrals over 12 weeks**
SEL reported one 'long wait' over 12 weeks in May which is above the national target of zero.
- Performance improved in quarter 4 with SEL achieving 86% for 28-day performance which is an increase from 76% in Q3 and above the national target.. There were zero incomplete referrals over 12 weeks.
- Standard CHC and Fast Track Reviews**
There is variation in the number of overdue Standard CHC and fast track reviews across the six boroughs. The number of individuals waiting for a Standard CHC reviews is 167. This is a decrease from the previous month of 200.
- There are 91 overdue fast track reviews. This is an increase from the previous month of 77.
- Funded Nursing Care Reviews**
The number of Funded Nursing Care Reviews has been decreasing since October 2024 (807) and is now 730.

CHC assessments completed within 28 days
Local monthly tracking



Incomplete referrals over 12 weeks
Local monthly tracking



Quarterly statutory reported position

	CHC assessments in an acute setting			% assessments completed in 28 days			Incomplete referrals over 12 weeks		
	Q4	Trajectory	Target	Q4	Trajectory	Target	Q4	Trajectory	Target
Bexley	0%	-	0%	74%	80%	80%	0	0	0
Bromley	0%	-	0%	97%	80%	80%	0	0	0
Greenwich	0%	-	0%	72%	80%	80%	0	0	0
Lambeth	0%	-	0%	83%	80%	80%	0	0	0
Lewisham	0%	-	0%	92%	80%	80%	0	0	0
Southwark	0%	-	0%	64%	80%	80%	0	0	0
SEL	0%	-	0%	86%	80%	80%	0	0	0

- Note: monthly reporting is in place as an 'early warning' and means that data issues can be identified and addressed within the quarter. Monthly and quarterly data may not align.

Recovery Actions

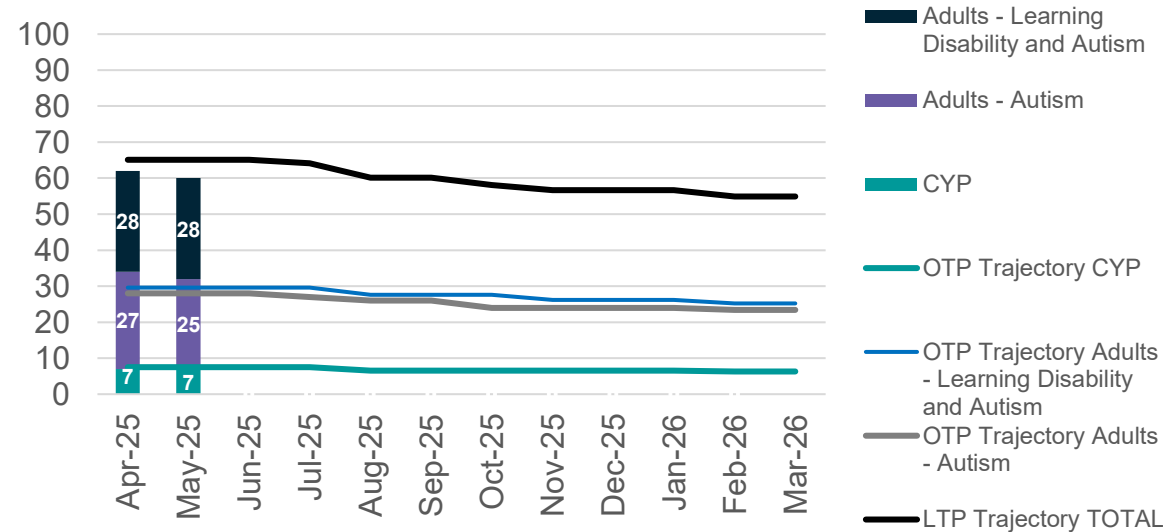
- The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, CHC teams have exceeded their savings targets.
- Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities.
- The ICB has recovered performance against the assessment targets and is achieving performance trajectories agreed with NHS England. The ICB has achieved pre-pandemic levels in Q4.

Learning disability and autism (LDA)

Notes and Issues

- At the end of May 2025, the target LDA inpatient position was surpassed: There were 60 inpatients, which is 5 below the target for the month. There were 53 adults (25 autism only diagnoses) in either non-secure and secure units, one below the target for adults, and 7 children and young people, 1 below target for CYP. There are 13 people due for discharge by end of June 2025.
- The target for 2025/26 is 48 adults – (25 with a learning disability and or autistic adults and 23 autistic adults) and six young people.
- Continued increase in demand for autism assessments for both adults and children and young people across all boroughs. Work to support referrals, capacity and productivity required to meet demand to support agreed access improvement plan being developed/secured.
- The target of 75% completion of Learning Disability Annual Health Checks has been met with 82% completed by end of March 2025. A total of 7471 checks were completed which is 367 more than last year. The focus in all boroughs will continue to be around assuring AHCs are of a good quality and on improving peoples experience of AHCs.
- Roll out of The Oliver McGowan mandatory training continues. The national team recently confirmed another year of funding subject to 30% coverage. Quarterly returns have been submitted. The Oliver McGowan code of practice was published on 19 June on DHSC website.

LDA Inpatient Position

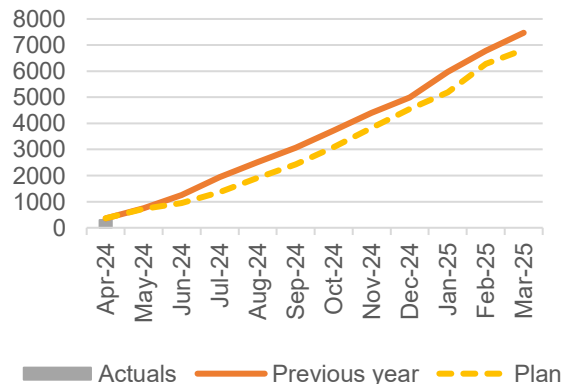


Recovery Actions

- Operational planning trajectories for 2025/26 have been set to consider the number of adults aged 18 and over from the ICB who have a learning disability (including those who may also be autistic) and the number of adults aged 18 and over from the ICB who are autistic (with no learning disability) who are in mental health inpatient care
- Community Autism Specialist services to support autistic only people are in development to prevent admission and support community placements. Along with existing services commissioned from MH providers these services will support the continued reduction in admission rate.
- Housing, Care and Support work in development to support discharge and prevent admissions.
- Working with providers to identify an action plan to address the high numbers of people on waiting lists/long waiting times for autism assessment as well as requirements to meet demand in the longer term, includes work on Right to Choose and accreditation of services.
- Digital DSRs roll out planned for Q1 early Q2 across SEL to support admission prevention and utilisation of Care Education Treatment Reviews (CETRs).
- LDA Specialist prescribing directly supports patients, primary care, annual health checks and the LeDeR Programme. The One Stop STOMP clinic to ensure optimised care and enhanced patient outcomes has started. The STOMP clinic will address the overprescribing of psychotropic medication.

LD AHCs: SEL and Borough Level Position

SEL – LD health checks YTD



	Apr 25 performance		Apr-25 Trajectory	2025/26 Plan
	%	Count		
Bexley	3%	43	48	908
Bromley	3%	34	50	938
Greenwich	3%	58	67	1248
Lambeth	4%	62	68	1279
Lewisham	2%	32	79	1472
Southwark	5%	68	52	975
SEL	3%	297	364	6825

ICB Board Meeting in Public

Title	Quality and Nursing				
Meeting date	July 16 2025	Agenda item Number	9	Paper Enclosure Ref	I
Author	Elizabeth Aitken, Deputy Medical Director and Clinical and Care Professional Lead Quality				
Executive lead	Gwen Kennedy, Interim Chief Nursing Officer				
Paper is for:	Update	X	Discussion	Decision	
Purpose of paper	To provide an overview of quality and nursing within the ICS for Quarter 3				
Summary of main points	Quality and Patient Safety: In Q4, 69 Patient Safety Incident Investigations and 4 Never Events were reported. There is ongoing work through quality improvement projects - GSTT is reviewing surgical checklists post-EPIC, while LGT is enhancing intraoperative handovers using the SWITCH checklist. 494 Quality Alerts were raised, with the trending themes reported include appointment/referral, transfer of care, discharge and poor. Improvement work is underway, including better discharge summaries and reducing inappropriate secondary-to-primary care requests. The Patient Safety Incident Response Framework (PSIRF) Phase 2 pilot in General Practice, led by the Health Innovation Network, begins in July with six SEL participants. Finally, peer reviews of paediatric audiology services identified areas for improvement. The SEL Paediatric Audiology Strategy Group is overseeing progress to ensure compliance with national standards. Safeguarding: The Care Leaver Covenant supports care leavers aged 16–25 into employment. In SEL, the NHS partners with Catch-22 to deliver this support. Since October 2024, 85 care leavers have engaged with the programme to explore NHS job opportunities. There has been an improvement in the uptake of the Emotional Well-Being service for Child Sexual Abuse. The ICB safeguarding and Business Intelligence (BI) teams have worked collaboratively to formulate a dataset using information from both A&E's and hospital in-patient settings. The dataset will eventually be used by Community Safety Partnerships, strategic commissioning and Public Health to gain insights to serious violence in South East London All Age Continuing Care (AACC): The NHSE Planning guidance for 2025/2026 outlines several key priorities for the programme will be achieved through standardised complex care specifications, improved sharing of placement data, and integrated at-scale commissioning practices. Continuing Healthcare performance improved, exceeding savings targets. Local Maternity and Neonatal System (LMNS): Findings from PSII investigation have resulted in improvement plans including expanded ultrasound surveillance. The national priorities identified for maternity and neonatal care will be incorporated into the work programme that already aligns with and addresses the key priorities Infection Prevention and Control (IPC): NHS England thresholds for key infections were met, but MRSA and E-coli cases exceeded targets. System-wide efforts on antimicrobial stewardship and system learning remain a priority.				

	Learning Disabilities and Autism (LDA): Continued increase in demand for autism assessments with work ongoing to understand the demand and capacity in SEL. Annual health check targets were met, and discharge targets for inpatients was achieved. Special Educational Needs and Disabilities (SEND): SEL SEND Network is focused on meeting medical needs in education settings and on the development of a data dashboard					
Potential conflicts of Interest	Nil known					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	This paper has considered the potential impact on individuals and groups with protected characteristics. No adverse impacts have been identified, and the proposed quality improvements are expected to promote equitable access and outcomes for all service users.					
Financial Impact	There is no financial impact associated with this paper.					
Public Patient Engagement	Patient engagement is outlined in the paper					
Committee engagement	Progress on the improvements are reported to the Quality and Safeguarding Committee					
Recommendation	The Board are asked to note the content of the report					



Quality and Nursing Report

NHS South East London Integrated Care Board
(ICB) 16 July 2025

1. Introduction

This report provides an overview of key performance updates from the Quality and Nursing Directorate across South East London Integrated Care Board (SEL ICB) for Quarter 4. It covers essential areas, including Quality and Safety, Safeguarding, All Age Continuing Care (AACC), the Local Maternity and Neonatal System (LMNS), Infection Prevention and Control (IPC), Learning Disabilities and Autism (LDA), and Special Education Needs and Disabilities (SEND).

2. Quality and Nursing Updates

2.1 Quality and Patient Safety

During Q4, there were a total of 69 Patient Safety Incident Investigations (PSIIs) reported. 4 Never Events were also reported during this period. Four Never Events were reported in South East London; one was in relation to a patient receiving two doses of methotrexate (for rheumatological indication) within 5 days meaning the patient received their weekly dose twice; second was in relation to a retained guide pin whilst the patient was undergoing total knee replacement surgery and two further wrong site surgery; one relating to an incorrect mole being removed and the other in relation to the incorrect skin lesion being removed. Trusts are focusing quality improvements on surgical safety as part of their patient safety improvement plans.

Quality Alerts (QAs) have been closely monitored, and the quality team meet on a weekly basis to review and theme the QAs reported across the system. A total of 494 quality alerts were reported in Q4. The trending themes reported include appointment/referral, transfer of care, discharge and poor communication. Bexley and



Greenwich Primary, Community and Secondary Care Interface Forum is currently carrying out 2 improvement workstreams targeted at improving the timeliness and quality of discharge summaries and reducing the number of inappropriate requests from secondary to primary care i.e. inappropriate prescribing and test follow up. There are also a number of system improvement workstreams being led by the ICB Medical Director through the System Interface Group.

There has been targeted improvement work from closed Quality Alerts:
Hyperemesis:

- Implementing a standardised template letter for GPs overseeing the management of people with hyperemesis. This will also assist with prescription of anti-emetics during pregnancy.
- A pathway is being mapped to address current issues with limited space for the assessment and treatment of people presenting with hyperemesis.

Clearer discharging information in relation to pregnancy loss:

- A pregnancy loss-specific discharge summary is currently being developed, which includes the nationally recognised Sands Teardrop Logo and relevant, non-abbreviated terms of loss at the top of the summary.

The Patient Safety Incident Response Framework (PSIRF) pilot Phase 2 in General Practice, led by the Health Innovation Network (HiN), is set to commence soon. This phase includes six participants from SEL: one GP Federation, two Primary Care Networks, two GP practices, and one hospice. An internal meeting will be held to identify the pilot leads before the HiN kick-off meeting on 4th July 2025.

SEL ICB undertook peer reviews of the paediatric audiology services against a set of key lines of enquiry in line with the Paediatric Audiology National Improvement Programme. There are a number of actions and improvements required for some providers following these. The ICB are working closely with providers to support. SEL Paediatric Audiology Strategy Group has been established to complete a detailed oversight of the improvement programme and ensure compliance with standards and best practices.

2.2 Safeguarding

The safeguarding function has made progress in relation to a number of deliverables and quality improvement programmes. The following is not an exhaustive list
The highlights for this quarter are:

- Children looked After and Care Leavers
- Child Sexual Abuse and the Emotional Well Being Service
- Child Death
- Quality Improvements
- Audit
- Governance
- Risks

The Care Leaver Covenant is a national inclusion programme that supports care leavers aged 16-25 to live independently through gaining employment opportunities. The NHS has supported the Covenant, and in SEL the support is delivered by our partners Catch-22. The SEL project began in October 2024, and since that time 85 positive contacts have been made with care leavers wishing to explore NHS employment.

There has been an improvement in the uptake of the Emotional Well-Being service for Child Sexual Abuse this is monitored through the SEL ICB contract monitoring with our Barnardo's partner. There continues to be ongoing work at place with raising awareness of this service.

The Child Death Oversight Group continues to meet, identifying themes and trends, and developing its interface with strategic commissioning. Specific work around self-harm, fatal self-harm and cluster responses progresses.

The ICB/ Kings Fund Safeguarding Leadership Programme continues. The Programme purposefully brings together a varied cohort of practitioners, developing their leadership skills and competencies through, for example, Action Learning Sets.

The ICB has also advanced its understanding of its role within the Serious Violence Duty. The ICB safeguarding and Business Intelligence (BI) teams have worked collaboratively to formulate a dataset using information from both A&E's and hospital in-patient settings. The dataset will eventually be used by Community Safety Partnerships, strategic commissioning and Public Health to gain insights to serious violence in South East London. The work, although at an early stage, has been praised by the NHS London Violence Reduction team.

The ICB has continued to improve compliance of the completion of the Safeguarding Case Review Tracker (S-CRT). Latest data shows that in the past twelve months; there is a reduction in the number of statutory reviews being commissioned across South East London. The reasons for this will be further explored. Regular audits take place and feedback to teams given.

The ICB team continue to support the system with compliance with the NHSE Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) and Safeguarding Integrated Data Dashboard (SIDD). Providers self-assess towards the P-SCAT and generally there was full compliance towards all NHS assurance requirements by the main SEL providers.

The Safeguarding team has significantly progressed the statutory requirements for safeguarding training across the ICB through a safeguarding competency strategy, delivering on all levels of training in line with the Intercollegiate Guidance. The team have also undertaken a workforce audit and gap analysis following the recent Government announcements and management change programme. During Q1, the team will reaudit safeguarding within the scope of the Internal audit plan for this year.



The ICS Safeguarding System Group has met for the second time. The group brings together the representatives from the SEL health system to identify themes, trends, learning and risk in order to share a partnership response across the SEL health economy. At place, the safeguarding teams continue to provide support at a borough level, for example through the delivery of training/advice and involvement in safeguarding Board and Partnership work. SEL wide team continue to offer support and advice to both SEL wide and place-based borough teams.

2.3 All Age Continuing Care (AACC)

AACC is a strategic programme of work that focuses on the policy areas of NHS Continuing Healthcare (NHS CHC), Funded Nursing Care (FNC) and Children and Young People Continuing Care (CYPCC). The AACC vision is to address unwarranted variation for individuals and families to have improved experiences transparency and consistency across all forms of continuing care including Adults Continuing Care, Children and with smooth transition.

The NHSE Planning guidance for 2025/2026 outlines several key priorities for the programme. These include optimising cost, productivity, and overall value by reducing agency and bank expenditure, and minimizing unwarranted variation in all-age continuing care spending and placement pricing. This will be achieved through standardised complex care specifications, improved sharing of placement data, and integrated at-scale commissioning practices. Additionally, the Neighbourhood Health guidelines emphasise that the focus for 2025/2026 should be on supporting adults, children, and young people with complex health and social care needs who require assistance from multiple services and organisations.

The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, CHC teams have exceeded their savings targets. Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities. There is variation in the number of overdue Standard CHC and fast track reviews across the six boroughs. The total number of individuals waiting for a Standard CHC review is 167. This is a decrease from 200 previously. Overall performance improved in Q4 for incomplete referrals over 12 weeks, with SEL achieving 86% for 28-day performance which is an increase from 76% in Q3 and above the national target.

2.4 Local Maternity and Neonatal System (LMNS)

The LMNS dashboard is in the final testing phase. It includes agreed metrics disaggregated by ethnicity and deprivation. Mortality data will be presented only at a SEL level due to the identifiable nature of small numbers. Next steps include assessing how neonatal operational delivery network data can be integrated into the dashboard.

SEL continues to lead regionally in the percentage of severely preterm babies born in the right place, and the proportion of mothers <34 weeks gestation receiving a full course of antenatal steroids.

Findings from PSII/MNSI investigations has shown the need for timely neonatal consultant presence for severely premature births, the need for additional training on intermittent auscultation of the fetal heart during labour, and improved assessment of blood loss during pool births. A review of stillbirths has resulted in expanded ultrasound surveillance to strengthen the care pathway.

Thrombosis and venous thrombosis embolism (VTE) are now the leading cause of maternal mortality (MBRRACE 2024). While updated NICE guidance is pending a national working group has been established to explore interim mitigations. Locally efforts are underway to ensure women at risk of VTE can be prescribed low molecular weight heparin (LMWH) early in pregnancy, prior to formal maternity care booking.

The ICB and LMNS collaborated with the Equality and Human Rights Commission on addressing racial disparities in maternity care. The report has now been published and includes SEL LMNS initiatives. The LMNS led preconception health campaign, part of the Women's and Girls Health Hub in partnership with Tommy's 'Planning for a healthy pregnancy preconception tool' commenced in March 2025. To date over 2000 people have completed the full preconception tool, campaign content reached over 870,000 views on social media with 12,689 landing page views recorded.

Work is ongoing to implement the Maternity and Neonatal Voices Partnerships (MNVPs) guidance in SEL. This supports system wide collaboration and co-production and is helping to reduce variation and inequalities for women across boroughs, ensuring that the service user voice is at the centre of the LMNS programme. The LMNS led on a QI project to identify opportunities for improving maternity vaccination uptake during the winter period. GSTT partnered with South East London Vision (SELVIS) who are a charity to follow up women after their 20-week anomaly scan.

A SELVIS member of staff offered 1:1 discussions and appointments for vaccinations Compared to autumn/winter 2023 at GSTT there was a:

- 15% increase in total number of pregnant people seen.
- 90% increase pertussis vaccination uptake
- 298% increase in COVID-19 vaccinations
- 154% increase in Flu vaccinations

On June 24th, the ICB received a letter from Jim Mackey and Duncan Burton regarding maternity and neonatal care, and the national independent investigation into maternity and neonatal services announced by the Secretary of State for Health and Social Care. The letter calls on NHS Boards responsible for maternity and neonatal services to prioritise the following areas:

- Addressing poor behaviour and negative team cultures
- Listening directly to families who have experienced harm and creating conditions that support staff to speak up

- Collaborating through co-production with Maternity and Neonatal Voices Partnerships
- Improving data on the quality of maternity and neonatal services
- Tackling inequalities, discrimination, and racism, including variations in service provision

The South East London LMNS already has a work programme in place that aligns with and addresses these key priorities.

2.5 Infection Prevention and Control (IPC)

Key activity during this quarter included ongoing general practice audits, visits prior to CQC inspections and teaching sessions. Lambeth and Southwark are currently undertaking a urinary catheter QI project to improve communication and catheter management in the community

SEL remains within NHS England set thresholds for cases of *Clostridioides difficile*, *P. aeruginosa*, and *Klebsiella* spp. however, it is currently above trajectory for *E. coli* and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases. There have been 40 MRSA bacteraemia cases reported year-to-date across all settings against a threshold of zero, with 15 classified as hospital-onset. Efforts continue across the system to support the Antimicrobial Stewardship agenda with well-established systemwide networks and forums.

2.6 Learning Disabilities and Autism (LDA)

At the end of Q4 March 2025, the inpatient target was achieved, there were 59 inpatients, which is two below the target position for the end of Q4. There were 53 adults in non-secure and secure units, one below the target for adults, and six children and young people, one below the target for CYP.

The development of Community Autism Specialist services to support autistic only people, gained momentum during Q4, the service seeks to prevent autistic people being admitted by intervening early and to support community placements. Along with existing Autism Support Services commissioned from Oxleas and SLAM these services will support the continued reduction in admission rate as nationally there is a focus on reducing the number of autistic people admitted to mental health units.

The target of 75% completion of Learning Disability Annual Health Checks (AHCs) was met early, with 77% completed by end of February 2025. By end of Q4 March 2025 85% of AHCs were completed representing 7469 checks completed, 365 more than previous year. The focus in all boroughs will continue to be around assuring AHCs are of a good quality and on improving peoples experience of AHCs. Operating Planning guidance confirmed no increase or change to the target; it remains 75% for 2025/26.

There was continued increase in demand for autism assessments for both adults and children and young people across all boroughs. During Q4 work done to explore the

capacity and funding required to reduce adult waits in the boroughs serviced by SLaM as well as to understand referrals, capacity and productivity required to meet demand. Work to develop a children and young people neurodiversity hub to undertake needs led assessments, continued during Q4.

