Integrated Care Board – Meeting in Public

13.45 to 16.45 on 08 April 2026

Brixton Tate Library, London SW2 1JQ
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	13.45
	Borough Showcase			
2	**Lambeth Borough**	-	AE	13.55
	Corporate business			
3	**ICB change programme update**	C		14.25
	Report for Assurance and discussion of current issues			
4	**Chief Executive Officer's report**	D	AB	14.35
5	**Board Assurance Framework**	E	TF	14.45
6	**Overall Report of the ICB Committees and Provider Collaboratives**	F	TF	14.55
7	**Performance Report**	G	RD	15.05
8	**Quality and Safeguarding Report**	H	DJ	15.20
9	**Finance Report**	I	MF	15.35
	Delivering our Integrated Care Strategy			

10	**Medicines Optimisation and Community Pharmacy**	J	VB	15.50
11	**Primary and Secondary Care Interface**	K	TG	16.10
	Closing Business			
12	**Any other business**	-	RD	16.30
	Public Questions and Answers	-	RD	16.35
	CLOSE 16.45			

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**

NHS South East London Integrated Care Board
Register of Interests declared by ICB Senior Leadership Team
Date: 08/04/2026

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. 2. Married to Managing Director, Kings Health Partners AHSC 3. Spouse is the Managing Partner at SHINE Executive Cpacjomg & Consultancy Ltd, providing life sciences and partnerships strategic advisory and coaching services. 4. Corporate Director of Integrated Health and Adult Social Care – role spans ICB and Lambeth Council.	Financial interest Indirect interest Indirect interest Non-financial professional interest	01-Apr-13 01-Apr-21 01-Oct-19	Current 31-Jul-23 Current 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. 2. Bale Crocker Associates Consultancy – Client Executive 3. Bale Crocker Associates Consultancy – Client Executive	Non-Financial Professional Interest Financial Interest Financial Interest	01-May-22 03-May-22 01-Oct-25	Current 31-Mar-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 2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT) 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 4. I undertake private practice at London Bridge Hospital 5. Honorary Treasurer for British Society for Rheumatology	Financial interest Financial interest Financial interest Financial interest Non-financial professional interest	01-Apr-20 07-Oct-09 01-Jan-15 01-Jan-12 01-Apr-20	Current Current Current Current Current
Diane Jones	Chief Nurse	1. Trustee of Group B Strep Support 2. Trustee of Sign Health 3. RNID Volunteered 4, Barts Health Volunteer	non financial personal Interest non financial personal Interest non financial personal Interest non financial personal Interest	03-May-21 03-Jul-23 05-Jan-26 04-Apr-25	Current Current current 04-Jan-26
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 2. Non-executive Trustee of Peoples Health Trust Charity.	Financial interest Non-financial professional interest	 02-Apr-24	Current Current
		1. Fellow of the Royal College of Radiologists	Non-financial professional interest	01-Jun-94	Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Prof. Clive Kay	Partner member, Acute	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
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

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Integrated Care Board meeting in Public

Minutes of the meeting on 28 January 2026

Online via teams

Present:

Name	**Title and organisation**
Richard Douglas [Chair]	ICB Chair
Andrew Bland	ICB Chief Executive Officer
Dr Angela Bhan	Bromley Place Executive Lead
Gabi Darby	Greenwich Place Executive Lead
Holly Eden	Director of Delivery for Neighbourhood and population health
Andrew Eyres	Lambeth Place Executive Lead
Tosca Fairchild	Chief of Staff
Georgina Fekete	Non Executive Member
Mike Fox	Chief Finance Officer
Dr Toby Garrood	ICB Joint Medical Director
Ceri Jacob	Lewisham Place Executive Lead
Prof Clive Kay	Partner Member Acute Care
Diane Jones	Chief Nurse
Peter Matthews	Non-Executive Member
Paul Najsarek	Non-Executive Member
Ade Odunlade	Partner Member Mental Health Services
Darren Summers	Southwark Place Executive Lead
Anu Singh	Non Executive Member
Dr George Verghese	Partner Member Primary Care

In attendance:

Sarah Cottingham	ICB Deputy CEO and Director of Planning
Ranjeet Kaile	ICB Director of Communications and Engagement
Tosca Fairchild	ICB Chief of Staff
Sara Taylor (item 2)	Principle Social Worker Lewisham
Emily Newby (item 2)	Children and Young People's Joint Commissioner
Clare Ross (item 10)	Head of Primary Care

1.	**Welcome and Apologies**
1.01	Apologies were noted from Diane Braithwaite, Amanda Pritchard, Dr Ify Okocha, Denise Lafitte and Ben Travis.
2	**Lewisham Showcase**
2.01	Sara Taylor and Emily Newby shared a presentation on the reforms to children's team and the Families First initiative in Lewisham which had successfully achieved pathfinder funding. The model of children's services was multi-disciplinary and multi-agency and aimed to improve integration and there had been a successful increase in involving clinical expertise into social care for children and their families as well as a reduction of risk, improved access to treatment and reducing the number of children entering care.

2.02	Tosca Fairchild asked about looked-after children, a vulnerable group who often experienced breaks in their care and inequalities. Sara Taylor noted that although some children in care had negative experience there were efforts to improve practice as well as support for care leavers and effort to seek kinship arrangements if possible as an alternative to taking into care. Emily Newell noted the published our corporate parenting strategy set out the pledge to our children in care and care leavers, and initiatives such as a care leavers nurse had proved successful.
2.02	Prof Clive Kay welcomed the multi-professional, multi-disciplinary approach set out within Lewisham and asked if this if this would continue for those being cared for if they moved to another borough or health providers. Sara Taylor noted that the pathfinder approach ultimately was intended to be rolled out nationally which would provide consistency.
2.02	Ade Odunlade noted that South London and Maudsley NHSFT was working to boost communication within the Trust and improve engagement on the work.
2.02	Dr George Verghese reflected that the collaborative working set out in the presentation essentially reflected how integrated neighbourhood teams would work. It was a particular achievement that the involvement of health professionals had been increased as workload pressures often made this difficult.
2.02	Dr Toby Garrood asked about the workload and pressure on services and how staff were coping. Sara Taylor explained that support included evaluation and review of workload, a workforce development programme and wellbeing support as well as reflective and multidisciplinary supervision.
2.02	Dr Angela Bhan commented that the hubs located in neighbourhoods would help join up services but thought would be needed on how to transform practice so that gains could be maintained from a resource intensive pilot to business as usual. High profile cases had shown that in some cases families were not able to adequately support children and an approach that focused on keeping children with families rather than in care needed to be mindful of safeguarding risk. Sara Taylor noted that in mainstreaming the work the focus would be on approaches that did not require additional resources such as group supervision, information sharing and getting systems to work together, for example a half day per month of a substance abuse practitioner had proved helpful for social workers to book in and discuss their cases.
2.02	Diane Jones noted the ongoing evaluation work and asked if this included feedback from families themselves. Sarah Taylor commented that although it was early in the programme for feedback from families there had been some cases where a difference in practice had been seen and by focusing on the whole relational framework the involvement of police or statutory services had been avoided.
2.02	Georgina Fekete asked if health economic data was being tracked, and whether there were systemic lessons to learn from the commission on adult social care currently taking place. Sara Taylor noted that there were no resources to measure economic health data currently.
2.02	Peter Mathew asked if the approach would be broadened to include all children, care leavers and relevant partners such as housing. Sara Taylor noted that the inclusion of housing workers in family health teams was making a real difference.

3	**EDI reports**
3.01	Tosca Fairchild presented EDI reports including Workforce Race Equality Standard, the Workforce Disability Equality Standard and the Workforce Sexual Orientation Equality Standard and noting improvements in some areas but remaining challenges. An action plan had been developed that addressed all areas, but it was suggested that be reviewed after the ICB changes had been made to ensure it was still suitable. The work of ICB staff networks had been valuable as a contribution to the reports and actions.
3.02	Sir Richard Douglas commended the transparency provided by the report but pointed out that the performance it revealed in this area was not good and the ICB would continue to need to work on the area.
3.03	Paul Najsarek commented that establishing whether there had been improvements by comparing data before and after the ICBs change programme could be made difficult given the programme would make significant changes to the workforce.
3.04	Andrew Bland suggested that action could not wait for the completion of the change programme which may take many months to be fully implemented, and that the right actions to improve the situation would need to take place irrespective of temporary difficulties in measurement. Tosca Fairchild added that some information was being gathered through measures such as quarterly staff feedback surveys and equality impact assessments of specific elements such as the voluntary redundancy process.
3.05	Georgina Fekete suggested a more systematic examination of the drivers of experiences reflected in the report might help assess the action plan and added that a more complete picture of the protected characteristics of Board members would be helpful if possible.
3.06	Diane Jones suggested that it would be useful to set a clear ambition for the organisation in relation to improvements in each of the areas. Sir Richard Douglas suggested that the Board could discuss this at one of its future sessions.
3.07	The Board approved the EDI reports for publication.
4.	**Chief Executive Officer's report**
4.01	Andrew Bland presented the report of the activities of the executive team • The report noted that the ICB board had decided to enter into a cluster arrangement with south west London ICB which would allow the two statutory organisations to support each other without merging. A shared Chair, CEO and executive team would be recruited and a staff consultation would be initiated. • The Board continued to discuss the ICB's strategic and operating plans over a number of sessions ahead of the submission deadline. • Dr Angela Bhan noted the decision in relation to Bromley Community Services award had been recorded for information and was now in mobilisation phase. Holly Eden highlighted to members the strong work described on the Primary and Secondary Care interface in the report.

4.02 4.03	The Board **noted** the chief executives report
5	**Board Assurance Framework**
5.01	Tosca Fairchild presented the board assurance framework noting 12 risks, generally stable since with the previous report. Key changes included • Review by the CFO and Executives which had allowed the risk score to be reduced in relation to Risk 606, relating to the ICS revenue financial plan for 2025–2026. • Responding to feedback and recognising the scale and complexity of the issue a new risk relating to neurodevelopmental diagnostic pathways included both children's and adult pathways and consolidated previous risks. • Three risks had been closed. The first related to community pharmacy messaging, which had closed following confirmation that GP Connect was now functioning. The second related to redundancy financial funding, which had now progressed. The third was a previous Lewisham risk relating to statutory task goals on neurodevelopmental pathways, which had been superseded by the newly defined risk. • Regular discussions with PELs continued, and discussions included topics such as neurodevelopmental pathways and the provider selection regime. • Work with partners on system risk development work continued with a regular group meeting to review risks across providers and consistent approaches to risk. • A future session with the Board was planned to review the approach to risk in light of future changes.
5.02	Georgina Fekete pointed out that the risk related to the change programme did not explicitly mention the ICB clustering process which could be kept under review.
5.03	Darren Summers highlighted the risk relating to autism and ADHD assessments where there were long waits for assessment and treatment of children and adults due to a volume of demand. Addressing this also had financial consequences for the system. The executive would discuss the issue shortly.
5.04	Paul Najsarek welcomed improvements to the BAF register. He observed that while the appearance of new risks was positive in that it indicated a working process of identifying issues, cases where risks appeared on the board assurance framework with a very high score from the outset might suggest that earlier opportunities for mitigating interventions were being missed.
5.05	The Board approved the board assurance framework.
6	**Overall Report of the ICB Committees and Provider Collaboratives**
6.01	Tosca Fairchild referred to the report of committee work, and directed the Boards attention to the request to approve review of Remuneration Committee Terms of Reference and the One Bromly Partnership but to disregard the Southwark partnership terms of reference pending further amendments. The Board were asked to accept the annual assessment confirming 'substantial compliance' with the ICB's emergency planning arrangements.

6.02	Peter Matthew noted a typographical error in relation to the work of the Greenwich charitable funds committee £17m to be changed to £1.7m.
6.03	The Board **noted** the report and **approved** the terms of reference of the Remuneration committee, **approved** the terms of reference of the Partnership Southwark Strategic Board, and **noted** the review of the One Bromley Partnership terms of reference.
6.04	The Board **accepted** the substantially compliant outcome of the ICBs annual EPRR core standards assessment.
7	**Performance Report**
7.01	Sarah Cottingham referred to the report summarising key performance issues and actions to recover. • There had been improved performance against 4hour and 12 hour UEC targets which had been maintained throughout the usual winter pressures period. Challenges remained although the report described initiatives to address them such as the work by Lewisham and Greenwich NHS trust on GIRFT. • Cancer performance on the 62-day target there had been positive results in diagnosis and rapid testing but much more to do to improve performance. • Referral to treatment times were affected by long waits and a number of challenges in specific specialties, although there had been a number of successful pieces of work and a national programme of 'sprints' was planned to optimise the position. • The report outline work on elective pathways and diagnostic work to support improvements. • The report outlined performance on a range of non-acute targets, which had not changed substantially with an improved position maintained over the year on areas such as eating disorders, talking therapies completion rates and numbers of GP appointments and take up of pharmacy first. Ongoing challenges included mental health out of area placements, perinatal mental health, CAHMS access and numbers of autistic patients and those with learning disability in in-patient settings. The paper detailed work with partners to improve these areas. The key focus for Q4 was to continue to improve the current years performance as well as focus on further initiatives for 2026-27 to support improvement of performance.
7.02	Sir Richard Douglas asked if the 'sprint' work was expected to significantly improve the position. Sarah Cottingham noted that there should be an improvement of around 1% which would be a significant challenge to achieve.
7.03	Prof Clive Kay noted that successive winters had been challenging but the winter just passed had been relatively good in terms of early planning, better communication and learning from initiatives.
7.04	The Board noted the performance report.
8	**Quality and Safeguarding Report**
8.01	Diane Jones presented the quality and safeguarding report

	• There had contribution by the ICB to the offensive weapons homicide review which worked to examining cases involving weapon-related offences to identify whether improved communication or joint working could have altered outcomes, and insights were shared during the review to support improvements. • The Continuing Healthcare team were now meeting the 28-day assessment standard and had made improvements quality assurance although the number of appeals and disputes currently remained high. • A maternity care bundle had been launched nationally including work on key areas identified through morbidity and mortality patterns including Venous thromboembolism, Pre-hospital and acute care, Epilepsy in pregnancy, Maternal mental health, and Obstetric haemorrhage with key actions to implement with providers. • Infection prevention control the system was above threshold for a number of infections and with increasing rates of C. difficile, E. coli and MRSA had been noted, consistent with national trends. Recent outbreaks had resulted in some ward closures but without significant impact on patient flow. • All areas were required to submit a local SEND reform plan and work was underway in place-based partnerships to honestly assess the current position and identify areas for long term development.
8.02	Georgina Fekete asked if as a newer member of the executive team the chief nurse had reflections on the main concerns.
8.03	Diane Jones noted that there was a good team in place, and although there were issues there were known. For example there were issues in relation to increasing mental health patients and particular issues in relation to children and young people and in emergency departments but the issues were known, monitored and the trusts work working to resolve. Where there may be potential to improve oversight could be areas such as dentistry, optometry and pharmacy, to ensure that there was a good oversight and assurance in relation to quality and safety issues.
8.04	Prof Clive Kay asked how providers could best learn from each other in the system, not just to share learning but to follow through and make sure these lessons were followed through. Diane Jones noted that this could happen in a number of ways, such as clinical groups, chief nurses. The key challenge was assigning time and the ICB could help in its convening role.
8.05	The Board noted the quality Report
9	**Finance Report**
9.01	Mike Fox presented the month 8 financial position for the ICB and the ICS. The ICB was currently reporting a break-even position but the ICS was currently behind plan with the deficit largely at Guys and St Thomas NHSFT but partially offset with better than planned performance at Kings College Hospital NHSFT. All providers and the ICB continued to forecast that a break even position would be achieved by the end of the year, albeit with risks relating to delivery of savings plans, impact of industrial action. The system retained a significant underlying financial deficit and there was remained concern about the number of non-recurrent measures being used to support the financial position. This would lead to a more significant challenge for 2026/27 planning.

	The ICB had successfully worked to help implement the new ISFE 2 ledger system.
9.02	Sir Richard Douglas reflected that the system seemed on track to meet its financial targets for the year, but noted the worsening underlying position as a result of short term fixes, so that the next years position remained risky. He congratulated the finance team on the implementation of the new financial system so far.
9.03	Tosca Fairchild noted that there was a risk of further industrial action in the years.
9.04	The Board noted the finance report.
10	**Primary Care – General practice variation and resilience**
10.01	Holly Eden stated that general practice was responsible for 90% of patient contacts, and delivered above expectation in increasing appointment activity at a faster rate than any funding increase. The scope of the work of general practice had increased over the last ten years to become more involved with long-term condition management and increased acuity as it helped to decompress acute sites. The sector through key leadership representatives had a strong relationship with the ICB based on a supportive approach to implementing sometimes challenging national policy. There were however clear stressors affecting the sector's long term sustainability and the resilience of particular practices, and significant variation in access and outcomes for patients. ICBs were being encouraged to use rigorous contractual routes to reduce this variation, but it was thought that given the problem was multifactorial and complex an approach which balanced with support for sustainability and resilience would be more effective. Clare Ross continued that unwarranted variation could often disproportionately affect the most deprived communities if not addressed, and the tools available to the ICB to do so were often skewed to wards activity and process measures. A proposed approach combined data and soft intelligence from Place teams to allow a consistent and structured approach to managing variation which majored on support for practices, reserving contractual action as a last resort. The approach was in tiers with universal support provided to all practices, targeted programmes for issues shared by a number of practices, and bespoke support for practices with specific issues. Population health would help support general practice by enabling capacity to be aligned to population need and in its strategic commissioning role the ICB would need to support general practices unique role as the foundation of good health for south east London residents.
10.02	Dr Angela Bhan noted that general practice was part of a system and was therefore affected by what happened in A&Es as well as neighbourhoods and suggested that the conversation should be expanded beyond those usually associated with general practice. She advocated building on strong practice as well as just levelling up, and on introducing new models that could help the ICB deliver what was needed within the national framework.
10.03	Dr Toby Garrood commented on the role of secondary care to support primary care, and the need to optimise advice and guidance and support neighbourhoods, as well as solve common issues. There was a possibility of an inverse relationship between continuity of care and access and it would be useful to measure continuity of care if this was possible.

10.04	Ceri Jacob supported the need to for acutes to support primary care given that it was the cornerstone of the system without which the other parts would fail. Aligning money to need was important and a different approach was needed to address variation, whilst recognising the impact of historical decisions to prioritise certain areas.
10.05	Georgina Fekete questioned whether more evidence needed to be gathered in the deep dive proposed given the limited resources and whether it would be better to address some of the known issues first.
10.06	Prof Clive Kay suggested that although more data may be needed for patients seen entirely in primary care, but suggested that for patients referred into secondary care and even those discharged there should be sufficient information already.
10.07	Holly Eden explained that what was currently known was the differences between different practices, but what was not known was how this aligned with underlying population need within that practice area due to the data focusing on process measures.
10.08	Prof Clive Kay expressed some concern that there was no longer a satisfactory formal relationship between secondary and primary care in support training education and initiatives such as joint rounds, and whether secondary care could do more to build this.
10.09	Holly Eden suggested that this linked to integrator work, and agreed that the relational work was important as well as the more process driven work from the national policy. Clare Ross suggested that there was previously much more work and better relationships, there was positive work to build on such as the work in Lewisham on referrals.
10.10	Dr George Verghese reflected that that with a larger workforce on both sides and a multidisciplinary team working both in primary and secondary care meant that the relationships may not take the same form as in the past. Understanding variation by triangulating a range of data, and describing patient feedback better would be important. There was also a question of access was not adequate then complex and proactive care as envisaged in neighbourhoods would be affected. Some of the solutions would lie with integrators and providers supporting each other rather than solely with strategic commissioners.
10.11	Gabi Darby reminded the board that the although primary care dealt with 90% of the contacts they accounted for around 10% of spend which illustrated the impact that small amounts of funding such as the system sustainability funding could have. Population differences were real at practice level even more than borough and had led to practices operating quite differently to each other. Although consistency in some areas was important, some different approaches and innovation should be allowed. An example of addressing variation in Greenwich there were only three staff available and so inevitably where practices had issues such as poor CQC reports these absorbed most of the capacity.
10.12	Andrew Eyres agreed that variation was complex and at different levels. The systematic approach could be welcome as the ICB tended to know more about very good or very poor practices, but a more systematic approach and at the right scale would be important.

10.13	Andrew Bland suggested that as had been noted the number of people who would be available in the ICB to deliver the approach were limited. Integrators offered could be a way to bring in greater resources, infrastructure support and clinical leadership. There were some limitations to what could be done without control of the national contract, and a way to support the primary care workforce.
10.14	Holly Eden added There was a lot of purchasing power around general practice even outside the national contract, and small amounts could be significant in this area.
10.15	Dr Toby Garrood commented that there were significant amounts of data to work with despite limited analytic capacity. The consensus document published as part of primary secondary care work was based on a comprehensive analysis of the key challenges facing clinicians in primary and secondary care and therefore the task was to promote this document.
10.16	Sarah Cottingham noted that the role of the board may be to state that equity of access experience and outcome for residents in relation to general practice was important. Wrap-around support from Integrators, and primary and secondary care interface work was importance but also setting an expectation of the core general practice offer.
10.17	Sir Richard Douglas summarised that the Board had agreed that there needed to be a proportionate exercise to explore variation. There was also a need to think realistically about what the role of the ICB as a strategic commissioner, and some questions about workforce and working within the national contract. He suggested that the executive take forward this work and report back briefly to the Board.
11	**Any other business**
11.01	There was no other business.
12	**Public Questions and Answers**
12.01	*A comment was made on the risks around long waits for neurodiversity and health checks for people with serious mental illness. Black communities were more likely to be impacted in emergency situations and the ICB were asked to maintain commitment to be accountable to safeguard the rights of black communities during the transition fund the VCSE organisations doing crucial work, and ensure the various decision-making boards were representative of the communities they served.* Sir Richard Douglas welcomed the comments made.
12.02	*A comment was made on community neighbourhood representation and the contribution that VCSE organisations could make.* Sir Richard Douglas said that the system had signed up to a VCSE charter and it would be useful to hear back the ways in which this was or was not working.
12.03	*An offer from a company to provide ultrasound diagnostic services.* The ICB would continue to respond to any queries via existing routes and correspondence.
	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 002	15-Oct-26	Board to consider approach to the BAF and risk	open	TF/AB	18-Feb-26	Scheduled for the May Board seminar session
ICB 003	15-Oct-26	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 May Board seminar session
ICB 004	38 Jan 2026	Board to receive an update on Primary Secondary care interface	to be closed	TG	08-Apr-26	On agenda

Board meeting in Public

Title	ICB Change programme update				
Meeting date	8 April 2026	Agenda item Number	5	Paper Enclosure Ref	E
Author	Ceri Jacob Lewisham Place Executive Lead and ICB Change SRO				
Executive lead	Ceri Jacob Lewisham Place Executive Lead and ICB Change SRO				
Paper is for:	Update		Discussion	x	Decision	
Purpose of paper	To provide a progress update to the Board on progress with implementation of the ICB change programme.				
Summary of main points	In March 2025, ICBs were informed of the need to reduce their running costs by 50% in a manner that reflects the ICB blueprint published in May 2025 and the three shifts set out in the 10-year Plan: • From sickness to prevention • From hospital to community • From analogue to digital This is part of a wider change programme that includes DHSE/NHSE and NHS providers. In December 2025, Southeast London (SEL) ICB and Southwest London (SWL) ICB took the decision to formally cluster under a single Chair, CEO and executive team. This was to improve resilience across key functions and to support delivery of the ICB blueprint. The two ICBs remain as separate statutory organisations with separate financial allocations. Teams from both ICBs have worked together to redesign a range of functions that will be delivered through shared teams for South London alongside other functions that will be delivered separately for the two ICBs. Both ICB Boards approved the proposed structures and consultation documents on 25 February and staff consultations were published simultaneously on 5 March. A second Voluntary Redundancy (VR) scheme was launched at the same time. This paper will update the ICB Board on progress with executive appointments, VR schemes, the consultation process and work to prepare for the transitions of functions set out in the ICB blueprint and preparation for the closure of Commissioning Support Units in April 2027.				
Potential conflicts of Interest	Some NHS providers are involved in discussions relating to the transfer of functions.				
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	An initial EIA has been completed. A final EIA will be completed once the new structures have been filled.				

