South East London Integrated Care System

NHS South East London

Integrated Care Board – Meeting in Public

13.30 to 16.30 on 28 January 2026

The Owen Centre, Lewisham Hospital Lewisham High Street SE13 6LH
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	13.30
	Borough Showcase			
2	**Lewisham Borough**	-	CJ	13.40
	Corporate business			
3	**EDI reports**	C	TF	14.10
	Report for Assurance and discussion of current issues			
4	**Chief Executive Officer's report**	D	AB	14.25
5	**Board Assurance Framework**	E	TF	14.40
6	**Overall Report of the ICB Committees and Provider Collaboratives**	F	TF	14.50
7	**Performance Report**	G	SC	15.00
8	**Quality and Safeguarding Report**	H	DJ	15.15
9	**Finance Report**	I	MF	15.30
	Delivering our Integrated Care Strategy			

10	**Primary Care – General practice variation and resilience**	J	HE	15.45
Closing Business				
11	**Any other business**	-	RD	16.15
12	**Public Questions and Answers**	-	RD	16.20
CLOSE 16.30				

Presenters

RD	**Sir Richard Douglas**	**ICB Chair**
AB	**Andrew Bland**	**ICB CEO**
SC	**Sarah Cottingham**	**ICB Director of Planning and Deputy CEO**
TF	**Tosca Fairchild**	**ICB Chief of Staff**
MF	**Mike Fox**	**ICB CFO**
CJ	**Ceri Jacob**	**Lewisham Place Executive Lead**
GK	**Diane Jones**	**ICB Chief Nurse**
RK	**Ranjeet Kaile**	**Director of communications and engagement**

Register of Interests

Date: 28/01/26

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	Financial interest	01-Apr-16	Current
		2. Trustee, Place2Be, an organisation providing mental health support in schools	Non-financial professional interest	01-Jul-22	Current
		3. Trustee, Demelza Hospice Care for Children, non-remunerated role.	Non-financial professional interest	01-Sep-22	Current
		4. Non-executive member, Department of Health and Social Care Board	Financial interest	01-Apr-24	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	01-Apr-22	Current
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	Non-financial professional interest	01-May-22	Current
		2. Non-executive director - Health Foundation (health research charity)	Non-financial professional interest	01-Mar-23	Current
		3. Trustee of Waythrough (formally Recovery Focus and Humankind), which is commissioned the provide NHS services.	Non-financial professional interest	01-Apr-22	Current
		4. Director of Paul Policy Practice Ltd	Financial Interest	24-Dec-21	Current
		5. Advisor to DA Languages Ltd	Non-financial professional interest	01-Jul-24	Current
		6. Improvement advisor to Blackpool Council	Non-financial professional interest	22-Sep-25	Current
		7. Chair of London Neighbourhood Delivery Board (NHSE London appointment)	Non-financial professional interest	01-Sep-25	Current
		8. Governor, Christ The King Primary School	Non-financial professional interest	03-Aug-25	Current
		9. Chair of NHS North Central London Integrated Care Board	Financial interest	07-Oct-24	30-Aug-25
Anu Singh	Non executive director	1. Independent Chair of Lambeth Adult Safeguarding Board.	Non-financial professional interest	01-Apr-21	Current
		2. Member of the advisory committee on Fuel Poverty.	Non-financial professional interest	01-Jan-20	Current
		3. Non-executive director on the Parliamentary and Health Ombudsman.	Non-financial professional interest	01-Apr-20	Current
		4. Chair of Black Country Integrated Care Board	Financial interest	01-Sep-24	30-Sep-25
		5. Chair of Northamptonshire ICB and Leicester, Leicestershire & Rutland ICB cluster	Financial interest	01-Oct-25	Current
Georgina Fekete	Non executive director	None	-	-	-
Crystal Akass	Chief People Officer	1. Chief People Officer at Guys & St Thomas's NHS Foundation Trust	Financial interest	05-Aug-24	Current
Dr. Angela Bhan	Director of Place, Bromley	1. Consultant in Public Health for London Borough of Bromley.	Non-financial professional interest	01-Apr-20	Current
		2. Professional public health appraiser for NHS England	Non-financial professional interest	01-Jul-22	Current
		3. Occasional assessor for CESR applications for GMC, on behalf of Faculty of Public Health	Financial interest	01-Jul-22	Current
Diana Braithwaite	Director of Place, Bexley	None	-	-	-

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Sarah Cottingham	Deputy Chief Executive and Director of Planning	None	-	-	-
Jennifer Daothong	Partner member, Local Authority	1. Chief Executive, London Borough of Lewisham	Financial interest	24-Sep-25	-
Gabi Darby	Director of Place, Greenwich	None	-	-	-
Holly Eden	Director of Delivery - Neighbourhood and Population Health	None	-	-	-
Andrew Eyres	Director of Place, Lambeth	1. Director of Lambeth, Southwark and Lewisham LIFTco, representing the class B shares on behalf of Community Health Partnerships Ltd for several LIFT companies in the boroughs.	Financial interest	01-Apr-13	Current
		2. Married to Managing Director, Kings Health Partners AHSC	Indirect interest	01-Apr-21	31-Jul-23
		3. Spouse is the Managing Partner at SHINE Executive Cpacjomg & Consultancy Ltd, providing life sciences and partnerships strategic advisory and coaching services.	Indirect interest		Current
		4. Corporate Director of Integrated Health and Adult Social Care – role spans ICB and Lambeth Council.	Non-financial professional interest	01-Oct-19	Current
Tosca Fairchild	Chief of Staff	1. Partner is a Consultant in Emergency Medicine & Deputy Medical Director UHDB NHS FT. Potential to undertake locum work.	Non-Financial Professional Interest	01-May-22	Current
		2. Bale Crocker Associates Consultancy – Client Executive	Financial Interest	03-May-22	31-Mar-25
		3. Bale Crocker Associates Consultancy – Client Executive	Financial Interest	01-Oct-25	Current
Mike Fox	Chief Finance Officer	1. Treasurer of PTA of Friends of Green Lane Primary School	Non-financial personal interest	16-Jun-23	Current
Dr. Toby Garrood	Medical Director	1. Shareholding in Serac Healthcare	Financial interest	01-Apr-20	Current
		2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT)	Financial interest	07-Oct-09	Current
		3. In my role at GSTT I have received research and service development grant funding from Versus Arthritis, Guy's and St Thomas' Charity, Pfizer, Gilead and NHSx	Financial interest	01-Jan-15	Current
		4. I undertake private practice at London Bridge Hospital	Financial interest	01-Jan-12	Current
		5. Honorary Treasurer for British Society for Rheumatology	Non-financial professional interest	01-Apr-20	Current
Ceri Jacob	Director of Place, Lewisham	None	n/a	n/a	n/a
Ranjeet Kaile	Director of Communications & Engagement	1. Director of Communications & Engagement, South London & Maudsley NHS FT	Financial interest		Current
		2. Non-executive Trustee of Peoples Health Trust Charity.	Non-financial professional interest	02-Apr-24	Current
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists	Non-financial professional interest	01-Jun-94	Current
		2. Fellow of the Royal College of Physicians (Edinburgh)	Non-financial professional interest	01-Jun-00	Current
		3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Financial interest	01-Apr-19	Current
Ade Odunlade	Partner member, Mental Health Services	1. Interim Chief Executive, South London and Maudsley NHS Foundation Trust	Financial interest	01-Dec-25	Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust	Financial interest	01-Nov-21	Current
		2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care	Financial interest	01-Jan-96	Current
		3. Director, Sard JV Software Development	Financial interest	2011	Current
		4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London	Financial interest	27-Sep-16	Current
		5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital	Financial interest	01-Jan-92	Current
		6. Fellow of the Royal College of Psychiatrists	Non-financial professional interest	01-Jan-92	Current
		7. Fellow of the Royal Society of Medicine	Non-financial professional interest	01-Jan-85	Current
		8. International Fellow of the American Psychiatric Association	Non-financial professional interest	01-Jan-85	Current
		9. Member of the British Association of Psychopharmacology	Non-financial professional interest	01-Jan-85	Current
		10. Member of the Faculty of Medical Leadership and Management	Non-financial professional interest	01-Jan-85	Current
		11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Non-financial professional interest	01-Jan-85	Current
Darren Summers	Director of Place, Southwark	1. Member of Council of Governors of Guys and St Thomas's NHS Foundation Trust as ICB representative	Non-financial professional interest	01-Jul-24	Current
Dr. George Verghese	Partner member, primary care	1. GP partner Waterloo Health Centre	Financial interest	01-Aug-13	Current
		2. Lambeth Together training and development hub director	Non-financial professional interest	01-Jan-22	Current
		3. Lambeth Healthcare GP Federation shareholder practice	Non-financial professional interest	01-Aug-19	Current

Integrated Care Board meeting in public

Minutes of the meeting on 15 October 2025

Present:

Name	Title and organisation
Richard Douglas [Chair]	ICB Chair
Dr Angela Bhan	Bromley Place Executive Lead
Andrew Bland	ICB Chief Executive Officer
Oge Chesa	For Lambeth Place Executive Lead
Georgina Fekete	Non-Executive Member
Mike Fox	Chief Finance Officer
Dr Ify Okocha	Partner Member Community Services
Dr Toby Garrood	ICB Joint Medical Director
Gwen Kennedy	Chief Nurse
Ceri Jacob	Lewisham Place Executive Lead
Anu Singh	Non-Executive Member
Peter Mathew	Non-Executive Member
Darren Summers	Southwark Place Executive Lead

In attendance:

Sarah Cottingham	Executive Director of Planning and Deputy CEO
Holly Eden	Director of Delivery - Neighbourhoods &Population Health
Ranjeet Kaile	Director of Communications and Engagement
Tosca Fairchild	Chief of Staff
Crystal Akass	CPO
Ben Travis	CEO Lewisham and Greenwich NHS FT

1.	**Welcome and Opening Business**
1.01	Sir Richard Douglas welcomed all to the meeting
1.02	Apologies were noted from Dr Geroge Verghese, Amanda Pritchard, Jennifer Daothong, Prof Clive Kay, Paul Najsarek, and Andrew Eyres.
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.	**Socio-economic development and addressing the wider determinants of health**
2.01	The Board heard from: • Lindsay Ballantyne who highlighted the opportunity to move from fragmented and short-term interventions on the wider determinants of health to a bold system-wide approach that centred community leadership and tackled structural drivers of health inequality.

- Tal Rosensweig who pointed out that the voluntary, community and social enterprise sector had strong and trusted relationships of trust with local people and a strategic and long term collaboration with the VCSE sector was necessary for the ICB to build trust with communities. A VCSE charter which had been in place had helped to increase leadership involvement of the VCSE sector across the system including in relation to neighbourhood work, but there remained work to create an ecosystem of shared leadership and decision making on resources. The VCSE alliance continued to help share insights and strengthen connections.
- Flora Faith-Kelly who explained that creative participation was known to help prevent long-term conditions by promoting physical activity, improving mental health, supporting better diets and strengthening social connection. Creativity could therefore be reframed as a public health tool rather than a luxury, and help address root causes of inequalities. Examples of partnership work such as a youth centre at the South Bank Centre, Bromley's 'singing for hypertension' programme, 'the makers nook' in Greenwich and the Ital community gardens in Lewisham.
- South London Listens, who used community organising tools to tackle deep-rooted health inequalities, building relationships based on trust, seeing, listening and valuing lived experience. Over 10,000 people had been engaged and 1000 trained as organisers, working in areas such as Horn Park on the wider determinants of health. The ICB had helped bring together the NHS local authority and communities to address issues such as housing. A health assembly was planned with 800 attendees.
- Jesse Ashiegbu presented on issues related to the relationship with the not-for-profit organisations. Not-for-profit organisations could be trusted to deliver and with serious investment and had demonstrated their ability to handle significant investment and the impact of its work but this had not been taken account of sufficiently. Rather than starting 'pilots', embedding the change that worked should be the priority. With mutual respect, not-for-profit organisations could work with health and care to turn trusted services into health creation hubs which would make the job of health services easier and cheaper and make the entire community happier.

2.02 Anu Singh noted that the ten year health plan had effectively left it up to Boards in their new strategic commissioning role to ensure the work moved from something that was seen as good to support but not part of core business, to the central starting point, so that the focus was no longer on divisions between primary, secondary and tertiary services.

2.03 Tosca Fairchild reflected on points made that the work was not recognised and pointed out that the way NHS targets were set did not make it easy to measure the impact the good work that was being done in the community.

2.04 Georgina Fekete welcomed the presentation and expressed interest in how the board could create enabling conditions by commissioning differently, for example saving money and promoting quality through a preventative approach. Food and nutrition had an important impact on long-term and short-term health and should also be included in work on the determinants of health.

2.05 Dr Ify Okocha remarked that the work presented was vital to addressing prevention and inequalities but raised the real challenge of whether it would be possible to sufficiently fund the work for the long term given other pressures on the finance.

2.05	Peter Mathew suggested that although there was consensus that the work was a good thing, but there needed to be a specific ask of the board and providers of what they would do next in support. The ICB would need to consider how it could take this work forward as part of strategic commissioning, and to the providers on how they could support.
2.06	Dr Toby Garrood related the discussion to the work on primary and secondary care, especially in neighbourhoods, and asked what could be done straight away to improve the relationships with the VCSE.
2.07	Ben Travis welcomed the presentation and acknowledged the pressures faced by voluntary organisations to survive. VCSE services which were also commissioned by local authorities and public health, there was a need for all parties to co-ordinate to avoid the unintended consequences of individual decisions and protect and grow the right services. Investment generally achieved greater return in the voluntary sector than in other sectors so it was a concern if the sector was diminishing.
2.08	Sir Richard Douglas pointed out that the basic foundation of a VCSE charter agreed across the system was already in place, and the money involved was small in comparison to the overall spend on the system. The challenge was therefore to ensure these commitments were followed through and the board could examine the issue in more detail at one of its seminars.
2.09	Andrew Bland welcomed the presentation, well timed in the context of changes to ICBs. Support for this work would not be mandated nationally and was therefore the responsibility of the system. South east London had made financial commitments in previous years in its medium-term financial strategy, but during each year had been forced to renege on this to achieve financial balance. Providers who would be taking on responsibilities in relation to integrators in boroughs, would also need to participate in finding ways to ensure funding could be directed towards commitments to the VCSE sector.
2.10	Jesse Ashiegbu pointed out the contrast with the approach to tech start-ups which would still be considered high value investments even if they failed for years to produce a return. There was a need for a change in approach: the success of models developed by community organisations spoke for itself, and needed to be recognised in a relationship of mutual respect. The NHS needed these organisations which had the trust of local communities, and would need to engage at grass roots level, not require these organisations to learn 'NHS system language' or navigate bureaucracy.
2.11	**Action: The board to convene an opportunity to consider response to the challenges raised in relation to SED and the VCSE**
3.	**NHS Planning update**
3.01	Sarah Cottingham noted that the planning process included both operational planning and five-year strategic planning. Although final guidance was awaited, the 10 Year health plan and draft guidance on the requirements was available and had started to inform work of planning groups. The first phase of foundational work would provide a basis for the plan would encompass existing joint forward plans and health and wellbeing plans in each borough. The task was now to outline operational planning in more detail as part of the second phase. Key risks and opportunities had been outlined in the paper and included dealing with uncertainty and legacy challenges around finance and performance, as well as achieving

	coherence over a range of strategic and operational outputs being developed concurrently.
3.02	The Board noted the update.
4	**Green Plan**
4.01	Tosca Fairchild presented the refreshed Green Plan which had been recommended to the Board by the executive committee. The plan highlighted achievements so far as well as future work and was informed by Green plans developed by local NHS trusts, noting that the plans were still going through final stages of internal governance in each organisation.
4.02	Georgina Fekete asked if the plan would concentrate efforts sufficiently towards the most effective actions, and whether actions to limit impact on the environment were sufficiently balanced with actions to adapt to the already changing climate, noting the Climate Change Committees advice to prepare for a minimum rise of 2 degrees above pre-industrial levels by 2050. Darren Summers reiterated the importance of adaptation citing recent heatwaves with loss of life in Paris that would need to be prepared for in south east London.
4.03	Peter Matthew asked how the system was *currently* performing against the Green targets which did not seem to be set out in the plan.
4.04	Darren Summers relayed comments from Dr Nancy Kuchemann emphasising the need for all staff to take responsibility and for leadership at Place to help primary care take the necessary actions, as well as clear accountability for making progress against the plan. Dr Toby Garrood asked how the ICS could guard against the green plan becoming a siloed piece of work but ensure individual accountability across the range of NHS work so that for example when designing improved pathways the need for transport to multiple appointments could be reduced.
4.05	Ben Travis suggested that if the plan represented the ICS there was more positive work which could be included, for example securing £20m external funding to install a heat pump for University Hospital Lewisham, and £2.5m for installing solar panels.
4.06	Anu Singh reflected on the scale of the problem the green plan was trying to address and suggested it needed a stronger sense of local identity and principles to bring together relevant areas such as transport or using local produce to help add social value for south east London residents.
4.07	Tosca Fairchild welcomed the comments noting that the ICB was required to report quarterly on climate change and brought biannual updates to the ICB board. Although financial resources were often a challenge for mitigation as well as adaptation work this did not need to stop local work with GPs and local partners such as the voluntary and community sector.
4.08	Sir Richard Douglas suggested a short update be brought to the Board addressing the points raised by members including ensuring effort was being directed to priority actions, the balance of mitigation and adaptation, measuring the effectiveness of actions, and fostering personal accountability. **Action**
4.09	The board **approved** the SEL ICS Green Plan refresh for 2025-2028.

5	**Chief Executives Report**
5.01	Andrew Bland referred the Board to the report which included contributions from across the ICB executive team, highlighting that • staff had been written to with a re-statement of the ICB's commitment to being an anti-racist organisation. • South east London had been able to support good applications from local areas to the National Neighbourhood Health Implementation programme. • ICBs nationally were unable to proceed with ICB reform pending national approvals relating to the implementing the changes - the executive team were meeting with staff on a weekly basis recognising that this was a stressful and uncertain time for colleagues.
5.02	The Board noted the CEO report.
6	**Board Assurance Framework**
6.01	Tosca Fairchild presented the board assurance framework. There were 14 south east London wide risks and 5 risks relating to local care partnerships which had been escalated to the BAF. Scoring had been increase for risks relating to urgent and emergency care pressures, the impact of the ICB change programme, and the financial impact of redundancy payments to staff. New risks were a risk relating to Paediatric audiology services (rated 12), and a risk related to children and young people's neurodevelopmental pathways from Bromley, Greenwich, Lambeth Lewisham and Southwark (rated 16). Risks where scores had been reduced were listed and included risk in relation to resident doctor industrial action following conversations between unions and the government. The SEL ICS risk leadership group had reviewed specialised commissioning transferred risks, and had discuss risks in relation to neighbourhoods, programme and corporate risks, and the approach to issue and actualised risks. The executive team were regularly engaged to ensure ownership of key risks and a consistent approach.
6.02	Mike Fox noted that although the risk related to the revenue financial plan was still rated 25, the intention was to formally review and reduce that score in the light of month six reporting and meetings that had taken place with NHSE region on the actions being taken in mitigation.
6.03	Peter Mathew questioned whether some of the risks had already crystallised for example in relation to impact on staff of the ICB changes, and ask how we were coping. Andrew Bland agreed noted that although there was good performance staff morale was noticeably lower and a number of vacancies and there would need to be an assessment of the risk this created in each directorate as the ICB changes progressed, for example interim and fixed term use had increased.
6.04	Georgina Fekete observed that some risks had been on the register for a very long time asked whether the ICB was making sufficient progress or needed to change its approach. It would be useful to have more detail on how this was challenged in committees. Sir Richard Douglas suggested some risks may effectively have become issues and it may be worth discussing how the issue would be managed on an ongoing basis.
6.05	Peter Mathew noted that at the audit committee the mitigations were not always easy to see in the summaries which include a large number of red rated risks.

6.06	Andrew Bland noted that the executive committee tended to focus on the movement of risks, rather than whether they were risks or issues, to judge whether progress was being made against what the ICB was trying to implement, rather than whether the issue had been completely resolved, in areas that had faced challenges for many years. **Action: Board to schedule a consideration of BAF and risk management going forward**
6.07	The Board approved the board assurance framework.
7	**Overall report of committee and provider collaborative**
7.01	Tosca Fairchild presented the committees report drawing attention to items escalated to the board for approval.
7.02	Sir Richard Douglas noted the annual governance review and advised that as the ICB changes progressed there would be a more thorough review of governance arrangements.
7.03	Andrew Bland noted that the board had considered an approach to the Bromley community services contract and an update on the decision making would be brought to the next Board.
7.04	The Board **noted** the annual governance review and the completion of the Fit and Proper Persons test for 2025.
7.05	The Board **approved**: • Revised Audit and Risk Committee terms of reference • Revised Remuneration Committee terms of reference • Revised Clinical and Care Professionals terms of reference • Revised terms of reference for the Healthier Greenwich Partnership
7.06	The Board **noted** that the 2024/25 audited accounts for the Greenwich Charitable Fund have been signed off by the Committee Chair and Chief Finance Officer, and the annual return submitted to the Charities Commission, as required by the Charities Act 2011.
8	**Performance Report**
8.01	Sarah Cottingham referred to the report which summarised performance against key targets in the 2025-26 plan. There had been positive progress for performance year to date despite a minor dip below trajectory in month 5. This included progress in relation to the faster cancer diagnosis standard, various community-based care indicators such as urgent community response, continuing healthcare and health checks for autistic people and people with learning disabilities. There remained performance challenges however, with very long 12 hour waits in emergency departments, pressure on diagnostics and ambulance handovers. Referral to treatment times had deteriorated in relation to those waiting over 65 weeks and the 62day cancer referral target was under pressure across all providers.

	A national mid-year review process was underway and meetings had been conducted between the NHS London Region, the ICB and NHS providers. The review focused on assurance of the delivery of 2025/26 plans, taking account of trajectories against recovery plans and any key risks with an emphasis in south London on financial performance and key targets such as A&E treatment times, cancer and diagnostics. There had also been feedback on demand management and primary care access, including dentistry and Pharmacy First.
8.02	Anu Singh asked if progress was on virtual ward utilisation was satisfactory given the potential for it to help with flow. Sarah Cottingham pointed out that it was difficult to disaggregate the impact of virtual wards in isolation from a range of other community alternatives on offer in south east London. Although evaluations such as the one undertaken by PPL had reported a positive impact, the real challenge was to demonstrate that the virtual wards were helping avoid hospital admission rather than offsetting pressures elsewhere.
8.03	Holly Eden added that the national capacity target did not take into account the existing community response offer in south east London. Despite evaluations it was difficult to understand the acuity of patients being supported and there was limited compelling evidence for virtual wards as a stand-alone service rather than part of other integrated hospital at home initiatives.
8.04	Dr Angela Bhan agreed added that implementing virtual wards varied in difficulty dependent on the type of housing and population in different places. Sometimes it proved very expensive to support someone in their own home.
8.05	Sir Richard Douglas suggested that irrespective of national capacity targets there was a need for the ICB to understand whether virtual wards were providing best value to patients for money available and make a decision accordingly.
8.06	Holly Eden suggested that the answer lay in better integration of services including virtual which allowed providers to deploy a flexible community offer given changing needs for example during winter in contrast to summer.
8.07	Georgina Fekete asked if there had been any changes since the last board discussion on diagnostic services. Sarah Cottingham noted that a demand and capacity review was ongoing and providers continued to insource and outsource capacity. The capacity in commissioned in CDCs was also being used.
8.08	The Board noted the performance report.
9	**Quality and safeguarding report**
9.01	Gwen Kennedy presented the report and highlighted that • All-age continuing healthcare performance continued to improve despite complexity across south east London. • South east London trusts were not directly involved in Baroness Amos' review of maternity services but would be following the work closely. Meanwhile work was ongoing to optimise maternity prescribing pathways to allow pregnant women to access the medicines they needed conveniently. South east London was participating in regional workforce initiatives to support students in placements and retain existing staff. • Infection prevention control work was of particular importance as winter pressures approached, and included a review of community services for

	individuals using catheters, which if not managed could lead to emergency department attendances. • The quality team were contributing to efforts to increase flu vaccination uptake across south east London • Progress was being made in discharging long-stay patients with learning disabilities and autism although despite pressures with new admissions. • SEND priorities would shortly be reviewed.
9.02	Georgina Fekete observed that there was no time frame on addressing the risks highlighted in relation to safeguarding. Gwen Kennedy noted that that the risks were part of ongoing programme of work.
9.03	Richard Douglas asked about paediatric audiology review which had been raised to the BAF. Sarah Cottingham noted that there had been an issue with accreditation with some providers in south east London. Immediate actions were underway to address the waiting list and ongoing actions to change commissioning arrangements and potentially consolidate.
9.04	The Board noted the quality and safeguarding report.
10	**Finance Report**
10.01	Mike Fox noted that ICS financial performance was broadly on plan. For months 4 and 5 the financial plan was met and there was a stable run rate. All partners had reiterated commitment to deliver their individual financial plans. It was important to note that this position was only achievable because of deficit funding support and the underlying deficit would need to be recovered. Despite the expectation there was a high level of savings and other measures that were non-recurrent and therefore did not address the underlying financial position expected to be a deficit of £300m at year end. Actions to support recovery of the underlying position formed part of the discussions at the mid-year review meetings with the NHSE London Region.
10.02	Georgina Fekete remarked on the contrast between the position being on track and the large underlying deficit and asked about progress with efficiencies and increasing recurrent savings relative to non-recurrent measures, as well as progress on capital planning.
10.03	Dr Ify Okocha noted that at Oxleas NHSFT there was a two year programme which would deliver recurrent savings in the second year.
10.04	Crystal Akass noted that one of the key challenges was that GSTT were behind on its plans to reduce workforce spend. Compared to other trusts there was less reliance on temporary staff and so less opportunity to reduce costs quickly. The focus was therefore on the longer term and how to reduce demand and reduce the cost of delivery.
10.05	Mike Fox added that capital spend was being compared to plan despite plans accounting for expenditure tending to be towards the end of the year. There was slippage on two significant capital programmes and the CFOs were meeting every fortnight to discuss possible brokerage approaches to manage the system capital allocation and mitigate this slippage.
10.06	The Board noted the finance report.

11	**Developing our Neighbourhood health Service**
11.01	Holly Eden introduced the update highlighting that Lambeth and Southwark had been successful in bidding to participate in the first wave of the National Neighbourhood Health Implementation programme. Lewisham and Bexley had also submitted excellent applications which received good feedback and so were well-placed for future bids. There were however some challenges that could impact future progress, including capacity both in the ICB and across providers despite good engagement. There was also a challenge in maintaining the positive engagement of general practice, with recent contract changes being experienced quite negatively and an expectation on the ICB in terms of its management of practices. A forthcoming review of the Carhill formula (the funding formula for general practices) was creating some uncertainty. There was also a risk that the neighbourhood work became increasingly health-centric and the focus shifted form proactive holistic and person-centred care.
11.02	Andrew Bland noted that the ICB was engaging meaningfully with practices and would seek to provide support for practices to participate in neighbourhoods in the context of national contract changes. National guidance would likely specify a minimum level of expectations for neighbourhood but the board would need to define the full expectations.
11.03	Sir Richard Douglas emphasised that national requirements were the minimum but the Boards job was to set out what more it would want to do for the local population.
11.04	Anu Singh suggested that the language in which the programme was described was important. The presentations at the start of the meeting had emphasised the importance of working with local community assets, however the report was structured in terms of compliance with a programme outside of the ICB. While the two approaches were not exclusive, the way things were measured and judged would influence what would be delivered, whether a national minimum or more organic process reflecting the diversity of the six boroughs and local neighbourhoods.
11.05	Sir Richard Douglas acknowledged that the ‘compliance’ related language might be off putting to others.
11.06	Holly Eden noted that at the last meeting a number of examples of real change on the ground had been set out, but did not quite convey how difficult it was to sustain change and ensure that the infrastructure changed to support that. In order to make space for some of the local work to thrive, it would be important to make sure the infrastructure as appropriately adjusted to support it.
11.07	Ceri Jacob suggested it was possible to deliver the essential elements such as INTs and emphasised the importance of local councils in addressing housing, employment, and environment on their health. There was so much change to deliver.
11.08	Peter Matthew noted that neighbourhoods might be a vehicle to take forward some of the work raised in the first presentation. A lot of good work had taken place already both in work VCSE and community as well and neighbourhoods and there was an opportunity to bring them closer together.

11.09	Andrew Bland suggested that both elements were essential highlighting the unprecedented level of engagement by GPs with VCSE.
11.10	Georgina Fekete suggested that in changes of this scale the cultural changes to ways of working needed to be embedded from the start. And asked what providers were doing differently to contribute to the work.
11.11	Crystal Akass asked if the ICB felt providers were sufficiently changing and developing their leadership of the neighbourhood agenda. There was lots of enthusiasm from staff currently but adaptation needed to work in the neighbourhood space would require further work.
11.12	Holly Eden reflected that there had only been integrators in place across all boroughs for a month and there had been good individual engagement, but more work to do in how the changes were reflected in the strategy of the trusts. Ultimately the activation of frontline staff in support of the agenda would be vital.
11.13	Ranjeet Kaile noted that there would be further work across all providers and communications teams to help support this staff activation.
11.14	The Board noted the update.
12	**Any Other Business**
12.01	There was no other business.
13	**Public Questions and Answers**
13.01	*A member of the public noted the increasing use of independent sector with the associated costs and outcomes, asking how it was proper to keep using the independent sector with its association with profit motive and privatisation rather than increasing capacity within the NHS.* *To help the NHS contribute to its green aspiration there was work that could be done with land, as well as just buildings, to mitigate climate change.* *Recognising that the Board meeting was not a discussion with the public, they pointed out that members of the public would want prompt and good service from a GP, preferably the same person who knows them, pointing out that in conversations as part of campaigning work, issues with access were often raised.*
13.02	Sir Richard Douglas welcomed the comments, and acknowledged that GP access was upmost in the minds of many local people. Noting the points made on the private sector he pointed out that only NHS tariff prices would be paid for work done by the private sector.
	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 001	15-Oct-25	To provide for information an update in response to the Board queries on the Green plan	to be closed			Update was brought to the board seminar on 19 November
ICB 002	15-Oct-25	Board to consider approach to the BAF and risk	open	TF/AB	18-Feb-26	Scheduled for the18 February Board seminar session
ICB 003	15-Oct-25	Board to consider response to challenge of ways it can better support social and economic development and VCSE working in line with the VCSE charter as posed at the October Board.	open	RK/AB	18-Mar-26	Scheduled for the 18 March Board seminar session

Board meeting in Public

Title	**Equality, Diversity and Inclusion reports**				
Meeting date	28 January 2026	Agenda item Number	3	Paper Enclosure Ref	B
Author	Halima Dagia, Equality, Diversity and Inclusion Manager Louis French, Equality, Diversity and Inclusion Officer				
Executive lead	Tosca Fairchild, Chief of Staff and Equalities SRO.				
Paper is for:	Update		Discussion		Decision	X
Purpose of paper	This paper presents the findings of the SEL ICB Workforce Race Equality Standards (WRES), the Workforce Disability Equality Standard (WDES) and the Workforce Sexual Orientation Equality Standard (WSOES) 2024–2025 reports and action plan for approval for and publication.				
Summary of main points	**Context:** South East London ICB has proactively adopted the WRES, WDES and WSOES as part of its commitment to advancing Equality, Diversity and Inclusion across the organisation. **The Workforce Race Equality Standard (WRES)** provides a national framework that identifies disparities in experience and opportunity between Global Majority staff and their White colleagues. The WRES supports organisations in understanding and addressing these gaps to ensure fair and equitable treatment for all staff. **The Workforce Disability Equality Standard (WDES)** compares the workplace experiences of disabled and non-disabled employees. The insights gained inform targeted action plans that help create cultures of belonging and trust, improve retention, widen the talent pipeline and support sustainable careers. **The Workforce Sexual Orientation Equality Standard (WSOES)** provides eight metrics that examine the experiences of LGBTQIA+ staff in comparison with their non-LGBTQIA+ colleagues. This enables organisations to strengthen inclusivity, enhance staff wellbeing and improve overall organisational performance. While these standards are not yet mandated for ICBs, South East London was an early adopter demonstrating its commitment to promoting an inclusive culture in which all staff are valued and supported to thrive. **Data collection:**				

	Although the reports are being produced and finalised in 2025/2026, they are retrospective in nature, drawing on data from 2024–2025. Workforce information has been extracted from ESR as of 31 March 2025, alongside staff survey results from 2024. All indicators/metrics have been calculated in accordance with the technical guidance for the WRES, WDES and WSOES This year's reports also incorporate comparison with previous years' outcomes, enabling monitoring of trends and assessment of progress over time. **Action Plan:** A comprehensive unified action plan **(attached following the WSOES report)** covering all three areas has been developed providing a clear framework to address key priorities and deliver measurable, positive change across the organisation. The actions will be delivered over a three-year period (from 24/25), and reviewed annually to ensure they are still appropriate, particularly in view of the ongoing Change Management Programme.					
Potential conflicts of Interest	None identified					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	**Positive Impact:** The implementation of the WRES, WDES and WSOES helps SEL ICB fulfil its statutory obligations under the Equality Act 2010, as well as the mandatory requirements established by NHS England. It will positively impact individuals from a Global Majority background, Disabled staff and LGB+ Staff as it includes actions aimed at enhancing their experiences and ensuring equitable processes.					
Financial Impact	None identified					
Public Patient Engagement	None					
Committee engagement	• Equalities Sub-Committee • Executive Committee					
Recommendation	The Board is asked to approve WRES, WDES and WSOES reports for publication by 31 March 2026.					

NHS
South East London

Workforce Race Equality Standard 2024/25

South East London Integrated Care Board

Compiled by Equality, Diversity and Inclusion Team

Data Snapshot Date: 31 March 2025

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NHS South East London

Introduction

NHS South East London

The NHS workforce is the foundation for NHS, there are 1.6 million employees, 350 different professions and all of this is made up of staff from different backgrounds and nationalities. Every individual, irrespective of their background, enriches the NHS with distinctive skills, which supports the NHS in delivering exceptional care and services for all. The NHS Workforce Race Equality Standard (WRES) ensures that employees from Global Majority backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The WRES has **nine indicators**: data for **four** indicators is sourced from workforce data, **four** indicators from the National Staff Survey and the data for the **final** indicator comes from the Board. SEL ICB use the data to develop and publish an action plan to ensure the continuous improvement of healthcare services and the wellbeing of both patients and staff. Research shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and improved patient safety.

All data used in this report is anonymous and retrospective. This year's WRES report is based on data from the 2024/25 financial year. It includes a **three-year** comparison to track progress and identify trends. To illustrate changes, we have used directional arrows and colour coding: green indicates improvement, red shows regression, and amber represents no change compared to the previous year.

Definition:

The term 'Global Majority' refers to people who are Asian, Black, Brown, Indigenous, of mixed heritage backgrounds or other non-white ancestries. Collectively, these groups represent approximately 80 - 85% of the world's population.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Indicator 1: Overview of ICB workforce and South East London Population

NHS South East London

Total workforce			
Category	Workforce %	Workforce no.	SEL Population %
Global Majority	43.7	293	39.8
White	55.1	369	60.2
Unknown/not stated	1.2	8	0.0
Total	100	670	100

- SEL ICB currently has a **total workforce** of 670, of which **43.7%** is Global Majority, **55.1%** is White and **1.2%** fall under the 'not stated/unknown' category (this may indicate that staff may not feel safe enough to share their ethnicity or may not be aware of how to update their details on the system).

- Please note that there has been a slight decrease in the number of the overall workforce of 684 from the previous year's report, representing a **2.1% reduction** due to the Management Cost Reduction.

- When compared to the **South East London population, 39.8%** of the community identifies as Global majority, indicating the organisation is **3.9%** overrepresented.

Indicator 1: Percentage of staff in AfC (Agenda for Change) pay bands.

NHS South East London

Non-Clinical						
Pay Band	Global Majority % - 23/24	Global Majority % - 24/25	White % - 23/24	White % - 24/25	Not stated / Unknown % - 23/24	Not stated / Unknown % - 24/25
Cluster 1: <1 to 4	63.6	50.0 ↓	36.4	50.0	0.0	0.0 ↔
Cluster 2: 5 to 7	45.2	46.6 ↑	53.3	52.9	1.4	0.5 ↓
Cluster 3: 8a and 8b	37.3	37.7 ↑	61.5	61.7	1.2	0.6 ↓
Cluster 4: 8c to VSM	20.6	23.1 ↑	77.2	75.4	2.2	1.5 ↓
Other	0.0	0.0 ↔	100	0.0	0.0	0.0 ↔
Total	**37.8**	**38.3** ↑	**61.0**	**60.9**	**1.5**	**0.8** ↓

Non-Clinical Staff

- Global Majority staff make up **38.3%** of the workforce, while White staff account for **60.9%**. A small proportion **(0.8%)** of the workforce have not stated their ethnicity.
- There is a higher concentration of Global Majority staff in Cluster 1 **(50%)** and Cluster 2 **(46.6%)** than the other clusters.
- There has been an increase of Global Majority representation in Cluster 3 (from **37.3%** to **37.7%**) and Cluster 4 (from **20.6%** to **23.1%**).
- In comparison, White staff respectively make up **61.7%** and **75.4%** of Clusters 3 and 4. This is telling us that Global Majority staff may be experiencing a glass ceiling effect.

Comparison to 2023/24:

- Total workforce decreased by **11** people (from **543** to **532**).
- The number of non-clinical Global Majority staff remained the same.
- Due to the smaller workforce, their percentage increased by **0.5% from 37.8 to 38.3.**
- The percentage of White staff remained largely consistent, with a **0.1%** decrease from **61%** to **60.9%** in 24/25.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Indicator 1: Percentage of staff in AfC (Agenda for Change) pay bands.

NHS South East London

Clinical						
Pay Band	Global Majority % - 23/24	Global Majority % - 24/25	White % - 23/24	White % - 24/25	Not stated / Unknown % - 23/24	Not stated / Unknown % - 24/25
Cluster 1: <1 to 4	0.0	0.0 ↔	0.0	0.0	0.0	0.0 ↔
Cluster 2: 5 to 7	79.3	74.5 ↓	20.7	21.3	0.0	4.3 ↑
Cluster 3: 8a and 8b	69.5	70.0 ↑	27.1	26.7	3.4	3.3 ↓
Cluster 4: 8c to VSM	45.2	40.7 ↓	51.6	59.3	3.2	0.0 ↓
Other	40.9	25.0 ↓	59.1	75.0	0.0	0.0 ↔
Total	61.7	64.5 ↑	36.2	32.6	2.1	2.9 ↑

Clinical Staff

- Global Majority staff make up **64.5%** of the workforce, while White staff account for **32.6%**. **2.9%** of the workforce come under not stated/unknown.
- Global Majority numbers are higher in all clusters apart from 4 (8c to VSM), where there are a slightly higher number of White staff (excluding 'Other', which also has higher numbers of White staff.)

Comparison to 2024:

- Total Global Majority clinical staff have seen a **2.8%** increase (from **61.7%** to **54.5%**).
- White clinical staff have seen a significant decrease of **4.9%** (from **36.2% to 32.6%**).
- It should be noted that several staff have left the organisation due to restructuring since the 2024 snapshot.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Indicator 1: Yearly Comparison

NHS South East London

Year on Year Comparison						
Financial Year	Overview		Non-clinical		Clinical	
	Global Majority %	White %	Global Majority %	White %	Global Majority %	White %
2022/23	40.7	56.0	36.1	62.1	50.4	43.4
2023/24	42.5	55.8	37.6	61.0	61.7	36.2
2024/25	43.7	55.1	38.3	60.9	64.5	32.6

The table above provides a three-year comparison, showing an overall upward trend in the representation of Global Majority staff across all categories.

- **Overall**: There has been a steady increase of **3%** in Global Majority staff over the past three years (from **40.7**% to **43.7**%).
- **Non-clinical roles**: Representation of Global Majority staff has grown more gradually in this category, with a **2.2%** increase over the same period (from **36.1%** to **38.3**%).
- **Clinical roles**: Global Majority has seen the most significant growth, with a sharp increase of **14.1%** (from **50.4%** to **64.5**%).

Indicator 2: Appointed following shortlisting
Indicator 3: Likelihood of formal capability process

NHS South East London

Year	Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts.	Indicator 3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
2022/23	2.1	0.0
2023/24	4.6 ↑	0.0
2024/25	3.95 ↓	0.0

The data shows a relative likelihood of **3.95** for applicants who are White being appointed. This is a decrease of **0.65** since last year's result and indicates that Global Majority staff are less likely to be appointed from shortlisting (see note below). There are continuous processes in place to ensure there is inclusive recruitment in place. The People and Culture Group will be undertaking a deep dive to understand the root cause and agree corrective action to be taken.

Note:

- A ratio (score) of **1** means equal likelihood of appointment between White and Global Majority applicants.
- A ratio (score) **below 1** means Global Majority applicants are more likely to be appointed.
- A ratio (score) **above 1** means White applicants are more likely to be appointed.

In the past 12 months, there have been no formal disciplinary investigations or hearings within SEL ICB. This trend is consistent with the previous three years, which also reported no cases, indicating a positive and sustained outcome.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

NHS South East London

While SEL ICB does not currently have a formal process for tracking non-mandatory training completed by staff, all staff have access to NHS Elect and NHS Leadership Academy courses.

For non-mandatory training requests over £500, a training review panel is in place to monitor, review, and approve such requests.

Year on Year Comparison			
Financial Year	Overview		
	Global Majority	White	Uknown/not stated
2023/24	3	0	0
2024/25	15 ↑	13	0 ↔

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

- Only **3** applications were received in 23/24 and **28** in 24/25, showing overall increased interest in non-mandatory training / personal development.
- Demographic reporting is optional, so some applicants did not provide data, causing slight discrepancies.
- Of those reporting, Global Majority applications rose from **3 to 15**, White applications from **0 to 13**.
- Increased engagement from both groups were evident in 24/25 compared to 23/24.

Indicators 5-6: Staff Survey Data

NHS South East London

Year of Staff Survey	Indicator 5 % staff experiencing harassment, bullying or abuse from patients, relatives or public		Indicator 6 % staff experiencing harassment, bullying or abuse from staff	
	Global Majority %	White %	Global Majority %	White %
2022	4.3	6.5	24.9	19.6
2023	9.2 ↑	4.9	23.5 ↓	19.9
2024	5.7 ↓	4.3	21.4 ↓	13.0

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

The table above presents data for Indicators 5 and 6, sourced from the National Staff Survey.

- **Indicator 5:** This year's results show a **3.5%** (from **9.2%** to **5.7%**) improvement compared to last year. In 2022, the percentage was at **4.3%,** followed by a significant increase to **9.2%**, and then a significant decrease to **5.7%** this year.

- **Indicator 6:** This year's score reflects a **2.1%** (from **23.5%** to **21.4%**) improvement on the previous year. The data shows a consistent positive trend over the three years, with a **3.5%** decrease compared to 2022.

- The improvements in both indicator 5 and indicator 6 suggest that our Anti-Racism Strategy and Zero Tolerance policy is working.

Indicators 7 - 8: Staff Survey Data

NHS South East London

Year of Staff Survey	Indicator 7 % staff believing that the ICB provides equal opportunities for career progression or promotion		Indicator 8 % staff experiencing discrimination at work from manager/team leader or colleagues	
	Global Majority %	White %	Global Majority %	White %
2022	38.4	58.2	12.1	7.2
2023	43.0 ↑	54.3	18.0 ↑	9.0
2024	42.9 ↓	61.1	17.3 ↓	5.8

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

The table above presents data for Indicators 7 and 8, sourced from the National Staff Survey.

- **Indicator 7:** There has been a slight decrease of **0.1%** (from **43%** to **42.9%**) in the belief that there are equal opportunities for career progression or promotion, this slight change suggests stability, particularly in the context of the recent change management programme. However, it is important to highlight that **57.1%** of respondents from Global Majority **did not** respond positively to this indicator. This may be an indication that Global Majority staff may not have the confidence in applying for senior roles or alternatively there is no opportunity to move upwards in their chosen career. Encouragingly, the overall trend over the past three years indicates steady progress, with a significant positive shift observed between 2022 and 2024.

- **Indicator 8:** This year's results indicate a slight improvement in the experience of Global Majority staff (from **18%** to **17.3%**).

Indicator 9: Board membership

NHS South East London

Board Membership.

	Global Majority	White	Unknown	Total
Total Board Members	2 (3) ↓	9 (7)	2 (1)	13 (11)
Voting Members	2 (3) ↓	9 (7)	2 (1)	13 (11)
Non-Voting Members	0 (0) ↔	0 (0)	0 (0)	0 (0)
Exec Directors	1 (2) ↓	6 (5)	1 (0)	8 (7)
Non-Exec	1 (1) ↔	3 (2)	1 (1)	5 (4)
No. of Staff Overall	293 (291) ↑	369 (382)	8 (11)	670 (684)
Difference - Board: Workforce %	**-28.0 (-15.3)** ↑	**14.0 (7.8)**	**14.0 (24.0)**	**N/A**

The table on the right depicts the percentage difference between SEL ICB's Board membership and SEL ICB's overall workforce, disaggregated by:

- Voting and non-voting membership of the Board
- Executive and non-exec membership of the Board

The snapshot of this data is 31 March 2025 and the data in brackets are the numbers from 31 March 2024.

Overview

- Please note that the data in the table pertains to board members employed by the ICB.
- There are a total of **13** Board members: **2** are Global Majority, **9** are White, and **2** are unknown.
- There are **8** executive directors: **1** who is Global Majority, **6** who are White, and **1** who is unknown.
- The difference between Global Majority Board members and Global Majority staff (workforce) is (minus) **-28%**.

Contact Us

NHS South East London

If you have any questions about this report, or would like it in a different format, please contact us at:

Equality, Diversity, and Inclusion Team

Email: equality@selondonics.nhs.uk

Workforce Disability Equality Standard 2024/25

South East London Integrated Care Board

Compiled by the Equality, Diversity and Inclusion Team

Snapshot Date: 31 March 2025

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NHS South East London

Introduction

NHS South East London

The NHS Workforce Disability Equality Standard (WDES) enables NHS organisations to better understand the experiences of their disabled staff, supporting positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in South East London.

The WDES has **ten indicators (metrics),** which enables a comparison of the workplace and career experiences of staff with disabilities or long-term conditions (LTCs) and those without. The data for four metrics is sourced from **workforce data**, five metrics from the **National Staff Survey** and the data for the final metric comes from the **Board**.

SEL ICB use the data to develop and publish an action plan to ensure the continuous improvement of healthcare services and the wellbeing of both patients and staff. Research shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and improved patient safety.

All data used in this report is anonymous and retrospective. This year's WDES report is based on data from the 2024/25 financial year. It includes a four year comparison to track progress and identify trends. To illustrate changes, we have used directional arrows and colour coding: green indicates improvement, red shows regression, and amber represents no change compared to the previous year.

Definition:

Disability is defined as having a physical or mental impairment that has a 'substantial' (takes much longer than it usually would to complete a daily task) and 'long-term' (12 months or more) negative effect on the ability to undertake daily activities. This definition covers a range of illnesses and conditions.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 1- Overview of ICB workforce and South East London Population

NHS South East London

Total workforce			
Category	Workforce %	Workforce no.	SEL Population%
Disabled	9.2	62	14.0
None disabled	86.6	580	86.0
Unknown/not stated	4.2	28	0.0
Total	100	670	100

- SEL ICB currently has a **total workforce** of 670, of which **86.6%** have no disability, **9.2%** have a disability, and **4.2%** fall under the 'not stated/unknown' category. It should be noted that the rate of non-disclosure has gone up from **3.5%** (2023/24) to **4.2%** (2024/25). This may indicate that staff may not feel safe enough to share that they have a disability or may not be aware of how to update their details on the system.

- Please note that there has been a slight decrease in the number of the overall workforce of 684 from 2023/24, representing a **2.1% reduction**.

- When compared to the **South East London population**, where **14%** of the community identifies as having a disability, it is evident that the organisation is not yet representative of the community from a disability perspective.

Metric 1- Percentage of staff in AfC (Agenda for Change) pay bands

NHS South East London

Non-Clinical						
Pay Band	With Disability/LTC % - 23/24	With Disability/LTC % - 24/25	Without disability/LTC % - 23/24	Without disability/LTC % - 24/25	Not stated / Unknown % - 23/24	Not stated / Unknown % - 24/25
Cluster 1: <1 to 4	9.1	11.1 ↑	90.9	80.6	0.0	8.3 ↑
Cluster 2: 5 to 7	13.3	13.0 ↓	82.9	83.7	3.8	3.4 ↓
Cluster 3: 8a and 8b	10.6	11.0 ↑	86.3	85.7	3.1	3.2 ↑
Cluster 4: 8c to VSM	6.6	4.5 ↓	91.2	91.0	2.2	4.5 ↑
Other	33.3	0.0 ↓	33.3	0.0	33.3	0.0 ↓
Total	**10.7**	**10.2** ↓	**86.2**	**85.9**	**3.1**	**3.9** ↑

Non-Clinical Staff

- **85.9%** of the workforce do not have a disability or a long-term condition (LTC).
- **10.2%** of non-clinical staff have a disability or an LTC.
- Bands 5-7 (**Cluster 2**) have higher representation of staff with a disability of LTC.
- There is a noticeable decrease in representation of staff with a disability or LTC in the higher bands.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Comparison to 2024:

- The total number of staff with a disability or LTC in a non-clinical role has decreased by **0.5%** (from **10.7%** to **10.2%**). This decrease can also be seen in Cluster 2, 4 and Other

Metric 1- Percentage of staff in AfC (Agenda for Change) pay bands

NHS South East London

Clinical						
Pay Band	With Disability/LTC % - 23/24	With Disability/LTC % - 24/25	Without disability/LTC % - 23/24	Without disability/LTC % - 24/25	Not stated/ Unknown % - 23/24	Not stated/ Unknown % - 24/25
Cluster 1: <1 to 4	0.0	0.0 ↔	0.0	0.0	0.0	0.0 ↔
Cluster 2: 5 to 7	13.8	8.5 ↓	82.8	83.0	3.4	8.5 ↑
Cluster 3: 8a and 8b	0.0	3.3 ↑	93.2	93.3	6.8	3.3 ↓
Cluster 4: 8c to VSM	3.2	7.4 ↑	90.3	92.6	6.5	0.0 ↓
Other	13.6	0.0 ↓	86.4	75.0	0.0	25.0 ↑
Total	**5.7**	**5.8** ↑	**89.4**	**89.1**	**5.0**	**5.1** ↑

Clinical Staff

- **5.8%** of clinical staff have a disability or an LTC.
- **89.1%** of the workforce have a disability or an LTC.
- Bands 5-7 (**Cluster 2**) has the highest percentage of employees with a disability or LTC.
- At each level of the cluster, there are large disparities in the number of clinical staff living with a disability or LTC than those without.
- **Comparison to 2024:** The total number of clinical staff identifying as having a disability or long-term condition has remained the same. However, the percentage has increased due to the change in the overall workforce. Notably, there were no disabled staff in Cluster 3 and only one in Cluster 4.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 1: Yearly Comparison

NHS South East London

Year on Year Comparison						
Financial Year	Overview		Non-clinical		Clinical	
	With Disability / LTC %	Without Disability / LTC %	With Disability / LTC %	Without Disability / LTC %	With Disability / LTC %	Without Disability / LTC %
2021/22	7.6	89.9	8.3	89.5	5.1	94.1
2022/23	6.4	83.9	7.9	87.6	3.2	75.7
2023/24	9.7	86.8	10.7	86.2	5.7	89.4
2024/25	9.2	86.6	10.2	85.9	5.8	89.1

The table above presents a comparison over the past four years. Overall, the percentages indicate a fluctuating trend, with a decrease in one year followed by an increase. However, the most recent data shows a slight decline in the total number of staff with disabilities / LTCs by **0.5%** (from **9.7%** to **9.2%**).