Learning from the lives and deaths of people with a learning disability and autistic people – LeDeR, worked across ICS with system partners to share learning. Key themes identified during 2024-25 were 1. Legal literacy (Mental Capacity Act) 2. Safeguarding issues 3. Reasonable Adjustments 4. Quality of care e.g, safety netting, DNA CPR, Diagnostic overshadowing.

The One Stop STOMP Clinic commenced during Q4. The clinic seeks to ensure optimised care and enhanced patient outcomes by addressing the overprescribing of psychotropic medication.

The roll out of The Oliver McGowan Mandatory Training continued during Q4 and the National team confirmed another year of funding subject to 30% coverage being achieved.

2.7 Special Education Needs and Disabilities (SEND)

The SEL SEND Network established since September 2024 focused on key issues impacting Special educational Needs and Disabilities during Q4:

1. Meeting medical needs in education settings – Task and Finish set up to work on this across SEL and to Liaise with NHSE London Region Team.
2. SEND Data Dashboard development Task and finish group to support the collation of data required across all six boroughs, utilising local, regional and national data.

3. Conclusion

The Quality and Nursing directorate continue to work with partners across the system to improve patient safety and service quality. Progress has been made across each of the directorate's functions. The teams are working on and setting their priorities for 2025/26.

ICB Board Meeting in Public

Title	Development of our South East London Neighbourhood Health Service					
Meeting date	16 July 2025	Agenda item Number	10	Paper Enclosure Ref	J	
Author	Holly Eden - Director of Delivery Neighbourhood and Population Health					
Executive lead	Holly Eden - Director of Delivery Neighbourhood and Population Health Ceri Jacob - Place Executive Lead Lewisham					
Paper is for:	Update	x	Discussion		Decision	x
Purpose of paper	To update the Board on progress in developing the South East London Neighbourhood Health Service.					
Summary of main points	The paper outlines the progress being made across South East London to develop our South East London Neighbourhood Health Service, with a focus on: • The design and implementation of Integrated Neighbourhood Teams for three initial priority populations • The development of the broader programme of work required to implement and sustain Neighbourhood services • The identification of our integrator arrangements in each place and approaches to driving maturity of these arrangements as a key enabler to the delivery of neighbourhood services • The development of a forward-look and long-term outcomes framework for neighbourhoods, driven through a theory of change approach..					
Potential conflicts of Interest	Not applicable.					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	None at this point however, an EIA will be required at the point the full implementation plans are approved in each place.					
Financial Impact	To support early development and implementation of the Integrators the ICB will make available non recurrent funding of £250k per Place.					
Public Patient Engagement	A range of public engagement exercises have been undertaken over the last 3 years which have contributed to the development of the integrated neighbourhood team models at a South East London level and within each place and to the outcomes framework for Neighbourhoods and the theory of change. Local Care Partnerships will continued to engage with the public during the detailed development and implementation of their INTs.					
Committee engagement	ICB Executive, Local Care Partnerships, Neighbourhood Based Care Board					
Recommendation	It is recommended that the Board note progress across all areas and in particular: • endorse the integrator arrangements for Bexley, Lambeth, Lewisham and Southwark					

- endorse the direction of travel in the development of outcomes framework and accompanying metrics and to provide initial feedback on areas of the outcomes framework that may need further iteration over the Summer



Development of our South East London Neighbourhood Health service

NHS South East London Integrated Care Board
(ICB) 16 July 2025

1. Introduction

- 1.1. Since the publication of the Government's Neighbourhood Health Service guidelines in early 2025, all six Places within South East London (SEL) have advanced their efforts to develop and implement Neighbourhood services. Building upon the Fuller Report (2022) and the approval of the SEL Integrated Neighbourhood Team framework by the SEL ICB Board in January 2025, progress has been made across four key areas:
- The design and implementation of Integrated Neighbourhood Teams for three initial priority populations
 - The development of the broader programme of work required to implement and sustain Neighbourhood services
 - The identification of our integrator arrangements in each place and approaches to driving maturity of these arrangements as a key enabler to the delivery of neighbourhood services
 - The development of a forward-look and long-term outcomes framework for neighbourhoods, driven through a theory of change approach.

2. Progress with implementing Integrated Neighbourhood Teams

- 2.1. The SEL Integrated Neighbourhood Teams Framework set out our approach as a system to designing and implementing integrated neighbourhood teams for three initial priority populations:
- Those living with three or more long term conditions
 - Those living with or at risk of frailty; and
 - Children and Young People with complex care needs
- 2.2. Since the endorsement of this approach by the ICB Board in January 2025, significant progress has been made in developing the neighbourhood model for these priority populations, implementing in early adopter sites and putting in place plans to spread and scale models during 2025/26 within each place.

Aging well and frailty

- 2.3. The SEL Integrated Care System (ICS) want to help residents live longer, healthier and happier lives. Our SEL Ageing Well Framework sets this agreed ambition within the framework of a neighbourhood health approach for this population group informed by the evidence-base and our local data.
- 2.4. All six places designed this framework together, building it iteratively through collaboration between residents, NHS partners, councils, our care sector, our voluntary care sector and local groups. The framework has been endorsed by our Local Care Partnerships (LCPs) and the SEL Neighbourhood Based Care Board:
 - Providing a common, unifying and integrated strategy for helping our residents live well as they age
 - Sets out our commitment to take a whole-person, local approach to ageing that supports people through the full ageing process, from fit older people to end of life care
 - Includes a central focus on prevention, early support and dignity in care
- 2.5. A visual representation of the SEL ageing well framework can be found at **Appendix A** to this paper.

3+ Long Term Conditions

- 2.6. Our neighbourhood model of care for people living with three or more long term conditions was approved in late 2024 following a deep period of co-production across our places and provider partners. Broadly the model focusses on three pillars:
 - Prevention and earlier identification of disease, including through a targeted testing approach that maximises population health approaches and neighbourhood care
 - Coordinated case management of complex care in the community through an integrated neighbourhood team, with a stronger focus on holistic assessment and care planning and coordination
 - Integrated acute care with in-reach into neighbourhoods from consultations and multi-speciality pharmacists working across all acute teams and neighbourhoods on education, case management and implementing novel pathways.
- 2.7. The model has been tested through early adopter neighbourhoods, initially focussing down on people living with cardio-metabolic conditions. The initial findings from these early adopters suggests that our neighbourhood model may assist with:
 - Reducing the gap in the identification of disease towards our expected prevalence more quickly than our business as usual care. Among early adopter sites, CKD identification rates rose 3.9% (from 43.8% to 47.7%) between April 2024 and February 2025, whilst non participating sites a smaller rise of 3.3% (from 43.2% to 46.5%).
 - Improving the medical optimisation of patients already living with disease at a faster rate. Among early adopter sites the prescribing of SGLT2 in-line with NICE guidance, increased 13.9% in patients with both CKD and diabetes when compared to an increase of 8.3% in non-participating sites
 - Improving key clinical outcomes with initial evidence suggesting greater improvement in blood pressure control in early adopter sites when compared to non-participating sites.
 - Reducing unplanned hospital activity with the age-standardised non-elective admission rate of patients living with Chronic Kidney Disease receiving care under the model reducing from 20 to 7 admissions per 100 patients, compared with the

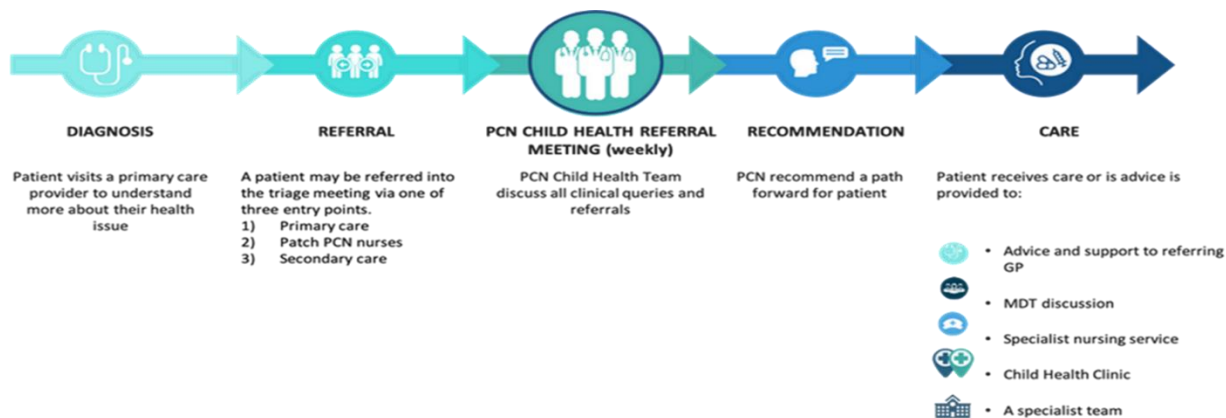
broader population living with CKD who saw a much smaller reduction from 36 to 34 admissions per 100 patients.

- Reducing some elective activity, with a decrease for 36 to 22 attendances per 100 patients within the specialities that were the focus for the pilot. However, it is important to note that there was an increase in outpatient activity into other specialties, potentially suggesting unmet need within this population group.

- 2.8. Early adopter neighbourhoods also experienced positive impacts on both staff and patient experience. Staff noted in particular improvements in trust and easier access to advice and support from working as part of a integrated neighbourhood team, with one member of staff saying *“This is the only model. We must see the patients health as a whole. Gone are the days of one appointment, one problem - we need to be linking them together”*
- 2.9. Patients reported a very high level of satisfaction with their care with 90.5% reporting that they felt involved in decisions about their care. One patient said *“No-one has every explained properly to me about my kidney and last week, the pharmacist explained [it] well to me, talked to me like a person, not just staring at the computer. [We] talked about my pension and finance[s] and [they] asked someone to call me and explained all to me”*

Children and Young People

- 2.10. The child health model offers **personalised, integrated care** pathways for children with general child health conditions and targeted early intervention care for children with long-term conditions. The model of care has changed the ways of working between hospitals, primary care, and child health specialists.



- 2.11. The child health model has made significant improvements in the care of children and young people with complex care needs and our initial priority is to spread and scale this model across all South East London neighbourhoods. It is recognised, however, that the model needs further evolution into a broader neighbourhood model for children and young people that can meet a larger range of health, care and wellbeing needs. So concurrently to our work to ensure the core child health model is implemented in all neighbourhoods, the SEL Children Transformation Group will be taking forward work to co-produce plans with places, providers, partners and residents to evolve this model further.
- 2.12. **Appendix B** to this paper outlines the current position on implementation of neighbourhood teams in each place in South East London as well as the key next steps

- 2.13. **The Board are asked to note progress with the implementation of the integrated neighbourhood teams for our three priority populations**

3. Broader Neighbourhoods programme

- 3.1. On 3 July 2025, the Government published “Fit for the Future: 10 year Health Plan for England”. This plan sets out a transformative vision for the National Health Service (NHS), with a focus on shifting from a reactive, hospital-centric model to a preventative, community-based, and digitally driven healthcare system.
- 3.2. This shift to the Neighbourhood Health Service is a key plank of this vision, and the 10 year health plan provides more detail on how this is expected to develop over time, from the initial development of integrated neighbourhood teams delivering integrated and proactive care to high risk populations towards a paradigm shift in how and where care is delivered, with increasing focus on predictive risk and genomics within the way we identify and manage need and the development of one stop shop Neighbourhood Health Centres within each neighbourhood.
- 3.3. To support the implementation of neighbourhood care in its fullest sense, we have developed a broader programme of work consisting of the following key workstreams:
- Delivery of INTs and Neighbourhoods at Place
 - Population Health Management approach & Data
 - Flexible Workforce Models and Culture Change
 - Comms and Engagement
 - Strategic Planning and Resource Allocation (beginning with work on modelling and impact and estates)
 - Digital
- 3.4. Each of these workstreams has developed high-level implementation plans for their objectives all of which will feed into the SEL Neighbourhood Based Care Board on a quarterly basis to enable the ICB to oversee and manage our collective progress.
- 3.5. Alongside the publication of the 10 year plan, NHS England are inviting expressions of interest from places to join phase one of the National Neighbourhood Health Improvement Programme (NNHIP) which will pioneer the shift to the Neighbourhood Health Services. South East London Integrated Care Board will be working across our six places to submit applications into this programme given our forward work in this area.
- 3.6. **The Board are asked to note progress with initialising workstreams within our broader neighbourhood programme**

4. Integrator Arrangements

- 4.1. As part of the London Target Operating Model, an integrator role is proposed for each place to ensure effective delivery of INT working. This aligns with a similar role originally proposed within the SEL INT framework.
- 4.2. For a number of months our six Local Care Partnerships have been working with local partners from across acute, community, mental health, primary care, social care and the voluntary and community sector to develop their integrator arrangements.
- 4.3. In June 2025, our Chief Executive wrote to LCPs and systems to set out the next steps for delivering a Neighbourhood Health Service in South East London. This included the

function of a system 'Integrator' to support and drive forward neighbourhood working. Place Executive Leads, on behalf of their borough partnership, were asked to confirm by the end of June 2025:

- Their Integrator arrangements and their adherence to those elements outlined in the case of Bexley, Lambeth, Lewisham and Southwark
- Their plan and timetable to achieve these same milestones in quarter three in the case of Greenwich and Bromley (who may wish to act faster if locally agreed).

4.4. Sent alongside the letter, was a high-level set of principles as to the function and form of an integrator. Additional information was also provided on how the ICB and LCPs would gain assurance on adherence to the function and form principles through the proposed integrator arrangements, ensuring a proportionate approach. This set out an initial key set of questions, central to the form and function of integrators, to be answered by the end of June 2025:

- Which statutory bodies and partners are included within the integrator arrangement being proposed. If the arrangement is a partnership arrangement, which organisation would be acting as the lead or host organisation (as set out within the principles related to form)
- What shared decision-making structures are planned to be put in place to support the integrator arrangements, and how is parity of voice being considered to enable effective neighbourhood working?
- How will the integrator arrangement ensure that resources and leadership are in place to deliver the integrator function and the development of integrated neighbourhood care either through the lead organisation, or via a broader partnership approach? It is recognised that the function will grow over time.
- What will be the first priorities for the integrator arrangements to support effective neighbourhood working, considering the South East London focus on delivery of integrated neighbourhood teams for our three priority populations?

4.5. The host statutory organisations and the broader partnership underpinning integrator arrangements within Bexley, Lambeth, Lewisham and Southwark have written to their Local Care Partnership executive and the ICB Chief Executive Officer responding to these questions. The responses are attached as **Appendices C - F** of this paper. These arrangements have been reviewed by both the relevant Place Executive Lead and the ICB Chief Executive Officer as well as LCPs and are now being presented to this Board for endorsement. Further work is required to agree the underpinning governance for these arrangements. Further and planned work is being undertaken in Bromley and Greenwich and those proposals will be brought forward in the coming months. In establishing integrator arrangements the ICB is seeking to support the optimal platform for local place partnerships of providers to respond to our local ambitions and those now outlined in the national Ten Year Plan.

4.6. A maturity framework for our integrator arrangements will be developed over July 2025 and then tested by Local Care Partnerships with their local integrator arrangements to assess the initial maturity of the arrangements over the Summer and early Autumn. Through this process, LCPs and local integrator arrangements will jointly agree key developmental priorities to strengthen the maturity of local arrangements. This is a developmental process aiming at strengthening the functional and relational approaches in place. At future stages of development of neighbourhood working, more formal assurance requirements may need to be put into place proportional to the scale of the function being undertaken.

- 4.7. To support early development and implementation of the Integrators and aligned to our operating plan principles, the ICB will make available non-recurrent funding of £250k per place integrator arrangements. It is proposed that the plan to utilise this funding is agreed at Place with the Integrator (including any partners in the Integrator arrangements) and the Place team, with a recommendation then made to the ICB Neighbourhood Board, with final sign off by the ICB Executive. It should demonstrably support establishment of the Integrator and implementation of neighbourhood ways of working, having reference to the maturity process outlined above.
- 4.8. **The Board is asked to:**
- **Endorse the integrator arrangements set out in Appendices C - F of this paper**
 - **Note the ICB Executive (post endorsement) agree and sign-off plans to utilise the £250,000 of funding to each local integrator arrangements to the ICB Executive Committee.**

5. Developing our shared outcomes framework for Neighbourhood Care

Objectives

- 5.1. Over the Spring and early Summer, work has been undertaken to develop an initial outcomes framework for Neighbourhood Care. This framework is intended to look at the anticipated outcomes for the full Neighbourhood transformation over a 10-year period, so beyond our initial priority of implementing integrated neighbourhood teams. Through this work, we are aiming to:
- Develop an outcomes framework that articulates what we will expect to see realised through neighbourhood working, and a means of understanding if we are on track.
 - Provide an opportunity to come together across the health, care and broader neighbourhood systems to set out the change we want to see for residents, patients, staff and South East London over a long period of time.
 - Ensure that this does not speak to our health colleagues only, by articulating the impact for social care, for wider wellbeing, and life outcomes across our population. It will need to capture the full scope of the ambition reflected by neighbourhood working.

Approach

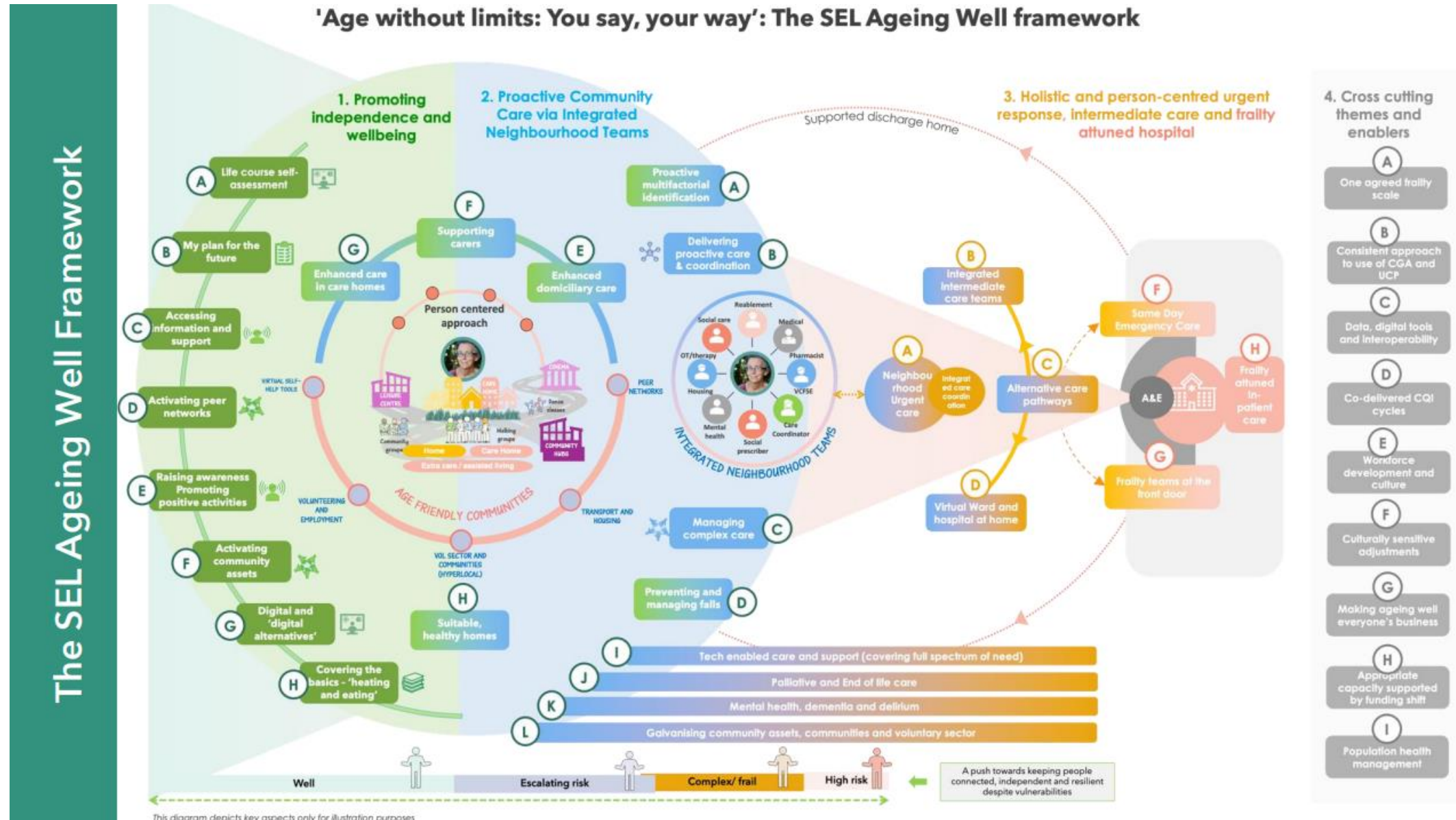
- 5.2. To achieve the above, we have needed to take an approach that starts with defining our broadest ambitions/ outcomes for neighbourhoods. We will then work backwards to articulate what these outcomes may mean for different population groups over the short, medium and long term. Finally, we will develop metrics that enable us to track our progress starting with things we can currently measure (that may give us limited visibility against the breadth of change) and then using advancements in population health management within our system to broaden our measures over time.
- 5.3. To support the complexity of this task, we are using a theory of change approach. Not only does this allow us to start broad and work backwards in a structured way, it helps us to map out the inputs, activities interventions required over these time periods to deliver the change we are looking for. This in turn feeds our work, ensuring that we are continually thinking about what we need to do next as a system to deliver this significant transformation
- 5.4. We have undertaken both group work and more focussed 1-2-1 discussions to build out this theory of change, ensuring representation from local authorities, business

intelligence and population health teams, place teams, broader ICB teams, providers, primary care, community representatives, VCSE representatives and public health. We have drawn in insight from engagement with residents through the Lets Talk Health and Care platform as well as targeted insight work that has been undertaken through the ICB and its partners.

- 5.5. We have also built on work that our early adopter neighbourhoods have done to define outcomes for their specific INTs as well as feeding in learning from other parts of the UK through the national neighbourhoods implementation group.