Financial Impact	The ICB must deliver a 35% reduction in its operating costs.
Public Patient Engagement	Not applicable to this paper
Committee engagement	ICB Senior Management Team (SMT).
Recommendation	The Board is asked to note the update.

ICB Change update

NHS South East London Integrated Care Board (ICB) 28 January 2026

1. Background

In March 2025, ICBs were informed of the need to reduce their running costs by 50% in a manner that supports three shifts expected to be set out in the 10-year Plan:

- From sickness to prevention
- From hospital to community
- From analogue to digital

The national 50% reduction equates to a target spend per head of population of £19. Each ICB's target reflects distance from this target after hosting arrangements have been accounted for. The SEL ICB target is 35%.

In December 2025, SEL ICB and SWL ICB agreed to enter a clustering arrangement to secure additional benefits of efficiency of scale and resilience. This included agreement for a single Chair, CEO and executive team. The ICBs remain as separate statutory organisations with separate boards and financial allocations.

Teams from both organisations have worked together to develop structures that will support a range of functions that will be delivered through shared teams under shared directors. Other functions will continue to be ICB specific. Arrangements for Place have not been altered as a result of clustering.

The SEL ICB and SWL ICB have aligned their staff consultations and change programmes to reflect the creation of shared teams and the need to ensure equity of opportunity in the restructuring process.

2. Executive team

As part of the clustering arrangements with SWL ICB, it was agreed that there would be a single Chair, CEO and executive team. Work is underway to recruit to this structure. The Chair, CEO and Chief Nurse and Quality Officer have been successfully appointed. Shared leadership roles with providers have also been confirmed. These are the Director of Communications and Engagement with SLaM (for both ICBs), the Chief People Officer with GSTT and the Chief Digital and Information Officer with GSTT (Both SEL arrangements only). Recruitment is underway for the Chief Finance and Compliance Officer, the Chief Commissioning Officer and the Medical Director roles. Place leadership is unchanged within this process.

3. Voluntary Redundancy (VR)

The ICB launched its first VR scheme, blind of structures, on 1 December 2026. This scheme has now closed and the overall position for VR1 is:

Outcome Category	Number of Cases
Settled agreement	52
Outstanding	2
Application withdrawn	6

Every VR applicant was eligible for legal support to ensure their decision making was supported by expert advice. In addition, dedicated HR sessions were provided where people taking VR could raise questions about the process and their own personal arrangements.

Each director has agreed how to manage any gaps in capacity resulting from the VR process ahead of the new structures being implemented. This has included consideration of potential impacts on other directorates.

A commitment had been given to staff to re-run the VR scheme once structures were known. Therefore, a second scheme, VR2, was launched alongside the staff consultation on 5 March. This will close on 2 April 2026. Staff may withdraw applications at any point up to the point where final agreement letters are signed.

Voluntary redundancy applications are not expected to achieve the full reduction required of c170 posts and at least half of all redundancies in SEL ICB will be through compulsory redundancy.

4. Consultation process and feedback

The staff consultation was published on 5 March and will close on 20 April 2026. Figure 1 sets out a high-level timeline for the consultation through to issuing of compulsory redundancy notices during October/November 2026. Exit dates for staff vary according to the required notice period for their role. During this notice period, the ICB will continue to support staff to secure Suitable Alternative Employment (SAE) and the ICB commissioned support offer will continue to be available during this time.

All responses submitted are formally acknowledged. Points of clarity or relating to personal circumstances and HR processes are answered immediately. All other comments will be responded to as part of the management response in May. This will confirm final structures for the ICB.

All Staff Briefings (ASB) with the CEO, SROs and directors continue to be held on a weekly basis and provide an opportunity for staff to raise questions. In addition to the ASBs, directorate specific sessions and "ask HR" sessions are also being held.

SEL and SWL are progressing to the same high-level timelines.

5. Transition

Transition to a new strategic commissioning ICB with much smaller structures will require significant redesign of operating models and ways of working. This includes within SEL ICB based teams, between SEL ICB based teams and within those teams that will be shared with SWL ICB under the new cluster arrangements. An organisational development (OD) programme is in development.

In addition to changes in the operating model and ways of working, governance of the ICB will need to change to reflect statutory responsibilities and role of the ICB within the SEL wider system. This will also need to reflect clustering arrangements with SWL ICB. Work is underway to review governance of the ICB and will be considered at future meetings of the ICB Board.

6. Transfer of functions and closure of the Commissioning Support Unit (CSU)

The ICB blueprint, published in May 2025, set out a range of functions that should be transferred from ICBs over time. Following an expression of interest (EOI) and application process with SEL NHS providers, the ICB agreed the following functions for transfer:

- Estates (excluding strategic estates)
- Medicines optimisation (delivery function, integrated and specialist function)
- Infection Protection and Control (IPC)
- HR and development for ICB staff and local workforce development
- Digital

ICB leads are working with provider colleagues to develop function specifications. Teams will be streamlined prior to any transfer. Most transfers are expected to take place in April 2027, with estates transferring in October 2026. An assurance process has been agreed that aligns with the NHSE assurance process. The Transition Committee is overseeing this process and will make recommendations to the ICB Board regarding final transfer plans.

CSUs are expected to close by April 2027. ICBs have been working together with NHSEL to agree future destinations for CSU provided functions with some needing to be re-procured during 2026/27. Workforce related functions are being reviewed through the London Chief People Officer Group, the DSCRO function is subject to a nationally led process and other functions are being reviewed by individual ICBs. Further updates will be provided to the Board as the work progresses.

7. Next steps

The staff consultation will close on 20 April. Feedback will be considered on a themed and individual basis, by directorate and across directorates. This will inform the management response and final structures, which are expected to be published towards the end of May.

Following this, work will commence to fill posts through slotting in, ringfenced interviews and, where a post remains unfilled, open competition.

Preparation for longer term actions to support transition to the new ICB structure and the clustering arrangement with SWL will continue.

Board meeting in Public

Title	Chief Executive Officer's Report				
Meeting date	8 April 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) 8 April 2026

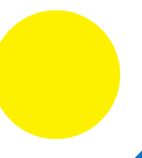
The report that follows provides an overview of the activities of the ICB and its partners across the system seeking to highlight those issues that the Executive Directors and their teams have been addressing over the last period and to record those developments of note in our work.

Since the Board last met in public, our system has continued to manage high levels of demand and operational pressure, achieved its 2025/26 financial plans on the whole, whilst coming together to agree system wide plans for 2026/27 in an exceptionally challenged policy and economic context. As we begin that new year, and at the time of writing, the system is already preparing its response to further rounds of Industrial Action, however and will be prioritising patient safety and seeking to minimise disruption to patients' care. As such the system will seek to balance a challenging plan for delivery against a backdrop of turbulence both within the health and care system, but as a result of wider global events.

Our agenda includes further detail upon the management of change process the ICB is pursuing, in partnership with colleagues in NHS South West London ICB, to secure a management structure and organisational form that responds to local ambition, national plans and the 'ICB Blueprint' that outlines the future functions for our organisation. This must be achieved within resources available to ICB that have reduced by 50% nationally from the beginning of this financial year (35% in the case of south east London). In order to achieve these requirements the ICB has entered a cluster arrangement with south west London allowing us to share resources and benefit from scaled functional delivery where appropriate, whilst maintaining two separate statutory bodies with responsibilities for their respective populations.

Management cost reductions of this size have required a significant change programme and will result in voluntary and compulsory redundancies for a significant number of our staff. This programme is progressing to plan and a consultation with all staff began on 5 March 2026 and will close on 20 April, before being responded to by the Executive team in May 2026. We wish to place on record our gratitude for the professionalism of our staff at this time and to acknowledge the anxiety and uncertainty this will be causing them. Our absolute commitment to support them and our work to ensure regular and open communication over this difficult time remains.

Our agreement to share functions with south west London ICB extends to shared leadership roles. The Board was made aware of the appointment of Sir Richard Douglas as the Chair of both ICBs at the end of last year. In February, I was fortunate enough to be appointed as the Chief Executive Officer of both ICBs, a role that I took up in the same month. It is an honour and a privilege to take on this role and to work across those organisations to ensure we secure



the best possible outcomes for the population across the 12 south London Boroughs. Appointments to executive team roles commenced in the first week of March.

When taken together our board papers today outline current system pressures, an incredibly challenging set of plans for the year we have just begun, alongside cost reductions in the management resources we have to address them. The scale and pace of these challenges require 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. Leadership changes

1.1. At the end of March 2026, the ICB bid farewell to our Deputy Chief Executive and Executive Director of Planning, Sarah Cottingham. Beginning her career in south east London in 1992, Sarah has made an enormous contribution to the system and across the last month our Board, teams and partners have been able to express their thanks and gratitude for Sarah's work and leadership. Board members will be aware that in advance of her departure, Annabel Appleby and Rupinder Dev took up the role of Acting Executive Directors of Planning from 1 March 2026

1.2. In the period since the Board last met in a number of leadership appointments have been made. King's College London NHS Foundation Trust will welcome Matthew Trainer as Chief Executive over the summer months. Matthew is currently the Chief Executive at Barking, Havering and Redbridge University Hospitals NHS Trust and is returning to south east London having held leadership positions in the Trust previously and more recently as the Chief Executive of Oxleas NHS Foundation Trust.

1.3. South London and Maudsley NHS Foundation Trust (SLaM) announced the appointment of Paul Calaminus as their new Chief Executive. Paul is currently Chief Executive at North East London NHS Foundation Trust. Paul will also join in the summer and returns to south east London having held leadership positions in SLaM previously.

1.4. Professor Clive Kay, who will retire in July this year, and Ade Odunlade continue as Chief Executives of Kings Colle Hospital NHS Foundation Trust and SLaM respectively until Matthew and Paul take up their new roles. We welcome them both to the system and look forward to working with them.

2. Equalities Update

Equalities Sub-Committee (ESC)

2.1. The Equalities Sub-Committee, chaired by the Chief of Staff and Equalities SRO, met in March and considered a range of topics including: a borough deep dive for Bexley, Healthwatch update, LGBTQ+ Health Inclusion Framework and discussions on upcoming statutory requirements (details below). The next ESC meeting will be held

in May and will be looking at the plan ahead for 2026/27 given the organisational transition and changes.

Public Sector Equality Duty (Equality Act 2010)

2.2. Fulfilling responsibilities under the Equality Act 2010, SEL ICB has developed a new PSED report and Equality Objectives. The 2025 PSED report highlights a broad range of activities undertaken by the ICB to meet its statutory duties. Case studies across the ICB include: black maternal health programme, sickle cell community pilot, Bromley homeless dental service, Southwark inclusive surgeries project and many others. A new set of equality objectives reflect a range of focus areas, such as engagement, planning, workforce and leadership, aligned with strategic commissioning where relevant, for implementation in 2026/27. Both reports will be published on the SEL ICB website in April 2026.

Gender Pay Gap

2.3. SEL ICB has compiled its Gender Pay Gap 2025 report which shows an increase in the gender pay gap between men and women from the previous year (from 5% in 2024 to 10.6% in 2025). The gender pay gap is not related to equal pay but describes the average earnings across the organisation and is influenced by gender balance and composition. The increase could therefore be a result of organisational change. As required, findings have been reported to the Government Equalities Office to meet the statutory reporting deadline of 30 March, and the report and related action plan will be published shortly.

Equality Delivery System 2022

2.4. SEL ICB has led a programme of EDS22 work across the South East London Integrated Care System (SEL ICS), convening and collaborating with south east London partners to implement this national quality improvement framework for equalities, developed by NHS England. In 2025/26, the focus has been on delivering implementation plans from previous assessments undertaken in 2023/24 and 2024/25. A SEL ICS task and finish group has met regularly during this period and conducted deep dives for:

- Domain 1: Commissioned or provided services
- Domain 2: Workforce health and wellbeing and
- Domain 3: Inclusive leadership.

2.5. Progress has been shared on ICB improvement plans at Equalities Sub-Committee meetings, and these are captured in an annual EDS22 summary report, currently being taken through governance processes. The overall EDS22 score for SEL ICB remains at 22, a rating of 'Achieving', based on the last assessment.

3. Planning Round Outcome

3.1. For the last few months, the Planning Directorate has been focussed on leading the coordination of the national strategic and operational planning process. The ICB made its final strategic and operational planning submissions on 12 February 2026,

alongside Trusts who also made individual submissions. There was close collaboration in the development of all plans to ensure alignment across the south east London system, including performance trajectories, activity, finance and workforce plans and strategic priorities for the next five years.

3.2. The SEL ICB Board had a number of briefing sessions, informal and formal meetings to input into, shape and sign off the ICB plans. These discussions included review of areas of non-compliance and delivery risk within the ICB operational plans, as well as in-depth discussion on the strategic plan, including its overarching strategic priorities and objectives, how it supports delivery of the national 10-year health plan and south east London population health needs and service priorities and use of the Strategic Investment Fund established to support targeted investment in strategic priority areas.

3.3. Following submission, there has been a regional and national review process for operational plans. This led to specific follow up discussions for some south east London organisations with regional and national teams which have now concluded, and final plans are in place.

3.4. It should be noted that whilst plans have been finalised, the pace and scale of required improvement over 2026/27 in relation to operational delivery, performance improvement and delivery of financial savings is significant. Alongside the need to progress transformative change for the medium term, aligned to the direction of travel set out in the strategic plan, this is an area of challenge and risk for the system. Delivery will be tracked against plan over 2026/27 to ensure an ability to identify issues and develop remedial action plans in a timely way.

3.5. Following final planning submissions, the Planning Directorate has been working to translate the agreed operational and financial plans into contracts with NHS providers and relevant independent sector organisations. These conversations are progressing well and are on track for contract agreement by 31 March 2026, with contract signature to follow.

4. Neighbourhood National Guidance Issuance

4.1. National neighbourhood guidance was published on 17 March 2026, setting out clear priorities and assessment expectations for ICBs in 2026/27. The requirements broadly align with the direction already underway in south east London, but places greater emphasis on clarity of plans, ownership and demonstrable impact. Two key documents were released:

1. The Neighbourhood Health Framework confirms neighbourhood working as the way services will be delivered and sets out priority actions for 2026/27, including:

    - Reducing non-elective admissions and bed days through strengthened neighbourhood-level urgent, rehabilitation and reablement services.
    - Tackling unwarranted variation and improving access to general practice, including delivery of new urgent access requirements.
    - Agreeing neighbourhood footprints based on natural communities and establishing integrated neighbourhood teams (INTs) focused on priority cohorts.

- Developing neighbourhood approaches to elective pathways and community waits, including meeting RTT standards and eliminating 52-week waits.
- Confirming use of pooled Better Care Fund resources, improving the primary–secondary care interface, and ensuring clear accountability, data-sharing and evaluation arrangements.

2. Population health commissioning – Fit for the future sets out expectations for ICBs to move towards population-health-based commissioning models over the next three years. It provides greater clarity on:
   - How commissioning models are expected to align and evolve over time
   - The pace of transition to population-based approaches
   - The role of Integrated Health Organisations (IHOs) and links to advanced trust status
   - Further national guidance and consultation expected during the year

4.2. All six south east London places are now developing or operating Integrated Neighbourhood Teams (INTs), with differing levels of maturity. INTs remain the primary delivery vehicle for neighbourhood care, bringing together primary care, community services, social care, mental health and the voluntary sector as “teams of teams” working around defined neighbourhood populations.

4.3. Priority cohorts remain people living with frailty and approaching end of life, people with multiple long-term conditions, and children and young people with complex needs.

4.4. During 2026/27 every place is expected to have at least one functioning INT and a minimum of 1.5% of the population supported through INT models by year end. There is an increasing emphasis on proactive care, supported by population health management tools rather than referral-only models.

4.5. The publication of national guidance confirms and sharpens the neighbourhood approach already underway in south east London. The system is now firmly in a delivery phase, with 2026/27 focused on demonstrating impact, reducing variation and embedding neighbourhood working as the default way of delivering care, whilst remaining flexible to emerging national policy and guidance.

5. Planning Directorate Update

Mental Health, Learning Disabilities and Autism Inpatient Quality Transformation Plan

5.1. In 2024, the Planning Directorate worked with the two mental health trusts to develop and agree a system mental health, learning disabilities and autism inpatient quality transformation plan in line with the expectations of the national inpatient quality transformation programme. This plan was endorsed by the SEL ICB Board in September 2024 and subsequently published on the SEL ICB website.

5.2. In February 2026, all ICBs were asked to provide an update to their Boards on progress and delivery of their plan by 31 March 2026. An update was shared with the Board in March as part of the informal Board and it has been agreed that a further update on delivery will be provided to the ICB Board in quarter three of 2026/27.

5.3. In addition to providing an update on the delivery of the system mental health, learning disabilities and autism inpatient quality transformation plan, ICBs were also asked to complete the following by 31 March 2026:

- Reviewing all current patients in St. Andrew's, ensuring the relevant welfare checks are in place and that discussions are underway to find alternative care provision for any patients at St. Andrew's. At the time of writing this paper, the ICB is aware of nine patients from south east London currently placed at St. Andrew's (placed by the ICB and South London and Maudsley NHS Foundation Trust). All welfare checks have been completed, however, discussions on finding alternatives for these patients will need to continue into Quarter 1 depending on individual patient need.
- Completing a national baselining tool on the current provision of mental health inpatient rehabilitation services. The ICB completed this work in November 2025 and the actions from this work will be taken forward as part of plans for 2026/27. An update on this will be included in the planned update on the system mental health, learning disabilities and autism inpatient quality transformation plan later in the year (as referenced above).
- Ensuring the relevant data reporting arrangements are in place for patients who are placed in inpatient beds outside of the sector. This work is being led by the two mental health trusts and any ICB teams placing patients outside of area (specifically ICB joint commissioning teams and the learning disabilities/autism programme). This will be an ongoing area of work over the next six months as it is ensured that the reporting arrangements are in line with national expectations, supported by the regional mental health team.

6. Quality Directorate Update

6.1. Throughout quarter three, the Quality team has maintained system oversight of patient safety, coordinated Patient Safety Incident Investigation (PSII) activity and supported provider-led improvement in line with agreed Patient Safety Incident Response Framework (PSIRF) plans. Phase 2 PSIRF pilot in general practice has ended after involving five south east London participants. Work now focuses on embedding the principles across general practice by integrating requirements into the south east London PSIRF policy, aligning requirements with Care Quality Commission preparedness tools and creating practical implementation supports e.g. flowcharts.

6.2. The Safeguarding team has progressed their workplan by improving system intelligence and oversight, including a shared Serious Violence Dataset and strengthened triangulation of serious violence/ VAWG insights with commissioning and statutory reviews. Work has progressed to mobilise the Families First Programme (with Lewisham as the pilot) and to roll out CP-IS Phase 2 across south east London. The Child Death Overview Panel (CDOP) internal audit has now been completed, with recommendations to be progressed during 2026/27.

6.3. The Local Maternity and Neonatal System (LMNS) has worked with the three acute trusts on Maternity Incentive Scheme (MIS) year 7 submissions. All trusts submitted their declarations and where they are not fully compliant appropriate action plans and mitigations are in place. A number of transformation programmes continue, focusing on prevention, population health, and workforce leadership development.

6.4. Progress has continued over the past number of months within the Learning Disability and Autism (LDA) programme to reduce reliance on inpatient care and strengthen quality and safety for people with a learning disability and autistic people through enhanced community provision, governance, medicines optimisation, and workforce capability. In relation to Annual Health Checks (AHC), at the end of January 2026 all boroughs in south east London surpassed the operational target and are on track to exceed the 75% target by the end of 2025/26.

6.5. In response to the Schools White Paper and national Special Educational Needs and Disabilities (SEND) reforms, south east London partners are developing Local Area SEND Reform Plans, supported by national advisers, with SEL ICB required to formally agree and sign off these plans through the Chief Executive by 18 June 2026.

7. Bexley Borough Update

Delivering Integrated Neighbourhood Care

7.1. **Ageing Well & Frailty Model** - Bexley is piloting an innovative Ageing Well & Frailty Model to provide more coordinated, proactive support for residents who are mildly to moderately frail. A core Integrated Neighbourhood Team, including health, social care, voluntary sector and library staff, delivers joined up, community-based care tailored to individual needs, with monthly multidisciplinary meetings bringing in additional specialist input when required. The aim is to promote wellbeing and independence for older adults by providing proactive multidisciplinary support that maintains mobility, confidence and social connection and enables early intervention to help people live well at home for longer.

7.2. The model operates through two distinct, but interconnected, components. Aimed at residents aged 50 and over who live in Sidcup and the surrounding areas, the Hub supports people who are mildly frail or at risk of becoming frail, for example those experiencing reduced confidence, social isolation, recent life changes or early difficulties with daily activities. The Integrated Neighbourhood Team focuses on residents who are moderately frail and need more practical help with daily living, maintaining independence, medication or mobility. Linking both is the Bexley Age Well Navigator, providing continuity and helping residents access support quickly.

7.3. The pilot is funded by SEL ICB and is the result of collaborative work through the Bexley Health & Wellbeing Partnership, co-designed with the London Borough of Bexley. Over the past year, partners have mapped demand and existing assets, developed a best practice framework, identified gaps and opportunities, engaged stakeholders and co-designed an end-to-end model. The pilot launched in January 2026 and is now being tested locally as a blueprint for future neighbourhood-based frailty care.

Investing in Primary Care

7.4. New General Practice Premium - The new Bexley GP Premium is designed to fund primary care activity that goes beyond core contractual requirements, directly supporting system priorities, population health management, and improved outcomes for residents. It enables targeted investment in preventative, proactive, and personalised care, particularly for priority groups such as people with multiple long-term conditions, frail adults, and children and young people. By incentivising services not consistently delivered through national contracts, it aims to address unmet need, reduce variation between practices, tackle health inequalities, and strengthen the role of general practice within neighbourhood-based care.

7.5. The new scheme is an activity-based, outcomes-focused model that commissions primary care to deliver holistic and preventative services beyond standard national Personal Medical Services contracts. It focuses on key population priorities outlined in the Joint Local Health & Wellbeing Strategy, supporting interventions such as: extended holistic appointments, improved asthma management, wound care, insulin initiation, GLP-1 administration, shared care agreements, and advanced care planning through Universal Care Plans.

7.6. The Bexley GP Premium aligns with national priorities, including the shift from treatment to prevention, hospital to community care, and analogue to digital systems. It is integrated with emerging Integrated Neighbourhood Teams (INT) to deliver coordinated, localised care that improves patient outcomes and experience. Payments are linked to both activity and outcomes, with some elements commissioned at Primary Care Network level to promote collaboration and reduce variation across practices.

7.7. A key feature of the scheme is its digital integration through Ardens Manager, which supports real-time monitoring of activity, outcomes, and payments. This system enables practices to identify and prioritise high-risk patients using predefined population health searches, streamline service delivery, and track performance.

7.8. The new Bexley GP Premium includes a Primary Care Network-level Collective Endeavour element. Aggregating practice-level activity to Primary Care Network (PCN) level encourages collaboration, shared learning, and equitable service delivery across neighbourhoods. High-performing practices support others, helping to reduce unwarranted variation and strengthen the emerging INT model/s.

Care and Support Closer to home

7.9. On 15 February 2026, a team from Hayshine Pharmacy delivered an outreach health initiative at the Sikh temple (Gurdwara) in Belvedere, organised by SEL ICB, bringing preventative care services directly into the community. The team provided free blood pressure checks, finger-prick testing for prediabetes and type 2 diabetes, alongside personalised wellbeing advice and appropriate signposting based on individual results. This approach supports improved access to early detection and preventative care within trusted community settings.