When broken down by staff group:

- **Clinical roles**: The only meaningful increase occurred in 2023/24, but the latest figures show only an increase of **0.1%** (from **5.7%** to **5.8%**) since the previous year.
- **Non-clinical roles**: There was an initial decline, followed by significant increase in 2023/24. While the latest figures show a decrease once again, it is only slight (**0.5%** - from **10.7%** to **10.2%**).

Metric 2: Appointed following shortlisting
Metric 3: Likelihood of formal capability process

NHS South East London

Year	Metric 2 The relative likelihood of applicants with a disability / LTC being appointed from shortlisting compared to those without	Metric 3 Relative likelihood of disabled staff entering the formal capability process.
2021/22	0.96	0.0
2022/23	0.88 ↓	0.0
2023/24	0.82 ↓	0.0
2024/25	0.37 ↓	0.0

The data shows a relative likelihood of **0.37** for applicants with a disability or long-term condition (LTC) being appointed. This indicates that **non-disabled applicants are less likely** to be appointed from shortlisting (see note below).

- Over recent years, the ratio (score) has steadily **declined**, with this year showing a **sharp drop**, which is a **negative** shift for non-disabled applicants in appointment outcomes.
- The years in which the organization came closer to achieving a 1:1 ratio may be **influenced** by the ICB's involvement in the **Disability Confident scheme**.
- The overall representation for disabled staff remain **underrepresented** within the organisation.

Note:

- A ratio (score) of **1** means equal likelihood of appointment.
- A ratio (score) **above 1** means non-disabled applicants are more likely to be appointed.
- A ratio (score) **below 1** means non-disabled applicants are less likely to be appointed.

In the past 12 months, there have been no formal disciplinary investigations or hearings within SEL ICB. This trend is consistent with the previous three years, which also reported no cases, indicating a positive and sustained outcome.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 4: Percentage of disabled staff experiencing harassment, bullying or abuse

NHS South East London

	Metric 4: % staff experiencing harassment, bullying or abuse…							
	Disability/LTC 2021 %	Disability/LTC 2022 %	Disability/LTC 2023 %	Disability/LTC 2024 %	No Disability/ LTC 2021 %	No Disability/ LTC 2022 %	No Disability/ LTC 2023 %	No Disability/ LTC 2024 %
…From the Public	9.3	6.2 ↓	5.1 ↓	7.5 ↑	5.8	5.8	7.8	3.9
…From Managers	19.8	19.6 ↓	25.3 ↑	14.1 ↓	7.9	10.7	9.7	8.3
…From Colleagues	16.7	20.6 ↑	23.5 ↑	17.6 ↓	10.9	11.9	12.2	9.1
% staff that reported the incident	34.6	44.4 ↑	31.4 ↓	46.2 ↑	47.5	46.2	38.5	35.9

Metric 4 comprises of **4** components, with data sourced from the staff survey results.

- The most recent findings from the **2024** staff survey indicate a **2.4% increase** (from **5.1%** to **7.5%**) in reports of harassment, bullying, or abuse from the public experienced by staff with a disability or long-term health condition. This may be due to lack of understanding or discriminatory behaviour from the public.
- Positively, there has been a significant **decrease** in such experiences from managers (down by **11.2% -** from **25.3%** to **14.1%**) and colleagues (down by **5.9% -** from **23.5%** to **17.6%**). This is due to the ICB's strong culture of zero tolerance to harassment, bullying or abuse combined with resources and awareness raising on workplace adjustments and hidden disabilities.
- Additionally, there has been a notable **14.8% increase** (from **31.4%** to **46.2%)** in the percentage of people reporting these incidents. This may be due to the culture shift from the awareness raising.
- In comparison, staff without a disability or long-term health condition report **significantly lower** levels of harassment, bullying, or abuse from the public, managers, and colleagues. However, they also have lower rates of reporting these incidents.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 4: Yearly comparison

NHS South East London

	Metric 4: % staff experiencing harassment, bullying or abuse…							
	Disability/LTC 2021 %	Disability/LTC 2022 %	Disability/LTC 2023 %	Disability/LTC 2024 %	No Disability/ LTC 2021 %	No Disability/ LTC 2022 %	No Disability/ LTC 2023 %	No Disability/ LTC 2024 %
…From the Public	9.3	6.2 ↓	5.1 ↓	7.5 ↑	5.8	5.8	7.8	3.9
…From Managers	19.8	19.6 ↓	25.3 ↑	14.1 ↓	7.9	10.7	9.7	8.3
…From Colleagues	16.7	20.6 ↑	23.5 ↑	17.6 ↓	10.9	11.9	12.2	9.1
% staff that reported the incident	34.6	44.4 ↑	31.4 ↓	46.2 ↑	47.5	46.2	38.5	35.9

- There was a steady **decline** in the percentage of staff with a disability experiencing harassment, bullying, or abuse from the public (from **9.3**% to **5.1**%), until **2024**, where a **rise** was observed (to **7.5**%).
- The data shows a **fluctuating** trend: a **decrease** in 2022 (from **19.8%** to **19.6**%), a **significant increase** in 2023 (to **25.3**%), followed by a **significant decrease** in 2024 (to **14.1**%) for incident involving managers.
- The trend for colleague-related incidents showed an **increase** over two consecutive years (from **16.7%** to **20.6%** and **23.5%** in 2022 and 2023, respectively) before a **marked drop** in 2024 (to **17.6**%). This is due to the ICB's strong culture of zero tolerance to harassment, bullying or abuse combined with resources and awareness raising workplace adjustments and hidden disabilities.
- The pattern was **mixed for reporting rates**: a **significant increase** in 2022 (from **34.6**% to **44.4**%), a **significant decrease** in 2023 (to **31.4**%), and another **significant increase** in 2024 (to **46.2**%). In this case, a higher percentage is considered a positive outcome.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metrics 5-7: Staff Survey Data

NHS South East London

Year of Staff Survey	Metric 5 % staff believing that the ICB provides equal opportunities for career progression or promotion		Metric 6 % staff that felt pressure from their manager to come to work, despite not feeling well		Metric 7 % staff saying that they are satisfied with the extent to which their organisation values their work	
	Disability / LTC %	Non-Disabled %	Disability / LTC %	Non-Disabled %	Disability / LTC %	Non-Disabled %
2021	51.7	55.2	23.1	7.6	41.1	56.3
2022	39.6 ↓	52.9	22.5 ↓	15.5	44.3 ↑	53.1
2023	42.9 ↑	54.4	30.2 ↑	14.0	33.0 ↓	50.6
2024	42.9 ↔	57.3	24.6 ↓	17.6	43.5 ↑	57.7

The table above presents data for Metrics **5** to **7**, sourced from the National Staff Survey.

- **Metric 5:** This year's results have remained unchanged. Reviewing the trend over the past four years, there was a decrease in 2022, an increase in 2023, and the figure held steady in 2024. This may be due to the Change Management Programme and national context. Non-disabled staff scores have consistently remained higher across over the 4 years.
- **Metric 6:** There has been a significant decrease this year in the number of staff who felt pressure to attend work while unwell (from **30.2%** to **24.5%**). This may be due to a shift to a more people focused culture. Over the last four years, the trend has been mixed with an initial decrease, followed by a significant increase in 2023, and then a notable decrease in 2024. Comparatively, non-disabled staff have consistently reported lower levels of pressure, highlighting a significant disparity.
- **Metric 7:** This year's data shows a significant increase in the percentage of staff who feel valued for their work (from **33%** to **43.5%**). The positive shift may be due to more awareness on what adjustments can be requested, however it should be noted that **56.5%** of those with a disability still did not feel valued for their work, which indicates more work is required. The four-year trend has been varied with an initial decline, followed by a sharp increase in 2023, and a further increase in 2024. However, non-disabled staff have consistently reported higher scores, with over 50% feeling valued each year.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metrics 8-9: Staff Survey Data

NHS South East London

Year of Staff Survey	Metric 8 % staff state employer has made adequate adjustments at work	Metric 9 Staff engagement score	
	Disability / LTC %	Disability / LTC	Non-Disabled
2021	76.0	6.1	7.1
2022	79.3 ↑	6.4	6.9 ↑
2023	56.5 ↓	6.0	6.8 ↓
2024	73.1 ↑	6.5	7.0 ↑

The table above presents data for **Metrics 8 and 9**, sourced from the National Staff Survey.

- **Metric 8:** There has been a significant improvement in the number of respondents reporting that they receive adequate workplace adjustments (from **56.5%** to **73.1%**). The trend shows a strong increase in 2022, a significant decline in 2023 (it should be noted that 2023 was the time in which the Management Cost Reduction was taking place), and another sharp increase in 2024.

- **Metric 9:** The staff engagement score (**6.5** out of **10**) rose by 0.5 points this year. While the trend over recent years has fluctuated with increases and decreases. The score has consistently remained above 6.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 10: Board membership

NHS South East London

Board Membership.

	With disability/LTC	Without disability/LTC	Unknown	Total
Total Board Members	1 (1) ↔	8 (7)	4 (3)	13 (11)
Voting Members	1 (1) ↔	8 (7)	4 (3)	13 (11)
Non-Voting Members	0 (0) ↔	0 (0)	0 (0)	0 (0)
Exec Board	1 (1) ↔	7 (6)	0 (0)	8 (7)
Non-Exec	0 (0) ↔	1 (1)	4 (3)	5 (4)
No. of Staff Overall	62 (66) ↓	580 (594)	28 (24)	670 (684)
Difference - Board: Workforce - %	**-2.0 (-1.0)** ↑	**-25.0 (-23.0)**	**27.0 (24.0)**	**N/A**

The table on the right depicts the percentage difference between SEL ICB's Board membership and SEL ICB's overall workforce, disaggregated by:

- Voting and non-voting membership of the Board
- Executive and non-exec membership of the Board

The snapshot of this data is 31 March 2025 and the data in brackets are the numbers from 31 March 2024.

Overview

- Please note that the data in the table pertains to board members employed by the ICB, not the Partnership Board.
- There are a total of **13** Board members: **1** has a **disability/LTC**, **8** do not, and **4** are unknown.
- All board members are voting members.
- There are **8** executive directors: **1** with disability (LTC) and **7** without.
- The difference between Board members with disabilities/LTCs and staff with disabilities/LTCs (workforce) is (minus) **-2%**.

Contact Us

NHS
South East London

If you have any questions about this report, or would like it in a different format, please contact us at:

Equality, Diversity, and Inclusion Team

Email: equality@selondonics.nhs.uk

NHS
South East London

Workforce Sexual Orientation Equality Standard 2024/25

NHS South East London Integrated Care Board

Compiled by Equality, Diversity and Inclusion Team

Data Snapshot Date: 31 March 2025

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NHS South East London

Introduction

NHS South East London

The NHS workforce is the foundation for the NHS, there are 1.6 million employees, 350 different professions and all of this is made up of staff from different backgrounds and nationalities. Every individual enriches the NHS with distinctive skills, which supports the NHS in delivering exceptional care and services for all. The Workplace Sexual Orientation Equality Standard (WSOES) offers organisations valuable insights into the experiences of their Lesbian, Gay, Bisexual+ (LGB+) staff WSOES enables organisations to implement positive change and foster inclusivity within the workplace. It was developed by University Hospitals of Morecambe Bay NHS Foundation Trust in collaboration with Lancashire LGBT (a charity organisation supporting the LGBTQ+ community). The WSOES is not yet mandatory but supports SEL ICB's commitment to sexual safety.

The WSOES has **eight metrics** comparing LGB+ staff experiences with non-LGB+ colleagues: data for **four** metrics is sourced from **workforce data**, **three** metrics from the **National Staff Survey** and the data for the **final** metric comes from the **Board**. SEL ICB use the data to develop and publish an action plan to ensure the continuous improvement of healthcare services and the wellbeing of both patients and staff. Research shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increased patient satisfaction and improved patient safety.

For the purposes of the WSOES report, our focus is specifically on LGB+ staff. Including trans staff within a comparison of heterosexual and LGBTQIA+ groups could be misleading, as trans individuals may identify as heterosexual. The standard is intended to examine sexual orientation, not gender identity.

Currently the WSOES is being discussed for national adoption. Monitoring for inclusion for **all** LGBTQIA+ staff can be achieved through initiatives like the WSOES, LGBTQ+ Health Inclusion Framework and the People's Promise.

Disclaimer:

Due to small sample sizes, changes in the data are not statistically significant and should be interpreted with caution. This limits the reliability of WSOES findings for an organisation the size of SEL ICB.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 1: Overview of ICB workforce and south east London population

NHS South East London

Total workforce			
Category	**Workforce%**	**Workforce no.**	**SEL Population%**
LGB+	**4.5**	**30**	**5.5**
Heterosexual / Straight	**87.0**	**582**	**86**
Unknown/not stated	**8.5**	**58**	**8.5**
Total	**100**	**670**	**100**

- SEL ICB currently has a workforce of **670**, of which **4.5%** identifies as LGB+, **87%** identifies as heterosexual/straight and **8.5%** fall under the 'not stated/unknown' category. This may indicate that staff may not feel safe to share what their Sexual Orientation is or may not be aware of how to update their details on the system.
- South East London's LGB+ population (as per the 2021 census) is **5.5%**, meaning the ICB is slightly under-representative of the community we serve (by **0.9%**).
- The workforce has decreased from 684 (2023/24) to 670 (2024/25) employees, representing a **2.0%** reduction.
- The percentage of individuals who come under the not state/unknown category has increased from **7.8%** to **8.5%**.

Metric 1: Percentage of staff in AfC (Agenda for Change) pay bands.

NHS South East London

Non-Clinical						
Pay Band	**LGB+ % - 23/24**	**LGB+ % - 24/25**	**Heterosexual / Straight % - 23/24**	**Heterosexual / Straight % - 24/25**	**Not stated / Unknown %- 23/24**	**Not stated / Unknown %- 24/35**
Cluster 1: <1 to 4	3.0	5.6 ↑	90.9	86.1	6.1	8.3 ↑
Cluster 2: 5 to 7	6.6	3.4 ↓	87.8	88.5	5.6	8.2 ↑
Cluster 3: 8a and 8b	6.3	9.1 ↑	84.8	82.5	8.9	8.4 ↓
Cluster 4: 8c to VSM	3.9	2.2 ↓	85.9	88.8	10.2	9.0 ↓
Other	0.0	0.0 ↔	90.9	0.0	9.1	0.0 ↓
Total	**5.5**	**4.9 ↓**	**86.7**	**86.7**	**7.7**	**8.5 ↑**

Non-clinical staff

- **LGB+** staff make up **4.9%** of the workforce, while **heterosexual/straight** staff account for **86.7%**. **8.5%** of the workforce come under the category of **not stated/unknown**.
- There is a higher concentration of LGB+ staff in **Cluster 3** however heterosexual/straight staff are significantly more prevalent across all bands.
- From **Cluster 4 onwards** LGB+ staff representation decreases, this suggests there may be possible barriers to career progression present.
- The percentage of staff with undisclosed sexual orientation is notably high across all bands, indicating a reluctance to disclose.

Comparison to 2024:

- The total number of LGB+ staff decreased by **4** (13.3%).
- There has been a decrease of 50% in Cluster 2.
- There has been an increase of 40% in Cluster 3.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 1: Percentage of staff in AfC (Agenda for Change) pay bands.

NHS South East London

Clinical						
Pay Band	LGB+ % - 23/24	LGB+ % - 24/25	Heterosexual / Straight % - 23/24	Heterosexual / Straight % - 24/25	Not stated / Unknown % - 23/24	Not stated / Unknown % - 24/25
Cluster 1: <1 to 4	0.0	0.0 ↔	0.0	0.0	0.0	0.0 ↔
Cluster 2: 5 to 7	0.0	2.1 ↑	100	91.5	0.0	6.4 ↑
Cluster 3: 8a and 8b	5.1	1.7 ↓	83.1	85	11.9	13.3 ↑
Cluster 4: 8c to VSM	6.7	7.4 ↑	86.7	92.6	6.7	0.0 ↓
Other	8.7	0.0 ↓	82.6	66.7	8.7	33.3 ↑
Total	**5.0**	**2.9** ↓	**87.2**	**88.3**	**7.8**	**8.8%** ↑

Clinical staff

- **LGB+** staff make up **2.9%** of the clinical workforce, while **heterosexual/straight** staff make up **88.3%**. **8.8%** of the workforce come under the category of **not stated/unknown.**
- This is a **2.6%** underrepresentation for LGB+ staff compared to the SEL community.
- Heterosexual/straight staff have significantly higher representation on all bands.

Comparison to 2024:

- The number of LGB+ staff has decreased by 3 since 2024/25 – 2 of which are staff from Bands 8A – 8B.
- Representation in 8C to VSM has remained consistent over the last year.
- Heterosexual/straight representation has also remained consistent (drastic % changes should be attributed to the overall decrease in **total** staff) from bands 8A upwards, but there has been a significant increase in bands 5 – 7.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 1: Yearly comparison

NHS South East London

Year on Year Comparison						
Financial Year	Overview		Non-Clinical		Clinical	
	LGB+ %	Heterosexual / Straight %	LGB+ %	Heterosexual / Straight %	LGB+ %	Heterosexual / Straight %
2023/24	5.4	86.8	5.5	86.7	5.0	87.2
2024/25	4.5	87.0	4.9	86.7	2.9	88.3

The table above provides a two-year comparison, showing an overall downward trend in the representation of LGB+ staff across all categories. Please note, there was a programme of management cost reductions in 2024/25.

- **Overall:** There has been a **0.9% decrease** from **5.4%** to **4.5%**.
- **Non-clinical:** Representation of LGB+ staff has **decreased by 0.6%** (from **5.5%** to **4.9%**).
- **Clinical:** This group has seen the **highest decrease** of LGB+ staff by **2.1%** (from **5%** to **2.9%**).

Metric 2: Appointed following shortlisting
Metric 3: Likelihood of formal capability process

NHS South East London

Year	Metric 2 The relative likelihood of LGBTQIA+ applicants being appointed from shortlisting compared to those without	Metric 3 Relative likelihood of LGB+ staff entering the formal capability process.
2023/24	1.4	0.0
2024/25	0.7 ↓	0.0

- In 2023/24, heterosexual applicants were **1.4** times more likely to be appointed following shortlisting (see note below).
- For 2024/25 data shows that heterosexual applicants are **0.7 times** as likely to be appointed, suggesting a higher appointment rate for LGB+ applicants.
- Although this shift indicates progress in addressing disparities, there is still a slight underrepresentation within the organisation a whole. Sustained efforts are still required to achieve more balanced representation overall including the encouragement of staff to disclose their sexual orientation.

Note:
- A relative likelihood of 1 indicates no difference in appointment rates between LGB+ and heterosexual/straight applicants.
- A value below 1 suggests LGB+ applicants are more likely to be appointed following shortlisting,
- A value above 1 means heterosexual/straight applicants are more likely to be appointed.

In the past 12 months, there have been no formal disciplinary investigations or hearings within SEL ICB. This trend is consistent with the previous year, which also reported no cases, indicating a positive and sustained outcome.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 4: Relative likelihood of LGB+ staff accessing non-mandatory training and CPD

South East London

Staff have access to paid-for training as well as generic training promoted across the organisation e.g. NHS Elect and NHS Leadership Academy courses.

For non-mandatory training requests costing more than £500, a training review panel is in place to monitor, review, and approve such requests.

Year on Year Comparison			
Financial Year	Overview		
	LGB+	Heterosexual / Straight	Unknown/not stated
2023/24	0	3	0
2024/25	1 ↑	20	7 ↑

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

- **3** training applicants in 2023/24, and **28** total applicants in 2024/25.
- Demographic reporting was optional, meaning some applicants chose not to disclose this information.
- Applicants might choose not to disclose their sexual orientation due to privacy concerns, fear of potential bias or discrimination, uncertainty about how the information will be used, or simply personal preference to keep that information confidential.
- Of those who reported: only **1** applicant identified as LGB+, the remaining **20** were heterosexual.
- This data aligns with findings from the 2023/24 WSOES report, where only 32% of LGB+ respondents (Metric 5) felt the ICB offered equal opportunities for career development.

Metrics 5-7: Staff survey data

NHS South East London

Year of Staff Survey	Metric 5 % staff believing that the ICB provides equal opportunities for career progression or promotion			Metric 6 % staff experiencing harassment, bullying or abuse from managers			Metric 7 % staff experiencing harassment, bullying or abuse from colleagues		
	L & G %	B %	Heterosexual / Straight %	L & G %	B %	Heterosexual / Straight %	L & G %	B %	Heterosexual / Straight %
2023	35.7	27.3	52.6	28.6	9.1	13.1	28.6	0.0	13.6
2024	57.1 ↑	N/A	55.1	7.1 ↓	N/A	9.2	0.0 ↓	N/A	11.5

The table above presents data for Metric 5 to 7, sourced from the National Staff Survey.

- **Overall:** All metrics have seen a highly positive change in the 2024 Staff Survey for both LGB+ and Heterosexual / Straight colleagues when compared to the 2023 staff survey. It should be noted, however, that the number of LGB+ staff responding to the survey this year is significantly lower (**14**), when compared to 2023 (**25**), which will have an impact on the proportionality of the results. Please note there is **no data** for bisexual staff for 2024 due to no staff identifying as bisexual on the survey.
- **Metric 5:** This year's results show a significant improvement for both Lesbian and Gay staff and heterosexual/straight staff, with Lesbian and Gay staff seeing an increase of **21.4%** (from **35.7%** to **57.1%**) and heterosexual staff **2.5%** (from **52.6%** to **55.1%**).
- **Metric 6:** This year's results shows a significant improvement for Lesbian and Gay staff by **21.5%** (from **2.6%** to **7.1%**) in the proportion of staff experiencing harassment, bullying or abuse from managers, indicating positive progress.
- **Metric 7:** Lesbian and Gay staff have seen a significant (from **28.6%** to **0%**) decrease in incidents of harassment, bullying or abuse from colleagues. Please note that the data for this year only includes Lesbian and Gay colleagues compared to 2023, which also included staff who identify as Bisexual.

Key	
↑ Positive upward trend	↑ Negative upward trend
↓ Negative downward trend	↔ No change
↓ Positive downward trend	

Metric 8: Board membership

NHS South East London

	LGB+	Heterosexual	Unknown	Total
Total Board Members	0 (0) ↔	9 (7)	4 (4) ↔	13 (11)
Voting Members	0 (0) ↔	9 (7)	4 (4) ↔	13 (11)
Non-Voting Members	0 (0) ↔	0 (0)	0 (0) ↔	0 (0)
Exec Board	0 (0) ↔	7 (6)	1 (1) ↔	8 (7)
Non-Exec	0 (0) ↔	2 (1)	3 (3) ↔	5 (4)
No. of Staff Overall	30 (37) ↓	583 (594)	57 (53) ↑	670 (684)
Difference - Board: Workforce %	**-4.0 (-5.0)** ↓	**-18.0 (-23.0)**	**22.0 (29.0)** ↓	**N/A**

The table on the left depicts the percentage difference between SEL ICB's Board membership and SEL ICB's overall workforce, disaggregated by:

- Voting and non-voting membership of the Board
- Executive and non-exec membership of the Board

The snapshot of this data is 31 March 2025 and the data in brackets are the numbers from 31 March 2024.

Overview

- Please note that the data in the table pertains to board members employed by the ICB, not the Partnership Board.
- There are a total of **13** Board members: **0** are LGB+, **9** are Heterosexual, and **4** are unknown.
- All board members are voting members.
- There are **8** executive directors: **0** who are LGB+, **7** who are Heterosexual, and **1** who is unknown.
- The difference between LGB+ Board members and LGB+ staff (workforce) is (minus) **-4%.**
- This should be an area of focus for board going forward.

WRES, WDES and WSOES Action Plan update

NHS South East London

The ICB Workforce Equality Standards and Gender Pay Gap Reports now operate under a **single** action plan, providing a clear framework to address key priorities and deliver measurable, positive change across the organisation. It has been agreed that the actions outlined in the report will span a three-year period to support effective implementation and ensure long-term impact.

These actions will be reviewed annually to maintain relevance and alignment with organisational goals. Due to the ongoing Change Management Programme (CMP), some actions were temporarily paused however have been revisited and completed. The accompanying action log outlines completed actions, those currently in progress, those on hold, and actions from the EDI Strategy that align with the Workforce Equality Standards.

- **Completed** actions: 17
- **Ongoing** actions: 3
- Actions **on hold**: 1
- Actions from **EDI strategy** that align: 9

Action Plan update – completed actions (1/2)

NHS South East London

Actions
Create concise job descriptions by working with hiring managers to rewrite job descriptions to focus on essential duties, required qualifications, and key responsibilities
Design additional recruitment training sessions and explore the potential for “Train the Trainer” recruitment workshops (through Enact) to equip SEL ICB staff with the skills needed to carry out a fair and equitable recruitment processes.
Review 2024 staff survey data to understand colleague experiences and integrate findings into the OD plan for FY 25/26, following which further actions will be developed and updated in the next report.
Strengthen and actively promote the Speak Up process
Develop and deliver training on workplace adjustments and the access to work process.
Develop awareness raising sessions, through ad hoc events or the Equalities Forum
Advertise ICS leadership training for SEL ICB staff.
Participate in the development of the ICS conference and awards session.
Training request form will be digitised, with mandatory fields for demographic and diversity data to ensure accurate information capture

Action Plan update – completed actions (2/2)

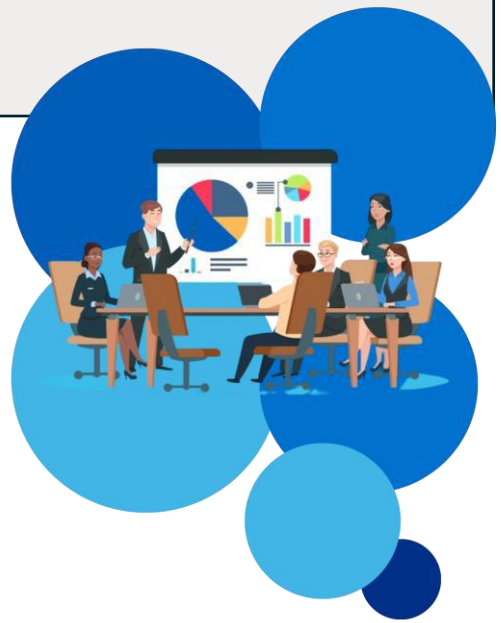
NHS South East London

Actions
Implement a Sexual Safety Charter
Ensure the accessible application form is available on request to use within Trac and NHS Jobs.
Develop and implement a process where applicants can request interview questions in advance.
Ensure that candidates, once an interview has been scheduled, are told in advance the names and job titles of the colleagues sitting on the interview panel.
Ensure interview panels are diverse, with all panel members required to complete mandatory unconscious bias training in advance of participation.
Revitalise the mediation service, including training more staff to become mediators
Raise awareness of the ICB's Mental Health First Aiders.
Ensure staff have an opportunity raise concerns as part of the appraisal process.
Long service awards/recognition certificates.

Action Plan update – on-track actions

NHS South East London

Action
Redesign the ICB's recruitment internet page layout to be more welcoming, user-friendly, and accessible, this will include: • A "What It Means to Work with Us" section highlighting values, mission, and staff experiences. • Videos showcasing staff at all levels within SEL ICB i.e. regarding the reasonable adjustments we offer etc. • Links to employee testimonials, benefits, and career growth opportunities. • Statement about why we are collecting equalities data/who can see it to encourage a higher disclosure rate.
Design and deliver enhanced line management training.
Develop and implement a formal workplace adjustments policy.



Action Plan update – EDI Strategy actions which align to the Equality Standard

NHS South East London

Strategic theme	Ongoing actions
Active leadership commitment	• Continue active discussion of EDI considerations at SMT throughout the consultation period, supported by the established role of the Executive Equalities SRO.
Being an inclusive employer	• Provide suite of EDI training to support staff through change` • Continue with the provision of mandatory EDI training on unconscious bias (which includes micro-incivilities and micro-aggressions) for Band 4 roles and above.
Progressing careers and talent development	• Invite guest presenters to discuss career journeys when speaking at EDI forums
Building staff support, health, and wellbeing	• Promote staff networks as safe spaces to discuss change • Implement in-house solutions and support e.g. workplace adjustments, allyship and compassion training.
Training, learning and development	• Use training needs analysis findings to understand training needs and priorities • Implementation of an EDI training offer, including EIA, workplace adjustments, allyship, EDI awareness, compassionate working, micro-incivilities and inclusive recruitment. • Staff networks to promote discussions on intersectionality

Contact Us

NHS
South East London

If you have any questions about this report, or would like it in a different format, please contact us at:

Equality, Diversity, and Inclusion Team

Email: equality@selondonics.nhs.uk

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Chief Executive Officer's Report**						
Meeting date	28 January 2026		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 15 October 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) 28 January 2026

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.

Since the Board last met in public, our system has managed the combined challenges of winter pressures, high levels of Flu and industrial action; whilst completing the initial planning requirements for next year and the medium term. This paper and those that follow it at our meeting outline the challenges and the outcomes secured against them in this period. I would like to place on record a clear recognition of the huge efforts made by our teams right across the system to prioritise patient safety and experience of care.

Alongside system management of current pressures and future plans, the ICB also took the decision to enter in to 'Cluster' arrangements with colleagues in NHS South West London ICB. This arrangement does not represent a merger. Both organisations will remain as separate statutory bodies serving their respective populations. It does reflect the view of both the South West London Board, and our own Board that there is advantage in working together and sharing some functions in order to maximise our effectiveness as strategic commissioners in the future and maximising the value of the collective investment we make in our running costs in future. Whilst each ICB will retain its own Board, it will share a Chair, a Chief Executive Officer and an executive team. These arrangements will be progressed over the coming days and weeks and importantly both ICBs will seek to consult their stuff on a new structure - securing the requirements of the model ICB Blueprint whilst living within the new management cost envelops - at the start of March.

As part of the same ICB reform process it is important to note that the ICB launched the first phase of a Voluntary Redundancy process and the Board will be updated at the time of the public meeting on the latest response to that opportunity.

When taken together our board papers today outline current system pressures, an incredibly challenging set of plans for the future, 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.

It remains 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. Equalities Update

Staff Equality, Diversity and Inclusion Strategy

1.1. South East London ICB has launched an Equality, Diversity and Inclusion (EDI) Strategy to complement its Anti-Racism Strategy. This strategy takes an intersectional approach across all protected characteristics and is built around seven key themes: Active leadership commitment, being an inclusive employer, progressing careers and talent development, tackling bullying and harassment, building staff support, health and wellbeing, service planning and engagement and training, learning and development.

1.2. The Strategy's overarching aim is to create and embed a tangible culture of anti-discrimination within the organisation. The EDI Strategy also contributes towards mandatory and statutory reporting and drives delivery of actions for the Workforce Race Equality Standard, Workforce Disability Equality Standard, Workforce Sexual Orientation Equality Standard, and Gender Pay Gap reporting.

Public Sector Equality Duty Report

1.3. The Public Sector Equality Duty (PSED) Report allows SEL ICB to demonstrate how it meets the requirements of the Equality Act 2010 and the PSED. The 2026 PSED report is on track for publishing on 31 March 2026. The report will include case studies on the amazing work being undertaken at Place level.

Islamophobia Awareness Month

1.4. Islamophobia Awareness Month (IAM) takes place annually in November. The Islamophobia Response Unit data shows a 365% increase in Islamophobic incidents since October 2023. IAM shines a light on the realities of anti-Muslim prejudice and highlights the positive impact of Muslim.

1.5. The 2025 theme, 'Flip the Script', encouraged challenge of stereotypes, hearing from those with lived experience, and creating space for open conversations. SEL ICB held an Equalities Forum and the session opened with an exploration of what Islamophobia means and the growing impact it continues to have across the UK. The discussion then brought together a panel of Muslim colleagues from across the organisation who shared their personal reflections on faith and identity; joined by Allies who spoke about the meaningful actions they take each day to support inclusion and challenge misconceptions in their work and teams.

Disability History Month

1.6. UK Disability History Month (DHM) 2025 ran from 20 November to 20 December, with the theme of "Disability, Life and Death." DHM reflects on the impact of discrimination on disabled people's lives and recognises the resilience driving progress towards inclusion. SEL ICB held an Equalities Forum, which focused on Neurodiversity Awareness - recognising that we all experience and engage with the world differently. The event was facilitated by the Chief of Staff and Equalities SRO. The guest speaker was from Neurobox and focussed on neurodiversity, including how it shapes the way of thinking and working and how to create an inclusive environment.

Equality Delivery System 2022

1.7. In November 2025 the Equality Delivery System 2022 (EDS22) Task and Finish Group met and discussed progression of the maternity services (Domain 1), focussing on improving access and experience for patients.

1.8. Key actions include delivering workshops and multilingual resources to enhance information access, implementing consistent postnatal guidance, and running a pre-conception campaign reaching over 500,000 people.

1.9. Commissioned services such as the Maternal Medicine Network and Perinatal Pelvic Health services address complex needs, whilst personalised care guides and simplified care plans support tailored maternity care. Safety remains a priority, with Patient Safety Incident Response Framework (PSIRF) plans in place. Patient experience is monitored through ongoing feedback mechanisms, CQC survey action plans, and co-production initiatives.

LGBTQ+ Health Inclusion Framework:

1.10. The NHS Confederation developed the LGBTQ+ Inclusion Framework, this is a tool used to benchmark and assess the impact of the working lives and experiences of LGBTQ+ staff within the workplace.

1.11. The self-assessment tool (survey) was launched to all staff on 24 November 2025 and was open for 3 weeks (a total of 126 survey responses were received). Analysis of the data is being undertaken, with the publication of the results in February 2026 to align with LGBTQ+ History Month.

Equality Impact Assessment:

1.12. An Equality Impact Assessment (EIA) is a risk assessment tool used to help identify positive or negative impacts when a service is commissioned, a new process or policy is put in place. EIAs help the ICB meet its Equality Act duties by improving services, strengthening planning, promoting inclusion, supporting engagement, and building trust with staff and the public.

1.13. The EIA process was redesigned in 2024 and introduced at the end of 2024 (including training) with 2025/26 being used to embed the process. Since the introduction of the new process, the number of completed EIAs has grown significantly (more than doubled). This suggests the new process is working, with staff showing greater awareness of equality issues and more confidence in using the EIA framework.

2. Industrial Action

2.1. The NHS has seen two periods of industrial action by resident doctors, each spanning five days, since the last report to the Board. All Trusts in south east London were impacted, however mitigating actions were put in place to maintain core services and ensure as much elective work as possible continued to be delivered. The second period of action, between 17 and 22 December, occurred during the winter period which created additional pressure. A system approach was maintained for these

periods of action, with regular reporting of activity and impacts through SEL ICB into NHS England to enable oversight of operational impacts and patient safety matters.

2.2. Regular horizon scanning to identify potential further periods of disruption takes place. Although the current British Medical Association (BMA) mandate comes to an end in January, members are in the process of being balloted on a further mandate.

3. SEL ICB EPRR Assurance

3.1. The annual self assessment of NHS South East London ICB's (SEL ICB) EPRR arrangements and delivery were reviewed by NHS England with SEL ICB receiving a substantially compliant outcome with core standards.

3.2. Although this is a reduction from full compliance in 2024, the reduction is entirely due to changes in the DSPT assessment and resourcing reduction that has been reported separately with full oversight by the Audit Committee. To give assurance, two south east London provider organisations were self-assessed as fully compliant, with the remaining four substantially compliant. No organisations were graded either partially compliant or non-compliant.

3.3. The assessment of providers is led by the SEL ICB's Chief of Staff and Accountable Emergency Officer (AEO). All providers will have reported their assessments to their boards by the end of January 2026, with SLaM reporting in March 2026, and have agreed action plans in place that have been shared with SEL ICB's AEO.

3.4. The full work of EPRR for 25/26 to support SEL ICB Board meet its obligations as a Cat 1 responder is attached in the Overall Committees Report.

4. ICB reform and 'Clustering' with South West London ICB

4.1. All ICBs are required to reduce their operating costs to £19/head of population. South East London (SEL) ICB developed proposed structures to achieve this in September 2025. However London ICBs are also required to work together to ensure London as a whole achieves the £19/head operating costs target.

4.2. In recognition of this requirement, SEL and South West London (SWL) ICBs agreed to explore if working collaboratively together would support both ICBs to achieve the financial target, strengthen their resilience and enhance their ability to recruit and retain the skills needed to become strategic commissioning organisations.

4.3. Following an initial assessment process, it was agreed that there are opportunities and benefits for both ICBs from working more closely together. Consequently, on 11 December 2025, both ICB Boards took the decision to formally cluster. As part of this decision, it was agreed that there should be a single Chair, Chief Executive Officer and executive team across the two ICBs with some functions also delivered through single teams.

4.4. This does not mean that the ICBs are merging. Both ICBs will remain as separate statutory bodies with separate Board structures and financial allocations.

4.5. Sir Richard Douglas has been appointed as joint Chair, subject to Secretary of State approval and work has commenced on the design of detailed structures for SEL and SWL ICBs with a view to commencing consultation with staff in early March 2026.

4.6. SEL ICB launched a VR scheme on 1 December 2025. Decisions on applications are scheduled to take place by the end of January 2026. A second VR scheme will be offered in March when the proposed structures are published as part of the staff consultation with compulsory redundancy being used to achieve the final reductions in staff needed to meet the £19/head target.

4.7. A range of support measures are in place to help staff through this period of significant change and will be maintained for the duration of the change programme.

4.8. Work at a London level continues to reduce operating costs in services currently hosted and provided on a once for London basis, including those provided by the Commissioning Support Unit (CSU), noting that CSUs will cease to exist from April 2027.

5. Planning Directorate Overview

Medium term planning

5.1. The Planning Directorate has been focussed on the coordination of the national strategic and operational planning process over the last couple of months. South East London ICB (SEL ICB) is working to the national deadline of 12 February 2026 for the submission of three-year operational plans and a medium-term commissioning strategy plan.

5.2. The operational plan will set out commitments in relation to the financial allocation and management of funding made available to SEL ICB to ensure expenditure plans match the funding that has been made available and key national performance standards and associated activity and care pathway plans for the next three years.

5.3. SEL ICB has been collaborating with its providers who are concurrently developing their own operational and strategic plans. This is to ensure alignment between SEL ICB's commissioning plans and provider plans and to ensure close working to secure jointly agreed delivery and improvement plans, noting these all require action across the system and end to end care pathway if national performance standards and priorities are to be met.

5.4. The commissioning strategy plan is linked and will articulate SEL ICB's overarching strategic objectives and priorities for the next few years, inclusive of the work to be done in south east London to deliver the national 10-Year Health Plan. Plans will focus on improving population health and outcomes, commissioning high quality, accessible and responsive services, and increasing the current level of patient satisfaction in local health services. Focus will be on four key delivery priorities which when brought together will support the delivery of these objectives – a step increase in the focus on prevention, enhancing community based care offer including through the development of neighbourhood based care, services and teams, the optimisation of digital opportunities and actions to support the sustainability of acute and specialised services.

5.5. The plan will set out the enabling borough and end to end care pathway actions that will need to be progressed over the next few years and the underpinning financial and allocative strategy. This includes the establishment of a dedicated Strategic Investment Fund to support pump priming and transformation investment in these four priority areas. Understanding the impact of SEL ICB's commissioning will be vital and an outcomes and evaluation framework will be developed to enable SEL ICB to track and evidence impact and value as well as inform future commissioning plans.

5.6. SEL ICB submitted an initial operational plan to NHS England on 17 December 2025. This showed some areas of performance challenge for the ICB and its providers, including on 62-day cancer performance, community waits and talking therapies.

5.7. Whilst SEL ICB's financial plan showed a break-even position, challenges remain in a number of south east London providers with a material gap to break even, plus the need to secure significant cost improvement plans. SEL ICB is working with providers to seek to improve the position in non-compliant areas for the final submission and to ensure there is collective confidence in the underpinning delivery plans.

5.8. The tight timeframes, more expansive nature of the planning process and outputs and the issues inherent in a very difficult financial position, from an allocation, income and expenditure perspective, and increasing performance standards means the 2026/27 planning round is particularly challenging. Key risks are the financial position, the pace and scale of required improvement over 2026/27 in relation to operational delivery but also expectations around the impact of transformative change in areas like prevention and neighbourhood care, plus existing and forecast levels of population need and inequality.

5.9. There have been a number of helpful opportunities to share, test and iterate approaches and outputs with the SEL ICB Board over the last couple of months and these will continue for work on the final submission for 12 February.

Obesity Pathway Improvement Programme Bid

5.10. Following endorsement from SEL ICB Executive teams, South East London ICB and South West London ICB submitted two joint bids to the Innovate UK Obesity Pathway Improvement Programme (OPIP) for a total of £6.9m of investment over 3 years across both bids.

5.11. This funding is aligned to strategic commissioning intentions to improve equitable access and management of lifestyle and weight management services – ensuring models of obesity care are better equipped to address the rising challenge of obesity in south London which disproportionately affects underserved communities. Both bids have been shortlisted to interview in mid-January with notification of outcome expected by the end of January. If successful, this funding will support the establishment of a south east London wide single point of access, integrated delivery and wrap-around support for weight-loss drugs in the community through general practice, community-pharmacy and specialist weight management services, and the development of new models of community-based care for children and young people and adults aligned to integrated neighbourhood teams.

Medicines optimisation

5.12. South East London ICB has secured £120,000 funding from NHS England over two years to strengthen system-wide Antimicrobial Stewardship (AMS) approaches. The funding is aligned to delivery of the UK National Action Plan on AMS and AMS elements of the NHS 10-Year Health Plan. The programme will develop integrated digital software to support AMS across existing platforms and enhance leadership for AMS to support both delivery and SEL ICB strategic commissioning, supporting quality, safety, and value.

5.13. In addition, a number of medicines projects agreed as part of the system sustainability programme are being progressed, focussed on improving value, safety, and financial control across prescribing and procurement. The programme comprises four workstreams: homecare transformation, medicines value and equity (including biosimilars and NICE technology appraisal implementation), appliances optimisation for wound care, catheter, stoma care and lastly polypharmacy. The programme is progressing well and is forecast to deliver significant cash-releasing savings and cost avoidance over the next five years. Delivery is established, with polypharmacy and medicines value workstreams already underway, and dedicated project management being mobilised for the homecare and appliance programmes to strengthen pace and oversight across the system.

6. Winter Pressures (including flu)

6.1. In early December, Trusts reported a significant increase in flu, norovirus and respiratory presentations across all sites, including high numbers of paediatrics. Significant pressure was also seen by the London Ambulance Service (LAS) causing many handover delays at Trusts across South East London. Mitigations were put into place which included the use of boarding, expanding escalation spaces and flexing GP hub capacity to manage respiratory cases in some boroughs to deal with the increase in demand.

6.2. In addition, Trusts were asked by NHS England to reduce bed occupancy to 80% prior to Christmas to accommodate patients requiring admission. All Acute sites held Multi Agency Discharge Events (MADE) targeting wards with high length of stay to unblock delays and increase capacity. Other sites put in new ways of working to decrease admissions. For example, at Princess Royal University Hospital, the site used Criteria to Admit standards for all patients to ensure there was a consistent structured way to determine if a patient needed to be admitted. Queen Elizabeth Hospital also linked their digital front door triage tool to local pharmacies in the area, resulting in a large number of patients being redirected to pharmacies as their attendance did not warrant a visit to the Urgent Treatment Centre or Emergency Department.

6.3. A number of initiatives were also put in place across South East London, including investment into a frailty community same day emergency care in Bromley, a new Integrated Care Coordination Hub with LAS in Greenwich, and housing link workers and Urgent Community Response capacity in Lambeth and Southwark.

6.4. The spike in flu and respiratory cases decreased prior to Christmas which also coincided with the Resident doctor industrial strike. All acute sites reported a decrease

in activity, including the LAS, which allowed the service to meet Category 1 and 2 response times.

6.5. In January, pressure has again increased at all south east London Acute sites and high levels of sickness have been reported, including call centres for 999 and 111. All Acutes have been working on increasing staff vaccination uptake through a number of targeted work programmes, with sites reporting higher uptake than last year. However, sites are still off target.

7. Award of Community Services Contract to Bromley Healthcare

7.1. A finalised contract has now been signed by Bromley Healthcare for delivering community services in Bromley. The new contract will commence in December 2026. This concludes the Direct Award C process.

7.2. In the intervening period, Bromley Healthcare will mobilise to meet the contractual changes. A mobilisation plan has been agreed and progress against this will be monitored.

7.3. To provide assurance that the contract requirements will be met, Conditions Precedent within the contract specify milestones for completion. The Board will be notified of progress against the mobilisation plan in the Summer and Autumn.

7.4. South East London ICB Board agreed on 21 May 2025 to proceed with undertaking an evaluation against Provider Selection Regime (PSR) Direct Award C. This decision followed a review of the PSR options with legal and procurement advice.

7.5. The evaluation process concluded that there was more than sufficient assurance to recommend the award of the contract to the Provider under Direct Award C. On 15 October 2025, SEL ICB Board:

- Approved the Contract Award of Bromley Community Services under PSR Direct Award C to the incumbent provider
- Agreed to the publication of the Contract Intention Notice under PSR
- Approved proceeding to contract discussions on successful completion of the standstill period and the award of contract within the terms of the Direct Award C submission.

7.6. As per the PSR regulations an Intention to Award Notice was published on 17 October 2025, with a standstill period until 30 October 2025. Within the standstill period no representations were received.

7.7. It can now be confirmed that a finalised contract has been signed by Bromley Healthcare for delivering community services in Bromley. The new contract will commence in December 2026. This concludes the Direct Award C process.

7.8. In the intervening period, Bromley Healthcare will mobilise to meet the contractual changes. A mobilisation plan has been agreed and progress against this will be monitored. To provide assurance that the contract requirements will be met, Conditions Precedent within the contract specify milestones for completion. The Board will be

notified of progress against the mobilisation plan in the summer and autumn of this year. More details of this process can be found in the Community Services update paper

8. Bexley Borough Update

Delivering Integrated Neighbourhood Care

8.1. The Bexley Integrated Child Health Model went live in the North Bexley Neighbourhood on 8 December 2025. 48% of Bexley's children and young people population are resident in the North Bexley Neighbourhood therefore the Model is providing access to almost half the population of young people.

8.2. Bexley is working towards mobilisation of the model in the Clocktower and Frognal Neighbourhoods by the end of March 2026 for borough-wide access. The Bexley model is a collaboration between Bexley Health Neighbourhood Care CiC (a local GP Federation), Oxleas NHS Foundation Trust and Lewisham & Greenwich NHS Trust.

8.3. Referrals to the new service have continued to increase since go live, which is supported and underpinned by embedded systems and processes for monitoring and evaluation.

Care and Support Closer to home

8.4. On 27 November 2025, the Bexley Wellbeing Partnership welcomed the south east London Winter Health bus at the Broadway Shopping Centre in Bexleyheath. The bus was on a two-week tour of sites in south east London to encourage take-up of Flu vaccinations.

8.5. The bus offered flu and COVID-19 vaccinations to those eligible, plus Vital 5 health checks for anyone interested; the team were supported by the Bexley Community Champions on the day. Working with Greenwich the bus was also located in the Morrisons Car Park, Thamesmead on 4 December 2025.

8.6. The Bexley Wellbeing Partnership teamed up with Welling United Football Club on Saturday 15 November 2025, for the Isthmian Premier League fixture between Welling United and Cray Wanderers, to talk about aspects of health and wellbeing with residents.

8.7. In the Fan Zone before the match the Health & Wellbeing market, including 11 local partner organisations and charities supported by the Bexley Community Champions, provided a range of support and advice including Blood Pressure Checks, advice on mental health, nutrition, exercise, cancer screening and awareness and smoking cessation.

Black History Month

8.8. To mark Black History Month, the Bexley Wellbeing Partnership, in partnership with the London Borough of Bexley's Global Majority Group, held a *'Let's Talk Your Health'* event on Thursday 23 October 2025 at The Family Hub in Erith.

8.9. The event brought together residents, colleagues and community partners, for discussions focused on improving health and wellbeing. Topics included the menopause, sexual health and reproduction, services for young people and cancer awareness. Residents were also able to have their Blood Pressure checked by colleagues from the Hayshine Pharmacy in Bexley.

9. Bromley Borough Update

Winter

9.1. The Winter Plan has broadly been delivered as intended, with strong utilisation of all additional resources deployed across the health and care system. Despite concerns about a more severe flu strain and additional pressures caused by increased numbers of patients with flu, a reduction in cases of flu has been seen from around mid-December. There is still a potential for flu cases to increase over the remainder of January and February. Cases of Covid and Respiratory Syncytial Virus (RSV) were no higher than normal. Flu vaccination is still being promoted and offered to anyone who is eligible.

9.2. Two successful multi-agency discharge events (MADE), held before and after Christmas, provided important support to patient flow and helped mitigate some of the seasonal pressures. Despite these efforts, the Princess Royal University Hospital (PRUH) has continued to experience significant operational strain, with several days marked by corridor care and prolonged waiting times, especially at the start of January. These pressures will be examined in detail as part of the winter evaluation to ensure learning is captured and future planning is strengthened.

One Bromley Cervical Screening Project Shortlisted for National GP Awards 2025

9.3. One Bromley's work to improve cervical screening uptake was successfully shortlisted for the 'Clinical Improvement Award: Public Health and Prevention' at the national GP Awards held in December 2025.

9.4. This collaborative project between South East London ICB and Public Health Bromley aimed to improve cervical screening across the borough using a targeted population health management approach. The project gathered patient feedback on reasons for variation in uptake through a public survey and then used these insights to design patient materials and develop a targeted approach to promotion. This included directing patient messages to the lowest uptake and highest deprivation areas across the borough. Alongside placement of Bromley branded patient information booklets in GP practices, sexual health clinics and other key locations, the messages were shared through online and print media. Key bus routes were selected for adverts on buses and at bus stops.

Bromley Health and Wellbeing Centre and One Bromley Wellbeing Hub Update

9.5. The Bromley Health and Wellbeing Centre at Ravensleigh House, 22 Westmoreland Place, Bromley, is now becoming operational, representing a key milestone in delivering the One Bromley vision for joined-up, preventative and community-based health and wellbeing support. Developed as a neighbourhood hub, the centre will support closer partnership working across health, local government and the voluntary

and community sector (VCSE) to help residents live well and promote health and care equity.

9.6. From 13 January, the One Bromley Wellbeing Hub will operate from the new centre, followed by the Dysart Practice relocating into the building on 19 January. Co-locating these services is central to One Bromley priorities around integrated neighbourhood teams, enabling more coordinated working across primary care, wellbeing services, council teams, and community partners and supporting people through joined-up, person-centred approaches.

9.7. The One Bromley Wellbeing Hub delivers a wide range of preventative and early intervention services, including social prescribing, support for mental wellbeing, carers' support, healthy lifestyle services, employment and financial wellbeing advice, and help for residents to remain independent and connected within their communities. These services play a vital role in the One Bromley partnership by supporting population health, reducing avoidable demand on statutory services and improving access to support at a neighbourhood level.

9.8. A key strength of the One Bromley model is the significant role of the voluntary and community (third) sector, with trusted local organisations working alongside NHS and council colleagues to deliver flexible, community-led support. Co-location within the Bromley Health and Wellbeing Centre strengthens these partnerships, improves referral pathways and enables a more seamless experience for residents.