Current status and next steps

- 5.6. A first draft of the broad outcomes framework for our long-term neighbourhoods ambition is attached as **Appendix G** to this paper. The underpinning theory of change can be found at **Appendix H**.
- 5.7. We will now be testing this outcomes framework with our system partners over the Summer. Concurrently, we will be applying the next layer of detail to the outcomes framework by applying it to our three priority population groups and developing the initial metrics we will use to track progress against our outcomes framework across these three groups. We will also be using the framework to inform our modelling and impact workstream which is beginning in July 2025.
- 5.8. **The Board is asked to endorse the direction of travel in the development of outcomes framework and accompanying metrics and to provide initial feedback on areas of the outcomes framework that may need further iteration over the Summer.**



Place	Current position	Next steps
Bexley	- Agreed Integrator model. - Agreed 3 neighbourhoods and 3 INT priority areas aligned to Joint Forward Plan (CYP, Ageing Well/Frailty and 3+ LTCs). - Agreed which neighbourhoods would test which INT model. - Approved LTCs and ICHT business cases. 3+LTCs INT teams being formed through a mixture of recruitment and realignment of staff across local partners and model live in one neighbourhood. - ICHT model developed and ready to mobilise in North Bexley Neighbourhood; INT team will be formed drawing on existing staff. - Ageing Well/Frailty engagement event held with partners and residents on 4th June 2025 to develop Bexley end-to-end model of care and agree core components of INT for Frognal Neighbourhood pilot – aligned to <i>SEL Ageing Well Framework</i>, endorsed by the Bexley Wellbeing Partnership in May.	June: 3+ LTCs pilot is underway in Clocktower Neighbourhood and an early lessons learnt local health & care system and resident workshop is planned for 21st August 2025. June: Finalise ICHT implementation plan and confirm go live date in North Bexley Neighbourhood and acute provider. July: Design Frailty INT with focus on moderately frail in Frognal Neighbourhood; develop implementation plan. August/September: Frailty INT pilot go live in Frognal. January 2026: Commence scaling INT models.
Bromley	- Agreed 4 geographic footprints of Bromley INTs - Sub-group of One Bromley Executive now drives and governs neighbourhood development in Bromley - Developed initial demographic, needs and assets insights for each neighbourhood - Focus on residents with 3+ long term conditions, residents living with frailty, those 18 or under with health and social needs and people discharged from hospital admission. - Intervention models being aligned to INT footprints and expanded: integrated care network (ICN), children health partnership (B-CHIP), hospital discharge pathway - New intervention model: multiple long term conditions (mLTC) pathway based on CKD pilot - Firm focus in all models on re-alignment of existing resource to secure best value for the Bromley pound - Agreed phased roll out plan of INT geographies	- Agree Integrator model - SW INT mLTC model localisation and go-live workshops following a QI approach, including resident engagement (Q1-2) - Socialisation and pre-work within other three INT footprints (Q1-2) - Review of ICN, B-CHIP and discharge models to align to INT footprints and expand in scope (Q1-2) - NE INT mLTC model localisation and go-live workshops following a QI approach, including resident engagement (Q3) - Initial localisation of ICN, B-CHIP and discharge models to INT footprints with expanded scope (Q3) - SE and NE INT mLTC model localisation and go-live workshops following a QI approach, including resident engagement (Q4) - Finalisation of implementation of ICN, B-CHIP and discharge models to INT footprints with expanded scope

Place	Current position	Next steps
Greenwich	• Worksteams established to progress INTs x3 – Care model design, Workforce, Population Health – each with a senior lead and each having now completed a commencement workshop with local system partners, and each with steering groups now established • Enablers now have local leads – Estates, Comms, Digital – to support INTs. Estates is the most progressed, having worked up Neighbourhood Hub options for each area, and incorporating INTs into our emerging Estates strategy • HGP workshop was held on 22nd May for bring all partners up to speed with current thinking and influencing next steps on INTs; and Greenwich Neighbourhood Care Board now set up/meeting	• Engagement, socialisation and ideally codesign with all general practices – beyond just a small number of representatives, is now needed. Primary Care engagement and OD plan is being worked up collaboratively to support this. • Agree Integrator model • Scaling up the existing frailty pathway using PHM data and principles is in discussion and will form the basis for community, acute, vol sec and PMS Premium resource distribution toward the Frailty and LTCs priority pathway: a Proactive Care INT • INT design resource has been appointed, to focus on how workforce and vol sector are being deployed and best utilised • Neighbourhood Hub locations x4 to be agreed and strategic plans for establishing these to be developed
Lambeth	• Agreed Integrator model • Agreed 5 neighbourhoods and 4 INTs to focus on (CYP, frailty, MLTCs and MH) • Developed initial insights for each care pathway • Identified name neighbourhood leads from each partners • Agreed which INT will be tested in each neighbourhood, along with a high level approach • Drafted, a high level delivery plan with resources identified (aligned to integrator conversations). This was signed off at the INT working Group (17th June) and the Lambeth Together Care Partnership Board (3rd July)	• July to December (led by integrator): Each neighbourhood will undertake detailed design for the INT models, using data insights and existing work to ensure there is a model for each care pathway • January 2026: review draft models for INTs and sign off at Lambeth Together Care Partnership Board • April 2026: All INT models are up and running.

Place	Current position	Next steps
Lewisham	- Integrator approach agreed with further work on underpinning governance required - First focus in 3+ LTCs - Completed the collaboration with people with lived experience to shape the Integrated Neighbourhood Team (INT) Model. - Memorandum of Understanding (MOU) with PCNs has been signed. - Job descriptions for all new roles in the Integrated Neighbourhood Teams (INTs) agreed and advertised from 16th May until 30th May - INT teams being formed through a mixture of recruitment and realignment of staff across by local partners and expected to be operational from July - Digital pathway is in place. The DPIA has been developed, and we're now working to secure full EMIS access for prescriber roles. (working with SEL digital for better solution to support integration). - Health Equity Fellows have been successfully recruited and have started engaging with the 6 VCSE groups to support the project. - Business case is being finalised and should be completed	- Population health reporting is being tested for use in Multi-Disciplinary Meetings (MDMs). Going live July - INT dashboard is currently being built within HealthIntent – this will be ready in time for team mobilisation. July - Wider GP engagement event to support the development of the GP voice within the integrator/ partnership governance June - Finalise the Integrator arrangement/governance – July – Aug - Detailed design of the Children with Complex Care INT – July-Sep - Proactive Ageing Well Service live. Further work via the Lewisham Older People Board to expand this to mobilise the Frailty Framework recently agreed for SEL
Southwark	- Integrator approach agreed - Agreed 5 neighbourhood INTs to focus on 3 cohorts initially (CYP, frailty and 3+ LTCs). - Drafted high level implementation plan and set up corresponding implementation programme governance. - Gathered initial population health insights and asset mapping for each neighbourhood. - Established a Primary Care Task & Finish Group to support primary care with the challenges raised around transitioning to new neighbourhood footprints.	- Design resource structure for implementation programme and operational delivery and identify and deploy resource against this (aligned to Integrator conversation). - Refine INT model using learning from existing work together with further insights and mapping across each neighbourhood. - October: first INTs launch under a programme of iterative testing and learning.

NHS South East London Integrated Care Board Place Integrator Assurance Process – Key Lines of Enquiry (KLoE)

Borough: BEXLEY

Integrator Form & Function: Bexley Care *Plus*

Date: Monday 23rd June 2025

1. Context

The London Target Operating Model (TOM) sets out the key ingredients for a successful integrator and broadly how it could operate. In line with the vision that the London TOM sets out, in Bexley the integrator will:

- **Be performed by Bexley Care Plus, a partnership, drawn from within the local system.** Recognising Bexley Place will be a key enabling layer for developing the Neighbourhood Health Service and the Integrated Neighbourhood Teams (INTs) which will sit at its core, supported by the SE London Integrated Care System, London Regional infrastructure and working in collaboration with other trusts outside of the SE London ICB.
- **Work as a partnership with local organisations** (including the 17 members of the Bexley Wellbeing Partnership and the Bexley Local Care Networks), to provide the range of required support, underpinned by clear organisational accountability to the Place Partnership, for ensuring the neighbourhood health service can function effectively, efficiently and sustainably in Bexley. This may include working with cross borough partners, for example in Greenwich, as well as voluntary and community sector partners.
- **Recognise its role cannot operate in isolation or replace individual responsibility, accountability and sovereignty** from partnering local organisations. Each must work together within its own remit but keeping in mind the greater good of the population with respect to the integrator role.
- **The Bexley Wellbeing Partnership will continue to provide the leadership and local accountability** for planning, delivering and evaluating improved population health and reduced inequalities, working with a wide range of partners in the borough and beyond.

2. Which statutory bodies and partners are included within the integrator arrangement being proposed? If the arrangement is a partnership arrangement, which organisation would be acting as the lead organisation (as set out within the principles related to form).

The integrator, **Bexley Care *Plus***, will be a partnership, underpinned by a formal partnership agreement between:

- London Borough of Bexley;
- Oxleas NHS Foundation Trust;
- The four Primary Care Networks (APL, Clocktower, Frognaal and North Bexley) that deliver care on the Bexley neighbourhood geographical footprints; and
- The local GP Federation, Bexley Health Neighbourhood Care CIC.

These partners build on existing arrangements in Bexley including:

- **Bexley Care** – a partnership between Oxleas NHS Foundation Trust and the London Borough of Bexley which works within and provides overarching management for current models of neighbourhood working in the three established geographical neighbourhoods; Clocktower, Frognal and North Bexley. Bexley Care was established in 2017 and integrates adult physical and mental health services provided by Oxleas NHS Foundation Trust with adult social care in the London Borough of Bexley under a single management structure.
- **Local Care Networks (LCNs)** – in 2017 Bexley also set out commitments and principles in the Bexley Local Care Partnership Memorandum of Understanding, which formed a partnership with a range of statutory and voluntary partners to deliver care on three footprints (Frognal, North Bexley and Clocktower). These three footprints will form the three neighbourhood geographies for the Integrator to work within and support.

The partners involved in **Bexley Care Plus** are in the process of approving a Memorandum of Understanding which sets out their commitment to work together over the coming months to formally constitute the Bexley Care *Plus* partnership and form the integrator, which is due for final endorsement by the Bexley Wellbeing Partnership in July 2025.

For ‘integrators’ and within this arrangement, there is a **requirement** for the inclusion of a lead NHS organisation which is:

- **Organisationally mature and able to operate at scale**
- **Part of the existing landscape**
- **Recognised as a partner and collaborator**
- **Credible and trusted.**

Oxleas NHS Foundation Trust has the size, scale, maturity and local footprint to enable it to act as the lead NHS organisation within the partnership. The partnership agreement will set out in more detail the responsibilities and accountabilities of Oxleas NHS Foundation Trust, the London Borough of Bexley, the GP Federation and the 4 Primary Care Networks.

3. What shared decision-making structures are planned to be put in place to support the integrator arrangements, and how is parity of voice being considered to enable effective neighbourhood working?

The Integrator Function will operate within a tiered governance structure, ensuring alignment across neighbourhood, place, and system levels:

- **Neighbourhood-Level Governance:** Local panels (the Local Care Networks), which have representation from residents, VCSE organisations, and service and social housing providers.
- **Place-Level Oversight:** Bexley Care *Plus*, as the partnership hosting the Integrator Function, aligned to the current Section 75 governance underpinning Bexley Care and accountable to the Bexley Wellbeing Partnership and Bexley Health & Wellbeing Board.
- **System-Level Alignment:** Coordination with the South East London Integrated Care Board (ICB) and Integrated Care System (ICS).

Bexley Care *Plus* will act as a **single management structure**, ensuring a unified approach to service delivery, resource allocation, and patient care. This structure establishes a single leadership team with representatives from each partner organisation, ensuring strategic alignment and coordinated decision-making where appropriate. All Partners will commit to developing a Bexley Care *Plus* structure that will optimise and build on current structures.

Bexley Care *Plus* will be governed by a Board with membership agreed as representatives from:

- Oxleas NHS Foundation Trust
- London Borough of Bexley
- 1x GP representative per Primary Care Network (North Bexley, Clocktower, Frognal and APL)
- GP Federation (Bexley Health Neighbourhood Care CIC)
- NHS South East London Integrated Care Board

This Board will provide assurances and report to Bexley Wellbeing Partnership and thus to NHS South East London ICB. The Bexley Care Plus Board will be aligned to the Bexley Care Section 75 Board – this will remain as its own distinct entity as it has a statutory purpose due to the Section 75 agreement which underpins the formation of Bexley Care. Likewise, the joint management structure of Bexley Care will remain and be adapted to the new integrator function.

The governance structures within each Local Care Network (neighbourhood) will report into the Bexley Care *Plus* Board.

Members of the Bexley Care *Plus* Board will have delegated powers from each of their sovereign organisations, with those organisations reserving decision making powers in certain circumstances. The delegation scheme for Bexley Care *Plus* will be dependent on, and follow, the individual scheme of delegation for each of the partner organisations and therefore may differ on an organisation-by-organisation basis. Where the board needs to take decisions which are outside of the scheme of delegation, this will necessitate an organisation to take that decision back to its own governance arrangements in a timely way. The details of the types and values of decisions which each organisation's representative can make, without needing to revert to their own organisation, will be set out in more detail in the partnership agreement.

A principles-based approach will ensure the Bexley Care *Plus* governance structures remain flexible enough to respond to emerging challenges and opportunities while providing the stability needed for long-term planning and consistent care delivery. This would include introducing regular governance stress tests to evaluate their adaptability to new policies, population health changes, and technological advancements, and agreed protocols that streamline decision-making during crises, ensuring swift action without bypassing accountability structures.

Decision-making will take place in alignment with the Collaboration Commitments outlined in the Memorandum of Understanding, with an aim to reach agreement by consensus.

4. How will the integrator arrangement ensure that sufficient resources are secured and in place to deliver the integrator function either through the lead organisation, or via a broader partnership approach? It is recognised that the function will grow over time.

The Memorandum of Understanding sets out some principles which partners have agreed, including sharing of resources.

Initially the workforce, estates, IT etc for Bexley Care *Plus* are expected to be drawn from the parties involved. Some resources will also be drawn from the SEL ICB – e.g. expertise to support transformation programmes, business intelligence support etc. It is not envisaged that the integrator picks up all potential functions immediately, but a plan will be put in place for the integrator to take on functions and for resources to be transferred from SEL ICB in order to support the transition. Partners recognise that providing these functions will

require investment and additional resources, including short term funding to support the transition. All providers are facing financial challenges, and these additional resources will need to come from the system.

The London Borough of Bexley currently jointly funds with Bexley, SEL ICB the Neighbourhoods Delivery Team. In addition, it is attended that Oxleas NHS Foundation Trust will also provide resources to support neighbourhood leadership.

5. What will be the first priorities for the integrator arrangements to support effective neighbourhood working, considering the South East London focus on delivery of integrated neighbourhood teams for our three priority populations?

The three current transformation projects which will form the basis of Bexley's neighbourhood health service and Bexley Care *Plus* (**Ageing Well/Frailty, multiple LTCs and Integrated Child Health**) will see pilots running over Q1 to Q3 2025/26. These pilots will inform the content of the Partnership Agreement. To date partners have developed high level end to end models of care, with input and co-production with local residents and drawing on the local assets in each neighbourhood. Building on the approach taken in developing the **Erith Hospital Vision**, Bexley will be conducting an exercise to consider greater utilisation and integration of **Queen Mary's Hospital site** in Sidcup, including a potential role for the integrator and wider neighbourhood health.

A further priority will be for the partnership to review the **NHS 10 Year Plan**, once it is published, to determine the requirements for the integrator and more broadly for Bexley and to integrate any actions into the plan for the development of Bexley Care *Plus*.

In addition, during this initial phase, we will **set up the governance for Bexley Care *Plus* in shadow form**, allowing for the development of effective ways of working and to provide an opportunity for those involved directly to develop the roles.

The formal partnership agreement will be developed over the coming year, with an ambition to sign off during 2026.

Commissioning Intentions for the emerging Bexley Care *Plus* will be set in January 2026, along with a further set of transformation programmes, to be overseen by the Bexley Wellbeing Partnership, providing assurances to the NHS South East London Integrated Care Board.

Bexley Care *Plus* – Signatories

Yolanda Dennehy, Director of Adult Social Care & Health, London Borough of Bexley

Iain Dimond, Chief Operating Officer, Oxleas NHS Foundation Trust

Abi Mogridge, Chief Executive, Bexley Health & Neighbourhood Care CIC (GP Federation)

Dr Clive Anggiansah, Community & Primary Care, Clinical Care Professional Lead, NHS SEL ICB

Dr James Stokes, Chair, APL Primary Care Network

Dr William Cotter, Chair, Clocktower Primary Care Network

Dr Sid Deshmukh, Chair, Froggnal Primary Care Network

Dr Huw Williams, Chair, North Bexley Primary Care Network

25th June 2025

By email only

Dear Andrew and Andrew,

We are submitting our response to the call for expressions of interest for delivery of the Integrator function in borough. Our response is framed around the specific questions that have been asked, and we look forward to ongoing discussions on the next steps with our Lambeth partners.

1. Which statutory bodies and partners are included within the integrator arrangement being proposed? If the arrangement is a partnership arrangement, which organisation would act as the lead organisation (as set out in the principles related to form)?

Lambeth has agreed that the integrator will be a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and Lambeth General Practice Provider Alliance (LGPPA). This partnership arrangement recognises the central role of both organisations in delivering care in the borough, and the importance of these services in supporting the development of a neighbourhood service with our wider partners including Lambeth Council, King's College Hospital, South London and Maudsley, the voluntary sector, and the wider network of primary and community care providers.

GSTT will be the statutory body hosting the partnership. We are establishing robust partnership arrangements that allow us to take an equitable approach, held together by key principles which govern our work (expanded on in the following section).

We recognise that the GP leadership arrangements within our Integrator partnership are evolving in response to the external environment. The LGPPA is undertaking a due diligence process which is being led by the ICB Lambeth Primary Care team and aims to provide assurance to the broader Lambeth Together partners around the LGPPA's operating function for both broader GP leadership organisation functions as well as core Integrator functions. We are expecting the due diligence process to conclude by October 2025.

Due to the immediate ask for the integrator to hold the £250,000 integrator development funding provided by SEL ICB, this will be held by GSTT on behalf the integrator, in service of the wider Lambeth Together Care Partnership organisation, with principles for spend being ratified by the partners with oversight of our Lambeth Together priorities.

2. What shared decision-making structures are planned to be put in place to support the integrator arrangements, and how is parity of voice being considered to enable effective neighbourhood working?

We recognise that our work around neighbourhoods will be led by the integrator, but that there will be significant input needed from all partners at an operational and strategic level in order to deliver on our neighbourhood ambitions. As the integrator, we will co-produce and codevelop our work with all relevant stakeholders and effectively communicate these changes throughout our local care partnerships.

The integrator will establish an Integrator Delivery Board (IDB) in July 2025. The IDB will have delegated authority from GSTT and the LGPPA to make decisions on behalf of the respective organisations and broader partners. The IDB will meet monthly. The integrator will utilise existing

partner governance functions to streamline functions and ensure that all Lambeth partners are part of the integrator delivery model. The IDB will therefore report quarterly into Lambeth Together via the Neighbourhood and Wellbeing Delivery Alliance (NWDA), recognising that this will ensure engagement with the right partner representatives. We also anticipate the IDB will work closely with equivalent structures in all SEL boroughs as part of a network of integrators to share best practice. We will also be maintaining close joint working across Lambeth and Southwark to make the best use of local resources and harness the opportunity for synergistic working at scale.

There will be core members from the integrator on the IDB. These will include:

- **GSTT:** ISM CEO, Evelina CEO, ISM Director of Partnerships and Operations, ISM Deputy Medical Director, Population Health Hub Consultant, Evelina Director of Strategy, Evelina Deputy Medical Director
- **LGPPA:** Managing Director, LGPPA directors x 4
- **NWDA:** Programme Director

The core principles of the IDB will be:

- Make decisions on allocation of resources within INT models
- Scrutinise and agree models of INT delivery (explored in more detail in following answer)
- Respond to emerging policy developments regarding neighbourhood health
- Demonstrate impact of neighbourhood health models of care
- Receive updates from delivery function

3. How will the integrator arrangement ensure that resources and leadership are in place to deliver the integrator function and the development of integrated neighbourhood care either through the lead organisation, or via a broader partnership approach? It is recognised that the function will grow over time.

Our integrator leadership model will include integrator specific governance as well as reporting and engagement with our broader partners. The Integrator Delivery Board's terms of reference will provide a jointly agreed structure for this governance, harnessing the collective resources of the integrator partners.

You will be aware that there is collaborative work taking place across Southwark and Lambeth with shared partners. We are exploring how we keep strong connections between our respective integrator models, whilst retaining the strong identities and attending to the needs in each borough. This work includes harnessing the input from our primary care leadership structures, and also within GSTT via the INT delivery committee, which reports into the Improving the Health of our Populations (IHOP) committee.

We will make the best use of our existing resources to design, develop and deliver an integrated neighbourhood care model. We will do this through agreement with Lambeth partners as well as using the initial learning from our models to support discussions around how we work to deliver the national 'three shifts' as models show impact.

We will continue to review our resources as the neighbourhood health model develops to ensure that the function is developing. We also recognise alignment with this and the work taking place

around the model ICB structure. The functions and use of partnership resources will formally reviewed within our Lambeth Together executive structures on an annual basis.

The existing Lambeth and Southwark Primary Care and Acute Interface Forum addresses prioritised interface issues like referrals, pathways and fit notes. We anticipate this group, and potentially other groups working in the partnership space, will transition into the integrator function to streamline the delivery of the neighbourhood health model.

4. What will be the first priorities for the integrator arrangements to support effective neighbourhood working, considering the South East London focus on delivery of integrated neighbourhood teams for our three priority populations?

Our first priorities are to deliver on the national ambitions around integrated neighbourhood teams, centred around the identified cohorts with additional local variation where required. Developing INTs to support care of residents with frailty, multiple long-term conditions and children and young people will provide a framework for our work.

Our key priorities will be to support operational coordination between sectors and partners across the borough and between INTs. This should enable us to identify the gaps across our fragmented pathways and services, and provide the opportunity to build interfaces and relationships, supporting workforce planning and business intelligence. Our principal aims will be to:

- facilitate population health management by promoting the sharing and effective use of data and information across organisations, enabling holistic care for our residents and improving population health outcomes
- collectively provide essential infrastructure supporting people, finance, governance, and risk management for INTs in a consistent way, harnessing existing local assets and resources.
- implement INTs, including recruitment of team managers and clinical leads, and working with local organisations to identify the resources/staff that will be deployed into INTs.

The initial priorities for this financial year are as follows:

- establishment of IDB in July 2025
 - each neighbourhood to undertake detailed design work before starting to deliver frontline change, using initial insights and learning to develop the model
 - commence partnership work around data and insights to help develop the future model

We recognise that the INT model is predicated on a population health management approach. Due to the similar integrator model across Lambeth and Southwark, we expect to share the development of this function across both boroughs to ensure an effective and efficient model. This will use resources from the Population Health Hub within GSTT, the data analytical function within the LGPPA and the respective federations in Southwark, and the business intelligence capacity within SEL ICB. The long-term aim of the population health management function will be to develop an integrated data set with a patient-identifiable data set that enables detailed risk stratification across our populations, working with the broader SEL ICS on any relevant ICS PHM tools or procurements. As a short-term aim, the population health management function will work with partner organisations

to create overarching data sets to focus our work in neighbourhoods and understand the enablers for data sharing.