8. Bromley Borough Update

Bromley Winter Vaccinations Update

8.1. Vaccinations this winter have been provided across the borough by GP Practices and Community Pharmacies. Vaccinations for Bromley's housebound population were conducted by Bromley Healthcare and GP practices, with over 1,600 vaccinations delivered at the time of writing.

8.2. Most recent data shows that:

- Over 22,000 COVID-19 booster doses were given in Bromley, achieving an uptake of over 60% amongst those aged 75 years and older. Vaccination teams have been visiting housebound residents and those living in residential and nursing homes to ensure they are offered a vaccination. Over 75% of eligible care home residents have received their booster vaccination to date.
- For flu, Bromley achieved an uptake of 71% for our over 65 year olds, with nearly 46,000 vaccinations delivered. Over 18,000 vaccinations were delivered to the under 65s at risk, and with an uptake of 41%.

8.3. Bromley has been working closely with the communications and engagement team and One Bromley partners to promote the benefits of vaccination and co-develop outreach initiatives. These initiatives included:

- Prominent advertising in The Glades Shopping Centre in central Bromley, publications in local newspapers and in the Our Bromley magazine.
- Six pop up vaccination clinics seeking to reach people who otherwise may not have taken up the vaccine offer, has resulted in over 100 people being vaccinated against flu and over 50 against COVID-19.
- A number of specific events such as one in Penge at the Kentwood Adult Community College, involving London Borough of Bromley Public Health providing health promotion advice on the day and an event targeting at-risk patients at the One Bromley Wellbeing Hub, offering both Flu and Covid vaccinations, along with floorwalkers on the day to explain the NHS App to visitors. Experience has indicated that events providing health information on a number of issues, alongside vaccinations, are more successful and well-received by patients.
- Maternity teams from King's College Hospital NHS Foundation Trust offered pregnancy vaccinations at the One Bromley Wellbeing Hub, providing flu, whooping cough and RSV vaccinations to this cohort. Flu vaccinations uptake for this cohort was nearly 45%.

Bromley Winter Update

8.4. Overall system performance remained broadly stable during the winter period. The proportion of patients waiting over 12 hours in the Emergency Department remained variable, averaging 10.7% against the 10% national threshold, whilst ambulance handover performance improved intermittently, with periods where delays fell significantly. Community alternatives to admission supported system resilience, with

Adult Hospital at Home maintaining strong utilisation, with occupancy ranging between 69% and 87%, peaking at 86.7% in November, and maintaining an average length of stay below the 7-day target. Work within the care home programme also supported system flow, with Bromley seeing a smaller increase in care home conveyances (around 5%) when compared with approximately 10% across London and south east London, and more recent data indicating an 8% year-to-date reduction.

8.5. Clinical advice pathways also remained active, with Consultant Connect call volumes consistent with previous winters and strong answer rates for medical and frailty specialties, typically exceeding 80%, although variation in utilisation across specialties persists. Primary care access was further supported through the Winter Access Collaborative, which delivered 7,677 additional same-day GP appointments across 19 practices, with patient feedback suggesting that 42.7% of respondents (approximately 3,023 patients) would otherwise have attended A&E or a UTC. Learning from the programme highlighted the need for improved interoperability to enable direct booking from UTC and community pharmacy services. Pharmacy First recorded 11,403 referrals, with most activity driven through patient self-referral (57.5%) and NHS111 triage (29.3%), meaning 86.8% of demand came through community access and urgent care triage routes, although there remains high utilisation for repeat medication requests via NHS111 and overall referral volumes remain relatively low compared with wider urgent care demand.

8.6. Whilst overall urgent and emergency care performance remained broadly stable, paediatric 4-hour performance remained around the 60% level across the winter period, fluctuating between 52% and 63%, although there were periods of relative stability, particularly during December, and length of stay for children and young people remained relatively short at around two days. A full evaluation of winter schemes and system performance will be undertaken in March and reported in April, including an assessment of the impact of key interventions, system performance trends and areas for improvement ahead of winter 2026/27.

CYP Audiology

8.7. The ICB is transferring Bromley's Tier 2 paediatric audiology services from Bromley Healthcare to Evelina London Children's Hospital from 1 April 2026. This decision follows a national NHS England Paediatric Hearing Services Improvement Programme, which highlighted challenges with both immediate and long-term delivery of the service in Bromley.

8.8. Evelina London has been selected as the provider for Tier 2 audiology across south east London, as it is the only service that is UKAS IQIPS-accredited and already responsible for all Tier 3 specialist services. Consolidating audiology provision aims to reduce variation, strengthen clinical governance, address workforce constraints, and ensure the long-term sustainability of the service.

8.9. From April 2026, Bromley children requiring routine audiology appointments will be seen at Evelina sites in Lambeth, Southwark, or Lewisham until a new Bexley, Bromley and Greenwich compliant site is established in 2026/27. Whilst this may create short-term travel challenges for some families, mitigations such as the NHS Healthcare Travel Cost Scheme will be available.

8.10. A joint communications plan will ensure that families, referrers and local stakeholders receive clear and timely information. The overall aim is to ensure Bromley children receive safe, high-quality, nationally compliant audiology care.

Bromley Health and Wellbeing Hub

8.11. Bromley's new Health and Wellbeing Centre, which opened in January, in the heart of the town centre, was formally opened by the Mayor of the London Borough of Bromley on 25 March. Located at Ravensleigh House on Westmoreland Place, the Centre brings a wide range of health and wellbeing services under one roof in bright, modern and accessible accommodation. It is also now home to the Dysart GP Surgery and the One Bromley Wellbeing Hub, previously based at The Glades.

8.12. In line with the NHS 10-year plan, the Centre plays a key role in the NHS's shift towards prevention, offering convenient access to health checks, practical advice and early intervention in addition to GP services. Services such as blood pressure checks, weight management, smoking cessation, lifestyle programmes, maternity services and the enhances community sickle cell service help people stay well for longer, avoid preventable illness and reduce pressure on local hospitals. Citizens Advice support is also available at the Centre.

9. Greenwich Borough Update

9.1. Greenwich has made rapid progress in its plans to deliver a Neighbourhood health and care service since the last update. A co-ordinator for each Neighbourhood has been nominated working to implement the frailty and long-term condition pathways and have kicked off work planning for mental health, children and young people. The delivery senior responsible officer has convened a first delivery committee of all partners and in the East Neighbourhood there have been significant successes delivering on priority work with carers, with housing and through a new partnership with the local children's hub. There has also been a launch for the new Transfer of Care Hub at Queen Elizabeth Hospital which will support smoother discharges in Greenwich and Bexley.

Primary Care

9.2. Greenwich has launched a borough-wide Proactive Care Pathway through the expansion of its Frailty service, with an ambition to increase caseloads by 50% in year one. The pathway broadens multi-disciplinary team (MDT) input, with a focus on moderate frailty and rising risk. Delivery is supported by non-recurrent Neighbourhood funding and Personal Medical Services (PMS) premium allocations, including a Local Incentive Scheme to improve frailty coding and further investment to increase Universal Care Plan completion.

9.3. The Long-Term Conditions (LTC) pathway, aligned with south east London frameworks and Public Health priorities (including hypertension, cardiovascular disease and diabetes), will launch in spring. This builds on the Heritage Primary Care Network (PCN) Chronic Kidney Disease multi-morbidity pilot, with a strong emphasis on prevention.

9.4. Following a pilot of the Local Child Health Team model in two PCNs, work has commenced to scope and design community-based child health clinics. This work will be data-led and undertaken collaboratively with system partners, supporting the extension of Children and Young People (CYP) Integrated Neighbourhood Team (INT) arrangements across Greenwich in line with south east London strategies.

9.5. An initial model for Neighbourhood leadership teams has been agreed, with recruitment underway for key roles including INT Clinical Leads, Neighbourhood Coordinators, Voluntary Community and Social Enterprise (VCSE) leads, and physical health, mental health and social care leads. Service restructuring is also progressing to better align district nursing, adult social care and other services to Neighbourhood footprints.

9.6. Neighbourhood Hub development remains a priority within the Estates and Spaces workstream. This builds on the Greenwich General Practice Estates Strategy, partnership site visits, and coordinated capital bids with Oxleas. Engagement with Regeneration and Housing partners aims to influence local regeneration plans and maximise Section 106 and Community Infrastructure Levy opportunities, including major developments in Thamesmead, Woolwich, Plumstead and Abbey Wood.

General Practice

9.7. Six of Greenwich's 29 GP practices are currently rated Requires Improvement by the Care Quality Commission (CQC). One practice had its GP partnership registration cancelled at short notice on 19 March 2026 and is now being managed by a caretaker provider pending a longer-term decision. Wider challenges include branch closures, partner retirements, contract changes, investigations, landlord disputes, space constraints and two Serious Incidents recorded in 2026 to date.

9.8. Despite these pressures, progress has been made. One practice has re-opened following refurbishment, two practices have recently achieved a *Good* CQC rating, and improvements continue in appointment access, extended access, telephony and the rollout of Pharmacy First. The ICB continues to support practices to improve quality, safety and long-term sustainability.

Integrated Commissioning – Children

9.9. Single Point of Access - The development of a Single Point of Access (SPA) for children's mental health and emotional wellbeing continues to progress. Multi-agency work is taking place designing clinical pathways within the SPA including referral pathways, the Multi-Disciplinary Team configuration for the SPA, clinical models and governance, the digital front end interface and financial modelling. The aim is to complete most of this work by May 2026 to then begin work on the implementation.

9.10. SEND System - Greenwich is continuing to review opportunities for how it strengthens the local system supporting children with special educational needs and disabilities (SEND). A national request by the Department for Educations and the Department of Health and Social Care has been made to ICBs and Local Authorities to complete a Local Partnership Maturity Assessment. Work is underway with partners to inform the completion of the assessment including a half day workshop between the ICB, Local Authority and Oxleas Children's Services. The framework itself covers 7 areas including:

- Co-production with parents and carers and children and young people
- Effective system leadership and governance
- Accurate understanding of needs and experiences of children and young people through effective use of quantitative and qualitative data
- High quality service delivery at universal, targeted and specialist levels to promote inclusion
- Effective Partnership working across education, health and social care
- Skilled and organised workforce across local authority, education settings, health and social care
- Targeted and judicious use of resources including place planning, sufficiency and use of capital

Integrated Commissioning – Adults

9.11. Home First, Urgent and Emergency Care, and Winter Resilience - The Adults team continues to work collaboratively to strengthen community provision and improve urgent and emergency care performance. The Transfer of Care Hub (TOC) opened in March, representing a significant milestone. Activity during "Super March" has delivered positive impact, with learning being embedded to support sustainability and inform future investment shifts from acute to community care.

9.12. The Eltham Community Hospital project has reached a key milestone, with the tender for care and support services launched and capital investment secured following design approval. Over £5 million has been leveraged to support local intermediate care services, enabling Eltham to develop further as a health and care hub aligned with Neighbourhood plans.

Section 106 Investment

9.13. In March, funding was awarded to Greenwich and Bexley Community Hospice to support improvements to the inpatient unit. The award marks the next phase of delivery, with opening anticipated later in 2026. Media coverage has generated positive feedback, and local teams are exploring opportunities for staff volunteering to complement the funded works.

Strategic Commissioning and Digital Transformation

9.14. The Digital Health and Care Technology (DHACT) service has been shortlisted for a Local Government Chronicle Award, with the outcome expected in early summer. Planning continues for the next phase, including the delivery of remote monitoring for virtual wards from April. Work is also underway to improve data flows and information-sharing arrangements, supporting robust evaluation and future investment decisions. DHACT remains a core enabler for Integrated Neighbourhood Teams.

9.15. Progress has also been made in developing proposals to invest Adult Social Care reform funding into integrated health and care data solutions for operational, commissioning and research purposes. This aligns with national ten-year plan requirements, with Greenwich working alongside partners, including Guy's and St

Thomas' NHS Foundation Trust and the Social Care Institute of Excellence to support delivery and evaluation.

Homecare Transformation

9.16. Homecare contracts have been extended, and engagement with residents and care workers has commenced as part of the INT-aligned transformation programme. This includes the launch of a Greenwich Care Workers Network. The programme continues to focus on fair pay, delegated health tasks and digital integration, with testing and evaluation ongoing.

Mental Health

9.17. Work has commenced to agree the approach to cross-system transformation of community mental health services, alongside frailty and LTC INT developments. This forms a key component of the wider mental health change programme and will ensure alignment with south east London and national requirements, informed by resident engagement through the mental health vision work.

10. Lambeth Borough Update

Our Health, Our Lambeth 2023-28

10.1. As the third year of implementation draws to a close, *'Our Health, Our Lambeth',* Lambeth's Five Year Health and Care Plan, continues to act as the borough's blueprint for integrated health and care delivery. The partnership has continued to sustain improvement with a clear purpose, whilst navigating ongoing service and resource challenges and responding to shifts in the national policy landscape.

10.2. The third annual review of *Our Health, Our Lambeth* provides an important opportunity to reflect on progress against agreed outcome measures, re-affirm priorities and ensure Lambeth's approach remains grounded in the needs of Lambeth residents.

10.3. During Quarter 4, partners have undertaken the process to renew the Action Plan for 2026/27, building on the progress made over the last three years, whilst ensuring ongoing alignment with the refreshed Lambeth Health and Wellbeing Strategy 2023-28, and the new ICB Five Year Strategic Commissioning Plan. Together, these plans provide a coherent framework that connects borough-level priorities with neighbourhood delivery and system-wide commissioning intentions, strengthening the collective ability to address inequalities and improve outcomes.

10.4. Partners also undertook a mid-point review of Lambeth's Health and Wellbeing Strategy 2023-28. The focus has been on ensuring the strategy remains meaningful, measurable and aligned to the borough's wider ambitions to reduce inequalities and strengthen prevention efforts. In February, the Lambeth Together Care Partnership Board and Lambeth Health and Wellbeing Board held a joint session to consider how to focus efforts over the coming years to best support the delivery of the second half of the Strategy. The Strategy refresh was approved by the Health and Wellbeing Board on 25th March.

Leadership and Governance

10.5. Board members recognised the career achievements of Richard Outram, Director of Adult Social Care, on his retirement after 39 years of dedicated service to social care. The recruitment process for the new Director of Adult Social Care is underway, and Richard Sparkes will be taking on the role of Interim Director of Adult Social Care until this process concludes.

Working in the Community

10.6. **Neighbourhood and Wellbeing Delivery Alliance (NWDA) -** Lambeth Together partners are expanding support for residents with chronic obstructive pulmonary disease (COPD) as part of Lambeth's shared commitment to bring more care closer to home in local neighbourhoods.

10.7. The North Lambeth Primary Care Network (PCN), in partnership with Guy's and St Thomas' NHS Foundation Trust, is launching a new proactive care service for people in North Lambeth living with COPD. The service will support up to 150 patients at a time and is designed to help identify problems early, provide support at home, and reduce the risk of avoidable flare ups and hospital visits. The service is delivered in partnership with Doccla, who support NHS proactive and virtual care services. The new remote monitoring service will benefit residents with extra support to stay well at home, reflecting the ambition to shift more specialist support into neighbourhood settings, enabling people to stay well for longer and maintain their independence.

10.8. **Living Well Network Delivery Alliance (LWNA) -** South London and Maudsley NHS Foundation Trust (SLAM) are currently consulting staff on proposed changes to community mental health services, which would mean the current Living Well Centres organise their staff to provide support based on the five Lambeth neighbourhoods and to simplify the range of different mental health support provided. If agreed, these changes would mean people are supported by teams more familiar to them and their area and that support offers and eligibility are clearer from September 2026. There will be a programme of engagement over the coming months with those that Lambeth support and their carers, particularly the small number of people who might see a change in where and/or who they get their support from.

10.9. **Children and Young Person Delivery Alliance (CYPA) –** The Children and Young Person Delivery Alliance have continued to develop integrated neighbourhood teams for young people in Lambeth. Building on earlier engagement with partners, the Alliance has completed a prioritisation process to focus effort on areas where a neighbourhood approach can add most value. Two pilot areas are being progressed. The first focuses on children and young people who are frequent attenders at Emergency Departments. This work is exploring how services can come together at neighbourhood level to better understand patterns of attendance, identify underlying needs and provide more coordinated support. The second pilot relates to transition into adulthood for young people with special educational needs. Partners are considering how health, education and social care can align more effectively to support smoother transitions and clearer forward planning as young people move towards adult services.

Equality, Diversity and Inclusion

10.10. Lambeth has been re-accredited as a Borough of Sanctuary. As part of the process, the Council has produced a Borough of Sanctuary Strategy 2025/2028, which highlights commitment to helping individuals seeking safety. The new Strategy was launched in February. For information - Learn more about Lambeth's Borough of Sanctuary recognition

10.11. Lambeth Health Determinants Research Collaborative (HDRC) has joined the national £50 million NIHR Cardiovascular Disease Inequalities Challenge Consortium, working with King's College London, the University of Nottingham and Boots as part of the CIRCLE PLUS partnership. This major programme brings community knowledge into the design of new approaches to cardiovascular health, aiming to reduce the higher risks faced by Black, Asian, Multi-Ethnic and more deprived communities.

10.12. In February, in partnership with the Black Prince Trust and Carers Hub, an event for Unpaid Older Carers Event attracted 60 older residents participating in activities such as digital skills training and chair-based exercise classes. Drop-in information and advice were available from Age UK Lambeth, Health and Wellbeing Champions, Carers Hub, Blue Sky Brokers (offering support on direct payments), and the Carers' Champion Social Worker. Information and support for Carers is available from Carers Hub Lambeth, who provide a range of services, as well as linking unpaid carers with opportunities in the community, including one to one advice and peer support.

Outcome of Inspections

10.13. Inspection of Local Authority Children's Services by Ofsted - During January 2026, Lambeth's Children's Social Care was subject to a full ILACS (Inspection of Local Authority Children's Services) by Ofsted. The overall result was Good with Outstanding support Care Leavers and marks a further improvement step on the journey that Children's Social care has been on for some years now. The report can be read here.

10.14. Youth Justice Services Inspection - Lambeth also had a full inspection from HMIP of its Youth Justice Services in October 2025. The findings report released in mid-January 2026, rated the service with an overall rating of "Good", with two of the four elements being inspected receiving an "Outstanding" rating.

10.15. Good Food Local London Award - Lambeth has received an award for Leadership in recognition of the borough's sustained work to promote good food and tackle food poverty and insecurity. Each year, boroughs are assessed on the actions they are taking to improve access to healthy, sustainable food and to address food poverty and insecurity. The work is assessed by independent organisations such as the London Food Link, part of food and farming charity Sustain, which represents more than 150 organisations. The results are then benchmarked and a league table published in the independent Good Food Local: London Report. Lambeth Council has consistently scored highly across a wide range of indicators and has topped the league table for several years.

11. Lewisham Borough Update

VCSE and neighbourhood working

11.1. Lewisham's VCSE Main Grants Programme was redesigned in 2025/26, shifting to a place-based model that strengthens neighbourhood working and better supports Integrated Neighbourhood Teams (INTs).

11.2. From April 2026, community support in Lewisham will be delivered through a more localised, neighbourhood-focused approach. Age UK Lewisham and Southwark, Lewisham Local, and four neighbourhood partners will jointly lead this new model.

11.3. As part of these changes, four Neighbourhood Community Hubs will be established. These hubs will offer residents easy access to local information, signposting, social connection opportunities, and wider community support.

11.4. A new Integrated Neighbourhood Team (INT) Key Worker role has been introduced. Embedded within each INT, these key workers will support residents to navigate the system and connect with the services that best meet their needs.

11.5. The Lewisham Local Care Partnership has also invested in VCS infrastructure delivered through the Lewisham Black Voluntary Network (LBVN) and Lewisham Local. This is strengthening Black-led grassroots organisations to become sustainable, funding-ready partners in reducing health inequalities in Lewisham. The programme is enabling structural development, leadership growth, and improved engagement between communities and the health and care system.

11.6. This has resulted in stronger, funding-ready organisations, improved governance, and groups better positioned to deliver health-related work.

Brazilian Care Model

11.7. Named after the country where it originated from, a new innovative service is being piloted in Lewisham for two years. North Lewisham Primary Care Network has recruited four Community Health and Wellbeing Workers (CHWWs) who will primarily be working in the Pepys Estate in Deptford. Each CHWW will be proactively going out and knocking on doors and building relationships with up to 150 households, visiting them each month to provide holistic support and advice on a range of different health and social care matters. Strongly aligned with the INT team and services, this integrated approach has strong overlap with Social Prescribing and Lifestyle/ Wellness Medicine services.

Hypertension programme

11.8. Significant progress has been made in raising awareness of Hypertension control in the borough through three public events held at Leisure Centres in Forest Hill, Deptford and Lewisham. Alongside interactive talks on how to take blood pressure tests, nutritional advice, physical exercise and optimising medications, a market place was held with a range of different stalls for point of care testing on blood pressure, chronic kidney disease and other conditions. Attendance has steadily risen at each event with the most recent one hosting over 120 residents. Feedback has been very positive, and more hypertension events will be held in 2026.

11.9. In addition, the Africa Advocacy Foundation (AAF), a local Black led VCSE organisation in Lewisham, has been commissioned to deliver a range of outreach work in local shopping centres, barber shops and religious establishments. AAF has also recruited over 20 Hypertension Champions from the local communities to participate in the outreach work and take blood pressure tests of members of the public. Named 'Let's Talk Blood Pressure', this new service is being evaluated by King's College London (KCL).

Community Opportunistic Detection of Irregular Heart Rhythm pilot

11.10. The Community Opportunistic Detection of Irregular Heart Rhythm (CODI-HR) pilot is a Lewisham-led service commissioned to improve the early detection of undiagnosed atrial fibrillation (AF), primarily through community pharmacies, but has evolved into a multi-arm detection model, including Health Equity Fellows (HEF)s, GP practices, and community health events. Launched in May 2024, the pilot uses a digital app to enable patients without a prior AF diagnosis or anticoagulation to complete short, repeated heart-rhythm measurements over seven days, increasing the likelihood of detecting intermittent AF.

11.11. Community pharmacists opportunistically identify eligible patients, support onboarding, and refer cases of possible AF to general practice, in line with the Lewisham AF primary care pathway. The service is positioned as a prevention-focused, community-based model aligned with NHS priorities to reduce AF-related stroke.

11.12. The service has seen 234 patients to date, with 16 patients with possible irregular heart rhythm detected, a 7% detection rate, comparatively the national prevalence for irregular heart rhythm is 2 - 3%. The service is due to be evaluated by Unity Insights Ltd, following its conclusion by quarter three, 2026/27.

Lewisham Dementia Strategy – Review and Refresh

11.13. Good progress has been made on the review and refresh of the Lewisham Dementia Strategy to ensure it remains fit for purpose and aligned with national best practice. The refresh is being delivered through a structured programme of data analysis, pathway review and coproduction, building on the existing dementia pathway pillars to inform a new strategy for 2026 to 2029.

11.14. Engagement has been undertaken across the system, including people living with dementia, unpaid carers, voluntary and community sector partners and statutory services, supported by themed workshops and targeted engagement activity. Emerging learning from service reviews, including the Dementia Hub, is helping to shape future priorities and commissioning intentions. This work supports Lewisham's continued ambition to be a Dementia Friendly Borough, with a strong focus on prevention, early diagnosis, reducing inequalities and enabling people to live well with dementia.

12. Southwark Borough Update

Partnership Southwark Strategic Board (PSSB)

12.1. The board met in public on 29 January 2026. A presentation was provided on the SLaM strategy refresh, which was welcomed by the board and discussed with interest. Governance arrangements were discussed and it was agreed that the proposed Southwark Neighbourhood Transformation Board be established as a sub-group of PSSB in shadow form pending the wider review of ICB governance. Its first meeting was held in February and discussed progress to date on neighbourhood health and plans for the coming year.

12.2. The Board considered the draft of the Southwark section of the ICB 5 Year Strategic Commissioning Plan, noting the priorities of neighbourhood health, frailty, mental health waiting times, prevention and health inequalities, and primary care access.