9.9. The relocation follows a planned move over the Christmas period, with the One Bromley Wellbeing Hub re-opening in its new location on 13 January and continuing to offer the same range of services and opening hours. The centre provides modern, accessible and spacious consulting and treatment rooms, designed to support multidisciplinary working and create a welcoming environment for the local community.

9.10. This development reflects strong joint working, and the continued partnership with Bromley Council is warmly welcomed, whose support has been integral in making this neighbourhood hub a reality. Whilst the centre is now becoming operational, a formal opening event will take place at a future date, to be confirmed once all services are fully established.

Bromley Falls in Care Homes Campaign

9.11. For older residents in Bromley's care homes and Extra Care Housing (ECH), falls are the leading cause of ambulance conveyances, unplanned hospital admissions and readmissions. At an engagement event in February 2025, Bromley's care home managers identified falls as the top priority. In response, as a local system, the Bromley Falls Campaign was launched in March. It is a two-pronged campaign to improve a) Falls management through a risk-stratified approach and direct access to the PRUH's Acute Frailty Assessment Unit (AFAU) for quicker diagnostics/treatment, and b) Falls prevention via a falls bundle to prevent future falls.

9.12. The campaign has been shared across all care settings, but enhanced support has been provided to settings with the highest volume of falls-related ambulance conveyances. The campaign appears to be making a difference. Since the launch a +16% increase in active Universal Care Plans (UCPs) and a -14% reduction in falls-related conveyances, compared to last year, have been seen.

9.13. The campaign attracted InSites funding via King's College Hospital NHS Foundation Trust, which was used to pilot the Raizer Emergency Lifting Chair in five care settings. Feedback from staff and residents so far has been overwhelmingly positive, and there has been a 41% reduction in the number of falls-related ED attendances at these sites compared to last year. Going even further, in December six care settings took part in a Go Decaf pilot to further prevent falls, with full support across supporting services. Both pilots end in February 2026, after which learnings will be shared widely.

10. Greenwich Borough Update

10.1. Over the last quarter there has been significant progress in Greenwich to advance Neighbourhood infrastructure and care pathway development for the three priority cohorts: Frailty, Long-Term condition (LTC) and Children and Young People (CYP). The utilisation of the new Digital Health and Technology (DHACT) Service continues to be high, offering good prevention potential. There has been a significant focus on flu vaccinations and on supporting the Queen Elizabeth Hospital site to maintain good flow as winter pressures have increased.

Neighbourhood Development progress entering 2026

10.2. Greenwich are reaching the 'go live' stage for expansion of the existing Frailty service into a Proactive Care Pathway covering the entire borough with an intended growth in caseload of ~50% on previous levels, extension of the MDT and proactive focus on people with moderate frailty and other risk factors. This will be supported by non-recurrent Neighbourhood funding and by £3 per weighted population (PWP) allocated from Greenwich's PMS Premium in general practice. The aspiration is to further support practices through a one-year Local Incentive Scheme (LIS) focused on improving frailty coding on Emis, and by a further £1 PWP investment into improving Universal Care Plan (UCP) completion rates.

10.3. The LTC's pathway will include a proactive care approach and is reaching maturity of design and system-wide support to launch in spring. This has been developed closely with south east London's LTC's efforts and leadership and actively takes the learning from the Chronic Kidney Disease (CKD) Multi-Morbidity Model of Care pilot in Heritage Primary Care Network (PCN). The LTC's approach has had strong input from the Public Health team in Greenwich and is therefore well-aligned to local thinking on Prevention; particularly focusing on hypertension, cardiovascular disease (CVD) and diabetes as priority LTCs for the Greenwich population.

10.4. There are now two (of seven) Primary Care Networks (PCNs) delivering a Local Child Health team approach to shifting care for children out of hospital through GP, paediatrician and specialist nursing community-based clinics. Planning is underway to design and develop CYP INT arrangements that cover all of Greenwich, in line with south east London priorities and forthcoming framework.

10.5. Greenwich has not historically operated on Neighbourhood footprints, and as such an options appraisal is underway to determine the optimum form of neighbourhood leadership and for individual service areas to plan alignment of teams (for example district nursing and adult social care).

10.6. Neighbourhood Hub development is ongoing, based on the strong foundations in 2024/25 of:

- Publishing the General Practice Estates Strategy, and actively using this to underpin local governance decision-making about, for example, lease extensions
- A collaborative, system-wide process towards identifying Hub opportunities
- Various site visits and partner discussions to work up localised opportunities
- Linking Local Infrastructure Grant/Utilisation & Modernisation Fund funding bids and investments into general practice to Neighbourhood Hub plans
- Coordination between South East London ICB and Oxleas as Integrator on capital bid applications

10.7. In 2026, work will continue with Regeneration and Housing colleagues in the local authority to influence Urban Regeneration Frameworks in four areas of Greenwich, including the Government's plan for a new town investment into Thamesmead, and to use the borough's Section 106 and Community Infrastructure Levy opportunities as effectively as possible.

General Practice

10.8. There are several general practice resilience challenges within Greenwich. Greenwich now has six (of 29) general practices rated 'Requires Improvement' by the Care Quality Commission (CQC). For one of these, the CQC is actively seeking to terminate the registration of the GP partners, and South East London ICB is taking appropriate contractual measures.

10.9. Additional challenges include:

- A branch site closing on 16 January and a nearby branch site that has been closed for several months due to dilapidation.
- Notice of impending GP partner retirements has been received for two practices, with the resultant permission to vary their ICB contracts to reflect new partnership arrangements (including an application to become single-handed) due through governance soon.
- There is a Freedom to Speak Up investigation ongoing in one practice.
- One practice is in a prolonged legal battle with their landlord to remain in their main site premises.
- Greenwich practices report significant space pressures and estates concerns.
- The primary care arrangements for residents in older people care homes, learning disability homes and Extra Care Housing requires review and transformation in 2026.

10.10. South East London ICB is working hard to support practices through the many day-to-day challenges. There is a strong programme and leadership approach to improving the quality, safety and sustainability and very active engagement with general practices to be effective and key partners in integrated Neighbourhood working.

Strengthening good interface working in Greenwich

10.11. An extensive update on the Greenwich and Bexley Primary, Community and Secondary Care Interface programme was provided in the October Chief Executive report, including successes with tackling inappropriate requests for onward referrals, fit notes, prescribing, investigations, etc. and delayed discharge summaries.

10.12. The Greenwich contribution to the urgent care and planned care recovery efforts has been a priority and will be the focus of the Interface programme in 2026, including optimising Advice and Guidance, Referral processes and Patient Initiated Follow Up, and working across Urgent Treatment Centres, Emergency departments, 111 and primary care to improve urgent care interfaces. Greenwich remains driven by the truth that efficient, safe and respectful interfaces between providers, services and pathways are an essential foundation for integrated Neighbourhood working.

10.13. Local successes have been recognised by the NHS Confederation, published as a case study on 3 December: Improving the primary and secondary care interface at Greenwich and Bexley | NHS Confederation

Integrated Commissioning – Adults

10.14. Homefirst, Urgent and Emergency Care and winter resilience - The Adults team continues to work alongside local partners to deliver actions which improve performance. For Greenwich there has been an improvement in discharge over recent times which should be strengthened by improved arrangements with the new Transfer of Care (TOC) Hub which has started operating.

10.15. Teams have worked collaboratively across Greenwich and Bexley to appoint a new senior leadership role to coordinate and oversee the new TOC approach. Work continues to deliver on the commitments following the Better Care Fund support programme in 2025. Current focus is on progressing work on the system visibility dashboard, continued focus on organisational development and system leaders' alliance.

10.16. Local forums which feed in and out of the Urgent & Emergency Care Board at Place including Homefirst and Resplendent, continue to meet. Recent collaboration includes:

- Seeking insights in to parking restrictions and how any unintended consequences can be understood by ensuring consultation with partners on new policies
- Work to identify key workers who may be eligible for intermediate housing options
- Collaboration with Lewisham & Greenwich NHS Trust on opportunities to bid for funds to shift investment from the acute to the community over winter which will be evaluated for impact ensuring learning is taken forward
- Discharge to Assess (D2A) and Step up/Down – identification of suitable empty space at Eltham Community Hospital leading to work with the LIFT co, ICB Estates team, Local Authority and other key stakeholders to produce a business case to invest in the building which levers national capital to make required alterations (over £3m) and the ability to avoid paying continued void costs. This collaboration has led to the agreement to go ahead with a procurement exercise to award the future contract to a provider who will then take on the lease and enable D2A and step up /down capacity for short term bed-based support to be secured. This also allows the

Local Authority to move provision from a site where more Extra Care provision in the Borough can be developed.

- Reablement - a comprehensive review of the in-house reablement service has been undertaken, which is also therapy lead working alongside Oxleas. This is now leading to short term work to continue to improve capacity and effectiveness. Longer term there is exploration of the opportunity to develop and commission a hybrid model which works alongside the homecare service in future. This builds on having had homecare workers undertaking rotations in the reablement service to adopt enabling practices when people have ongoing care needs as well as adding capacity.

Investment from S106

10.17. In recent years, the Local Authority has designed and implemented an approach to ensuring S106 money is invested wisely and in line with local needs and legal agreements with developers. Recent projects include:

- LGT and Greenwich health – collaborative project to invest in the Queen Elizabeth Hospital A and E department and increase space for steaming within the UTC. This opened ahead of winter with an official launch event in December, supported by the Leader of RBG and Lead Cabinet Member alongside senior leaders from across the partnership. Press coverage highlighted the success and shared the expected impacts which are already being felt by patients and staff.
- GBCH – the hospice developed a proposal to invest in the inpatient unit. This followed feedback from residents and staff about improvements which could be made to the environment including it being suitable to meet local resident cultural and other individual needs. The hospice undertook extensive engagement, and the funding will now lead to a project completion this year which is also partially funded from Government capital funds. These fell short of what was required to make the improvements and without the S106 funds contributing the project would not have been to the same scale and impact. This supports the commitment to ensure, that where possible people do not die in hospital and supports system resilience. The Lead Cabinet member recently visited the hospice to understand how the works would improve staff and resident experience and was impressed with the services the hospice provides.

Digital Health and Care Technology Service (DHACT)

10.18. Following the launch of this service in April, the first integrated one of its kind nationally, demand has been higher than anticipated. This is excellent progress and consistent with national policy requirements. Impacts are being evaluated and there is positive feedback from residents and staff.

10.19. Recent work has included modelling demand and costs across the next 2-3 years and planning the phases of further development and access across pathways. This includes opportunities to align to Neighbourhood health and care design work.

10.20. This is one of the key consistent offers across Greenwich Borough to support modern proactive care. The team continues to explore additional capital and revenue investment opportunities including those which will be critical to any ambitions to

expand the service beyond the original scope and align to local needs. There is a resident and staff design group who will continue to advise on evolution of the service.

10.21. Whilst there has been evaluation of Adult Social Care (ASC) impact, work continues on data access issues with both Oxleas and South East London ICB to ensure evaluation of resident, staff, process and productivity benefits for health. This will be critical to unlock to enable comparison to the original intended outcomes and benefit assumptions. The aim is for the Healthy Greenwich Partnership to enable streamlined data sharing across patient care, commissioning, and research, supporting various community services without creating complex or multiple arrangements.

10.22. In January, the Digital Health and Care Technology Board will make decisions on the health monitoring next steps, the first being implementation in virtual wards as they transition from the current disconnected arrangements and grow clinical confidence and oversight within the new service.

10.23. Developing and embedding the monitoring and response service, which has been transformed from the telecare service which existed in house previously in the Royal Borough of Greenwich, will continue.

10.24. The Department of Health and others continue to take a keen interest in how this service develops.

Homecare Transformation

10.25. The INT programme also includes work to continue to build on the current homecare model, to transform in line with new policy and to support more localised integrated working. The design phase begins in quarter 1. The scope currently includes ASC needs, Continuing Healthcare, specialist support for those with learning disabilities and mental health needs, Extra Care and support and children's.

10.26. There will be close work with key stakeholders and residents to design the new model which hopefully promotes independence, connections to communities, and encourages joined up working in local places and is sustainable and ethical.

Mental Health

10.27. There is a complete system review of mental health leading to a transformation programme across partners. This is now moving to a new phase from 2026 to support the Feel Well commitments. Work will begin with Oxleas, SEL Mind and other voluntary & community sector partners to review the community mental health offer including the mental health Hubs and consider how these can further transform and align to INT footprints. Current work will support this and enable collaboration across partners. This remains critical including how the Mental Health Alliance is developed locally.

10.28. The current scope is supported accommodation but with a hope to expand this over time to include more community based and peer led support options. This will be informed by critical pieces of work undertaken so far:

- Mental health vision – work with residents and workers to hear and understand their views of what is working well and what they believe needs to improve
- Mental health needs assessment supported by public health

- Mapping of assets and support including those available in local communities and not commissioned
- Comprehensive review of S117 cases with outcomes shared locally and action beginning, including with Oxleas to progress review of cases and ensuring appropriate transfer to other commissioning authorities where required or discharges for those no longer eligible

10.29. SEND System - A programme of work is taking place in Greenwich to develop a more sustainable and relational Special Educational Needs and Disabilities (SEND) system. This is aimed at supporting children and young people to flourish and is broadly looking at four areas, including:

- Ensuring there is a comprehensive and effective support offer
- Spending more time with children & young people and their families
- Building capacity and capability in the SEND system
- Transforming the experience of families

11. Lambeth Borough Update

Our Health, Our Lambeth

11.1. *'Our Health, Our Lambeth',* the Lambeth Together Health and Care Plan, continues to provide a clear and stable framework for integrated working in the borough. Lambeth is now more than halfway through delivery of the 2023–2028 plan and, whilst recognising operational and financial challenges, the partnership has maintained a clear focus on delivering for residents.

11.2. '*Our Health, Our Lambeth'* remains closely aligned with the government's 10 Year Health Plan and its three core shifts: from hospital to community, from sickness to prevention, and from analogue to digital. A key area of progress this year has been the design and development of the Integrated Neighbourhood Teams (INTs) that will initially support residents who are frail, residents with multiple long-term health conditions and children and young people with complex needs. The five neighbourhoods in Lambeth will increasingly become the organising unit for delivery, bringing together primary care, community services, mental health, social care and voluntary and community sector partners along with Lambeth residents to shape and design the approach.

11.3. As part of the National Neighbourhood Health Implementation Programme (NNHIP), along with Partnership Southwark, Lambeth is creating a new neighbourhood model for people with long term conditions, acting as a national 'first wave' site. Lambeth is leading a co-design process with all local partners to define and test a model to support the priority cohort of adults with three or more long-term conditions, with at least one being cardiovascular disease, Type 2 diabetes and/or chronic kidney disease. An agile test and learn phase from January to March 2026 will inform the wider scale up of the model across the whole borough from April 2026.

Leadership and Governance

11.4. Lambeth is undertaking a governance review across the Lambeth Together Care Partnership Board and the Health and Wellbeing Board with the aim of ensuring closer alignment in response to emerging national policy and recognising their complementary roles in setting direction, overseeing delivery and providing system-wide leadership for health and wellbeing in the borough.

11.5. Lambeth will work with partners across both boards to implement a revised model to ensure oversight and delivery of the borough's refreshed Health and Care Plan and Health and Wellbeing Strategy, aligned to the 10 Year Health Plan.

11.6. The Lambeth Health and Wellbeing Bus remains in demand across the borough, visiting community sites and events to bring health and wellbeing advice, blood pressure testing and winter vaccinations to Lambeth residents. Joining the bus team, Board members take part in 'Board on the Bus' sessions, speaking directly to residents about their experiences and health and care priorities and how this might inform Lambeth's work as a partnership.

Working within the Community

11.7. Neighbourhood and Wellbeing Delivery Alliance (NWDA) - The Women and Girls' Health Hub in Lambeth officially opened in September at Minnie Kidd House, Clapham. This marked an important step in improving access to women's health care locally and follows the successful virtual triage pilot, which has been running since March 2025. Lambeth is one of three pilot sites in south east London selected to develop and test this new model of care. The Hub has been informed by a needs assessment and a co-production process with residents, commissioners, the VCSE sector, and focus groups, which prioritised key areas such as pre-conception, long-acting reversible contraception, heavy menstrual bleeding, and menopause. The physical Hub is community-based and provides high-quality clinical advice and support for women and girls across the life course, through collaborative multidisciplinary teams in gynaecology, sexual and reproductive health, and GPs with a Special Interest. Early evaluation from the virtual phase showed 65% of referrals were successfully managed through advice and guidance, meaning these women avoided being added to already long secondary care waiting lists.

11.8. Living Well Network Alliance (LWNA) - The Alliance continues to develop its refreshed community service offer and is now finalising the proposed model with service users, carers, staff and partners. Key changes are expected to be introduced in the first half of 2026. This model should see reduced waiting times to access adult mental health services as well as clearer, more consistent pathways for different mental health needs. The LWNA has also published its 6th annual Progress Report, which demonstrates the Alliance's progress against key priorities using both data on impact and real-life case studies. The Alliance has produced a new 4-minute film that showcases the Evening Sanctuary at Mosaic Clubhouse - a safe and supportive alternative to A&E for Lambeth residents in mental health crisis, which has diverted over 500 potential A&E visits during the first half of 2025/26.

11.9. Children and Young People's Alliance (CYPA) - The Alliance has made good progress on the development of integrated neighbourhood teams for children with complex needs. A series of workshops in November and December brought together staff teams

and leaders from across Lambeth to identify priority areas for INTs and to discuss opportunities for services to work together more closely. Two broad themes came through strongly: support for children and families with emerging or increasing risk and better joined-up support for children with complex needs, disabilities, and special educational needs, including those who are below the threshold for statutory support. The Alliance is now in a strong position to begin outlining the core outcomes for INTs to deliver. The next phase will focus on turning this shared understanding into clear plans for delivery.

11.10. Lambeth Together Equality, Diversity, and Inclusion (EDI) Group - During 2025, a key focus has been overseeing the adoption of the Patient and Carer Race Equality Framework (PCREF) in Delivery Alliances and Programme areas. The publication of Healthwatch Lambeth's report: A Fulfilling Life on Black men's mental health in October shone a light on the continued inequalities in access, cultural sensitivity, and trust in local services. The EDI Group has agreed to lead on developing a system-wide response that builds on the work to date informed by the PCREF. Following the successful Inspire health and wellbeing event for Lambeth black communities held in October, where over 450 residents attended to connect with local health and wellbeing support, planning for 2026 is already underway for the Inspire 2026 event and the team are exploring how Lambeth can secure funding to sustain and grow this important work as an annual fixture in the Lambeth Together calendar. The ambition is for the event to become a key element in the borough's prevention and equity approach, linking and celebrating cultural pride with better health outcomes.

12. Lewisham Borough Update

HSJ Award – Reducing Health Inequalities

12.1. Lewisham's work to tackle health inequalities has received national recognition at the 2025 HSJ Awards. North Lewisham Primary Care Network (PCN) and Red Ribbon Living Well were named winners of the Primary and Community Care Innovation of the Year award for their initiative, Health Equity Partnership: A Symbiotic Approach to Tackling Health Inequalities.

12.2. This year-long, co-designed programme brought together NHS and voluntary sector partners to tackle health inequalities in one of Lewisham's most deprived communities.

Integrated Neighbourhood Teams (INT) – Long-Term Conditions (LTC)

12.3. Good progress has been made in the delivery of the Integrated Neighbourhood Teams (INT) for Long-Term Conditions across Lewisham. All core INT-LTC posts have now been successfully recruited to, establishing the full multidisciplinary workforce across neighbourhoods.

12.4. New population health management reporting is now in place and is being used by teams to identify patients with long-term conditions who are at highest risk, enabling more targeted, preventative and coordinated care.

12.5. The INT LTC model has also introduced a Lifestyle Medicine approach, supporting prevention, self-management and improved long-term outcomes alongside clinical care.

12.6. To strengthen the holistic approach, Lewisham Council and the ICB have jointly commissioned a lead Voluntary and Community Sector (VCS) organisation for each neighbourhood. These VCS partners are embedded within each INT and support residents with social and wider wellbeing needs, ensuring integrated, person-centred care.

Perinatal mental health

12.7. Strengthening the perinatal mental health offer remains a key priority for Lewisham Place. The offer continues to develop and is progressing towards a core, recurrently funded model. In Quarter three, five VCSE organisations were procured to provide emotional wellbeing support to parents during the perinatal period. These contracts aim to build capacity within the VCSE sector and increase support for expectant and new parents - helping them to stay resilient, emotionally well, and connected. The focus is on preventative support and early intervention for low-level mental health needs during pregnancy and the postnatal period (up to one year after birth).

Asthma friendly schools

12.8. In Quarter three, the proportion of Lewisham schools achieving Asthma Friendly certification rose to 19%, the highest rate across south. This improvement reflects strong joint working between Children's & Young People (CYP) Joint Commissioning, Lewisham and Greenwich Trust's (LGT) Asthma Coordinator, and Public Health. Work continues to encourage more schools to become certified, and Lewisham's approach is now being adopted across south east London.

MH 24/7 Neighbourhood Mental Health Centre

12.9. Implementation of the 24/7 Neighbourhood Mental Health Centre being established for the neighbourhood 2 in Lewisham is progressing well. The service is operating out of Southbrook Road on an interim basis and is offering extended service hours (Mon – Fri 08.00-20.00 and Sat-Sun 09.00 – 17.00) and has begun implementation of a day programme. There remains additional access to daily crisis slots.

12.10. Coproduction remains ongoing with a proposal to rename the provision to the Heather Close Community Mental Health Centre once relocated. Phase 2 of recruitment has been completed and the following care streams are live:

- Assertive Outreach
- Psychosis Low Intensity
- Trauma, Mood & Anxiety; Personality disorder due Q4
- Debt and welfare support provider procurement underway
- Evaluation via Ipsos Mori underway with stakeholders and King's College London appointed to lead local evaluation.

Positive Ageing Well Service Pilot

12.11. The Lewisham Proactive Ageing Well Service (PAWS) was launched in October 2024 with two years of funding to support older people in maintaining, improving or preventing deterioration in frailty. The service is delivered entirely in patients' homes,

aligning with the NHS 10-year plan's goals to prioritise preventative care and shift towards community-based support.

12.12. 13.12. Central to PAWS is the use of Comprehensive Geriatric Assessments (CGAs) with the team aiming to complete up to 30 each month. These assessments inform personalised Universal Care Plans (UCPs) and Advance Care Plans, ensuring that care reflects patients' preferences, most of whom welcome this approach.

12.13. A key achievement of PAWS is the significant reduction in emergency department (ED) attendances and hospital admissions: both fell by 51% amongst patients who received the service. Additionally, there has been a notable 139% increase in the use of Urgent Community Response services, compared with the nine months prior to PAWS' implementation. This shift demonstrates the effectiveness of proactive, advanced care planning in reducing acute hospital demand and supporting patients in the community.

13. Southwark Borough Update

Health and Wellbeing Board

13.1. At the December Southwark Health and Wellbeing Board meeting, a significant focus was placed on the Healthy Work and Lives priority programme, which aims to embed employment support within health services and promote staff wellbeing across the borough.

13.2. The Board reviewed progress on initiatives such as the Connect to Work scheme, which integrates employment advice into healthcare settings, and creative and cultural skills programmes designed to broaden opportunities for residents.

13.3. The Social Value Framework was highlighted as a key driver in encouraging more employers to adopt the London Living Wage, with the number of accredited employers rising to 452. Staff engagement in wellbeing activities was strong, with 1,485 staff participating in various programmes.

13.4. The Board also discussed the expansion of the Rose Voucher scheme, providing healthy food options, and the development of affordable leisure activities to further support staff and community wellbeing. Emphasis was placed on the need for continued integration of health and employment support, as well as the importance of targeted wellbeing programmes for staff.

13.5. The Health Protection Annual Report 2024/25 was discussed, which provided a comprehensive overview of communicable disease control, vaccination uptake, sexual health, screening, environmental hazards, and emergency preparedness in Southwark. The report highlighted persistent challenges, including low vaccination rates for diseases such as measles and whooping cough, which pose ongoing risks to public health. Climate change was identified as an emerging threat, with increased environmental hazards impacting vulnerable populations. The Board discussed the importance of targeted outreach and partnership working to address these issues, particularly among groups at higher risk of health inequalities.

National Neighbourhood Health Implementation Programme (NNHIP)

13.6. Lambeth & Southwark have been selected as one of 43 first wave sites in the National Neighbourhood Health Implementation Programme (NNHIP). This joint NHS England and Department of Health & Social Care initiative supports delivery of the neighbourhood health ambitions in the NHS Long Term Plan, initially focusing on designing and implementing Integrated Neighbourhood Teams (INTs) for people living with long term conditions.

13.7. Between October and December, engagement with staff across health, care, VCSE organisations and residents through a series of workshops, informed the development of an INT service model to be tested during January-March 2026. Key workshop themes including strong existing local foundations, the critical role of the VCSE sector, the importance of holistic, person-centred care and the culture change required to support new ways of working. The initial test phase will focus on people with cardiovascular related long-term conditions, with a strong emphasis on prevention, wider determinants of health and proactive outreach. Learning will inform scaling of the model across Lambeth and Southwark during 2026/27.

Integrated Neighbourhood Teams

13.8. South East London ICB is pump-priming the core Integrated Neighbourhood Team (INT) infrastructure in Southwark to accelerate delivery of INTs for the three population groups: children and young people with complex needs, people with multiple long-term conditions, and people living with frailty.

13.9. Recruitment of clinical lead and neighbourhood managers' roles will take place between January and March, alongside alignment of secondary care consultant capacity to neighbourhood footprints. This time-limited investment will establish an initial infrastructure, recognising the crucial role that wider health, care, voluntary and community services will play in INTs.

HSJ Award for Wound Care

13.10. The Southwark Ambulatory Lower Limb Service has been shortlisted in the Health Service Journal (HSJ) – Independent Healthcare Providers Award 2026, under the category Best Provider of Community and Primary Care. Following a successful first stage selection, the service is one of nine finalists in the mentioned category. The second stage involves a virtual presentation scheduled for 29 January. The Winner will be announced at the Award Ceremony on 19 March 2026.

Delayed Discharges Deep Dive

13.11. At its November meeting the Partnership Southwark Strategic Board completed a deep dive into delayed discharges from hospital to better understand trends in performance data. Colleagues from Guy's and St Thomas's Hospital, Kings College Hospital and the Council's Adults Social Care team presented data, insight and analysis which resulted in a rich partnership discussion and agreement of actions. Existing discharge mechanisms are being used to develop an action plan with a report back to the Board expected in Summer 2026 to review progress.

SEND Commissioning Strategy

13.12. The Integrated Commissioning team have recently completed a commissioning strategy for Special Education Needs and Disabilities (SEND) which has been approved by the SEND and Inclusion Strategic Partnership Board made up of key stakeholders. The strategy establishes key principles and priorities, and detailed commissioning plans are now being developed.

Ofsted CQC visit

13.13. In the summer of 2025, Southwark was one of six local areas across the country to receive a 'thematic visit' from Ofsted and the Care Quality Commission (CQC) to explore arrangements in place for children with Special Educational Needs and Disabilities (SEND) who are not in school.

13.14. The purpose of thematic visits like this is to make informed recommendations to improve national policy. The report bringing together insights from the thematic review has now been published **here**. Gratitude is extended to all of our colleagues and residents who contributed to the visit, which was also regarded as a valuable learning exercise for informing local improvement plans.

Board meeting in Public

Title	**ICB Board Assurance Framework**					
Meeting date	28 January 2026	Agenda item Number	5	Paper Enclosure Ref	E	
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	x	Discussion		Decision	x
Purpose of paper	The latest Board Assurance Framework (BAF) sets out the controls and assurances demonstrating 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 appraised 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 7 January 2026.					

Summary of main points	**1. Current position:**
	
	• There are 12 SEL risks and 5 LCP risks (in each of Bromley, Greenwich, Lambeth, Lewisham and Southwark LCPs) which currently sit above risk tolerance thresholds.
	
	2. Changes since last report:
	
	• The following changes to the BAF were made following review of risks by risk leads, LCPs, Place Executive Leads (PELs) on 10 November 2025, and Executive Committee on 7 January 2026:
	  • **Reduced risk score:** SEL 606 (ICS revenue financial plan 2025/26)
	  • **New BAF risks:** LEW 644 (neurodevelopmental diagnostic pathways – autism ad ADHD).
	  • **Closed BAF risks:** SEL 598 (community pharmacy consultation messaging not returned to GP practices); SEL 628 (financial impact of ICB redundancies); LEW 360 (failure to deliver to statutory timescales for completion of ASD health assessments.					

	3. System risk development: • SEL ICS Risk Leadership Group met at the end of September 2025 to consider potential risks related to neighbourhood health services, risk governance for programme and corporate risks, and arrangements for the management of actualised risks or issues. The most recent session on 20 January 2026 focussed on EPRR risk and risk governance, learnings from partner risk review exercises, and risks related to the 10-point plan for Improving Doctors' Working Lives.					
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	SEL ICS Risk Leads meeting held on 30 September 2025 and 20 January 2026. PELs meeting held on 10 November 2025 SEL ICB Risk Forum, 11 November 2025 Executive Committee, 7 January 2026					
Recommendation	The Board is asked to review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 7 January 2026.					

South East London Integrated Care System

NHS South East London

SEL ICB Board Assurance Framework January 2026

Prepared for SEL ICB Board, 28 January 2026

Context and latest updates

- **The ICB's risk appetite matrix allows the Board to set 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 approved an updated Risk Management Framework in July 2025 as per the agreed policy review schedule. Risk appetite thresholds were 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 4).**

Discussion of risks at key meetings / committees

A. Place Executive Leads (PELs) meeting

- On 10 November 2025, the ICB Risk and Assurance team and PELs completed the latest comparative review of risks across the Local Care Partnerships (LCPs).
- The group examined newly added areas of risk added by LCPs. There were two areas with follow up actions:
    - Provider selection regime (PSR): a potential risk around non-standard contracts in place for CHC and MH contracts. It was agreed that a small group of integrated directors of commissioning from the LCPs would come together to look into this further and report back by end January 2026.
    - Neurodiversity assessment pathways: review of whether the current risk relating to neurodiversity assessment pathways for CYP should be expanded to also include adults and CYP. Risks for Bromley, Greenwich, Lewisham and Southwark have been subsequently updated to include adults.

B. SEL Executive Committee (ExCo)

- The ICB **Executive Committee met on 7 January 2026** to consider the draft BAF, as well as receive updates on 'place' risk registers, 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**, subject to the anticipated update to the Lewisham risk related to neurodiversity assessments pathways being amended to also include adult pathways. This has been updated and reflected in this paper.

SEL ICS System Risk Development

- 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

- The most recent sessions, held on 30 September 2025 and 20 January 2026, focused on:

    1. Integrated neighbourhood team working and how SEL system partners will respond to that as individual providers and collectively as an ICS. The partner risk leads confirmed that INTs were being discussed at their Board meetings in November/December 2025, and that this area would come back for further review at a future meeting.

    2. Management of programme and service level risks in each partner organisation. Partners discussed their approaches to management of these types of risks. Partners shared approaches to governance and looked to see how current internal processes may be improved.

    3. Management of issues versus risks. Both KCH and the ICB have done work to reframe and redraft longstanding issues as new risks.

    4. EPRR related risks and London regional risks discussed at the London Health Resilience Partnership (LHRP). A presentation by the ICB's Associate Director for Corporate Operations provided a summary of the framework within which EPRR operates, the pan-London EPRR risk structures and how this fits into the risk processes in SEL.

    5. Lessons from KCH's risk management risk refresh exercise.

    6. Risk related to implementation of 10-Point Plan to Improving Doctors Working Lives.

- The SEL system BAF comparison pack continues to be shared with the risk leads group.

Structure of the BAF

- 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 9 - 11). **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 12). 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 13.**

Role of the Board and recommendation

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 appraised 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 7 January 2026.

Key points and summary of changes (1 of 2)

Key points to note

- Risks reflect the assessed position as recorded on the ICB's Datix system for risk management on 15 December 2025..
- The current version of the BAF includes 12 SEL risks above threshold and 5 LCP risks (Bromley, Greenwich, Lambeth, Lewisham, Southwark). There remain no risks above threshold for Bexley LCP.

Escalation and de-escalation of BAF risks

- No risks have escalated or de-escalated off the BAF.

Newly added BAF risks

- **1 new risk** with a score greater than the risk appetite threshold has been **added** to the BAF:
  - **LEW 644** relates to neurodevelopmental diagnostic pathways (autism and ADHD). This has been added following the discussion on the risks relating to this area at the PELs meeting on 10 November and updated in January 2026 to include adults. This risk falls under the strategic category and has a current score of 16.

Key points and summary of changes (2 of 2)

Closed BAF risks

- **3 previous** BAF risks have been **closed:**
    - **SEL 598** related to post community pharmacy consultation messaging not returned to the GP practice (digital community pharmacy programme) has been closed because all practices across SEL have now enabled GP connect in line with NHSE contract requirements as of 1 October 2025. This means that all post-event messaging flows to the relevant GP practices via GP connect.
    - **SEL 628** related to the financial impact of ICB redundancies. This has been closed because in November 2025 the ICB received confirmation of funding for potential redundancies related to the ICB change programme.
    - **LEW 360** related to failing to deliver on statutory timescales for completion of ASD health assessments. This risk has been closed, and the relevant elements of this risk have been incorporated into the newly added risk 644, relating to CYP neurodiversity assessments (see previous slide).

Score changes

- **1 risk** has been **changed in score**:
    - **SEL 606,** relating to the ICS revenue financial plan 2025/26, has been reduced in score from 25 to 15. This follows a recommendation of the CFO and Executive Committee as a result of the ICS being broadly on financial plan at month 6. This will be reviewed again at month 9.

Summary of SEL risks exceeding tolerance levels (1 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Finance	**606**	ICS revenue financial plan 2025/26	Agreed plan and future delivery risk profile to year end and governance in place to review and oversee monthly progress; organisational expenditure controls in place covering particularly pressures (e.g. agency spend). Governance in place to plan and deploy in-year mitigations to secure year-end break-even	12	15
Data and Information Management	**597**	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services	SEL ICB has established core data and cyber risk controls, including clear asset ownership, secure system configuration, vulnerability management, and resilience and recovery arrangements. A Cyber Incident Response Plan is in place for identity and access controls, assurance arrangements, and security monitoring are established to protect essential services.	9	12
Operational: relating to the effective day to day running of the ICB organisation (MCR)	**601**	ICB Change Programme – workforce capacity risks	Agreement to cease some non-priority work to focus on must do areas, reappraisal of consultation timeline aligned to national guideline, and programme governance structure in place.	15	16
	602	ICB Change Programme – impact on staff	Weekly CEO-led all staff briefings in place, dedicated intranet and MS Teams space for transparent communication, regular “ask HR” sessions in place.		20

Key: Primarily system risk Primarily ICB risk

Summary of SEL risks exceeding tolerance levels (2 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Clinical, Quality and Safety	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics.	HCID and pandemic plans in place, collaboration with system to minimised impact on the workforce, hybrid working in place, process for re-deployment established, and Staff offered vaccines.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.	Monthly assurance pack reviewed at CHC group, tracking of FNC reviews, and individual borough plans set out how boroughs will clear overdue reviews.		12
	437	Disruption to IT/Digital systems across provider settings due to external factors	DSPT compliance indicates monitoring is in place to detect potential security problems and track ongoing effectiveness. An up-to-date incident response plan grounded in thorough risk assessments take account of network and information systems supporting the operation of essential functions and covers a range of scenarios.		15
	630	Risk of harm to patients within SEL paediatric audiology services, due to poor quality of care as identified by the site visits.	Lookback review completed by SME and capacity in place for patients to be seen – those with high/moderate clinical needs prioritised.		12

Key: Primarily system risk Primarily ICB risk

Summary of SEL risks exceeding tolerance levels (3 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**384**	Successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	Clear structures in place between clinical networks, workstreams and APC executive, which ensure clarity in responsibility and accountability and better oversight of programmes across elective and non-elective) Significant regional and national oversight of elective transformation programmes and clinical leadership capacity has been increased.	12	16
	386	Ongoing pressures across SEL UEC services	Intensive system support In place to manage pressures across the system. The system control centre operates 24/7. Focussed work on care pathway changes including those out of hospital increasing UEC access for MH crisis. Escalation arrangements support management of pressures and proactive work to develop community offer.		16
	391	Increased waiting times for autism diagnostics assessments.	Backlog clearance to reduce waiting times includes development of services to meet demand, clinical leads recruited to focus on autism across all ages. Autism strategy approved and launched, and core offer for CYP autism assessment developed and agreed.		16
	504	Cancer performance targets.	System-wide commitments to improved cancer performance, access and waiting times including faster diagnosis standard, and 62-day treatment standard Cancer planning embedded within boarder operational and capacity planning, which went through internal and external assurance (regional and national). Quality and safety monitored through continuous surveillance. Ongoing oversight is maintained through the SEL ICB cancer executive.		16

Key: Primarily system risk Primarily ICB risk

Summary of LCP risks exceeding tolerance levels

Risk Category	Risk ID	Risk title / summary of risk	Key controls include	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**Bro 509**	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.	SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Exploring the opportunity to join arrangements with other boroughs to ensure residents have equity of access to medication and review pathways	12	16
	Gre 635	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16
	Lam 129	Waiting time targets for children and young people waiting for an autism or ADHD assessment is unacceptably long.			16
	Lew 644	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16
	Sou 520	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			16

Key: Primarily system risk Primarily ICB risk

‘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	Score
602	ICB Change Programme – impact on staff	20
129	Waiting time targets for children and young people waiting for an autism or ADHD assessment is unacceptably long.	16
384	Elective care transformation programmes	16
386	Ongoing pressures across SEL UEC services	16
391	Increased waiting times for autism diagnostics assessments	16
504	Cancer performance targets	16
509	CYP diagnostic waiting times for autism and ADHD targets not being met.	16
520	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.	16
635		16
644		16
601	ICB Change Programme – workforce capacity risks	16
437	Disruption to IT / digital systems	15
606	ICS Revenue financial plan 2025/26	15
404	ICB oversight of new & emerging HCID & pandemics	12
468	Variation in performance with funded nursing care	12
597	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services	12
630	Risk of harm to patients (SEL paediatric audiology services) due to poor quality of care as identified by the site visits.	12

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 C. SEL risks greater than risk appetite

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Risk Category	Risk Appetite Score	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	Harriet Aganpong	Sarah Collingham	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives	There is a risk of non delivery in a range of elective care transformation programmes (theatres, admitted, non admitted) led by the Acute Provider Collaborative. This is caused by the limited bandwidth of clinical and operational leadership. 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 scalebable 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.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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 (across 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 ICS. This will be kept under regular review to ensure that sufficient clinical capacity is in place, and that it can be supplemented as necessary.	No gaps	Minutes of APC Executive meetings, and key workstreams (e.g. Non-Admitted, Theatres), 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 challenged 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
386	Kelly Hudson and Sara White	Sarah Collingham	Ongoing pressures across SEL UEC services	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.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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 ste safety. SCC operates 24/7 providing in and out of hours system support. Operational plan for 2025/26 includes a number of performance improvement trajectories, 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,. Proactive work to develop community offer including the roll out of urgent community response and development of our virtual ward offer. Ongoing management of impact for UEC via recovery process including monthly recovery meetings with UEC SROs and local UEC leads in place and acute.	None	The daily SCC provide immediate system support to retain ste 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	Carol-Ann Murray	Gwen Kennedy	Increased waiting times for Autism diagnostic assessments	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory obligations and increased spend due to non-contracted 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.	Clinical, Quality and Safety	7 - 9	3	4	12	4	4	16	Implementation of services for backlog clearance by Odaxa 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 diagnose 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 (S256) 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 16/17 to 18 year olds before adulthood to prevent longer waits in adult services. - Piloting SEL CYP Neurodiversity 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 Ltd 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	Simon Beard - Associate Director Corporate Governance.	Tosca Fairchild - Chief of Staff	New and emerging High Consequence Infections Diseases (HCID) & pandemics	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more waves. This could cause disruption to the operation of the ICB with staff illnesses/absence and reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	Clinical, Quality and Safety	7 - 9	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. Antiviral 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 plan 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 complex infectious disease outbreaks. Once completed, the ICB HCID response plan will need to be reviewed for alignment.	SEL ICB - System approach utilised and implemented for HCIDs. EPRR Practitioners network is in place enabling early sharing of informations' 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	Pin Bhandal, Associate Director ICT	Nisha Wheeler, Deputy Chief Digital Information Officer	DIGITAL – Disruption to IT-Digital systems	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. 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.	Clinical, Quality and Safety	7 - 9	2	5	10	3	5	15	Supply Chain -DSPT compliance indicates that for some organisations 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 – DSPT compliance indicates that assets underpinning essential services are identified, prioritised and have clear ownership assigned. SEL ICB have implemented information assurance policies, processes and procedures, DSPT Compliance indicates that Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity. Network and information systems and technology are designed to protect essential functions form cyber security attacks, Security Culture - processes are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles. DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures. Relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk. Such controls are in place that it limits the access to the designated area/files/premises or incorporates different levels of accessibility. Access controls are monitored or revoked where necessary. Up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of network and information systems supporting the operation of your essential function(s) and covers a range of incident scenarios. Accessible and secured current backups of data and information needed to recover operation of your essential function(s) following an adverse impact to network and information systems.	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, There are opportunities to further enhance cyber incident response measures.	DSPT Compliance Status of System Partners, Respective organisational assurance plans, to include: intrinsic assurance - process based assurance activities, primarily during design and procurement, Extrinsic assurance - external certification, such as cyber essentials, cyber essentials plus, ISO 27001 etc,or security evaluation, Operational assurance - activities necessary for maintenance, including plans for business continuity and cyber incident response, Implementation assurance - providing assurance that implementation has been conducted correctly, Some organisations hold additional information security certifications/accreditations. Cyber incident plan developed October 2025 (forms part of DSPT/CAF assurance plan) - Inclusive of work books	Not all DSPT requirements are audited annually, Individual organisation assurance plans may include gaps that impact quality of assurance
468	Jane Wade - Head of CHC/CYPCC Governance Assurance and QIPP	Lizzie Wallman - Deputy Chief Nurse	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	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.	Clinical, Quality and Safety	7 - 9	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 close the overdue reviews.	no gaps, No gaps in controls	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	Carl Glenister	Sarah Collingham	Cancer Performance	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.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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 stretching 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 specialties. Targeted support is in place to strengthen delivery capability where required.	No current gaps in assurance identified.
597	AD of IT - Pin Bhandal	Nisha Wheeler - Deputy Chief Digital Information officer	IGAT (SEL-CORP): Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services	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.	Data and Information Management	7 - 9	4	3	12	4	3	12	Asset Management – assets that underpin our essential services are identified, prioritised and have clear ownership assigned. 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. A primary Cyber Incident Response Plan is in place, with accompanying scenario playbooks in development. Using and sharing information - use and share information for direct care. B = You lawfully and appropriately use and share information for purpose outside of direct care. DSPT Compliance indicates that Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity. SEL ICB closely manage and maintain identity and access control for users, devices and systems accessing the network and information systems supporting your essential function(s). There is an established assurance plan, including external assurance, and risk management framework that supports our risk management approach. Supply Chain -DSPT compliance indicates that for some organisations 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. SEL ICB have implemented information assurance policies, processes and procedures, SEL ICB has various mechanisms in place to ensure security defences remain effective and to detect cyber security events and incidents which may potentially impact essential functions	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, There are opportunities to further enhance cyber incident response measures	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, Certification – CE+, Compliance – Secure Email Standard DCB 1596, 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 - Submitted 30th June 2025 - Approaching standards and action plan in place	Data Security and Protection Toolkit Compliance submitted - action plan work in progress for completed prior to end December, Scenario based cyber incident response testing to align with 2025/26 cyber incident response plan
601	Sarah Collingham/ Ceri Jacob	Andrew Bland	ICB Change Programme – Capacity risks	There is a risk that the ICB will face significant capacity challenges during the design and delivery of the ICB change programme. Ongoing uncertainty on consultation timelines, combined with a vacancy freeze and restrictions on recruitment, is leading to workforce gaps. This increases the risk of burnout for staff covering extended portfolios and threatens delivery of statutory responsibilities, ICB objectives and priority areas of work.	Operational: relating to the effective day to day running of the ICB organisation (MOR)	13 - 15	5	4	20	4	4	16	Proposals tested through scenarios with a detailed transition plan being developed. Agreement to cease some non-priority work to focus on statutory and "must-do" areas., Reappraisal of consultation timeline aligned to issue of national guidance and review by ICB Board and the ability to more easily secure fixed term contracts and secondments for additional time-limited capacity. Programme governance structure in place (SMT, Transition Committee, Operations Group, NHSE guidance on voluntary redundancy and the process for moving to consultation, plus confirmation of redundancy funding have provided a framework for the timeline for consultation. There remains a requirement to work in lock-step with other London ICBs, which will further determine timelines. Risk score does not change.	None	Change Programme Group with joint SROs meets weekly. Participation in London Transition Group to ensure safe transfer of functions.	None
602	Sarah Collingham/ Ceri Jacob	Andrew Bland	ICB Change Programme – Staff morale and wellbeing	There is a risk of low staff morale, health and wellbeing impacts, and wider disengagement as a result of the ICB change programme. Increased uncertainty around future structures, consultation length, and job security has led to a potential for increased staff anxiety and change fatigue. This may lead to higher sickness absence, reduced productivity, disruption to business as usual delivery, and disengagement from the consultation process.	Operational: relating to the effective day to day running of the ICB organisation (MOR)	13 - 15	5	4	20	5	4	20	Weekly CEO-led all-staff briefings with executive team in attendance., Dedicated intranet and MS Teams space to support transparent communications. Access to HR/OD support, including psychological support and wellbeing offers. Regular "Ask HR" sessions and targeted staff training/support. Executive commitment to review current limitations on staff access to training and development opportunities, with a view to extend these within the year 25/26 (subject to agreement).	None	Change Programme Group with joint SROs in place – meeting weekly. Ongoing monitoring of staff feedback through HR channels.	None currently identified
606	David Maloney	Mike Fox	ICS revenue financial plan 2025/26	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. Under-delivery against elective recovery commitments. Inability to recover income in line with planning guidance.	Finance	10 - 12	5	5	25	5	3	15	Breakeven plan for 2025/26 agreed by ICS Executive and ICS SSG, 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. Oversight 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. Monthly review by SEL CFOs and SEL CFO group, Funding received from NHSE, KOH 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, Controls agreed. Budgets agreed. Update at month 4 - ICS is off plan by £0.6m YTD, with a break-even forecast outturn	Identified CIP's and CIP forecasts do not currently meet targets,.	Non recurrent deficit funding received from NHSE, enabling a breakeven plan, Budgets agreed. SEL CFO group meeting fortnightly. SSG meeting monthly. Internal control totals agreed.	CIP plans do not meet targets. Monthly run rate forecasts do not yet show required improvement, Assurance on delivery of FYE of 2024/25 CIP schemes
630	Liz Aitken	Gwen Kennedy - Chief Nursing Officer	Risk of harm to patients due to poor quality of care	Risk of harm to patients due to poor quality of care as identified by the site visits (8-12% recall nationally come to harm approx. 85 patients for SEL).	Clinical, Quality and Safety	7 - 9	4	3	12	4	3	12	Odaxa backlack review completed by SME and capacity in place for patients to be seen. BHC backlack review of patients seen by the clinician with clinical compentency concerns are being reviewed in July and August by the same SME who completed the Odaxa backlack. Once this has been completed the patients with high / moderate clinical need will be prioritised in the capacity available. The rest of the BHC backlack patients whom were seen in the soundproofed room will then be reviewed with SME support. These patients have been noted by audiologists as lower risk given the risk associated with the ambient noise would be overdiagnosis rather than underdiagnosis.	SME capacity for BHC ambient noise cohort and recall appointments needs to be identified	Patients identified as high or moderate risk to be prioritised with existing capacity.	No Gaps In Assurance

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Risk Category	Risk Appetite Score	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
Bro 509	Sean Rafferty	James Postgate	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB, arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	3	3	9	4	4	16	Additional administrative support to bring additional capacity to wait list management. Regular monitoring meetings, Clear targets identified by the ICB with SLAM to reduce 52+week waiting times, SEL -wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis, SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Exploring the opportunity to join arrangements with other boroughs to ensure residents have equity of access to medication and review pathways.	Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. Limited ability to influence activity and quality within private 'Right to Choose' pathways. Data completeness and standardisation across providers and places not yet consistent. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments.	Oversight through the SEND Improvement Board, Place SEND Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYPMH Delivery Group and borough governance. Autism Partnership Board reporting into Learning Disability and Autism Oversight Board and Mental Health Oversight and Co-ordination Board when appropriate.	Inconsistent and incomplete BI reporting across places pending full implementation of the SEL-wide dashboard. Limited independent verification of data accuracy and trajectory modelling. Assurance over 'Right to Choose' activity and spend still under development.
Gre 635	Jenny Lamprell, Rana Amin, Ronaeta Campbell	Lisa Wilson, David Borland	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB, arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	5	5	25	4	4	16	Greenwich is just formalising the Autism Strategy, and as part of the newly established integrated commissioning team, a performance tracker on the waiting times and financial impact will be created. Data analytics will need to be supported by Oxleas as the local provider for ADHD/ASD diagnosis to track the impact of these delays, as well as the financial impact. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. SEL -wide neurodevelopmental improvement programme established to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places	No data for ADHD (waiting list or post-diagnostic), Autism, no register required, within OOF, akin to LD or SMI, and so very reliant on each practice to code accurately, hence the clinical variation. Whilst national RTC is in place, no control over volume and diagnosis asked for. Cannot control GP shared care with private contractors. Workforce capacity across community specialist diagnostic teams remains below demand. Limited ability to influence activity and quality within private 'Right to Choose' pathways. Data completeness and standardisation across providers and places not yet consistent. Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand.	Oversight through the SEND Improvement Board, Place SEND Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYPMH Delivery Group and borough governance. Autism Partnership Board reporting into Learning Disability and Autism Oversight Board and Mental Health Oversight and Co-ordination Board when appropriate.	Inconsistent and incomplete BI reporting across places pending full implementation of the SEL-wide dashboard. Limited independent verification of data accuracy and trajectory modelling. Assurance over 'Right to Choose' activity and spend still under development.
Lam 129	Laura M Griffin	Integrated Director for Children and Young People	Diagnostic waiting times for neurodiversity assessments - children and young people	There is a risk that waiting time targets for children and young people waiting for an autism or ADHD assessment is unacceptably long. This is caused by high demand and recovery from Covid-19. This impacts on the ICB's ability to ensure waiting time targets are met and could affect the organisations reputation. This could also have an adverse affect on CYP who are waiting for a diagnosis.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	4	2	8	4	4	16	Transformation funding proposal from Evelina London is going through contract management meetings route in order to build paediatric capacity to manage this. The additional capacity in place is overseen by Evelina Contract Management meeting - any issues escalated and managed there. Initial trajectory of referrals has been now seen as incorrect as referrals have continued to increase; a number of mitigatory steps in place now to re-define trajectory and reduction of waiting list. Total number of CYP on this list across L&S exceeds 1000. Saturday clinics are also now in place as well as additional trained staff. Additional consultants in post to increase diagnostic capacity.	Covid impact on finances means that transformation schemes will not all be fully funded however proposal to continue this during 23/23 has been submitted. Covid impact on the diagnostic itself meant that there were inherent delays, face to face appointments are necessary. This is an international issue.	Bi-monthly contract monitoring meetings with Evelina. Monthly ADHD meetings with Evelina and SLAM. Monthly reporting of position now coming direct from Evelina to Place, Council also monitoring this indicator... Regular meetings with local management team to develop and standardise EPIC report, Initiative to address longest wait times tracked in local performance, Ongoing oversight of diagnostic performance by the Lambeth Together Assurance Group	No Gaps in assurance at this time.
Lew 644	Simon Whitlock, Head of Children and Young People	Cari Jacob, Place Executive Lead	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB, arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	4	4	16	4	4	16	Clear targets identified by the ICB with SLAM to reduce 52+week waiting times, SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. SEL-wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis, SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Exploring the opportunity to join arrangements with other boroughs to ensure residents have equity of access to medication and review pathways SLAM validating ASD and ADHD waiting lists and in process of establishing borough-based ASD and ADHD teams; multiple private providers contracted to support with backlog clearance.	Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. Limited ability to influence activity and quality within private 'Right to Choose' pathways. Data completeness and standardisation across providers and places not yet consistent. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments.	Oversight through the SEND Improvement Board, Place SEND Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYPMH Delivery Group and borough governance.	Inconsistent and incomplete BI reporting across places pending full implementation of the SEL-wide dashboard. Limited independent verification of data accuracy and trajectory modelling. Assurance over 'Right to Choose' activity and spend still under development.
Sou 520	Jubin Mama - Commissioning Manager, Social and Emotional Wellbeing, CYP Integrated Commissioning	Russell Jones - Assistant Director, Integrated Commissioning	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB, arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	4	2	8	4	4	16	Additional administrative support to bring additional capacity to wait list management, Regular monitoring meetings, Clear targets identified by the ICB with SLAM to reduce 52+week waiting times, SEL -wide neurodevelopmental improvement programme established under the CYP MH and Wellbeing Partnership Board to oversee ASD and ADHD diagnostic pathways, waiting times, and consistency of the core offer across SEL boroughs / places. New integrated diagnostic pathway from April 2025 enabling movement between ADHD and Autism assessments, reducing duplication and re-referral delays. Targeted capacity investment including non-recurrent and recurrent funding to providers to expand assessment capacity, weekend clinics, and workforce recruitment initiatives. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis, SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Exploring the opportunity to join arrangements with other boroughs to ensure Southwark residents have equity of access to medication and review pathways	Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand. Limited ability to influence activity and quality within private 'Right to Choose' pathways. Data completeness and standardisation across providers and places not yet consistent. Funding for additional diagnostic capacity remains non-recurrent and therefore unsustainable without future investment commitments.	Oversight through the SEND Improvement Board, Place SEND Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYPMH Delivery Group and borough governance. Autism Partnership Board reporting into Learning Disability and Autism Oversight Board and Mental Health Oversight and Co-ordination Board when appropriate.	Inconsistent and incomplete BI reporting across places pending full implementation of the SEL-wide dashboard. Limited independent verification of data accuracy and trajectory modelling. Assurance over 'Right to Choose' activity and spend still under development.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Overall Committees Report**						
Meeting date	28 Januar 2026		Agenda item Number	6	Paper Enclosure Ref		F
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 28 January 2026

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 15 October 2025. In addition the ICS benefits from two provider collaboratives 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	26 November 2025	7 January 2026	9 October 2025	29 October 2025	15 October 2025	29 October 2025	22 September 2025	9 September 2025	15 October 2025
	-	-	-	18 November 2025	-	-	24 November 2025	11 November 2025	29 October 2025
	-	-	-	-	-	-	-	13 January 2026	12 November 2025
	-	-	-	-	-	-	-	-	26 November 2025
	-	-	-	-	-	-	-	-	10 December 2025
	-	-	-	-	-	-	-	-	17 December 2025
	-	-	-	-	-	-	-	-	7 January 2026

	Local Care Partnerships						
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**Transition Committee**
Meeting date	27 November 2025	25 September 2025	22 October 2025	6 November 2025	25 September 2025	27 November 2025	7 November 2025
	-	27 November 2025	-	8 January 2026	27 November 2025	-	25 November 2025
	-	-	-	-	-	-	9 December 2025
	-	-	-	-	-	-	-

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, ICB Medical Director

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.	Dr Toby Garrood, ICB Medical Director
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
Transition Committee	The purpose of the Committee is to provide assurance and oversight of the ICB SEL Change Programme for the ICB Board, ensuring a safe and coherent transition, managing local risks, tracking progress and overseeing the development of organisational design and implementation of the change process, including the transfer of functions to providers over time.	Georgina Fekete, Non-Executive Member
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) Iain Dimond (Greenwich) Dr Di Aitken & Cllr Nanda Manley-Browne (co-chairs, Lambeth) Vanessa Smith & Fiona Derbyshire (co-chairs, Lewisham) Dr Nancy Kuchemann & Cllr Evelyn Akoto (co-chairs, Southwark)

4. Recommendations to the Board for Decision / Approval

4.1 The Board is asked to **APPROVE** the attached revision to the Remuneration Committee terms of reference (Appendix A), to explicitly confirm its authority to approve any proposed redundancy, severance or settlement costs and payments, using the wording recommended by NHS England.