We welcome the opportunity to discuss our plans in more detail.

Many thanks,



Louise Dark
Chief Executive Officer
Integrated and Specialist Medicine Clinical Group
Guy's and St. Thomas' NHS Foundation Trust



Dr George Verghese
Executive Director
Lambeth General Practice Provider Alliance

Lewisham Integrator proposal- (form and function)

27th June 2025

First Steps

Lewisham is developing a partnership arrangement. The partnership will be based on equality of voice in shared decision-making, and strong collaboration. Ensuring an equal voice from general practice, the voluntary and community sector (VCS), and South London and Maudsley NHS Foundation Trust (SLaM). It is recognised that an NHS statutory body will be required to act as a host on behalf of the Integrator partners. The proposed host at this time is LGT, subject to confirmation from all partners that assurances put in place as part of our ongoing work on underpinning governance are satisfactory.

- Lewisham Council Adult Social Care, Children and Public Health
- Lewisham and Greenwich Trust
- Primary Care
- South London and Maudsley NHS Foundation Trust (SLaM)
- Voluntary and Community Sector (VCS)

What shared decision-making structures are planned to be put in place to support the integrator?

- Dedicated Board to support the development and implementation of the Neighborhood programme – Feeds into the Lewisham Health and Care Partnership Board but reports into the partner organisations governance structures
- New Integrated Neighbourhood Operational Group that will report into Neighbourhood Board
- Four local groups to oversee the development of INTs, each aligned to one of Lewisham's neighbourhoods
- New monthly leadership forum, to agree agenda items for the Neighbourhood Board and develop the integrator
- Initially the collective voice of primary care will be secured through the Primary Care Leadership Forum
- Work is underway to confirm how the collective voice of the VCSE will be secured
- We will develop ways of ensuring our local population voice is part of the co-design process

Confirming the Integrator: First Steps *(contd.)*

How will the integrator arrangement ensure sufficient resources to deliver the integrator function?

- In development: MOU for the Dedicated Partnership Team and Integrator Functions. This will outline the staffing structure, roles, and responsibilities of the dedicated team supporting the partnership and integration functions. It will include details on funding allocations, reporting lines, and governance arrangements.
- In development: MOU for Neighbourhood Working. This will serve as a contractual agreement between partners to formalise their responsibilities and mutual expectations around neighbourhood-based working. The MOU will also detail each partner's financial contributions to support delivery.

What will be the first priorities for the integrator arrangements to support neighbourhood working?

- The initial focus will be on the Integrated Neighbourhood Teams (INTs) supporting long-term conditions (LTC), which will be operation in September 2025. This scope will then expand into other areas of work including INTs for children with complex needs.
- Work has already started for people frailty & those approaching EOL via the new PAWS service, more work is required to implement the full frailty framework
- GPs will develop a functional structure that represents general practice voice within the Integrator arrangement and supports Primary Care to take a stronger leadership role in the operational management of INTs.
- Development of the aforementioned MOUs and new governance structure are immediate priorities for the Integrator to support neighbourhood working.

23rd June 2025

By email only

Dear Darren and Andrew,

We are submitting our response to the call for expressions of interest for delivery of the Integrator function in borough. Our response is framed around the specific questions that have been asked, and we look forward to ongoing discussions on the next steps with our Southwark partners.

1. Which statutory bodies and partners are included within the integrator arrangement being proposed? If the arrangement is a partnership arrangement, which organisation would act as the lead organisation (as set out in the principles related to form)?

Southwark has agreed that the integrator will be a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and a new joint venture between Southwark GP Federations: Improving Health Limited (IHL) and Quay Health Solutions (QHS). This partnership arrangement recognises the central role of both organisations in delivering care in the borough, and the importance of these services in supporting the development of a neighbourhood service with our wider partners including Southwark Council, King's College Hospital, South London and Maudsley, the voluntary sector, and the wider network of primary and community care providers.

GSTT will be the statutory body hosting the partnership. We are establishing robust partnership arrangements that allow us to take an equitable approach, held together by key principles which govern our work (expanded on in the following section).

We recognise that the GP leadership arrangements within our Integrator partnership are evolving in response to the external environment. IHL and QHS are undertaking work to establish a joint venture for general practice. We are expecting the process to conclude by October 2025. Due to the immediate ask for the integrator to hold the £250,000 integrator development funding provided by SEL ICB, this will be held by GSTT on behalf of the integrator, with principles for spend being ratified by the partners with oversight of our Partnership Southwark priorities.

2. What shared decision-making structures are planned to be put in place to support the integrator arrangements, and how is parity of voice being considered to enable effective neighbourhood working?

We recognise that our work around neighbourhoods will be led by the integrator, but that there will be significant input needed from all partners at an operational and strategic level in order to deliver on our neighbourhood ambitions. As the integrator, we will co-produce and codevelop our work with all relevant stakeholders and effectively communicate these changes throughout our local care partnerships.

The integrator will establish an Integrator Delivery Board (IDB) in July 2025. The IDB will have delegated authority from GSTT, IHL, QHS and North and South Southwark Primary Care Networks (PCN) to make decisions on behalf of the respective organisations and broader partners. The IDB will meet monthly. The integrator will utilise existing partner governance functions to streamline functions and ensure that all Southwark partners are part of the integrator delivery model. IDB will provide progress reports to the Southwark INT programme executive that will also receive proposals that require further review and support from wider system partners. We anticipate the IDB will work

closely with equivalent structures in all SEL boroughs as part of a network of integrators to share best practice. We will maintain close joint working across Lambeth and Southwark to make the best use of local resources and harness the opportunity for synergistic working at scale.

There will be core members from the integrator on the IDB. These will include:

- **GSTT:** ISM CEO, Evelina CEO, ISM Director of Partnerships and Operations, ISM Deputy Medical Director, Population Health Hub Consultant, Evelina Director of Strategy, Evelina Deputy Medical Director
- **IHL and QHS:** IHL Managing Director, QHS Executive Director, NSPCN Clinical Director, SSPCN Clinical Director, Southwark Local Medical Committee
- **Partnership Southwark:** Director of Partnership Delivery and Sustainability (non-voting member that will attend during transition period).

The core principles of the IDB will be:

- Make decisions on allocation of resources within INT models
- Scrutinise and agree models of INT delivery (explored in more detail in following answer)
- Respond to emerging policy developments regarding neighbourhood health
- Demonstrate impact of neighbourhood health models of care
- Receive updates from delivery function

3. How will the integrator arrangement ensure that resources and leadership are in place to deliver the integrator function and the development of integrated neighbourhood care either through the lead organisation, or via a broader partnership approach? It is recognised that the function will grow over time.

Our integrator leadership model will include integrator specific governance as well as reporting and engagement with our broader partners. The Integrator Delivery Board's terms of reference will provide a jointly agreed structure for this governance, harnessing the collective resources of the integrator partners.

You will be aware that there is collaborative work taking place across Southwark and Lambeth with shared partners. We are exploring how we keep strong connections between our respective integrator models, whilst retaining the strong identities and attending to the needs in each borough. This work includes harnessing the input from our primary care leadership structures, and also within GSTT via the INT delivery committee, which reports into the Improving the Health of our Populations (IHOP) committee.

We will make the best use of our existing resources to design, develop and deliver an integrated neighbourhood care model. We will do this through agreement with Southwark partners as well as using the initial learning from our models to support discussions around how we work to deliver the national 'three shifts' as models show impact.

We will continue to review our resources as the neighbourhood health model develops to ensure that the function is developing. We also recognise alignment with this and the work taking place around the model ICB structure. The functions and use of partnership resources will formally reviewed within our Partnership Southwark executive structures on an annual basis.

The existing Lambeth and Southwark Primary Care and Acute Interface Forum addresses prioritised interface issues like referrals, pathways and fit notes. We anticipate this group, and potentially other

groups working in the partnership space, will transition into the integrator function to streamline the delivery of the neighbourhood health model.

4. What will be the first priorities for the integrator arrangements to support effective neighbourhood working, considering the South East London focus on delivery of integrated neighbourhood teams for our three priority populations?

Our first priorities are to deliver on the national ambitions around integrated neighbourhood teams, centred around the identified cohorts with additional local variation where required. Developing INTs to support care of residents with frailty, multiple long-term conditions and children and young people will provide a framework for our work.

Our key priorities will be to support operational coordination between sectors and partners across the borough and between INTs. This should enable us to identify the gaps across our fragmented pathways and services, and provide the opportunity to build interfaces and relationships, supporting workforce planning and business intelligence. Our principal aims will be to:

- facilitate population health management by promoting the sharing and effective use of data and information across organisations, enabling holistic care for our residents and improving population health outcomes
- collectively provide essential infrastructure supporting people, finance, governance, and risk management for INTs in a consistent way, harnessing existing local assets and resources.
- implement INTs, including recruitment of team managers and clinical leads, and working with local organisations to identify the resources/staff that will be deployed into INTs. The initial priorities for this financial year are as follows:
- establishment of IDB in July 2025
 - each neighbourhood to undertake detailed design work before starting to deliver frontline change, using initial insights and learning to develop the model
 - commence partnership work around data and insights to help develop the future model

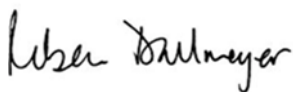
We recognise that the INT model is predicated on a population health management approach. Due to the similar integrator model across Lambeth and Southwark, we expect to share the development of this function across both boroughs to ensure an effective and efficient model. This will use resources from the Population Health Hub within GSTT, the data analytical function within the LGPPA and the respective federations in Southwark, and the business intelligence capacity within SEL ICB. The long-term aim of the population health management function will be to develop an integrated data set with a patient-identifiable data set that enables detailed risk stratification across our populations, working with the broader SEL ICS on any relevant ICS PHM tools or procurements. As a short-term aim, the population health management function will work with partner organisations to create overarching data sets to focus our work in neighbourhoods and understand the enablers for data sharing.

We welcome the opportunity to discuss our plans in more detail.

Many thanks,



Louise Dark
Chief Executive Officer
Integrated and Specialist
Medicine Clinical Group
Guy's and St. Thomas' NHS
Foundation Trust



Rebecca Dallmeyer
Executive Director
Quay Health Solutions
North Southwark



Nigel Smith
Executive Director
Improving Health Limited
South Southwark

SEL Neighbourhood Working Outcomes Framework

July 2025

An outcomes framework for neighbourhood working

The roll-out of neighbourhood **working reflects an ambitious transformation of our ways of working and operating as a system** - without a clear strategic direction we risk drifting apart in our efforts, and diluting and losing sight of our impact. The development of an outcomes framework **provides our system with an opportunity to clearly articulate what we will expect to see realised through neighbourhood working**, and a means of understanding if we are on track.

It also provides a significant opportunity to come together across the health and care system to set out the change we want to see for patients, staff and South-East London more broadly.

Our outcomes framework will:



Reduce duplication across the system by drawing together all strands of outcomes development into one concise framework



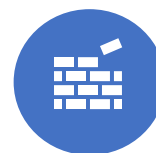
Provide strategic direction to all system partners delivering neighbourhood working, developing a shared understanding of what we are trying to achieve, and balancing consistency and alignment in delivery while creating structured space for local variation



Develop buy-in to the neighbourhood model from all system partners, reflecting and creating alignment with our partners' wider short and long-term priorities



Develop an evidence base from which we can test and learn new and more effective ways of delivering integrated services



Set the foundations for a longer-term shift in incentives and resourcing to deliver shared outcomes aligned with the “three shifts”



Build on what patients and staff have told us is important to them

An outcomes framework for neighbourhood working

The emergent outcomes framework presented in this document has been developed through engagement with colleagues from across the system, and aims to reflect the impact we anticipate for all partners and residents. Crucially, this **cannot stop with health; the impact will be felt across** social care, the voluntary and community sector, and those working within the wider determinants – only with everyone in the system participating and realising this impact can the neighbourhood model achieve its holistic ambitions for transforming how we deliver services. **This outcomes framework attempts to capture the full scope of this ambition reflected by neighbourhood working.**

The framework is structured by four key domains which cover the scope of impact we expect to see from neighbourhood working:

- *System resource and sustainability*
- *Workforce impact and staff experience*
- *Resident experience and community impact*
- *Population Health, Prevention, and Inequalities*

Interwoven across each of these is an emphasis on environmental sustainability. Entries which explicitly relate to the environment are marked with a yellow tree symbol. 

The outcomes presented here have been derived from a theory of change which traces connections between outcomes and outputs, and the inputs and activities which the system needs to undertake in order to realise these – this approach provides a means to interpret and disaggregate the complexity of benefits realisation for system transformation, and means we can be confident our outcomes can be realised through the changes we will undertake.

This is a first version of our outcomes framework. We will continue to engage across the system to refine our emergent outcomes and finalise these into a final framework – this will be used as the basis for forthcoming modelling work to develop an impact model which will monitor our progress against our chosen outcomes.

Outcomes framework

System resource and sustainability

Ensuring our services are able to support South East London residents long into the future

Outcomes



The system achieves financial and environmental sustainability and resilience over the long term

Residents stay well for longer, especially those from disadvantaged communities, with a reduced need for crisis management, and improved prevention and early intervention

More residents are accessing services locally, in the community

Example metrics

Reduction in demand for acute services (especially for social issues)

Activity increases across community-based services, including VCSE and wider-determinants

Delays in demand for intensive social care placements

Acute length of stay

Reduction in commissioning activity, linked to successful demand reduction

Workforce impact and staff experience

Delivering a skilled and motivated workforce ready and equipped to power the transformation

Outcomes

Staff feel more relevant to and embedded into their communities, and better able to deliver culturally competent care and support.

Staff feel part of “one team”, feel equal with their system counterparts, and more supported to do their jobs to the best of their ability

The system has a resilient and sustainable workforce across all partners, and has an improved ability to attract, recruit, and retain staff

Example metrics

Staff turnover and retention

Staff movement across the system, and the proportion and distribution of integrated posts

Existing and new staff survey measures (such as if staff feel able to collaborate across organisational boundaries)

The proportion of hand-offs

Workforce utilisation

Workforce skill mix measurement (including digital skills)

Resident experience and community impact

Transforming the way residents and communities experience their services and manage their health and wellbeing

Outcomes

Residents, particularly those from underserved communities, trust, and feel valued and understood by, their services and the professionals they interact with, and know that their input has a direct impact on their care and wider services

Residents and carers have improved confidence in managing their health and wellbeing through accessing the right services, and have reduced anxiety around their needs



Communities are supported to thrive as local services are improved, more residents are supported to become or remain economically active and in employment, and environmental quality is improved

Example metrics

Improved patient satisfaction survey measures

Happiness metrics

The proportion of self-referrals across services

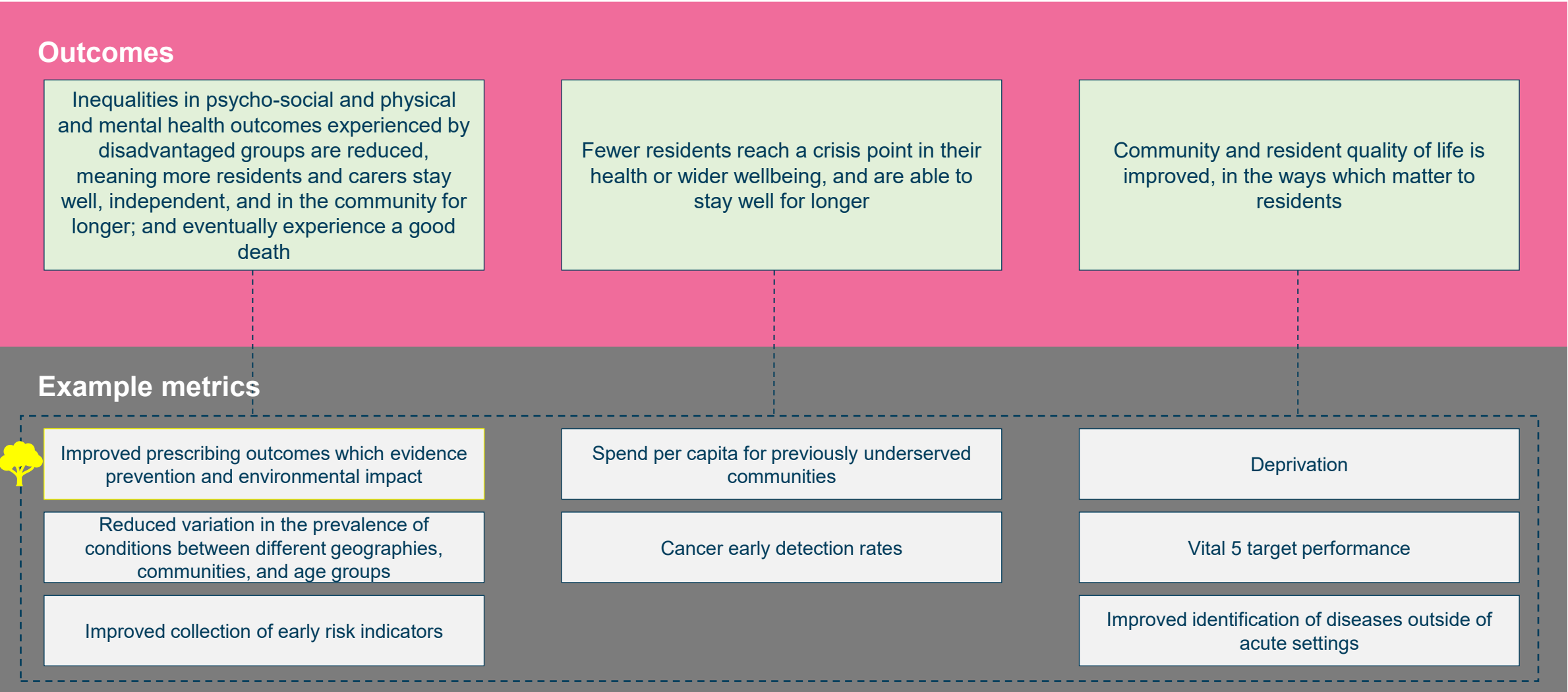
Reduction in economic inactivity due to ill health

Increased utilisation of VCSE services

Engagement activity levels with local communities

Population Health, Prevention, and Inequalities

Keeping residents and communities well for longer through prevention and addressing inequalities



SEL Neighbourhood Working Theory of Change

Introduction

The roll-out of neighbourhood **working reflects an ambitious transformation of our ways of working and operating as a system** - without a clear strategic direction we risk drifting apart in our efforts, and diluting and losing sight of our impact.

We need to **clearly articulate what we will expect to see realised through neighbourhood working**, and a means of understanding if we are on track – this will be captured by a SEL-wide outcomes framework which sets out the scale of the ambition for neighbourhood working beyond our initial priority of implementing Integrated Neighbourhood Teams (INTs), through a clear and succinct set of outcomes across the key domains where we expect to see impact.

Our outcomes must reflect the impact neighbourhood working will have **across the system**, for all partners and residents. **This cannot stop with health**; it must articulate the impact for social care, for wider wellbeing, and life outcomes across our population. It will need to capture the full scope of the ambition reflected by neighbourhood working.

Process

The transition to neighbourhood working constitutes a transformation of our entire system, and the impact of this will appear in complex and interconnected ways.

In order to have confidence our outcomes are connected to inputs and activities which the system is undertaking, and to identify where there are gaps in these activities, the outcomes framework will be developed through a theory of change approach, tracking inputs to outcomes.



A theory of change situates outcomes and activities within their wider context to explain how and why outcomes are achieved – we believe this approach can hold the complexity of the evolving neighbourhood model and landscape, and maintain a focus on long term, shared outcomes.

This document sets out the theory of change, which was developed through engagement and two focussed workshops with wide system partners over June 2025.

Developing our theory of change provided an opportunity for partners to come together and coalesce around a long-term vision for neighbourhood working.

This document: user guide

The theory of change is structured across four key outcome domains:

- **System resource and sustainability**
- **Workforce impact and staff experience:**
- **Resident experience and community impact**
- **Population Health, Prevention, and Inequalities**

Interwoven across each of these is an emphasis on environmental sustainability. Entries which explicitly relate to the environment are marked with a yellow tree symbol. 

Please note: our theory of change is laid out to provide an indication of the logic which connects inputs to activities to outputs to outcomes, however to hold the complexity of benefits realisation from system transformation, it should not be read as a strict logic diagram.

Some entries are duplicated across domains in order to provide a more complete picture of how outcomes will be achieved, and some are deeply connected with other domains within the logic diagram.

This document reflects the first version of our theory of change, and further iterations will be made as we continue to engage and refine our vision for neighbourhood working.

Outcomes

The system achieves financial and environmental sustainability and resilience over the long term

Residents stay well for longer, especially those from disadvantaged communities, with a reduced need for crisis management, and improved prevention and early intervention

More residents are accessing services locally, in the community

Outputs

Reduced wastage and duplication of activity between individuals, and within and between organisations

Environmental sustainability and conscientiousness is embedded in our system-wide culture

The system has an improved ability and confidence to follow what works, and stop what doesn't

Community services are better able to identify, care for, and support residents with high and increasing risk of ill health

There are increases in the delivery of proactive and preventative care and support, including increased partnership and collaboration with the voluntary sector

Staff across the system have a 'single view' of the resident

Residents are better able and more confident to manage their own health and wellbeing, and make plans for later in life

System resource shifts into the community

Activities

Staff take up environmental training opportunities in sustainability in social care

System functions are aligned, with staff deployed effectively across organisations

Population Health Management insights are embedded within planning, delivery, and monitoring and evaluation, supported by a training offer for the workforce

Resources are flexibly shifted in different ways to address inequalities

Decisions are made based on need and outcomes, rather than system limitations

Wider system partners align to and deliver within the neighbourhood model, and are provided with the support and resource to be able to do so effectively

Genuine co-production and community voice are embedded in decisions to redirect investment to wider services including the VCSE

Services are designed, commissioned, and effectively evaluated on an outcomes-basis, based on population health needs and aligned to population groups, with commissioning decisions removed from organisational siloes, and an emphasis on reducing wastage

Shared care plans for the highest acuity/ more complex residents, shared across all system partners

Community professionals draw specialist input into the delivery of residents' care

Residents use self-management and education tools to enable them to manage their own health and wellbeing

Inputs

A cultural emphasis and willingness to focus on long-term (10 years+) transformation and outcomes, and sustainable value

A single Population Health Management approach, useable analytics tools, and shared data across all system partners

An effective Integrator in each Place, enabling integration, a "shift left" of resources and the sharing of risk

Alignment and accountability across the system to a shared outcomes framework, tracked by a single benefits realisation tool with metrics which directly capture impact

Flexible resourcing mechanisms in place such as pooled funding and integrated workforce models; simplified payment mechanisms, and outcomes-based incentives

Investment in partnership working for the long-term, and a commitment to genuine collaboration and equal partnership between all partners at every level

Digital tools that are responsibly designed, interoperable, and future ready - including accessible self-management tools, a single patient record, and AI approaches

Outcomes

Staff feel more relevant to and embedded into their communities, and better able to deliver culturally competent care and support.