12.3. The Board also reviewed the key metrics in the assurance report and focussed on issues around immunisation and vaccination rates. A further report will be produced on local arrangements, programme capacity and responsibilities across the partnership, including an update on forthcoming NHSE delegation arrangements.

Southwark Health and Wellbeing Board – March

12.4. The March Health & Wellbeing Board had a strong Neighbourhood Health focus, including presentations on the Council-led Neighbourhoods Programme and updates from ICB and Integrator leads on the development of Integrated Neighbourhood Teams. Boroughs are currently awaiting national guidance setting out the respective roles of Health & Wellbeing Boards and ICBs in developing and delivering local Neighbourhood Health Plans. The Board reaffirmed the importance of alignment, partnership working and shared leadership across the system and agreed to hold a dedicated workshop in May to progress this agenda and shape next steps locally.

Neighbourhood Development

12.5. Dr Minal Bakhai, Director of Primary Care & Community Transformation and Neighbourhood Health Lead at NHS England, is visiting all 43 sites participating in the National Neighbourhood Health Implementation Programme (NNHIP). In February, she visited Southwark and Lambeth, providing an opportunity to showcase local progress in designing and mobilising Integrated Neighbourhood Teams (INTs) for people living with multiple long-term conditions.

12.6. The visit included discussions with front-line staff and senior leaders from the ICB and the Integrator (Guy's & St Thomas' NHS Hospital FT and Southwark Primary Care Provider Alliance). Conversations focused on key enablers and challenges, including digital innovation, use of linked datasets, workforce development, and the actions required at place, regional and national levels to support delivery at scale.

Southwark Neighbourhood Estates Workshop

12.7. The Southwark INT Workshop, held on 3 February. ICB colleagues brought together system partners to develop a shared understanding of national and South East London expectations for neighbourhood hubs, whilst exploring how estates can better

support integrated neighbourhood working. Representatives from organisations including GSTT, London Borough of Southwark, the ICB, King's College, SLaM, Public Health, and the VCS collaborated in neighbourhood-based groups, using provided context on local challenges, opportunities, and guiding principles to inform discussions.

12.8. Discussions highlighted current collaboration strengths, areas for improvement, and key requirements such as space, access, digital capability, co-location, and governance. The ICB is awaiting the final workshop outputs, which will summarise key findings and recommend next steps for advancing neighbourhood hub development in Southwark.

Frailty INT Workshop

12.9. The Frailty Integrated Neighbourhood Team (INT) engagement workshop was held on 4 February 2026 to share the progress in Southwark so far. Workshop participants endorsed a neighbourhood based, jointly delivered frailty INT model to provide holistic, continuous care and reduce duplication. Key enablers highlighted included integrated working with VCSE/ community partners (including faith groups), stronger outreach and a single point of coordination, supported by shared care planning and better information sharing. Main risks relate to cross-partner record sharing, inconsistent frailty identification, geography/ cohort overlap and uneven workforce representation/ resources.

INT Mobilisation and Integrator Recruitment

12.10. Southwark Place is pump-priming Integrated Neighbourhood Team infrastructure, including clinical and management roles at neighbourhood level, to support the launch of teams in April 2026. Recruitment commenced in January. The response was positive with applications representing a mixture of professional backgrounds and experience. Clinical leads for each neighbourhood have now been appointed and will start in April. Their role will involve delivering direct patient care and continuing to develop the INT service model, in part through building close working relationships with wider health, care and VCSE services in their neighbourhood. The neighbourhood manager interviews were completed in March and start dates are being confirmed. In addition, a number of services will be aligned to neighbourhood footprints from April, including Neighbourhood Nursing, alongside named consultant leads for each of the three cohorts.

Japanese Delegation Visit

12.11. In January 2026, Southwark Adult Social Care welcomed a delegation from Setagaya City, Japan, who visited Southwark to explore international best practice in integrated care and community-based support. The delegation was especially interested in the work on hospital avoidance and early discharge support, shared care records, multi-disciplinary working, GP services, neighbourhood-based models, and specialist housing provision.

Southwark Health and Social Care Scrutiny Commission – Improving Access to General Practice

12.12. Place leads attended the Southwark Health and Social Care Scrutiny Commission on 2 March to provide an update on how the ICB is working with General Practice to make access quicker and easier for all. The presentation covered local delivery of the national Modern General Practice Access approach and outlined how the ICB is working with practices to ensure services remain accessible for people at risk of digital exclusion which is of particular interest to the Commission.

12.13. Although overall performance has improved from last year the members of the Commission were concerned about the variation in performance across different practices and welcomed the approach being taken by the team to support practices to improve access.

Work Well

12.14. Work Well is a new, three-year government-funded programme jointly sponsored by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC). Funding will be allocated at Place level, although the distribution of South East London (SEL) funding across boroughs has not yet been finalised.

12.15. The ICB was required to submit a draft proposal on 13 March, setting out delivery plans for each borough, with delivery expected to commence from November. The Southwark element of the proposal has been developed by the Employment and Skills Manager at Southwark Council and Public Health, and the ICB. The proposal is underpinned by clear principles:

- Building on existing success in integrating employment and health support (such as Connect to Work),
- Embedding Work Well within the Southwark Works employment service, and
- Aligning with Integrated Neighbourhood Teams where possible to support a neighbourhood-based approach.

12.16. The approach responds to need identified through the recent Annual Public Health Report and JSNA focusing on work and health. Funding is proposed for new roles (including work and health coaches within Southwark Works) and targeted interventions to address gaps such as Musculoskeletal (MSK) conditions, mental health and pain management support. Priority cohorts include people in work with long-term conditions, working-age young people with mental health needs, and small employers without access to occupational health provision.

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 18 March 2026.					

Summary of main points	**1. Current position:**
	
	• There are 10 SEL risks and 6 LCP risks (1 in each Bexley, 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) n 9 February 2026, and Executive Committee on 18 March 2026:
	  • **Escalation of risks**: Bex 606 (neurodevelopment assessment pathway - autism and ADHD, for CYP and adults).
	  • **New BAF risks**: SEL 651 (disruption to ICT/Digital systems affecting ICB and provider systems).					

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- **Closed BAF risks**: SEL 437 and 597 (disruption to IT systems across our provider settings and the ICB falling victim to a cyber-attack).These risks were consolidated as 651 (as above).
- **De-escalation of risks**: SEL 606 (ICS revenue financial plan 2025/26).
- **Additional update following Executive Committee review**:
a. SEL 630 (paediatric audiology service) – controls updated to reflect latest position.
b. Review of latest CQC inspection summaries to cross-reference with ICB BAF system risks.

3. System risk development:

- The most recent SEL ICS Risk Leadership Group meeting have focussed on potential risks related to neighbourhood health services, risk governance for programme and corporate risks, and arrangements for the management of actualised risks or issues, EPRR risk and risk governance, learnings from partner risk review exercises.

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<tr><td>Potential conflicts of Interest</td><td colspan="6">None identified</td></tr>
<tr><td rowspan="2">Relevant to these boroughs</td><td>Bexley</td><td>x</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr>
<tr><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr>
<tr><td>Equalities Impact</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Financial Impact</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Public Patient Engagement</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Committee engagement</td><td colspan="6">SEL ICB Audit and Risk Committee, 29 January 2026

PELs meeting, 9 February 2026

SEL ICB Risk Forum, 10 February 2026

Executive Committee, 18 March 2026</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board is asked to review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 18 March 2026.</td></tr>
</table>

SEL ICB Board Assurance Framework January 2026

Prepared for SEL ICB Board, 8 April 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 5).**

Discussion of risks at key meetings / committees (1 of 2)

A. Place Executive Leads (PELs) meeting

- On **9 February 2026**, the ICB Risk and Assurance team attended the PELs meeting to discuss the comparative review of risks across the Local Care Partnerships (LCPs).
- In addition to the comparison of risks across the boroughs, the group considered the following key areas:
    1. Scores for the finance related risks given year end position and relative discrepancies in scores across the LCPs. The scores were subsequently reviewed and rescored where relevant.
    2. Greenwich LCP’s newly added risk around community MSK procurement. It was confirmed that the community MSK procurement risk is Greenwich specific and does not affect other LCPs and is therefore not a risk.
    3. Integrated Neighbourhood Team delivery related risks – There was agreement that a risk relating to INT delivery will be added by all LCPs in the new financial year. The Primary Care Plus group, together with the risk and assurance team will draft a generic risk for LCPs to adapt and localise as appropriate.
    4. Neurodiversity assessment (autism and ADHD) risks and whether these should focus exclusively on the impact of early intervention for children. This was informed by expert opinion input at Audit and Risk Committee on 29 January 2026, where differing risk profiles for children and adults were highlighted. Following discussion, there was agreement that the neurodiversity assessment risks should remain as it is currently specified, incorporating all age. This will be reviewed again in 2026/27.

Discussion of risks at key meetings / committees (2 of 2)

B. SEL Executive Committee (ExCo)

- The ICB **Executive Committee met on 18 March 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 further clarification on two areas:

I. SEL risk 630 - paediatric audiology services within SEL

- Confirmation from the risk owner on the controls and whether they reflected the most up to date position of how the risk is currently being managed.
- Update: the risk owner provided clarity on the latest position with the mitigations in place and the controls summary has been updated to show this.

II. Recent CQC reports for SLaM and KCH

- The Executive Committee requested review of recent provider CQC reports to cross-reference the assessments with current ICB system risks recorded on the BAF.
- Update: This was completed and no changes to ICB BAF risks are recommended at this time. The ICS Risk Leadership Group is scheduled to discuss recent CQC reports and learning from risk response at its April meeting.

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 have focussed 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 for information.

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 10 - 12). **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 13). 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 14.**

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 18 March 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 9 March 2026.
- The current version of the BAF includes 10 SEL risks above threshold and 6 LCP risks (Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark).

Escalation of risks

- **1 risk** with a score greater than the risk appetite threshold has **escalated** onto the BAF:
  - **Bex 642** relates to neurodevelopment assessment pathways (autism and ADHD) for CYP and adults. This has been increased in score to 16, and the risk description has been updated to include adults, to align with the other LCPs.

Newly added BAF risks

- **1 new risk** with a score greater than the risk appetite thresholds has been **added** to the BAF:
  - **SEL 651** relates to disruption to ICT/Digital systems affecting the ICB and providers systems. This risk has a current score of 12 and sits under the data and information management category. This has been added following the consolidation and closure of two previous BAF risks (SEL 437 and SEL 597).

Key points and summary of changes (2 of 2)

Closed BAF risks

- **2 previous** BAF risks have been **closed:**
    - **SEL 437 and 597** related to disruption to IT systems across our provider settings and the ICB falling victim to a cyber attack have been closed and consolidated into one new risk (SEL 651).

De-escalation of risks

- **1 risk** has de-escalated off the BAF:
    - **SEL 606,** relating to the ICS revenue financial plan 2025/26, has been reduced in score from 15 to 9, in line with target rating. This is because the year-to-date financial position at month 10 across the ICS is £5.8m ahead of plan, with a full year forecast of break-even.

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
Data and Information Management	**651**	Significant disruptions to the ICT and digital systems across out provider and/or supply settings.	Up-to-date incident response plan in place. DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures. 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.	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.	Staff offered vaccines, HCID and pandemic plans in place, collaboration with system to minimised impact on the workforce, hybrid working in place, process for re-deployment established.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.	Monthly assurance pack reviewed at CHC meeting, tracking FNC reviews, and individual borough plans set out how boroughs will clear overdue reviews.		12
	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
	630	Paediatric audiology pathways: Risk of harm to patients 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 – high risk patients prioritised and seen by alternative SEL provider, and the two paediatric audiology services to transfer to alternative provider by the end of April 2026 and September 2026.		12

Key: Primarily system risk (blue: 391, 630) Primarily ICB risk (green: 404, 468)

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
	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	**Bex 642**	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
	Bro 509	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.			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.

Key: Primarily system risk (blue); Primarily ICB risk (green)

Impact \ Likelihood	1	2	3	4	5
5					
4			468	384, 386, 391, 504, 601, 642, 509, 635, 129, 644, 520	602
3				404, 630, 651	
2					
1					

ID	Summary risk descriptions
602	ICB Change Programme – impact on staff
384	Elective care transformation programmes
386	Ongoing pressures across SEL UEC services
391	Increased waiting times for autism diagnostics assessments
504	Cancer performance targets
601	ICB Change Programme – workforce capacity risks
642	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.
509	
635	
129	Waiting time targets for children and young people waiting for an autism or ADHD assessment is unacceptably long.
644	Residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments.
520	
404	ICB oversight of new & emerging HCID & pandemics
468	Variation in performance with funded nursing care
630	Risk of harm to patients due to poor quality of care as identified by the site visits (paediatric audiology)
651	Significant disruptions to the ICT and digital systems across out provider and/or supply settings.

Appendices: risk scoring matrices

Risk scoring matrices (1 of 3)

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

Likelihood x Severity = Risk Score

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

Likelihood Matrix:

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

Risk scoring matrices (2 of 3)

Severity matrix

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data [Information Management Risks]	Damage to an individual’s reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team’s reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

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

Appendix 1. SEL risks greater than risk appetite thresholds

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Target Likelihood	Target Consequence	Target Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
384	Harriet Agyepong	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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 teams due to: Multiple asks of the same clinical and operational teams (e.g. a single specialty is asked to introduce a range of initiatives simultaneously). This could result in confusion over priorities, teams being overwhelmed or lacking the resource and support required to secure impactful and sustainable delivery. Inadequate capacity for clinical and other leads to engage and co-design initiatives with partners across primary and secondary care, leading to lack of awareness, buy-in and adherence to new pathways/ways of working with consequent inconsistency and inefficiency of care pathways. Insufficient oversight and awareness of the range of asks on teams (e.g. elective, cancer, urgent care), and what support might be needed to enable delivery. This will impact on the ICB's ability to meet statutory obligations and will impact on the waiting times for services that residents receive, with resulting potential impacts on patient experience, quality of life and outcomes alongside broader socioeconomic impact. It will also impact delivery of optimal care for those with long-term conditions if patients requiring treatment cannot be seen in a timely way in the most appropriate setting.	3	4	12	4	4	16	3	3	9	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 Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	4	4	16	4	4	16	3	3	9	Robust daily intensive system support in place, led and coordinated by the SEL ICB System Control Centre, to review, manage and smooth pressures across the system, agree mutual aid and support site safety. SCC operates 24/7 providing in and out of hours system support. Operational plan for 2025/26 includes a number of performance improvement 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 site safety across all SEL sites, with SEL SCC meeting the required national specification. SEL operational plan for 2025/26 is again being assured by means of the SEL UEC Recovery Plans and monthly review meetings with each local system. Each local system will manage their recovery plan through their local UEC Board with SEL UEC Board having oversight of performance against trajectory. Monthly call with UEC local system leaders to review current performance issues. Further assurance through London UEC and MH UEC Boards.	None - no known at time of reporting
391	Carol-Ann Murray	Gwen Kennedy	Clinical, Quality and Safety	7 - 9	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.	3	4	12	4	4	16	4	4	16	Implementation of services for backlog clearance by Oxleas 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 (£256) 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 List the assurance evidence. SEL LDA Operational Board Agenda and Minutes. to be relaunched during 2025/26. Minutes from the quarterly Joint Region and System LDA Heath Partnership meeting.	No gaps on assurances
404	Simon Beard - Associate Director Corporate Governance	Tosca Fairchild - Chief of Staff	Clinical, Quality and Safety	7 - 9	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.	4	4	16	4	3	12	4	2	8	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 information/ horizon scanning in relation to HCIDs, which will ensure organisations can take early mitigating actions. HCID plan reviewed and updated in 2024. Refreshed plan has been endorsed by ICB AEO and approved for publication by ICB Executive Committee. SEL ICB Head of EPRR and the Bromley PEL Angela Bhan, have been involved in the initial scoping discussion for the pan London MoU and are engaged in the ongoing development work.	No gaps in assurance
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Diane Jones - Chief Nursing Officer	Clinical, Quality and Safety	7 - 9	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.	4	4	16	3	4	12	2	4	8	This risk is monitored at the NHSE assurance meeting monthly. The SEL Head of CHC/CYPCC governance assurance and QIPP has oversight of this risk. There is a monthly assurance pack produced which goes to the CHC review meetings. The CHC monthly assurance report tracks FNC reviews. There are monthly meetings held at place level where this risk is discussed. There are individual borough plans setting out how boroughs will clear the overdue reviews.	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 backlog.	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 Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	4	4	16	4	4	16	3	3	9	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.
601	Sarah Cottingham/ Ceri Jacob	Andrew Bland	Operational: relating to the effective day to day running of the ICB organisation (MCR)	13 - 15	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.	5	4	20	4	4	16	4	4	16	Programme governance structure in place (SMT, Transition Committee, Operations Group). 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. Change Programme Group with joint SROs meets weekly. Participation in London Transition Group to ensure safe transfer of functions. 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. All directors are confirming how they will manage gaps resulting from the first round of VR. These will be reviewed collectively for any interface issues.	None	Programme governance structure in place (SMT, Transition Committee, Operations Group).	None
602	Sarah Cottingham/ Ceri Jacob	Andrew Bland	Operational: relating to the effective day to day running of the ICB organisation (MCR)	13 - 15	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.	5	4	20	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
630	Liz Aitken	Diane Jones - Chief Nursing Officer	Clinical, Quality and Safety	7 - 9	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).	4	3	12	4	3	12	2	3	6	Look-back review completed by SMEs. High risk patients prioritised and seen by alternative SEL provider. Clinical harm review panel established and two moderate harms reported. DoC completed by provider. The first patient tracking list has been reviewed by a subject matter expert with high risk patients prioritised and seen by another SEL provider. Two low and two moderate harms identified. DoC completed by provider. The second patient tracking list is under review with high risk patients prioritised and seen byalternative SEL provider. 100 patients left to review, due to complete by end of April 2026. Potential clinical harms to be reviewed by panel. The paediatric audiology services to transfer to another SEL provider by the end of April 2026 and September 2026, which will streamline services under an Improving Quality in Physiological Services (IQIPS) accredited service to ensure high quality of care.	SME and estate capacity to complete final face to face review of recall and patient tracking list patients before handover to alternative SEL provider.	Patients identified as high or moderate risk to be prioritised with existing capacity. Lookback review of patients seen by the clinician with clinical competency concerns has been completed and no harms identified. All high risk patients identified and appointed. Ongoing clinical review of lower risk patients.	The rest of the patient tracking list patients to be reviewed and assessed for recall needs.
651	Pin Bhandal - Associate Director of ICT	Nisha Wheeler - Deputy Chief Digital Information Officer	Data and Information Management	7 - 9	Digital - Disruption to ICT/Digital systems affecting the ICB and providers systems.	There is a risk of significant disruptions to the ICT and digital systems across out provider and/or supply settings. This may be caused by external factors such as cyber attacks, gaps in security controls, human factors (including phishing and social engineering) or change initiatives implemented by the NHS, healthcare and service providers. The consequences of this occurring is significant disruption or delay to the provision of clinical services potentially affecting patients health and care. This may cause financial and reputational damage, particularly if a data breach leads to penalties from the Information Commissioners Officer or service user negligence claims. Subsequently resource levels would likely be significantly impacted by this level of disruption.	4	3	12	4	3	12	3	3	9	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. 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. DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures. NHS SEL ICB Data Protection Impact Assessment process includes capturing details of any new flows as new projects, systems and changes are implemented throughout the ICB. 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. 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. 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, change advisory board process is in place to support review of any proposed system changes proposed by partners or digital solutions providers which are then risk and impact reviewed with necessary mitigation actions identified and / or rollback process agreed as necessary prior to any approvals taking place. 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. 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. Security Culture - processes are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles. Relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk. There is an established assurance plan, including external assurance, and risk management framework that supports our risk management approach. Regular audits are completed to ensure that the appropriate access and controls are in place for user accounts.	The SEL ICB Cyber incident response plan testing exercises are still in planning for 2025-26 and not yet completed. Inclusion of Digital /ICT risk management approach to be linked into Corporate Risk management framework	2024-25 DSPT/CAF compliance. Cyber Essentials and Cyber Essentials Plus accreditation achieved. Governance structure and policies in place (IG Framework and suite of policies and procedures). DCB1596 - NHS Email Security Standard. Cyber Security Operation Centre members - 24/7 Monitoring capabilities	ICT Disaster recovery /Cyber incident planning exercise to be completed for 2025-26. Risk management Framework - Links of Digital/Cyber security risk approach to be incorporated (In progress with Assurance team). RSM internal audit - Pending outcomes of 2025-26 DSPT/CAF internal audit assurance taking place in March 2026. 2025-26 DSPT/CAF submission due end June 2026.

Appendix 2. LCP risks greater than risk appetite thresholds

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Target Likelihood	Target Consequence	Target Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
Bex 842	Gita Prasad	Diane Braithwaite	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Neurodiversity Assessment Pathways	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.	4	3	12	4	4	16	2	3	6	SEL Commissioning leads on the ASD and ADHD diagnostic pathways are developing an Assessment Hub to support priority screening and support for patients referred for a diagnosis. Locally, Bexley has expanded access to pre-and post-diagnostic support for ADHD and autism to support CYP and families while they wait for a diagnosis and post diagnosis. Oxleas our provider has sub-contracted an independent provider Healios to increase capacity and support with increased demand for autism assessments. 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. 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. Investment into waiting list initiatives, and waiting well initiatives in place.	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.	This has been raised as a concern across the local partnership and work is underway to consider how we can collectively support CYP based on presenting need rather requiring a formal diagnosis. Pre-and -post diagnostic workshops are available and have been scheduled. Other than ADHD prescribing, CYP can access health services without a diagnosis and waiting times for most health services are within national targets. The pilot assessment hub is due to start in Q3 for 2025/26 and will support with expediting access to assessments for ADHD and autism and alleviate some of the demand on the core commissioned pathway. Oxleas has increased output for autism assessments and is working to streamline their processes to meet increased 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.	Demand is still outstripping capacity and data indicates demand has significantly increased in recent months. This is likely to impact CYP who would require ADHD medication the most as other treatment pathways can be referred to without a diagnosis. Staff sickness in community paediatrics may further compound capacity concerns and negatively impact waiting times further. Quarter Three performance report on the ASD diagnostic pathways shows adverse performance with the number of ASD assessments completed decreasing from 172 in Q2 to 146 in Q3 and the average waited time of those seen increasing. Therefore overall risk is raised to 16.
Bro 506	Sean Rafferty	James Postgate	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	3	3	9	4	4	16	2	2	4	CYP ASD/ADHD Project established led by a project manager with buy-in across Oxleas, Bromley Healthcare and Bromley Council. 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	No gaps	Project Manager in place. Action plan developed and submitted to reduce waiting times. Governance through the CYP Mental Health and Wellbeing Partnership Board	Further work between Bromley Healthcare and Oxleas CAMHS on joint decision making
Gre 830	Jenny Lampreit, Rena Amin, Roneeta Campbell	Lisa Wilson, David Borland	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	5	5	25	4	4	16	2	3	6	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. 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 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.	No data for ADHD (waiting list or post-diagnostic). Autism, no register required, within QOF, 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	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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 impact's 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.	4	2	8	4	4	16	2	2	4	Transformation funding proposal from Evelina London is going through contract management meetings route in order to build paediatric capacity to manage this. Te 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. This will be monitored monthly at place through 23/24, 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	Ceri Jacob, Place Executive Lead	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	4	4	16	4	4	16	4	3	12	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.	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	Russell Jones - Assistant Director, Integrated Commissioning	Claire Belgard, Acting Director of Integrated Commissioning	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	4	2	8	4	4	16	2	2	4	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. 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.