4.2 The Board is asked to **APPROVE** the attached revision to the Partnership Southwark Strategic Board (PSSB) (Southwark Local Care Partnership) terms of reference (Appendix B), noting proposed changes made to quoracy, membership and frequency of meetings. Given time limitations, these amendments have been agreed by PSSB Chairs Action and will be presented at the next PSSB meeting on 29 January 2026.

4.3 The Board is asked to **NOTE** that the One Bromley Partnership (Bromley Local Care Partnership) have reviewed their terms of reference (Appendix C) and proposed no changes.

4.4 The Board is asked to formally **ACCEPT** the substantially compliant outcome of the ICBs annual EPRR core standards assessment, noting the areas assessed as being substantially (rather than fully) compliant are resourcing, ongoing review of business impact assessments (BIAs), and Data Protection and Security Toolkit (DPST) validation. This reflected that work was ongoing to update the BIAs for the current year at the point of assessment, and to complete a handful of areas on the DPST which have subsequently been resolved.

The Board is asked to note that achievement of core standards was self-assessed this year, followed by an independent review of the assessment outcomes with NHS England to identify areas where support could be provided. A similar process was undertaken by the ICB with provider Trusts, under the leadership of Tosca Fairchild as Accountable Emergency Officer. Across the system, two organisations achieved full compliance, with five organisations obtaining substantial compliance. All five organisations with substantial compliance raised the same areas of concern as detailed above for the ICB.

For context, attached as Appendix D is the Emergency Preparedness, Resilience and Response (EPRR) annual report that was recently submitted to the ICBs Executive Committee, to provide a summary of activity that has taken place in the year. Any learning from incidents or training and exercising is identified through after-action reviews and shared across the sector

and region for the benefit of other organisations, with the ICB maintaining a database of lessons learned to monitor and evaluate any actions to address issues identified.

4.5 For transparency, the decision to recommend to proceed with the 111 procurement was agreed with Board members on 16 December 2025.

4.6 The Board is asked to confirm its **APPROVAL** for the ICB to continue to enter into a Section 75 agreement with the London Borough of Lewisham to govern the BCF pooled fund in Lewisham. The value of the pooled budget for 2025/26 is £53,440,286. SEL ICB's contribution is £32,348,460. Approval has already been obtained from the local authority. This has previously been discussed in public at the Lewisham Local Care Partnership meeting in July 2025.

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	15 October 2025	• The Committee endorsed the extension of contracts for community dental services. • The Committee gave final approval on a speciality primary care guideline for acute knee injury, following engagement with clinical networks. • The Committee expressed support for pre-hospital video triage scheme. • The Committee endorsed the ICBs procurement annual summary and compliance report. • The Committee approved organisational policies in relation to change management, HR partnership and Patient group directives. • The Committee approved the release of £250k to each of Bromley Lambeth Lewisham and Southwark to help develop integrators.
2.	Remuneration Committee	29 October 2025	• The Committee approved amendments to the ICBs Voluntary Redundancy Scheme, recommended following review by NHS England.
3.	Executive Committee	12 November 2025	• The Committee approved the submission of joint bids working with South West London ICB for financial support with obesity pathway transformation. • The Committee supported a trial of a south east London Data Lab meeting to provide supportive forum for staff to test ideas and share expertise on analytical and statistical approaches and use of data to generate insights.
4.	Greenwich Charitable Funds Committee	13 November 2025	• The Committee approved the extension of the contract with Groundwork London for three years with effect from July 2026.
5.	Remuneration Committee	18 November 2025	• The Committee approved local adoption of the national Voluntary Redundancy Scheme arrangements, as approved by HM Treasury.
6.	Executive Committee	26 November 2025	• The Committee approved the panel recommendation in relation to the accreditation of Innovate ADHD Ltd as a provider of adult ADHD services in

			south east London
7.	Executive Committee	10 December 2025	• The Committee approved an option for the continuation of the Clinical Effectiveness South East London and focus on contribution to integrated neighbourhood teams. • The Committee made a recommendation to the Board in relation to the procurement of 111 services.
8.	Executive Committee	17 December 2025	• The Committee received a proposal in relation to consolidation of Tier 2 Audiology Services and agreed that the proposal should return to the committee with more information on potential impact.
9.	Executive Committee	7 January 2026	• The Committee approved the refreshed information governance policy, information governance framework, Registration Authority policy and Quality Impact Assessment guidance. • The Committee approved the release of £250k to Bexley and Greenwich to help develop integrators.

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.	Digital Committee	9 September 2025	• The Committee discussed workplan and terms of reference and noted updates from its subsidiary groups. • Future plans and options for the Lewisham Analytics platform were discussed, with a further update to be brought to the November meeting. • Lessons Learned from the Synnovis incident were discussed and noted. • The Committee discussed how best to embed appropriate digital expertise into pathway redesign work.
2.	People Committee	22 September 2025	• The Committee noted **no significant risk changes**, only minor adjustments reflecting progress on people strategy priorities. Through discussion, the need for a future session on workforce retention and **workplace safety** was agreed. The ICS People Programme restructure impact was acknowledged. • Three strategic areas formed the core of the meeting. 1. **Digital transformation** is a core focus of the 10-year health plan, with key priorities including AI, reduced bureaucracy, and a Single Patient Record. The SEL update outlined work is aligned to these priorities with a strong focus on safe, well-governed AI deployment. Future efforts will prioritise neighbourhood-level digital enablement and strengthening workforce digital confidence. 2. SEL's vision is a unified **Population Health Management** approach, focused on tackling system complexities, strengthened data and analytics infrastructure, driving evidence-based investment for health improvement. Work to review workforce development to enable the approach is planned.

			3. **Neighbourhood Health:** The approved workforce plan is progressing through staff activation, leadership development, governance workshops, and collaborative learning initiatives. • Strong progress on the SEL **EDI** programme was shared, highlighting extensive engagement through webinars, a stocktake, a SEL wide conference, and the launch of a shared Inclusion Collective Repository to drive system-wide best practice.
3.	Audit & Risk Committee	9 October 2025	• Committee members noted progress made against the internal audit workplan for the year, including follow up reviews on previous audits with negative opinions. • The Committee received a progress report on anti-crime services activity, together with an update on new obligations under the Economic Crime Act. • Members reviewed the Board Assurance Framework and received an update on the work to develop a system risk approach across the ICS. • Progress was reported against the 2024/25 Data Security and Protection Toolkit action plan. • The Chief Financial Officer provided a report on special payments, debt write offs and tender waivers, and an update on the implementation of a new financial system (ISFE2). • The Chief of Staff presented a paper on security arrangements in the ICB, and updates to the Audit and Risk Committee terms of reference to be approved by the Board at the October meeting.
4.	Executive Committee	15 October 2025	• The Committee received an update on planning noting continued release of national guidance. • The Committee received an update on an incentive scheme for urgent dental care, noting the cost implications and utilisation on the current fully procured urgent dental service.
5.	Greenwich Charitable Funds Committee	15 October 2025	• The Committee received an update from Groundwork London which advised a total of 117 grants worth £17million have been awarded. A new strand, ‘micro

			grants', was introduced to fund pilot projects and small initiatives, and was proving popular with funding activity in every ward in Greenwich. • An update on programme developments was provided with a summary from DG Cities of their evaluation process and key outcomes and recommendations. • A review of the VCS Grants programme, transferred to Public Health earlier in 2025, would take place.
6.	Executive Committee	29 October 2025	• The Committee received an update on the planning round noting summaries produced of guidance. • The Committee received an update on progress with changes to the GP online access contract implemented from 1 April 2025, noting a mixed response in south east London and a central approach taken to ensure consistency. • The Committee received an update on usage and promotion of the NHS App, noting 64.1% of SEL residents had registered for the App. • The Committee noted a month 6 finance report noting a break even position for the ICB and reporting a YTD deficit position broadly in line with plan for the ICS.
7.	Remuneration Committee	29 October 2025	• Committee members considered pay awards following review and noted an advisory note to the VSM pay framework. • Amendments to the ICBs Voluntary Redundancy Scheme, recommended following review by NHS England, were approved by the Committee.
8.	Clinical & Care Professional Committee	29 October 2025	• The Committee members received an update on some work being undertaken by the Health Innovation Network (HIN) on the primary and secondary care interface. • The Committee received an update from the System Sustainability Programme on the five priority schemes identified to help get the system back into financial balance and the INT modelling being undertaken to identify workforce opportunities. • Members received an update on the development of the Neighbourhood Health Service in SEL, noting the importance of linking interface improvements with neighbourhood development and patient experience.

			• An overview of the activity of the Engagement Assurance Committee was provided for members awareness.
9.	Transition Committee	7 November 2025	• The Committee heard an update on national developments and release of guidance on strategic commissioning as well as ongoing discussions about redundancy funding. • The Committee heard and discussed an update on work with SWL ICB to identify those areas where work together would be beneficial and increase resilience of both ICBs, asking that the work include assessment of benefit as well as risk. • The Committee agreed key lines of enquiry that the committee would use to judge whether proposals would achieve its aims.
10.	Digital Committee	11 November 2025	• An update was received on the Electronic Patient Record procurements for Lewisham & Greenwich NHS Trust and South London & Maudsley NHS FT. • A report on progress made on digital enablement for the future integrated neighbourhood teams was delivered and discussed. • An update on the London Health Data Strategy was received with good progress made on engagement. • Options to increase digital skills in south east London were considered, with support given to the acquisition of additional training subject to identification and approval of funding.
11.	Executive Committee	12 November 2025	• The Committee received updates including the response to the recent industrial action. • The Committee received an update on planning and initial information on expected financial allocations. • The Committee noted the continued approach of bringing deep-dive updates on the ICBs corporate objectives to the committee.
12.	Remuneration Committee	18 November 2025	• The members met to discuss and approve local adoption of the national Voluntary Redundancy Scheme arrangements, as approved by HM Treasury.

13.	People Committee	24 November 2025	• **Social Care focus:** Social care providers highlighted critical challenges including inconsistent training and integration with the NHS, workforce shortages and retention issues (driven by pay disparities and sponsorship limits), fragmented career pathways, funding pressures, digital integration gaps, and the need for stronger collaboration and strategic workforce planning to ensure safe, sustainable care delivery. Whilst a range of social care related work is underway, a small sub group was identified to meet and identify priorities for stronger collaboration. • The **SEL AHP support worker workforce** item, highlighted survey findings on career development gaps and introduced a key **prospectus** mapping 40 opportunities to improve progression, satisfaction, and system-wide visibility. • **Workforce risk:** A key discussion on **racism and anti-semitism impacting staff** was held. This stressed the **importance of EDI** and informed decisions to review EDI group membership re the inclusion of smaller providers and reflect discrimination in the strategic workforce risk to maintain focus and monitor progress. • The Committee approved the proposal for the January meeting to focus on the future approach of the People Committee.
14.	Transition Committee	25 November 2025	• The Committee heard an update on phase 2 of work to examine function by function the opportunities and benefits of working with SWL ICB based on the work of subject matter experts in both ICBs and discussed ICB decision making. • The Committee considered updated key lines of enquiry that the board might use to consider whether the proposals provided sufficient benefits.
15.	Executive Committee	26 November 2025	• The Committee received updates on the planning round including the need to submit bids for capital funding. • The Committee noted the annual safeguarding report which highlighted how the ICB continued to meet its statutory responsibilities and key function. • The Committee discussed a proposal to build an common framework to organise health outcomes for the population to help evaluate the impact of interventions and support research and innovation. • The Committee received a finance report for month 7 and noted a ICB break-even position and a small adverse variance against plan for the ICS.

16.	Integrated Performance Committee	26 November 2025	• Members received a paper updating the Committee on the progress made by Greenwich LCP on its five chosen priority areas and neighbourhood-based care. • Development of the SEL Outcomes Framework was discussed, with proposals on how to address the challenges limiting the impact of a comprehensive framework which would pull together the current local and national schemes. • The Committee received a report on the month 7 ICB and ICS financial positions, noting a break-even position for the ICB and a £26.5m deficit for the ICS. £176.9m of efficiencies had been delivered, with a forecast underlying exit position of £257.2m, and an expectation capital allocations would be spent in the year.
17.	Transition Committee	9 December 2025	• The Committee discussed the proposed transfer of the delivery of some ICB functions to other NHS organisations including a discussion on timing and the need to measure effectiveness and get the most out of any transfer. • The Committee considered a risk register that had been delivered relating to the overall change programme that had been identified, making suggestions on areas of focus.
18.	Executive Committee	10 December 2025	• The Committee noted the submission of an initial return on planning indicating whether the ICB expected to submit a compliant plan in a range of areas. • The Committee discussed and supported the direction of travel in principle of a digital system architecture recommendation intended to support the three shifts in the ten year plan arising from work on a single data repository. • The Committee heard a presentation on the London secure data environment as a way to deliver objectives on proactive care, neighbourhood working and strategic commissioning, as well as research and development. • The Committee discussed the development of an innovation ecosystem to draw together the assets and specialist areas to support innovation.
19.	Executive Committee	17 December 2025	• The Committee received an update on planning. • The Committee discussed the corporate objective of providing Learning Disability Annual Health checks. • The Committee received a financial report on month 8.

20.	Executive Committee	7 January 2026	• The Committee received a presentation on mental health support teams in schools and discussed the option to develop a core model for SEL to address current variations in models of delivery and level of provision between boroughs. • The Committee received and noted the annual EPRR report for 2025, equality reports and the Board Assurance Framework. • The Committee received an update on Integrator development and maturity. • The Committee received the latest summary of system performance.
21.	Quality & Safeguarding Committee	7 January 2026	• The Committee received a safeguarding update, including review of training compliance, NHSE assurance outcomes, and progress against workplan. • An update was received on quality alerts and a deep dive into ENT complaints. • PSIRF updates were received from across the system, and a planned pilot for a single overarching policy for general practice was discussed. • The quality planning framework approach was endorsed by the committee. • An all age continuing care update was received noting good performance, increased training and the piloting of a AACC virtual ward round tool. • IPC and medicines optimisation teams provided updates on activity and project work • Latest patient experience data was presented, noting an increase in complaints and key areas of concern being CHC, minor eye conditions, community ENT and mental health pathways. • Updates on inpatient activity for learning disability, autism and SEND was reported, plus confirmation the service specification for commissioning of community autism services had been completed, that intensive support teams would be in place for boroughs for 2026/27, and a procurement framework and plan was being developed to support Trust responsibility for Oliver McGowan training from March.
22.	Digital Committee	13 January 2026	• The Committee received a presentation on the Health Information and Management Systems Society (HIMSS) assessment currently underway in Guys and St Thomas's and Kings College Hospital NHS FTs.

			• Upcoming services changes for the London Care Record were discussed. • The Committee noted updates from its subsidiary groups.

Appendix 1

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 November 2025	4. Health & Care Reforms: Neighbourhood Health Plan Development	The Bexley Wellbeing Partnership Committee received a report on the Health & Care Reforms and the Neighbourhood Health Plan Development. The purpose of the report was to make the Bexley Wellbeing Partnership Committee aware of the national guidance received to date, which emphasised strengthening the role and responsibilities of Health & Wellbeing Boards and how the Bexley Wellbeing Partnership should approach addressing the new requirements and the development of the 2026/27 Neighbourhood Plan. The Bexley Wellbeing Partnership Committee: **(i)** **Noted** the proposed governance review across the Bexley Health & Wellbeing Board and Bexley Wellbeing Partnership Committee for implementation in 2026/27. **(ii)** **Endorsed** the approach and timelines for reviewing and health strategies and plans in the immediate term (during 2025/26), including developing the Local Neighbourhood Plan as aligned to the Joint Health & Wellbeing Strategy.

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 November 2025	Joint Forward Integrated Plan 2025/26: Progress Report	The Bexley Wellbeing Partnership Committee received the Joint Forward Integrated Plan 2025/26: 6 Month Progress Report. The report captured key successes from April to September 2025, highlighted challenges and learning. The Bexley Wellbeing Partnership Committee: • **Noted** the report for information and assurance.
2.	27 November 2025	Better Care Fund: Quarter 2 Return 2025/26	The Bexley Wellbeing Partnership Committee received a report on the Better Care Fund Quarter 2 Return for 2025/26. The Quarter 2 performance reflects continued progress in promoting independence, timely discharge and reduced reliance on long-term care. Areas such as discharge complexity require ongoing system focus. The Bexley Wellbeing Partnership Committee: • **Reviewed** the report and the mitigations/actions highlighted in Appendix 1 for each of the metrics RAG rated as red based on the latest reporting period.
3.	27 November 2025	Local Care Partnership Assurance Report	The Bexley Wellbeing Partnership Committee received the Local Care Partnership Performance Report. The report highlighted the latest position against key areas of local performance, highlighting achievements against national targets, agreed trajectories and other comparators. The Bexley Wellbeing Partnership Committee: • **Reviewed** the report and the mitigations/actions highlighted in Appendix 1 for each of the metrics RAG rated as red based on the latest reporting period.

4.	27 November 2025	*Let's Talk:* Diabetes	• The Bexley Wellbeing Partnership Committee in its *Let's talk* session heard an overview of public health data on diabetes in the borough from Dr Nicole Kylnman, Director of Public Health. Pippa Ashford and Julie Page, from the Community Diabetes Team, Oxleas NHS Foundation Trust talked about the support available to residents. Malsa Ibrahim from the National Diabetes Prevention Programme presented on the *Healthier You Diabetes Prevention Programme.* The committee heard from residents with a lived experience perspective, Mei Wells, Peter Bellingham and Linda Bellingham, who run a monthly peer support group in Bexleyheath.

Appendix 2

Bromley Local Care Partnership – One Bromley

1. Recommendations to the Board for Decision/Approval

1.1 There were no recommendations made to the Board during this period.

2. Decisions made by Bromley LCP Under Delegation

2.1 Below is a summary of decisions taken by the One Bromley LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	25 September 2025	Item 7 – Updates to the Bromley NHS Act 2006 s. 75 Agreement for 2025-26	• The One Bromley Local Care Partnership Board approved the current 2025/26 arrangements.
2.	27 November 2025	Item 6 – One Bromley Executive Committee and One Bromley Local Care Partnership Board Terms of Reference	• The One Bromley Local Care Partnership Board approved the annual review of the Terms of Reference for the One Bromley Executive Committee and One Bromley Local Care Partnership Board.

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.	25 September 2025	Item 6 – Homeless Service Update	• Colleagues from the Bromley Homeless Service updated on work undertaken and its impact. Bromley's Homeless Health Hub established in 2023 tackles health inequalities by providing holistic care that reduces A&E attendances and improves patient outcomes. • The Board received powerful testimony of the impact of the service from a person with lived experience of homelessness who now volunteers there. The Board noted the update.
2.	25 September 2025	Item 8 – One Bromley Winter Plan 2025-26	• Bromley's Winter Plan for 2025-26 was presented. Developed collaboratively across One Bromley and aligned with national priorities, the plan ensures robust governance and focuses on A&E performance, vaccination, and alternative care pathways, and uses stress testing, modelling and real-time data to maintain resilience and system-wide readiness. The Board discussed the Winter Plan at length and per the paper recommendations: • Acknowledged the plan, endorsing the system wide commitment to collaborative delivery across organisations to manage winter pressures and whole system risk. • Noted the seven key performance indicators set by NHS England and expected performance. • Noted the Board Assurance Framework for the System Winter Plan had been approved by the A& E Delivery Board, alongside the Trust Assurance Framework which was approved by the Trust Executive. • Noted changes to be made to the plan following the NHSE Winter Stress Test in September.

3.	25 September 2025	Item 11 – Month 4 SEL ICB Finance Report	• The One Bromley Local Care Partnership Board received the Month 4 Finance Report, with Bromley LCP expecting a £35k underspend, due to overspends in mental health and continuing healthcare offset by community and prescribing underspends. A new financial system went live on 1st October.
4.	25 September 2025	Item 12 – Primary Care Group Report	• The Board noted the Primary Care Group Report.
5.	25 September 2025	Item 13 – Procurement and Contracts Group Report	• The Board noted the Procurement and Contracts Group Report.
6.	25 September 2025	Item 14 – Performance, Quality and Safeguarding Group Report	• The Board noted the Performance, Quality and Safeguarding Report.
7.	27 November 2025	Item 7 – Care Home Programme Successes	• LCP members received a briefing on Bromley's Enhanced Health in Care Home Programme, which supports fifty care settings through quality improvement initiatives aligned with NHS England's Enhanced Health in Care Homes Framework. Key priorities include falls prevention, end-of-life care, and dementia management, with notable impacts including reduced London Ambulance Service (LAS) activity growth (5% vs 10% regionally), improved Universal Care Plan uptake (over 70% of residents have a completed plan) and enhanced workforce confidence via RESTORE2 training. Collaborative efforts and strong care setting engagement underpin these successes. • The LCP noted the current Enhanced Health in Care Homes (EHCH) programme workplan and priorities, and its recent successes.
8.	27 November 2025	Item 9 – Month 6 SEL ICB Finance Report	• The One Bromley Local Care Partnership Board received the Month 6 Finance Report. SEL ICB and Bromley LCP are forecasting breakeven positions for the year, with overspends in Mental Health and Continuing Healthcare offset by prescribing and community underspends.

			• Planning guidance for 2026–27 indicates lower uplifts, cost improvement plans and system-wide alignment will be critical, with further detail to be discussed at at the January Local Care Partnership Board. The Board noted the report.
9.	27 November 2025	Item 10 – Primary Care Group Report	• The LCP Board noted the Primary Care Group Report.
10.	27 November 2025	Item 11 – Procurement and Contracts Group Report	• The One Bromley Local Care Partnership Board were updated that following a detailed procurement process, the SEL ICB Board had awarded a new Bromley Community Health contract to Bromley Healthcare. There would be a new specification, and the contract would begin in December 2026, for five years, with the option to extend for a further two years. The ICB are working with Bromley Healthcare to begin mobilising the contract.
11.	27 November 2025	Item 12- Performance, Quality and Safeguarding Report	• The LCP Board noted the Performance, Quality and Safeguarding Report.

Appendix 3

Greenwich Local Care Partnership – Healthier Greenwich Partnership (HGP)

1. Recommendations to the Board for Decision / Approval

1.1 There were no decisions referred to the Board for decision or approval at the meeting held on 22 October 2025.

2. Decisions made by Healthier Greenwich Partnership LCP Under Delegation

2.1 There were no decisions taken by the Healthier Greenwich Partnership LCP under delegation from the Board at the meeting held on 22 October 2025

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.	22 October 2025	Agenda item 6. Feel Well	• The LCP members received a report on 'Feel Well' in particular, relating to mental health in Greenwich neighbourhoods and how existing engagement channels are used for the work • The LCP members noted that there is an overlap between mental health and addiction • The LCP members were shown the mental health landscape for Greenwich in context of population, risk factors, health conditions and mental health conditions, and how the partnership aims to address these issues
2.	22 October 2025	Agenda item 6.2. Feel Well - Addictions	• The LCP members were shown an insight into what constitutes addiction and noted that addictions is influenced by genetic and environmental factors

			• The LCP members were advised about what had gone well and what improvement opportunities had been identified • Strategic plan development, stakeholder recommendations and key priorities were shared with LCP members

3.	22 October 2025	Agenda item 6.3.
		Feel Well – Mental Health, Learning Disabilities and Autism
			• The LCP members were told that three high impact activities had been identified for 25/26 and were advised about what had gone well and where improvement was still required
			• The LCP members were advised that six strategic priorities had been identified as part of a two-year interim plan, which are:
			  ○ Increase local awareness and understanding
			  ○ Tackle health and care inequalities
			  ○ Education and employment
			  ○ Community resilience
			  ○ Personalised support
			• Professional training and learning

4.	22 October 2025	Agenda item 6.4.
		Feel Well – Live Well and Mental Health Hub
			• The pathway for Adult Social Care and prevention approach was shared with LCP members
			• The LCP members noted what had gone well in 24/25 and where additional work was needed
			• The LCP members also noted information on the following:
			  ○ Holistic Front Door example
			  ○ S106 funding that was provided to The Forum, the new premises for MIND
			  ○ Equality grants that had been awarded to grassroots organisations
			• The LCP members were advised that Greenwich participated in a pilot for STOMP which had been well received by service users and carers

5.	22 October 2025	Agenda item 6.5.	• The LCP members noted what had gone well in 24/25 and where there was more work to be done

		Feel Well – Staff and Resident Communications	• The LCP members were advised that the Learning Disability Partnership, referred to as the 'Peoples Parliament' and supported by Advocacy in Greenwich had been introduced
6.	22 October 2025	Agenda item 7. Neighbourhood Programme Update	• The LCP members noted that the ICB Board had endorsed the appointment of Oxleas NHS Trust as Integrator for Greenwich • The LCP noted that there was a successful Neighbourhoods Launch on 15 October 2025 • LCP members were advised that Stone King had been appointed to support the development of the partnership and how to make effective use of resources
7.	22 October 2025	Agenda item 8. Healthier Greenwich Charitable Funds Update	• The LCP members received a report from Groundwork London on the progress of the Healthier Greenwich Charitable Funds • The LCP members noted the following: ○ 95 organisations have received funding ○ A community panel has been started to ensure the fund meets the needs of local residents • DG Cities have been appointed to provide an independent evaluation of the fund
8.	22 October 2025	Agenda item 9. Integrator appointment	• The LCP members were advised that the SEL ICB Board had endorsed the appointment of Oxleas NHS Trust as Integrator for Greenwich
9.	22 October 2025	Agenda item 12. 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.

Appendix 4

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.	6 November 2025	Deep Dive – Children and Young People Alliance	Members of the Partnership Board: • Approved the progress report on the work of the Children and Young People Alliance against the activities outlined in Our Health, Our Lambeth - Lambeth Together health and care plan 2023-28. • Approved the health inequalities and prioritisation approach based on work from Act Early South London, to help guide and design implementation of integrated neighbourhood teams for the Children and Young People Alliance. • Heard directly from children and young people in Lambeth about the health and care issues that matter most to them, including where resources should be focused and how their voices can be embedded in decision-making and future planning.
2.	6 November 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 17 September 2025; and ratified decisions made at the Primary Care Commissioning Committee (PCCC) on 17 September 2025.
3.	6 November 2025	Business Planning 2026/27	Members of the Partnership Board: • Approved the proposed approach for the 2026/27 Business Planning Process, noting the national requirements and timelines.

			• Agreed to work with their respective organisations, alliances, and partners to support the production of prioritised and deliverable local plans.
4.	6 November 2025	Carer's Strategy Update	Members of the Partnership Board: • Noted the actions and outcomes delivered in Year 1 of the Carer's strategy and • Supported the actions underway and planned for Year 2 of the strategy.
5.	8 January 2026	Deep Dive – Staying Healthy	Members of the Partnership Board: • Approved the progress report on the work of the Staying Healthy Programme against the activities to deliver NHS Health Checks as outlined in Our Health, Our Lambeth - Lambeth Together health and care plan 2023-28. • Considered the preliminary findings of the Department of Health and Social Care pilots (Health Checks at Work and Health Checks online) and the potential application of learning locally for the core NHS Health Checks programme and wider system. • Provided relevant feedback for the Department of Health and Social Care to help inform national thinking in lieu of any future national roll out of the pilots.
6.	8 January 2026	Business Planning 2026/27	Members of the Partnership Board: • Approved and provided feedback on the content of the draft priorities outlined in the appendix of the plan. • Noted the timeframes of the 2026/27 business planning round.
7.	8 January 2026	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 November 2025 and ratified decisions made at the Primary Care Commissioning Committee (PCCC). Ratification of the decision concerning the Alternative Provider Medical Services (APMS) Care Home Provider contract breach will be enacted by chairs action following Members review.

3. Agenda Items of Note

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

1.	6 November 2025	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received an update on key developments since the last Lambeth Together Care Partnership Board meeting in public on 4 September 2025, including decisions made under the South East London Integrated Care Board scheme of delegation.
2.	6 November 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 and the associated Integrated Assurance Report presented on 16 September 2025.
3.	8 January 2026	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received an update on key developments since the last Lambeth Together Care Partnership Board meeting in public on 6 November 2025 including decisions made under the South East London Integrated Care Board scheme of delegation.
4.	8 January 2026	Lambeth Together Assurance Sub-Group (LTAG)	Members of the Partnership Board noted the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 25 November 2025.

Appendix 5

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.	25 September 2025	Item 5 Primary Care Network changes	**The Board were asked to give formal ratification (as the original decision had to be made outside the usual board meeting schedule due to timing constraints) on the Primary Care Network changes.** Lewisham Place received a formal business case from ICO Health Group and Novum Health Partnership, proposing to voluntarily leave Sevenfields PCN and establish a new PCN. Sevenfields PCN leadership has been working closely with the Local Medical Committee (LMC) to manage the transition, including an interim plan to support the shift from one PCN to two: • The formation and viability of the new PCN. • The impact on the remaining Sevenfields PCN. There is continued collaboration between both PCNs within the same neighbourhood, especially in relation to the Integrated Neighbourhood Teams (INT) programme. **The LCP Board approved the Primary Care Network changes.**
2.	25 September 2025	Item 6 Lewisham Integrated Neighbourhood	**The Board were asked to give formal approval to the Lewisham Integrated Neighbourhood Partnership and governance arrangements**

		Partnership and governance arrangements	The partnership has been designed to support the rollout of neighbourhood working and integrator functions, as outlined in the London Target Operating Model. Development is at an early stage and further guidance is expected. However, the partnership will meet monthly to progress these workstreams and refine the integrator role. As a result, the Board were asked to approve the Integrated Neighbourhood Steering Committee Terms of Reference. **The LCP Board approved the Lewisham Integrated Neighbourhood Partnership and governance arrangements**

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.	25 September 2025	Item 3 PEL report	Vanessa Smith, co-chair to the LCP Board for the last 12 months noted that Neil Goulbourne, LGT would assume the role from the next meeting (November 2025) alongside Fiona Derbyshire, Lewisham Citizens' Advice Bureau.
2.	25 September 2025	Item 4 Virtual Ward procurement decision/outcome	The LCP discussed the Virtual Ward procurement decision/outcome, noting that: • **Lot 1 – NHS at Home:** This service is designed to support patients with high needs requiring short-term hospital at home care. A soft launch began on 1st October 2025, with communications and public notices expected to be issued by the end of this week. The service will operate at reduced capacity during a two-month mobilisation phase, with full operational delivery targeted for January 2026. • • **Lot 2 – NHS Virtual Plus (Health Monitoring):** Lot 2 focuses on proactive digital monitoring for patients with long-term conditions. The procurement decision is currently subject to challenge and an evaluation panel has been convened. Subject

			to the outcome, a notice of award is expected by the October 2025, following a five-day standstill period. The service is aiming to go live between December 2025 and January 2026. This is dependent on the outcome of the procurement process.
3.	25 September 2025	Item 7 Engagement on developing Trust Strategy 26/31	The LCP received a representation from Lewisham and Greenwich NHS Trust (LGT) on the progress made in developing their 2026-2031 strategy. The Trust noted significant progress since 2018, including an improved CQC rating and the beginning of a digital transformation which included launching a patient portal and planning to procure a new electronic patient record system. The Trust was also aiming to be a more engaged partner in Lewisham, acknowledging ongoing challenges in improving services, patient experience, and system-wide collaboration. Integrated Neighbourhood Teams (INTs) are a key focus, with efforts to strengthen prevention and patient empowerment. Feedback from a recent Lewisham People's Partnership survey highlighted concerns around emergency care pathways, digital transformation, long hospital stays, and delays in A&E. There was also a recognised need to redesign outpatient care to be more efficient and community-focused, while ensuring digital inclusivity and better support for patients and carers.
4.	25 September 2025	Item 8 Co-production	The members discussed co-production, recognising recent increased involvement and collaboration and the range of models and definitions to develop a joint set of principles that partners agreed on. However, it was noted that improved coordination between partners was needed and next steps were discussed to embed the agreed principles into routine practice, clarify responsibilities across organisations and undertake further cross-partner planning on 'how' to take the work forward.
5.	25 September 2025	Item 9 LCP performance data report	The members received a report on performance in Lewisham, noting: • Some targets were being met whilst others remain challenging. • Of particular concern was the low completion rate of physical health checks for people with serious mental illness. The work is overseen by the All-Age Mental Health Alliance and supported by a dedicated working group focused on improving GP engagement and data sharing with SLAM.

			• There are ongoing efforts to improve immunisation uptake, including the development of a local vaccine chatbot, a refreshed immunisation strategy and targeted community engagement especially through faith leaders and warm spaces. • CHC assessments have shown improvement, others continue to require focused attention and collaborative action.
6.	25 September 2025	Item 10 Risk Register	The LCP members reviewed the borough risk register, noting the financial position remained stable but persistent pressures in prescribing and Continuing Health Care (CHC) remained, with concerns around ADHD assessments and low vaccination uptake, particularly for flu although plans to address these were under development.
7.	25 September 2025	Item 11 Annual Children and Young People Safeguarding Report	The statutory Safeguarding Children and Young People annual report for April 2024 to March 2025 was presented, noting that despite improvements, local challenges remain. The report highlighted that Lewisham is a pilot site for the Families First for Children programme, which aims to improve support through innovative and multi-agency approaches for children of Black heritage of all age groups. Three child safeguarding practice reviews were commissioned, with a fourth approved. These addressed serious issues such as suicide and abuse.
8.	25 September 2025	Item 12 Finance	The members received an update on the month 4 financial position, noting: • At borough level, a breakeven position with a savings target of 5% noted, for which full delivery was anticipated. • Updates on the overall ICB and ICS financial positions • a £2.5m underspend for local authority adult social care and health, with significant risks around the rising cost of care packages.
9.	27 November 2025	Item 3 PEL report	The PELs report included: • an update on the national agreement on redundancy funding and details of the preparatory steps and timetable for the ICB voluntary redundancy (VR) scheme. It was noted that work continues at London level to achieve the £19 per head running cost requirement, with South East London ICB exploring joint functions with South West London ICB to enhance savings and resilience.

			• A brief on the The National Strategic Commissioning Framework now published, which would underpin ICB development, as it implements the NHS 10-year plan. • an update that the first formal Integrated Neighbourhood Committee would be convening with the partnership comprising primary care, VCSE, Council, LGT, and SLAM with LGT hosting the integrator.
10.	27 November 2025	Item 4 Lewisham Neighbourhood II & Central 24/7 Community Mental Health Centre	The LCP received a presentation on the Lewisham Neighbourhood II & Central 24/7 Community Mental Health Centre. Discussion included the new membership model which was co-produced with service users, carers and community representatives and runs in pilot form until March 2027, key initiatives and the reduced A&E attendances early data indicated the project was achieving. Next steps focused on developing co-production principles and strengthening neighbourhood integration.
11.	27 November 2025	Item 5 Joint Forward Plan against NHS 10 Year Plan and Planning Guidance Update	The members discussed the Lewisham Joint Forward Plan and alignment of key priority areas to the NHS 10-year plan, noting areas requiring further development , and the planning framework now underway at London/provider level and Place.
12.	27 November 2025	Item 6 Damp and Mould Project	A presentation was received on the damp and mould project, which is aligned with the recently published health and well-being strategy that runs to 2030 and seeks to develop a damp and mould pathway to creating a shared understanding to prioritise repairs for those most at risk.
13.	27 November 2025	Item 7 Hypertension update	An update was received on progress with Lewisham's hypertension programme, agreed by the board in March last year, noting recruitment of hypertension champions and lead outreach work, and the "Stop it, Check it, Treat it" campaign roll out.
14.	27 November 2025	Item 8 Main Grants Funding	The LCP were updated on funding arrangements through: • The Better Care Fund, noting the shift in the Main Grants Programme towards a commissioning model

			• the new Neighbourhood Grants model which is linked to the integrated neighbourhood team, focusing on local needs and community engagement, alongside borough-wide grants for communities of interest such as Black-led organisations, arts, culture, and sports. A Cabinet report would follow in January 2026, after which implementation would begin with neighbourhood teams and partners.
15.	27 November 2025	Item 9 LCP performance data report – Oct 2025: Focus on Physical Health Checks for those with Severe Mental Illness (SMI)	Discussions focussed on national targets delivered locally with implications for health inequalities such as immunisations, hypertension control, GP access, CHC, physical health checks for SMI. Positive progress was noted in achievement of CHC targets, GP access, and child vaccination. Physical health checks for people with Serious Mental Illness still remained a major challenge but a plan to reintroduce SMI health checks into the PMS premium (locally commissioned services) next year was expected to strengthen contractual levers.
16.	27 November 2025	Item 10 Risk Register	The members discussed the local risk register, noting most areas of risk remained unchanged.
17.	27 November 2025	Item 12 Finance update	The members received an update on the latest financial position, noting: • At borough level, an ongoing YTD and full year forecast breakeven position, with key areas of overspend risk in CHC, mental health and prescribing. • Updates on the overall ICB and ICS financial positions • From a wider borough perspective, an adverse variance to budget at month 6 of £1.0m for Adult Social Care and £2.3m for Children and Young People.

Appendix 6

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 The board agreed at its November meeting to a change in governance arrangements in relation to the sub-groups reporting to the Partnership Southwark Strategic Board. It was agreed that revised terms of reference for sub-groups would be presented to the next board for agreement.

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 November 2025	2: Delayed Discharges Deep Dive	The item was tabled as the board had previously requested a deep dive into delayed discharges following a deterioration in key discharge KPIs for Southwark patients. A joint presentation was provided by key staff from King's, GSTT and social services who are closely involved in managing delayed discharges from hospital, exploring the underlying causes of recent delays, and potential quick win improvements. It was found the bulk of bed days lost related to discharges to care homes. Key challenges include limited local care home capacity, care home discharge assessment processes, family choice delays and increasing complexity of cases. Suggested improvements include improved discharge to assess systems, better communication

			with care homes, weekend discharges, and housing adaptations to support home care. Preventative work and closer system collaboration were emphasised. The board discussed plans to incorporate these issues into the Discharge Operational Delivery Group's improvement plan, with an update due at a future board meeting during summer 2026.
2.	27 November 2025	3: Healthwatch Annual Report	The board heard from Healthwatch Southwark representatives following the Healthwatch Annual report being published. Community Healthwatch ambassadors shared recent initiatives with the board and discussed two key reports which have been published: with one focussing on barriers faced by adults with learning difficulties or autism and the second focussing on mental health services.
3.	27 November 2025	5: Governance Update	The board reviewed and agreed to proceed with a revised governance structure, following feedback on the proposed diagram and supporting papers. The updated structure includes clearer relationships between committees, partner representation, and plans to consult on and agree terms of reference to ensure transparency. Draft terms of reference will be developed and shared at the January board meeting for formal approval.
4.	27 November 2025	6: Planning Update	The board received an update on the NHS 2026/27 planning process, including the Medium-Term Planning Framework and the newly published Strategic Commissioning Framework, with implementation starting in January. Guidance on neighbourhood health planning and centres is delayed, but the South East London ICB Five-Year Commissioning Strategy will allow Southwark to refresh priorities.
5.	27 November 2025	7: Place Executive Lead Report	Updates included key staff changes, ICB Reform, progress of primary care procurements as well as recent events including 'South London Listens' assembly and a celebration of Flexi-care services. Reports from the Board's main sub-groups were also presented.
6.	27 November 2025	8: Integrated Assurance Report	A summary report was provided of the report received by the Integrated Governance and Assurance Committee highlighting key changes since the previous report. A range of KPIs were examined highlighting areas of strength and areas of concern.

			Reports were also received on Safeguarding, Risk, Finance, CHC and medicines optimisation.

Appendix 7

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 October 2025 to 14 January 2026.

No.	Meeting date	Items for Board to note
1.	19 December 2025	The APC Committee in Common met on Friday 19th December to consider the wider context for the NHS as a whole and the SEL system, and to consider the APC's scope and priorities in the light of that. They agreed that, pending the outcome of the upcoming acute service review, the APC Joint NDs should prepare a short term (roughly 6 months) work plan, building on the successful network led clinical transformation projects (e.g. single points of access, streamlined pathways etc) but also critically reviewing the whole portfolio to ensure a focus on projects with the best benefit profile, including potential financial benefits. This will that include consideration of the existing governance structures and processes - again with a view to ensuring maximum benefit/impact. This work plan is currently in preparation and will be discussed with the APC Executive in February.

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 October 2025 to 14 January 2026, for Board information.

No.	Meeting	Meeting date	Agenda item	Items discussed
1.	Multiple Executive Advisory Groups	October to January	Operational planning including four year capital prioritisation	Reflection on Planning Guidance and consideration of work to be undertaken collaboratively and/or in an aligned way to minimise duplication/triplication of work in order to meet submission deadlines through December to February.
2.	Multiple Executive Advisory Groups	October to December	Guy's Surgical Centre FBC	A multidisciplinary session involving members of different EAGs was convened to consider the draft full business case for the Guys Centre. Colleagues remain supportive of the proposal in principle but also highlighted a number of issues to be to be addressed and resolved before formal support will be given. The case is due to be discussed again at the APC Executive following further work.
3.	Finance & Estates Group	October and January	Ortho/MSK – business case for continuation of pilot	The SEL single point of access (SPOA) for ortho/ MSK went live as a pilot in March 2025. Key impact measures include: • >one third of orthopaedic referrals diverted to more appropriate care • non-admitted PTL reduced by 14% • new model net cost saving estimated at ~£17 per referral (equivalent to about £100k pa – for comparison the Ortho network direct costs ~£80k per year) The Finance and Estates Group has agreed the pilot should continue to BAU, with trusts committing to identify how this will br funded within operating plans.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 Below is a summary of decisions taken by the Mental Health Collaborative, for the Boards awareness.

No.	Meeting date	Agenda item	Items for Board to note
1.	Nov 2025	Future collaboration	The committees in common agreed to focus on several areas for wider collaboration including developing service approaches to ensure alignment with the 10 Year Health Plan and support neighbourhood-based developments, improving productivity and psychosis pathways.

2. 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.	Nov 2025	NHS 111 option 2 mental health crisis line	The mental health provider collaborative committees in common received a comprehensive update including its current performance, data insights, and the planned integration of local crisis lines. The committees expressed support for the direction of travel for NHS 111 Phase 2, with the bringing together of a south London single front door and the future opportunities this will open to consider access and responsiveness improvements into crisis services.

NHS
South East London

NHS South East London Integrated Care Board

Remuneration Committee

Terms of Reference

Approved by ICB Board: January 2026

1. Introduction

1.1. The NHS South East London Integrated Care Board (ICB) Remuneration Committee [the "committee"] is established as a committee of the ICB. The committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2. These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3. All members of staff and members of the ICB are directed to co-operate with any requests made by the Remuneration Committee.

2. Authority

2.1. The Remuneration Committee is authorised by the ICB Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

2.2. For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

3. Purpose

3.1. The committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks, including Agenda for Change, for all employees including senior managers/directors (including board members).
- The pay of Non-executive directors, excluding the chair, will be confirmed by a separate panel, specifically for this purpose, and will not include non-executive directors.

3.2. Members of the remuneration committee shall not discuss their own remuneration and conditions of service.

3.3. Consideration and determination of the remuneration and conditions of service for members of the remuneration committee shall be delegated to the ICB's Chief Executive, in discussion with the ICB chair, who shall seek the ratification of the Board for decisions made in this respect.

4. Duties

4.1. The committee's duties are as follows:

4.2. For the Chief Executive, Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms

4.3. For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)
- Determine and approve the arrangements for termination payments (including voluntary and compulsory redundancies) and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate
- Determine and approve any additional allowances, outside of the adopted pay framework, for the ICB's staff. Where a responsibility allowance is requested for staff in Agenda for Change bands 2-7 and is less than £2,500 p.a. this can be approved by the Executive Committee.

4.4. For clinical and professional leads:

- Determine and approve the remuneration for clinical and professional leads across the ICB.

5. Membership and attendance

5.1. The committee members shall be appointed by the Board in accordance with the ICB constitution.

5.2. The Board will appoint four members of the committee including the ICB chair, one non-executive member of the Board and two partner members of the ICB board.

5.3. The chair of the Audit & Risk Committee may not be a member of the Remuneration Committee.

5.4. The chair of the Board may be a member of the committee but may not be appointed as the chair.

5.5. When non-executive pay remuneration is to be discussed / determined, a separate panel will be convened the members of which will be the five partner members of the ICB board.

5.6. When determining the membership of the committee, active consideration will be made to diversity and equality.

5.7. Only members of the committee have the right to attend committee meetings, but the chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee.

5.8. Meetings of the committee may also be attended by the following individuals who are not members for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's Associate Director of HR or their nominated deputy
- The ICB's Chief Financial Officer or their nominated deputy
- The Chief Executive or the Chief of Staff

5.9. The chair may also ask the person responsible for writing the remuneration committee paper to attend to facilitate discussion and respond to questions.

5.10. The chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.11. No individual should be present during any discussion relating to:

- Any aspect of their own pay
- Any aspect of the pay of others when it has an impact on them, e.g. a peer's pay.

6. Chair and Vice Chair

6.1. In accordance with the constitution, the committee will be chaired by a non-executive

member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the committee.

6.2. The vice chair of the committee will be one of the partner members. In the absence of the chair, the vice chair will chair the meeting.

6.3. The chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

6.4. When non-executive pay remuneration is to be discussed / determined, the partner members present on the panel shall elect one of their number to chair the meeting.

7. Meeting Quoracy and Decisions

7.1. The Remuneration Committee will meet a minimum of twice a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2. The committee will meet in private.

7.3. The committee will meet as required and arrangements and notice for calling meetings are set out in the Standing Orders.

7.4. The Board, chair or chief executive may ask the Remuneration Committee to convene meetings to discuss particular issues on which they want the committee's advice or decision.

7.5. In accordance with the Standing Orders, the committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.6. For a meeting to be quorate 75% of the members are required including the chair.

7.7. If any member of the committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

8. Decision making and voting

8.1. Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

8.2. Decisions will be taken in according with the Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the chair may call a vote.

8.3. Only members of the committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

8.4. Where there is a split vote, with no clear majority, the chair of the committee will hold the casting vote.

9. Procedure of decisions made outside of formal meetings

9.1. The committee chair will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the committee chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

9.2. The ICB's corporate and business support team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of this meeting.

10. Behaviours and Conduct

10.1. The committee will take proper account of national agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

10.2. Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

10.3. Members of, and those attending, the committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

10.4. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

11. Accountability and reporting

11.1. The committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

11.2. The minutes of the meetings shall be formally recorded by the secretary.

11.3. The Remuneration Committee will submit a report on activity as part of the Boards committee summary . Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

12. Secretariat and Administration

12.1. The committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the chair with the support of the relevant executive lead
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair.

13. Review

13.1. The committee will review its effectiveness at least annually.

13.2. These terms of reference will be reviewed at least annually and earlier if required.

13.3. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS South East London Integrated Care Board

Southwark Local Care Partnership Committee: Partnership Southwark Strategic Board

Terms of Reference

~~June 2024~~January 2026

1. Introduction

1.1. The NHS South East London Integrated Care Board (ICB) Local Care Partnership committee [the "board", locally known as Partnership Southwark Strategic Board] is established as a committee of the ICB and its executive powers are those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2. These terms of reference set out the role, responsibilities, membership and reporting arrangements of the board, under its terms of delegation from the ICB Board.