Staff feel part of “one team”, feel equal with their system counterparts, more supported to do their jobs to the best of their ability

The system has a resilient and sustainable workforce across all partners, and has an improved ability to attract, recruit, and retain staff

Outputs

Staff affiliate themselves more with the neighbourhood(s) they support and the area they work in, over their organisations

The thinking space and freedom for staff to respond to resident needs in a genuinely preventative and holistic way, be creative, and deliver an improved and more holistic standard of care to residents, and have the knowledge of local services to be able to do so

A culture of partnership across the system, and increased trust among staff and between organisations to be able to work toward shared outcomes

Better work/life balance, and less burnt-out or stress among staff

Activities

More staff deliver more care and support in the community

Staff across the system work closely and collaboratively across providers through a trusted assessor approach, communicating frequently and consistently using one common language, with time to understand shared outcomes, each other's roles and sharing learning

Unnecessary bureaucracy is reduced, and staff spend more time with residents - applying the skills and expertise they are trained in and best at

The workforce across the system is flexibly deployed in response to local need

Staff use accurate and up-to-date information flows to inform service delivery across both planning and the delivery of care and support

Staff access support and training to make best use of digital tools

Inputs

Permission for staff to work at the edge of their job descriptions; and the supporting flexible workforce models, integrated tariffs, performance structures, and clinical governance in place to enable this

Strong, shared, and visible Place-based and neighbourhood leadership, equal across all partners

Good career pathways in place, and updated workforce training and a cross-competency framework to support neighbourhood working and good knowledge of services

Leadership infrastructure in place to facilitate collaborative working, including governance and risk management, shared outcomes, and joint decision making

Digital tools that are responsibly designed, interoperable, and future ready – including the adoption of a single patient record

Outcomes

Residents, particularly those from underserved communities, trust, and feel valued and understood by their services and the professionals they interact with, and know that their input has a direct impact on their care and wider services

Residents and carers have improved confidence managing their health and wellbeing through accessing the right services, and have reduced anxiety around their needs

Communities are supported to thrive as local services are improved, more residents are supported to become or remain economically active and in employment, and environmental quality is improved

Outputs

Residents only tell their story once and experience continuity of care with every contact

Residents are treated as whole people, and families are treated as whole families, and are supported with holistic care at every point of access which takes into complete account their psycho-social context

Residents receive the right level of information and communication to better understand the support available to them

Residents, especially those in greatest need, experience shorter waiting time to access the right care, support, or treatment (including specialist treatment)

Residents access the right care and support first time

Residents are able to take greater ownership of their health and wellbeing, understand their own pathway, and proactively self-manage

Services are rooted in the community, better designed to meet the needs of residents and communities as they experience them, and more often benefit from community-sourced innovation

Community and town centres are invigorated, with improved spaces for community collaboration, connection, and action

Activities

Staff exercise increased understanding, knowledge, and respect among the workforce for the different communities they serve

Staff work in a highly collaborative and communicative way across organisations to deliver care to residents, moving away from referrals in favour of human-human communication

Staff co-produce care plans with residents

Community-based professionals draw upon specialist input as needed to deliver holistic care to residents locally

Technology and data-sharing are used and deployed responsibly

Staff and services speak in a common language, and provide coordinated and consistent support to residents and communities to understand and interact with new ways of delivering services, including self-managing their health and support needs

Services are always co-designed with the residents and communities - without outward organisational affiliations, accessible in the places where residents are in the community that feel safe (including online and in physical hubs)

Existing community organisations and hubs which serve all population groups, especially underserved groups, are active in delivering and shaping local services

There is greater grassroots action and community activation around the intersection of the environment and health and wellbeing outcomes

Inputs

Reduced multiple points of access

An outcomes, resident-centred culture, where staff are always supported to act in the interests of residents and communities over organisational interests

Commitment to genuine collaboration and equal partnership working between all partners at every level including community partners, VCSE partners, and partners working within the wider determinants

Easy to use tools and improved information available to residents, in formats accessible to all, to help them to manage their own health and wellbeing needs

Neighbourhood footprints which resonate with communities

Resident, community, and grassroots voices embedded in neighbourhood design and governance with consistent remuneration

A cultural commitment to fostering healthy environments

Investment in community infrastructure (including training, environment and estates, and digital) and the VCSE sector to support full participation in the neighbourhood model

Outcomes

Inequalities in psycho-social and physical and mental health outcomes experienced by disadvantaged groups are reduced, meaning more residents and carers stay well, independent, and in the community for longer; and eventually experience a good death

Fewer residents reach a crisis point in their health or wider wellbeing, and are able to stay well for longer

Community and resident quality of life is improved, in the ways which matter to residents

Outputs

Improved and earlier identification of patients with unmet needs, escalating risk, or complexities, and fewer preventable issues are medicalised

The need for more intensive forms of social care support is prevented and delayed

Residents and communities access the support they need locally within their neighbourhoods

Resources are more equitably distributed to support underserved communities

Residents are better able to manage their own health and wellbeing and plan for later life

Services are locally tailored to meet local population health needs

Activities

Up-to-date and reliable patient data is maintained across the system including social and demographic data

Resources are flexibly shifted in different ways to address inequalities

Transparent, accessible, consistent, and relevant messaging for communications and engagement with residents around accessing and shaping services locally

Services are commissioned based on outcomes and population health needs, supported by integrated commissioning

All partners are active within INTs, including LAs and VCSE, such that residents are able to access preventative support across a broadened set of services and settings (including schools, libraries, and barber shops)

Active travel schemes are in place to support residents to access services

Population Health Management analytics and modelling are applied by neighbourhoods and Places to both planning and care delivery: to tailor resourcing and interventions, and to systematically and proactively flag and identify individuals vulnerable to health and social inequalities, rising risk, or the effects of climate change

Inputs

Clear roles and responsibilities, and the right resource in place with respect to proactive case management

Professional and organisational responsibility for population outcomes, rather than for separate caseloads

Strong leadership which promotes the proactive and equal involvement of all system partners in the planning and delivery of neighbourhoods, and clear shared systems of governance, risk, and accountability to support this

A consistent Population Health Management and risk stratification approach, and user-friendly Population Health Management tools which support all user groups (including commissioners & planners, clinicians, care givers, and VCSE partners)

A clear vision from leadership for neighbourhood working, for both the short and the long-term

Codesign and community and grassroots voices embedded within decision making across the system, with consistent remuneration

A shared view of population and patient needs through integrated data and effective information sharing across sectors

Embedded approaches to services relating to the wider determinants (such as housing)

Accessible estates, especially for underserved communities

Digital tools that promote self-management among residents, with access to personal data

ICB Board Meeting in Public

Title	SEL primary and secondary care interface						
Meeting date	16 July 2025	Agenda item Number		11	Paper Enclosure Ref		K
Author	Toby Garrood, Medical Director						
Executive lead	Toby Garrood, Medical Director						
Paper is for:	Update	x	Discussion		Decision		
Purpose of paper	To discuss progress on improving working across the primary and secondary care interface and to present to the Integrated Care Board the SEL interface consensus document that has been developed.						
Summary of main points	The interface between primary and secondary is one of the key channels through which patients and their care flow. It needs to be patient focussed, delivering the best possible experience of care and clinical outcomes whilst ensuring that there is efficient use of resources. However, frustrations are common with all stakeholders having to contend with multiple touch points, at times inadequate communication, failure to make use of all the expertise in the system at the right time and poor use of patients' and clinicians' time. Ultimately, these failures of effective cworking and pathway integration lead to poor experience for all stakeholders, particularly patients, and inefficient use of resources which can result in poor patient experience, fragmentation of care and potentially worse outcomes. Over the last 2 years we have established interface groups across the system to address national and local priorities. Here we describe progress with particular reference to the SEL Interface Consensus Document. This document describes agreement around ways of working across the interface. It has been co-produced with stakeholders cross the system and is intended to provide clear guidance with a view to simplifying processes, minimising uncertainty, reducing unnecessary workload and improving patient experience. It will be published as a 'live' document subject to periodic updating and iteration, informed by patient and stakeholder feedback as well as dedicated workstreams..						
Potential conflicts of Interest	None identified						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	The principles are intended to improve patient pathways and experience of care and reduced some of the impacts of health inequalities						
Financial Impact	More efficient cross-system work is expected to improve cost-effectiveness of clinical pathways						
Public Patient Engagement	Previous patient engagement has informed this work and Healthwatch were involved in its production. A dedicated workstream to test the document with patients is underway.						

Committee engagement	The document has been agreed at the System Interface Group and approved by the SEL Clinical and Care Professional and Executive Committees
Recommendation	The Board is asked to note the contents of the report and the progress made in developing our agreed response to primary and secondary care interface issues and opportunities.



SEL primary and secondary care interface

NHS South East London Integrated Care Board
(ICB) 16 July 2025

1. Background and recent progress

- 1.1. The interface between primary and secondary care is one of the key channels through which patients and their care flow. It needs to be patient focussed, delivering the best possible experience of care and clinical outcomes whilst ensuring that there is efficient use of resources.
- 1.2. However, frustrations are common with all stakeholders having to contend with complex processes, multiple touch points and duplication, at times inadequate communication with poor transfer of information, failure to make use of all the expertise in the system at the right time and poor use of patients' and clinicians' time. It is not always clear to patients where to seek help and how to access advice at the right time and it may be unclear where responsibilities should be, for instance around prescribing and drug monitoring.
- 1.3. In May 2023 NHSE stipulated 4 areas for particular focus in its delivery plan for recovering access to primary care (onward referrals, complete care, call and recall and clear points of contact), and asked ICBs to establish local mechanism to address high priority issues.
- 1.4. In 2023 we undertook discovery work including stakeholder engagement in primary and secondary care; themes are summarised in appendix 1. This validated the national priorities and highlighted a number of other areas identified as areas of particular challenge, many of which impact on patient experience and, potentially, outcomes.
- 1.5. Over the last 18 months local interface groups have been established with representation from all acute providers and boroughs, the four groups being as follows:
 - Lambeth and Southwark/GSTT/KCH (Denmark Hill)
 - Bromley/PRUH
 - Lewisham/ UHL
 - Greenwich and Bexley/QEH

- 1.6. All four groups are represented at the System Interface Group which brings together learning and identifies system-wide priorities requiring a collaborative approach. This meets bi-monthly and is chaired by the ICB Medical Director.
- 1.7. A key priority has been the publication of a system primary and secondary care interface consensus document which describes agreed principles around working where patient care is moving across the interface.
- 1.8. Each group has made significant progress in the priority areas, particularly around onward referral and the issuing of fit notes. As described below, specific workstreams have been established to progress these and other priority areas. As well as formal meetings, informal face to face events have been arranged which are helping to strengthen working relationships between primary and secondary care clinicians. Areas of particular local progress include:
 - Publication of local guidelines with regards to onward referral and issuing of fit notes.
 - Ongoing work to develop specific guidelines for discharge summaries.
 - Development of clinical guidelines for provision of specialist advice from primary to secondary care, and for the management of patient results and follow up.
 - The appointment of consultants to primary care liaison roles in Bromley.
 - The roll out of a letter sent to clinical teams when inappropriate requests are made from secondary to primary care in Lewisham and Greenwich.
 - Publication of a local interface working consensus document in Bromley.
 - Regular formal and informal meetings, both virtual and face to face, to build relationships and strengthen cross-interface working.

2. The SEL primary and secondary care Interface document

- 2.1. Some of the challenges encountered at the interface are related to a lack of clarity around agreed pathways and specific roles and responsibilities. Where there was ambiguity or uncertainty we wanted to co-produce a document for SEL which describes agreed ways of working with a particular emphasis on improving patient experience.
- 2.2. A draft document was produced in November 2024 drawing on local feedback as well as examples of principles from elsewhere. This was shared with stakeholders from all acute and mental health providers trusts, primary care, commissioners and Healthwatch.
- 2.3. Successive rounds of iteration culminated in a workshop in April 2025 where the principles were discussed and areas for further development identified including agreement around specific workstreams. The document has been agreed at the System Interface Group, the SEL ICB Clinical and Care Professional (CCP) Committee and the ICB Executive Committee
- 2.4. The document is attached in appendix 2. As well as addressing the 4 national priorities, a number of other domains are included representing agreed local priorities. These include:
 - General principles
 - Onward referral (ensuring that GPs are not expected to make referrals that would be more appropriately done in secondary care),



- Communication, including discharge summaries, outpatient letters and fit notes.
- Call and recall (arranging follow up tests and appointments).
- Principles of referral.
- Supporting patients while waiting and managing expectations.
- Advice and guidance.
- Prescribing and discharge medicines.

- 2.5. The principles are intended to be as clear and unequivocal as possible, with the document's brevity designed to maximise exposure. Some of the principles are not yet achieved but represent agreed target standards as services and pathways are improved. There are a number of domains which will be further clarified or developed over time, for instance the timescale within which patients can be expected to be informed of an appointment.
- 2.6. The document will be published online. This 'live' document will be periodically updated as process, pathways etc. are developed and as we get feedback from stakeholders. The document has been produced with reference to available patient engagement work and with the involvement of Healthwatch. Our intention is to test the principles further with patients and, ultimately, to publish a patient-facing version which details the standards of care that they can expect at the interface.
- 2.7. This document can only have impact if it is visible and the principles are shared and reinforced widely. We are working on a communications approach which will include webinars as well as attendance at face to face and online meetings in secondary and primary care.
- 2.8. A number of organisations have already expressed interest in including the principles in induction programmes, e.g. for resident doctors and consultants, and we will work with system partners to support this.
- 2.9. Although the document has a current emphasis on pathways between general practice and acute providers we will work with mental health and community providers to ensure they represent interfaces more broadly.
- 2.10. It is critical that we ensure continued visibility of the document and respond to feedback. We are about to pilot a new tool which will allow clinicians to easily raise concerns and give feedback about interface working. As well as making it easier to report specific issues, this will also allow people to make suggestions about how interface working and the document can be improved. We are exploring how we can build in an innovative component that would provide real time updates on data received and thematic breakdown. A more detailed breakdown of feedback and action taking will be published regularly.

3. Patient engagement

- 3.1. As we embark on the next stage of this work, we will be working with system partners to develop our understanding of patient experience as their care moves between healthcare providers. Our work to date has drawn on previous exercises, including a London-wide deliberation programme in 2024. As we undertook our initial discovery work, a frequent reflection was that patient engagement was not always undertaken

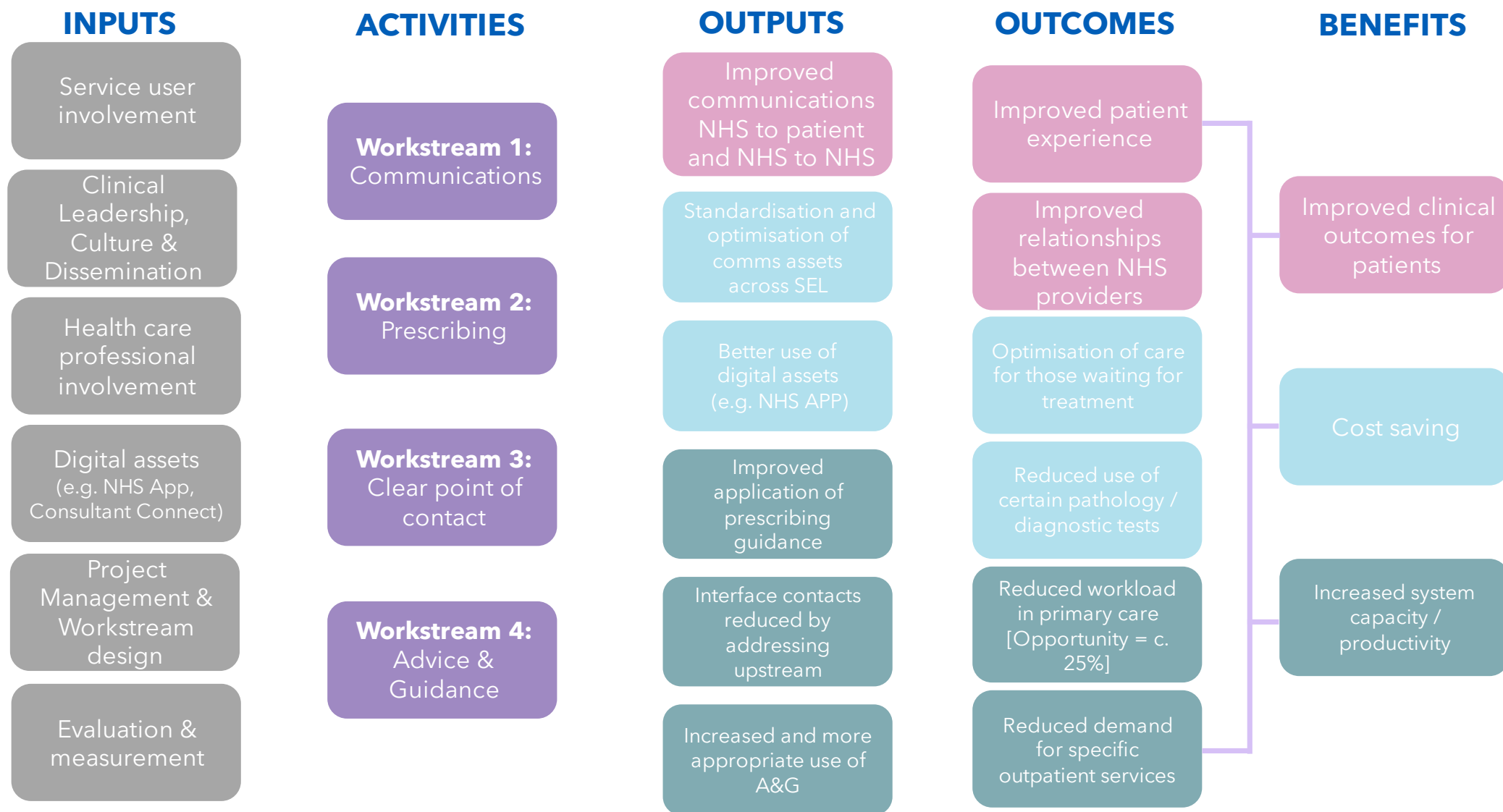


meaningfully or at the right time, and our view is that it is essential that we get it right for patients as we make improvements. Over the next 6 months we will be talking to patients in primary and secondary care to hear their experiences, in particular with regards to communication. This will inform further work, in particular the development of guidelines with regards to clinic letters and discharge summaries. With the centrality of the NHS App in the NHS Ten Year Plan this help us ensure that we are better informed as to how patients would like to be involved in their care

4. Next steps

- 4.1. We have identified a number of priority workstreams which have now been established with the support of the South London Health Innovation Network. Each of these, led by one of the Medical Director team, will involve further patient and stakeholder engagement. They will take an evidence-based approach based on clear problem definition and validation with patients and clinicians. This programme is supported by the South London Health Innovation Network. Specific workstreams are as follows:
 - Communications: a focus on discharge summaries and clinic letters, and how they are received both by clinicians and patients. The workstream will make use of user research to design, agree and implement a set of standards for these communications, which can be adapted to digital systems within all providers across SEL.
 - Prescribing: a focus on the existing interface prescribing policy and its application. The workstream will start by defining the problems with prescribing at the interface and understanding existing use of policies and the SEL formulary.
 - Clear point of contact: a focus on non-clinical communications for administrative functions and ensuring that patients and clinicians can navigate easily to the information or department they require. This will include understanding current issues with this type of communication, what information is required when, and what is driving the need for these points of contact.
 - Advice and guidance: this workstream will support the ICB's Planned Care Team and Acute Provider Collaborative to spread and embed best practice use of Advice & Guidance across SEL.
- 4.2. Over the next 12 months we will continue to develop local solutions to the priority areas described above and work with patients and staff across our system build on achievements to date. As the ICB transitions to the new model set out in the Model ICB Blueprint we will work with our boroughs to ensure that local priorities are supported and that where system-wide solutions are required we will continue to work collectively.
- 4.3. We will introduce mechanisms for more accessible and robust monitoring of the impact of these changes with a view to demonstrating sustainable improvement. As local groups develop, we will ensure sharing of best practice with a view to learning from each other to deliver the best possible patient care across the interface.
- 4.4. We will work with mental health and community providers to ensure that guidelines work for health professionals and patients in all settings. As we develop neighbourhood health services across our system, we will use these foundations to ensure we take a patient-focused, agile and adaptive approach to ensuring the development of seamless, patient-focused pathways.

Figure 1: draft logic model describing drivers of improved interface working



Appendix 1: Thematic summary of issues identified in initial discovery work

Patient-focussed: these relate to the patient experience of moving between primary and secondary care and the potential impact on outcomes of care. Opportunities include:

- Improving experience of waiting to minimise adverse impact on patient outcomes and wellbeing.
- Making it easier to access the right advice from the right service/provider at the right time.
- Reducing adverse patient experience of moving between services.
- Ensuring patient information moves with the patient to minimise the need for repetition.
- Ensuring patients are engaged early in service improvement and redesign.

Operational: these are issues which create additional work in the system due, for instance, to inefficient processes or suboptimal communication. Opportunities include:

- Making internal referrals directly rather than requiring it of the GP.
- Ensuring the information in communication such as discharge summaries and outpatient clinic letters is clear with clarity of requested actions from primary care.
- Clearly defining responsibility for accessing and communicating investigation results and ensuring that patients know when and from whom to expect them.
- Offering GPs access to expert advice which is consistently reliable and accessible.
- Removing redundancy and unnecessary choice in referral pathways so that patients get referred to the right place, first time and removing unwarranted variation in thresholds for accepting referrals.
- Getting the best possible value from feedback data in the recognition of key themes and identify opportunities for improvement.

Process and pathway design: these relate to areas where we might enhance our approach to process and pathway improvement and transformation. Opportunities include:

- Exploring how we might standardise approaches to pathway and service design through a recommended portfolio of tools and techniques.
- Giving staff access to opportunities to develop skills in complex service design.
- Exploring how we can ensure there is time and resource in our system to tackle complex problems.

- Agreeing principles to ensure that all stakeholders are engaged in problem definition and solution identification, with a particular focus on the patient's experience of care, whilst avoiding assumptions about user experience.
- Creating a network of clinical and care professional leaders in SEL where it is easy to find the right help and build productive collaborations.
- Designing referral criteria and pathways that are consistent and recognise the needs of both referrer and provider.