ICB Board Meeting in Public

Title	Overall Committees Report				
Meeting date	8 April 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 8 April 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 29 January 2026. 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	-	-	29 January 2026	30 January 2026	26 February 2026	27 January 2026	26 January 2026	10 March 2026	21 January 2026
	-	-	-	-	-	-	-	-	4 February 2026
	-	-	-	-	-	-	-	-	18 February 2026
	-	-	-	-	-	-	-	-	4 March 2026
	-	-	-	-	-	-	-	-	18 March 2026

	Local Care Partnerships					
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
Meeting date	22 January 2026	29 January 2026	25 February 2026	5 March 2026	22 January 2026	29 January 2026
	-	-	-	-	-	-
	-	-	-	-	-	-

Transition Committee
16 January 2026
11 February 2026
3 March 2026

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 none

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	21 January 2026	• The committee approved the recommendations of the accreditation panel in relation to a provider for orthopaedic services and a provider for ophthalmology services.
2.	Executive Committee	4 February 2026	• The committee approved the recommendation of the accreditation panel in relation to a provider for Adult ADHD Assessment and Treatment services • The committee endorsed the revised proposal for implementation timelines, noting support to be provided from PELs on communications and EQIA, and calling for an early resolution of estates issues from all involved.
3.	Executive Committee	18 February 2026	• The committee approved the award of the Clinical Waste service for south east London to the approved bidder.
4.	Executive Committee	4 March 2026	• The committee endorsed an approach presented to the ICBs statement of health inequalities noting improved formatting and ongoing work to improve data, consistency and measurement of outcomes, and to link to neighbourhood work.

			• The committee approved ICB policies in relation to change management, safeguarding supervision and information sharing for child protection.
5.	Executive Committee	18 March 2026	• The committee endorsed medicines and pharmacy schemes for 2026/27 aimed to improve equity of access, support neighbourhoods and enable delivery of financial plans, including a successful Pharmacy First Plus model proposed for roll out across south east London. • The committee endorsed the publication notice of the ICBs intention to award a contract for level 2b neuro-rehabilitation through the Most Suitable Provider route under the Provider Selection Regime regulations. • The committee reviewed and recommended the Board Assurance Framework.

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.	Transition Committee	16 January 2026	• The committee examined initial outputs of work with subject matter experts across both SWL and SEL ICBs on areas where working together would be beneficial. • The committee received assurance that the proposals as developed met the emerging national guidelines. • The risk register maintained in relation to the ICB programme was reviewed.
2.	Executive Committee	21 January 2026	• The committee received an update on planning ahead of submission deadline noting work on improving performance and financial plans. • The committee reviewed an plan produced by the ICBs internal auditors, discussing the content and sequencing of proposed audits. • The committee discussed the corporate objective for flu vaccination, noting activity and communications being undertaken but some ‘vaccination fatigue’ affecting uptake across population groups.

			• The committee discussed proposals for how the ICB would be governed from 1 April, commenting on proposals for shared committees and focus on neighbourhood development.
3.	People Committee	26 January 2026	• The committee session focussed on considered future governance arrangements for the Committee, in the light of the 10 Year NHS Plan and Model ICB and NHSE blueprints.
4.	Clinical & Care Professionals Committee	27 January 2026	• The committee indicated support amendments to the Chronic Obstructive Pulmonary Disease (COPD) guidelines. • The committee indicated support for Commissioning Proposal for an "Amber 3" Medicines Shared Care Service • The committee received an update on engagement, noting a recent engagement assurance subcommittee which had received reports on creative health, efforts to reduce Black maternal health inequalities, and an update on the online engagement platform. • The committee received an update on the primary and secondary care interface work in particular on the maturity matrix, and work with the Health Innovation Network to build a sustainable set of resources to continue the work. • The committee received an update on the population health management programme including workstreams of system leadership and engagement, data architecture, analytics and implementation support. • The committee received an update on the ICB change programme noting a significant reduction in clinical professional leadership proposed.
5.	Audit & Risk Committee	29 January 2026	• The committee received an update from our external auditors on the planning of the 2025/26 audit and the Value For Money audit for the year. • Internal audit reported on their progress against the 2025/26 workplan, discussed the progress of the ICB against its identified management actions, and considered the deep dive work being undertaken on continuing healthcare and child death reviews audit. The committee also approved the 2026/27 internal audit workplan. • Members received a report from TIAA on their anti-crime work in support of the ICB, noting the need for Board training on the Offence of Failure to Prevent Fraud and work on the fraud risk assessment. • Special payments, debt write offs and tender waivers were noted, with an update on roll out of the new finance ledger (ISFE2) and review of the gifts and hospitality register completed. The 2026 workplan for the committee was agreed.

6.	Remuneration Committee	30 January 2026	• The Committee considered and approved voluntary redundancy application payments and approved acting up arrangements to cover the Executive Director of Planning role.
7.	Executive Committee	4 February 2026	• The committee discussed the demand, waiting times and spend in relation to neurodiversity services including ADHD and ASD, noting the pressures felt in south east London and nationally and the need for clear leadership and new approaches in this area. • The committee received an update on planning ahead of submission deadline noting final work on performance and financial plans. • The committee noted a report on finances for month 9 • The committee noted a report on performance.
8.	Transition Committee	11 February 2026	• The committee examined the draft documents produced as outputs for work with South West London ICB to finalise the extent of collaboration on functions ahead of the clustering of the two ICBs. • The committee discussed the criteria against which it would assess the transition to the clustered arrangement: delivering within the £19per head financial limit for both ICBs without detriment to one ICB at the expense of another, to adhere to a range of principles in identifying and developing areas in which to work together more closely, and to create organisations which were fit for the future purpose of ICBs. • The risk register maintained in relation to the ICB programme was reviewed.
9.	Executive Committee	18 February 2026	• The committee discussed the provision of the SELNet website and noted how it was used and the potential to support the primary care automation programme, and agreed in principle to support an expansion of the service subject to clarification of funding. • The committee received the gender pay gap report for the organisation, noting that there it showed some inequality and welcoming further work to understand reasons and improve the position. • The committee heard a presentation from South London and Maudsley NHSFT on its refreshed strategy and accompanying programme of engagement, highlighting the importance of engagement with Place on measures to prevent mental ill health.

			• The committee discussed the corporate objective relating to hypertension, noting that despite the target not being met there was positive progress in controlling hypertension, and discussed how to share approaches from areas where this had worked well.
10.	Greenwich Charitable Funds Committee	26 February 2026	• The board members received an update from Groundwork London providing detail of funds that had been granted, with applications remaining open until the end of April 2026: ○ Enabling Grants: 11 grants awarded totalling £42,000.00 ○ Micro Grants: 25 grants awarded totalling £116,000.00 ○ Delivery strand, small, medium and large awards: 26 applications totalling £1.15m • The board members received a proposal for proposed budget allocations for 2026/27, noting that most budget allocations were to remain the same, except for the Delivery Medium grant which would be increased reflecting high demand for these grants • The board members were advised that due to the anticipated ICB restructure the governance structure of the Greenwich Charitable Funds would need to be changed. It was noted that a board committee will still be required as the corporate trustee is SEL ICB.
11.	Transition Committee	3 March 2026	• The committee received an update on the process to transfer some ICB functions to providers, noting timing and work with providers to agree specifications. • The committee discussed how it would maintain oversight of the transition over the course of the year, discussing the transfer of functions, the completion of equality impact assessment, and oversight of implementing policies in relation to the consultation, management response and post filling and redundancy processes. • The risk register maintained in relation to the ICB programme was reviewed.
12.	Executive Committee	4 March 2026	• The committee received an update on the full business case developed for the Guy's surgical centre to increase surgical capacity and improve experience for patients and staff in response to rising demand, asking questions on timescales and funding. • The committee were updated on a draft proposal to utilise "Work Well" funding intended to help people unemployed or at risk of becoming unemployed through ill health. • The committee noted a report on finances for month 10 • The committee noted a report on performance.

13.	Digital Committee	10 March 2026	• The committee received an update on the newly launched Frontline Productivity Programme, the successor to the Frontline Digitisation Programme and the engagement work to identify digital schemes in south east London to submit for funding through the programme. • The committee received an update on progress with the digital enablement work for Integrated Neighbourhood Teams, noting the roadmap, vision and guiding principles that were being developed to support digitally enabling neighbourhood health. • The committee received an update on Cyber Community of Practice which had examined work across south east London to improve mobility of staff across south east London organisations by exploring standardised and mobile logins and access. There had also been a discussion of work to submit to the frontline productivity programme including bids for vulnerability management. Further meetings of the group were planned to ensure cyber issues were discussed. • The committee received an update on the London Care Record noting efforts across London to align the platforms on which the London Care Record was based by March 2028. In south east London there were also discussions ongoing with Lewisham and Greenwich NHST to ensure LCR could continue to be delivered but in an affordable way given financial pressures.
14.	Executive Committee	18 March 2026	• The committee received updates on progress with the ICB change staff consultation, and work to support response to Meningitis B and respond to technical issues with the transfer of reports to some GP practices. • The committee discussed the corporate objective relating to health checks for people with serious mental illness, noting a below trajectory performance and variation across providers and places. A key issue was identified as data quality and further work was agreed on south east London wide approaches to improve performance. • The committee heard a proposal for academic research working with NHS trusts and the Metropolitan Police in relation to patients in emergency departments experiencing severe mental health crisis.

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.	22.01.2026	4. Five Year Strategic Commissioning Plan: Bexley Neighbourhood Delivery Plan	• The Bexley Wellbeing Partnership Committee received a report on the Five-Year Strategic Commissioning Plan: *Bexley Neighbourhood Delivery Plan*. The purpose of this paper was to provide the Bexley Wellbeing Partnership Committee with an overview of the Bexley 5-year strategic Neighbourhood Delivery Plan. The plan summarises Bexley's population health needs and outlines the high-level local actions to address those needs in 2026/27 and beyond. **The Bexley Wellbeing Partnership Committee:** **(i)** **Approved** the Five Strategic Commissioning Plan **(ii)** **Provided** feedback on any key areas to support its successful implementation.
2.	22.01.2026	5. Joint Prevention & Early Intervention Grants Programme	• The Bexley Wellbeing Partnership Committee received a report on the Voluntary Sector Prevention and Early Intervention Grants: Future Arrangements. London Borough of Bexley Adult Social Care (ASC) and the NHS South East London Integrated Care Board (Bexley) provide jointly funded Prevention and Early Intervention grants to a range of voluntary sector organisations to the value of £1.03m. The grants were issued for five years from 2020 to 2025. • The purpose of the paper was to provide the Bexley Wellbeing Partnership Committee with an overview of the decision to renew the jointly funded grants. **The Bexley Wellbeing Partnership Committee:**

			(i) **Endorsed** the renewal of the PEI grants as agreed by the Place Executive Lead and the intention to widen access to include the Autism Partnership and that this aligns with the South East London Integrated Care System's Voluntary, Community and Social Enterprise Sector Charter. **(ii)** **Supported** the future arrangements of the PEI grants to include prevention and early intervention for children and families **(iii)** **Noted** the intention to align the delivery of the PEI grants to Bexley's Neighbourhood delivery planning.

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.	22.01.2026	6. Better Care Fund: Quarter 3 2025/26 NHS England Return	• The Bexley Wellbeing Partnership Committee received a report on the Better Care Fund (BCF) Quarter 3 2025/26 NHS England Return. The report highlights that all national BCF conditions have been met in Quarter 3, including joint planning, delivery of agreed objectives, compliance with funding conditions and effective operation of the section 75 partnership arrangements. **The Bexley Wellbeing Partnership Committee:** • **Noted** the report is for information and assurance to the Bexley Wellbeing Partnership Committee.

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.	29 January 2026	Item 7 – One Bromley Involvement Charter	• The One Bromley Local Care Partnership Board discussed and approved the One Bromley Involvement Charter.

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.	29 January 2026	Item 6 – Bromley Chapter of the Five Year Strategic Commissioning Plan	• The Bromley chapter of the Five Year Strategic Commissioning Plan was presented. There is a strong focus on Integrated Neighbourhood Team working and delivery across agencies.

			• A further plan is required to be created later in the year, which will have scope to include more detail around Neighbourhoods and the Better Care Fund. Guidance is awaited to support creation of this plan. • The One Bromley Local Care Partnership Board agreed the Bromley Chapter and this would now go to the South East London ICB Board for approval.
2.	29 January 2026	Item 7 – One Bromley Involvement Charter	• The One Bromley Involvement Charter was presented to the Board. This sets out a shared commitment to involving residents and communities in shaping health and social care services across Bromley. While each One Bromley organisation may have its own processes and priorities, the Partnership would collectively uphold the principles in the charter. This ensures consistency in values whilst allowing flexibility in how involvement is delivered. • This would be coordinated by the One Bromley Communications and Engagement workstream, which includes engagement professionals. Progress would be monitored through feedback, case studies and evidence of impact and approaches adjusted based on learning. • The Board noted, commented upon and agreed the One Bromley Involvement Charter.
3.	29 January 2026	Item 8 – Month 8 SEL ICB Finance Report	• The One Bromley Local Care Partnership Board received the Month 8 Finance Report. SEL ICB was reporting a year to date and forecast-out-turn breakeven position against its revenue resource limit and financial plan. The Bromley place budget is also forecasted to have a breakeven position at year end. Financial planning for 2026-27 was underway.
4.	29 January 2026	Item 9 – Partnership Report	• The Bromley Health and Wellbeing Centre had opened, and the Hub previously based in the Glades had recently relocated to the site. This is another example of great partnership working and thanks were given to all for the hard work and support that had gone into this.
5.	29 January 2026	Item 10 – Primary Care Group Report	• The Board noted the Primary Care Group Report.

6.	29 January 2026	Item 11 – Procurement and Contracts Group Report	• The Board noted the Procurement and Contracts Group Report.

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

2. Decisions made by Healthier Greenwich Partnership LCP Under Delegation

No.	Meeting date	Agenda item	Items for Board to note
1.	26 February 2026	Agenda item 6. Neighbourhood Hubs	The LCP Members approved the proposal to continue the development of investment for Neighbourhood Hubs in Greenwich and noted that funding sources and planning are still being considered.

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.	26 February 2026	Agenda item 5. Developing the CYP Neighbourhood offer and aligned programmes	• The LCP members received a report on Developing the CYP Neighbourhood offer and aligned programmes based on the SEL CYP Integrated Neighbourhood framework • The LCP members noted that 10 core framework functions were agreed

			• The LCP members were shown the implementation roadmap, noting that a test INT will be implemented by the end of 26/27 and fully embedded by 2029
2.	26 February 2026	Agenda item 7. Five Year Strategic Commissioning Plan	• The LCP members noted a report about the Five Year Strategic Commissioning Plan which detailed the delivery priorities • The LCP members were advised that the ICB Board approved the plan in February 2026 and have submitted the plans to NHSE • The LCP members were advised that detailed information relating to population health and neighbourhood delivery plans were included in the appendices
3.	26 February 2026	Agenda item 8. Thamesmead APMS Contract Award	• Following on from a robust procurement process and agreement at the HGP in private on 26 November 2025, the LCP members were advised that the APMS contract for Thamesmead has been awarded to Addison Road Medical Practice • The LCP members noted that the transition and mobilisation for the existing and new providers is in progress with no issues raised
4.	26 February 2026	Agenda item 9. Neighbourhood Investment Plans	• Members of the LCP noted that the identification of recurrent and non-recurrent funds to be used for the integrator role, long-term conditions and frailty would be re-allocated to neighbourhood development which had been approved at the HGP in private on 28 January 2026
5.	26 February 2026	Agenda item 11. Risk update	• The LCP members noted the risk update which advised: ○ There are 18 active risks on the register, 17 of which have been reviewed and updated since November 2025 ○ Risks are updated monthly and include notes on actions and mitigations that are being taken ○ The risk around achieving financial balance has been reduced ○ Autism and ADHD assessment has a high score inline with other boroughs in SEL

6.	26 February 2026	Agenda item 5. Developing the CYP Neighbourhood offer and aligned programmes	• The LCP members received a report on Developing the CYP Neighbourhood offer and aligned programmes based on the SEL CYP Integrated Neighbourhood framework • The LCP members noted that 10 core framework functions were agreed • The LCP members were shown the implementation roadmap, noting that a test INT will be implemented by the end of 26/27 and fully embedded by 2029

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.	5 March 2026	Lambeth Learning Disabilities Intensive Support Team	Members of the Partnership Board: • Endorsed the ongoing development and implementation of the Lambeth Intensive Support Team, a function hosted by NHS South London and Maudsley and NHS Guy's and St Thomas', preventing placement breakdowns and hospital admissions through rapid, flexible, community-based responses for people with learning disabilities who may also be autistic. • Supported the partnership working with Lambeth Adults Social Care and South East London Integrated Care Board (Lambeth) to continue to mobilise around jointly agreed system objectives.
2.	5 March 2026	Lambeth Together Primary Care Commissioning Committee (PCCC)	Members of the Partnership Board: • Noted and supported the content of the slide pack. • Ratified decisions made at the Primary Care Commissioning Committee on 21 January 2026 and the Extraordinary Primary Care Commissioning Committee on 14 January 2026.

3.	5 March 2026	Lambeth Together Business Planning 2026/27	Members of the Partnership Board: • Noted the progress made since the last Partnership Board meeting. • Provided feedback and approved the draft activities for 2026/27 outlined within the appendix of the board pack. Approved the timeframes and remaining actions leading to the final Lambeth Together Health and Care Plan refresh for 2026/27.

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.	5 March 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 8 January 2026, including decisions made under the South East London Integrated Care Board scheme of delegation.
2.	5 March 2026	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 27 January 2026.
3.	5 March 2026	Living Well Network Alliance (LWNA) Progress Update	Members of the Partnership Board: • Noted the proposed changes to neighbourhood working in our Living Well Centres, South London and Maudsley (SLaM) NHS Foundation Trust's £675k voluntary, community and social enterprise (VCSE) tendering and highlights from our 2024/25 Progress Report. Heard from Marcus, the subject of Lambeth's Mosaic Clubhouse Evening Sanctuary film.

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.	22 January 2026	(4) 2026/27 Lewisham LCP System Intentions	• Approval was sought from the Board outlining the proposed system intentions for 2026/27. Some highlights included: ○ Achievements delivered during the previous year 2025/26 – such as Lewisham and Greenwich Trust (LGT) and adult social care setting up a home first service, procuring the new virtual ward service and delivery of a proactive care service for Children and Young People (CYP). ○ Ongoing performance, capacity and financial challenges, such as reducing waiting times for MSK (musculoskeletal) and improving cancer screening uptake, although there is still a way to go. ○ Key areas of focus for the coming year include prevention, neighbourhood working and a full review of SEND pathways, particularly ADHD and ASD, noting continued growth in referrals, despite recent investment. **The LCP Board approved the 2026/27 Lewisham LCP System Intentions update.**
2.	22 January 2026	(5) Five Year Strategic Commissioning Plan:	• The ICB 5-year Strategic Commissioning Plan was sought for approval and had been shared with members of the Integrated Neighbourhoods Committee for comment. It is a high-level summary covering a wide range of areas, with further detailed planning to

		Lewisham Template update	follow up - particularly through the development of the Integrated Neighbourhood Health Plan. It would also be the point at which links would be strengthened to the Health and Wellbeing Strategy once guidance is received. **The LCP Board approved the Five-Year Strategic Commissioning Plan: Lewisham Template update.**
3.	22 January 2026	(6) Options Appraisal and Recommendation for a Direct Award of Contract to Kooth	• Approval was sought for an options appraisal with a recommendation for a direct award of contract to Kooth, for the provision of digital emotional wellbeing services for children and young people. The direct award to Kooth was under the NHS Provider Selection Regime (PSR) for a further two-years. By doing this, continuity of care would be maintained, and it would also avoid disruption of services. Financial overview is; o Financial Overview: Current Contract Value: £1,105,000 (incl. VAT) – approx. £92,000 per borough annually. o Proposed Direct Award Value: £1,135,000 (incl. VAT) – approx. £95,000 per borough annually. • The rationale for a direct award was to ensure continuity of care with a well-established service with evidence of strong service user feedback. The proposed contract period would also undertake a full review of the digital emotional wellbeing market and co-production with young people, with a view to future competitive procurement. **The LCP Board approved a two-year direct award of contract to Kooth.**

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 January 2026	(3) PEL report	The Place Executive Lead report highlighted two key aspects: • Update to the LCP members on the ICB change management programme, noting the conclusion of the initial voluntary redundancy phase and the decision by the SEL ICB and SWL ICB boards to formally cluster in their December 2025 Boards. The ICBs would remain as two separate statutory bodies with separate Boards and financial allocation, however, there will be a single Chair, Chief Executive and executive team. • North Lewisham Primary Care Network (PCN) and Red Ribbon Living Well were named winners of the Health Service Journal (HSJ) Primary and Community Care Innovation of the Year award for their initiative, Health Equity Partnership: A Symbiotic Approach to Tackling Health Inequalities.
2.	22 January 2026	(7) Lewisham GP Access Improvement – Updated Plan	• The Lewisham GP Access Improvement Plan was discussed, noting it would include detailed data on appointment volumes, NHS app as a digital front door to the NHS, workforce composition, enhanced access provision and the role of community pharmacy. Also, an update on Same Day Urgent Care (SDUC). The plan aims to: ○ Empower patients around self-referral pathways and community pathways. ○ Implement a new model - 'Modern General Practice Access' ○ Pharmacy First ○ Expanded GP teams. • There was also a comms and engagement campaign to highlight the above services throughout the borough. In terms of SDUC, there was a subset of work that focused on access and some of this was implicit within the wider programme, while some is more distinct, with a specific emphasis on improving same day urgent care.
3.	22 January 2026	(8) Planned Care – Outpatients Transformation and Elective Improvement	• Highlighting outpatient transformation was a major element of the 10-year plan, centred on the three strategic shifts: from hospital to community, analogue to digital, sickness to prevention, some key areas of work were highlighted to the members, including:

			• The need to recover to NHS constitutional standards by 2028/29, specifically 92% treated within 18 weeks (RTT).
			• LGT's delivery against the Long-Term Plan which include:
			  ○ Launch and rollout of the patient portal with strong adoption.
			  ○ Redesign of the ENT booking model in a highly challenged service.
			  ○ Introduction of a selective improvement programme.
			  ○ Early work on AI opportunities aligned with the digital ambition.
			  ○ Preparation for a new EPR to support streamlined, standardised pathways.
			  ○ Waiting list reduced 70k → 55k
			  ○ 52-week waiters halved
			  ○ On track for 62% within 18 weeks this year
			  ○ Significant reductions in first-appointment waits across multiple specialties.
			  ○ Diagnosis performance improving (above last year) and investment in Oncology.
			  ○ A patient portal launched.
			  ○ Broad rollout of Referral Assessment Service (RAS)/Advice and Guidance.
			• Developments regarding interface work across acute and primary care.

4.	22 January 2026	(9) LCP Assurance Performance data report – December 2025	The performance assurance report for December 2025 we presented, reflecting on year on year improvements for Serious Mental Health checks (up around 8%), with learning disability health checks remaining strong with work underway to assure quality and CHC assessments as significantly improved. However it was noted that flu vaccination rates - and to a lesser extent children's vaccination rates - remain very challenging despite considerable local effort. GP appointments had been reviewed and whilst there were some data quality issues, there had been some improvements, especially in increased face to face appointments. A fuller deep dive was scheduled for the next Board meeting.
5.	22 January 2026	(10) Risk Register	• The Lewisham risk register was discussed, with most risk scores remained broadly static. The main exception was risk 644, Adults and CYP Neurodevelopmental diagnostic pathways (Autism and ADHD), which had worsened only because

			Lewisham had aligned scoring with the rest of southeast London. Significant system-wide work was underway to improve pathways, including better triage, oversight of private providers and streamlining local NHS pathways. CHC was showing slight improvement: although still over budget, the position was much better compared to last year.
6.	22 January 2026	(11) Annual Adult Safeguarding report	• The Annual Adults Safeguarding Report, outlining statutory responsibilities, partnership arrangements, training delivery, and assurance mechanisms was presented with the report highlighting the following key areas of focus: ○ Multi-agency working ○ Workforce development and supervision ○ Learning from safeguarding adult reviews and domestic homicide reviews ○ Governance and Accountability arrangements ○ Asylum and Initial Accommodation Centres ○ Primary Care and Safeguarding Training ○ Care Homes Older People ○ Serious Violence Duty including Domestic Abuse Violence Against Women and Girls and learning from statutory reviews ○ Learning from Adults Deaths and statutory review ○ Modern Slavery ○ LeDeR Learning from the lives and deaths of people with a learning disability and autistic people The members all acknowledged the importance of safeguarding activity and of sustained system-wide collaboration.
7.	22 January 2026	(12) Finance Update	The members received a report on the financial position and full year forecast at month 8 for the delegated Place budget, SEL ICB, and the wider ICS overall. Key pressures at Place continued to be Continuing Health Care (CHC), prescribing and mental health, with ADHD assessments (£2.2m over budget), representing £1.7m more expenditure than last year. This was a major concern for next year's planning. Lewisham Council's financial position was included in the report for noting.