1.3. All members of staff and members of the ICB are directed to co-operate with any requests made by Partnership Southwark Strategic Board.

2. Purpose

2.1. 'Partnership Southwark' seeks to ensure that partners can design, plan, deliver and evaluate their work together to improve health and care services and outcomes for residents. The partner organisations represented through the core members of the Partnership Southwark Strategic Board may opt to bring their formal delegations to the decisions of the Board. Southwark Council will act through the delegated authority of Cabinet and Executive Leads.

2.2. The board is responsible for the effective discharge and delivery of the place-based functions[1]. The board is responsible for ensuring:

a. The place contribution to the ICB's agreed overall planning processes including the effective planning and delivery of place based services to meet the needs of the local population, with a specific focus on community based care and integration across primary care, community services and social care, and including mental health, managing the place delegated budget, taking action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local

[1] As defined by the South East London Integrated Care Board in the relevant delegation agreement

Care Partnership to ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider ICS.

b. The Local Care Partnership can secure the delivery of the ICS's strategic and operational plan as it pertains to place, and the core objectives established by the LCP for their population and delegated responsibilities.

c. The Local Care Partnership plays a full role in securing at place the four key national objectives of an ICS, aligned to ICB-wide objectives and commitments as appropriate:

   i. improve outcomes in population health and healthcare
   ii. tackle inequalities in outcomes, experience and access
   iii. enhance productivity and value for money
   iv. help the NHS support broader social and economic development

d. The representation and participation of the Local Care Partnership in the wider work of the ICS and Integrated Care Board, contributing to the wider objectives and work of the ICS as part of the overall ICS leadership community.

3. Duties

3.1. **Place-based leadership and development:** Responsibility for the overall leadership and development of the Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes, development and relationship building activities and meaningful local community and resident engagement. The LCP also needs to support the Place Executive Lead to ensure they are able to represent LCP views effectively whilst also considering the needs of the wider ICS.

3.2. **Planning:** Responsibility for ensuring an effective place contribution to ~~ICP/~~ICB wide strategic and operational planning processes. Ensuring that the Local Care Partnership develops and secures a place based strategic and operational plan to secure agreed outcomes and which is aligned with the Health and Wellbeing strategic plan and underpinned by the Joint Strategic Needs Assessment (JSNA) and a Section 75 agreement. The LCP must ensure the agreed plan is driven by the needs of the local population, uses evidence and feedback from communities and professionals, takes account of national, regional and system level planning requirements and outcomes, and is reflective of and can demonstrate the full engagement and endorsement of the full Local Care Partnership.

3.3. **Delivery**: Responsibility for ensuring the translation of agreed system and place objectives into tangible delivery and implementation plans for the Local Care Partnership. The LCP will ensure the plans are locally responsive, deliver value for money, support equity of access, outcomes and experience and support quality improvement. The LCP will develop a clear and agreed implementation path, with the

resource required whilst ensuring the financial consequences are within the budget of the LCP and made available to enable delivery.

3.4. **Monitoring and management of delivery:** Responsible for ensuring robust but proportionate mechanisms are in place to support the effective monitoring of delivery, performance and outcomes against plans, evaluation and learning and the identification and implementation of remedial action and risk management where this is required. This should include robust expenditure and action tracking, ensure reporting into the ICB as required, and ensure local or system discussions are held proactively and transparently to agree actions and secure improvement where necessary.

3.5. **Governance:** Responsible for ensuring good governance is demonstrably secured within and across the local Care Partnership's functions and activities as part of a systematic accountable organisation that adheres to the ICB's statutory responsibilities and adheres to high standards of public service, accountability and probity (aligned to ICB governance and other requirements). Responsibility for ensuring the LCP complies with all legal requirements, that risks are proactively identified, escalated and managed.

4. Accountabilities, authority and delegation

4.1. Partnership Southwark Strategic Board is accountable to the Integrated Care Board of the SEL Integrated Care System. The board will be the prime committee for discussion and agreement for its agreed specific local delegated funding and functions and will work as part of South East London ICS.

4.2. The LCP Committee will provide regular updates to the Health and Wellbeing Board via the Place Executive Lead and Co-Chairs ensuring the alignment of work

4.3. The partner organisations represented through the core members of the Partnership Southwark Strategic Board may opt to bring their formal delegations to the decisions of the Board. Southwark Council will act through the delegated authority of Cabinet and Executive Leads.

4.4. The Place Executive Lead has directly delegated powers from the ICB, including responsibility to take due account of statutory responsibilities in respect of safeguarding and equalities, diversity and inclusion, whilst working with other partners.

4.5. The Place Executive Lead will have responsibility for the management of delegated local NHS budgets and will be held accountable for ensuring budgets are delivered on plan.

4.6. Through the Place Executive Lead/Strategic Director of Integrated Health and Care (and respective ICB and Council governance processes), this board will have delegated responsibility for the commissioning of local services including:

- Primary care commissioning
- Community services commissioning
- Client group commissioning
- Medicines Optimisation related to community based care
- Continuing Healthcare

In addition, the council will present to the board the commissioning of services which are joint funded by the ICB and the council, where the council is the lead commissioner:

- Integrated Community Equipment Service
- Mental Health Supported Housing

5. Membership and attendance

5.1. Core voting members of the board will include representatives of the following:

a. 2 x Co-chairs (1 appointed, 1 Council-nominated Cabinet Member)

b. 1 x Local Care Partnership Place Executive Lead

c. 1 x Local Authority Director Adult Social Care

d. 1 x Local Authority Children's Social Care

e. 1 x Local Authority Director of Public Health

f. 2 x Primary Care Network Leads (North & South) – Clinical Directors

g. 1 x Community Services Provider (GSTT)

h. 1 x Mental Health Services Provider (SLaM)

i. 1 x Acute Services Provider (KCH)

j. 2 x Care Provider lead (with one vote between them)

k. 1 x VCS Lead

l. 3 x VCSE Sector Representatives (with two votes between them)

m. 1 x Healthwatch Lead

5.2. The following postholders will be invited to join the board in attendance, and will not be voting members:

a. 1 x Local Care Partnership Director of Partnership and Sustainability (ICB)

b. 1 x Director of Integrated Commissioning (Southwark Council/ICB)

c. 1 x Associate Director of Finance ICB

d. 1 x ~~Associate~~ Assistant Director of Finance Local Authority

e. 1 x Local Medical Committee Representative (rotating)

f. 1 x GP Federation Representative (rotating)

g. 1 x Lay Member

h. 1 x CCPL forum chair

6. Chair of meeting

6.1. The meeting will be chaired by two co-chairs (an appointed clinical chair and a Council-nominated Cabinet Member chair covering health and well-being).

6.2. At any meeting of the board the Co-Chairs shall preside.

6.3. If the presiding Co-Chairs are temporarily absent on the grounds of conflict of interest, then a person chosen by the board members shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of core members including as a minimum a co-chair and the Place Executive Lead or their nominated deputies.

~~7.1. The quorum of the board is that the following must be present:~~

- ~~1 x Local Care Partnership Place Executive Lead~~
- ~~1 x Local Authority Director Adult Social Care or Director Children's Social Care~~
- ~~1 x Local Authority Director of Public Health~~
- ~~1 x Primary Care Representative~~
- ~~1 x Community Services Provider~~
- ~~1 x Mental Health Services Provider~~
- ~~1 x Acute Services Provider~~
- ~~1 x VCS Lead or VCSE Sector Representative or Healthwatch Lead~~

7.2. In the event of quorum not being achieved, matters deemed by the Chair to be "urgent" can be considered outside of the meeting via email communication.

7.3. The board will operate with reference to NHS England guidance and national policy requirements and will abide by the ICB's standards of business conduct. Compliance will be overseen by the chair.

7.4. The board agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

7.5. Members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. The aim of the board will be to achieve consensus decision-making wherever possible. If a vote is required, the core members are the voting members of the Local Care Partnership. Each core voting member has one vote.

8.2. Core voting members are expected to have a designated deputy who will attend the formal Local Care Partnership with delegated authority as and when necessary.

9. Frequency

9.1. The board will meet a minimum of ~~six~~ four times per year (in public) with ability to have a private session as Part 2 in addition to this. The board will meet in private for informal development sessions between public meetings a minimum of 6 times per year.

9.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

9.3. Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the board Chair and meeting secretariat.

9.4. Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

10. Reporting

10.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

10.2. The board will report on its activities to ICB Board. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the board; and any actions agreed to be implemented.

10.3. The minutes of in public meetings shall be formally recorded and reported to the NHS ICB Board and made publicly available.

11. Board support

11.1. The LCP will provide business support to the board. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the

meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Review of Arrangements

12.1. The board shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the board considers this appropriate or necessary.

NHS South East London Integrated Care Board

Bromley Borough

One Bromley Local Care Partnership Board

Terms of Reference

VERSION 4.0

November 2025

Version History	Date	Comment	Status
1.0	July 2022	Draft approved by One Bromley Local Care Partnership Board and SEL ICB Board	Approved
2.0	September 2023	Updated terms of reference approved by the Local Care Partnership Board Meeting 28.9.23	For approval by the ICB Board 15.11.23
3.0	November 2024	Updated terms of reference approved by the Local Care Partnership Board Meeting 28.11.24	Approved
4.0	November 2025	Updated terms of reference approved by the One Bromley Local Care Partnership Board	

1. Introduction

1.1 The One Bromley Local Care Partnership Board [the "committee"] is established as a committee of the South East London Integrated Care Board and Bromley Council and its executive powers are those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2 These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board and Bromley Council.

1.3 All members of staff and members of the ICB are directed to co-operate with any requests made by the One Bromley Local Care Partnership committee.

2. One Bromley Five Year Strategy

2.1 The One Bromley Five Strategy was approved by the One Bromley Local Care Partnership Board in May 2023 and sets out our ambition to improve the wellness of the people of Bromley. We will achieve this by shifting the focus of our work to prevention, focusing on people living with long term conditions, frailty, Core 20Plus5 health inequalities and those at risk of emergency admission for physical or mental health. Our plan therefore takes a population health management approach to focus on prevention at scale, continuity of care and more holistic approach to people's needs.

2.2 The strategy sets out three key priorities on this:

- Improving population health and wellbeing through prevention and personalised care
- High quality care closer to home delivered through neighbourhoods
- Good access to urgent and unscheduled care and support to meet people's needs

2.3 The strategy sets out the One Bromley Culture and wider enablers:

- One culture to help us deliver joined up services
- Asset based community approach with engaged population.
- One Bromley organisations are tied to the wellbeing of the populations we serve.
- Maintaining and securing resources for the needs of children and adults in Bromley
- Workforce, estate, digital tools (including analysis and artificial intelligence) and finance in place to deliver our priorities.

2.4 Five priority programmes are set out to support the delivery of the three key priorities:

1. Evidence driven prevention and population health.
2. Neighbourhood teams on geographic footprints.
3. Implement care closer to home programmes

4. Primary care sustainability.
5. Integrated Urgent Care.

3. Purpose

3.1 The committee is responsible for the effective discharge and delivery of the place-based functions[1]. The committee is responsible for the following functions:

a. One Bromley Local Care Partnership Board is responsible for the effective planning and delivery of place based services to meet the needs of the local population in line with the ICB's agreed overall planning processes. There is a specific focus on community based care and integration across primary care, community services and social care. The Board, through the Place Executive Lead, is expected to manage the place delegated budget, to take action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local Care Partnership. The Board will ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider ICS.

b. The One Bromley Local Care Partnership will support and secure the delivery of the ICS's strategic and operational plan as it pertains to place, and the core objectives established by the One Bromley Local Care Partnership for their population and delegated responsibilities.

c. The One Bromley Local Care Partnership plays a full role in securing at place, the four key national objectives of ICSs, which are to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and to help the NHS support broader social and economic development, aligned to ICB wide objectives and commitments as appropriate.

d. The One Bromley Local Care Partnership will ensure representation and participation in the wider work of the ICS and Integrated Care Board, contributing to the wider objectives and work of the ICS as part of the overall ICS leadership community.

[1] As defined by the South East London Integrated Care Board

e. As far as it is possible, it is the intention that decisions relating to Bromley will be made locally by the One Bromley Local Care Partnership.

f. This committee will have responsibility for the planning, monitoring and delivery of local services, as part of the overall strategic and operational plans of the ICB Board:
   - Primary care services
   - Community services
   - Client group services
   - Medicines Optimisation related to community based care
   - Continuing Healthcare

g. The One Bromley Local Care Partnership Board will be the prime committee for discussion and agreement for its agreed specific local funding and functions and will work as part of South East London ICB.

h. The committee has a responsibility to manage the delivery of the annual delivery plan, the associated budget and performance for the areas in scope, ensuring that best value and optimal outcomes are delivered in these areas. The committee has a responsibility to ensure effective oversight of its delivery plan, associated budget and performance and for escalating to the SEL ICB if material risks to the delivery of plans are identified.

i. A purpose of the committee is to provide assurance to the ICB on the areas of scope and duties set out below.

4. Duties

4.1 **Place-based leadership and development**: responsibility for the overall leadership and development of One Bromley Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes, development and relationship building activities and meaningful local community and resident engagement. One Bromley Local Care Partnership also needs to support the Place Executive lead to ensure they are able to represent LCP views effectively whilst also considering the needs of the wider ICS. One Bromley Local Care Partnership will provide Bromley based leadership, challenge, oversight and guidance to the Primary Care Oversight Group for the delivery of primary care services in Bromley. One Bromley Local Care Partnership will have oversight on the Contracts and Procurement Sub-Committee which will provide assurance on contracts and procurement activities to One Bromley Local Care Partnership and will

identify and manage organisational and strategic risks related to these areas.

4.2 **Planning**: Responsibility for ensuring an effective place contribution to ICP/B wide strategic and operational planning processes. Ensuring that the One Bromley Local Care Partnership develops and secures a place based strategic and operational plan to secure agreed outcomes and which is aligned with the Health and Wellbeing strategic plan and underpinned by the Joint Strategic Needs Assessment (JSNA) and a Section 75 agreement. One Bromley Local Care Partnership must ensure the agreed plan is driven by the needs of the local population, uses evidence and feedback from communities and professionals, takes account of national, regional and system level planning requirements and outcomes, and is reflective of and can demonstrate the full engagement and endorsement of the full One Bromley Local Care Partnership. Produce and implement an annual delivery plan aligned to the ICB's strategic plans and objectives. Monitor and manage the delivery of this plan, in line with agreed outcomes and indicators of delivery

4.3 **Delivery**: Responsibility for ensuring the translation of agreed system and place objectives into tangible delivery and implementation plans for the One Bromley Local Care Partnership. One Bromley Local Care Partnership will ensure the plans are locally responsive, deliver value for money and support quality improvement. One Bromley Local Care Partnership will develop a clear and agreed implementation path, with the resource required whilst ensuring the financial consequences are within the budget of the LCP and made available to enable delivery.

4.4 **Monitoring and management of delivery**: Responsible for ensuring robust but proportionate mechanisms are in place to support the effective monitoring of delivery, performance and outcomes against plans, evaluation and learning and the identification and implementation of remedial action and risk management where this is required. This should include robust expenditure and action tracking, ensure reporting into the ICS or ICB as required, and ensure local or system discussions are held proactively and transparently to agree actions and secure improvement where necessary. One Bromley Local Care Partnership will ensure delegated budgets, including running costs are deployed effectively and within the agreed envelope

4.5 **Governance**: Responsible for ensuring good governance is demonstrably secured within and across One Bromley Local Care Partnership's functions and activities as part of a systematic accountable organisation that adheres to the ICB's statutory responsibilities and adheres to high standards of public service, accountability and probity (aligned to ICB

governance and other requirements). Responsibility for ensuring the One Bromley Local Care Partnership complies with all legal requirements, that risks are proactively identified, escalated and managed.

4.6 **Transformation**: To provide overall leadership, guidance and control to the local transformation programme led through the One Bromley Executive Sub-Committee, ensuring agreed outcomes are delivered.

5. Accountabilities, authority and delegation

5.1 One Bromley Local Care Partnership Committee is accountable to the Integrated Care Board of the SEL Integrated Care System.

6. Membership and attendance

6.1 Core voting members of the committee will include the following:

a. Joint Chairs/Chairmen - Leader of Bromley Council and Clinical Lead for One Bromley
b. Borough Lay member
c. Local Care Partnership Place Executive Lead
d. Bromley Council Portfolio Holder for Adult Care & Health
e. Director of Adult Social Care
f. Director of Children's Services
g. Director of Public Health
h. Two PCN Clinical Directors with one vote between them
i. Bromley Healthcare
j. Oxleas NHS Foundation Trust
k. King's College Hospital NHS Foundation Trust
l. VCSE sector, BTSE
m. St Christopher's Hospice
n. Bromley GP Alliance

6.2 Non-voting members in attendance, for Part 1, will include:

a. Local LMC Chair
b. Local Healthwatch representative

6.3 Officers in attendance

a. Assistant Director (LBB) and Director (ICB) of Integrated Planning and Commissioning
b. One Bromley Integrated Care Programme Director

c. One Bromley Borough Director of Organisational Development
d. SEL ICB Associate Director of Finance

The SEL ICB Accountable Officer, Chief Financial Officer and other South East London ICB executive directors may attend, as may Bromley Council's CEO, and other relevant senior officers from Bromley Council. Unless specifically invited to do so, only voting members or their alternates and relevant officers will normally attend part 2 of the meeting.

7. Chair of the meeting

The meeting will be chaired jointly by the One Bromley Local Care Partnership Senior Clinical Director and the Leader of Bromley Council.

If the presiding chair/chairman is temporarily absent, for example on the grounds of conflict of interest, a deputy chair/chairman shall be identified and preside.

8. Quorum and conflict of interest

8.1 The quorum of the committee is at least 50% of the following must be present:

a. Joint Chairs/Chairmen - Leader of Bromley Council and Clinical Lead for One Bromley
b. Borough Lay member
c. Local Care Partnership Place Executive Lead
d. Bromley Council Portfolio Holder for Adult Care & Health
e. Director of adult social care
f. Director of children's services
g. Director of public health
h. Two PCN Clinical Directors with one vote between them
i. Bromley Healthcare
j. Oxleas NHS Foundation Trust
k. King's College Hospital NHS Foundation Trust
l. VCSE sector, BTSE
m. St Christopher's Hospice
n. Bromley GP Alliance

8.2 In the event of quorum not being achieved, matters deemed by the chairs/chairmen to be 'urgent' can be considered outside of the meeting via email communication.

8.3 The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICS's standards of business conduct. Compliance will be overseen by the chairs/chairmen.

8.4 The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life, the Nolan Principles which are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

8.5 Members will be required to declare any interests they may have in accordance with the ICB Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

9. Decision-making

9.1 The aim of the committee will be to achieve consensus decision-making wherever possible. If a vote is required, the core members (the voting members of the committee) and the Chairs/Chairmen are the voting members of the One Bromley Local Care Partnership. Core members are expected to have a designated deputy who will attend the formal One Bromley Local Care Partnership meetings with delegated authority as and when necessary.

10. Frequency

10.1 The committee will meet once every two months (in public) with ability to have closed session as Part B in addition to this. When meeting in public, One Bromley Local Care Partnership will be open to public questions submitted in writing three days in advance of the meeting. Questions will generally be answered at the start of the meeting

10.2 All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

10.3 Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the committee Chair/Chairman and meeting secretariat.

10.4 Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

11. Reporting

11.1 Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

11.2 The committee will report on its activities to ICB Board. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the committee; and any actions agreed to be implemented.

11.3 The minutes of meetings shall be formally recorded and reported to the NHS ICB Board and made publicly available.

11.4 The meeting will be recorded to assist with production of the minutes. Once these are drafted, the recording will be deleted.

11.5 For the purpose of performance assurance for contracts delegated to the borough from the ICB Board; to report to the ICB's Integrated Governance and Performance Committee on risks, performance variance and the actions planned to deliver and sustain improvement.

12. Committee support

12.1 The embedded governance and admin team will provide business support to the committee. The meeting secretariat will ensure that:

- Papers for the meeting will be issued at least 5 working days before each meeting.
- Compilation of the annual work plan is produced
- Agreement of the agenda with the Chairmen and Place Executive Lead
- Collation of papers
- Collation of a glossary for each meeting

13. Review of Arrangements

13.1 The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.

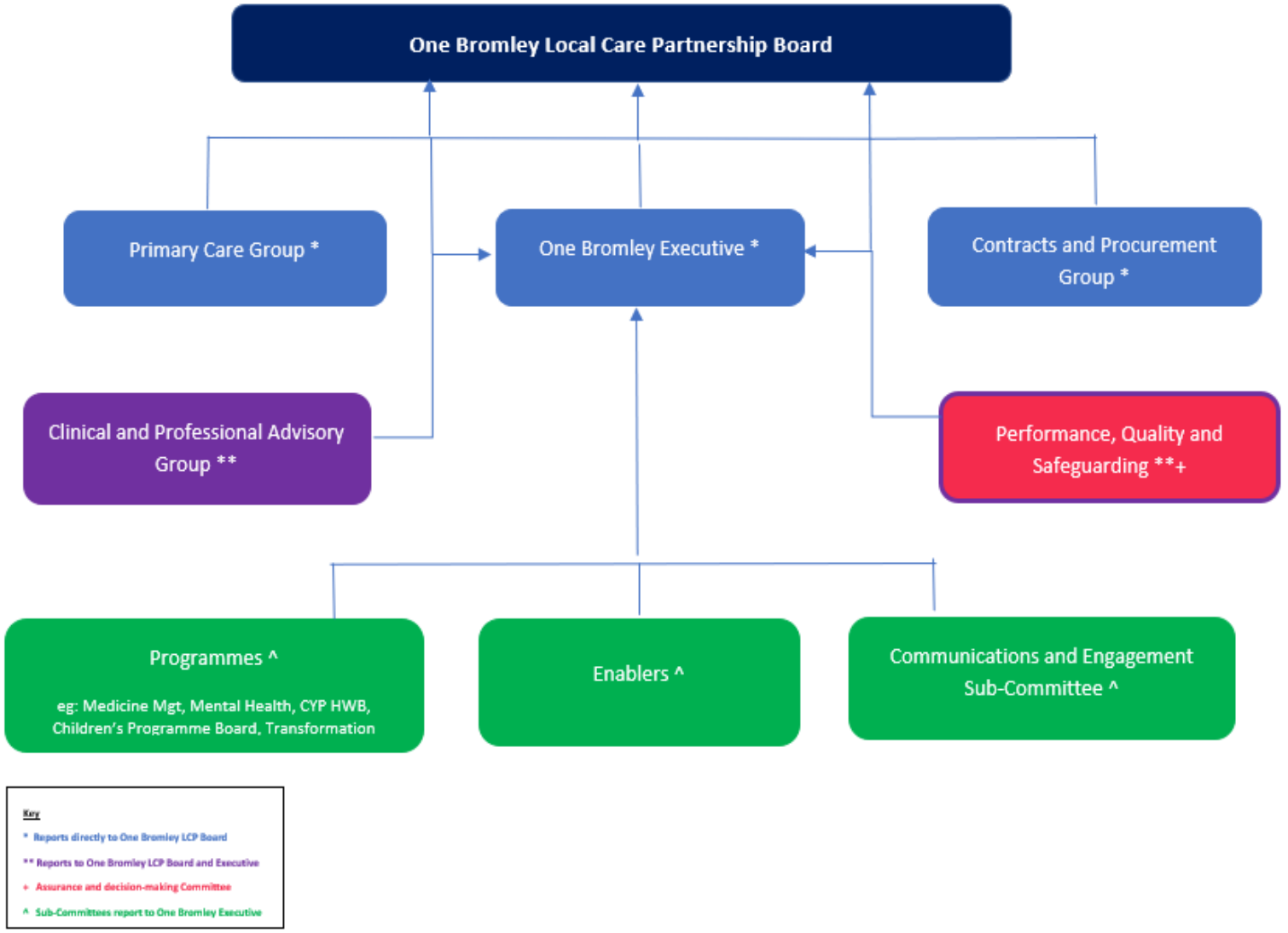
14. Glossary

CCG	Clinical Commissioning Group
SEL	South East London
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
LCP	Local Care Partnership, in Bromley, this is called One Bromley
KCH	Kings College Hospital
PRUH	Princess Royal University Hospital
BTSE	Bromley Third Sector Enterprise
VCSE	Voluntary Community Sector Enterprise
BGPA	Bromley General Practice Alliance
PCOG	Primary Care Oversight Group
CPAG	Clinical and Professional Advisory Group
LMC	Local Medical Committees

Appendix 1: Structure Chart

ONE BROMLEY

Structure for One Bromley Local Care Partnership (LCP) Board and Sub-Committees



Annual report on ICB Emergency planning, resilience and response (EPRR) Activity in 2025 (January – December)

Introduction

The Executive Committee is responsible for assuring the effective functioning of emergency planning and business continuity for the ICB. In addition, as part of the NHS England core standards for EPRR, which the ICB is assessed against each year, as a minimum the ICB should report to its Board on an annual basis the training and exercising it has undertaken, and details of any incidents.

The purpose of this report is to provide SEL ICB Board with oversight of the activities undertaken in the year and their outcomes, as a method of assurance to the Board that the ICB has met its obligations in this area. The outcome of the annual core standards assessment is highlighted within the overall committees report presented to the Board in January 2026 to ensure that compliance with the core standards is met.

Resourcing

As part of the core standards, the ICB is obliged to identify an accountable emergency officer. This should be a senior member of the organisation, usually at director level, who holds executive responsibility for the EPRR portfolio. For NHS South East London ICB, this responsibility is held by the Chief of Staff, Tosca Fairchild. Operational activities are delivered by the ICB EPRR team, comprising the Associate Director for Corporate Operations, Head of EPRR and Health & Safety and Emergency Planning Manager. It should be noted that the Emergency Planning Manager role has been vacant since May 2025.

The Diploma in Health Emergency Planning, Resilience and Response (DipHEPRR) is the recognised professional qualification for Health Emergency Planning. The Head of EPRR and Health & Safety holds this qualification and the Associate Director for Corporate Operations is currently undertaking the DipHEPRR course (funded by NHS England), due for completion in the first quarter of 2026.

Policy and Plans

The ICB has separate EPRR policy and plan documents in place. Both documents have been reviewed, updated and approved in December 2025. After embedding the ICB's Business Continuity Management System (BCMS) throughout 2024, there was a review conducted in November 2024 and a decision made to move this document to a three-year review schedule, with caveats for review if there is a significant staffing or organisational change or a significant Business Continuity incident takes place. The EPRR team have worked with Directorates and Place to ensure that their individual Business Continuity Plans and Checklists have been updated to reflect changes to directorates and Place. It should be noted that the ICB's Adverse Weather plan has been reviewed twice in 2025 in line with the seasonal updates from UKHSA and the Met Office. The ICB's Mass Casualties Plan was reviewed and updated in line with the new LHRP Mass Casualties Framework. All EPRR plans and the policy were presented and approved by the Executive Committee. All policies are available to all staff via the ICB's SEL SharePoint Intranet file depository.

The EPRR team recognises that development and refresh of the ICB's plans is a dynamic process in response to emerging issues and ensures there is a continual review process to ensure plans remain relevant and suitable for use.

Throughout 2025 the ICB EPRR team have been involved in the writing of LHRP Framework documents for Pandemic Response and Events, Mass Casualties Response and Risk Management; these documents will enhance organisational response in London.

Exercises

In order to meet the core standard for training and exercising, the ICB is required to undertake:

- A six-monthly communications test
- An annual tabletop exercise
- A live exercise at least once every three years (the Pandemic response was seen as fulfilling this requirement recently)
- A command post exercise every three years (the Pandemic response was seen as fulfilling this requirement recently)

Under the leadership of the Accountable Emergency Officer (AEO), the ICB EPRR requirements have been met in 2025, with involvement in the following training and exercises:

Date	Activity	Tactical Lead	AEO/Strategic Lead
Exercises			
14/01/2025	Exercise Lignum Vitae – Multi Agency Live Exercise	Francesca Davies	Tosca Fairchild
20/01/2025	Provider Comms Exercise	Amanda Wixon	Tosca Fairchild
20/02/2025	Exercise Hermes – NHSE Comms Exercise	Amanda Wixon	Tosca Fairchild
26/02/2025	Exercise Lignum Vitae – TCG + SCG capabilities	Amanda Wixon	Tosca Fairchild
04/04/2025	Exercise Solaris – LRF Pandemic Flu – Workbook	Francesca Davies	Tosca Fairchild
16/04/2025	Provider Comms Team Tabletop Exercise In person	Amanda Wixon	Tosca Fairchild
28/04/2025	ICB Comms Team Virtual Tabletop Exercise	Amanda Wixon	Tosca Fairchild
24/04/2025	Provider Comms Exercise	Amanda Wixon	Tosca Fairchild
01/05/2025	Exercise Fracti – Multi Agency Tabletop ICB Led	Amanda Wixon	Tosca Fairchild
12/05/2025	Exercise Toucan – NHSE National Comms Exercise	Amanda Wixon	Tosca Fairchild
13/06/2025	CT Martyn's Law – In person Table top	Amanda Wixon + Simon Beard	Tosca Fairchild
12/06/2025	ICB Comms Exercise	Amanda Wixon	Tosca Fairchild
17/07/2025	Exercise Centum – Mass Casualties – NHSE Led	Amanda Wixon, Simon Beard	Micheal Boyce
24/09/2025	Provider Comms Exercise	Amanda Wixon	Tosca Fairchild
30/09/2025	Exercise Melville 2 – Kent and Medway Exercise	Amanda Wixon	Tosca Fairchild
22/10/2025	Exercise Hermes 2 – NHSE Comms Exercise	Amanda Wixon	Tosca Fairchild
30/10/2025	Lewisham Exercise Lemur – Multi Agency in person	Amanda Wixon + Simon Beard	Tosca Fairchild
05/11/2025	Exercise Pegasus – National Exercise	Amanda Wixon	Tosca Fairchild
09/12/2025	Royal Borough of Greenwich – Flood Exercise – Multi-Agency in person	Amanda Wixon	Tosca Fairchild
Organisation training			
13/01/2025	CBRNe Training for Non-Acute Train the trainer	Amanda Wixon + Simon Beard	Tosca Fairchild
17/02/2025	ICS Workshop – Mass Counter Measures	Francesca Davies	Tosca Fairchild
11-13/03/25	Emergo senior Instructor Course	Francesca Davies	Tosca Fairchild
29/04/2025	TCG training/exercise – Met Police	Amanda Wixon	Tosca Fairchild
22/05/2025	Loggist training with NHSE London	Amanda Wixon	Tosca Fairchild
26/06/2025	ICS Workshop – Business Continuity	Amanda Wixon	Tosca Fairchild
08/10/2025	ICS Workshop – CBRNe Non Acute Settings	Amanda Wixon	Tosca Fairchild

01/09/2025	Cyber workbook planning	Amanda Wixon + Michael Knight	Tosca Fairchild
10/10/2025	EPRR in Primary Care – SEL Net planning	Amanda Wixon	Tosca Fairchild
24/10/2025	AEO Quarterly Session – Session 1	Tosca Fairchild	Tosca Fairchild
10/11/2025	Martyn's Law – National Webinar	Amanda Wixon + Simon Beard	Tosca Fairchild

During this period there has been 'Principles of Health Command Training' for all new Directors on Call (DoCs), which has been facilitated by the London Region EPRR Team. The SEL ICB team co-ordinated attendance from across the ICS. The SEL ICS has a good number of their DoCs trained and the training has been well received.

The ICB has not added any new Directors on Call or Senior Managers on Call (SMOC) to the rota during 2025. Updates to processes and procedures have been cascaded via email with the offer of one-to-one update training; this was accepted by 3 DOCs. 2026 will see a run of CPD sessions for both DOCs and SMOC which will include some short and sharp table-top and command post exercises/workshops featuring Cyber and Martyn's Law awareness.

Our Acute settings have benefitted from CBRNe Train the Trainer courses facilitated by NHSE London Region and this has seen all three acute providers increase the number of trainers they have, with all three providing CBRNe packages at their respective sites.

In addition to internal training, the EPRR team are involved in the scoping and delivery of the TNA for EPRR in London, and have active participation in the South East London, Kent and Medway Trauma Network EPRR group.

Communications exercises have continued throughout the year, with responsibility for provider communications exercises now falling to the ICB. These exercises have been well received by the providers and the ICB is assured that the system would be able to more than adequately respond in an emergency.

Incidents
The SEL ICB operates a director on call system to ensure there is senior management availability 24/7 from commissioners to support the local health system. This rota is currently managed in consultation with the SEL OC Team. There are 20 ICB directors actively participating in the DOC rota and there are 5 managers on the SMOC rota.

During 2025 there have been the following incidents requiring ICB involvement or oversight:

Date	Site/Place Involved	Incident
16-23/01/2025	LGT	Unable to restore power after works undertaken - switch to generator
19/01/2025	Oxleas	Fire at QMH due to MH pt. 5 LFB vehicles attended, 22 evacuated 3 treated by LAS.
14/02/2025	SLaM	Person on roof at Maudsley Hospital
05/03/2025	KCH	Critical failure of the King's ICT network at 1400 - 1800
08-10/04/2025	KCH	Flooding in virology, serology and microbiology labs @ DH
17/04/2025	GSTT	Bomb threat made to Evelina via GSTT PALS team email
19/06/2025	GSTT	Yellow liquid in NICU ventilators - Oil non-suspicious
28/06/2025	KCH	Service road to PRUH Emergency Department (ED)t closed from A21 for 6 hours
25-30/07/2025	ALL	Resident Doctors Industrial Action
25/07/2025	KCH	Loss of internet across the KCH estate
01/08/2025 – 22/09/2025	KCH + BHC	NRS equipment supply issues affected community services and discharge

14/08/2025	GSTT	Non-suspicious chemical explosion in the basement at Guy's
01/10/2025	GSTT	Gaza invacuation
22-23/10/2025	KCH	Water supply switch off at the PRUH for planned maintenance overnight
11/11/2025	KCH	Service road to PRUH ED closed from A21 for 6 hours
14-19/11/2025	ALL	Resident Doctors Industrial Action
18-22/11/2025	SLaM	Boiler issues at Lambeth site (Ladywell Unit) causing issues with hot water
01-12/12/2025	GSTT	Water chlorination issue at Pembury Water Plant affecting water supplies at GSTT remote dialysis units in Pembury area.
16/12/2025	LGT, GSTT,KCH	Carbon dioxide incident - SE7 (Charlton). 11 conveyed across QEH, LGT, PRUH, 19 seen and discharged by LAS HART on scene. No incidents declared by receiving sites. All 5 SEL sites stood up by LAS.
17-22/12/2025	ALL	Resident Doctors Industrial Action

The Chief of Staff and Accountable Emergency Officer is the lead executive for industrial action taking the lead strategic lead role as part of SEL's Gold team that includes the CMO, CNO and Executive Director of Planning. For each of the periods of industrial action (IA), affecting SEL, the ICB has stood up an Incident Management Team and has chaired the system response to the issue, co-ordinating system mutual aid and situational awareness, and liaising with Region as appropriate. After action reviews have been conducted, at the conclusion of each incident, to ensure learning is identified and actioned to ensure the ICB's preparations for future incidents are as robust as possible.

For the periods of action that have impacted individual trusts, the EPRR team have ensured that there is appropriate support and liaison in place with the trusts, ICB and NHSE London Region. Assessments of the impact on the ICS were undertaken to ensure that the appropriate management structure could be put into place.

Most of the list of incidents above have not required a full Incident Management team to be mobilised, they have involved differing levels of involvement from the EPRR team to ensure that information was shared. SMOCs and DOCs were briefed to ensure that the ICB upheld the requirements of the Civil Contingencies Act 2004. In times of localised incidents, the EPRR Team and SEL OC work collaboratively to ensure that the ICB Incident Response Plan is enacted as required.

Learning Cascade

Following any exercises or live incidents, the ICB EPRR team ensure a review is carried out to identify any lessons that can be learned to improve processes and future response plans. These outcomes are shared across the system and London Region through a range of engagement forums including:

- Representation at the Lessons Identified, Lessons Learned (LILL) sub-group of the London Health Resilience Forum (LHRP). The ICB's AEO if the sponsor and the ICB's Head of EPRR is a co-chair of this regional group
- Reporting of any incidents and exercises and key outputs in the SEL sector report for the quarterly LHRP meeting
- Membership of the regional training and exercising LHRP sub-group
- Maintenance of a system-wide lessons learned database, which is shared across system EPRR teams to inform future exercise planning and development of response plans
- Informal discussions at the weekly EPRR practitioners forum, comprising EPRR professionals from the ICB, the five NHS Trusts in SEL, and Bromley Healthcare

Multi-agency discussions and feedback in the six Borough Resilience Forums which are organised and led by the local authorities

Engagement
The ICB has participated in emergency planning activities at borough, system and regional level through:

- Participation in local authority and blue light services exercises
- Attendance at all Borough Resilience Forum meetings throughout the year (four meetings per year for each borough)
- Attendance at London Health Resilience Partnership to represent the sector
- Attendance at NHS England (London) Region ICB Meetings
- Membership of NHS England (London) Region EPRR business continuity forum, training and exercising consortium, EDI network, Risk advisory Group and Lessons Learnt forum (LILL)
- Co-chair for the Greener, LILL and Risk groups above
- The SEL AEO is the executive sponsor for the Lessons Learnt Forum across London
- Participating in NHS England webinars for Industrial Action, Paediatric Pressure, Cyber Security and Weather
- Facilitating at the London Health Resilience Partnership – Risk Resilience Workshop
- Chairing of a SEL ICS EPRR Practitioners Forum
- Leading four SEL ICS EPRR Practitioners Workshops – looking at key areas of the Core Standards
- Engagement with Kent and Medway ICB for sharing of intelligence
- Quarterly assurance visits to all providers
- Supporting the AEO to chair the new SEL LHRP
- Undertaking the Annual Assurance process for Core Standards for the ICS
- Presenting at the South East Region EPRR Annual Conference around Lessons from Vermillion Dune and the indirect consequences of Cyber incidents.

Within SEL, the system LHRP has met quarterly with excellent representation from across the system. This meeting is chaired by the ICB AEO with the Director of Public Health for Southwark as co-chair. The key responsibilities of the SEL ICS LHRP are to:

- Maintain oversight of the key health EPRR risks across SEL ICS via an ICS wide health EPRR risk register
- Oversee and review risk based SEL ICS sector-wide health plans to respond to priority risks and emergencies
- Provide strategic overview of the NHS EPRR annual assurance process as directed by the National EPRR Core Standards
- Ensure that the outcomes from the NHS EPRR annual assurance process, in conjunction with other relevant strategic documents, are used to set strategic direction for health resilience across SEL ICS
- Provide the health focus for issues raised by the SEL ICS BRFs
- Provide support to the NHS, UKHSA and DPH representatives on the BRFs in their role to represent health sector EPRR matters
- It should be noted that each constituent organisation remains responsible and accountable for the effective response to emergencies in line with their statutory duties and obligations. As with BRFs, the SEL ICS LHRP has no collective role in the delivery of emergency response
- Provide a conduit for the health organisations in SEL ICS to the London LHRP

Risk
The corporate team maintains the SEL EPRR risks which are generally scored low/medium. There are currently four EPRR risks recorded, of these risks one relates to High Consequence Infectious Diseases (HCID) and Pandemics, one to Adverse Weather and two to planning.

Risk No	Description	Inherent risk score	Residual risk score
33	There is a risk that acute and community providers within SE London will be unable to accelerate or step up their processes to provide an appropriate response to the service demands created by an unplanned incident. Which could result in disruption of services provided to those needing medical care,	3 x 3 = 9	2 x 3 = 6
34	There is a risk that NHS SEL would be unable to maintain its business-as-usual activities in the event of an incident which could affect NHS SEL business continuity and/or system wide provisions. This could be caused by insufficient incident planning, prolonged incidents where there appears to be no end in sight or staff redeployment in the event of an incident leaving gaps within the ICS / wider system. This could lead to disruption of health provisions for the population of South East London, staff being unclear on their work priorities or potential reputational damage for the ICS.	4 x 3 = 12	2 x 3 = 6
403	There is a risk that the services provided by the ICB could be impacted by the effects of extreme adverse weather. It could lead to reduced staffing and overall ICB productivity which would ultimately halt working processes across South East London this could be through loss of utilities, transport difficulties, potential disruption to the supply chain, damage caused to the infrastructure of an ICB working environment, loss of or interruption to IT infrastructure, staff absence due to illness or injury. With the introduction of hybrid working the ICB needs to consider the wider impact to staff who could be disproportionately affected due to their hybrid location.	4 x 3 = 12	4 x 2 = 8
404	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more waves. This could cause disruption to the operation of the ICB with staff illnesses/absence and reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	4 x 4 = 16	4 x 3 = 12

As risk 404 has an inherent risk rating that was RED several mitigations have been put in place to reduce the risk. These include the ability for staff to work in a hybrid manner, seasonal flu vaccine provision to staff, supporting staff through the Occupational Health and Employee Assistance Programme, horizon scanning via a number of forums including Borough Resilience Forums and Local Health Resilience Partnership and the review of the ICB HCID and pandemic plan. It is hoped that this risk will be further reduced when the UKHSA produce the Memorandum of Understanding for ICBs in London; the SEL EPRR team are part of the working group for this process and this will provide additional mitigations for this risk once implemented. It should be noted that the SEL ICB has had utilised the HCID and Emerging Pandemic Plan to horizon scan for and the management of an MPOX case in London.

Assurance
Due to ongoing changes in the NHSE London Region and to ensure that London is more representative of the systems across the UK, all ICBs in London were given the responsibility to undertake the 'Annual Core Standards Assurance process'. This involves checking the rating of the 65 Core Standards. There was no deep dive focus this year.

This has seen the EPRR team review provider core standard submissions, undertake a comparison from 2024, review of relevant documents, chair a face-to-face meeting with each provider EPRR team and AEO to confirm the ICB's assurance of the rating provided by the organisation. This year there was once again a self-assurance approach with the ICB EPRR team undertaking a review that confirmed they were assured that organisations could meet their requirements.

The EPRR team undertook face to face meetings with the providers, giving structured and constructive feedback, highlighting areas of good practice and areas where enhancements could be made. Once meetings were completed the EPRR team provided comprehensive reports to the providers and a letter of confirmation of their assurance rating within 2 weeks of the meeting. A summary report was then provided to NHSE London Region.

The ICB EPRR arrangements were also subject to the assurance review, carried out by the NHSE London EPRR team on 20 November. The ICB received its formal assurance report from NHSE London region on 5 December 2025, confirming that the ICB is **Substantially Compliant** with praise given to the EPRR team for the continued strength of 'System Working' across South East London.

This assurance review has shown a reduction in the assurance level from '**Fully Compliant**' to '**Substantially Complaint**'. This is driven by the impact of available resource during the ICB reshaping process and changes to the DSPT assessment. The EPRR team is able to confirm that it has received notification from NHSE National that the ICB's DPST assessment is now at the required standard, with the action plan that was set for the Digital and IT team being fully completed.

At this time, due to organisational change the EPRR team continues to have a vacancy in the team which is impacting the team resilience and work rate.

Praise

- SEL ICB has continued to lead by example and maintain excellent relationships with providers, despite resource issues and organisational instability
- There were four ICB holistic workshops completed throughout the year, enabling collaborative working, fruitful conversations and shared learning across the system
- SEL ICB continues to support System and Regional EPRR conferences and webinars and have presented topics such as: lessons, good practice and adverse weather EPRR assurance confirmation 2025/26
- A CBRN working group is in progress to focus on non-acute settings with a plan to work with the group and look at a training package in 2026
- Engagement with Kent and Medway ICB – Including participation in Exercise Melville II, Exercise Fracti, and regular ICB to ICB team engagement sessions

The EPRR team has received positive feedback from our provider organisations about how we have undertaken the process and thanking the team for the structured and constructive feedback.

Future Planning

The SEL ICB team will continue to focus on embedding both the Incident Response Plan and Business Continuity Management System across the ICB. This will include devising and implementing EPRR bespoke training and exercising for the Directors and Senior Managers on Call and working with both directorate and Place teams to ensure that they have a firm understanding of their tailored business continuity plans, ensuring they are current and fit for purpose.

System learning and collaboration is an important element of the ICB's EPRR response as the organisation works as part of a system to respond to incidents. Work will continue to explore opportunities for joint learning and development with system partners and the wider London community of ICBs, working with NHS England and continuing to grow the engagement of the system through the SEL LHRP, SEL EPRR Practitioners forums and holistic workshops to enable fluid system working. Next year will see a focus on Martyn's Law as it nears implementation in 2027 and Cyber resilience which is an area of intrigue for all providers.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Performance Report**					
Meeting date	28 January 2026	Agenda item Number	7	Paper Enclosure Ref	G	
Author	ICB Risk and Assurance and ICB Performance teams					
Executive lead	Sarah Cottingham, 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 and assurance of 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 recovery improvement actions that are in progress.					
Summary of main points	The report shows encouraging progress in a number of areas. SEL combined trust performance against the 4-hour A&E performance target has broadly been in line with improvement trajectories during 2025/26, and is in line with the month 8 planning trajectory. The new target for the percentage of 12-hour delays (from arrival) has now been met for three consecutive months having not been achieved previously in 2025/26. System level performance against the cancer faster diagnosis standard has broadly remained in line with the agreed trajectory, and though marginally below the plan for October, is expected to achieve the 80% target by year end. The SEL system also performs well on use of a faecal immunochemical test (FIT) to support referral for lower gastrointestinal (LGI) suspected cancer. 62 day cancer performance targets remain challenged across SEL, with improvement work underway but noting the complexity of these care pathways many of which are shared across providers with associated operational performance challenges. GP appointment volumes remain above plan, with good uptake of Pharmacy First clinical conditions and hypertension services in community pharmacy. The health check targets for people with a learning disability and autistic people is also above planned trajectories to meet the year end targets.					

	At the same time, significant pressures remain. These include in urgent and emergency care flow, mental health crisis presentations and demand for admissions, waits for community paediatrics and diagnostics and an above planned number of LDA inpatients. Some challenges also persist in securing mental health access targets. The number of 65-week-waits for elective treatment rose during the first half of 2025/26 following a period of downward movement at the end of 24/25 but has fallen during Q3 25/26. Referral to Treatment Times is a key area of challenge with a significant focus on care pathway transformation to support sustainable delivery of waiting times targets and the optimal management of demand. The paper outlines the recovery actions underway across these areas.					
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, 7 January 2026					
Recommendation	The Board is asked to note the update and provide any comments around system assurance and delivery oversight.					

South East London Integrated Care System

NHS South East London

SEL System Performance Summary January 2026

SEL ICB Board - 28 January 2026

South East London Integrated Care System

Contents

Summary of YTD position – January 2026 (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 for the 4-hour performance standard, and there has been some gains in handover delays.
	  o SEL trusts combined view of 4-hour performance in November was 75.1% (based on SitRep data), which met the month 8 trajectory.
	  o SEL 'footprint' performance, which includes activity from stand alone Urgent Treatment Centres, was 76.2%.
	• The new target for the percentage of 12-hour delays (from arrival) was also met in November. SEL has now met this target for the previous three months.
	• Demand, capacity and flow challenges continue across physical and mental health, with ongoing improvement work across the care pathway from front door management to discharge. This includes embedding Emergency Department alternatives, admission avoidance and supported discharge, including reducing the number of delayed days post-discharge ready date (DRD) and the number of patients with a length of stay of over 7 days to support pathway flow.
	• Winter plans across trusts and the ICB are active to support winter pressures management.

Cancer	• System level performance against the faster diagnosis standard has broadly remained in line with the agreed trajectory, and though marginally below the plan for October, is expected to achieve the 80% target by year end. • The SEL system continues to perform well on use of a faecal immunochemical test (FIT) to support referral for lower gastrointestinal (LGI) suspected cancer. The proportion of referrals accompaniment by a FIT result has increased each month during 25/26 and remains above the planned trajectory. • 62-day performance, however, has remained a challenge for SEL. The system focus continues to be improving pathway efficiency, inter-trust transfers and treatment capacity. Focused support is being provided to address service and provider level specialty challenges, with a focus on urology, lung and breast services.
Referral to Treatment Times (RTT)	• While there was significant focus on RTT performance, including an emphasis and focus on the implementation of transformation initiatives, 65-week-waits rose during the first half of 2025/26 following a period of downward movement at the end of 2024/25. There is an enhanced focus in SEL on the system and process changes needed to optimise the management of long waiters and the number of 65-week-waits has fallen during quarter three of 2025/26 but with more work over Quarter 4 to clear our over 65-week waiter backlog. • General Surgery, Bariatrics, Urology, Vascular and ENT are the most challenged specialties for long waiters and remain priority areas for recovery. Progress in outpatient transformation and demand management is supporting system performance with an on going focus on improvement through pathway transformation.
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, echocardiography and audiology. Recovery plans are in train with additional capacity through insourcing and outsourcing, and the implementation of clinical decision support tools to assist with demand management. SEL-wide demand and capacity reviews for imagining are underway to support longer term sustainability.

Summary of YTD position – January 2026 (2 of 3):

Area	YTD summary and key issues
Mental health including crisis and flow	• Mental health services continue to experience year-to-date pressure, particularly across crisis pathways. Crisis services have seen high levels of Emergency Department (ED) presentations and inpatient admission demand. The number of out of area placements was stable and in line with plan during the first quarter of 2025/26 but has increased since July 2025. In October, there were 65 out of area placements against a plan of 33. • All providers are delivering internal flow improvement plans, and system-wide work is underway to reduce ED delays and support timely discharge, focusing on reducing length of stay, purposeful admission, stepping down patients and providing alternatives to admissions where appropriate. • Urgent Children and Young People (CYP) eating disorder targets have been met. • The number of people with serious mental illness receiving physical health checks is below plan for quarter 2 but shows an improved position compared to the same period in 2024/25. • SEL Talking Therapy performance for the number of people completing a course of treatment has improved during 2025/26 and has exceeded trajectory during the most recent two months. The targets for reliable improvement and reliable recovery have broadly been in line with the national targets, noting some monthly variation above and below plan. • Performance has remained below the planned trajectories for the number of people accessing perinatal and children and young people service. Perinatal Access and CYP Access. Actions are in place to support improvement in these areas.
Primary care access	• Appointment levels have exceeded plan year-to-date, noting some variation in performance above and below monthly planned trajectories. Appointments totalled 938,712 in October 2025, which is above the operating plan target of 805,992. • Borough-level improvement plans are in place, and 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. • Boroughs are working with practices identified in the Commissioning and Transformation Support (CATS) GP dashboard to understand reasons for adverse variances and to offer them additional support as required. • Support is being provided to practices to help ensure they are delivering a total triage model for access. • As of beginning December 2025, SEL ICB is compliant with online consultation contractual requirements and has put robust arrangements in place to ensure this is monitored rigorously. This is borne out by the Wave 17 Health Insight Survey (HIS), which shows that SEL ranks second in London for ease of contacting practices online and is above both the London and England averages for this measure.
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 92% of SEL community pharmacies providing all three services as of October 2025. Since the start of the *Pharmacy First* service across community pharmacy in SEL in February 2024, there have been approximately 124k consultations for the seven clinical conditions, approximately 237k for hypertension consultations (blood pressure and ambulatory monitoring), and 28k oral contraception consultations (both initiation and ongoing supply) – up to October 2025. • Ongoing work is focused on improving referral pathways, data quality and promoting services in community pharmacy.