Cultural: these are areas of focus for building productive and collaborative relationships across the interface. Opportunities include:

- Establishing forums at system and/or place which enable identification of key issues across the interface with prioritisation and implementation of actions.
- Ensuring that organisational structures and governance are clearly visible, described and navigable to those leading change projects.
- Enhancing mutual understanding of clinical and operational pressure across organisational boundaries.
- Building in feedback systems and loops that allow rapid iteration of pathway and process improvement.

Appendix 2

SEL Primary and Secondary care interface consensus document

General principles

1. Treat all colleagues with respect.
2. Keep the patient at the centre of all we do. All interactions with patients should add value.
3. Clinicians should seek to undertake any required clinically appropriate actions themselves within the limits of their professional competency.
4. Ensure patients are kept fully informed of their care and next steps in their pathway. Patients should know who is responsible for the next stage of their care, when their next appointment is and who to contact in the event of delays.
5. Where possible speak to colleagues directly if in doubt. A clinical conversation/communication could enable a real-time solution for patients which may avoid onward referral. .
6. Take appropriate responsibility for tests or actions that may need to be done in the future.
7. There should be a shared health promotion agenda across primary and secondary care interface.

Specific domains

1. Onward referral

- 1.1. Consultants will arrange onward referral without referring back to the GP where appropriate. This may apply to ongoing management of the same condition, an unresolved diagnostic pathway or a need for urgent advice (such as cancer).

2. Communication (Discharge summaries, clinic letters and fit notes)

- 2.1. All clinical and patient communications will comply with the agreed standards.
- 2.2. All secondary care services will issue fit notes when needed, covering the period of any episode of care. Extensions will be issued by the patient's own GP team.
- 2.3. For patients who self-discharge or leave a clinical pathway against advice, secondary care will produce clinical communication to conclude that episode of care.
- 2.4. If a patient does not attend an outpatient appointment, the clinician will attempt to reach them by telephone before recording as DNA.
- 2.5. Secondary care will ensure clear and timely communication to the GP following every patient contact. Secondary care should send discharge summaries within 24 hours of discharge; and clinic letters within 10 days of the episode of care.

3. Call and recall (arranging follow-up tests and appointments)

- 3.1. Clinicians who organise tests are clinically accountable for tests and communication of results with patients. There may be local variation depending on commissioning arrangements (for example, new diagnosis of diabetes mellitus by Mental Health teams will require referral back to GPs).
- 3.2. Where patients are under shared care, guidance should be followed with regards to surveillance such as blood monitoring. Where there is lack of clarity, guidelines should be developed or adapted.

4. Points of contact (in both directions)

- 4.1. Hospitals and primary care teams (GP, PCNs) will provide a simple, clear and equitable point of contact for queries from patients, hospitals, primary care and other services.

5. Principles of referral (including rejection vs advice)

- 5.1. GPs will make the intended outcomes clear, including patient expectations, when referring patients to secondary care.
- 5.2. Primary care assessments should be completed when referring to secondary care.
- 5.3. Patients must have consented to, and be clear on the reasons for referral.
- 5.4. When patients are referred for surgical intervention, GPs will continue to optimise long-term conditions management.
- 5.5. Up to date, simple and easy to navigate directories of services and management guidelines will be available across the system.

6. Supporting patient expectations whilst waiting

- 6.1. For patients referred to secondary care, an approach of 'Waiting Well' will be taken.
- 6.2. On receipt of a referral, secondary care services will send the patient an appointment as quickly as possible, agreeing a time or letting the patient know about the waiting time.
- 6.3. Whilst waiting for a first appointment, it will be clear to patients who they should contact for general information and in the case of any deterioration.
- 6.4. Provider services will have publicly accessible data regarding waiting times.
- 6.5. Patients will be offered a simple way to make changes to appointments taking into account reasonable adjustments and without delaying access to care.

7. Advice and guidance (including telephone advice)

- 7.1. Before making a referral from primary care, GPs will consider whether existing clinical guidelines, written advice and guidance or a telephone call could avoid a referral.
- 7.2. Secondary care will always provide clear guidance on their reasons for declining a referral and advise on an alternative clinical pathway.



8. Prescribing and discharge medicines

- 8.1. The clinician who wishes to prescribe a new medication for the patient, will undertake appropriate pre-treatment assessment and counselling with the patient and outline the need for ongoing prescription to the GP.
- 8.2. Medications that are required immediately will be prescribed during that clinical consultation.
- 8.3. New medications prescribed during a clinic consultation, or discharge medications after hospital admission, will cover an initial period of at least 14 days, or longer as locally agreed.
- 8.4. Primary and secondary care teams will use the [SEL Interface prescribing policy](#) , [SEL formulary](#), and Discharge Medicines Service to support efficient prescribing of medications.
- 8.5. When recommending ongoing prescribing from the GP, secondary care will first check locally agreed prescribing formulary and reference relevant shared care agreements.

ICB Board meeting in Public

Title	Delivery of our Integrated Care Strategy: Review of Winter – Urgent & Emergency Care (UEC)				
Meeting date	16 th July 2025	Agenda item Number	12	Paper Enclosure Ref	L
Author	SEL Urgent & Emergency Care Team				
Executive lead	Sarah Cottingham, Executive Director of Planning				
Paper is for:	Update	x	Discussion	x	Decision
Purpose of paper	For information and assurance. The paper outlines our key winter priorities and areas of focus for 2024/25 in relation to urgent and emergency care services, summarises our performance over the winter period and sets out our system learning. It also details work to date to prepare for winter 2025/26 at both local and SEL level.				
Summary of main points	The paper provides an overview of winter planning conducted for 2024/25 which was coordinated through our three local UEC Boards – (i) Bexley, Greenwich and Lewisham, (ii) Bromley, and (iii) Lambeth and Southwark. This included SEL UEC Board oversight and review of winter and recovery plans. Winter planning was supported by the annual system-wide UEC winter workshop involving Place-based and SEL teams, providers and clinical staff. Local UEC Boards also identified risks and mitigations for each local system to support planning. Key areas of focus for winter included: • A system-led approach to developing a consistent Criteria to Admit (CTA) approach, with all SEL Trusts completing a CTA audit. • Implementation of a single point of access pilot for the London Ambulance Service (LAS) for Urgent Community Response teams, which included training webinars to LAS, Pendant Alarm and care home colleagues, • The implementation of NHSE Mental Health Flow action cards which were further enhanced by our local Clinically Urgent Transfer Protocol enabling us to identify mental health patients who urgently required transfer from the Emergency Department (ED) into a mental health bed. • A SEL communications campaign aimed at helping people find their way to the right care was piloted, which underwent significant testing with focus groups before launch. • The continued implementation of our urgent and emergency care improvement plans over the winter period (such as Same Day Emergency Care pathways), underpinned by additional winter initiatives to support us in responding to winter demand. • The proactive identification of key risks and mitigations. As part of winter planning, our System Co-ordination Centre (SCC) monitored and coordinated the real time management of system and winter pressures, including ensuring all escalation protocols were fit for purpose. SEL undertook significant review and development work in relation to these escalation processes as part of its winter planning preparation. In support of collaborative working across winter, tools				

were developed to support the escalation process, such as the mental health and acute trust action cards developed in collaboration with providers and clinical leads to reduce delays and manage emerging issues across SEL. As part of the operating model already in place across SEL, the SCC provided 24/7 operational coverage via standing daily meetings with providers including weekends and on-call overnight.

An overview of SEL winter 2024/25 performance is also provided in the paper, with the system having achieved 75.7% performance against the national 4-hour target of 78% in March 2025.

In summary:

- Performance was variable, noting Kings Colleague Hospital achieved their trajectory throughout the year and Guy's and St Thomas' Trust delivered their year-end trajectory.
- Overall performance fell below trajectory from September 2024 through to March 2025. Winter performance was, however, better than in 2023/24 and improved monthly from December to March.
- There was an increase in the number of 30+ and 60+ minute ambulance handover delays reported in the latter half of the year, and an increase in the number of patients in hospital staying over 14 and 21 days over the winter period.

Trusts reported that the issues impacting on performance over winter related to in-hospital flow challenges, delayed discharges, high bed occupancy rates, waits and congestion in our Emergency Departments including for mental health patients requiring admission, staffing issues and surges in demand and ambulance arrivals.

Each local UEC Board has subsequently carried out a review of winter to identify what worked well and areas of challenge across their systems. Lessons learned will feed into operational and winter planning for 2025/26.

Key learning points from winter included:

- The benefit of monthly UEC recovery meetings held with local system leads and the SEL SROs for UEC, which enabled effective month-by-month reflection of what was working and what required further actions/risk mitigation.
- Allowing for more time to plan for winter, which has been reflected in this year's timing of our SEL winter workshop, which will take place in mid-July.
- Building from the significant UEC improvement work that took place across SEL over winter and which is now continuing. This includes some material changes in the way estates are used including for example, the multi-speciality Same Day Emergency Care unit at Denmark Hill and the opening of the Urgent Treatment Centre at University Hospital Lewisham.
- The benefit of the enhanced clinical and operational leadership in UEC that we secured in 2024/25 and as part of our winter planning work has enabled us to provide regular development, testing and review of improvement actions and evidence-based pathways.

We have now started planning for winter 2025/26, with a SEL planning workshop scheduled to take place on 11th July to kick start this process. In addition, a NHSE Regional UEC event is taking place on 15th July on winter preparedness which we will be participating in as a system. Focus will also be given to our 2025/26



	operating plan which covers year-round performance trajectories and pathway improvements. We have sought to streamline and prioritise our UEC improvement plans for 2025/26 to ensure a concerted focus on fewer high impact actions that will support flow and performance, better enabling teams to combine improvement work with effective UEC pathway management over the winter months. Key priorities include maximising alternatives to EDs, embedding Criteria to Admit, improving in-hospital flow and discharge and mental health crisis pathways. The national Urgent and Emergency Care Plan for 2025/26 has recently been published and this sets out key priorities for systems including specific winter deliverables and expectations. Our plans will include a consideration of the actions and approaches required to deliver on these in SEL. NHSE will also require that winter plans are developed and tested and signed off by every Board and Chief Executive within each system.					
Potential conflicts of Interest	None					
Sharing and confidentiality	N/A					
Relevant to these boroughs	Bromley	x	Bexley	x	Greenwich	x
	Lambeth	x	Southwark	x	Lewisham	x
Equalities Impact	UEC pathway improvement seeks to ensure equity of access, experience and outcomes for urgent and emergency care services in SEL.					
Financial Impact	Funding for UEC and winter is built into our start year plans and budgets.					
Public Patient Engagement	Previous engagement on UEC as part of our Joint Forward Plan engagement.					
Committee engagement	SEL UEC Board and our three local UEC Boards covering Bexley, Greenwich and Lewisham, Bromley and Lambeth and Southwark oversee our annual UEC planning process and winter plan development. The ICB Executive received regular updates on winter pressures and performance and formally reviews performance on a monthly basis. Regional assurance processes take place annually to review system winter preparedness.					
Recommendation	For information, noting further updates can be provided as the system develops its winter plan over the summer months.					



ICB Board Meeting Urgent & Emergency Care – Review of Winter 2024/25

16th July 2025

Winter 2024/25 - Plans & Risks

SEL Winter 2024/25 – Summary

- **Winter planning process** coordinated through our three local Urgent and Emergency Care (UEC) Boards - Bexley, Greenwich and Lewisham (BGL), Bromley, and Lambeth and Southwark (L&S), covering whole UEC care pathway, physical and mental health.
 - Winter plans include the continued delivery of our **start year UEC improvement plans**, which are focussed around a combination of work to address local challenges and issues and the delivery of overarching national and SEL priorities at a local level.
 - They further include a specific consideration of further **winter initiatives** which would add value in terms of helping support local systems in addressing winter pressures, inclusive of agreed additional funding.
 - Our winter planning processes further include a **SEL oversight and review** of winter and recovery plans, which was supported by an annual system-wide UEC winter workshop which brings all local UEC Boards together to share learning, discuss priorities and consider risk and mitigations.
- **Our SEL System Co-ordination Centre (SCC) monitored** and coordinated the management of system and winter pressures, including ensuring all escalation protocols were fit for purpose for the winter.
 - Clinically led work with each of our Mental Health (MH) and Acute Emergency Departments (EDs) enabled us to implement the **NHSE MH Flow action cards** with both system and operational actions to improve our management and oversight of MH patients waiting in ED. Action cards covered adults, older adults and children and young people as well as those with complex learning difficulties and/or on the autism spectrum. Action cards were further enhanced by our own local Clinically Urgent Transfer Protocol which enabled identification of mental health patients who urgently required transfer from the ED into a mental health bed.
 - In a similar way, we implemented **internal and system flow action cards, developed with each of our Acute Emergency Departments (EDs)**. This has enabled better comparison of pressures by site and supported the SCC in responding to requests for mutual aid across SEL.

SEL Winter 2024/25 – Summary

- As part of our winter planning we agreed three key areas of **system wide work** focussed on pathway change and improvement, the piloting of a single point of access and communications as summarised below:
 - System-led approach to **implementing Criteria to Admit (CTA)** – all Trusts completed a CTA audit. We have put into place a clinically-led CTA programme across SEL which will continue into 2025/26, to improve flow and systematise admission protocols.
 - **Urgent Community Response (UCR)** – implementation of a single point of access (SPOA) winter pilot for London Ambulance Service (LAS), 4 UCR training webinars to LAS, Pendant Alarm and care home colleagues, plus Provider led targeted care home visiting learning and sharing initiatives and the establishment of a LAS/UCR shadowing initiative.
 - SEL **communications campaign** aimed at helping people find their way to the right care was piloted in Lewisham from January – March before evaluation and wider roll out. The campaign underwent significant testing with focus groups.
- Over the winter period, over and above real time system management coordinated by the SCC, significant **performance monitoring and management** of key performance metrics against plan is undertaken nationally, regionally and locally.
 - As part of this we also **review the delivery of our winter plans** and determine any required recovery action.
 - We also keep a close focus on **risks and mitigations**.
 - We seek to **capture learning** to inform future planning, to ensure that learning is reflected in both our start year UEC plans and priorities but also in our future winter planning.

Recognised 2024/25 Risks and Mitigations – SEL Wide

Our planning includes a key focus on risks and mitigations. Local UEC Boards identify risks and mitigations for the local system which are provided in the appendix. A consolidated overview of our key SEL-wide system risks and mitigations is then drawn from these local assessments as set out below.

Risks	Mitigations
Demand – risks around increased demand over winter that make Emergency Department (ED) front door and wider management of demand and flow challenging. Specific challenges paediatrics (known seasonality), Mental Health (MH) crisis, wider seasonal demand e.g. flu/respiratory.	Communications campaign - signposting alternatives to ED. Specific consideration of Children & Young People (CYP) winter planning requirements. MH crisis – improved management of patients in community settings, use of crisis alternatives, timely discharge from EDs, MH Action Cards. Vaccination - focussed campaigns around flu/Covid to maximise uptake. Capacity - additional capacity to meet increased winter demand.
Flow – risks around care pathway flow resulting in ED congestion, lack of flow through the UEC pathway, exit block from ED and from hospital settings.	UEC improvement actions - optimising ED streaming, attendance and admission avoidance, Same Day Emergency Care (SDEC), medical/surgical assessment and admission, length of stay and discharge improvement, plus Criteria to Admit (CTA) development work. MH crisis improvement – maintain 72-hour improvement and further reduce ED waits, alternative pathways, admission, length of stay and discharge improvement.
Quality, safety and resilience – historic challenges over the winter period, improvements over the first half of the year insufficiently embedded to guarantee sustained delivery, risk of non bedded areas being bedded when under pressure, fragility and variation across sites going into winter, enhanced quality and safety risks from long waits in ED, admission delays and overcrowding.	New pathways/facilities designed to avoid scope for bedding. Continued push and focus on UEC improvement plan actions over the second half of the year. Effective and timely system management, including implementation of action cards, with real time monitoring, management and escalation, whole pathway management and smoothing of demand/pressures across sites.
Resourcing constraints – lack of additional winter pressures funding and wider financial constraints, lack of bandwidth to drive forward improvement alongside day-to-day demand and pathway management, risks around staffing availability/shortages.	Focus on process/pathway improvements within existing resources. Targeted use of available funding based on previous impact evaluations of winter pressures initiatives. System support to help secure improvement plans. Workforce planning including staff vaccination.

Winter Review – What Worked Well

Local UEC Boards carried out an annual review of winter, feeding into a SEL-wide discussion at the SEL UEC Board and Winter Workshop. Lessons learned feed into operational and winter planning for the following year. Local system actions and anticipated impact are set out in the appendix.

Bromley/PRUH system

- **Winter Illness Hubs** - 9,444 patients seen
- **98% UTC performance**
- **Flu vaccination:** Highest in SEL – 53.4% general, 79% care homes
- **Digital/Comms:** Record web hits; increased
- **Pharmacy First use**
- **Hospital at Home** - daily patient capacity grew to 596, virtual ward occupancy >75%
- **Admission Avoidance:** 21% reduction in LAS conveyances
- **Falls Bundle launched**
- **Voluntary sector Post-Discharge Support:** 765 welfare calls, 194 visits, 79 received ongoing support

Lewisham/UHL system

- Improved **discharge passports**
- **Early and proactive planning** helped prioritise high-risk patients
- **Key services** like SDEC, NHS@home, Transfer of Care (TOC) Hub, Pharmacy First PLUS, and the Redirect service supported flow and reduced pressure on emergency care
- **Extra therapy staffing** in high-need areas; stable workforce in the complex discharge team
- **Stronger GP/ASC relationships** improved care coordination and continuity
- **Joint working across pathways** e.g., LGT therapy, LIMOS, D2A, SLAM, and GPs
- **Regular MDTs** and therapy meetings enabled better care coordination and reduced hospital admissions
- Quick **access to funding**.

Lambeth & Southwark/GST/DH system

- **Protecting Front Door:** used urgent community response (UCR) and virtual wards to manage patient flow and reduce unnecessary ED visits
- **Single Point of Access (SPOA):** establishing a SPOA; improving wound care and catheter pathways
- **Expanded/improved discharge lounges** - expansion on both sites enabled increased capacity

King's DH/ Southwark

- **Safety at Home scheme** – continued implementation, length of stay (LOS) reduction of 2-3 days
- Co-location of **SDEC** – expanded opening times and additional capacity

GSTT/ Lambeth

- **SDEC relocation** – increased capacity.
- **Additional Flow Coordinator** – Three new posts; 890 avoidable breaches intervened (Dec '24 - Mar '25)
- Edward Ward – **additional bed capacity** to absorb winter pressures

SLAM

- Schemes supported **step down and discharges** to meet discharge targets

Bexley & Greenwich/QE system

- **Improvements in governance**, focusing on reporting, trajectories, and actions related to those trajectories
- **Reviewed discharge incentives** to improve understanding and relationships
- Ran a **daily TOC hub** during Super March, which has been made permanent with funding
- **Shared data** through a dashboard and the implementation of a system to track actions against complex discharges
- **Understanding bed capacity** needs and the acute medical model business case to reduce length of stay
- Supported 122 patients, avoided 59 admissions via **early intervention and MDT screening**
- Working with hospital and community partners to **reduce length of stay** of clients in acute hospital setting

Winter Review – Challenges

Bromley/PRUH system

- Low **redirection rates from UTC** (IT)
- Use of **H@H for care residents** did not improve throughout winter
- **AFAU remained bedded** the majority of winter
- **Stroke demand** remained challenging
- **Paediatric short stay** bed impact
- Issues with **medication** was the consistent challenge identified in post discharge welfare calls
- **Lost capacity** and underutilised community provision in discharge pathways
- The **reach of the comms team** was restricted by limited capacity with planning starting too late
- Unknown residents presenting with underlying **social factors**
- **Low uptake of staff flu vaccination programme** and impact on workforce
- Maximising use of alternative care pathways from LAS

Lewisham/UHL system

- **Very high patient volumes** - limited and lack of rehab space; reliance on boarding, and pressure to maintain patient flow
- **Relentless pressure on staff** impacting on morale - expectations to maintain business as usual under extreme conditions
- **Poor IT access and outdated equipment** hampered clinical efficiency, especially for therapists
- **Delays in receiving and deploying winter funding** limited recruitment and support of additional staff
- **Community services** limited capacity
- Poor coordination of **flu vaccine delivery** led to low uptake, contributing to staff sickness and admissions
- Housing access particularly challenging out of hours, with long delays forcing reliance on pan-London services despite local capacity

Lambeth & Southwark /GST/DH system

- **Volumes and acuity** of patients continues to rise; increasing complexity in attendances/admissions offsetting any benefits made by good admissions avoidance pathways and flow
- All sites had low uptake of **staff flu vaccinations** and experienced **high rates of sickness absence**; work is needed to increase uptake in 2025/26

King's DH/ Southwark

- **Workforce** – winter workforce schemes a challenge due to time to recruit/on-board. Consideration of alternatives schemes, or use of existing staff to support with winter pressures
- **Staff Rosters** – Review staff rosters and alternative mix of senior decision makers over Christmas and New Year

SLAM

- Further focus needed on **mental health delays in ED** and plans to address
- Further work needed around **access and use of crisis support** for known patients

Bexley & Greenwich/QE system

- Significant improvement plans in place for UEC pathways which **required clinical pathway and cultural changes** which take time to embed making it challenging to make gains over winter.
- **ED demand and flow** resulting in a congested ED, with bed capacity, occupancy and flow driving delays in admission and requiring boarding onto wards to manage demand. Significant reliance on boarding over the winter period, with boarding becoming business as usual rather than an escalation measure.
- Lack of available resource to fund all potential winter initiatives with some delays in **agreeing funding or completing transfers of funding** with knock-on delays in implementation of agreed initiatives (e.g. recruitment).

Escalation Processes

- Significant national focus on system coordination and management of winter pressures through System Coordination Centres (SCC).
- National specification and delivery requirements.
- As part of this, a specific focus for winter 2024/25 was on setting clear escalation steps as pressures build alongside clarity as to actions to be undertaken in response to these pressures within providers and from the wider system.
- SEL undertook significant review and development work in relation to these escalation processes as part of its winter planning preparation.

A summary of SCC requirements and the processes through which pressures are monitored and managed daily:

- Operates under NHS England's Required Operational Standards (v3.0, Feb 2025).
- 24/7 operational coverage via standing daily meetings with providers including weekends and on-call team for overnights.
- Coordination across system partners for escalation, mutual aid, and performance oversight.
- Monitoring via enhanced national Operational Pressures Escalation Level (OPEL) framework which includes Acute, Mental Health and Community providers.
- Integrated data used by the team via real-time dashboards for urgent and emergency care metrics (UEC-RAIDR) – OPEL, ED and capacity related operational information, LAS system monitoring ambulance arrivals and calls awaiting response.
- Monitoring and improving mental health flow across acute and community settings.
- Management of tertiary repatriation escalations.
- Daily regional operational reporting, including 72-hour waits in EDs across SEL.
- Daily Situation Reports, weekly reviews, and post-winter debriefs for continuous improvement.
- Ability to access and utilise other SCC across England to support escalation needs.