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 No items were decided under delegation from the Board in this period.

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.	29 January 2026	SLaM Strategy Refresh	The board discussed SLaM's draft strategy, noting the refresh aims to sharpen the vision, focus on a smaller set of priorities, and improve outcomes through stronger engagement, clearer accountability and better partnership working. Members reflected on key themes including early intervention, workforce, data sharing, access and waiting times, alignment with wider system strategies, and the importance of service user and community voices. The board noted that the shift from sickness to prevention is not directly referenced and discussed the need for a wider partnership approach to this. The board welcomed the engagement approach, offered feedback on the proposed priorities.

2.	29 January 2026	Governance Review – Terms of Reference	The board discussed the proposed Partnership Southwark governance changes, noting that while the overall direction had been agreed previously, some elements are being paused to align with the wider SEL ICB governance review. The board heard that the Southwark Neighbourhood Transformation Board will proceed in shadow form from February, with terms of reference in development and further one-to-one engagement planned. Members raised points regarding clarity on merged programmes, representation and invitations, and the governance diagram.
3.	29 January 2026	Strategic Commissioning Plan	The board discussed the development of the Five-Year Strategic Commissioning Plan and its alignment with the medium-term planning framework, noting the inclusion of updated local priorities, the new primary care access priority, and the structure of the Neighbourhood Delivery Plan. Members raised points about clarity across the various plans, the need to reflect key issues, and the importance of ensuring priorities are manageable and connected through governance. An action was agreed to review how the 5-year plan and Neighbourhood Delivery Plan align.
4.	29 January 2026	Strategic Director for Health & Care and Place Executive Lead Report	The board discussed updates across key governance and delivery groups, noting strong focus on neighbourhoods and children and young people. The board heard updates from the Integrated Governance and Assurance Committee, including upcoming deep dives on Talking Therapies and GP access, as well as ongoing financial pressures and paused terms of reference reviews. The board also received updates from the Partnership Southwark Delivery Executive on neighbourhood development, cohort work, and the integrator’s progress, and from the Primary Care Committee on GP practice visits, estates planning and medicines optimisation.
5.	29 January 2026	Integrated Assurance Report	The board discussed current performance, noting challenges with community health waiting times, primary care access variation, and long-standing issues in Talking Therapies recovery rates, with deep dives scheduled at IGAC. The board also heard about immunisation trends, including dips in childhood and flu vaccination rates, and noted concerns about the impact of workforce changes on future delivery. Members raised points about delegation of responsibilities, variation across the borough and progressing community service improvements.

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 15 January 2026 to 20 March 2026.

No.	Meeting date	Agenda item	Items for Board to note
1.	APC Executive 6 February	APC Interim Workplan	Following the discussion at the APC Committee in Common in December 2025, the Joint MDs developed an interim six-month workplan to Summer 2026, based on a critical review of the programme portfolio and governance. This will coincide with the conclusions of the Acute Service Review, supported by Carnall Farrar, and it is anticipated that this will be a key determinant of future APC priorities.
2.	APC Executive 6 March	Ortho/MSK business case	The APC Executive formally approved the Ortho/MSK FBC, and the service is in the process of transitioning to BAU across the providers, with financial support from the ICB via its Strategic Investment Fund.

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 15 January 2026 to 20 March 2026, for Board information.

No.	Meeting	Meeting date	Agenda item	Items discussed
1.	Multiple Executive Advisory Groups	January to February 2026	Operational planning including four year capital prioritisation	Multiple Executive Advisory Groups (EAGs) and their subgroups provided a forum for discussion on operational and medium-term planning, including collaborative working to prepare for submission of four-year capital plans

				under the national capital programme for Return to Constitutional Standards.
2.	Multiple Executive Advisory Group and sub-groups	February to March 2026	Acute Service Review (Carnall Farrar work)	The SSG lead for this work and the Carnall Farrar team have attended a number of EAG and subgroup meetings in the pre-mobilisation and mobilisation phases of the work. The governance structure for the Acute Service Review (Carnall Farrar work) links to the APC governance structure at multiple points, eg Finance & Estates Group supporting financial analysis, Performance & Planning for collective engagement with BI and performance leads.
3.	Ops & Strategy	12 March 2026	Advice & Refer/ Single Point of Access	NHSE has mandated very significant changes in how referrals for secondary care are managed with all referrals routed via an “advice and refer” single point of access (SPOA). The approach in SEL is being developed via the joint ICB/Acute trust Outpatients Group, with a briefing provided to the Ops & Strategy Group in March and further collaborative work required.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 No key decisions of note have been highlighted for the Boards attention.

2. Agenda Items of Note

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

No.	Items of note
1.	The 'NHS111 Mental Health Service' is delivered by South London and Maudsley NHS FT for all residents across south east and south west London. Over the course of the next 6 months, the mental health crisis lines operated by each SLP Trust will be integrated into NHS111 Mental Health, starting with SL&M's crisis line service in April. Following a full evaluation of the learning from this initial change, Oxleas will integrate its crisis line in July, followed by South West London and St George's in September.
2.	Following a period of temporary closure, the Child and Adolescent Psychiatric Intensive Care Unit at the Bethlem Hospital site, operated by SL&M, re-opened on 2 March. This means south London children and young people needing this level of psychiatric intensive care no longer need to be placed out of area.
3.	The South London Partnership has identified a number of areas for collaborative working to reduce variation and share best practice. This includes considering secondary mental health services links into integrated neighbourhoods as these develop across south London, driving forward productivity initiatives, and developing psychosis pathways to improve patient and family outcomes.

Board meeting in Public

<table>
<tr><td>Title</td><td colspan="5">Performance Report</td></tr>
<tr><td>Meeting date</td><td>8 April 2026</td><td>Agenda item Number</td><td>7</td><td>Paper Enclosure Ref</td><td>G</td></tr>
<tr><td>Author</td><td colspan="5">ICB Risk and Assurance and ICB Performance teams</td></tr>
<tr><td>Executive lead</td><td colspan="5">Rupi Dev and Annabel Appleby, Executive Director of Planning</td></tr>
<tr><td>Paper is for:</td><td>Update</td><td></td><td>Discussion</td><td>x</td><td>Decision</td></tr>
<tr><td>Purpose of paper</td><td colspan="5">The report provides the Board with a summary of current system performance across a range of national performance metrics. It is intended to ensure Board members are appraised of progress against key operational planning commitments for 2025/26 and understand the areas of challenge, risk and improvement focus.

The report supports the Board's oversight of delivery by setting out the latest available data and together with a summary analysis across a range of key performance areas, including urgent and emergency care, cancer, referral to treatment, diagnostics, primary care, mental health, community services and continuing healthcare.

Where performance is below trajectory, the paper outlines the agreed recovery actions and improvement trajectories.</td></tr>
<tr><td>Summary of main points</td><td colspan="5">The report shows progress in a number of areas.

The trajectory for the percentage of 12-hour delays from arrival in A&E was met in February 2026. This means that the target has been achieved for 5 out of the previous 6 months.

System level performance against the faster diagnosis standard has broadly remained in line with the agreed trajectory during 2025/26, and though below target for the most recent month, is expected to achieve the 80% year end target. The SEL system also performs well on use of a faecal immunochemical test (FIT) to support referral for lower gastrointestinal (LGI) suspected cancer

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.

National CHC performance standards being met most months in south east London for the proportion of CHC assessments completed within 28 days and the number of incomplete referrals over 12 weeks.

At the same time, significant pressures remain. These include in referral to treatment times (RTT), cancer, diagnostics, urgent and emergency care,</td></tr>
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<table>
<tr><td></td><td colspan="6">mental health crisis presentations and long waits for inpatient beds, waits for community paediatrics, and the number of LDA inpatients. Some challenges also persist in securing mental health access targets.

The number of 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 reduced significantly from the peak in the first six months of 2025/26.

The paper outlines the recovery actions underway across these areas.</td></tr>
<tr><td>Potential conflicts of Interest</td><td colspan="6">None identified</td></tr>
<tr><td rowspan="2">Relevant to these boroughs</td><td>Bexley</td><td>x</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr>
<tr><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr>
<tr><td>Equalities Impact</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Financial Impact</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Public Patient Engagement</td><td colspan="6">Not directly applicable to the production of this paper.</td></tr>
<tr><td>Committee engagement</td><td colspan="6">ICB Executive Committee, 1 April 2026</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board is asked to note the update and consider any implications for system assurance and delivery oversight.</td></tr>
</table>

SEL System Performance Summary April 2026

SEL ICB Board - 8 April 2026

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Summary of YTD position – April 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. However, performance in January and February 2026 has been below the planned level. The SEL trusts combined view of 4-hour performance in February was 72.7% (based on SitRep data), which was below the month 11 trajectory of 73.5%. Published SEL 'footprint' performance, which includes activity from stand alone Urgent Treatment Centres, was 73.9%, which is an improvement from the 72.6% reported in January but below the national expectation of 78%. This is reflective of the continued pressures in emergency departments. • The new target for the percentage of 12-hour delays (from arrival) was, however, met. This means that the target has been achieved for 5 out of the previous 6 months. • Demand, capacity and flow challenges continue across physical and mental health, with ongoing improvement work across the care pathway. This includes front door management and use of alternatives to emergency departments, implementation of 'Criteria to Admit' (CTA) across sites and in-hospital management, including same day emergency care and improving lengths of stay for patients. • Enhanced 'sprint' actions took place across all sites to improve 4-hour and 12-hour performance throughout March.
Cancer	• System level performance against the faster diagnosis standard has broadly remained in line with the agreed trajectory, and though it has fallen below plan for January, 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 LGI 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 the system. 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.
Referral to Treatment Times (RTT)	• South east London is achieving the planned improvement trajectory for referral to treatment under 18 weeks during 2025/26. However, long waiters remain in a number of challenged specialties. • 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. The number of 65-week-waits has fallen during the second half of 2025/26. In January 2026, there were 209 65-week-waits which is down from a peak of 792 in August 2025. RTT transformation is a major focus in 2026/27
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 being actioned with additional capacity through insourcing and outsourcing, and the implementation of clinical decision support tools to assist with demand management. There is a continued focus on maximising the available capacity in the SEL Community Diagnostic Centres and reviewing the consistency of the direct access offer across SEL.

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

Area	YTD summary and key issues
Mental health including crisis and flow	• Mental health services continue to experience significant year-to-date pressure, particularly across crisis pathways. Although overall presentations at emergency departments have remained steady over the last quarter, there has been an increase in the length of time people are spending in the department and the waiting time for inpatient bed. There has been some month fluctuations in the number of out of area placements during 2025/26. In January, there were 55 out of area placements which does not meet the plan of 14. • 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. • The urgent Children and Young People (CYP) eating disorders waiting time standard was met in January, however the routine target was missed again. This is being driven by staffing issues which, looks set to continue through to the end of the financial year. • SEL Talking Therapy performance for the number of people completing a course of treatment increased in January. The improvement rate target was met but the reported recovery rate fell below the 48% target, with reported performance of 44%. Monthly delivery across these metrics has varied throughout 2025/26. • 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 803,463 in January 2026, which is above the operating plan target of 741,865. • 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. • Boroughs are providing ongoing support to practices to help ensure they are delivering a total triage model for access.
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 96% of SEL community pharmacies providing all three services as of February 2026. Total service activity has surpassed the operating plan targets every month in 2025/26. • Since the start of the Pharmacy First service across community pharmacy in SEL in February 2024, there have been approximately 161k consultations for the seven clinical conditions, approximately 283K for hypertension consultations (blood pressure and ambulatory monitoring), and approximately 49k oral contraception consultations (initiation and ongoing supply and emergency contraception) up to February 2026. There have also been 11,524 emergency hormonal contraception consultations after going live on 29th October 2025. • Ongoing work is focused on improving referral pathways, data quality and promoting services in community pharmacy.

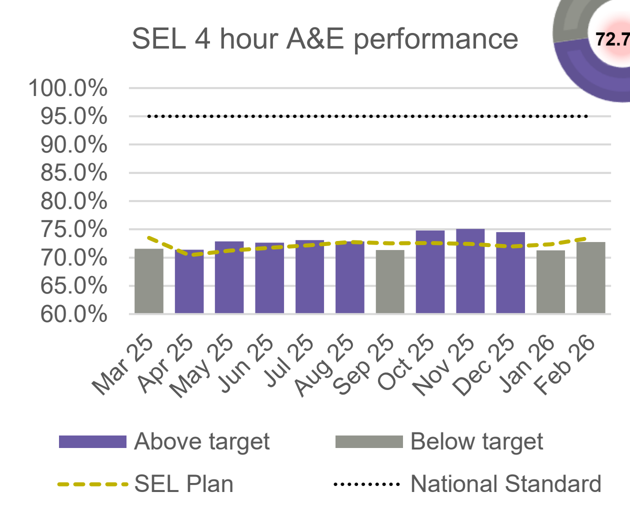
Summary of YTD position – April 2026 (3 of 3):

Area	YTD summary and key issues
Community waits and urgent community response (UCR)	• SEL UCR services continue to meet or exceed targets, though delivery of the referral rate target continues to present a challenge. Work continues with providers and referrers to establish changes to be made to current services to enable them to better respond to referrals and to increase the number of referrals from 111/999. • 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, driven primarily by neurodiversity. There was a significant increase in September 2025 due to a change in the way that one provider is reporting ADHD and ASD. Work is underway to test and pilot a new model of care, supported by additional investment into services to reduce overall waiting times. • The most recent month's data is showing an improved position. Community wait list numbers show a decrease of 1,203 on the previous month; this is mainly due to a positive reduction in patients waiting 18 to 52 weeks. Waiting time performance has improved marginally. The proportion of patients seen within 18 weeks increased from 57% to 59%. Long waiters (over 52 weeks) reduced from 6,669 to 6,311 – a decrease of 358. This was driven by positive progress in reducing long waits in Podiatry / Podiatric Surgery at GSTT. Long waiters in Community Paediatrics showed a slight increase this month particularly for patients waiting over 104 weeks. This service area will receive specific support from NHSE England and will be part of a CYP transformation programme in 26/27.
Virtual ward	• Virtual ward capacity has exceeded plan year to date. Reported utilisation has varied due to data and operational challenges. Reported utilisation rates have been negatively impacted by non-submission of data for one borough providers. This pause in reporting was agreed as part of transition arrangements as the service moved to a different provider, with the expectation that it will commence at the end of quarter four. • Work continues on improving the effectiveness of virtual Ward services with a particular focus on developing standardisation and consistency. In quarter four, the programme prioritised engagement with key stakeholders, including patients and UEC leads. This is to better understand operational and experiential challenges across UCR and Virtual Ward pathways. The findings will support a comprehensive review and optimisation of SEL VW and UCR models, ensuring alignment with the core minimum standards set out in the NHSE national operating framework.
Continuing healthcare (CHC)	• CHC performance improved across 2024/25 and into 2025/26, with delivery of the 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. • February 2026 performance (local reporting) against the number of referrals completed within the 28-day timeframe was 88% 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. • Overall review activity has increased, with a significant number of FNC reviews remaining overdue. Teams continue to work to their locally agreed improvement plans.
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. The increase in admissions slowed in January and February 2026, going up again in March. • For adult admissions, the majority have had previous admissions. This is often 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. • Increasing demand for all age autism assessments remains a system-wide challenge as reflected in the community waits position mentioned above. • 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

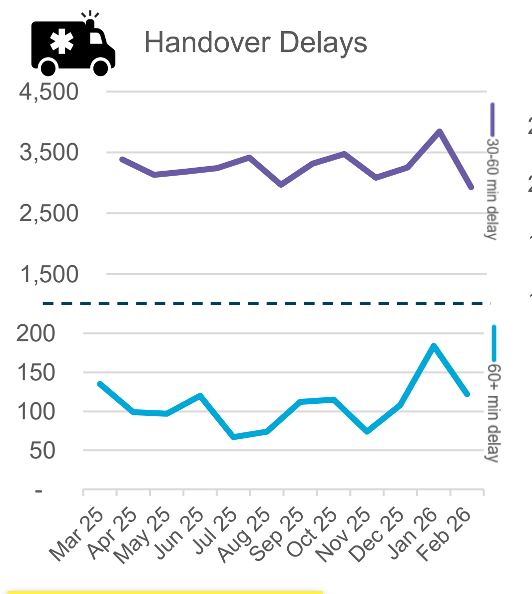
Notes and Issues

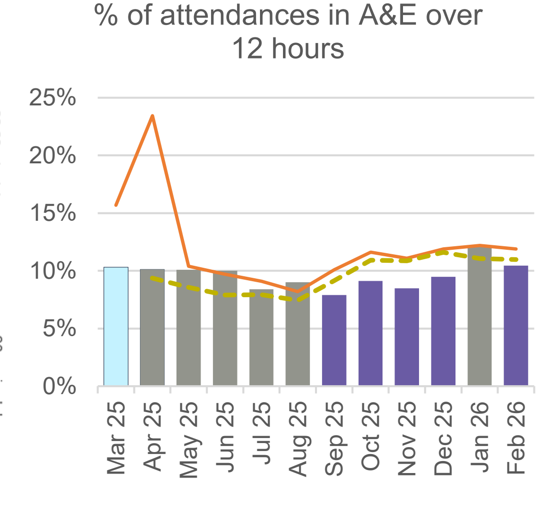
- ED performance – February SitRep data showed performance of 72.7% across the three acute Trusts which did not meet the provider combined trajectory. Published performance for SEL in January (including standalone UTC activity) was 73.9%, an improvement on the 72.6% reported in January.
- Ambulance handovers decreased in February across both 30-60 and 60+ minute delays following a peak in January.
- The target for the percentage of 12 hours waits (from arrival) was met in February.
- Bed occupancy levels increased compared with the previous month. The target for the percentage of patients discharged on their DRD was missed with reported performance of 88.6% vs. 92% target.
- SEL narrowly missed the target set for average LoS post DRD with reported performance of 8.3 days against a target of 8.2 days.

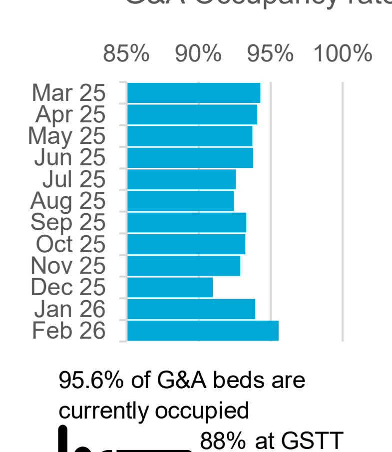


Recovery Actions

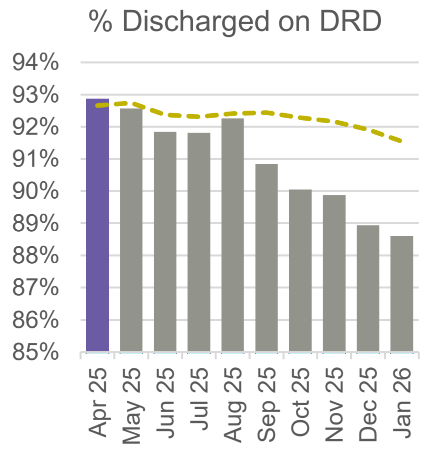
- Local systems/providers are delivering plans for 2025/26 to help meet agreed improvement trajectories. Improvement actions continue to focus on:
  - Front door management – use of alternatives to ED, ED triage and streaming, redirection, use of admission avoidance, MH crisis pathway, hospital handovers.
  - Implementation of 'Criteria to Admit' (CTA) across all sites.
  - In-hospital management – same day emergency care, length of stay improvement.
- Continued focus on reducing discharge delays.
- Enhanced 'sprint' actions, including enhanced senior decision making, MADE events and optimisation of alternative to ED pathways, took place across all sites to improve 4-hour and 12-hour performance throughout March.
- NHSE released details of a UEC Capital Incentive Scheme which will make additional capital available to Trusts that meet stretch performance targets by the end of the financial year.

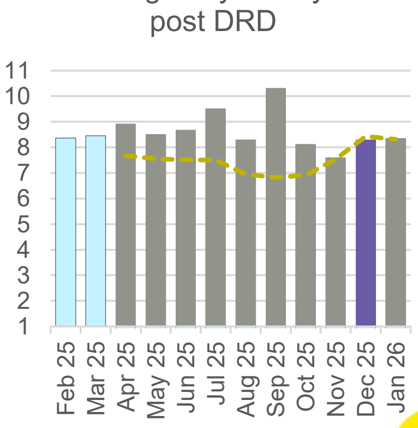






95.6% of G&A beds are currently occupied
88% at GSTT
98% at KCH
98% at LGT





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

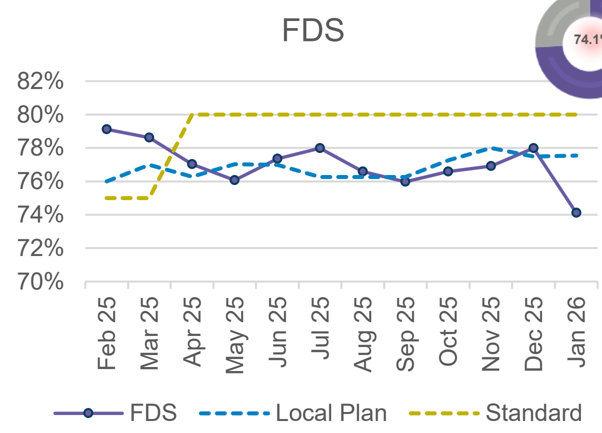
Linked to Risk: 386

Cancer

Actual
Standard Target
Operational Plan

Notes and Issues

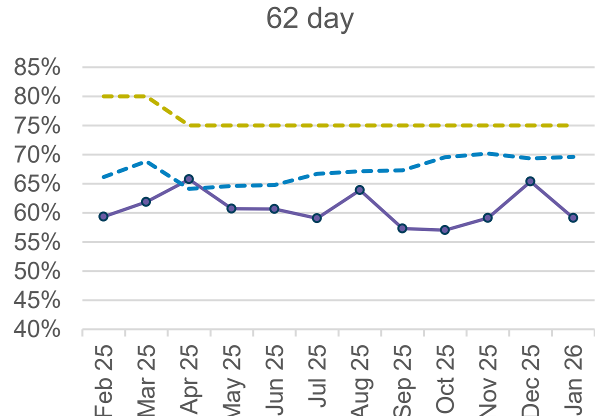
- Faster Diagnosis Standard (FDS) performance has dipped in January but is expected to be on plan for year end. Trajectories have been agreed to meet the national aim of reaching 80% by year end.
- 62-day performance remains a challenge for the system. Timely and effective Inter-Trust Transfer are a critical focus to improve performance, along with treatment capacity. Specific drivers are the lung and urology pathways.
- Backlog position has improved and is now more in line with 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.