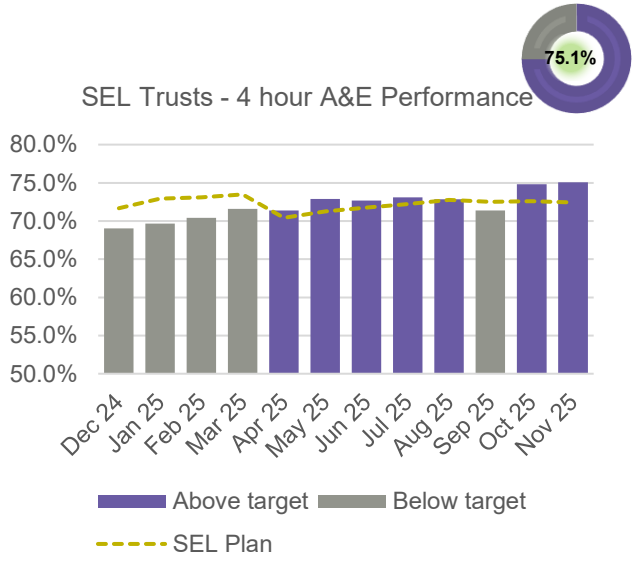
Summary of YTD position – January 2026 (3 of 3):

Area	YTD summary and key issues
Community waits and urgent community response (UCT)	• The number of people waiting over 52 weeks has remained above trajectory during 2025/26 and continues to be a significant challenge particularly in community paediatrics. There was a significant increase in September 2025 due to a change in the way that one provider is reporting ADHD and ASD. This may also have inflated the number reported as waiting over 52 weeks and an action plan is in place to cleanse this data at Trust level. This is not expected be concluded before the end of 2025/26. • SEL is not meeting the national UCR rate of referrals per 100,000 population target of 180. This has been a relatively consistent position during 2025/26. All providers are developing plans to increase referrals in 26/27. Data validation work continues with SEL UCR services to ensure that all UCR services are submitting fully to the CHS Sitrep and that published data aligns with the internal data held in Trusts.
Virtual ward	• Virtual ward capacity has exceeded plan year to date, though utilisation has varied due to data and operational challenges. Reported utilisation rates have been negatively impacted by non-submission of data for one provider. This omission is due to the transition to a new provider and the pause in reporting has been agreed during this period, with the expectation that it will commence in Q4 25/26. • Work continues on improving the effectiveness of Virtual Ward services with a particular focus on developing standardisation and consistency in the management of patient acuity through development of a shared 'acuity tool'.
Continuing healthcare (CHC)	• CHC performance improved across 2024/25 and into 2025/26, with national standards being met most months for the proportion of CHC assessments completed within 28 days and the number of incomplete referrals over 12 weeks. There is variation in the number of overdue standard CHC and fast track reviews across the six boroughs. The number overdue reviews however remains relatively static, but an on going pressure in some areas. • November 2025 performance (local reporting) against the number of referrals completed within the 28-day timeframe was 83% which remains above the national target of 80%. The number of incomplete referrals over 12 weeks remained at zero which is in line with the national standard.
Learning disability and autism	• SEL is not currently achieving the planned trajectory to reduce for the number of inpatients during 2025/26. This is due to an increase of late notifications during quarter 2 and new diagnoses while in mental health hospital. This has continued during Q3. Forecasted discharges are however expected to return inpatient numbers to within planned trajectories. • Increasing demand for all age autism assessments remains a system-wide challenge. Work is progressing on CYP Neurodiversity Hub and diagnostic pathway redesign, community development and Right to Choose accreditation for providers to support further improvement in 2025/26. • All boroughs in south east London are achieving the annual health check (AHC) trajectory to achieve the agreed 75% target for 2025/26

Urgent & Emergency Care

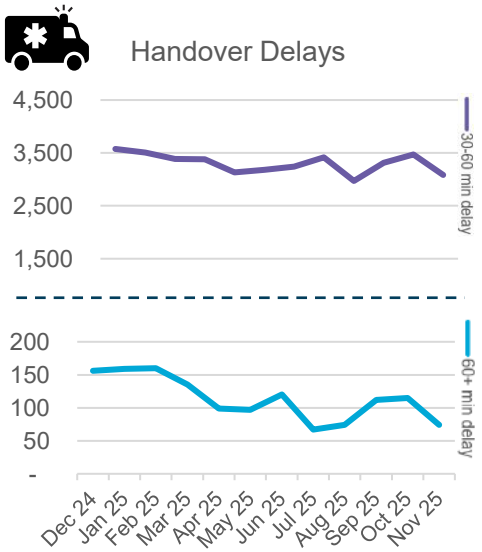
Notes and Issues

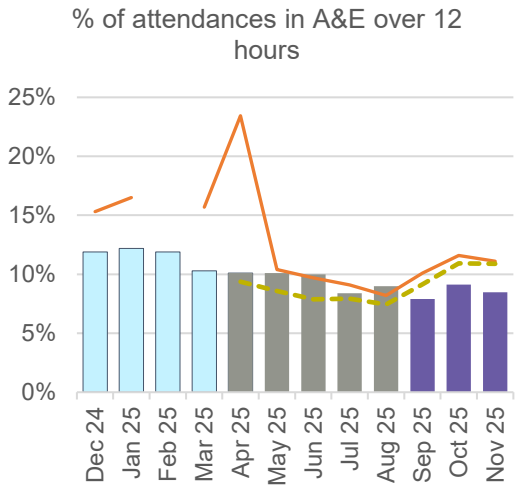
- Emergency Department (ED) performance – November SitRep data showed performance of 75.1% across the three acute Trusts which met the provider combined trajectory. Published performance for SEL in November (including standalone UTC activity) was 76.2%, a small improvement on the 76.0% reported in October.
- Ambulance handovers reduced in November across both 30-60 and 60+ minute delays.
- Bed occupancy levels also decreased slightly compared with the previous month.
- The new target for the percentage of 12-hours-waits (from arrival) was met again in November.
- The target for the percentage of patients discharged on their discharge ready date (DRD) was not achieved. A higher than planned average length of stay post DRD was also reported.

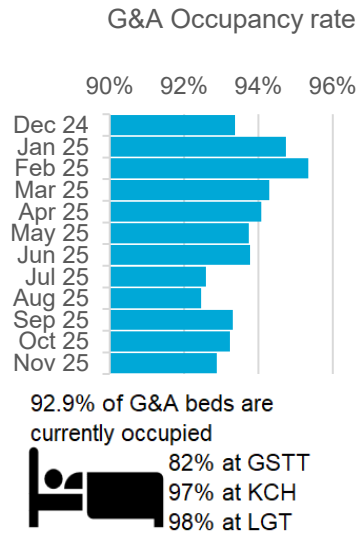


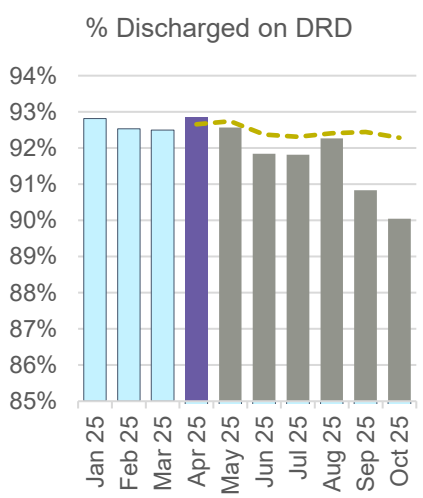
Recovery Actions

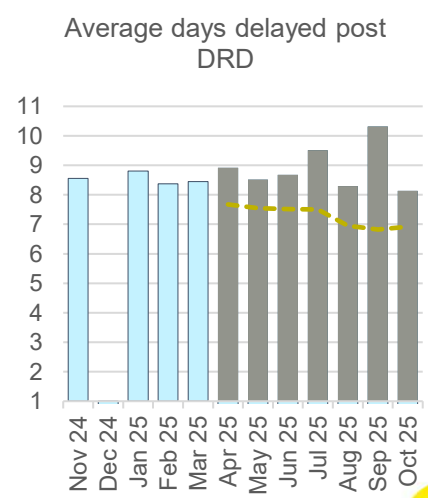
- Local systems/providers are implementing plans for 2025/26 to help deliver agreed improvement trajectories. Improvement actions continue to focus on:
  - Front door management – use of alternatives to ED, ED triage and streaming, redirection, use of admission avoidance, MH crisis pathway, hospital handovers.
  - Implementation of 'Criteria to Admit' (CTA) across all sites.
  - In-hospital management – same day emergency care, length of stay improvement.
- SEL provider trusts and the ICB have been implementing actions to support enhanced provision over the winter to manage winter pressures.
- Significant focus remains on improving discharge performance and ensuring bed occupancy rates reduce.











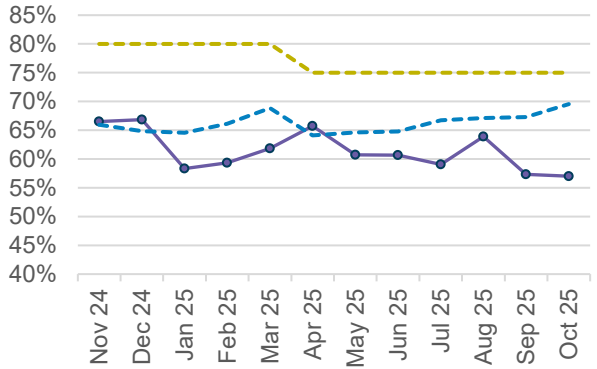
No Target | Target met | Target not met | Last Year | Plan

Cancer

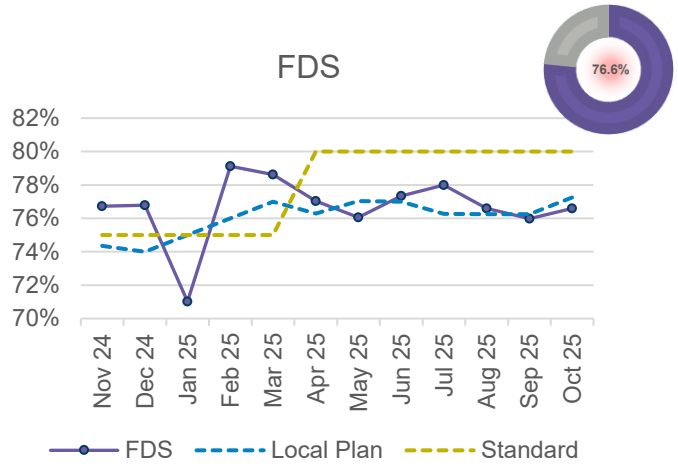
South East London Integrated Care System

Notes and Issues

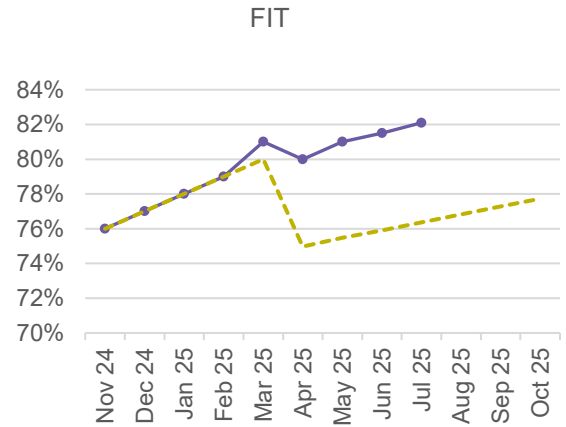
- Faster Diagnosis Standard (FDS) performance remains on plan for the year. Trajectories have been agreed to meet the national aim of reaching 80% by year end.
- 62-day performance remains a challenge for the system. Timely and effective Inter-Trust Transfers are a critical focus to improve performance, along with treatment capacity at GSTT. Specific drivers are the lung and urology pathways.
- Backlog position has been consistent but does need to reduce further to match the position of our peers in London.
- The system continues to perform well against the Faecal Immunochemical Test (FIT) targets. FIT is used to support referral for suspected lower gastrointestinal cancer.



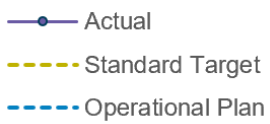
(Standard Target 75%)
% of patients with first treatment within 62 days of urgent GP referral



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



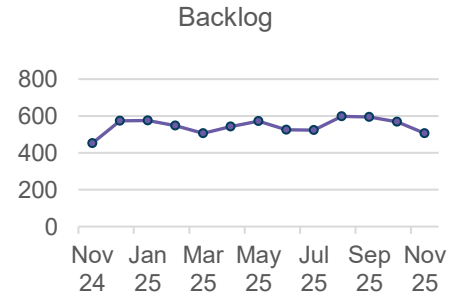
Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a **faecal immunochemical test** result, with the result recorded either in the 21 days leading up to the referral, or in the 14 days after the referral



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.
- Participate in national trials and programmes to contribute to advancements in cancer detection and management.
- Waiting list validation and review including clinical review.
- Increased theatre capacity.
- Cancer is recognised as a priority pathway within capacity planning.
- The Cancer Alliance is working to produce a system recovery plan that will reflect the complexity of challenges associated with shared pathways across SEL. This will identify key actions for all SEL providers.

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



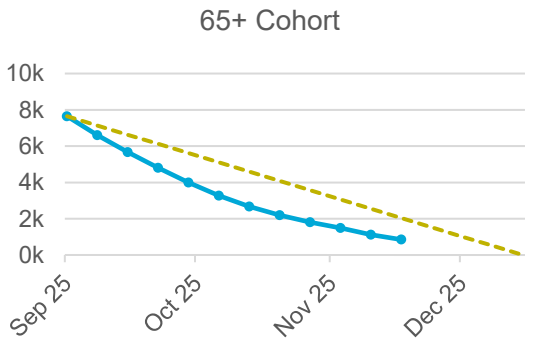
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period

Referral to Treatment (RTT): Long Waiters

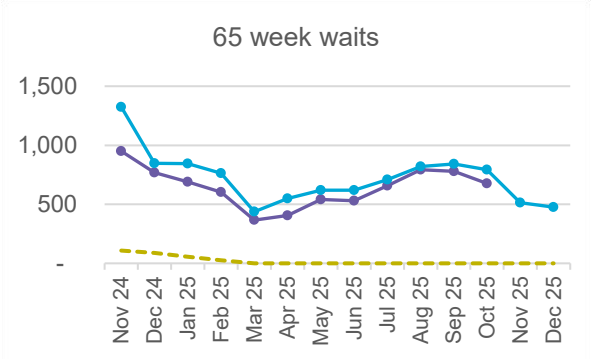
Latest Published month	Oct 25
Previous Published month	Sep 25
Latest weekly data	07/12/25
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

- The focus for 2025/26 is on delivering on the 65-week-wait challenge in addition to wider RTT metrics on 18-week performance.
- 65-week-waits rose during the first half of 2025/26 following a period of downward movement at the end of 24/25. There is an enhanced focus in SEL on the system and process changes needed to optimise the management of long waiters and the number of 65-week-waits has fallen during quarter three of 2025/26
- General Surgery, Bariatrics, Urology, Vascular and ENT are the most challenged specialties for 65+ week waits.
- A data quality deep dive has identified 16 breaches of over 104 week waits.

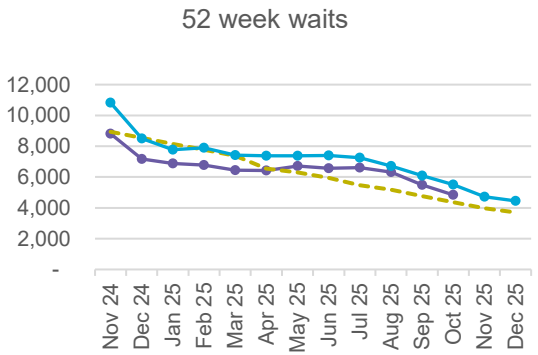


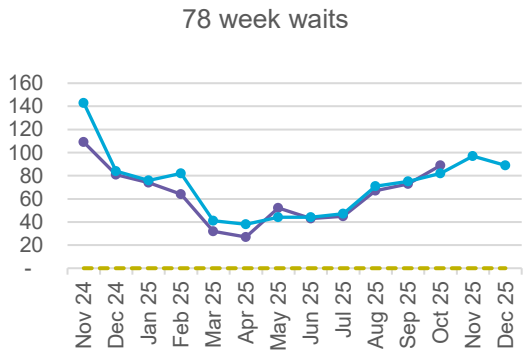
65+ Cohort
(total pathways which will breach 65+ weeks by 31/12/2025 if not seen)



There are currently **477** patients at SEL Trusts who have been waiting more than 65 weeks to start treatment.

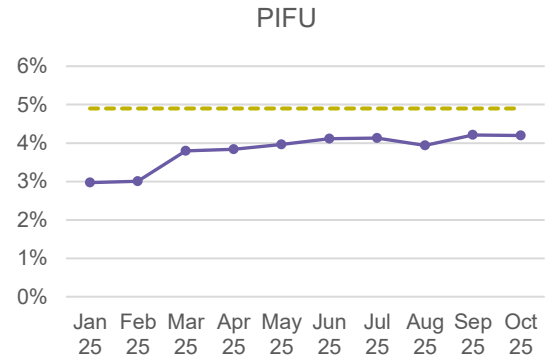
RTT Patients still waiting Oct 25	52+	65+	78+	104+
This month	**4,841**	**675**	**89**	**16**
Plan	× 4,360	× -	× 0	× 0
Last month	▼ -657 (-13.6%)	▼ -103 (-15.3%)	▲ 16 (18.0%)	▲ 13 (81.3%)
Latest week	**4,451**	**477**	**89**	**8**





Recovery Actions

- Waiting list validation including the sprint programme. This includes additional funding for trusts who can validate waiting lists at levels above those achieved in previous years.
- Optimising Advice and Guidance, straight to test, patient initiated follow up (PIFU) to release more capacity for first outpatient appointment
- Mutual aid between providers in certain challenged specialties
- Adoption of the nationally recommended Getting It Right First Time (GIRFT) Further Faster pathway
- Additional capacity through outsourcing and insourcing



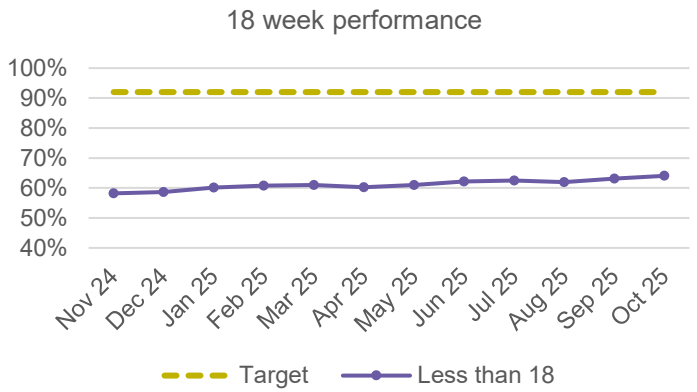
Referral to Treatment: Demand Management

South East London Integrated Care System

Latest Published month	Oct 25
Previous Published month	Sep 25
Latest weekly data	07/12/25
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

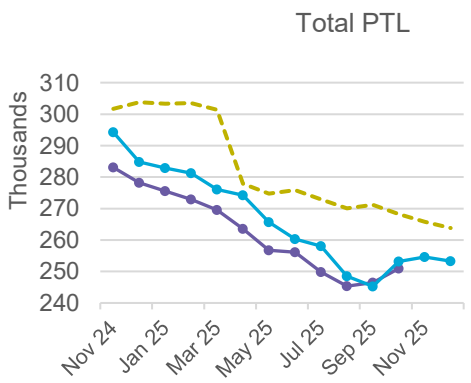
- 18+ weeks performance and time to 1st appointment are new metrics for 2025/26. The national expectation is 65% and 72%, respectively. Trust specific targets are, however, based on an improvement of 5 percentage points from the November 2024 position.
- The SEL operational plans included trajectories for the delivery of the trust specific targets for the above metric.
- Although not a specific operational plan metric, a reduction in total PTL size is another metric being monitored nationally.
- Advice and Guidance (A&G) through electronic referral continues to perform well, with improved provision and timely responses. However, the diversion rate has continued to decline, which may reflect changes in referral or triage behaviour.
- There is an ongoing focus on triage which is required to improve provision and identify opportunities for improving the rate of appropriate diversion.

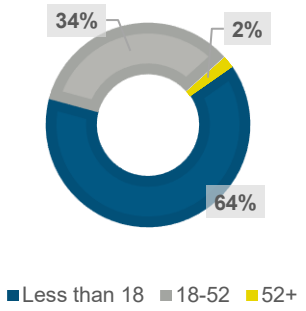


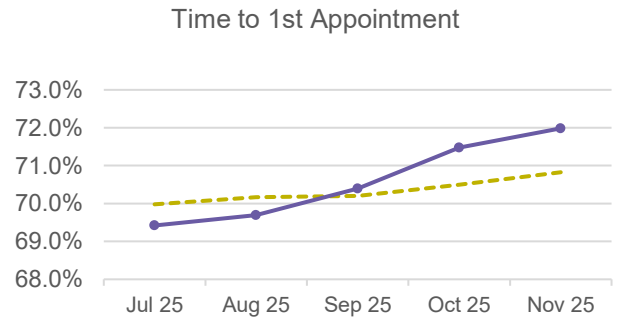
Recovery Actions

- Improved use of advice services and a priority focus on increasing and improving triage as the most evidence-based intervention (EBI) for demand management.
- Outpatient transformation including straight to test to improve waiting times at the beginning of RTT pathways.
- There has been a focus during quarters 1 and 2 on A&G, triage, booking processes, improving Did Not Attend rates and scaling PIFU.

RTT Patients still waiting Oct 25	Total	<18 ww	18 week perf
This month	250,975	160,737	64.05%
Plan	✓ 301,697		× 92%
Last month	▲ 4461 (1.8%)	▲ 5168 (3.2%)	▲ 0.9% (1.5%)
Latest week	253,294	161,673	63.83%





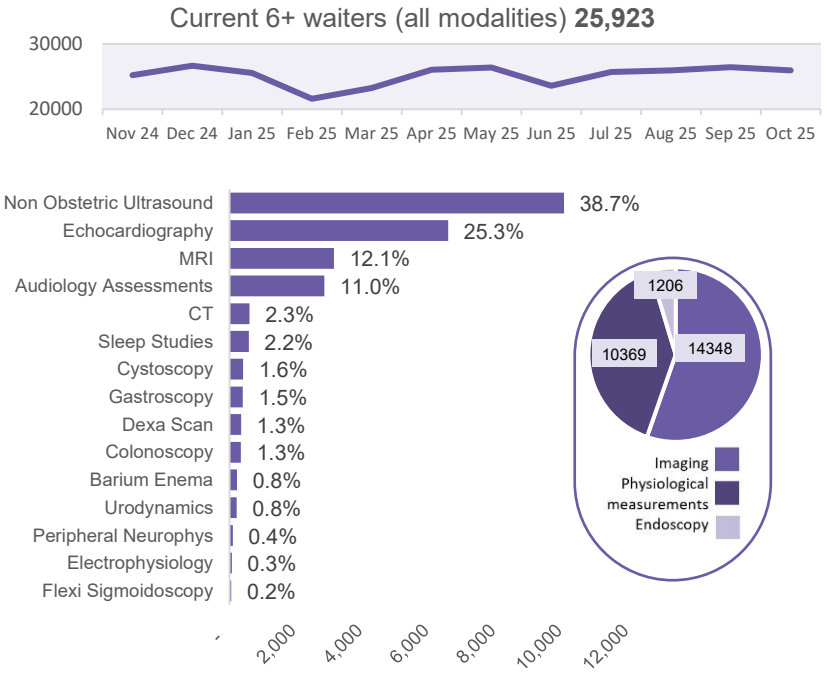


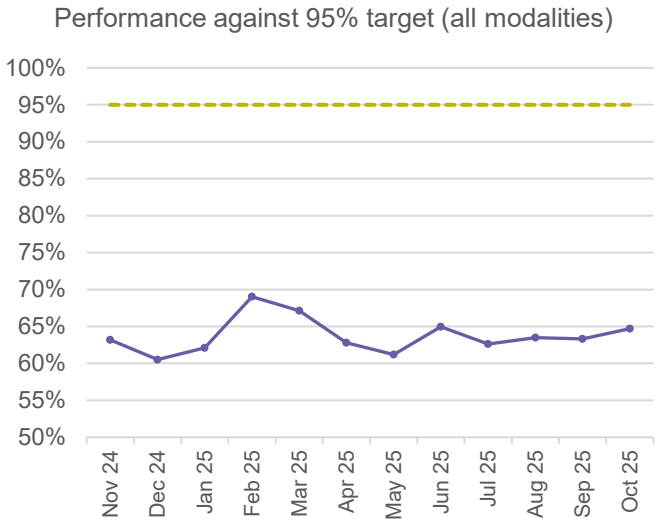
DEMAND MANAGEMENT METRICS	Current	Mar-25	National	Trend
eRS Advice & Guidance				
Provision	40%	38%	nk	▬
Turn Around Time	66%	61%	65%	▲
Diversion Rate	77%	79%	65%	▲
Consultant Connect				
Provision	67	69	n/a	▼
Answer Rate (calls)	45%	43%	64%	▲
Answer Rate (messages)	99%	99%	99%	▲
Diversion Rate (calls)	17%	20%	61%	▼
Diversion Rate (messages)	66%	68%	50%	▬
Referral Triage				
Provision	38.4%	28.9%	16-68%*	▲
Turn Around Time	56%	64%	nk	▼
Diversion Rate	14%	13%	14%	▬
**range of London systems. SEL is 2nd highest in London*				

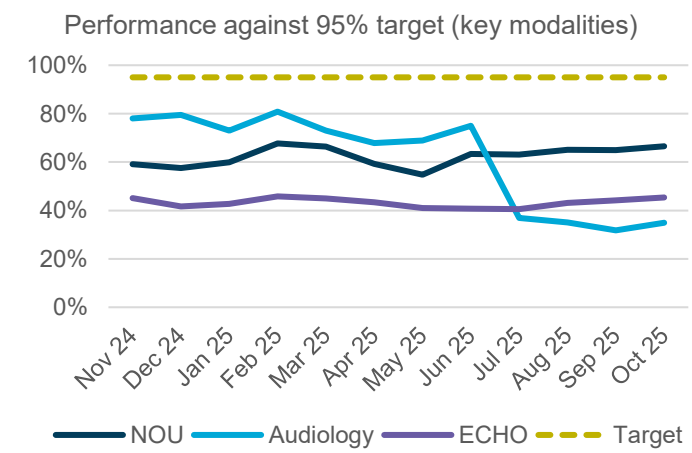
Diagnostics

Notes and Issues

- No new targets were set for diagnostics for 2025/26,
- Improving waiting times is key to supporting the delivery of RTT and cancer.
- SEL's current diagnostic performance is challenged. Focused recovery actions are underway.
- Key modalities where performance is challenged include non-obstetric ultrasound (NOUS), echocardiography and audiology (partly due to a change in policy on how patient pathways are managed/reported).
- There has also been an issue with the number of 13-week waiters, which had been improving. The change in the policy on how audiology patient pathways are reported has, however, resulted in an increase.

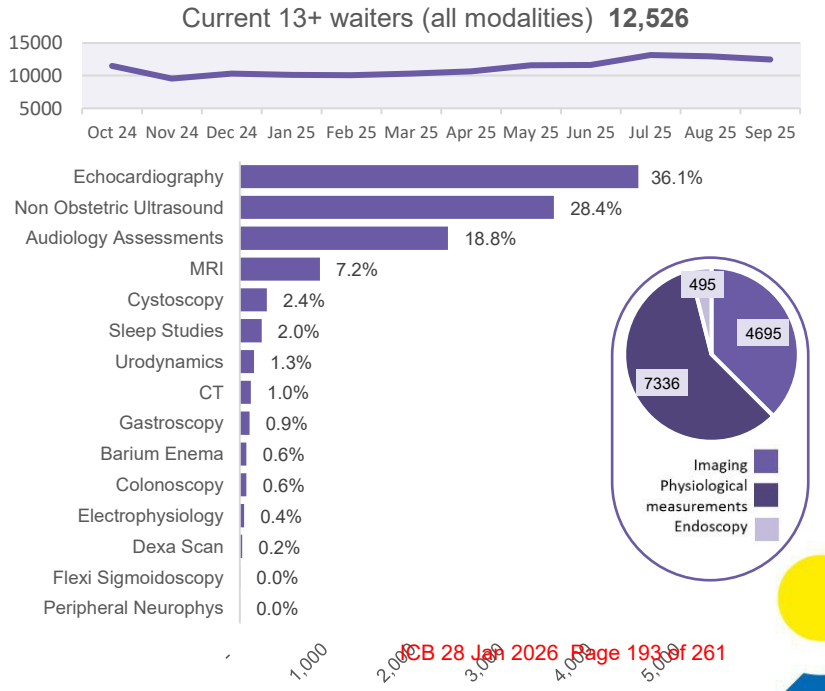






Recovery Actions

- Clinical and administrative validation of the overall diagnostic PTL.
- Implementing a clinical decision support tool to assist with demand management.
- Additional capacity by maximising on-site capacity, in- 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, echocardiography will be included in this work.
- Maximising the available capacity at the Community Diagnostic Centres.

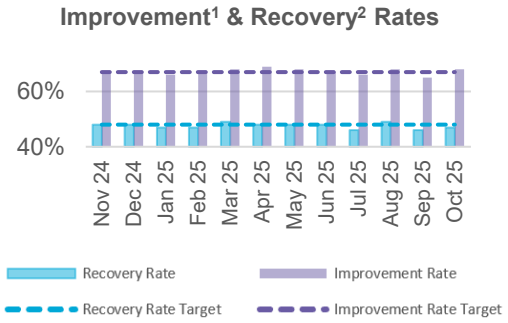


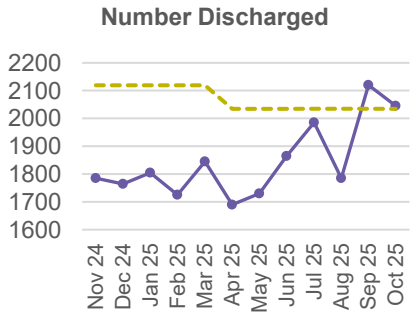
Mental Health

Notes and Issues

- The waiting times target for urgent CYP eating disorder referrals was met in October, but the target was missed again for routine referrals. This is driven by staffing issues and is expected to continue for the remainder of the financial year.
- CYP access performance remains below target in October. There has been a change in how one of the trusts is reporting CYP ADHD and ASD which has a more significant impact on overall performance across SEL than anticipated.
- SEL Talking Therapy performance for the number of people completing a course of treatment exceeded trajectory for the second month in the financial year in October. The target for improvement was met, and the reliable recovery target was narrowly missed with reported performance of 47% vs. 48% target.
- Perinatal access is performing below trajectory in October with reported performance of 1,715 vs a target of 1,808.
- The number of people with SMI receiving physical health checks is below plan for quarter 2 but shows an improved position compared to the same period in 2024/25.

Talking Therapies (IAPT)

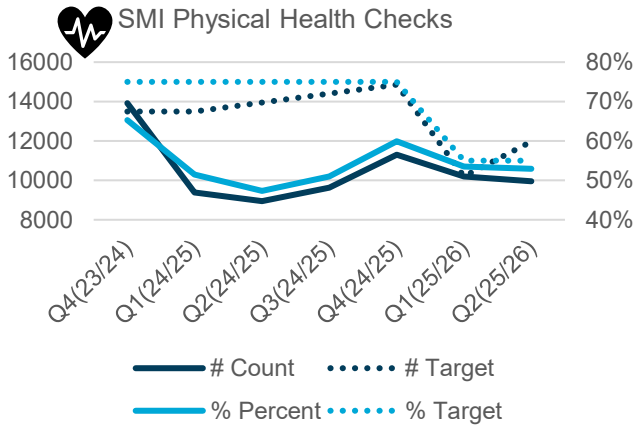




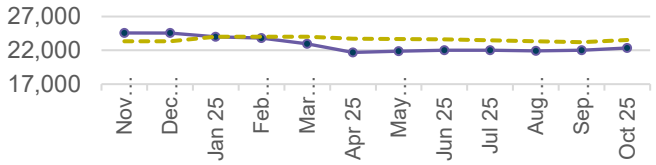
1. Reliable improvement rate for those completing a course of treatment.

2. Reliable recovery rate for those completing a course of treatment and meeting caseness

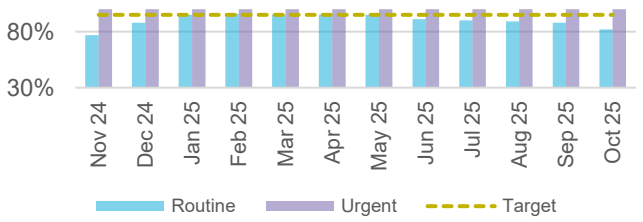
3. Number of patients discharged having received at least 2 treatment appointments in the reporting period



No. young people accessing NHS funded MH services

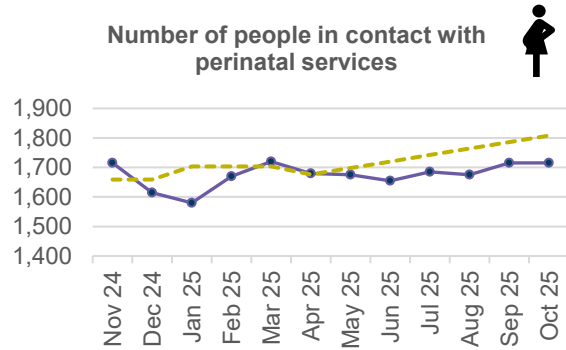


CYP Eating Disorders: % achieving standard



Recovery Actions

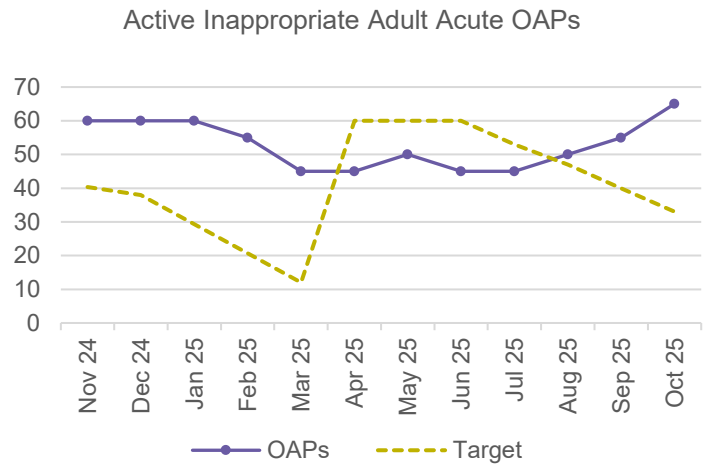
- Continued support available to ensure all providers can submit data.
- Data Quality Improvement Plans (DQIPs) embedded in the contracts for the two major mental health providers in south east London. DQIPs are reviewed and updated regularly.
- Local improvement plans in place to increase the number of Physical Health Checks undertaken for people with SMI.
- All Talking Therapies services have plans in place to support performance improvement against the targets for the number of people completing a course of treatment and those achieving reliable recovery and improvement.



Mental Health Crisis & Flow

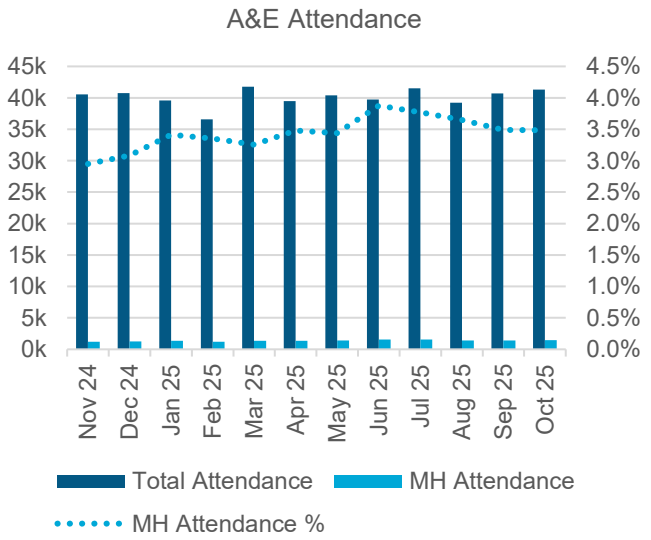
Notes and Issues

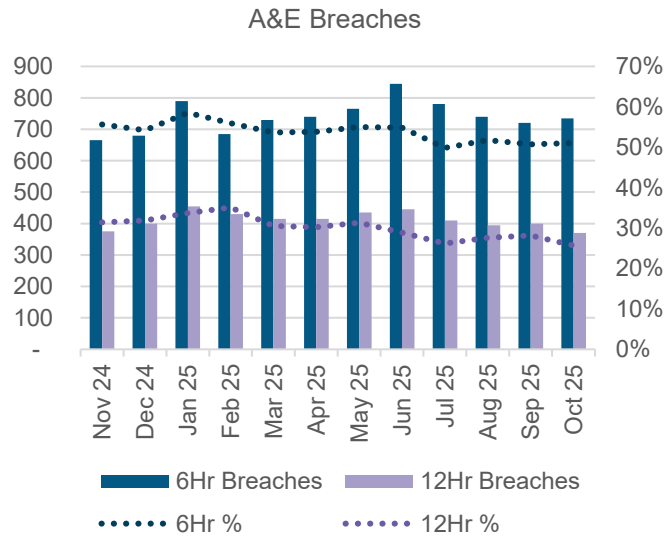
- Mental Health (MH) emergency pressures remain with some very challenging days reported in recent months.
- The number of inappropriate out of area placements (OAPs) has increased in October with 65 active reported against a plan of 33.
- A&E data shows that the proportion of MH presentations in ED in October was consistent with the previous month at around 3.5%. 51% of MH patients waited more than 6 hours in ED and 26% more than 12 hours.
- A&E breaches remain disproportionately high for MH patients. SEL's operational plan for 2025/26 supports the commitment to reducing the number of MH breaches.
- SEL is delivering against the average Length of Stay target. October performance was 50 days against a target of 52.2.

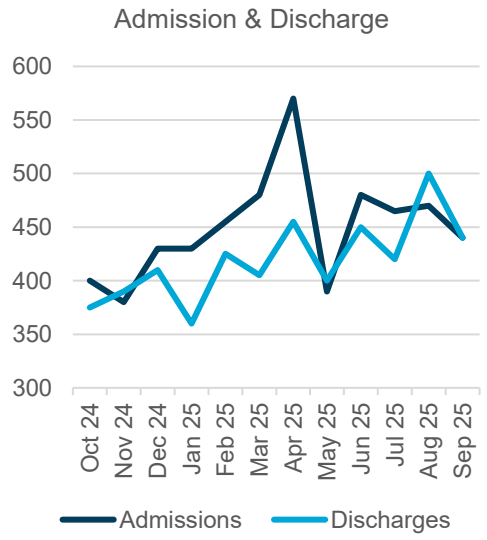


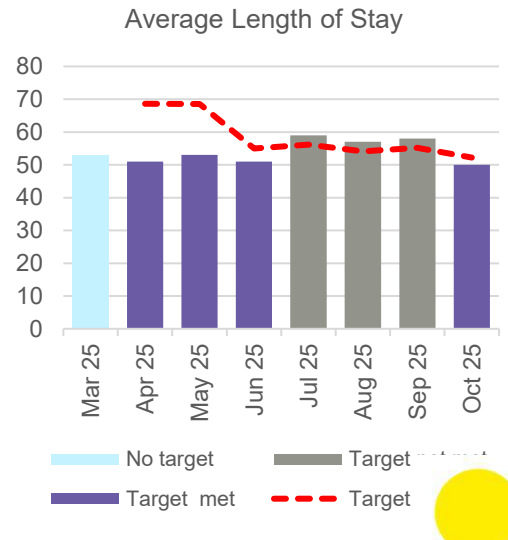
Recovery Actions

- There continues to be a focus from all system partners on expediting discharges for those patients that are clinically ready and reducing 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.
- MH Trusts continue to work with private providers to ensure Out of Area Placements (OAPs) data is submitted via MHSDS correctly. Improvements are noted but the data is still not flowing correctly for all providers.









Primary care access

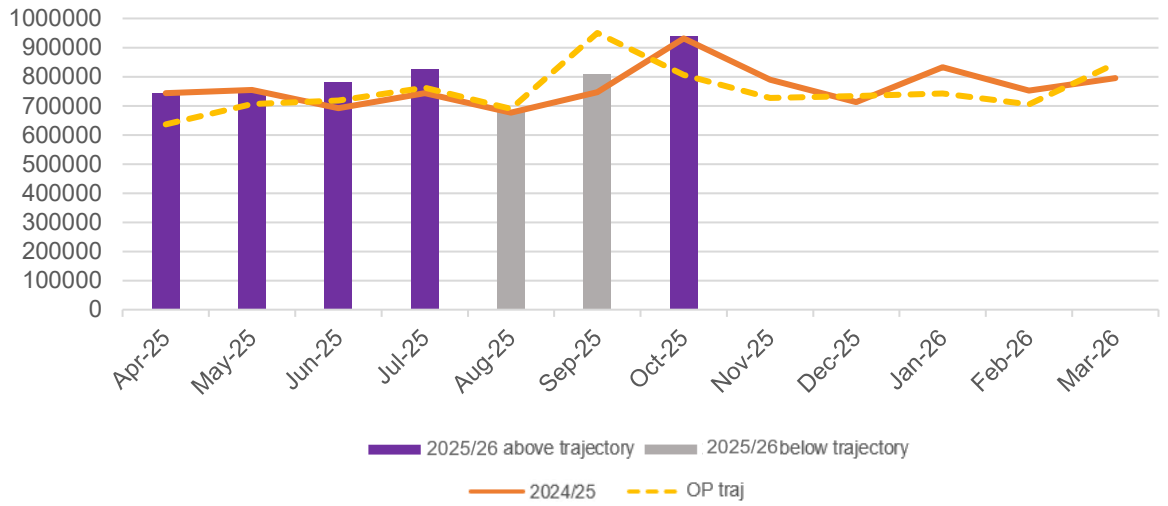
Notes and Issues

- 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 938,712 in October 2025 against the operating plan target of 805,992.

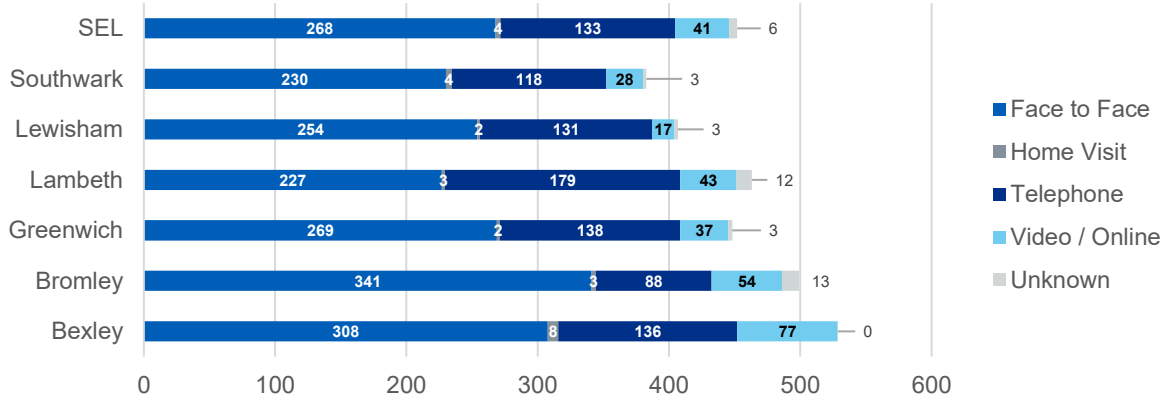
Recovery Actions

- 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.
- Work is taking place 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.
- The analysis of the latest available patient experience data has been completed, and practices with the highest levels of unwarranted variation have been identified. Place-based teams continue to lead on this work, prioritising which practices require support and agreeing targeted interventions. Support may be delivered via the Training Hub or through locally agreed programmes and initiatives.
- A practical support offer for general practice resilience has been agreed, building on the sector's views of what is needed now and in the future. The offer, aims to promote equity of provision, access, experience, and outcomes across general practice.
- Boroughs are working with practices identified in the Commissioning and Transformation Support (CATS) GP dashboard to understand reasons for adverse variances and to offer them additional support as required.
- As of 3 December 2025, SEL ICB is compliant with online consultation contractual requirements and has put robust arrangements in place to ensure this is monitored rigorously. This is borne out by the Wave 17 Health Insight Survey (HIS), which shows that SEL ranks second in London for ease of contacting practices online and is above both the London and England averages for this measure.

Primary care access: appointments
National data vs operational plan trajectory



Rate of access per 1,000 population (October 25)

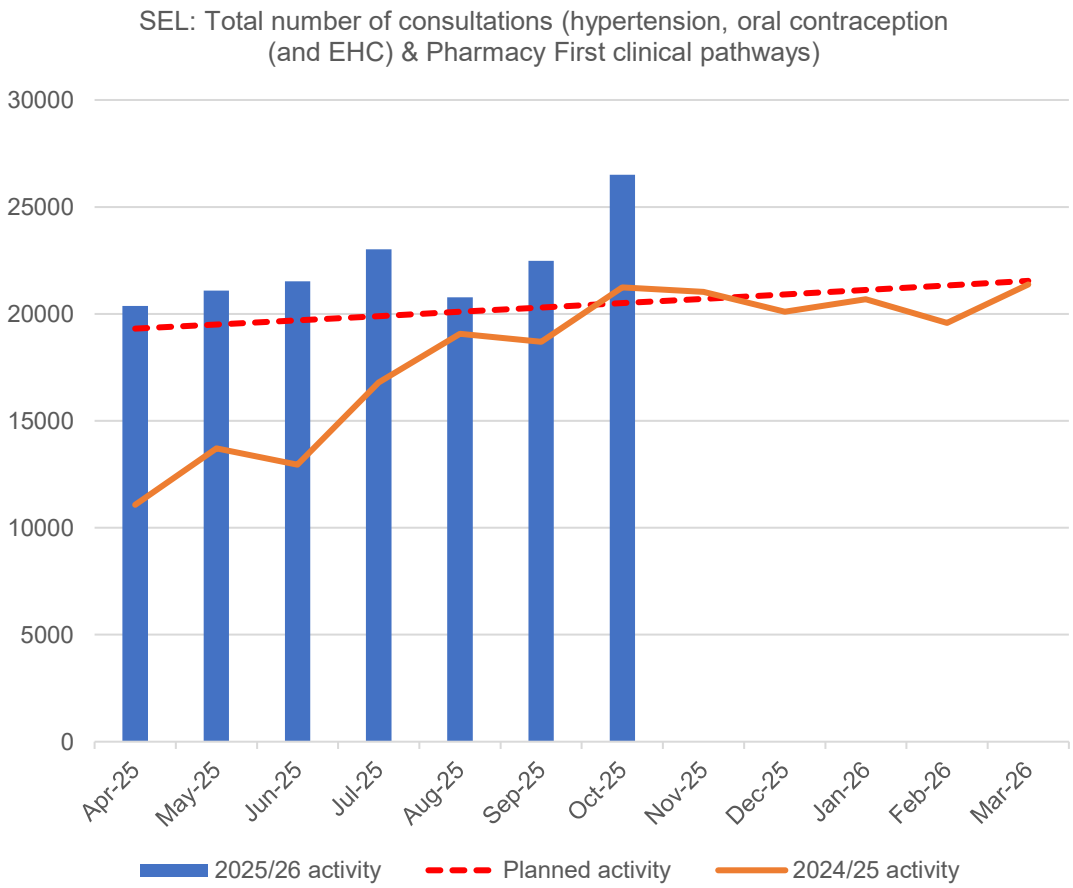


Note on data source: All charts use the nationally published PCN level GPAD data to calculate borough level reporting: Appointments in General Practice - NHS England Digital

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

Notes and Issues

- In October 2025, 312 (of 324) pharmacies were providing Pharmacy First services, with 306 providing hypertension screening and 304 providing oral contraception.
- As of June 2025, pharmacies must be registered to provide all three services to qualify for threshold payments. In SEL 299 pharmacies were providing all 3 services in Oct 25.
- From Feb 24 to Oct 25, approximately 124,000 clinical pathway consultations have been conducted by SEL community pharmacies
- Updated oral contraception service which include emergency hormonal contraception (EHC), went live on 29th Oct. There were 165 EHC consultations across SEL in the first 3 days of the service being available.
- Toolkit created for Community Pharmacies to support implementation and drive services



Note: The chart/data on this page uses indicative management information from the NHS BSA – Manage Your Service (MYS).

Recovery Actions

- 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. messaging from GP practices.
- Working closely with SEL LPC to support services in community pharmacy.
- Refresh of Community Pharmacy Neighbourhood Leads (CPNL) programme. Part of this role will be to support an increase in services available in community pharmacy.
- National Pharmacy First campaign runs from the end of October to early January 26.
- Work continues with LPC to provide support to pharmacies that are not currently providing all 3 services and provide support and training.
- Working with LAS NHS111 colleagues to support with training, and how to improve referrals to community pharmacy.

UCR and community waits

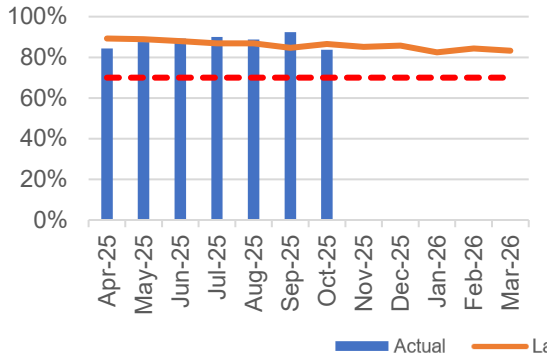
Notes and Issues

- October UCR performance data shows SEL providers exceeding the 2- hour and 2-day response standards.
- Provisional October performance against the standardised rate of referral target is 43 against a target of 180. Noting, that this does not include all providers. The latest complete data set from September was 95.
- The total number of patients reported on the Community Services waiting list for services in scope in SEL was 37,692 – a marginal increase of 204 on the previous month. This was primarily due to an increase (337) in reported long waiters in Community Paediatrics at a single provider.
- Of the total number of patients waiting, 21,464 (57%) have been waiting less than 18 weeks for a first appointment. Services contributing most to overall wait numbers are: Community Paediatrics (45%), MSK (11%), and Podiatry/Podiatric Surgery (9%).

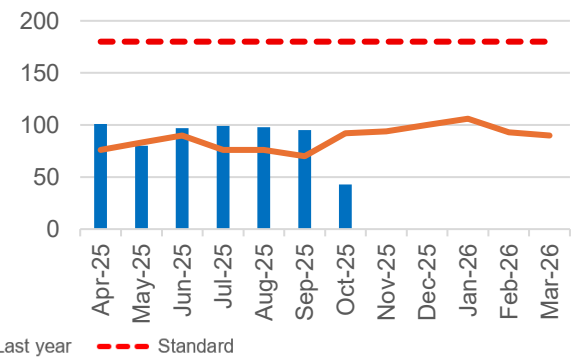
Long waiters:

- The number of patients waiting over 52 weeks for a first appointment increased from 5,451 to 6,767. Of the 5,725 patients waiting 52-104 weeks 4,855 (85%) were in Community Paediatrics, with small numbers across a range of other services.
- The number of patients waiting over 104 weeks decreased from 1,309 to 1,042. This is primarily driven by Community Paediatrics, which accounts for 99% of the list.