The SCC works across the SEL system throughout winter responding to pressures and providing support. An example of the collaborative working for winter 2024/25 across SEL were the **mental health and acute trust action cards** developed in **collaboration with providers and clinical leads** to reduce delays and manage emerging issues across SEL (examples below).

Acute Trust Actions – as part of internal/external escalation



South East London

Additional Trust Actions expanding the National OPEL Acute trust actions

- ❑ Rigorous CTA checklist for each admission, including Consultant only Decision to Admit – and /or utilise the expertise of the Site Team as review of CTA Tool, assessing suitability for alternative pathways other than admission – 24/7
- ❑ Clinical Leads/Clinical Directors to perform 'Senior Support Round'/'Challenge and Confirm' Board Rounds on every ward, along with MDT consisting of Community Rep, Site Team Rep, Matron – to increase discharge profile – *In hours Only*
- ❑ Contact Transport Director to increase Transport availability – improve timeliness of transport to discharge patients – *In hours only*
- ❑ Contact Pharmacy to focus or put additional pharmacists to improve late notice turnaround of TTOs – *Daytime only 7/7*
- ❑ Increase/Expand Discharge lounge utilisation/criteria, supported by additional staff – Matrons to attend each ward, to review all patients going home, with aim that all patients go to discharge lounge, where clinically safe to do so, whether waiting hospital transport or their own transport. *During discharge lounge opening hours.*
- ❑ Temporarily extend the discharge lounge opening hours.
- ❑ Additional Housekeeping resource to clean beds and 'turn them around' for new admissions. *Daytime request made 7/7, outputs covering OOH too*
- ❑ Admissions to wards during meal-times, handover times, all other protected times to reduce capacity in ED. 24/7
- ❑ CTA Tool used, led by Clinical Lead/Site Team, of all patients on medical admissions awaiting core ward bed – to increase discharge profile from Med Assessment Units. 24/7
- ❑ ED Consultant and HoN to review list of patients in ED (or waiting for ED) to determine if suitable to transfer to UTC – 24/7
- ❑ SDEC Leads and HoN to review list of patients in ED (or waiting for ED) to determine if suitable to transfer to SDEC – 24/7
- ❑ Consider enacting, or prepare to enact, full capacity protocols (FCPs) to mitigate forecast G&A capacity deficit – 24/7
- ❑ External transfers in – place on hold unless life or limb threatening 24/7

SELICS MH Escalation Process for Adults and CYP

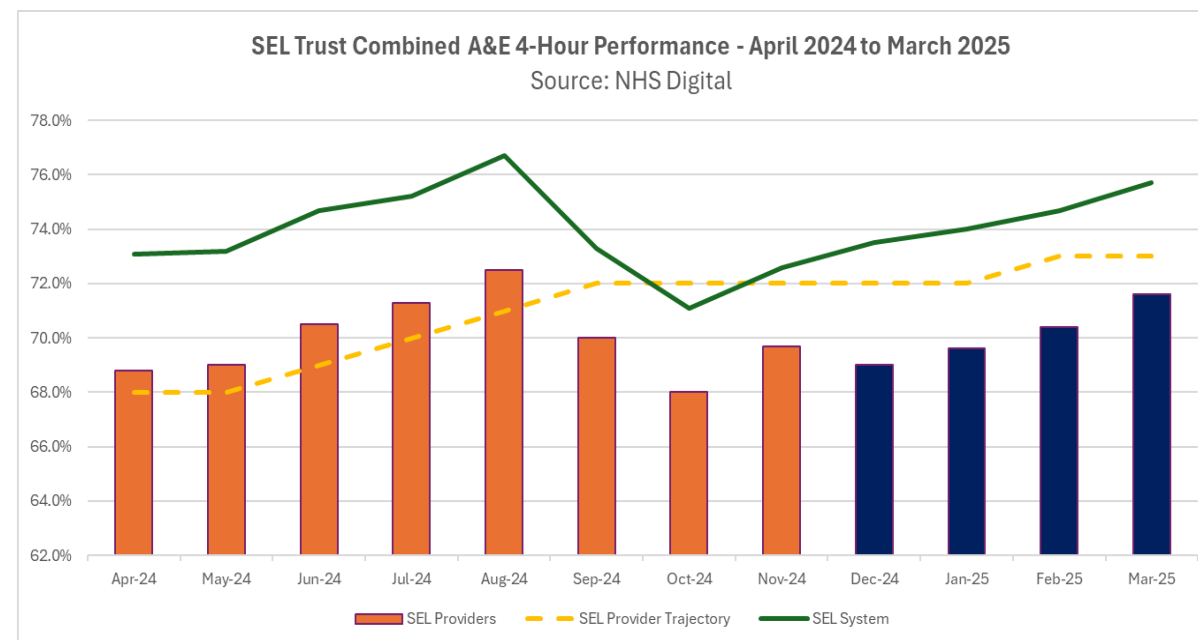
Acute and Mental Health Provider actions	
Pre-DTA	
In-hours - this includes weekends	- Any patients in ED longer than 12 hours awaiting either a decision or have a confirmed outcome must be highlighted to relevant Named Lead for > 12 hour waits. - For CYP: If accountability is disputed between Local Authority and CAMHS, post 24 hours, named leads from both organisations must work towards a resolution (escalating to COO level). After 48 hours, unresolved disputes are escalated to the SCC/ICB, which will facilitate discussions to determine responsibility. At 48 hours, if dispute persists, SCC will involve SEL ICB Gold or equivalent to work towards a resolution. - London Compact and Who Pays Guidance principles still apply and should be followed regarding senior escalation points. - If clinical disagreement exists – SEL SCC to speak to the SCC for where the disputed Trust resides, to ask that they request their MH providers to join a virtual mini case conference, to be organised by the Acute Trust Silver, for the clinicians to reach an agreement on treatment plan.
Post-DTA	
In-hours – this includes weekends	- SEL SCC chair twice daily MH calls 7-days a week. These calls are for discussing all MH (inc. CYP) patients with a DTA in ED or an in-patient ward and have completed their acute physical health care. - Calls are divided as: SLAM/DH/UHL/GSTT 10:15 and 15:00. Oxleas/QEH/PRUH 11:00 and 16:15. - Attendees at these calls are operational teams from both acute and MH providers, PLN team representatives, SCC members and senior managers from MH providers who can make appropriate decisions regarding patient plans. - Post-call the tracker is shared via email with operational teams and long wait leads at acute and MH providers, Acute and MH COOs, Acute and MH CEOs and ICB CNO/CMO – this is emailed twice a day by the team. - Any MH patients waiting longer than 72 hours are emailed to relevant MH and acute providers executive leads, ICB leads including chief nurse. This is also submitted to London UEC ROC via established routes. - In cases of disputed responsibility between a SEL MH Trust and/or an external MH Trust, the acute site and mental health trust must establish the patient's history and identify the responsible Trust or ICB within 24 hours. If the dispute persists beyond 24 hours, named leads from both organisations must work towards a resolution, potentially escalating to COO level. After 48 hours, unresolved disputes are escalated to the SCC/ICB, which will facilitate discussions to determine responsibility. At 48 hours, if dispute persists, SCC will involve SEL ICB Gold or equivalent to work towards a resolution.
Overnight Escalation	For patients with a DTA at risk of breaching the 12-hour standard overnight, a pragmatic approach should be followed: - Unless the patient fits the criteria of the 'Clinically Urgent Transfer Protocol' or if a dispute in ownership occurs, MH delays, due to lack of beds, will be picked up in the morning SEL SCC MH System calls, 7/7. - Should either provider have concerns overnight then a call should be made by the respective Director on call to the MH Director on call.

The above does not replace activation of the Clinically Urgent Transfer Protocol where applicable, which is a 24/7 response.
The above should not stand in the way of COO/CEO to COO/CEO calls if there are concerns around safety in EDs due to numbers of MH patients either waiting assessment or admission, or where disputes occur.

Winter Performance 2024/25

A&E 4-Hour Performance 2024/25

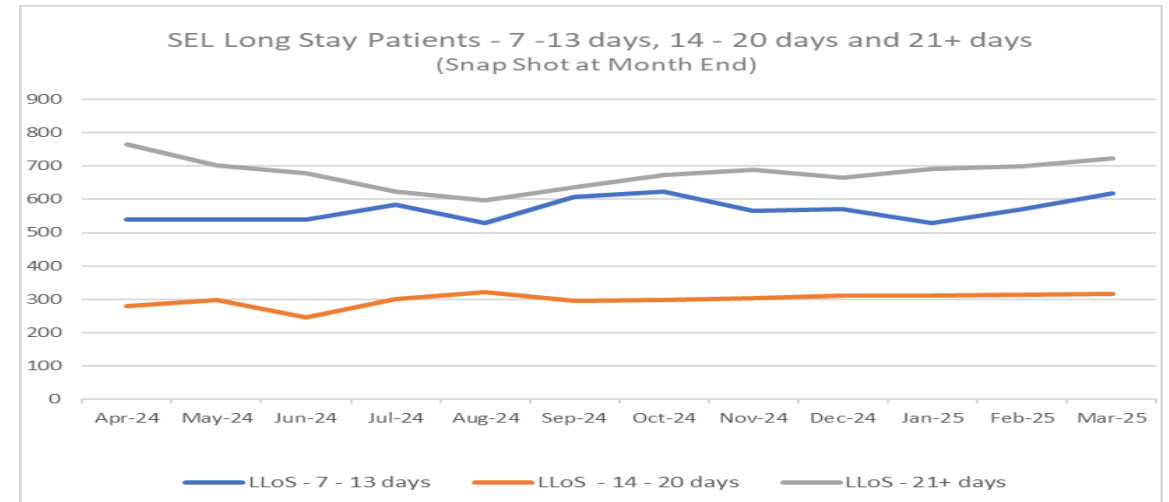
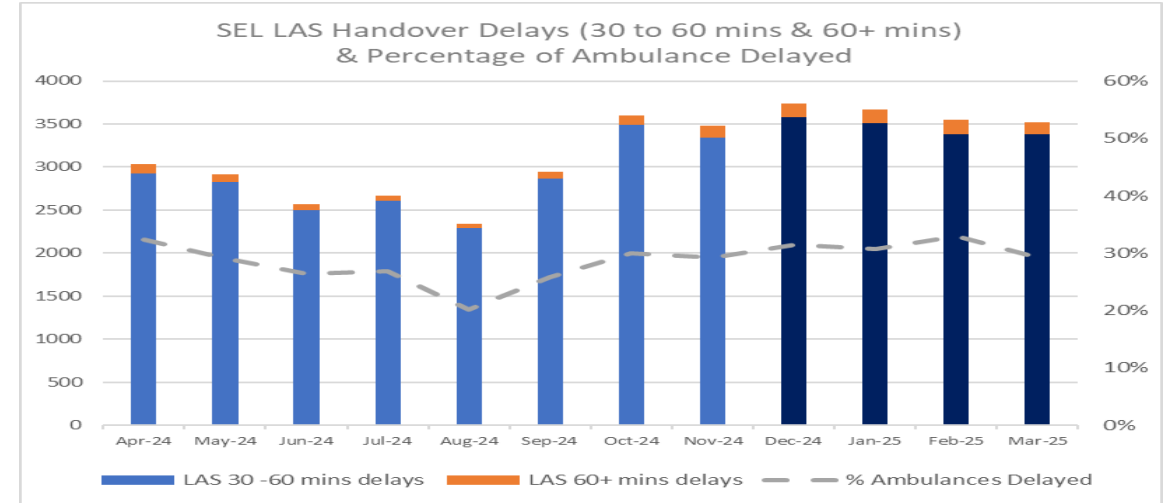
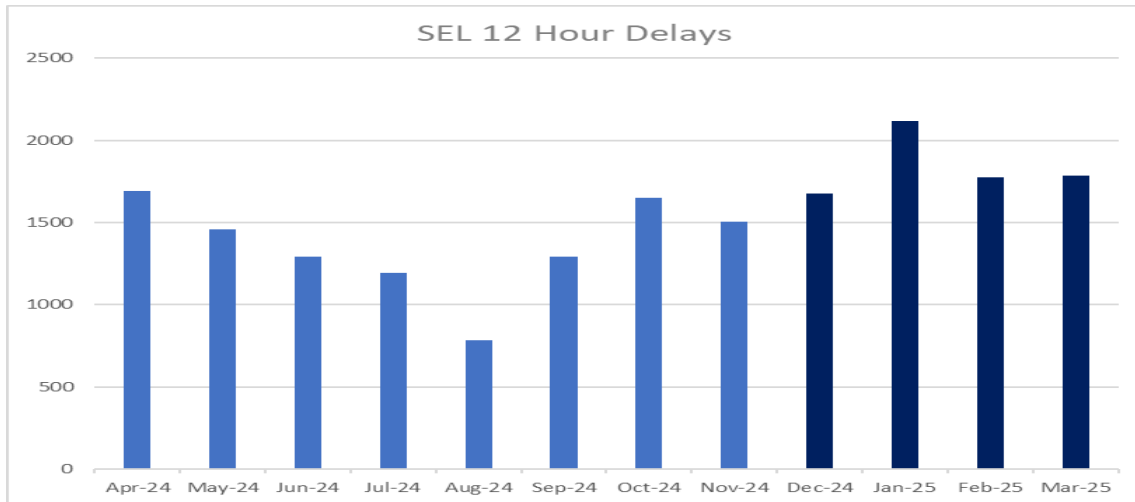
- Year-end performance for the SEL system was 75.7% against the national ambition of 78%.
- Performance trajectories for ED 4-hour performance were set at provider level in 2024/25. The graph to the right sets out performance against the aggregate trajectory for all SEL providers.
- Performance was variable by Trust, with King's achieving their trajectory throughout the year and GSTT delivering their year end trajectory.
- Performance fell below trajectory from September 2024 through to March 2025. However, winter performance was better than in 2023/24 and whilst SEL performance dropped in December a sustained improvement in performance was seen over the remaining winter months.
- System wide performance, which includes standalone UTC activity, tracked at around 4 to 4.5% above the combined acute trust position.
- Issues impacting on performance over winter included in-hospital flow challenges, delayed discharges, high bed occupancy rates, long delays in ED, particularly for mental health patients requiring admission, staffing issues and surges in demand and ambulance arrivals.



* Winter Months

UEC Supporting Metrics 2024/25

- Wider underlying UEC metrics demonstrated a deterioration over the winter months:
 - An increase in the number of 30+ and 60+ minute ambulance handover delays was reported in the latter half of the year. SEL saw an increase in the number of 12-hour plus ED waits over the winter months with a peak in January. In 2024/25 12-hour delays were measured from time of 'decision to admit' (DTA), this changes in 2025/26 to time of arrival in the department.
 - SEL reported an increase in the number of patients in hospital staying over 14 and 21 days over the winter period.



Key Learning from 2024/25

Key Learning Points from Winter 2024/25

- Throughout winter we held monthly **UEC recovery meetings** with local system leads and the SEL SROs for UEC, which enabled effective month-by-month reflection of what was working and what required further actions/risk mitigation with some supportive challenge to systems.
- There is a **varying picture of demand and acuity across SEL** - with February representing a month of low attendance demand followed immediately by high demand in March. There is an opportunity to consider how we manage peaks and troughs in demand most effectively, noting there is not always a clear correlation between demand and performance as evidenced by our Q4 performance trend.
- Last year the **SEL winter workshop** was held later in the year, following feedback the workshop for 2025/26 has been brought forward to mid July to enable systems more time to utilise and apply the learning from the event. Timing also aligns with work being undertaken at regional level with a winter preparedness workshop taking place in mid July.
- There was **significant UEC improvement work** that took place across SEL over winter and has continued. This has included some material changes in the way estates are used allowing for large scale change work including for example, the multi-speciality SDEC at Denmark Hill, and the opening of the UTC at UHL. This will support improved ED 4-hour performance and flow with the key benefits being felt in 2025/26.
- We have sought to **streamline and prioritise our UEC improvement plans** for 2025/26 to ensure a concerted focus on fewer high impact actions that will support flow and performance, better enabling teams to combine improvement work with effective UEC pathway management over the winter months.
- The benefit of the **enhanced clinical and operational leadership** in UEC we secured in 2024/25 and as part of our winter planning work, as evidenced by the trust and mental health action cards as well as local pathway work enabling us to provide regular review and interactive testing and development of improvement actions and evidence based pathways.
- Each year we **review the learning from winter**, at both local and SEL level, and this is integrated into winter planning for the following year.

UEC Improvement & Winter Planning 2025/26

SEL UEC Improvement Priorities 2025/26

- Our 2025/26 operating plan covers year-round performance trajectories and pathway improvement. In addition, in June 2025 the national UEC Plan requirements for 2025/26 were published and taking these forward will also be embedded in our plans. Our key collectively agreed system wider priorities for 2025/26 are summarised below, noting local Boards will be working to secure these as well as addressing locally agreed priorities. Winter planning for 2025/26 will build from these and our agreed performance commitments.

Maximising alternatives to ED

Test the opportunities of the Neighbourhood Health model in delivering UEC pathways out of hospital including optimising UTC, Virtual Wards and UCR, plus multi morbidity, frailty pathways and pathways for complex CYP.

Target pathway improvements/shifts focused on care that can be managed outside of ED (e.g. wound care and catheter management).

Maximise effective redirection from ED where appropriate, including consistent SDEC models for CYP.

Improving access to UEC

Consistent implementation and embedding of criteria to admit (CTA) tool.

Reduce 12-hour delays and reduce the gap between 12-hour waits for MH and physical health.

Optimise digital front door.

Consider viability and scope of Single Point of Access (SPoA) for urgent care pathways in SEL to support in year enhancement.

Improve access for urgent MH assessments including launching the MH UTC at SLAM.

Improving in-hospital flow and discharge

Embed the SEL discharge standards to deliver improvement in Discharge to Assess, and discharge pathway delays (for both simple and complex discharges) plus secure earlier in the day discharges.

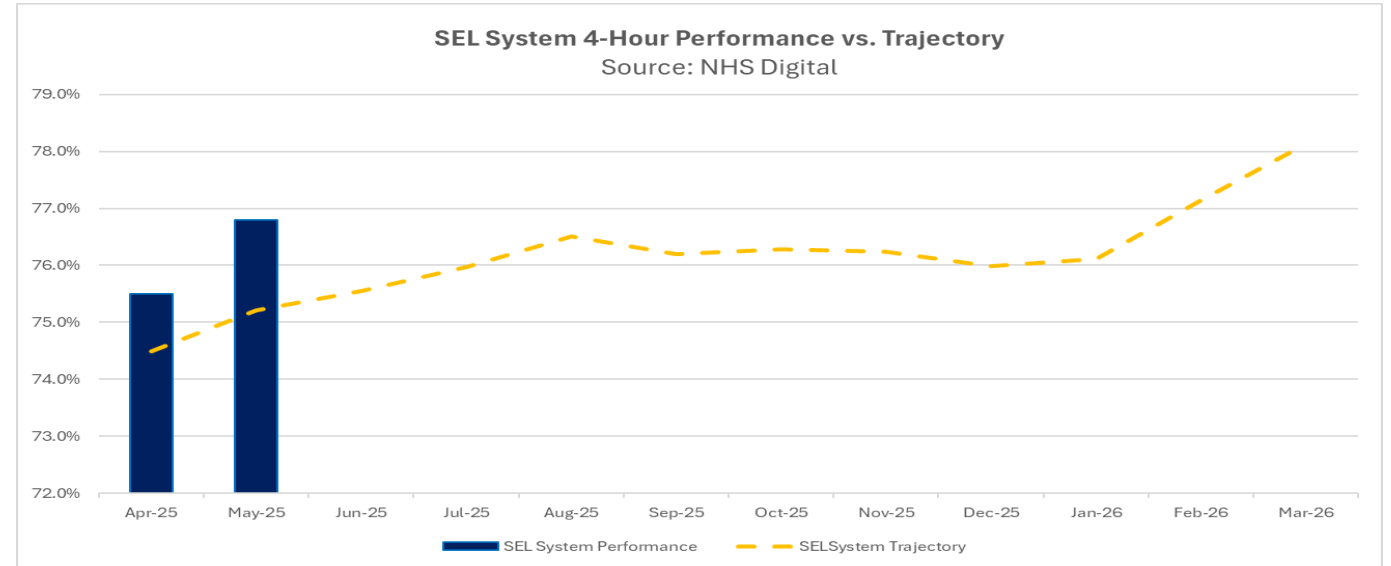
Improve Transfer of Care Hub processes and outcomes, including evaluation of investment in TOC posts.

Flow initiatives for Mental health including inpatient bed access and utilisation, purposeful admission, flow within ED (for MH) and CYP.

Expected Outcomes – which we will be monitoring over 2025/26 to assess the impact of our agreed improvement actions:

- Improved A&E 4-hour target, ambulance handover times, 12 hour waits and reduced gap between physical and MH waits
- Earlier in the day discharge, reduction in escalation beds and boarding, improvement in length of stay and reduced discharge delays
- Improvement in ED admitted conversion rate, increased use of alternatives e.g. SDEC, reduction in patients admitted >12 hours from arrival

- In 2025/26 the operational plan required trajectories for the following key UEC metrics:
 - A&E 4-hour performance – Trust & System level
 - 12-hour delays (from arrival in ED)
 - The number of patients discharged on their 'discharge ready date'
 - Average length of delayed day post Discharge Ready Date (DRD)
 - Average ambulance handover times
- 2025/26 is the first year that systems have been asked to provide a system wide (including standalone UTCs) trajectory for 4-hour performance. The SEL plan reflects the ambition to deliver the national expectation of 78% performance.
- We have performed above trajectory for 4-hour performance in April and May. Individual providers all delivered performance above their set trajectories in May.
- Providers were asked to commit to reducing ambulance handover times. We set very challenging trajectories in this area and have not met our planned handover performance year to date.
- All local systems have improvement plans in place to support delivery of all operational planning trajectories.



2025/26 Ambulance Handover Trajectories

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
GSTT	00:20:35	00:19:35	00:18:35	00:17:35	00:16:35	00:16:35	00:16:35	00:16:35	00:16:35	00:16:35	00:16:35	00:16:35
KCH	00:22:31	00:21:31	00:20:31	00:19:31	00:18:31	00:18:31	00:18:31	00:18:31	00:18:31	00:18:31	00:18:31	00:18:31
LGT	00:19:42	00:18:42	00:17:42	00:16:42	00:15:42	00:15:42	00:15:42	00:15:42	00:15:42	00:15:42	00:15:42	00:15:42

2025/26 Handover Performance (Published) - NHS England)

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
GSTT	00:21:42	00:21:50										
KCH	00:23:21	00:23:59										
LGT	00:22:00	00:21:38										

There are 3 key requirements in the national UEC plan and these are summarised below. These national requirements are being built into our local UEC improvement and winter plans (see appendix), including through our local and regional winter preparedness workshop.