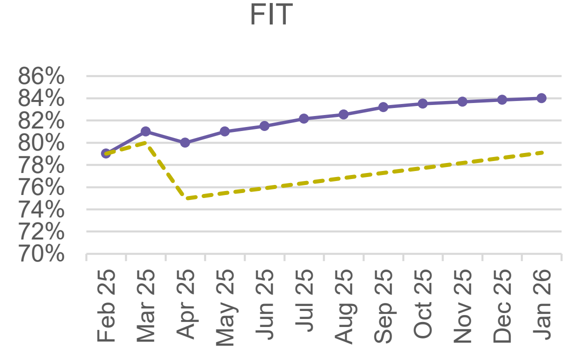
Faster Diagnosis Standard (Standard Target 80%)
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days

Recovery Actions

- Streamline cancer pathways and optimise diagnostics.
- Ensure timely communication of diagnoses and rule-outs within 28 days.
- Promote utilisation of rapid diagnostic clinics, FIT testing, teledermatology, and personalised stratified follow-up.
- Improve early diagnosis, patient experience, and resource utilisation.
- Proactively mitigate potential risks related to workforce, technology systems, and industrial action.
- Allocate necessary funding to support key actions.
- Waiting list review and validation
- Increased theatre capacity
- Cancer is recognised as priority pathway for available capacity
- The Cancer Alliance have produced a system recovery plan considering the complexity of shared pathways across SEL. This pulls together key actions for all 3 providers.

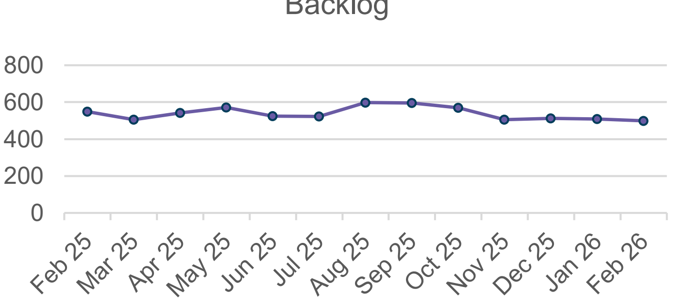


(Standard Target 75%)
% of patients with first treatment within 62 days of urgent GP referral



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

Please note that this is the only metric on this page that is not included in the Systems operational plan for 25/26. It is included 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

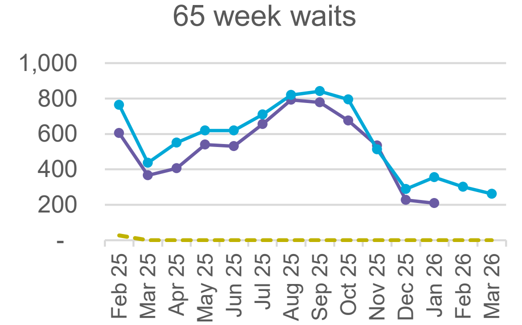
Linked to Risk: SEL 504

Referral to Treatment: Long Waiters

Latest Published month	Jan 26
Previous Published month	Dec 25
Latest weekly data	08/03/26
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

- The focus for 2025/26 is on delivering on the 65 ww 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. The number of 65-week-waits has fallen during the second half of 2025/26
- General Surgery, Bariatrics, Urology, Vascular and ENT are the most challenged specialties for 65+ ww.
- Zero 104 ww breaches were reported in January.

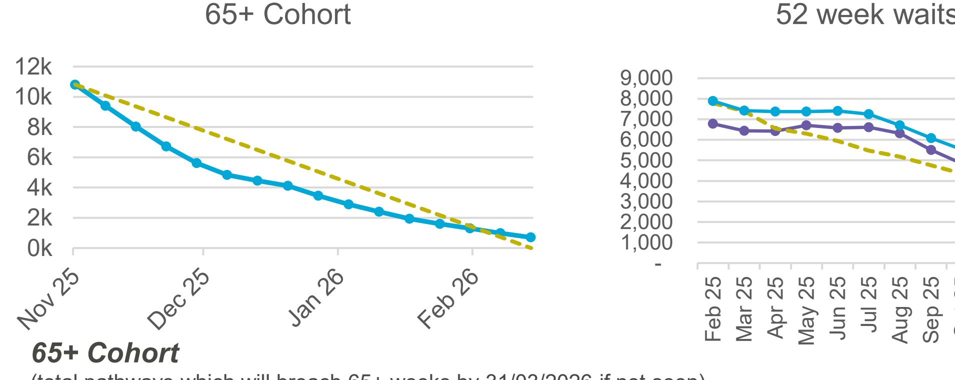


There are currently **262** patients at SEL Trusts who have been waiting more than 65 weeks to start treatment.

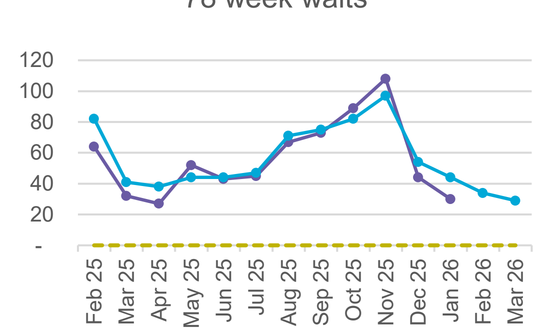
RTT Patients still waiting Jan 26	52+	65+	78+	104+
This month	**4,075**	**209**	**30**	**-**
Plan	× 3,394	× -	× 0	✓ 0
Last month	▲ 270 (6.6%)	▼ -18 (-8.6%)	▼ -14 (-46.7%)	▼ -3 ()
Latest week	**3,797**	**262**	**29**	**1**

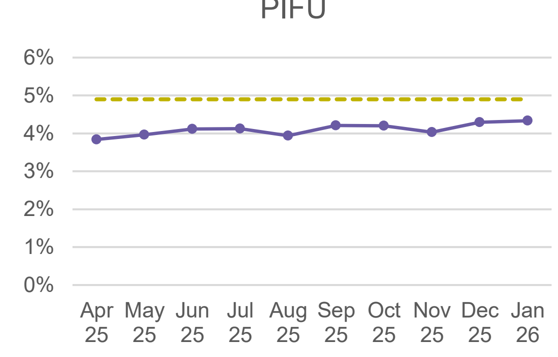
Recovery Actions

- 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. This is key driver behind the reduction in PTL experienced so far this year
- Additional funding has been allocated to maximise the reduction of 52+ week waiters by the end of Q4.
- Introduction of 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



65+ Cohort
(total pathways which will breach 65+ weeks by 31/03/2026 if not seen)





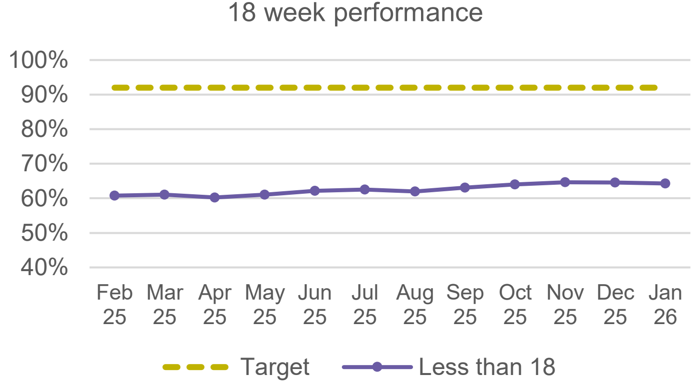
Linked to Risk: 384, 385

Referral to Treatment: Demand Management

Latest Published month	Jan 26
Previous Published month	Dec 25
Latest weekly data	08/03/26
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.



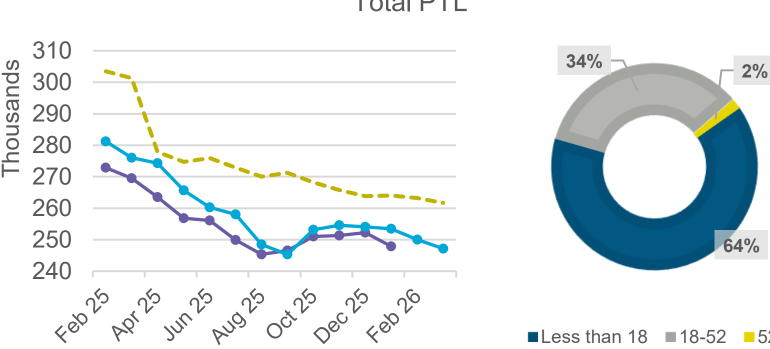
RTT Patients still waiting Jan 26	Total	<18 ww	18 week perf
This month	**247,889**	**159,452**	**64.32%**
Plan	✓ 303,498		× 92%
Last month	▼ -4342 (-1.8%)	▼ -3498 (-2.2%)	▼ -0.3% (-0.4%)
Latest week	**247,156**	**158,637**	**64.18%**

Recovery Actions

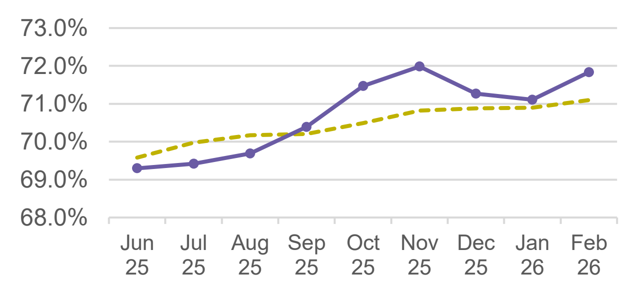
- Improved use of advice services and a priority focus on increasing and improving triage as the most evidence-based intervention (EBI) for demand management.
- Outpatient transformation including straight to test to improve waiting times at the beginning of RTT pathways.
- There has been a focus during 2025/26 on A&G, triage, booking processes, improving Did Not Attend rates and scaling PIFU.

DEMAND MANAGEMENT METRICS	Current	Mar-25	National	Trend
eRS Advice & Guidance				
Provision	40%	38%	nk	▬
Responded in <48hrs	63%	61%	65%	▲
Diversion Rate	73%	79%	65%	▲
Consultant Connect				
Provision	67	69	n/a	▼
Answer Rate (calls)	51%	43%	64%	▲
Answer Rate (messages)	100%	99%	99%	▲
Diversion Rate (calls)	19%	20%	61%	▼
Diversion Rate (messages)	72%	68%	50%	▬
Referral Triage				
Provision	39.5%	28.9%	16-68%*	▲
Responded in <48hrs	64%	64%	nk	▼
Diversion Rate	16%	13%	14%	▬

*range of London systems. SEL is 2nd highest in London



34%
2%
64%
Less than 18 ■18-52 ■52+

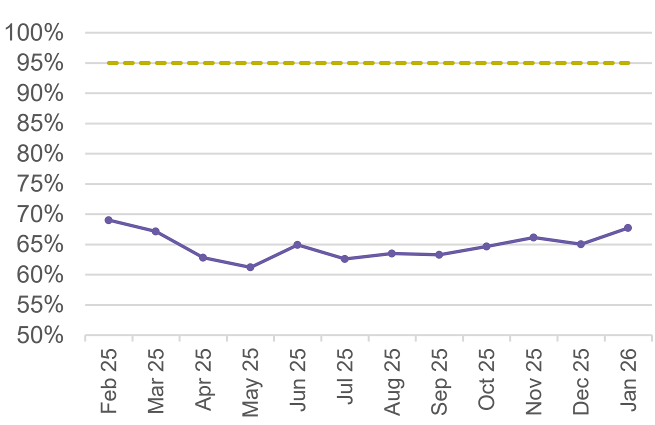


Linked to Risk: 384, 385

Diagnostics

Notes and Issues

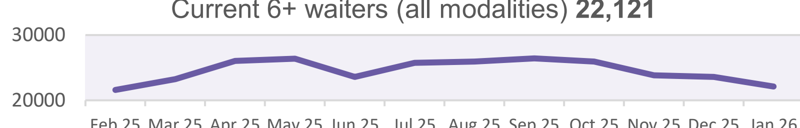
- No new targets were set for diagnostics for 2025/26, However, the expectation is that improvement in waiting times is key to supporting the delivery of RTT and cancer.
- SEL's current diagnostic performance is challenged. Focused recovery actions are underway.
- Key modalities where performance is 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.
- There were 9,331 > 13 ww reported in December, which is reduction when compared with the previous month (10,113).

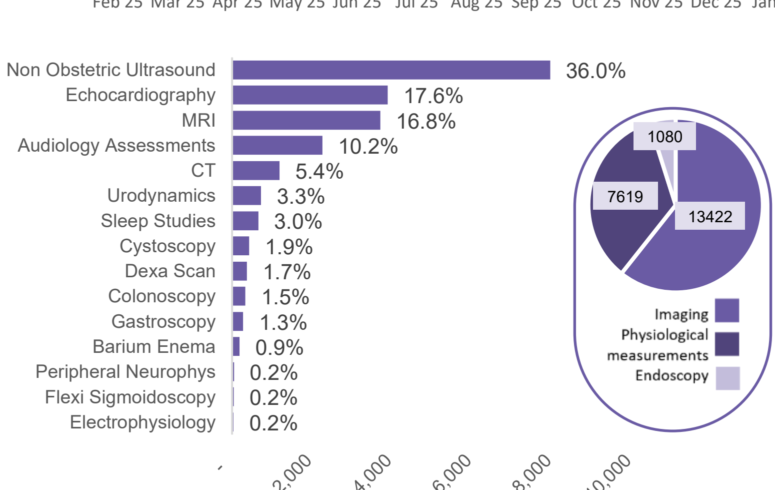


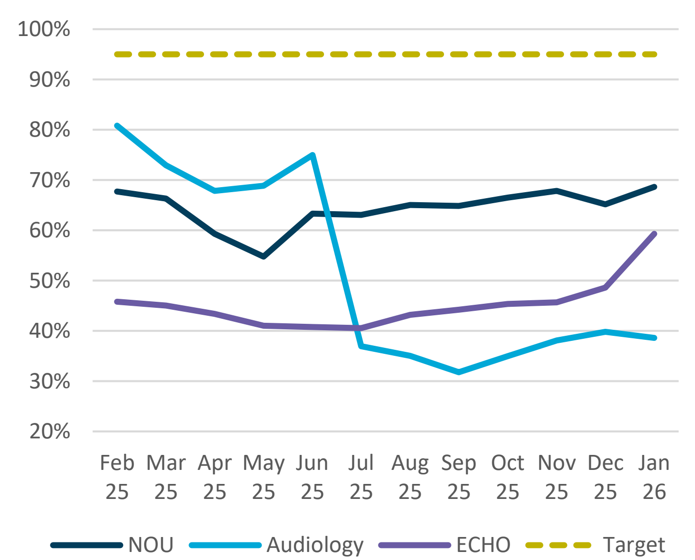
Recovery Actions

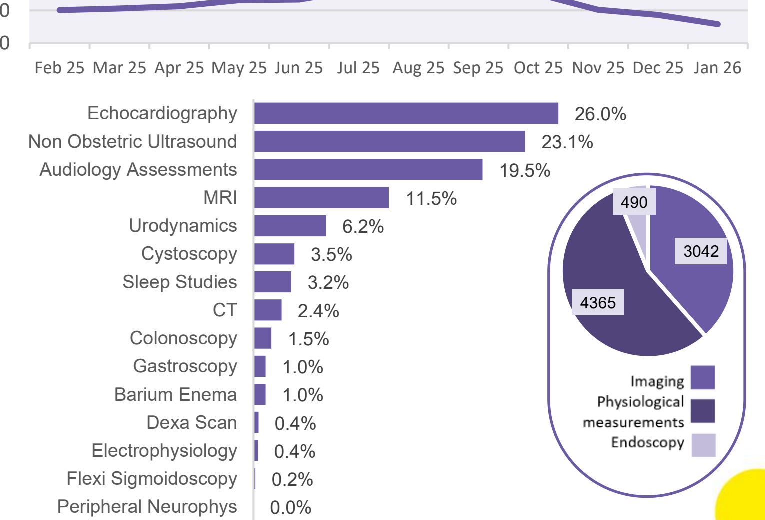
- Clinical and administrative validation of the overall diagnostic PTL.
- Implementing a clinical decision support tool to assist with demand management.
- Additional capacity by maximising on-site capacity, in- and outsourcing.
- As part of the operational planning process local trajectories for further 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 and reviewing the consistency of the Direct Access offer across SEL

Current 6+ waiters (all modalities) **22,121**







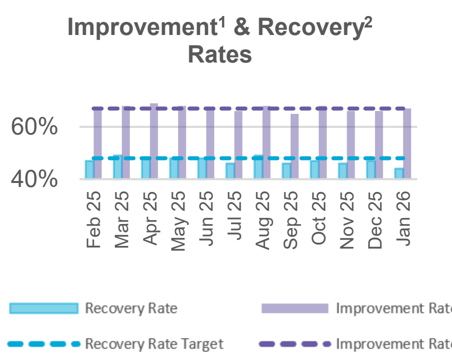


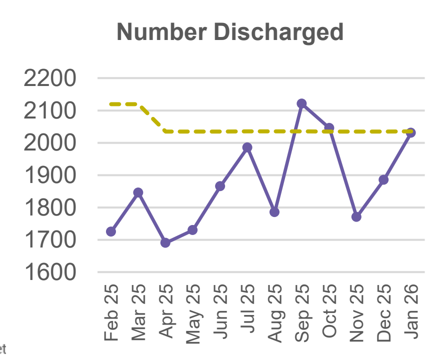
Mental Health

Notes and Issues

- The waiting times target for urgent CYP eating disorder referrals was met in January, but performance continues to fall below target for routine referrals. This is driven by staffing issues and is likely to continue for the remainder of the financial year.
- CYP access performance remains below target in December. 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 increased in January. The improvement rate target was met but the reported recovery rate fell below the 48% target, with reported performance of 44%.
- Perinatal access continued to perform below trajectory in January with reported performance of 1,720 against a target of 1,874.
- Quarter 3 SMI PHC performance was published and showed an increase in the number of completed health checks. Performance does, however, remain below trajectory.

Talking Therapies (IAPT)

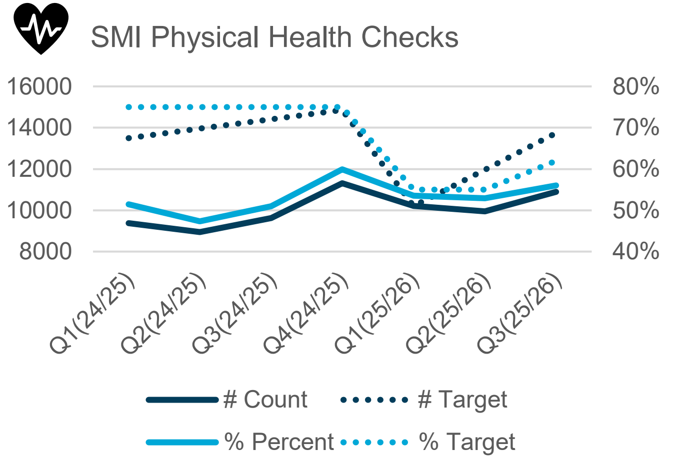


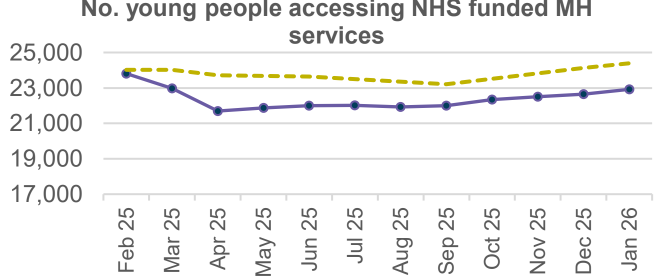


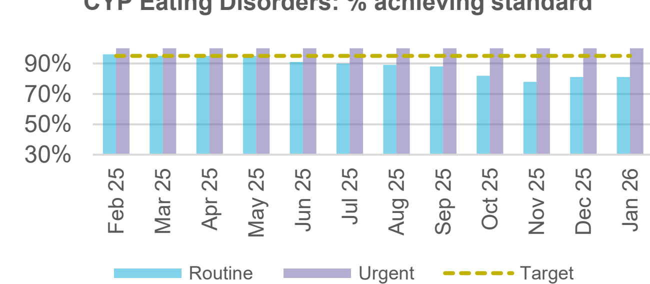
1. Reliable improvement rate for those completing a course of treatment.

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

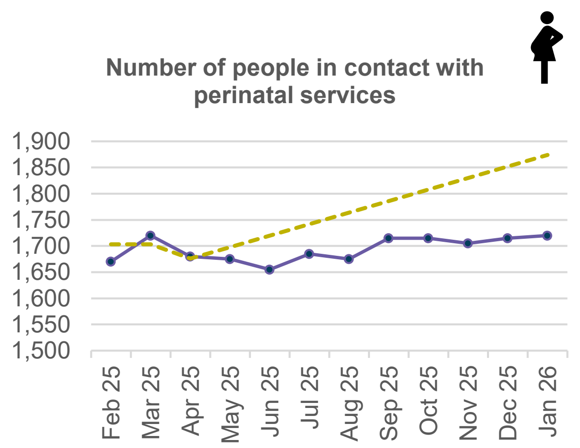






Recovery Actions

- 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.

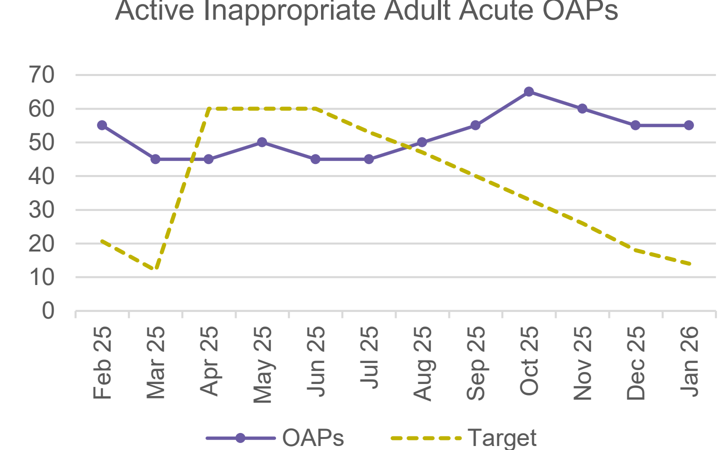


Linked to Risk: 387

Mental Health Crisis & Flow

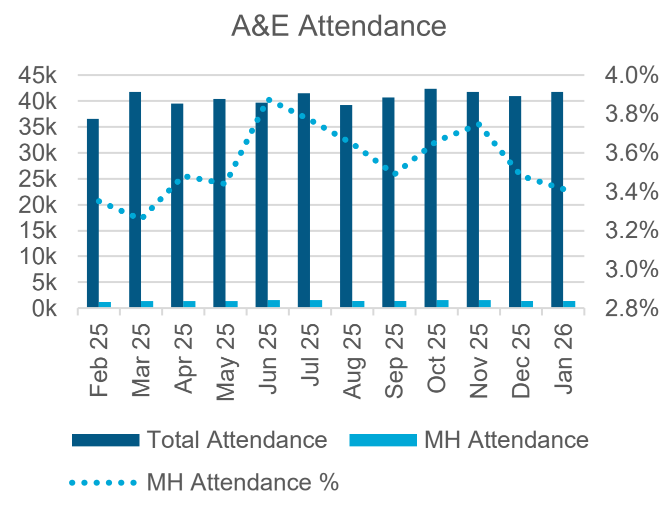
Notes and Issues

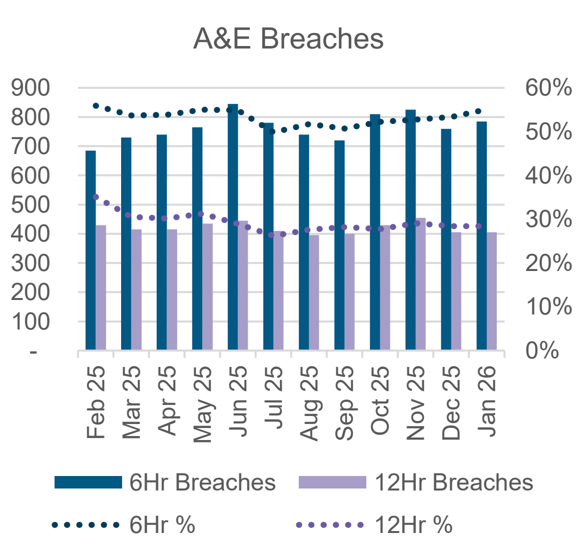
- Mental Health emergency pressures continue with some very challenging days for providers again reported over recent months.
- The number of inappropriate out of area placements (OAPs) remained static in January with 55 active placements reported against a plan of 18.
- A&E data shows that the proportion of MH presentations in ED in January remains consistent with previous months at around 3%. 55% of MH patients waited more than 6 hours in ED and 28% 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 met the length of stay target in November with performance of 49 days against a target of 52.2.