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

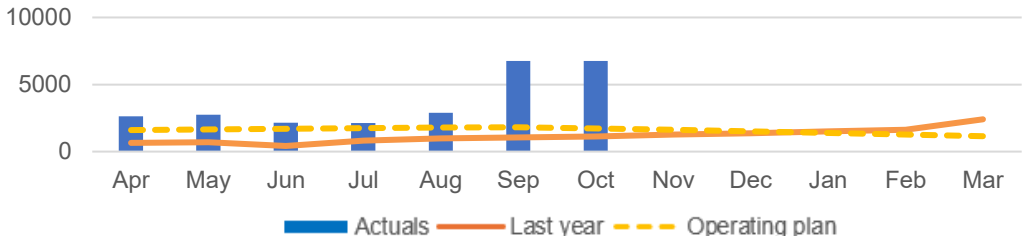


Standardised rate of referral per 100,000 population**



**Latest month is provisional data and does not include data from all providers

Community waits >52 weeks***



***April 24 to Feb 25 data does not include data from all providers

SEL Waiting List Breakdown (Oct 25)	
Weeks	**Number of waiters**
0-1 weeks	**2,706**
>1-2 weeks	**3,078**
>2-4 weeks	**3,781**
>4-12 weeks	**7,659**
>12-18 weeks	**4,240**
>18-52 weeks	**9,461**
>52-104 weeks	**5,725**
>104 weeks	**1,042**

Recovery Actions

UCR:

- Data validation work continues with SEL UCR services to ensure that all UCR services are submitting fully to the CHS Sitrep and that published data aligns with the internal data held in Trusts.

Community wait list:

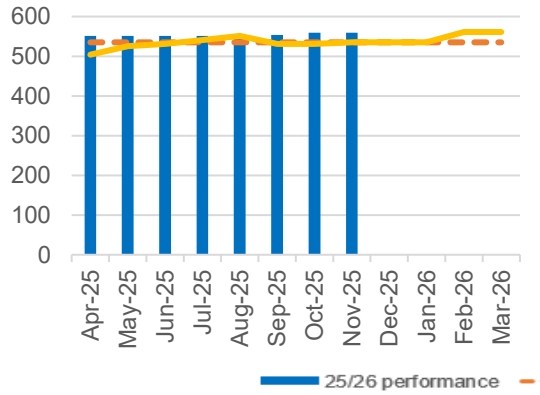
- Long waits in Community Paediatrics continue to present the largest challenge for south east London. The ICB is working with providers to develop and implement a new clinical model for a neurodiversity hub. The hub will be piloted during quarter 4.
- Two providers in south east London have identified issues with how waits for some services were being recorded, which may have led to inflated long wait figures. They are now validating and cleansing the data while putting improvement actions in place, including changes to processes and additional capacity.

Virtual Wards

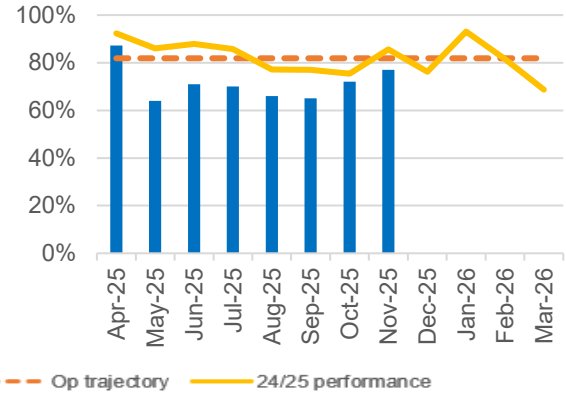
Notes and Issues

- SEL Virtual Ward capacity is above plan at 559 beds against a target of 535.
- The average utilisation for November was 77%, which is below the planned level of 82%. Reported utilisation rates have been negatively impacted by non-submission of data for one of the borough providers. This omission is due to the transition to a new provider and the pause in reporting has been agreed, with the expectation that it will commence in quarter 4.

Capacity (beds) vs plan



Occupancy vs plan



2025/26 Plans and Actions

- In an effort to increase standardisation and consistency of practice across SEL providers, providers have demonstrated their acuity tools to the SEL Virtual Ward Community of Practice. Work to develop a single SEL tool will be taken forward by the Community of Practice in 2026.
- The Virtual Ward data submission and reporting is transitioning to a new virtual ward minimum data set. A reconciliation feature has been added to the reporting dashboard to compare data with the existing sitrep. The transition is expected to help improve submission completeness and accuracy.

Average of snapshots November 2025

October 2025	Av. Capacity	Average Utilisation
SEL actuals	559	77%
SEL Plan	535	82%

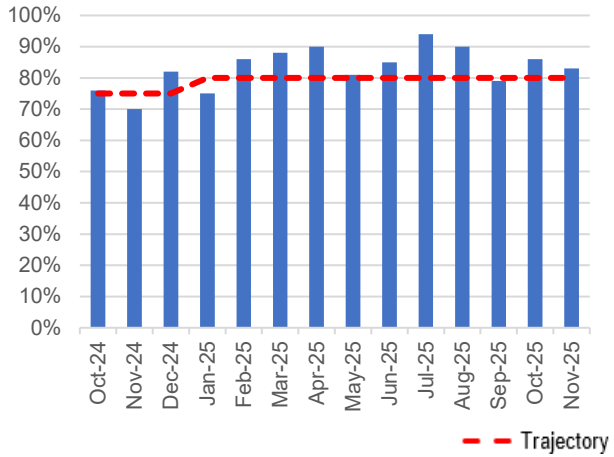
Note: Occupancy data incomplete for one provider during November 2025

NHS Continuing Healthcare

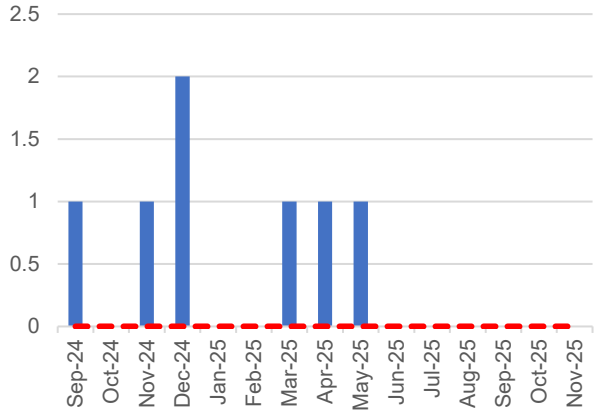
Notes and Issues

- **28 day performance:**
- November performance (local reporting) against the number of referrals completed within the 28-day timeframe is 83%. This is a decrease from the October performance of 86 % and above the national target of 80%.
- Incomplete referrals over 12 weeks: SEL reported zero 'long wait' over 12 weeks in November which meets the national requirement.
- The quarter 2 statutory reported position for SEL was 84% for 28-day performance which is above the national target. There were zero incomplete referral over 12 weeks which is in line with the national target.
- 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 Standard CHC reviews is 148.
- There are 63 overdue fast track reviews. This is a reduction from the previous month of 73.
- Funded Nursing Care Reviews: The number people waiting for Funded Nursing Care Reviews has decreased from the previous month of 721 to 687. Overall, the number of overdue reviews remain static.

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		
	Q2	Trajectory	Target	Q2	Trajectory	Target	Q2	Trajectory	Target
Bexley	0%	-	0%	83%	80%	80%	0	0	0
Bromley	0%	-	0%	86%	80%	80%	0	0	0
Greenwich	0%	-	0%	85%	80%	80%	0	0	0
Lambeth	0%	-	0%	84%	80%	80%	0	0	0
Lewisham	0%	-	0%	85%	80%	80%	0	0	0
Southwark	0%	-	0%	81%	80%	80%	0	0	0
SEL	0%	-	0%	84%	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

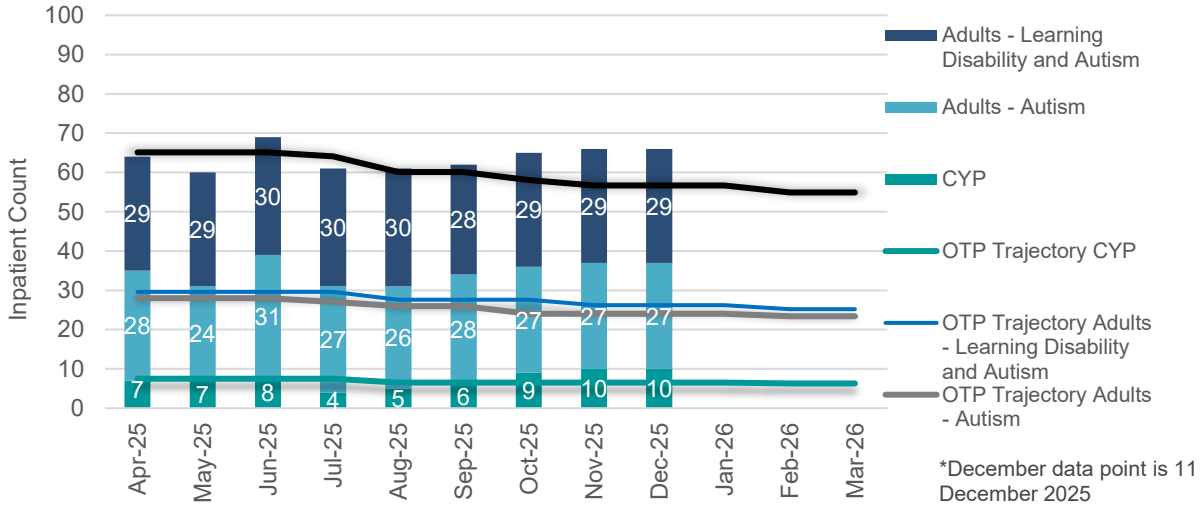
- The ICB recovered performance against the assessment targets during 2024/25. 28 day performance has continued to be achieved during 2025/26 and remains above the national target of 80%.
- Boroughs continue to work to locally agreed trajectories to reduce the number of patients waiting for Standard CHC, Fast Track and Funded Nursing Care Reviews
- Monthly reporting processes are undergoing revision to ensure alignment with emerging All Age Continuing Care reporting requirements.

Learning disability and autism (LDA)

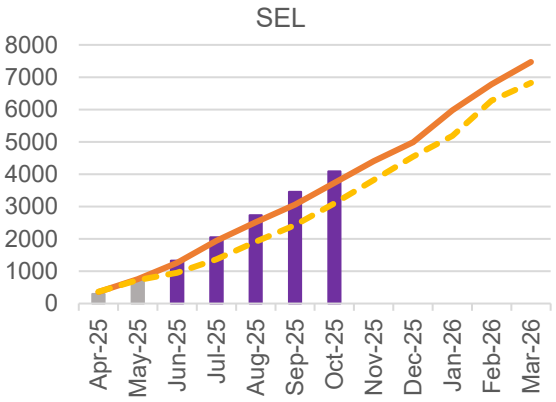
Notes and Issues

- 11th December (latest position), showed the target LDA inpatient position not being met. There were 66 inpatients, 9 over the Q3 target (57). There were 11 people due for discharge by end of Q3 and 27 due to discharge by the end of Q4.
- The year-end target for 2025/26 is 48 adults (25 with a learning disability and/or autistic adults and 23 autistic adults) and 6 young people.
- There continues to be an increase in demand for autism assessments for both adults and children and young people across all boroughs.
- The trajectory to achieve the year end target of 75% completion of Learning Disability Annual Health Checks remains on track. The focus in all boroughs will continue to be around assuring AHCs are of a good quality and on improving people's experience of AHCs.
- Continued roll out of The Oliver McGowan mandatory training to provide essential skills and knowledge to ensure safe and compassionate care for autistic people and individuals with a learning disability. Project Management support has been extended to March 2026 to support the achievement of the 30% target.

LDA Inpatient Position



LD AHCs: SEL and Borough Level Position



	October 25 performance		Oct-25 Trajectory	2025/26 Plan
	%	Count		
Bexley	41%	520	412	908
Bromley	42%	541	425	938
Greenwich	42%	717	566	1248
Lambeth	40%	701	580	1279
Lewisham	43%	887	667	1472
Southwark	54%	718	442	975
SEL	44%	4084	3094	6825

Recovery Actions

- Operational planning trajectories for 2025/26 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 Dynamic Support Registers (DSRs) launched in August 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.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Quality and Nursing**					
Meeting date	28th January 2026	Agenda item Number	8	Paper Enclosure Ref	H	
Author	**Elizabeth Aitken, Deputy Medical Director and CCPL Quality**					
Executive lead	**Diane Jones, Chief Nursing Officer**					
Paper is for:	Update	X	Discussion		Decision	
Purpose of paper	To provide an overview of quality and nursing across the ICS for Quarter 2					
Summary of main points	**Quality and Patient Safety:** In Q2, 23 Patient Safety Incident Investigations and 2 Never Events were reported. There is ongoing work through quality improvement projects across the Trusts that have reported Never Events linked to Patient Safety Incident Response Plans. 473 Quality Alerts were raised, with the trending themes reported include appointment/referral, transfer of care, discharge, communication and diagnostics. Improvement work is underway, including a review of telephony services and improved pathways between services to improve efficiency. **Safeguarding**: Safeguarding work in Q2 has centred on strengthening system leadership, data quality and multi-agency working. The Serious Violence Dataset is ready to go live and has been positively recognised by regional partners. The ICB continues to contribute to the Offensive Weapons Homicide Review pilot in Lambeth and Southwark. Progress continues with Child Protection Information System (CP-IS) implementation in scheduled care settings, and professional development activity has expanded system capability. **All Age Continuing Care (AACC)**: AACC continues to meet national timeliness KPIs, including the 28-day decision standard. National policy developments and the Model ICB Framework require SEL ICB to refine assurance, reporting and quality oversight. **Local Maternity and Neonatal System (LMNS)**: All three acute providers are on track for MIS Year 7 submissions. A new Maternity Care Bundle will launch in January 2026, requiring system-wide compliance with five best-practice elements, including VTE and maternal mental health. **Infection Prevention and Control (IPC)**: The most recent surveillance data shows the SEL ICS position is above trajectory for cases of E. coli, Clostridioides difficile, Klebsiella spp., P. aeruginosa, and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases. **Learning Disabilities and Autism (LDA)**: Inpatient numbers have continued to rise, particularly among autistic adults not previously known to services and children with new diagnoses identified during admission. Boroughs remain on track to achieve discharge targets, including complex long-stay discharges. Significant progress includes development of Community Autism Services, full coverage of Intensive Support Teams, and strengthening AHC quality ahead of future operational requirements. **Special Educational Needs and Disabilities (SEND)**: The SEND Network remains active while awaiting national SEND Reform. All local areas have been tasked with producing Local SEND Reform Plans based on the national principles of early, local, fair, effective, and shared.					

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	Quality and Safeguarding Committe					
Recommendation	The Board are asked to note the content of the report					

South East London Integrated Care System

NHS South East London

Board Report

Quality and Nursing

January 2026

We are a partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and the voluntary and community sector

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 2. 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 Q2, a total of 23 Patient Safety Incident Investigations (PSIIs) were reported, along with 2 Never Events. Both of these Never Events related to retained foreign objects (retained swabs) post-procedure. There is ongoing work through quality improvement projects across the Trusts that have reported Never Events linked to Patient Safety Incident Response 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 473 quality alerts were reported in Q2. The trending themes reported include appointment/referral, transfer of care, discharge, communication and diagnostics. During Q2, an increase was noted in QAs being reported to Accident and Emergency services across all acute providers. This is likely due to the higher volume of patients presenting to departments. The key themes were linked to transfer of care, discharge and appointment/referral issues. Much of this improvement work is being picked up by the System Interface Group led by the ICB Medical Director.

There has been targeted improvement work across a number of secondary care providers in South East London from QAs:

- Following delays in responding to calls, South London and Maudsley (SLaM) have reviewed their telephony services and introduced a clinician to monitor the Single Point of Access (SPA) inbox to ensure referrals are properly screened and prioritised.
- Lewisham and Greenwich NHS Trust have improved referral pathways between physiotherapy and orthopaedics, reducing unnecessary GP involvement and improving efficiency.
- King's College Hospital NHS Foundation Trust is running a quality improvement project to enhance the completeness and clarity of discharge summaries.
- A review of the discharge pathway has been undertaken by Oxleas and Guy's and St. Thomas Trust to improve communication and discharge planning especially for complex cases requiring care packages. This also includes early family engagement and accurate assessments are now emphasised to prevent delays and readmissions.

The Patient Safety Incident Response Framework (PSIRF) pilot Phase 2 in General Practice, led by the Health Innovation Network (HiN) is progressing. The pilot teams include five participants from SEL: one GP Federation, two Primary Care Networks, one GP practice, and one hospice. The pilot is focusing on operationalising PSIRF for general practice. Emphasis is on making PSIRF business as usual and linking it to CQC preparedness. This then focuses on embedding the principle of compassionate involvement and psychological safety in reporting, with efforts to embed these culturally.

2.2 Safeguarding

The safeguarding function continues to progress a number of deliverables and quality improvement programmes. The following has been the focus during Q2.

SEL ICB Serious Violence Dataset:

- The ICB Serious Violence Dataset utilises information derived from the Emergency Care Data Set (ECDS) and In-Patient treatment data to provide high level information related to SEL ICS hospital contacts for serious violence. The dataset will help Community Safety Partnerships, strategic commissioning and public health to gain insights into serious violence in SEL and will support the ICBs development of a Serious Violence Duty (SVD) strategy.
- The dataset was developed by the SEL ICB Business Intelligence/ Central Safeguarding teams and is now ready to go live. It has been praised by the NHSE London Violence Reduction Unit as an example of a high-quality innovation.

Offensive Weapons Homicide Review (OWHR):

- The London Boroughs of Lambeth and Southwark are two of the pilot sites for OHWR's, which are new statutory reviews aimed at understanding if partners could have worked more effectively to prevent deaths involving an offensive weapon. The ICB have contributed to the pilot through being a Relevant Review Partner. Review reports are currently proceeding through the respective OWHR governance processes. Preliminary themes have been identified. The action and recommendations will be overseen by the relevant Community Safety Partnerships

Families First Programme (FFP):

- This project aims to deliver an integrated multi agency health intervention by strategically aligning existing resources, infrastructure and partner capabilities. The following will be considered: resource maximisation, partnership and engagement, governance and accountability, deliverables, timelines, planning, risks and mitigation. SEL ICB will optimise through identifying opportunities, best practice and economy of scale.

Child Protection Information System (CP-IS) in Scheduled Care Settings:

- CP-IS helps health and social care staff to share information securely between local authorities and NHS organisations to better protect society's most vulnerable children.
- Phase 2 of CP-IS is advancing as planned. The first segment has been evaluated and ready to go live. The second segment is ready for further roll out across SEL. SEL Providers have been updated through the System Safeguarding Group and Place Safeguarding Leads. Primary Care requires further consideration in how best to approach at scale.

Quality Improvement:

- The ICS Safeguarding System Group has met for the fourth time. The group brings together the representatives from the SEL health system to identify themes, trends, learning and risk across the SEL health economy, sharing solutions, ideas and innovations. This quarter's focus has been on CP-IS and the ICB model of good practice.
- Learning and Development for Safeguarding Professionals across the system including Named GPs. This has included the delivery of Internal Management Training for statutory reviews. The purpose is to improve legal accountability, quality improvement, practice excellence and promoting a learning culture. The strategic impact is to support the ICB assurance and regulatory compliance, build competence in safeguarding leadership, reduce risk exposure through robust documentation and defensible decision-making.
- The ICB central Safeguarding team has significantly improved the statutory requirements for safeguarding training across the ICB through a safeguarding competency strategy, delivering on all levels of safeguarding training. Compliance rates are reported through the Quality and Safeguarding Committee.

Safeguarding Internal Audit (formal review) and Child Death Overview Process:

- Good progress has been made in meeting actions with one outstanding action remaining. This is related to the Safeguarding Case Review Tracker (S-CRT) and the quality of data inputted. Further auditing and feedback to Designates working at place is in progress.
- The Child Death Overview Process audit is completed with a set of recommendations which will be worked through in 2026

Safeguarding Risks:

- Workforce challenges remain in some Provider safeguarding teams across the sector, caused through either sickness or continued vacancies. This has an impact on service delivery. Ongoing discussion and support are in progress with the relevant Provider. Mitigations include use of bank staff and recruitment.

Challenges relate to suitability for specialist posts in Children Looked After (CLA) and Safeguarding. The risk relating to CLA is on the local risk register for the ICB/Provider.

- Increased numbers of out of borough CLA placed in SEL heightens challenges to deliver timely health assessments. Ongoing delays regarding late notification and incomplete paperwork from local authorities may exacerbate these issues. There is ongoing partnership working to solve this issue.

2.3 All Age Continuing Care (AACC)

All Age Continuing Care (AACC) is a national reform programme covering NHS Continuing Healthcare (CHC) and Children and Young People's Continuing Care (CYPCC). The AACC Vision 2023–2028 aims to reduce unwarranted variation and improve experience, transparency and consistency across all continuing care pathways, including smooth transitions between services.

The Model ICB framework confirms ICBs as strategic commissioners and has prompted a review of AACC functions to explore opportunities to streamline delivery while maintaining statutory accountability. The Model ICB AACC / CHC Good Practice guidance (published in September 2025) sets out recommendations to support improved quality, efficiency and sustainability, while retaining AACC and CHC functions within ICBs. Delivery is structured around four High Impact Actions: Strategy & Leadership; People & Skills; Delivery Models & Commissioned Functions; and Strategic Enablers.

The organisation is currently meeting national key performance indicators for the timeliness of eligibility decisions, including the 28-day target with performance monitored through routine monthly and quarterly reporting. Governance and oversight arrangements are in place to support Board and Committee scrutiny of performance information; however, assurance continues to be kept under review to ensure reporting remains sufficiently comprehensive and reflective of emerging requirements.

Notwithstanding compliance with timeliness targets, there are indicators of reduced assurance in relation to decision quality and consistency. This includes a sustained level of complaints and MP enquiries, together with a higher-than-average rate of Independent Review Panel overturns (37% compared to a regional average of 19%). These indicators suggest a need for continued focus on quality assurance, learning, and communication. Actions are underway to review overturned decisions, strengthen feedback and learning processes, and further refine reporting to improve patient-level insight. The Board will continue to receive regular updates and will seek additional assurance where required.

2.4 Local Maternity and Neonatal System (LMNS)

The LMNS are currently working through plans for future assurance of maternity and neonatal services which currently sits within the LMNS but will be the responsibility of the NHSE regional maternity team from January 2026. This will require clear guidance of

what is required and how this aligns with LMNS improvement and transformation work and strategic commissioning plans.

Maternity Incentive Scheme (MIS) Year 7:

The LMNS has been working across the three acute trusts on evidence submissions for MIS year 7 submissions. Each trust is claiming compliance with the standards and agreed local improvements.

Maternity Care Bundle

A new maternity care bundle that sets a baseline for best practice to reduce maternal mortality and morbidity will be formally launched in January 2026. Like the Saving Babies Lives Care Bundle there will be an expectation of compliance with the five elements:

- Venous Thromboembolism (VTE)
- Pre-hospital and acute care
- Epilepsy in Pregnancy
- Maternal mental health
- Obstetric haemorrhage

Transformation

Current transformation work taking place within the LMNS includes:

- Best practice guidance for care of babies with jaundice across SEL
- A Standard Operating Procedure (SOP) is being created for a LMNS neonatal mortality review group which will set out clear expectations on how learning is shared across the system avoiding duplication in reporting. The aim of the group is to identify themes, share learning and create system wide actions and innovations.
- The Maternal Medicine Network is working with the Cancer Alliance to create multi-disciplinary team (MDT) care pathways for women with a new or recurrent breast cancer diagnosis. This will then be rolled out to all tumour groups.
- The workforce and education workstream has an upcoming collaboration between the HiN and Upskill to create bitesize learning using AI technology. This will include mobile based micro tutorials; conversational role-play with AI powered avatars and virtual reality. Focus will be on escalation, conflict, incivility, inequality and inequity.
- Workforce education and training in progress across the LMNS includes a labour ward coordinator development programme, trauma informed care, debrief training, birthrights training, working with language barriers and healthcare and building informed care to support refugee and asylum-seeking women.
- LMNS preconception health project as part of the women's and girls' health programme will move into the next phase with further targeted education campaigns based on learning from Phase 1
- The final iteration of co-produced Personalised Care and Support Plans (PCSP's) is awaiting LMNS sign off. These will support informed decision making for women and birthing people.

Issues:

GP prescribing for pregnant people further work is in progress and discussions are occurring at various interface meetings to try and reach a consensus on how this risk can be mitigated and avoided.

Intergrowth 21 Estimated Fetal Weight charts - Concerns have been raised about the Intergrowth 21 Estimated Fetal Weight charts, as they result in fewer cases of small-for-gestational-age fetuses being identified (<10th centile), potentially missing enhanced surveillance. NHSE and RCOG have instructed all maternity services to stop using these charts and switch to an alternative recommended chart. LGT is the only trust in South East London still using them and is implementing mitigation measures while planning the transition.

2.5 Infection Prevention and Control (IPC)

Activities include ongoing general practice audits, Care Home and Primary Care training sessions. The IPC team supported World Antimicrobial Awareness week (WAAW) and promoted education webinars throughout the week as well as supporting development of digital resources to promote Global Handwashing Day on 15th October.

The most recent surveillance data shows the SEL ICS position is above trajectory for cases of E. coli, Clostridioides difficile, Klebsiella spp., P. aeruginosa, and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases. This is in line with the overall position in London year to date. There have been 25 MRSA bacteraemia cases reported since April 2025 across all settings against a threshold of zero, with 17 classified as hospital-onset. Of these, 10 cases occurred in community settings, 6 at KCH, 3 at LGT, and 8 at GSTT. Efforts continue within individual organisations, and across the system the Antimicrobial Stewardship agenda has well-established systemwide networks and workstreams.

2.6 Learning Disabilities and Autism (LDA)

During Q3 the increase in the number of inpatients continued from that seen at the end of Q2. For adult admissions this is due to autistic people not known to services or on the Dynamic Support Registers. There have also been some admissions of people discharged within the last five years and likely due to non-compliance with medication for a mental illness such as psychosis. While admissions appear to be appropriate, the use of the Dynamic Support Register to review the risk of admission and undertake Care Education Treatment Reviews (CETRs) is essential to preventing admissions by intervening in the community and putting in place the right care and support needed.

For children and young people there has been a significant increase in the numbers admitted, unlike adults, these new admissions to hospital are due to new diagnoses of autism during an inpatient stay and often characterised by complex social and family circumstances.

The number of people with expected discharge dates (EDD) are anticipated to be within planned target at the end of the year. While there is a level of unpredictability around admission and discharges, boroughs are working to achieve at times complex discharges which may for example involve the Court of Protection and Ministry of Justice restrictions. There are at least three discharges expected of people in hospital over ten years during Q3 and Q4, which will be an achievement towards providing the least restrictive environment and quality of life in the community.

During Q3, Community Autism Service development, to support autistic only people, continued with a service specification, funding and outcomes agreed. This development seeks to prevent admissions and support discharge alongside other autism support services previously developed to support people who may also have a mental illness.

Intensive Support Teams (ISTs) for people with a learning disability were also secured and recruitment commenced in Q3, ensuring that there is IST coverage in all SEL boroughs to support discharge and prevent admissions.

All boroughs in SEL at the end of Q2 surpassed the operational target and are on track to exceed the 75% target by the end of 2025/26. The focus in all boroughs continues to be around assuring AHCs are of a good quality and on improving peoples experience of AHCs. This is particularly important going forward into 2026/27 as there are new operational planning targets for AHCs where a percentage target will no longer be sought, but evidence of AHCs completed with a Health Action Plan (HAP).

Learning from the lives and deaths of people with a learning disability and autistic people (LeDeR), continues to highlight learning from the reviews. In November, Bromley commissioners and the LeDeR team ran a webinar for multi-agency partner organisations, including frontline staff and managers, health professionals, and those working across private, voluntary, and independent sectors. In September the team launched the SEL LeDeR information page on SEL Net.

The SEL One Stop STOMP Clinic pilot in Greenwich and Lewisham identified significant overmedication among people with learning disabilities, with around 25% potentially receiving psychotropic medication without a clear clinical indication. This poses avoidable risks to safety, quality of life and health inequalities. The pilot confirmed the clinic's value in improving safe prescribing, structured reviews, and compliance with national requirements, but highlighted gaps in provider awareness, referrals, training, and communication with service users and carers.

To address this, a SEL Collaborative Network was established in Q2 with South London Health Innovation Network support, and preparations are underway for a SEL-wide rollout. System recommendations include embedding STOMP within core LD pathways (Annual Health Checks, social care reviews), strengthening CLDT and pharmacy capacity, aligning STOMP/STAMP pathways, engaging independent providers, and using LeDeR learning to reduce preventable harm.

SEL ICB continue to offer SEL NHS staff Tier 1 and Tier 2 training sessions. The completion rates as of 12th December are at 28% for Tier 1, 22% for Tier 2.

East of England are publishing a procurement framework in early 2026 at which point, the training will be available to purchase via direct award. The programme team plan to purchase additional training sessions until the end of March 2026 using this framework and have a plan in place to reach the 30% target for both Tier 1 and Tier 2 training in March 2026.

2.7 Special Education Needs and Disabilities (SEND)

The SEL SEND Network has continued to meet while awaiting SEND Reform. All Local Areas have been asked to produce and Local SEND Reform Plan outlining how the area will transition to a new SEND system built on the five principles set out by the Secretary of State for Education: early, local, fair, effective and shared.

All Local Authorities will be provided with SEND Advisers and Financial Advisers to help prepare and plan for reform. Colleagues from the regional Department for Education (London Vulnerable Children's Unit) will be in touch in the new year to discuss what this means for a Local Area.

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 2026/27.

ICB Board meeting in Public

Title	**Finance Report**						
Meeting date	28 January 2026		Agenda item Number	9	Paper Enclosure Ref	I	
Author	ICB Finance Team						
Executive lead	Mike Fox, ICB Chief Finance Officer						
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 8.						
Summary of main points	As at month 8, the key headlines are: • The **ICB** is reporting a year to date **break-even** position. • The **ICS** is reporting a YTD deficit of **£25.8m**, **£2.4m behind plan**. This represents an overall £0.3m deterioration compared to month 7. • **GSTT** are reporting a YTD deficit of **£29.0m**, **£4.2m adverse to plan**. This represents an adverse movement of £1.5m in-month. • **KCH** are reporting a YTD surplus of **£2.0m**, **£1.6m ahead of plan** and an improvement of £1.1m compared to month 7. • The **ICS** continues to forecast a **break-even** financial position for year-end. For month 8, shorter than normal finance reports were produced concentrating on the headline year to date financial position. This was as a result of the ongoing implementation of ISFE2 (including the associated changes to ICB financial reporting requirements), and the timing of key committees in December, including the Executive Committee. The usual finance reports will be produced from month 9. An update on the month 9 financial position will be provided to the Board by the Chief Finance Officer at the meeting.						
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 Reports.						
Public Patient Engagement	Not applicable						
Committee engagement	ICB committees, including the ICB Executive Committee, receive regular updates on the financial position. The financial position of the ICB and ICS as at month 8 was reported to the Executive Committee on 17 December 2025.						
Recommendation	The Board is asked to note the report and discuss any actions in relation to the financial position.						

NHS
South East London

SEL ICB Finance Report

Month 8 2025/26

Note Regarding Month 8 Financial Reporting – Post ISFE2 Implementation

NHS South East London

- A new national financial ledger system (ISFE2) was implemented across all ICBs and NHSE on 1st October 2025.
- Finance teams had no access to the new ledger before 1st October, nor was there any access to a test environment.
- Month 8 financial reporting has been undertaken at a Place level and shared with ADoFs and PELs, following a review of the month 7 reporting where no major issues were found. The year-to-date balances are recorded on the ledger, but the forecast outturn figures are still not being transacted on the ledger as the national module is still not working as expected. This is understood to be the case for month 9 as well as the national NHSE team are still working to find a solution.
- NHS England have amended ICB financial reporting requirements with many items within the current monthly financial return not being required in Month 8, although the reporting requirements have increased from month 7 with elements such as MHIS being required this month. The forecast outturn is still needed to be manually adjusted in the IFR for month 8, at an aggregate level.
- At month 9, there will be the requirement to complete a set of draft accounts, and we have been advised that NHS England and SBS are working on the templates to ensure a smooth delivery and these are expected to be available in the next few days.

Contents

NHS South East London

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 8, 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. There have not been any major movements in the run rate to report this month. Within this reporting, the ICB has delivered **£40,202k** of savings YTD compared to the plan value of £39,035k.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year-end after the "equalisation" (implementation of the risk-share) of the delegated primary care budgets and for 2 boroughs non-recurrent support in respect of the new ICES contracts.**
- The ICB is showing a YTD underspend of **£1,527k** and forecast out-turn position of an underspend of **£2,004k** against the **running cost allowance.**
- All other financial duties have been delivered for the year to month 8 period.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	3,878,993	3,878,993	5,794,877	5,794,877	
Operating Under Resource Revenue Limit	3,878,993	3,878,993	5,794,877	5,794,877	
Not to exceed Running Cost Allowance	20,497	18,970	30,746	28,742	
Month End Cash Position (expected to be below target)	5,600	2,958			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	99.9%			
95% of non-NHS creditor payments within 30 days	95.0%	98.6%			
Mental Health Investment Standard (Annual)			537,494	549,166	

2. Executive Summary

NHS South East London

- This slide summarizes the month 8 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 following slide sets out the month 8 financial performance for each budget line and place.
- The ICB's financial allocation as at month 8 is **£5,794,877k**. In month, the ICB has received an additional **£1,091k** of allocations. The additional allocations related to £500k for National Recovery Support, £499k for Wayfinder funding to support the PEP NHS App for Bromley and £92k for GIRFT for Community MSK. **As at month 8, the ICB is reporting a year to date (YTD) break-even position.**
- Due to the routine time lag, the ICB has received six months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£2,195k overspend YTD across PPA and non PPA** budgets. The overspend continues to be variable across the Places.
- The continuing care financial position is **£267k underspent** at month 8, which is an improvement on last month. The boroughs which are most impacted with overspends are Lewisham, Bromley and Greenwich (to a much lesser degree) which is a continuation of the trend from last year. Lambeth, Southwark and Bexley are all reporting underspends this month.
- The YTD position for **Mental Health services** is an overall **overspend of £6,337k** which is a deterioration on last month. This is generated by pressures on cost per case services with all boroughs impacted. **ADHD and ASD assessments** are also a significant financial pressure, with both activity and costs increased significantly in this financial year. The new referral centre arrangements for these assessments is now live and started at the beginning of November.
- Places are also being impacted by the current contractual difficulties in the **community home equipment contract**, led by the London consortium. A full year cost pressure of **circa £1,500k** has been included in financial positions. Contractual changes were implemented from August.
- 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 left the ICB in June, which leaves a small number of impacted staff who remain at the ICB.
- Two places are reporting overspends YTD at month 8 – **Bromley (£232k)** and **Lambeth (£8k),** with a break-even position being forecast by all. Places have been tasked to identify additional mitigations to offset financial risks, to ensure delivery of their financial plans.
- In reporting this month 8 position, the ICB has delivered the following financial duties:
    - Underspend of **£1,527k YTD** against its management costs allocation, with the monthly cost of displaced staff being charged against the provision.
    - 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 8 the ICB is reporting an overall **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. Summary of Financial Performance at Month 8

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance									
Acute Services	54	255	(1)	0	(17)	(14)	(203)	-	**73**
Community Health Services	26	439	40	(0)	4,502	1,419	203	-	**6,629**
Mental Health Services	(168)	(752)	(1,333)	(1,258)	(1,263)	(1,499)	(0)	(64)	**(6,337)**
Continuing Care Services	447	(959)	(15)	1,422	(1,131)	501	-	-	**267**
Prescribing	(435)	453	(1,065)	(365)	(1,531)	(1,101)	-	1,849	**(2,195)**
Other Primary Care Services	(24)	133	110	197	165	20	-	(81)	**520**
Other Programme Services	(0)	-	1,197	-	-	581	0	(5,327)	**(3,549)**
Programme Wide Projects	(0)	-	1,067	-	(933)	6	-	199	**338**
Delegated Primary Care Services	168	684	(336)	(197)	195	(44)	-	(431)	**40**
Delegated Primary Care Services DPO	-	-	-	-	-	-	0	1,507	**1,507**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	675	**675**
Corporate Budgets	181	199	133	(5)	13	191	-	1,320	**2,032**
Total Year to Date Variance	**249**	**452**	**(203)**	**(205)**	**(0)**	**61**	**0**	**(353)**	**0**
Equalisation of P/Care	**(168)**	**(684)**	**334**	**197**	**-**	**44**	**-**	**277**	**-**
Total Year to Date Variance	**81**	**(232)**	**131**	**(8)**	**(0)**	**105**	**0**	**(76)**	**0**

- As highlighted on the previous slide, the ICB reported an **overall break-even position at month 8.**
- Key areas of overspend were in mental health services (£6,337k) and prescribing (£2,195k) with offsetting underspends in community, primary care services and corporate budgets.
- Two places (Bromley and Lambeth) reported overspends year to date.
- A **break-even position is being forecasted at year-end**, both individually at a place level and in aggregate across the ICB.

South East London
Integrated Care System

South East London ICS Finance Report – Month 8

Executive Summary

Organisation	Year-to-date			Full Year		
	Plan Incl. DSF	Actual	Variance	Plan Incl. DSF	Forecast	Variance
	£m	£m	£m	£m	£m	£m
GSTT	(24.8)	(29.0)	(4.2)	0.0	0.0	0.0
KCH	0.4	2.0	1.6	0.0	0.0	0.0
LGT	0.0	0.1	0.1	0.0	0.0	0.0
Oxleas	0.0	0.1	0.1	0.0	0.0	0.0
SLaM	1.0	1.0	0.0	0.0	0.0	0.0
Provider total	**(23.4)**	**(25.8)**	**(2.4)**	**0.0**	**0.0**	**0.0**
SEL ICB	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
System total	**(23.4)**	**(25.8)**	**(2.4)**	**0.0**	**0.0**	**0.0**

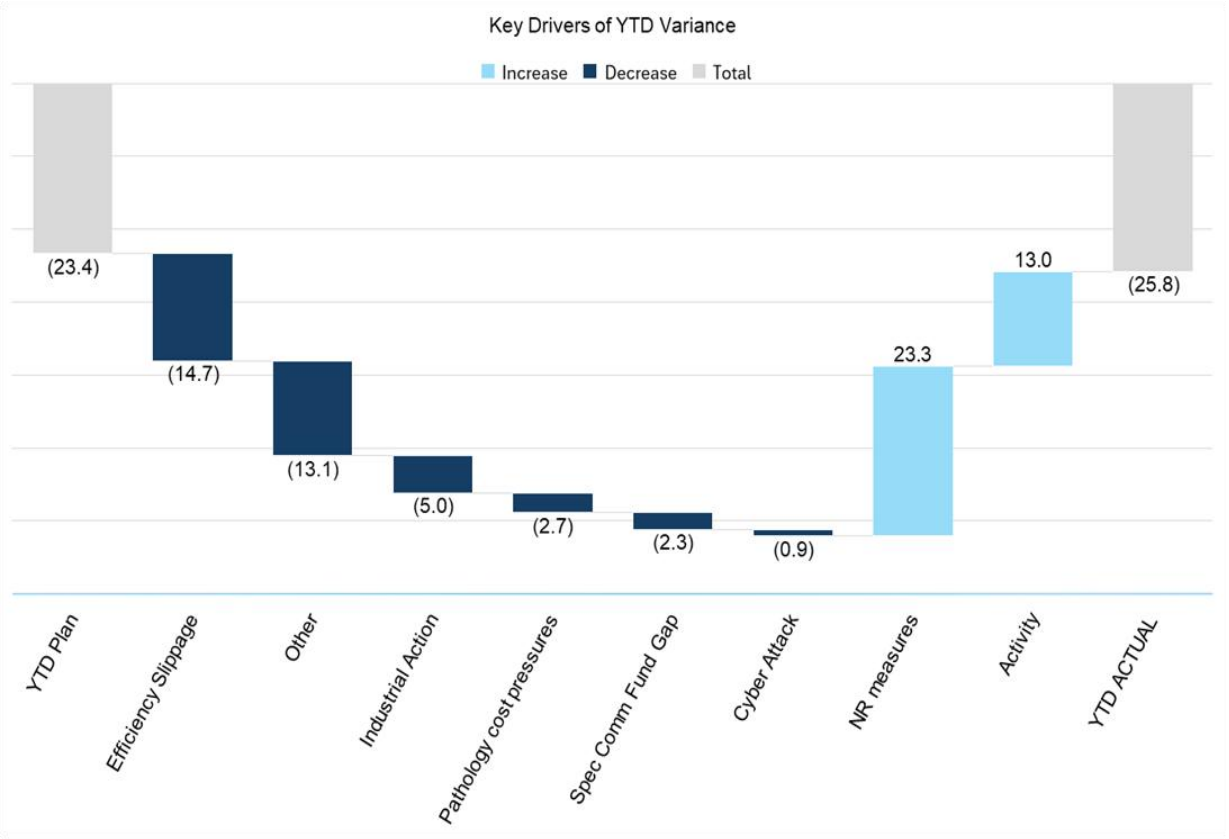
- At month 8, SEL ICS is reporting a **YTD deficit of (£25.8m), £2.4m behind plan.** This represents an overall **£0.3m deterioration** compared to month 7.
- GSTT are reporting a YTD deficit of **£29.0m, £4.2m** adverse to plan. This represents an adverse movement of **£1.5m** in-month.
- KCH are reporting a **YTD surplus of £2.0m**, **£1.6m ahead of plan and an improvement of £1.1m** compared to month 7 driven by activity catchup and run rate improvement.
- All other organisations are reporting either a YTD break-even position or a slight surplus of £0.1m.
- **At month 8, the ICS system forecast remains at a break-even financial position.**

Analysis of ICS Month 8 YTD Position

At Month 8, SEL ICS is reporting a **year-to-date deficit of (£25.8m), which is £2.4m adverse to plan.** This is a deterioration of £0.3m compared to Month 7. The position is driven by the following:

- Net efficiency slippage across providers totalling £14.7m, comprising:
  - £8.4m at KCH – mainly on delays in planned private patient income schemes (£5.1m) and clinical transformation schemes (£3.3m).
  - £4.5m at LGT – timing difference of existing schemes compared to plan.
  - £2.0m at SLaM – slippage against plan with gap being bridged.
  - Partially offset by £0.2m over-delivery at GSTT.
- YTD impact of the previous 2 industrial actions is £5.0m; £2.0m at KCH, £1.8m at LGT, £1.13m at GSTT, and £0.07m at Oxleas.
- Pathology year-to-date pressures of £2.7m at GSTT due to delayed price reductions.
- Other cost pressures at GSTT:
  - £2.3m – specialised commissioning funding gap
  - £0.9m – legal costs related to prior-year cyber attack
- £13.1m other impacts; £14.0m balance sheet flex timing at GSTT offset by £0.9m non recurrent mitigations across providers.

The above were offset by £13.0m increased activity income; KCH -£11.0m and £2.0m at LGT. There were non recurrent mitigations of £23.3m applied at GSTT.



South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**General Practice Variation and Resilience**					
Meeting date	28 January 2026	Agenda item Number	10	Paper Enclosure Ref	J	
Author	Holly Eden, Director of Delivery – Neighbourhoods and Population Health					
Executive lead	Clare Ross, Head of Primary Care					
Paper is for:	Update	x	Discussion		Decision	x
Purpose of paper	This paper outlines for the Board, variation within access, experience and outcomes across general practice, drivers for variation and broader sustainability challenges and the proposed SEL-wide support and oversight model					
Summary of main points	General practice across South East London faces sustained pressure with rising demand, flatlining workforce and strain within the GP Partnership Model. Local and regional neighbourhood frameworks highlight the centrality of general practice sustainability for neighbourhood-based care. These pressures could threaten the stability of those models and risk widening inequalities, including increasing unwarranted variation in access, experience and outcomes for our population. Significant variation exists across general practice within South East London. Whilst we have lots of activity and process data available across general practice that demonstrate variation, it is not always easy to understand where variation may be warranted due to population need and therefore to effectively tailor our efforts. NHSE have set requirements for ICBs around general practice variation that we are regularly assured against. We are required to demonstrate suitable contractual rigour within our approach. Locally we recognise that variation has multiple, complex drivers some of which are at practice level, and some at a system or national level. These drivers include funding distribution, workforce pressures, administrative processes, digital maturity and commissioning approaches SEL ICB has developed a structured methodology to identify and assess variation, and to ensure a standardised and proportionate response to variation that aligns support with contractual levers where appropriate. We have also developed, through the Neighbourhood Based Care Board, a tiered model of sustainability support (universal, shared challenges and bespoke) to enable proactive, equitable sustainability and resilience support for all practices that will help to address some of the drivers of variation. Even with sustained action to reduce unwarranted variation, demand for general practice services is rising at a greater rate than capacity increases. As demand for care grows, we need to consider how we support an effective balance between convenient access and continuity of care within general practice. This will require us to think about general practice access through a broader lens that considers utilization, effectiveness and equity. It may also require us to be brave and explore					

	alternative access models for people with lower health need who value convenience and speed over continuity of care – being cognisant of the impact that new models would need to have on funding and resourcing for practices if they are going to be effective. This work needs to be taken forward through a multi-disciplinary approach that brings together place leadership, strategic commissioning expertise, end to end care pathway specialism and primary care leadership.					
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 attached paper outline significant variation in access, experience and outcomes across South East London, with some equalities analysis. A deep dive is recommended to consider this further					
Financial Impact	None at this stage. However, challenges with the existing approach to funding general practice are noted in the report as a potential driver for variation.					
Public Patient Engagement	There has been significant public engagement at a place and regional level on general practice services. The report also include key data on patient experience of services.					
Committee engagement	The Sustainability Offer has been designed and endorsed through the Neighbourhood Based Care Board					
Recommendation	It is recommended that the Board: 1. Sponsor a deeper dive into variation within general practice to: a.) ensure that we understand more fully what variation may be warranted, and support us in strengthening our approach to identifying unwarranted variation (based on the data available to us) b.) consider how we maximise and best direct our existing resources to support practices to reduce unwarranted variation (e.g. CESEL and our sustainability core offer); and c.) identify further steps that we could take as commissioners to support practices to reduce unwarranted variation where it exists. 2. Approve the SEL-wide approach to identifying and managing variation in the delivery of services across our general practice contractors. 3. Endorse the SEL-wide sustainability support offer developed via the Neighbourhood Based Care Board, noting a shared commissioning approach across the 6 places and SEL teams taking place to implement the offer in 26/27 4. Consider its shared appetite for developing alternative models of care that respond to people with lower levels of health need who value convenience and speed of access, and considering the cross-organisational scope and impact					

	and agree whether an MDT group should be established to scope this work further during 2026/27

South East London Integrated Care System

NHS South East London

Primary Care – General Practice Variation and Resilience

January 2026

Introduction

PURPOSE OF THIS PAPER

- To provide a **system-wide assessment of the current state of general practice**, including pressures, variation, and sustainability challenges.
- To present a **proposed approach for reducing unwarranted variation, strengthening resilience, and embedding general practice within neighbourhood-based care** models.
- To outline the **case for coordinated SEL-level action**, including why a refreshed support model is required in local, London, and national contexts.
- Set out **what we are asking of the Board** in relation to endorsement, direction, and next steps.

WHY IS THIS IMPORTANT

- Locally we have **variability of access, experience and outcomes for our population** that is in part driven by growing pressures across the general practice sector
- At a London Level, the **Neighbourhood Health Service Case for Change** set out challenges with general practice sustainability which would impact its ability to be the **bedrock of neighbourhood care**
- At a National level, the ICB has **specific requirements related to general practice variation that we are regularly assured against**.

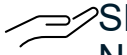
STRUCTURE OF THE DOCUMENT

Executive Summary and recommendations for the Board – Provides a summary of the key points within this paper and recommendations on actions **(slides 3 - 5)**

Context and Case for change – Demand, workforce, inequalities, and system pressures driving the need for action **(slides 6-10)**

Understanding Variation and its Drivers across General Practice – Data insights, impact on access, outcomes and experience, and identification of practices needing support **(slides 11-17)**

Meeting our ICB Requirements to Manage Variation – Sets out a methodology for identifying, assessment and managing variation in general practice services **(slides 18 – 22)**



Supporting Resilience and Sustainability – Outlines the SEL Sustainability Offer developed through the Neighbourhood Care Board **(slides 23 – 30)**

Adopting New Care Models – Balancing convenience of access with continuity of care and implications for neighbourhood working **(slides 31 - 35)**

South East London Integrated Care System

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Executive Summary

Key Messages

- South East London's general practice is under sustained pressure, with demand rising faster than capacity.
- Workforce levels have stagnated while nearly a quarter of staff intend to leave, increasing instability.
- Significant variation exists in access, experience and outcomes, disproportionately affecting deprived areas.
- These pressures threaten the stability of neighbourhood-based care models and risk widening inequalities.
- A consistent, system-wide approach is recommended to reduce unwarranted variation.
- This includes a structured data-drive framework for identifying, assessing and responding to practices with higher levels of variation, as well as escalation routes including contractual levels where appropriate
- We have also co-produced a tiered support model for broader general practice sustainability covering universal support, shared challenges and bespoke packages that will ensure proportion, equitable support for all practices
- The proposed model is anticipated to strengthen sustainability and reduce reliance on reactive performance management

Summary of recommendations to the Board

It is recommended that the Board:

1. **Sponsor a deeper dive into variation within general practice to:**
   - **a.) ensure that we understand more fully what variation may be warranted, and support us in strengthening our approach to identifying unwarranted variation (based on the data available to us)**
   - **b.) consider how we maximise and best direct our existing resources to support practices to reduce unwarranted variation (e.g. CESEL and our sustainability core offer); and**
   - **c.) identify further steps that we could take as commissioners to support practices to reduce unwarranted variation where it exists.**
2. **Approve the SEL-wide approach to identifying and managing variation in the delivery of services across our general practice contractors.**
3. **Endorse the SEL-wide sustainability support offer developed via the Neighbourhood Based Care Board, noting a shared commissioning approach across the 6 places and SEL teams taking place to implement the offer in 26/27**
4. **Consider its shared appetite for developing alternative models of care that respond to people with lower levels of health need who value convenience and speed of access, and considering the cross-organisational scope and impact and agree whether an MDT group should be established to scope this work further during 2026/27**

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Context and Case for Change

General Practice Under Strain

South East London Integrated Care System

- **South East London's general practice is under strain.** Despite deep commitment from our workforce, a combination of rising demand, systemic inequities, and workforce attrition has left general practice stretched and vulnerable.
- **The general practice workforce has also flatlined in recent years**, in the face of a growing population and high burnout and retention challenges.
- **And with nearly 25% of staff indicating they intend to leave***, action is required to create a more sustainable, equitable, and attractive environment for primary care.
- Across London, **a 20% reduction in practices over a decade**** reflects both consolidation and systemic failure. The accompanying administration is also taking away from strategic thinking and transformation.
- **There is uneven access to resources and workforce, differences in digital maturity and high variation in care between practices,** as well as a lack of appetite for taking on the risk of partnerships from younger GPs. There is also variation in how engaged practices are, particularly around the neighbourhood agenda and accessing available support.
- **This echoes wider qualitative concerns of a sector in distress.** Indications from the Fuller Report suggest that South East London will experience a further acceleration of these trends over the next ten years unless there is significant change in how primary care is delivered.
- **CQC & support ratings:** 7.4% of practices are rated as "Requires Improvement" overall; over 15% have at least one underperforming domain. Practices report needing most help with high-frequency users, demand and capacity data, and developing a shared vision.

Why does this matter for neighbourhoods?

General practice is unique as a place where we register a population and provide preventative and proactive care, with continuity for those who need it. Thus, general practice is well-placed to serve as a strong foundation for neighbourhood working.