Key requirements	Expected Outcomes
Focus as a whole system on 7 priorities to achieve improvements that will have the biggest impact on urgent and emergency care services this winter	Category 2 receive an ambulance within 30 minutes (such as those with a stroke, heart attack, sepsis or major trauma)
	Maximum ambulance handover time of 45 minutes
	78% minimum A&E 4 hour target
	Reduce 12 hour waits for admission or discharge from ED compared to 2024/25, so that this occurs less than 10% of the time
	Reducing the number of patients waiting in ED for longer than 24 hours while awaiting a mental health admission.
	Reduce delays in patients staying 21 days over their discharge-ready-date
	Seeing more children within 4 hours in ED
Develop and test winter plans to be signed off by every Board and chief executive within each system by summer 2025. <i>They must achieve a significant increase in urgent care services provided outside hospital.</i>	Improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19 to improve uptake by at least 5 percentage points (Nationally)
	Increase the number of patients receiving urgent care in primary, community and mental health settings , including the number of people seen by Urgent Community Response teams and cared for in virtual wards
	Meet the maximum 45-minute ambulance handover time standard
	Reducing patients waiting over 12 hours , and making progress on eliminating corridor care
	Set local performance targets by pathway to improve patient discharge times , and eliminate internal discharge delays of more than 48 hours in all settings
Stress test and refine plans in September 2025	Reduce length of stay for patients who need an overnight emergency admission by at least 0.4 days (nationally)
National improvement resource aligned to support areas that will have biggest impact	Additional National investment in: SDEC and UTCs (new centres); MH assessment centres and MH additional capacity; Expansion of Connected Care Records

Appendix

Overview of local system winter plans for 2024/25 and 2025/26 UEC Workstreams

Actions & expected impact

Action(s)	Expected Impact
All Places Increased focus on patient comms and care options Focus on intermediate care provision and virtual ward step down capacity Focus on escalation ways of working: relationships, protocols, joint roles	Admission / attendance avoidance LOS reduction
Lewisham / UHL Recruitment of front door redirection nurse SDEC growth Urgent care response increased capacity Commencement of care home liaison role Home First ward in reach Investment in discharge enabling roles	Attendance avoidance Admission avoidance, ED space freed up Attendance avoidance / LOS reduction
Bexley and Greenwich / QE UTC pathway maximisation SDEC expansion Expanded UCR offer Block booking of private beds for additional capacity Planning for additional 26 beds on QE site to be operational September 2025. Investment in joint discharge enabling roles	Attendance reduction, ED space freed up Attendance avoidance ED space freed/ boarding pressures reduced LOS reduction

Risks & mitigations

Risks	Mitigations
Insufficient beds to meet demand particularly on the QEH site	Focus on length of stay, discharge planning and internal and external delays for patients with NMCTR. Escalation beds open.
Balancing ED overcrowding with ward boarding and ambulance handover standards	Refreshed escalation, full capacity triggers and de-escalations in ED/site. 2 hourly huddles with actions implemented within ED. Senior nurse led daily oversight of ward boarding risk levels.
Insufficient proportion of patients diverted away from ED to 0 day LOS services (SDEC, CDU, EPU, SAU)	Focussed work streams on SDEC pathway growth. Business case approval for extending opening hours for SDEC. Missed opportunities and admission criteria audits to be undertaken Oct.
Delays to patients being discharged which impact on admission pathways and ED crowding	Focus on internal and external delays with separate workstreams. Improved oversight of data and coaching of staff. Recruitment of additional TOCC roles to enable faster discharges.
Reduced social care funding leading to delays in discharges	Focus on reducing care home placements where appropriate at point of discharge. Introduction of care home liaison officer in Lewisham.
System response and alignment of capacity	Escalation relationships in place. Joint roles in Lewisham. Moving to joint roles Bexley + Greenwich. BCF intermediate care fund D&C capacity review.

Strategic Alignment	Lewisham Local Care Partnership Priorities			
Objectives	- To reduce the need for attendance at ED in UHL and acute admissions where these could have been prevented by earlier intervention - Work closely with all system partners to ensure that appropriate attendances are quickly managed, and inappropriate attendances are minimised through referral away to suitable alternatives - To ensure good flow through the hospital and reduced LOS, matching best benchmarked peer borough for LOS - To fully embed the Home First approach and ethos in Lewisham, resulting in a high proportion of patients discharged home, with excellent follow up support where needed improving long-term outcomes for discharged patients			
Workstreams	① Attendance Avoidance	② ED Front Door	③ UHL Flow	④ Discharge (Home First)
Success Measures Year 5	- Same Day Urgent Care model is well understood and provides access to same day urgent care for Lewisham residents commensurate with demand - Integrated model of hospital at home including UCR in place	- Attendances at UHL ED are 90% appropriate (<15% No. treatment, No investigation type 3) - Attendance levels same as best benchmarked peer borough - Meeting 78% 4-hr performance target	- Reduced 7, 14 & 21+ day LOS to match best benchmarked peer Trust 80% discharges before 5pm 55% discharges before 2pm	- Reduction in patients discharged to care homes to best benchmarked peer borough - Increase patients not needing further care/support following enablement - Improved patient outcomes following stay at Brymore
Success Measures Year 2	- UCR referrals pm increase towards national average of 157/100,000 65+ population (275 pm) - ED attends for Falls 65+ reduced - Admissions due to Falls 65+ reduced	- Meeting 78% 4-hr performance target- broken down into Type 1 and Type 3 and contributions of workstreams - Reduction in Type 3 attendances for participating GP practices (redirect project)	- Weekend discharges increased as a proportion of weekday discharges (target 70%) - Average LOS NEL (Meds) (excl. <u>0 day</u> LOS) reduction	- Number of days delay for pathway 3 patients reduced - Virtual Ward: step-down / step-up; specialties; patient acuity levels well defined - C'ty therapies – RTT 7 days for discharge patients
Deliverables Year 2	- Falls pilot operational and impact monitored - UCR expansion plan developed and agreed with LGT/ICB - Same Day Urgent Care model development ongoing	- SDEC Redirection - Pilot in place to trial referrals away from ED with named GP practices (N'hd 2) - ED 4-hr performance- Type 1 and Type 3 improved - Reducing attendance to ED by GP referrals	- Assess impact of Passports project- and complete Business Case for continuation based on success - Average LOS NEL (Meds) (excl. <u>0 day</u> LOS) reduced - Increased number of successful Discharges before 17:00	- Care Homes Liaison Nurse pilot in place and impact monitored - Virtual Ward increased specialty pathways in place, and impacting on earlier discharges - Therapies & enablement report recommendations agreed & in process of implementation

Lewisham, Bexley & Greenwich UEC Board

Bexley, Greenwich and QE Workstreams 2025/26

Objectives

1. Work with system partners to reduce the need for patient attendance at ED at QEH and reduce acute admissions where these could have been prevented by earlier intervention and use of other more appropriate alternative services and pathways including secondary care, primary care, community and other services.
2. To effectively manage attendances to ED that could be re-directed to other more appropriate services and ensure only appropriate admissions are made
3. Ensure good flow through the hospital from non-admissions, Trust admission through to discharge, reducing LOS and utilising alternative supportive discharge routes

Key Workstreams

1

C2A (criteria to admit)

2

SDECs

3

Front Door

4

Discharge

5

Mental Health

Success Measures

- Deep dive into VW to be completed in September
- All clinicians trained and positive about the CTA framework
- Overall reduction in admissions
- Reduction in pressure for beds.

- Increased volume of patients through SDEC
- Extension of SDEC opening hours to 7 days a week 12 hours a day for all services .

- Improved 4- hour performance.
- Increase in step down referrals into community services.
- Redirection pathways fully utilised

- Full TOCC model to be in place Q4
- Improve the daily discharge profile
- Increase in the number of discharges at the weekends
- A decrease in the number of stranded patients.

- Elimination of 72-hour stays for mental health patients.
- Reduction of 12-hour MH breaches from arrival and DTA.

Deliverables

- Demand and capacity modelling for VW and pathway embedding
- Progress the digital CTA tool and roll out of education programme

- Increased attendance through all SDEC pathways.
- Embed pathways as routine practice

- Senior oversight and stronger co-ordination with community services .
- In reach nurses to focus on front door to prevent admissions
- Increase in redirection from the UTC and increased use of the digital front door.

- Implement full TOCC model with new senior role
- Board round improvements
- Weekend planning
- Stranded patient reviews

- Working with system partners to eliminate 72 hour fit for discharge MH patients on medical wards.
- External reporting of all patients with a 12-hour stay from arrival in ED.

Bromley UEC Board Winter Planning 2024/25

Actions & expected impact

Action(s)	Expected Impact
Enhancement of ADU, Medical SDEC, and Integrated H@H	Enhances ED performance, supports better LAS handovers, and reduces long waits, aiming for a 10% improvement in non-admitted rates in ED.
Implementation of Winter Illness Hubs and Enhanced Primary Care Support	Boost primary care capacity, leading to a reduction in Type 3 attendances at emergency departments.
System-Wide Winter Plan Including Escalation and Management Strategies	Coordinated approach to managing surges, utilising system-wide resources to improve system response during peak demand.

Risks & mitigations

Risks	Mitigations
ED Performance and Capacity	Acceleration of the ADU facilities expansion and recruitment of additional staff Implementation of a new paediatric CDU model, and hypertension management training for GPs Review and optimisation of stroke pathways and non-bedding of the SDEC (agreement with King's executives)
Capacity Limitations	Expedited move of MADU to increase ADU capacity with additional staffing to be finalized Planned relocation and expansion of Medical SDEC to provide more pathways and prevent the need to bed SDEC.
Admission & Attendance Avoidance – Primary & Comm Care support	Refocus and alignment of H@H with MADU, alongside a pilot in care homes for virtual monitoring and targeted interventions with high-use care homes
Workforce Resilience	Escalation models for both primary and secondary care Winter investment funds to enhance workforce resilience through comms and engagement. General communications strategies to support the workforce through challenging winter conditions.

Strategic Alignment		Bromley Local Care (UEC Board) Partnership Priorities					
Objectives	We will co-develop an urgent health and social care plan across our partnership and with our communities to simplify same day access to physical, mental health, social support and third sector care when it is needed. Our ambition is people receive the right care, in the right place, at the right time - reducing escalation of need and hospital admission, particularly for our frail, elderly and higher users of services. This will mitigate growth in costs to the Bromley health and care budget while supporting the sustainability of our urgent care providers. It will build on, and augment, our current provision to form a highly integrated and responsive model meeting the population needs using resources available.						
Key Workstreams	1 C2A (criteria to admit)	2 Stroke	3 SDEC	4 Discharge	5 Front Door	6 Mental Health	
Success Measures	- All clinicians trained compliant and positive about the CTA framework - Low % of declined patients due to community capacity constraints	- Reduction in door to needle time - Improved 4-hour standard for stroke patients - Reduction in stroke mimics through earlier decision making	- Increase of patients seen in Medical SDEC - Increase in direct to SDEC from LAS and UTC - Frailty SDEC is open consistently - Community SDEC functioning with clear pathways	- Increase in the number of patients discharged before lunch - Epic Passport fully mobilized - Reduction in unplanned readmissions	- Improved 4-hour performance including <u>paeds</u> 50% of patients seen treated and Discharged by UTC - Reduction in Pharmacy First conditions treated by UTC - Reduction in patients accessing 111 <u>inhours</u>	- Reduced LOS in adult and children mental health beds - Improved discharge processes - Fewer emergency readmissions	
Improved patient experience and outcomes							
Deliverables	- Live templates for CTA on EPIC - Training for clinicians on the CTA framework - Training and tools available for clinicians to understand alternative care pathways for patients not meeting CTA	- Support/commission the London Stoke collaborative for 24/7 pre-admission telemedicine assessment - Embed actions to improve flow for Stroke patients	- Apply actions to improve productivity <u>De-escalate</u> AFAU - Develop pathways for community SDEC - Restructure provision to mobilise community SDEC	- Roll out Home Before Lunch to whole site and south sites - Training on use of EPIC discharge passport by MDT with clear Sop and guidance - Risk stratification tools being used by discharge system to proactively identify and manage risk	- New UTC Contract mobilized - Full interoperability of IT systems between UTC and P/care - Streaming and redirection pathways fully established	- Sustain AAA team model across winter - Maintain 24/7 agile MH assessment <u>capacity</u> Clinician training on discharge and flow	

Lambeth & Southwark UEC Board GSTT Winter Planning 2024/25

Actions & expected impact

Risks & mitigations

Action(s)	Expected Impact	Risks	Mitigations
Workforce to assist flow: - Additional Nurse Streamer at front door of ED.- completed - Ongoing Exploring E-triage. - UTC now in new location, recruitment completed and ongoing monitoring of rota fill	- Maintaining patient safety at the front door, and earlier identification of sick patients thus meeting the standard for a meaningful assessment within 15mins at the front door – achieving - Type 3 >95% - to ensure positive impact on overall performance – achieving	Finance	- Explore cost savings - Review of clinical pathways and ongoing workforce reviews ensuring value for money and good utilization - Weekend work at risk – reviewing to see how existing workforce can be utilised to continue this work
Maximizing SDEC (Medical, Surgical & Frailty): - SDEC medicine in new location. - Work with Clinical Group to increase activity & maximise space utilisation	0.5% - 1% - Increase the number of patients accessing SDEC, increase in direct referrals from ED	Capacity in ED	- SLAM implementing the Carnall Farrar Recommendations - Bed capacity - Crisis access - Reduced LOS - Escalation of out of area patients - System-level resilience and surge planning, to avoid becoming overwhelmed at times of peak demand - Reinforcing daily grip and oversight of delivery plan, including through building on the existing escalation arrangements to avoid excessive ED and ambulance handover times - Additional Virtual Ward / Hospital @home beds - Provision of an additional ward during winter months to respond to winter pressures
Discharges: Reducing delays post discharge-ready date (combining the two published metrics (a) the % of patients discharged on their discharge-ready date and (b) the average delays for patients not discharged on their discharge-ready date)	- Discharge over 30% of our total discharges by 12pm - Discharge over 70% of our total discharges by 12pm - Increase weekend discharges by 50% - Reduce the number of complex discharges to a minimum - Achievement against NHSE ambition for capacity expansion and utilisation - Streamlined discharge process for patients and unpaid carers	Exit block to main hospital wards	- Winter ward currently open to 14 beds, increasing to 28 from 15th Jan - ACCS moving to new location of Mitchener from the 15th Jan 2025. - The Flow Programme continues to support flow through from ED to Acute Admissions Ward and NW discharges
Intervention Area (Improving discharge, transfer of care and community care): GSTT Flow programme - Improving earlier access to inpatient beds to prevent delays across the ED pathway - e.g. (MSAU, AAW)		Increased Demand	- Primary Care Access Recovery Plan (PCARP) work supported by PCNs and Practices, as well as self-referral - Increasing senior decision making at the front door (nurse streamer & e-triage) - Maximising use of UTCs and Same Day Emergency Care (SDEC) services - Maximising use of alternative pathways
MH Access and Flow: Increasing bed capacity to support patient flow by implementation of the Carnall Farrar Report and Strategy - 5 Point action plan	- Reduce ED breaches - All type performance improvement 1-2%. - Significant reduction in 12- hour LOS - Improving operational efficiency in ED - Improved patient experience		

Strategic Alignment	Lambeth Local Care (UEC Board) Partnership Priorities with GSTT				
Objectives	1. Work with system partners to reduce the need for pt. attendance at ED in GSTT and acute admissions where these could have been prevented by earlier intervention and use of other more appropriate alternative services and pathways including secondary care, primary care, community and other services. 2. To effectively manage attendances to ED that could be re-directed to other more appropriate services and ensure only appropriate admissions are made 3. Ensure good flow through the hospital from non-admissions, Trust admission through to discharge, reducing LOS and utilising alternative supportive discharge routes e.g. hospital@home				
Key Workstreams	1	2	3	4	5
	C2A (criteria to admit)	SDECs	Majors/ Major C – (ambulatory)	Discharge LOS pathway 0 & 1s	Mental Health
Success Measures	• Increase of utilisation of @home across the Emergency Floor – namely ED, SDEC and Acute Admissions Ward • Increased utilisation of veteran pathways for appropriate patients.	• Short-term goal to increase pts attending SDEC-Med to 50 • Increase LAS trusted assessor attendance to SDEC-Medicine and SDEC-Frailty. • Formalise a combined weekend offering of a mixed Medicine and Frailty SDEC service.	• 78% all type performance. • Type 1 target of 60%. • Continued rigorous validation of breach data. • Never exceeding a 2 hour wait in our Ambulatory Majors to drive performance of type 1 in the area.	• 45% of all discharges through St Thomas will go through the discharge unit • Maintain LOS at 15 days	• Elimination of 72 hour stays for mental health patients. • Reduction of 12 hour MH breaches from arrival and DTA.
Deliverables	• Reporting data trends of patient referrals/ numbers through both @home and veteran referral pathways.	• Increased attendances through all SDEC pathways. • Increased trusted assessor presentations ahead of establishing a KPI. • SOP for weekend frailty pathway in new combined model to completed and shared with wider sector partners.	• Resident doctor staffing re-build in line with footfall in department both daily and weekly. • All type performance reporting with ability to breakdown by type and specifically by Majors.	• Increased discharge via disch. unit • Flow dashboard (Data productivity) • Leadership model implemented; Epic infrastructure built; estate engaged • Improve Board/Ward Round behaviours, reduce P1 patients remaining beyond DRD • T&F groups via flow program to drive improvement • Increase D2A via @home; ToCP productivity; Time to OT review; segment ToCP; rapid restart reablement	• Working with system partners to eliminate 72 hour fit for discharge MH patients on medical wards. • External reporting of all patients with a 12 hour stay from arrival in ED.

Actions & expected impact

Action(s)	Expected Impact
Maximising the use of UTCs and improving ambulance handovers/ direct access: Volume of re-directs to ED to be less than 50% of Greenbrook reviewed each day	Maintain performance above 95%
Relocation of SDEC: Complete build for new multi co-located specialty SDEC space within the first floor- increasing volume of patients to be assessed through SDEC by 10%	3-4% performance gain across the year
MAU - embedding service: - Provide 16 trolleyed space for Medical assessment from ED- therefore releasing the equal volume of ED Majors cubicle space each day - Increase % of Golden Discharges, increased use of Discharge Lounge and re-launch of NEPTS criteria (as interim arrangement currently for NEPTS)	3-4% performance gain across the year 30% of all discharges before 11 am reduces cubicle block in later part of the day
Discharges: - Substantiate patient flow lead role - Increase % of Golden Discharges, increased use of Discharge Lounge and re-launch of NEPTS criteria (as interim arrangement currently for NEPTS) - Increase % of Golden Discharges, increased use of Discharge Lounge and re-launch of NEPTS criteria	Reduction of pathway zero delays by 25% 30% improvement in discharges before 12 midday 15% increase in discharges into lounge
MH Access and Flow: - Increasing bed capacity to support patient flow by implementation of the Mental Health Carnall Farrar Report and Strategy - 5 Point Action Plan - Review potential for MH SLAM space	Reduce ED breaches All type performance improvement 1-2%. Significant reduction in 12- hour LOS, improving operational efficiency in ED and patient experience

Risks & mitigations

Risks	Mitigations
Limited internal flow	- Implementation of new Medical Assessment Unit - Ongoing work with the Patient Flow Group
Reduced speciality response time	- Re-launch of IPS - To be worked through via the Patient Flow Group
Capacity in ED	- Review of SDEC capacity and opening hours - Continue to progress move of SDEC to 1st floor Jubilee Wing to free up capacity in ED
MH patients within ED leading to blocked cubicles	SLAM implementation of the Carnall Farrar Recommendations - Bed capacity - Crisis access - Reduced LOS - Escalation of out of area patients
UTC performance	Daily performance reviews with Greenbrook (UTC Provider)

Strategic Alignment	Southwark Local Care (UEC Board) Partnership Priorities with Kings, Denmark Hill					
Objectives	1. Work with system partners to reduce the need for pt. attendance at ED in GSTT and acute admissions where these could have been prevented by earlier intervention and use of other more appropriate alternative services and pathways including secondary care, primary care, community and other services. 2. To effectively manage attendances to ED that could be re-directed to other more appropriate services and ensure only appropriate admissions are made 3. Ensure good flow through the hospital from non-admissions, Trust admission through to discharge, reducing LOS and utilising alternative supportive discharge routes e.g. hospital@home					
Key Workstreams	1	2	3	4	5	6
	C2A (criteria to admit)	SDECs	Flow	Discharge	Mental Health Assessment Unit	Digital Front Door
Success Measures	• Reduce pressures within the acute medical bed base • Reduction in outlying position for medicine • Increase volume of patients managed through SDEC • Overall admission reduction by 3-4 patients per day	• Increase volume of patients through SDEC • Extension of SDEC opening hours to 7 days a week 12 hours per day for all services	• Full implementation of live bed state • Increase use of discharge lounge to support early discharges • Use of Estimated Date Discharge and Golden Patients	• Implement full TOC model • Continue with on-site provision of social care • Use of Hardship Fund to support discharges • Use of capacity system in EPIC to drive discharges	• Reduce overcrowding of ED Majors area as measured by reduction in 12hrs+ MH LOS • Low risk MH patients who need to stay beyond first MH assessment transfer to the new MH unit (MHAU)	• Improve time from arrival to confirmatory ED Triage Assessment • Improved patient satisfaction with reduced queues found from Friends and Family Test (FFT) feedback from current baseline • Streamlined streaming and triage assessment, with greater accuracy and efficiency
Deliverables	• Reduction in admissions of 11-13% per week • Admission avoidance for 3-4 patients per day • Improvement in type performance by 1% each day	• Supports CTA work and if performance in new unit reflects the plans an increase in T1 of between 1% -2%	• DTAs at 8am to be fewer than 15 physical health each day	• DTAs at 8am to be fewer than 15 physical health each day	• Reduction in MH LOS • Utilisation of new MHAU (Mental Health Assessment Unit)	• Current project plan outlines full system design configuration, patient feedback mechanisms, change management plans, and post-implementation evaluation through patient engagement. • Adoption rate for ambulatory adults to be above 70% by end of FY 25/26 following embedding • Improved patient satisfaction from Friends and Family Test (FFT)