Neighbourhoods need to wrap around GPs and support care for their registered population. The GP role needs to evolve as they become part of neighbourhood multi-disciplinary teams (MDTs).

The interface between general practice and social care needs to improve and acute clinicians will also need to be involved more in the health of the populations they serve rather than just being involved in reactive care.

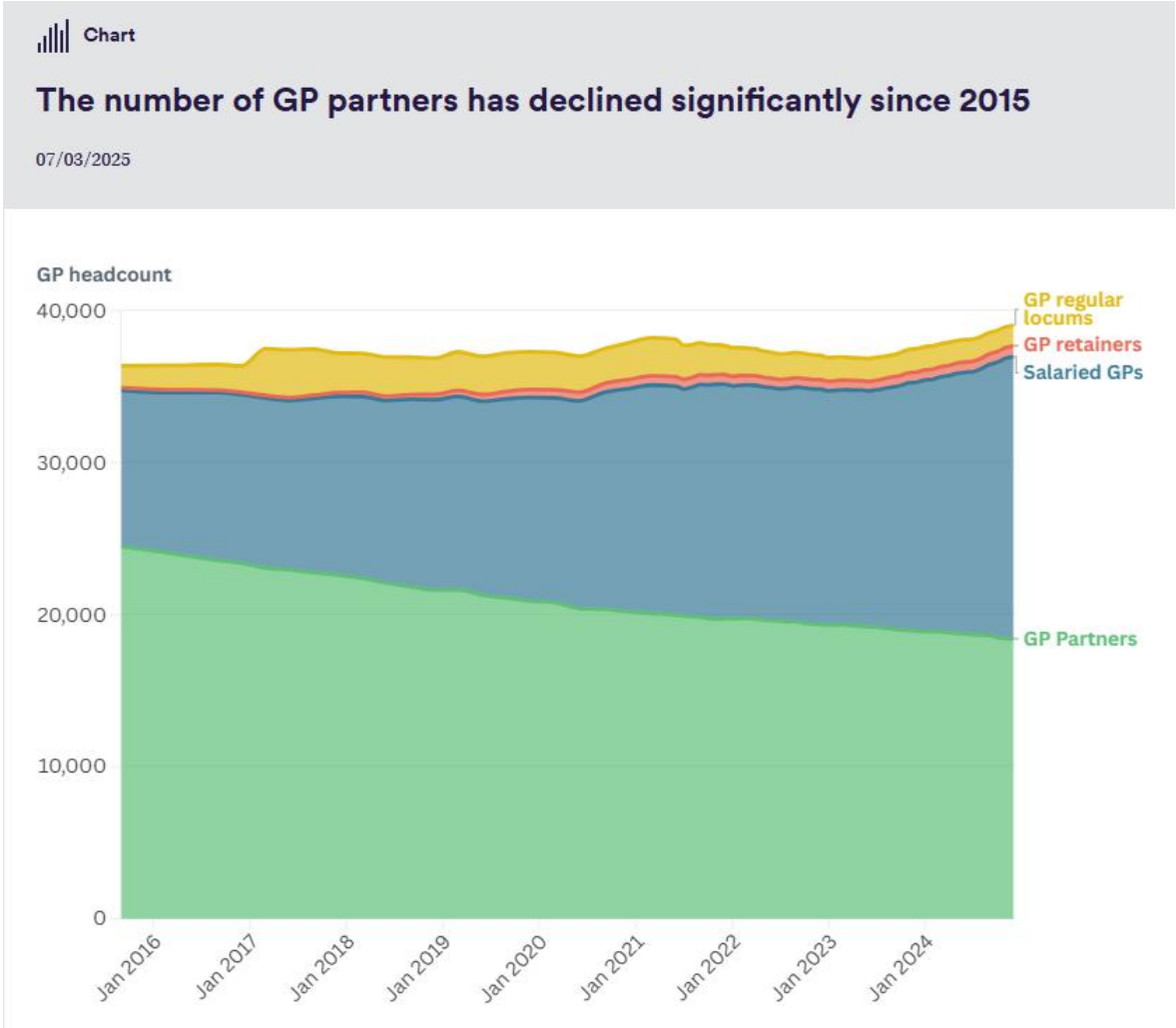
In some cases, practices may need even more hands-on support. Integrators and PCNs/GP Feds could be a source of that support providing e.g., more shared back-office functions or operational support.

**SEL Workforce Development Hub Report May 2025*

** NHS England — London » The Case for Change: Executive summary

Longer term sustainability of the general practice model (1 of 2)

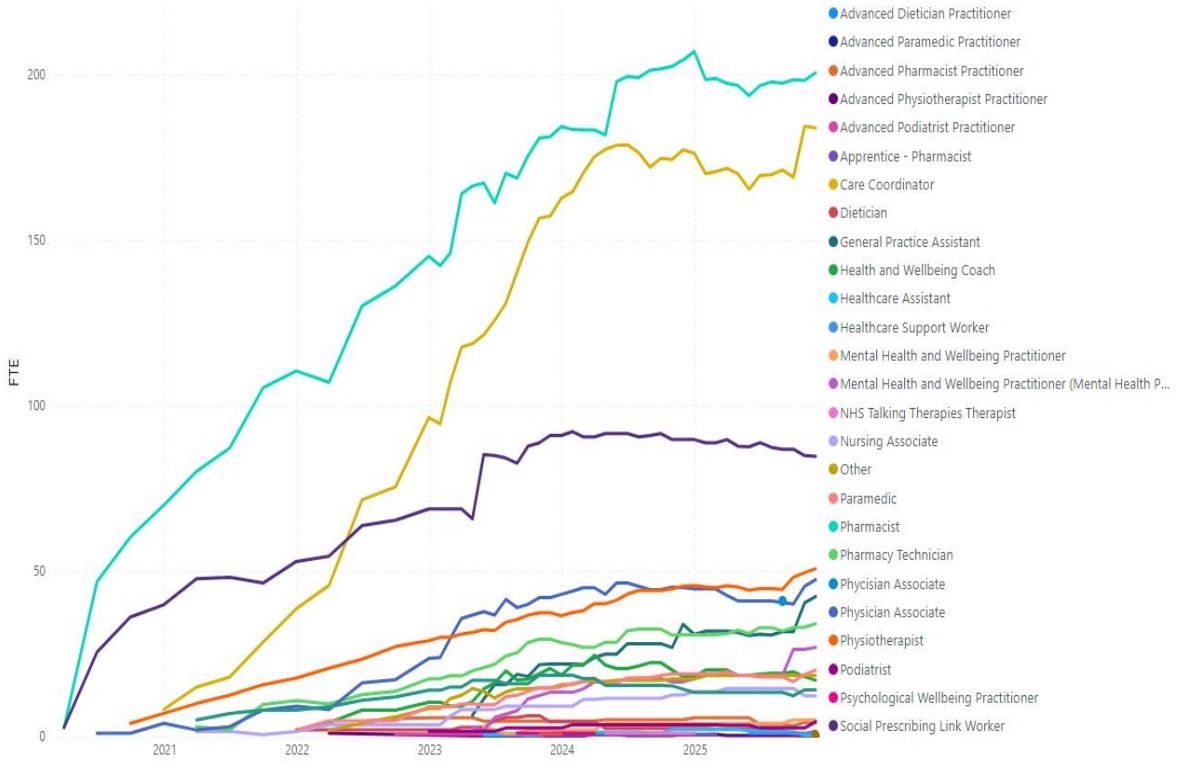
- The GP Partnership Model predates the formation of the NHS. GP partnerships are independent autonomous businesses, contracting with NHS England – via delegation to integrated care boards – to deliver GP services. Partners operate as self-employed contractors, delivering NHS services to contractual specifications.
- Alongside clinical work, GP partners are business owners. They employ staff and manage the finances, estates and administration associated with running a practice. Most GP partnerships are unlimited liability partnerships. This means that while partners are entitled to a potentially unlimited share of business profits, they are also personally responsible for all financial liabilities such as losses and debts.
- The GP Partnership Model is showing considerable strain, which has been worsening over time. Nationally:
  - the number of GP partners has dropped by more than a quarter (29.1%) in the last decade, with the largest falls among GPs aged under 40 (61.3%). More partners work in wealthier parts of the country.
  - This trend is continuing. Between June 2024 and September 2025, the number of FTE partners declined by 4.1% and the number of partners under the age of 40 declined by 17.0%*



*The partnership model in general practice predates the NHS. Is now the time to change it? | Nuffield Trust

Longer term sustainability of the general practice model (2 of 2)

- Alongside the challenges facing the GP partnership model, there have also been considerable changes to the funding of general practice services since the introduction of Primary Care Networks in 2019 with an increase over time in the proportion of spend on general practice services that is distributed via Primary Care Networks.
- In 2022/23, more than 11.3% of government investment in general practice was directed through Primary Care Networks, up from 2% in 2019/20*. It should be noted that this comes at a time of increased funding overall.
- The greatest share of PCN funding has been used to support the diversification of the staffing model within general practice via the Primary Care Network “Additional Roles Reimbursement Scheme”. This has particularly increased recruitment of pharmacists, care coordinators and social prescribing link workers as part of the primary care team.
- PCN funding is subject to tighter controls nationally than the bulk of general practice investment, and there are national limitations on the types and numbers of some roles that PCNs can recruit to. Until 2024, GP roles were not able to be recruited to.
- There has been significant variation in how PCNs have chosen to deploy new roles, some operating at practice level and others at scale.
- Tensions between practices and Primary Care Networks seem to be on the rise. Within South East London, we have managed several intra-PCN disputes requiring mediation or particular support. Local Medical Committees have anecdotally noticed a similar trend.
- It is currently unclear how new neighbourhood contracting approaches will impact on this changing landscape. There is certainly nervousness across some of the profession regarding Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) contract forms and what these will mean for the GP Partnership Model.
- *Performance Tracker 2025: General practice | Institute for Government



Appointments in General Practice – Facts and Figures

Despite the pressure and strain, general practice remains highly productive delivering increased activity and providing significant support to our population across South East London. This is being achieved during a period of uncertainty and change for the sector as new care models develop including the introduction of total triage, greater digital care and the implementation of neighbourhood-based care

In 2024/25, general practices in South East London delivered **9.16m appointments**. This represents an average of **2.4 appointments per registered patient**.

Up to and including November 2025, general practice in South East London has delivered **6.3 million appointments**. This is a **3.7% increase on the same period last year**.

40.7% of appointments **are longer length appointments** (i.e. exceed 10 minutes) compared to 37.9% nationally

86.8% of appointments in SEL are **delivered within 2 weeks** (compared to 80.5% nationally)

44.1% of appointments in SEL are **delivered on the same day** (compared to 43.1% nationally)

Greater use of telephone appointments compared with the national average, and lower face to face appointments.

Strengthening general practice and tackling the issues impacting on its sustainability will both ensure it is able to act as the bedrock for neighbourhood care whilst reducing unwarranted variations in access, experience and outcomes

Source: National General Practice Appointments Data

South East London Integrated Care System

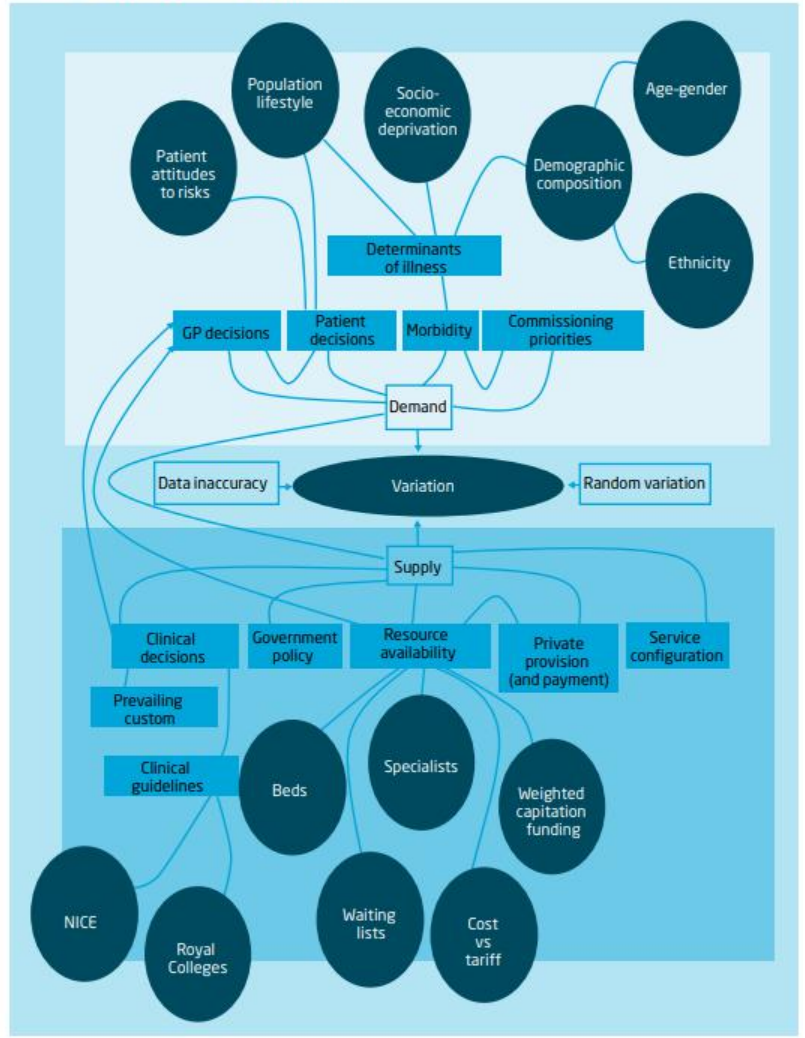
NHS South East London

Understanding variation and its drivers across general practice

Variation and our requirements as an ICB

- Variation can either be warranted - due to patient need or other factors like patient-directed decision-making - or unwarranted - driven by a range of complex interlinking factor.
- ICB's are being required to take greater steps to manage down variation in primary care, particularly general practice. Within the 2025/26 operating plan guidance, ICBs were required to put in place action plans to "improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation". This requirement will continue and increase in importance nationally within 2026/27.
- Whilst various tools exist to support ICBs to identify variation across general practice at both a national and local level, the tools are relatively blunt using predominantly activity or process measures to understand variation. There are significant underlying data quality issues and limited ability to understand whether variation is warranted due to population need
- Once unwarranted variation has been identified, managing down that variation is equally complex given the significant number of factors that may drive the variation identified. The diagram opposite (King's Fund) provides a useful visual as to the complexity of this issue.
- Within general practice, often the complex mix of challenges driving variation are also impacting on resilience and future sustainability of the practice and therefore putting in place the right support to tackling the causes of variation is a key part of both supporting the sustainability of general practice services across South East London whilst also improving access, experience and outcomes

Figure 1 Mapping causes of variation



SEL variation in access, experience and outcomes within general practice

Patient Experience (2025 GP Patient Survey)

- Our patients use more in-person and NHS App routes to access than nationally – noting this data precedes implementation of new online access requirements.
- Patient experience of access is broadly in line with national levels, however there are some areas where we fall below national averages:
    - Mixed digital adoption – we perform well for online booking and records access and are weaker for repeat prescriptions. Digital ease-of-use is slightly lower than the national average.
    - We perform significantly below national averages for continuity of care, both in patients being aware they have a named GP and on being able to book appointments with their named GP.
    - We perform slightly lower on patient experience of contact, especially clarity about next steps, i.e. is the patient clear on how their query is going to be dealt with
- The SEL results suggest that both admin processes and workforce pressures are impacting patient experience, with high variation between practices evident

Access (General Practice Appointment Data and internal BI dashboards)

- If you exclude specialist practices (e.g. care home practices) the number of appointments offered per 1000 patients ranges significant by practice. In October 2025 this ranged between 217 and 787 per 1000 patients. It should be noted that data quality is poor, particularly the coding and mapping of activity to different appointment groups so you are not comparing like for like, but this does not negate the fact that significant variation in access does exist
- Appointment usage across SEL is broadly proportionate to population amongst people of white, black, and Asian ethnicities (ranging from an average of 2.84 to 3.31 appointments per patient per year within these groups). There is greater variation when you consider the ranges across our 6 places. Data demonstrates a markedly lower appointment usage of our population coded as "other" (average of 2.12 appointments per person) or "unknown" (average of 1.87 appointments per person).
- 59.5% of appointments are used by women, who make up 50.16% of our registered population. The share of appointment usage does not seem to differ significantly by IMD, this is despite the likelihood that will be high levels of health need within our most deprived areas.

Outcomes (internal BI dashboards)

- There is marked variation in outcomes across practices as well. Some of this variation may be warranted or explainable due to differences in population health need, but beyond this significant variation remains. Commissioning approaches can help to address variation in outcomes. Across SEL we commissioned a diabetes scheme within general practice that incentivized overall achievement of key indicators at a Primary Care Network levels, alongside reduced intra-PCN variation in achievement at PCN level. This increased our overall SEL achievement from 63.8% in 2022/23 to 72.5% in 2023/24 whilst reducing variation within and across PCNs.

Variable alignment of resourcing to need

277,000 patients are recurrent attenders in general practice in SEL, with 10 or more contacts in a year. 41% of these patients are rated as “green” for health need (i.e. patients that are generally well).

65,000 patients are classified as high recurrent attenders in general practice in SEL, with 20 or more contacts with general practice in a year. 27.5% of these patients are rated as “green” for health need.

7,000 patients are classified as very high recurrent attenders in general practice, with over 40 contacts with general practice in a year. 17% of these patients are rated as “green”.

Higher rates of anxiety, depression and irritable bowel syndrome are identifiable within patients with higher use of general practice services.

Data Source: Ardens

Variation in workforce

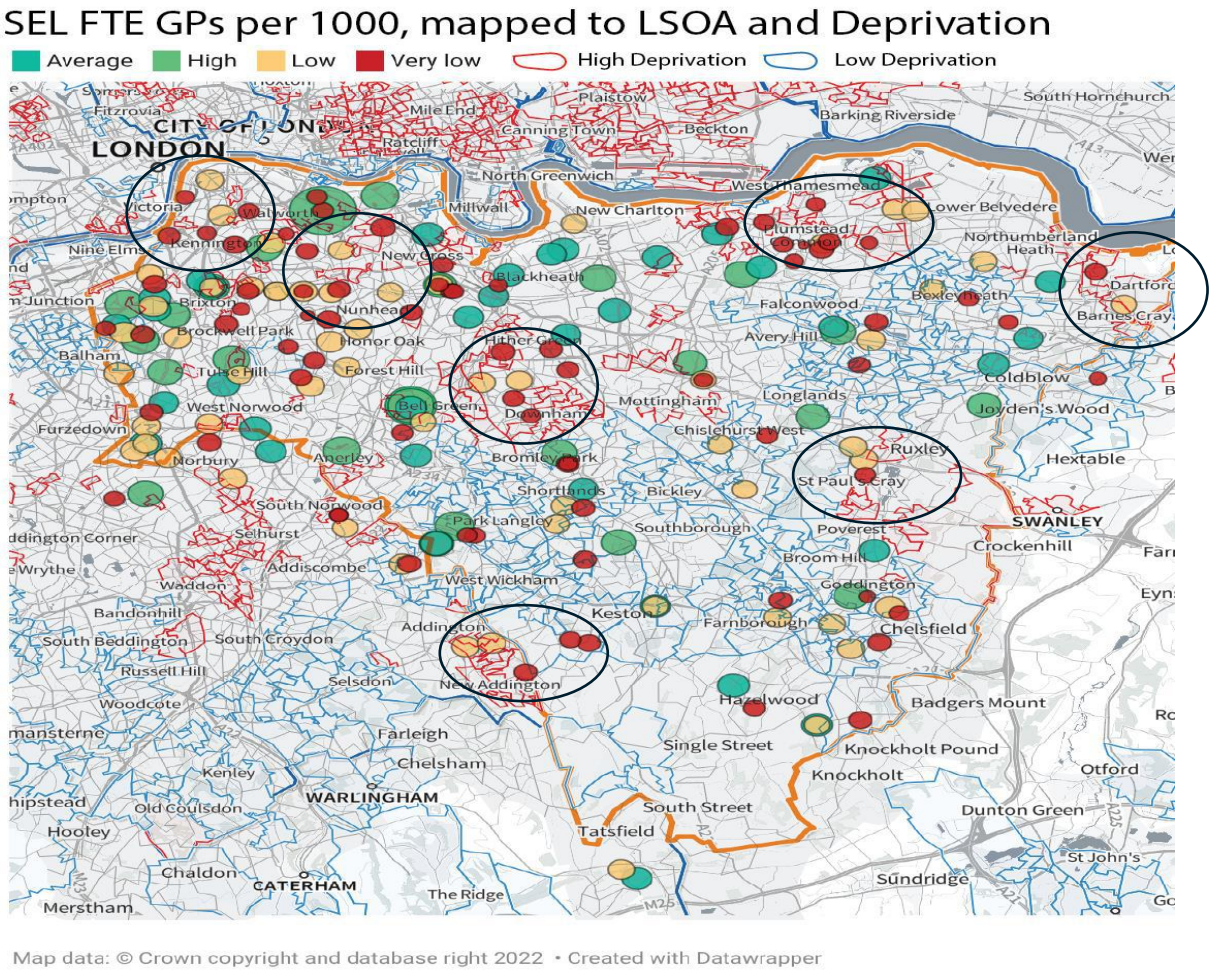
Whilst overall GP numbers are on the rise, there is **a body of evidence nationally that areas of higher deprivation tend to have lower numbers of whole-time equivalent GPs per patient, with** 38 FTE qualified GPs per 100,000 weighted patients in the most deprived decile, an approximately 49 FTE GPs per 100,000 weighted population in the least deprived decile.

Research completed by the Royal College of GPs in 2024 highlighted that **London has the greatest number of registered patients per fully qualified GP in the country**, making this issue particularly acute.

Our local data demonstrates pockets of high deprivation with lower FTE GPs per head of population. This issue is driven by a number of causes, including:

- Deprivation is associated with **greater job pressures for GPs**, including managing complex patients
- **Recruitment challenges** across all areas (partners, salaried and locum GPs) which can contribute to burnout and exacerbate retention problems
- **Funding disparity** with practices in deprived areas receiving less funding that those in the least deprived areas which impacts on the number of staff that can be recruited to meet need. This is partly explained by the Carr-Hill formula (the formula used to define payment per weighted patient) which does not fully adjust funding to account for deprivation, potentially underrates the needs of young patients – directing more funding towards older patients and is based on out of date data sources for some metrics (including staff costs and population density).
- The **quality of estate**, which can drive limitations in the physical space available in some areas to increase service provision

There is a correlation between the disparity between GP workforce and deprivation and **variation in access, experience and outcomes for our population**



Data Source: National Workforce Reporting System
Maps via SHAPE

Variation in a general practice services commissioning

Prevention, screening, vaccs and imms	Alcohol Intervention					Yes	
	Enhanced Prevention Scheme				Yes		
	Obesity (Adults)	Yes					
	Obesity (Children)	Yes				Yes	
	Screening - Bowel and Breast	Yes	Yes		Yes	Yes	
	Childhood Immunisations		Yes	Yes			Yes
	Flu Vaccination		Yes		Yes		Yes
	Cytology			Yes			
	HIV screening				Yes		
Diagnostics	Phlebotomy		Yes	Yes		Yes	
	Ambulatory Blood Pressure (self-care)						Yes
	Atrial Fibrillation (manual pulse checks)						Yes
Long Term Conditions and planned care	Blood Pressure Management (CHD, Hypertension, Stroke/TIA)						Yes
	Chronic Pain				Yes		
	Diabetes - Pre-diabetes Annual Review						Yes
	Diabetes Management			Yes	Yes		Yes
	Planned Care Pathways				Yes		
	Pre-diabetes Annual Review						Yes
	Referral Management	Yes		Yes		Yes	
	Wound Care	Yes	Yes	Yes		Yes	Yes
Integration / Care Coordination	Care Planning (Univeral Care Plan)	Yes	Yes				
	Care Home Supplementary Support	Yes					
	Frailty and End of Life	Yes				Yes	
	Frequent Users of General Practice	Yes					
	Housebound Annual Reviews			Yes			
	Integrated Case Management / MDT working		Yes			Yes	
	Long Term Conditions				Yes		Yes
	Pharmacy First+			Yes			
Mental Health and Learning Disabilities	ADHD		Yes				
	Dementia and Serious Mental Illness	Yes					
	SMI Health Checks		Yes		Yes		
Resilience, infrastructure and support	Minimum Practice Income Guarantee Equalisation			Yes			
	Patient Experience	Yes				Yes	
	Practice Development - Planning and Implementation		Yes				
	Quality and Safety				Yes		
	Safeguarding	Yes	Yes	Yes	Yes	Yes	Yes

Specific services commissioned from general practice, outside of the core general practice contract vary across South East London. Where multiple places are commissioning services within a common area there will often be variation in the scope and specification of schemes as well as price, and measurement.

Some of the variation in service offer is driven by population need and alignment to broader commissioned offers through – primary care at scale organisations, secondary care, community and the VCSFE. However, other drivers for variation do exist - including variation in available investment at place level and independent decision-making

The variation in offer and approach, particularly where we have shared population need across the whole of South East London can pose challenges in enabling a.) effective end to end pathways of care for patients, and b.) a strong foundation for consistent neighbourhood models.

As we move forward as an ICB, we need to move to increasingly collaborative and coordinated commissioning of primary care (including general practice) aligned to population need, our 5 year strategic commissioning plan and care pathways.

*Note that additional services relating to medicines management in general practice are currently commissioned but have been excluded as there is a separate piece of work underway to develop a consistent medicines management offer across SEL. Services currently in place include those related to specific drug categories (DMARDs, anticoagulants, insulin etc) and specific care pathways (e.g. gender reassignment)

Key Take-Aways and Recommendations

- The high-level data outlined in this pack demonstrates that significant variation in general practice experience, access and outcomes exists across South East London.
- The next section sets out our approach to managing down variation. This articulates that drivers of variation at a practice-level will include differences in resourcing (particularly workforce), administrative and clinical processes and decision-making. More broadly at a system and national level drivers may include differences in commissioning priorities and approach and challenges in aligning funding to need.
- **It is recommended that the Board sponsor a deeper dive into variation within general practice to:**

  a.) ensure that we understand more fully what variation may be warranted, and support us in strengthening our approach to identifying unwarranted variation (based on the data available to us)

  b.) consider how we maximise and best direct our existing resources to support practices to reduce unwarranted variation (e.g. CESEL and our sustainability core offer); and

  c.) identify further steps that we could take as commissioners to support practices to reduce unwarranted variation where it exists.

South East London Integrated Care System

NHS South East London

Meeting our ICB requirements to manage variation within general practice

Reducing variation across general practice

NHSE have set out requirements for the ICB to reduce general practice variation, including expectations that ICBs will increasingly use contractual levers, under our delegated commissioning responsibilities, to achieve this.

Using national methodologies, we have **20 practices which demonstrate significant levels of variation** across key domains (with workforce and vaccination and screening rates particularly driving this) and we are regularly assured on our approach to reducing this variation.

Locally, as set out previously, we recognise that variation is driven by a complex set of factors which are not all within a practice's immediate control. Over the last two years we have been testing and iterating our approach to aligning data-driven insight on variation with softer intelligence of resilience and sustainability challenges. A negative variation dashboard has been developed for SEL that covers five domains. Unwarranted Variation Dashboard - Power BI This is being further developed with other relevant indicators being added. This, alongside soft intelligence, and national data is used to identify practices requiring support. The five domains are:

Practices with high levels of variation that place them within the bottom 10% in SEL are flagged and will be given targeted, additional support. Given the national policy focus on general practice access and patient experience. Our initial focus will be on practices struggling with access, however wider indicators that could contribute to access issues will be considered.

Access – an example of reducing variation

Our approach will initially focus on supporting practices in accessing the help they need to improve. We have worked with general practice and all 6 places to develop a common and consistent support offer for general practice which is described further on in this pack. Whilst each place will work with their practices, a consistent process and approach across the ICB ensures all practices receive equitable support.

Whilst our first step must be support, we may face circumstances in which practices do not engage in the process or are unable to improve standards – in which case contractual levers will be considered including remedial breach processes.

Over time, this approach will then be extended to all domains. NHSE are expected to articulate further expectations of ICB's in this area over the next few weeks as part of the primary care action plan requirements for the next 3 years

Action following RAG rating

Red Rated Practices:-

A standardised approach will be taken for red rated practices:-

- An improvement plan will be required and the practice will be required to take part in a support programme from the SEL Workforce Development Hub who have been commissioned to undertake the following - *Working in partnership with ICS colleagues both at SEL and place level, the Primary Care Support Team will undertake targeted visits and interventions to explore barriers, share learning, and develop tailored improvement plans. Each visit will include preparation, on-site review, and follow-up, supported by clinical and management expertise.*
- Failure to take part in the support programme, may result in remedial action being taken against the practice.
- Further support from primary care, digital and IT colleagues may also be agreed as part of the improvement plan.
- If after six month, there is no improvement, contractual action may be taken.

Amber Rated Practices:-

Commissioners will agree with amber rated practices, a plan to reduce variation that supports practices to improve, according to their circumstances. Support could include but not be limited to:-

- Practice review of their own data to explore possible causes and solutions
- Targeted quality improvement support
- Peer learning and sharing best practice
- Workforce and capacity assessment to review staffing levels, skill mix and appointment availability in practices of concern
- Tailored support for digital tools
- Support practices to carry out their own patient survey data and support the development of an appropriate action plan
- If after six months there is no improvement, the practice will move to a “red” rating and the steps above implemented

Key Take-Aways and Recommendations

- We are required by NHSE to take a structured and consistent approach to reducing variation in the delivery of services by our general practice contractors. The requirements we must meet are articulated in operating plan guidance and the ICB is regularly assured on our delivery against stated plans.
- We have developed a consistent SEL wide approach to meeting these requirements, utilizing shared local data. This approach prioritizes providing targeted support to practice who are demonstrating the highest-level of variation, but also recognizes our need to meet our delegated responsibilities for the commissioning of general practices.
- Our approach will be tested through an access lens to start, before being broadened out to other domains.
- The next section sets out our approach to improving resilience and sustainability of general practice, given the multiple drivers of variation and the overall factors influencing the sustainability of the sector as a whole.
- **It is recommended that the Board approve the SEL-wide approach to identifying and managing variation in the delivery of services across our general practice contractors.**

South East London Integrated Care System

NHS South East London

Supporting resilience and sustainability

The benefits of support to system and practices

As set out previously, variance in access, experience and outcomes across general practice is driven by a complex set of factors which are often aligned to resilience and broader sector sustainability. A shared SEL-wide support offer is vital both for the system - to deliver resilience, equity, and better patient outcomes - and for practices themselves, who need practical, flexible help to manage pressures and plan for the future. A shared offer will also help secure the stability of general practice as the foundational bedrock for neighbourhood care.

System case for a support offer

- **Support resilience:** General practice is under sustained pressure. Without structured support, practices risk burnout, workforce loss, and service instability.
- **Improve patient care:** Enables practices to focus on what matters most - timely, safe, and equitable care.
- **Tackle variation and inequalities:** A system-wide offer helps level the playing field so patients across SEL receive consistent standards of access and quality.
- **Shift from reactive to proactive:** Prevents issues escalating into crisis by identifying and addressing challenges earlier.
- **Strengthen neighbourhoods and INTs:** Ensures general practice is confident and equipped to play its part in integrated models of care.
- **Show value and recognition:** Signals that the system values general practice, listens to its challenges, and invests in future sustainability.

Practice case for a support offer

- **Relieve day-to-day pressure:** Practical help with demand, data, and workforce issues, freeing up time for patient care.
- **Tailored to their reality:** Flexible support shaped by feedback and adapted to individual practice needs, not one-size-fits-all.
- **Invest in their teams:** Training and development that helps staff feel valued and retained.
- **Strengthen the business:** Support with finance, HR, estates, and succession to ensure resilience and reduce risk of performance management.
- **Shared learning:** Opportunities to connect with peers, share good practice, and be part of a wider improvement effort.
- **Improve patient care and relationships:** Tools and models that improve patient experience, outcomes, and safety.
- **Influence wider change:** Ensures practice voices shape how neighbourhoods and INTs develop.

Why is it so important to have consistency of general practice offer?

A consistent general practice support offer is essential for equity, sustainability, and neighbourhood success. Without it, access to support becomes patchy, variation deepens, and neighbourhood working risks fragmentation. Consistency doesn't mean uniformity, but it does mean clarity on expectations, equitable support, and aligned system delivery.

- **Equity of opportunity:** Every GP and practice deserves access to the same level of support (e.g., training, guidance, system development offers) regardless of borough or historic engagement. Variation can undermine trust and demoralises staff.
- **A resilient foundation for neighbourhoods:** Neighbourhoods rely on functional practices. If primary care is under-supported in some areas, neighbourhood models may fragment. A failing practice won't just affect its patients, it could destabilise local systems and affect funding flows within and between neighbourhoods.
- **Preventing widening gaps:** Inconsistent engagement and support will likely lead to widening variation in access, outcomes and sustainability. SEL-level coordination prevents postcode lotteries in GP support, workforce development, and operational help.
- **Making change possible in a resource-constrained system:** In the context of workforce and financial pressures, we can't afford duplication or gaps. Standardisation (not uniformity allowing for local delivery) ensures efficiency.
- **Engagement is everyone's business:** We know there are pockets in SEL where there is weaker primary care engagement. Practices that understand the direction of travel towards neighbourhoods and modern general practice are more likely to engage. Consistency helps all practices see where they fit, why it matters and what support is available and essentially be in a position to recognise the importance of engagement and make the required changes to be involved in neighbourhood working.
- **Delivery partners must align:** It doesn't necessarily matter *by who* or *how* support is delivered whether that be through integrators, training hubs, PC support teams, LMCs but they should work to the same offer, language and expectations.

Our Support Offer

South East London wants to create a system-led, data-informed, equitable model for supporting general practice sustainably. This is in line with the NHS Confederations' six proposed shifts to achieve strategic commissioning that will help drive a sustainable health and care system. The support offer has been developed through the Neighbourhood Based Care Board, acknowledging the key link made within the London Case for Change between general practice sustainability and neighbourhood-based care. All 6 places have collaborated on the offer working with SEL team colleagues.

Key proposals outlined in this support offer include:

- **Peer-first and supportive:** engagement and support will start with peer-based conversations, recognising that it can be difficult for practices to be open about challenges. This ensures the offer feels safe, collaborative and focused on improvement, not performance management.
- **Proactive and equitable support:** moving beyond self-referral and relationship-driven access to allocate support strategically. SEL want to commission and deliver support proactively, using local intelligence to reach practices that would benefit the most.
- **Tiered support:** all practices will have access to a consistent, universal offer. Where practices face common challenges, programmes will bring them together to share solutions. Where local, specific issues arise, bespoke support will be co-designed to meet those needs. This tiered approach ensures that all practices are supported to build resilience, while additional help is available when and where it is most needed.
- **Flexible commissioning:** enabling rapid access to bespoke support based on real-time intelligence and practice need, rather than one-size-fits-all offers.
- **Clear central access:** ensuring practices know where and how to find support. This includes maximising existing central functions such as SELNet, but will also require clear and consistent communications so practices can easily see what is available.
- **Outcomes-based monitoring:** tying support delivery to clear, measurable outcomes so that support can be scaled and tailored as needed. This ensures SEL and practices can be confident that the support on offer is beneficial, impactful and tailored to their needs.

The Neighbourhood Based Care Board recognises that other parts of the primary care eco-system are also facing significant resilience and sustainability challenges, and the Board are exploring how to build on this approach to better support other pillars, with community pharmacy discussions underway.

High-level view of support offer

SEL's refreshed general practice support offer sets out a clear, systematic approach so every practice knows what is available and how to access it. The support will be available to every practice, that includes universal and bespoke packages co-designed where deeper needs exist delivered in a proactive, equitable, and collaborative way.

Engage practices to identify needs

Consistent, predictable and relationship-based engagement with local practices to:

- **Hold trusted conversations via peer and network engagement** where practices feel safe to raise concerns, and where they can be supported to identify support needs.
- **Communicate support offer at every opportunity** so that practices are aware of what is on offer.
- **Use data and insight** to proactively identify and open conversation about emerging and potential needs.
- **Targeted outreach** via direct contact, 1-2-1 visits and protected discussion time where needs might be emerging.

Identify appropriate support

- **Central resource** (SELNet) holds a clear, accessible menu of all available support offers that all practices can draw down from.
- **Needs are triaged** through borough leads based on local intelligence from practices, borough teams, training hub, CESEL, LMC and networks.
- **Support is matched collaboratively with practices,** ensuring the right mix of universal, or bespoke input is agreed together and that the support provided is proportionate to need and delivered before practices reach crisis point.

Tailor and deliver support

Support is delivered through a mix of "one-to-many" and practice-specific approaches:

- **Universal offers:** open access to online training, QI collaboratives, toolkits, dashboards and peer forums.
- **Shared challenge programmes:** bringing practices together around common needs (e.g. neighbourhood working, workforce morale).
- **Bespoke packages co-designed with practices around specific needs** such as specific CQC / performance improvement.

Delivery is designed to be flexible, proactive, and not punitive, focused on improvement and resilience.

Measure outcomes and adapt

- **Practices receive ongoing engagement** to ensure changes embed and support has delivered expected outcomes.
- **All support is linked to clear outcome metrics monitored via feedback loops** providing real-time insights both during and after support so support can be flexed accordingly.
- **Where improvement is on track, practices move to lighter-touch support**; where risks persist, escalation to more intensive or bespoke input is triggered.
- **Impact and delivery of support is reported openly** through SEL dashboards and borough leads to enable the "core" support offer to evolve as needed over time, and build transparency and trust.

What practices need support on

The below outlines the core areas of support that every practice should be able to access to build resilience and deliver high-quality care. While individual practices may need bespoke help with concerns specific to their local context, these domains represent the essentials that must be available consistently across SEL to ensure equity, stability, and a strong foundation for neighbourhood working.

Understanding and responding to patient need	Helping practices listen to and engage patients, manage expectations, and communicate effectively
Change management and quality improvement	Practical help for change management, process mapping, identify inefficiencies, and make sustainable improvements using QI methods.
Strengthening non-clinical workforce and entry-level roles	Support with structured pathways and induction support for non-clinical and entry-level staff - especially for roles like newly qualified nurses.
Understanding and using data (including PHM)	Building confidence and skills in interpreting and acting on data, including population health insights, to inform service planning and improvement.
Business operations	Strengthening core operational skills such as finance, HR, contract management, succession planning, and running the practice as a resilient organisation. This should also include any clinical updates; and support to think through the most efficient scale for care delivery, and back-office functions to maximise financial resilience.
System and partnership working (e.g., navigating interfaces with secondary care and VCSEs)	Helping practices work effectively across organisational boundaries, improve referral/escalation pathways, and strengthen links with VCSE partners.
Digital transformation	Supporting practices to adopt, optimise, and embed digital health / AI tools in a way that improves patient care and efficiency while reducing workload.
Workforce and team development (including retention, team culture, leadership and OD)	Building strong, inclusive teams including integrated workforce planning and succession planning; supporting retention, preventing burnout, improving wellbeing and morale, and leadership skills; and fostering shared ownership.
Clarifying and supporting neighbourhood working	Defining the purpose, benefits, and practical steps for neighbourhood/PCN collaboration, and supporting practices to engage meaningfully.
Specific CQC / performance improvement	Providing bespoke help for practices at risk.
Infrastructure (e.g. estates)	Helping practices assess, plan and improve their premises and infrastructure to meet patient and staff needs.

Tiered Approach

SEL's general practice support offer is designed to be fair, systematic, and proportionate. Where practices face common challenges, programmes will bring them together to share solutions. And where local, specific issues arise, bespoke support will be co-designed to meet those needs. This tiered approach ensures that all practices are supported to build resilience, while additional help is available when and where it is most needed.

All three "tiers" of support will be available to all practices; it will depend on their need for what, and when they access this. SEL will also signpost and link into complementary national and regional offers, such that SEL does not duplicate and makes best use of existing support.

Shared challenges

Informed by data, practices that share challenges will be brought together and targeted support will be provided to address and share common challenges. This will likely include:

- System and partnership working – improving referral pathways, links with VCSEs.
- Clarifying and supporting neighbourhood working – enabling PCN/neighbourhood collaboration.
- Strengthening non-clinical workforce and entry-level roles – structured pathways, induction support.
- Workforce and team development – workforce planning, recruitment, retention, morale, leadership, OD.
- Understanding and responding to patient need – engaging patients, managing expectations, communication.

Bespoke support

Practices that have specific, local challenges will be offered support that is tailored. This should be proactive and help avoid the need for performance management in future. This is likely to include:

- Specific CQC / performance improvement – intensive support for at-risk practices.
- Infrastructure (e.g., estates) – premises assessment and planning.

Universal support

Every practice will have access to this support on an ongoing, regular basis. Information about the offer, and resources will be centrally held on SELNet. This will include:

- Business operations – finance, HR, contracts, resilience, clinical updates
- Change management and quality improvement – process mapping, workflow efficiency, QI methods.
- Understanding and using data (including PHM) – data confidence and skills.
- Digital transformation – adoption and optimisation of digital tools.

Key Take-Aways and Recommendations

- All 6 places across South East London have collaborated to develop a consistent SEL-wide support offer for general practice sustainability.
- This approach has been developed through the Neighbourhood Based Care Board, recognising the important relationship between general practice sustainability and neighbourhood care as outlined in the London Case for Change.
- The approach will offer tiered support to providers through a mixture of universal support, bespoke packages for specific practice need and grouped offers for practices with shared challenges
- The offer aims to provide a menu of support that can meet most challenges facing the sector
- Other parts of the primary care eco-system are also facing significant resilience and sustainability challenges, and we are exploring how to build on this approach to better support other pillars, with community pharmacy discussions underway.
- **It is recommended that the Board endorse the SEL-wide sustainability support offer developed via the Neighbourhood Based Care Board, noting a shared commissioning approach across the 6 places and SEL teams taking place to implement the offer in 26/27**

South East London Integrated Care System

NHS South East London

Adopting new care models (including neighbourhood health)

Access vs Continuity

There is a clear national policy direction to improve access to general practice and significant effort has been aligned to this priority over the last few years. A strong link has been made between improving access, particularly ease of contact and appointment availability and improving patient experience of NHS services with primary care access seen as “critical to not only managing wider system pressures but also rebuilding the public’s faith in its NHS”. The measures used nationally to support this to date have been broadly focused on activity (the number of appointments) and patient experience data on the ease of contact.

In 2025, new contract requirements were put in place around online access. These require all practices to respond to non-urgent online consultation requests within the same day.

The focus to date on activity, ease of contact and speed of response to non-urgent online consultations – whilst important – risks us focusing on a narrow interpretation of access, as well as losing sight of other key characteristics of general practice that are both critical for the quality of care and underpinning proactive, integrated care models (i.e. those we wish to deliver within neighbourhood care)

A practical example of this is the challenge to balance between access and continuity of care. Evidence demonstrates that where patients see the same doctor at each visit, there are benefits for general practice workload and patient health, this grows as the length of that continuity grows. However, seeing the same GP meant that people waiting on average 18% longer between visits, compared with patients who saw different doctors.

As demand for care grows and capacity increasingly becomes challenge, we need to strike the right balance between convenient access and continuity of care as well as ensure that we are thinking about general practice access through a broader lens that considers utilization, effectiveness and equity.

Maximising general practice capacity within future care models

NHSE have looked to support this tension through the introduction of alternative care pathways for patients with lower-level urgent care need, for example through the Pharmacy First programme. Equally plans outlined in the 10 year health plan could potentially support this further – such as AI-powered advice via the NHS "doctor in your pocket" planned in future years.

We will need to both maximise national opportunities and also consider going further through locally-designed alternative care pathways to ensure we are supporting general practice to maximise its unique role in our system. The deep dive suggested earlier in this paper into understanding access patterns by demographics and population health need will be important to identify where new interventions are required to support our patients more effectively – we know from existing evidence that these increasingly require solutions outside of the traditional health system (for example meeting increasing demand on general practice from people concerned about their finances and housing).

Another key need is to ensure practices have the tools and support necessary to adopt population segmentation and risk stratification within their practice, to proactively tailor care and also to inform workforce, capacity allocation and flow models.

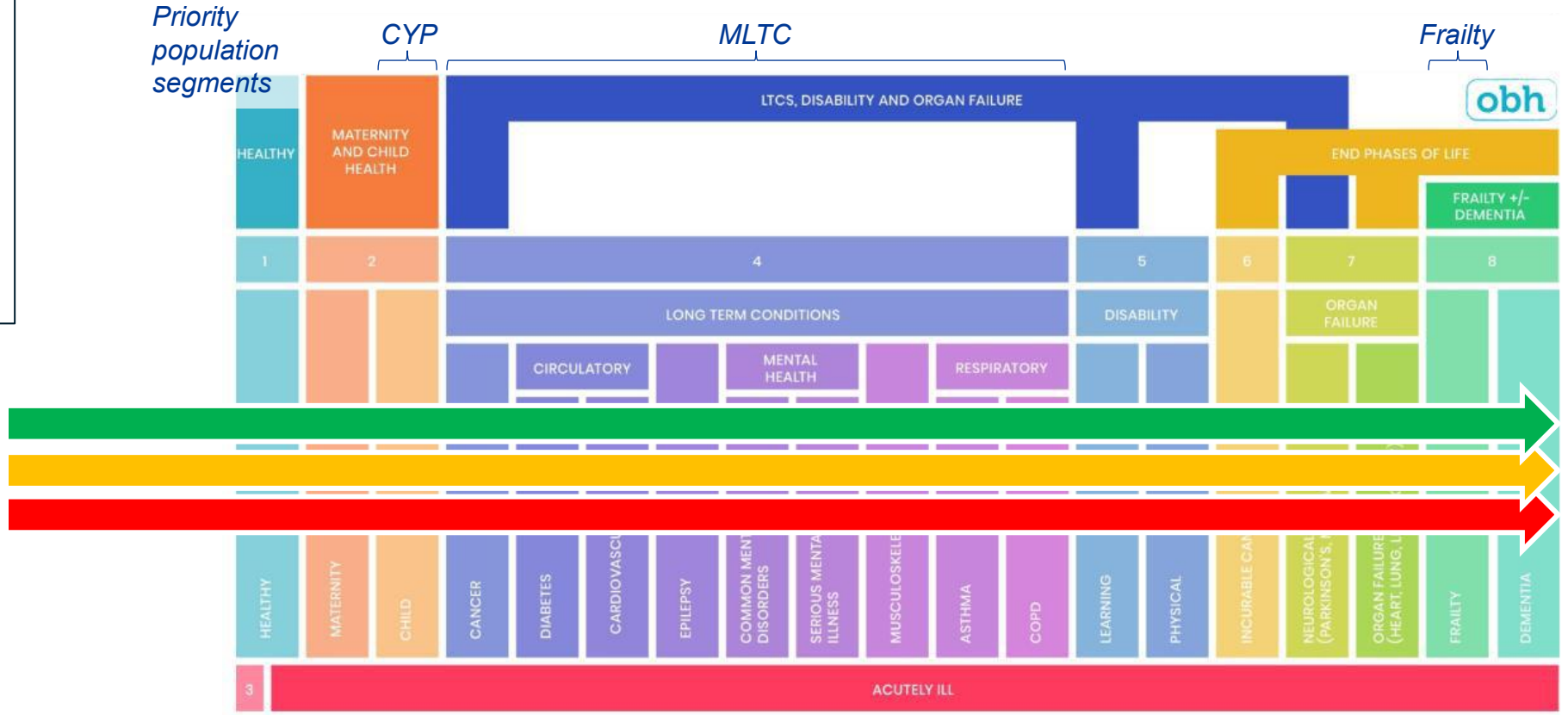
This will evolve over time, but initially across South East London we have worked to ensure that all practices have access to common and consistent population segmentation and stratification tools:

- The first is Bridges to Health, which segments populations into eight core groups where there is sufficient similarity in care need. This model aligns well to our priority populations for integrated neighbourhood teams across South East London.
- The second is a "Red, Amber, Green" model, built based on early adopters to segmentation within general practice (Frimley) which is a more simplistic model of segmentation but one which helps identify patients who would benefit from continuity (red), those who benefit from coordination (amber) and those who are broadly healthy (green). This can be particularly effective in supporting total triage models and aligning general practice capacity appropriately to need.
- The third is "QRisk2" which is a prediction algorithm for cardiovascular disease and can enable discrete identification of patients who would benefit from intervention (i.e. lipid lowering therapy) due to their risk.

Population segmentation model: tools now available for practices

Both approaches are embedded within Ardens which ensures each practice has access to PID-level information on patients within each segment, and places/SEL-level teams have access to aggregate, anonymised data. The tools can be overlayed, i.e. GPs can pull out 'Red' for each segment (e.g., patients in the LTC segment who are 'Red').

1. A consistent (interim) segmentation approach is applied to include the three priority cohorts of CYP/ frailty/ MLTC. [For simplicity, we have initially utilised the Bridges to Health model as this was a cost-efficient and recognised model; this may be evolved over time in-line with the SEL Population Health programme and work at a London and national level around segmentation]



2. The Ardens RAG model is applied across the entire population.

1. Source: Outcomes Based Healthcare at Part 2: Whole Population Segmentation Models – Outcomes Based Healthcare

What could we consider?

As an ICB, there is scope for us to give deeper consideration to how we balance access to care for our population with relatively low health need who value speed and convenience, with our population with more complex health need who value continuity and coordination of care.

Whilst the second area is being explored via the development of Integrated Neighbourhood Teams, the former (i.e. a future model to improve convenient access to care for people with relatively low health need) is less developed. There are also key opportunities which will develop over the next three years that we may be able to harness. These include:

- The expanding role of community pharmacy building on Pharmacy First
- The procurement of new SEL 111 and IDU services that could facilitate new models of integrated access at a place level
- New opportunities to support self-referral or direct referral pathways as shared data and population health tools enable greater confidence
- Investment in alternative care offers supported by increased VCSFE provision that could support patients with mental wellbeing, non-health care need and connectedness.
- The impact of “GP in the Pocket” on same day urgent care and how we can maximise new technology to improve patient outcomes and system sustainability

This would require an MDT approach bringing together place leadership, primary care leadership, strategic commissioners for UEC, community and primary care (both general practice and community pharmacy), digital transformation leadership and VCSFE partners to develop options that maximises new opportunities, improves access, experience and outcomes for our population and supports general practice sustainability over the longer term.

It is recommended that the Board consider its shared appetite for developing alternative models of care that respond to people with lower levels of health need who value convenience and speed of access, and considering the cross-organisational scope and impact and agree whether an MDT group should be established to scope this work further during 2026/27

Supporting general practice as the bedrock to neighbourhood health

- Successful neighbourhood care will rely on **robust, resilient but also innovative general practice**.
- The approach set out here will help to drive **greater resilience and sustainability** of the sector, as well as **increase readiness to adopt innovation** that drives forward new models of care to **better meet the changing needs of our population.**
- To maximise our approach, we will need to ensure that there is **effective neighbourhood and place level wrap-aound support** to primary care which includes:
  - **Increased access to resources that already exis**t across our system and could be shared, such as training and education resources developed and operated by our Trusts and others. We have already seen examples of this through the development of end of life care educational resources by our hospices that are accessible to the whole of primary care
  - **Effective infrastructure through integrator partnerships** and host organisations e.g. workforce, digital and estates infrastructure that can drive innovation and greater integration of care
  - **Levelling up of provision across SEL** to support **core baseline** provision and ensure **consistency of offer** for our population – this includes ensuring a common set of enhanced general practice provision, the necessary support for care planning and care coordination and enabling the general practice role in case management and integrated neighbourhood teams
- These objectives align with principles being articulated around the **use of the Strategic Investment Fund** across South East London