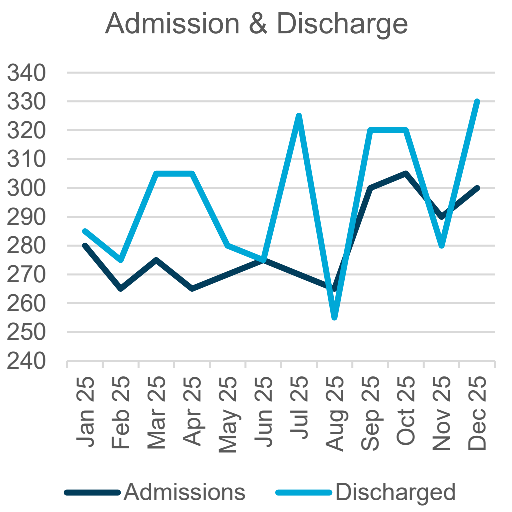


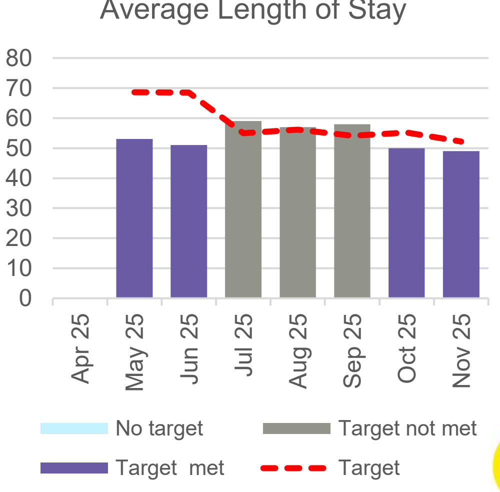
Recovery Actions

- 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 OAPs data is submitted via MHSDS correctly. Improvements are noted but the data is still not flowing correctly for all providers.









Linked to Risk: 387

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 803,463 in January 2026 against the operating plan target of 741,865.

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.
- 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.
- Boroughs are working to ensure that practices are delivering online consultation access throughout core hours.

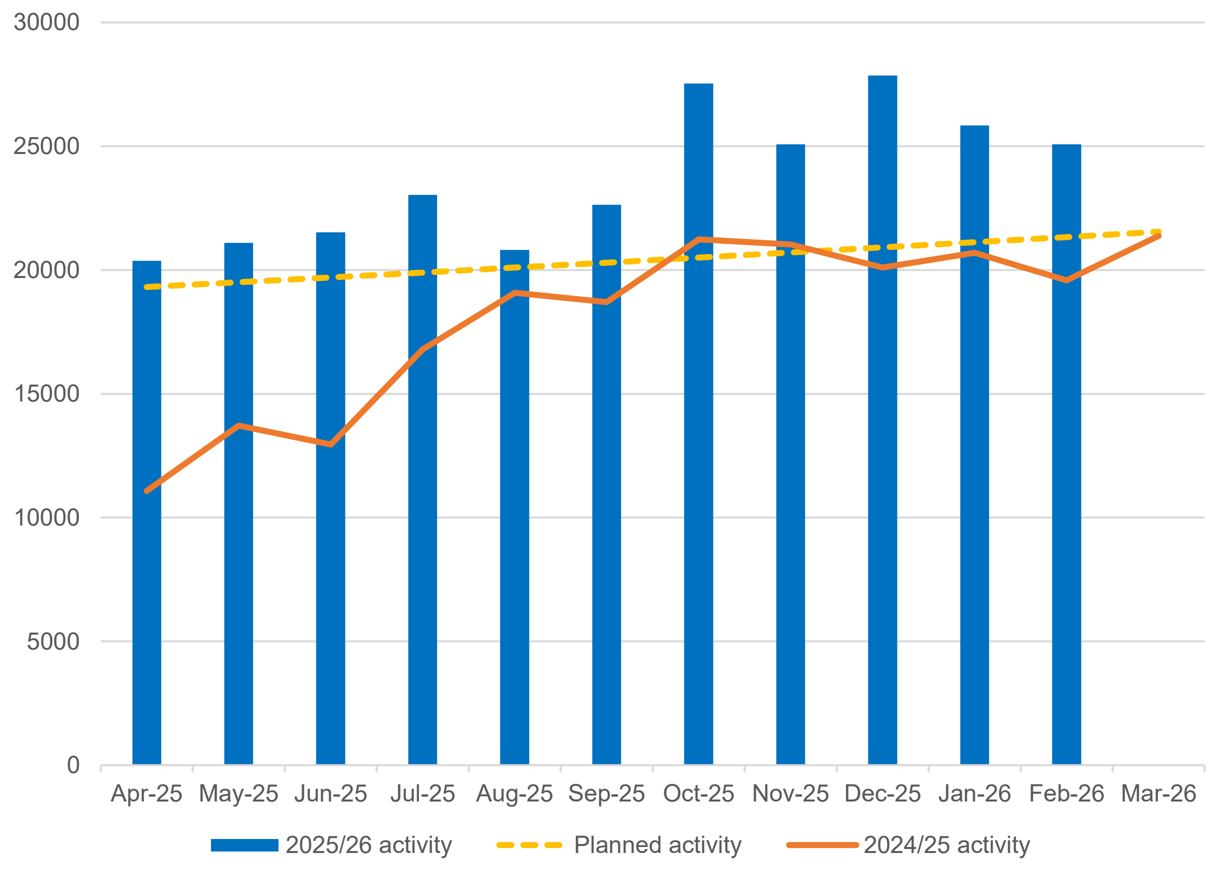
Note on data source: charts use the nationally published PCN level GPAD data to calculate borough level reporting: Appointments in General Practice - NHS England Digital

Linked risk: Lew 528, Gre 621

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

Notes and Issues

- In February 2026, 309 pharmacies (of 324) were providing Pharmacy First services, with 306 providing hypertension screening and 303 providing oral contraception
- From February 2024 to Feb 2026:
  - Approximately 161,000 clinical pathway consultation have been conducted by SEL community pharmacies
  - Approximately 283,000 hypertension consultations have been conducted by SEL community pharmacies
  - Approximately 49,000 contraception consultations have been conducted by SEL community pharmacies
- Updated oral contraception service which include emergency hormonal contraception (EHC), went live on 29 October. There have been 11,524 EHC consultations across SEL since the service became available.
- In February 2026, 298 SEL pharmacies were providing all 3 advance services and qualified for additional monthly threshold payments.
- The number of GP practices referring into the services has increased compared to previous months. The latest data shows that 17 GP practices have not referred into any of the three 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
- Digital IT facilitators supporting GP practices to increase use of referral tools available to Community Pharmacy
- Working closely with SEL LPC to support and provide training to community pharmacy, in particular those that are not already providing all three services
- Community Pharmacy Neighbourhood Leads (CPNL) proactively engaging with local pharmacies to support with provision of the three services.
- Encouraging of shared learning between peers; often via borough Pharmacy Network Meetings.

Linked to Risks: Bex 585

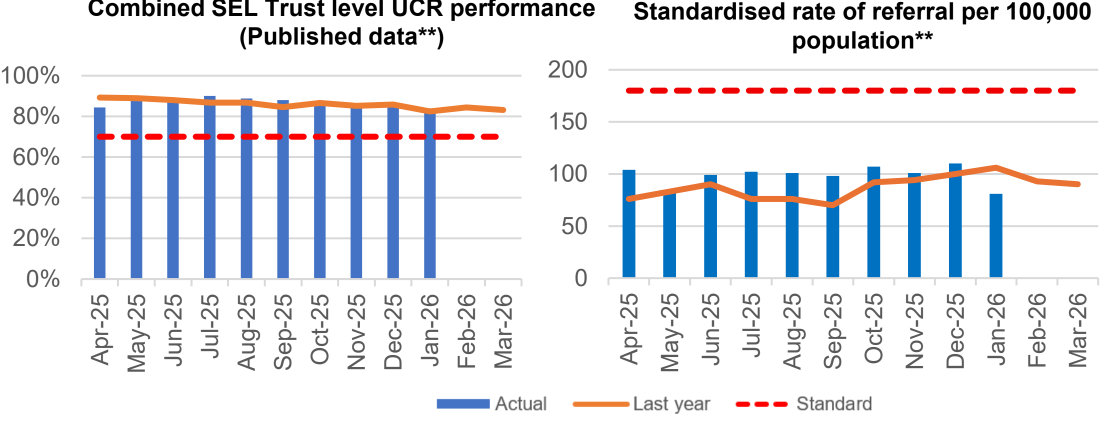
UCR and community waits

Notes and Issues

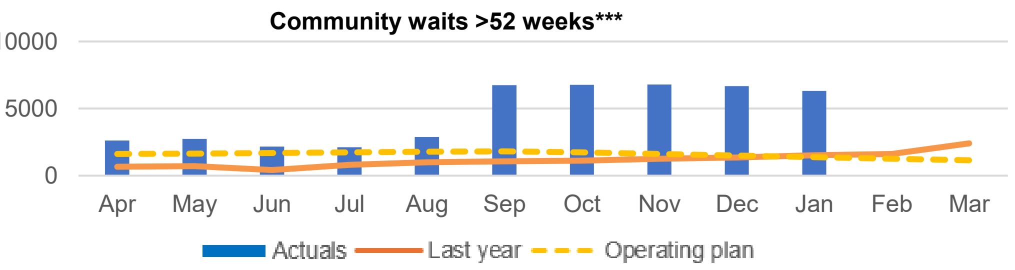
- January Urgent Community Response (UCR) performance data shows SEL providers exceeding the 2- hour and 2-day response standards.
- The latest complete month of reporting (December 2025) for standardised rate of referral was 110 per 100,000 population. This is below the target of 180 but is showing an improved position.
- The total number of patients on the Community Services waiting list (for services in scope) was 36,349. This is a decrease of 1,203 on the previous month.
- Of the total number of patients waiting, 21,455 (59%) have been waiting less than 18 weeks for a first appointment.
- Services contributing most to overall wait numbers are: Community Paediatrics (44%), MSK (9.7%), and Podiatry/Podiatric Surgery (9.2%).

Long waiters:

- The number of patients waiting over 52 weeks for a first appointment has decreased from 6,669 to 6,311. Of the 5,151 patients waiting 52-104 weeks 4,957 (96%) were in Community Paediatrics, 163 in Podiatry/Podiatric Surgery with small numbers across a number of other services .
- There were 1,160 patients waiting over 104 weeks, an increase from 1,098 in the previous month.. Community paediatrics account for nearly all the list.



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



***April 24 to Feb 25 data excludes GSTT.

SEL Waiting List Breakdown (Jan 26)

Waiting time	Number of waiters
0-1 weeks	**3,362**
>1-2 weeks	**2,727**
>2-4 weeks	**3,750**
>4-12 weeks	**7,952**
>12-18 weeks	**3,664**
>18-52 weeks	**8,583**
>52-104 weeks	**5,151**
>104 weeks	**1,160**

Recovery Actions

UCR:

- SEL UCR services continue to meet or exceed compliance targets. However, meeting the standardised referral rate target continues to present a challenge. Work continues with providers and referrers to establish changes to be made to current services to enable them to better respond to referrals and to increase the number of referrals from 111/999.

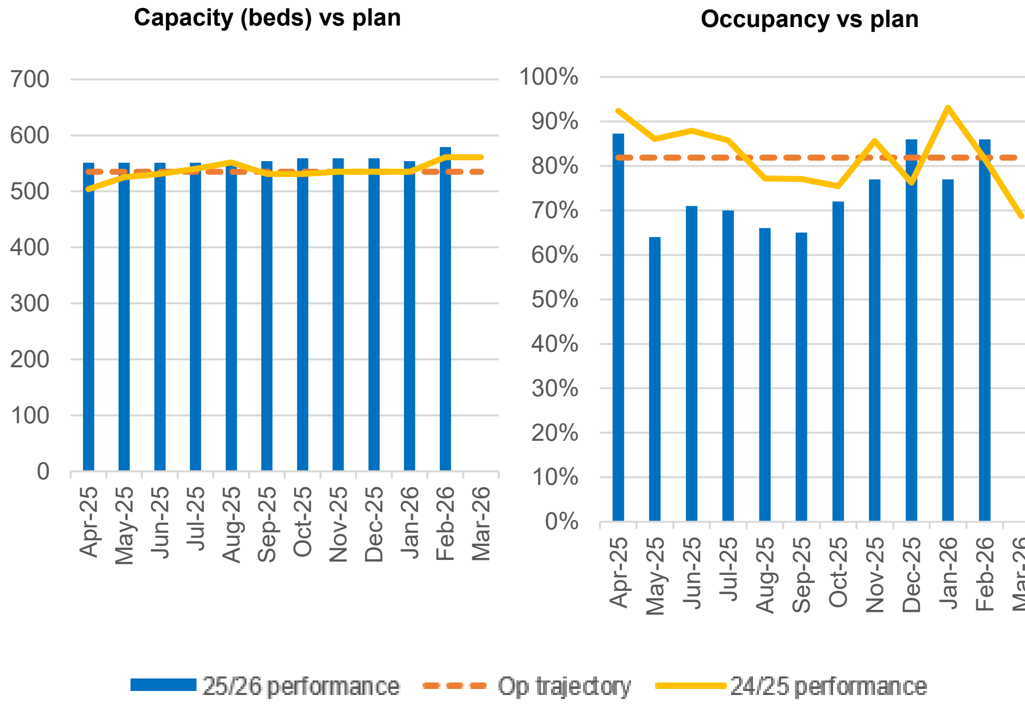
Community wait list:

- Long waits in community paediatrics continue to present the largest challenge for all SEL providers, driven primarily by neurodiversity waiting times. The overall number of waiters has remained largely consistent as capacity fails to keep pace with referral demand. Work is underway to test and pilot a new model of care, supported by additional investment into services to reduce overall waiting times. In addition to the transformation programme planned for 2026/27, SEL will be receiving support from NHSE Getting It Right First Time (GIRFT).
- Meetings with providers have commenced to review their detailed actions and to test robustness of recovery plans for community long waits. Providers are also being supported by the Community Provider Network facilitating a fortnightly task and finish group. Work has commenced on reducing variation with the aim of reaching a consensus on referral and eligibility changes.
- ICBs can expect further support from NHSE with tools to address wait lists through the CHS Waiting Times Action Plan and High Impact Action Checklist.

Virtual Wards

Notes and Issues

- SEL Virtual Ward capacity is above plan at 579 beds with a target of 535.
- The average utilisation for February was 86%, which is slightly above the plan of 82%. Reported utilisation rates have been negatively impacted by a gap in reporting following the transfer of one service to a different provider. This was agreed as part of a transition period with reporting expected to commence at the end of quarter four.



Average of snapshots February 2026

December 2025	Average Capacity	Average Utilisation
SEL actuals	579	86%
SEL Plan	535	82%

2025/26 Plans and Actions

- Work continues across south east London to support the improvement of virtual ward services, engaging with key stakeholders including urgent and emergency care (UEC) leads and service users to better understand operational and experiential challenges across UCR and Virtual Ward pathways.
- An online patient and public focus group was held, attended by service users and carers with experience of SEL Virtual Ward and UCR services. The feedback from this session will be used to support greater consistency in delivery across south east London. A key enabler of this work is the development of a SEL-wide Hospital@Home l, currently being progressed through the SEL Hospital@Home Community of Practice.
- Work is underway to ensure that services are compliant with the national operating framework and can deliver effective admission avoidance.

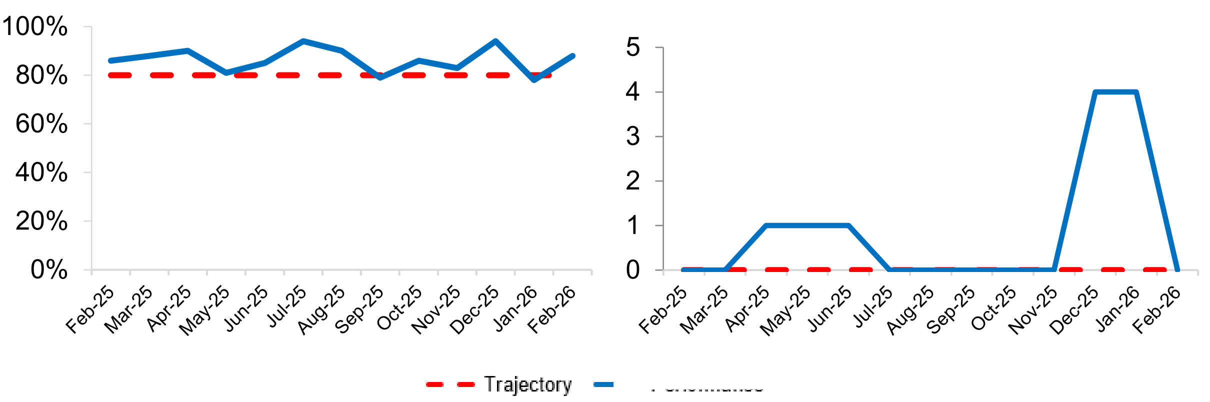
Linked to Risk: Gre 474

NHS Continuing Healthcare

Notes and Issues

- February performance (local reporting) against the number of referrals completed within the 28-day timeframe is 88%. This is an increase from the January performance of 78% and above the national target of 80%.
- Incomplete referrals over 12 weeks: SEL reported zero 'long wait' over 12 weeks in February which meets the national requirement.
- The quarter 3 statutory reported position for SEL was 82% for 28-day performance which is above the national target. There were four incomplete referral over 12 weeks which is above national target of 0.
- Standard CHC and Fast Track Reviews: There is variation in the number of overdue standard CHC and fast track reviews across the six boroughs. The number of individuals waiting for a Standard CHC reviews increased to 183.
- There are 89 overdue fast track reviews. This is an increase from the previous month of 81.
- Funded Nursing Care Reviews: The number of FNC Reviews increased from 713 to 717 in February.

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		
	Q3	Trajectory	Target	Q3	Trajectory	Target	Q3	Trajectory	Target
Bexley	0%	-	0%	85%	80%	80%	0	0	0
Bromley	0%	-	0%	91%	80%	80%	0	0	0
Greenwich	0%	-	0%	68%	80%	80%	0	0	0
Lambeth	0%	-	0%	89%	80%	80%	0	0	0
Lewisham	0%	-	0%	60%	80%	80%	4	0	0
Southwark	0%	-	0%	88%	80%	80%	0	0	0
SEL	0%	-	0%	82%	80%	80%	4	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

- Boroughs continue to work to agreed trajectories to reduce the number of patients waiting for Standard CHC, fast track and Funded Nursing Care Reviews, although a significant number remain overdue.
- Incomplete referrals over 12 weeks reduced to 0 in February, meeting the national requirement in the reporting period and showing an improved performance from January where 4 referrals over 12 weeks were reported.

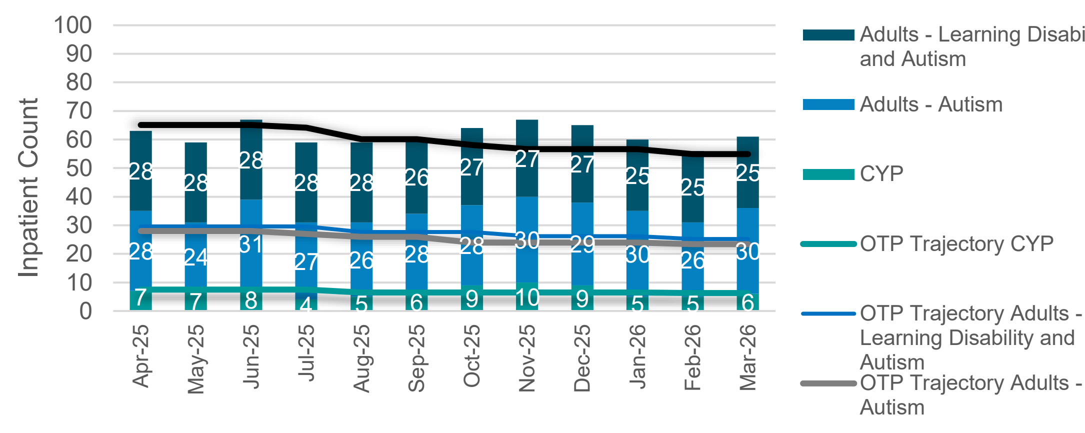
Linked to Risk: SEL 468

Learning disability and autism (LDA)

Notes and Issues

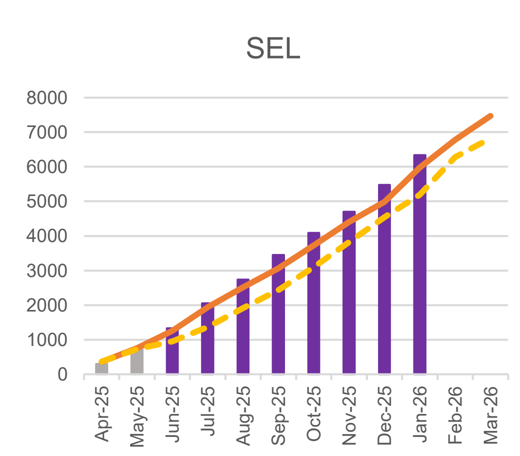
- Operational planning trajectories for 2025/26 were set to consider the number of adults aged 18 and over from the ICB who have a learning disability (including those who may also be autistic) and the number of adults aged 18 and over from the ICB who are autistic (with no learning disability) who are in mental health inpatient care
- On the 18 March, the target LDA inpatient position was not being met. There were 61 inpatients, 6 over the Q4 target of 55.
- There were 55 adults (30 autism only diagnoses) in non-secure and secure units. The target for 2025/26 is 48 adults (25 with a learning disability and/or autistic adults and 23 autistic adults) and 6 young people. Though there are people due for discharge before the end of the month, the target for 2025/26 is not expected to be met.
- There continues 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 (AHCs) remains on track and is expected to be achieved by all boroughs. 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.
- The Oliver McGowan mandatory training continues to be rolled out to provide essential skills and knowledge to ensure safe and compassionate care for autistic people and individuals with a learning disability. Uptake is currently 30% for Tier 1 and 28% for Tier 2. There is a target of 30%.

LDA Inpatient Position



Note: March data point is 18th Mar 2026.

LD AHCs: SEL and Borough Level Position



	January 26 performance		Jan-26 Trajectory	2025/26 Plan
	%	Count		
Bexley	68%	847	690	908
Bromley	68%	880	714	939
Greenwich	68%	1185	949	1248
Lambeth	64%	1134	972	1279
Lewisham	65%	1338	1120	1473
Southwark	71%	949	741	976
SEL	67%	6333	5190	6823

Recovery Actions

- Community autism specialist services to support autistic only people developed 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. The service specification has been agreed, and providers are working to mobilise services from April 2026.
- 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.
- 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 on 11th 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.

Linked to Risks: SEL 389, SEL 390, SEL 391, Gre 615, Gre 635, Bex 642, Bro 509, Lam 129, Lew 644, Sou 520

ICB Board Meeting in Public

Title	Quality and Nursing				
Meeting date	8 April 2026	Agenda item Number	8	Paper Enclosure Ref	H
Author	Annette Fogarty, Associate Director of Quality and Patient Safety Elizabeth Aitken, Clinical and Care Professional Lead, 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 3				
Summary of main points	**Quality and Patient Safety:** In Q3, 19 Patient Safety Incident Investigations and 4 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. 466 Quality Alerts were raised, with the trending themes reported include transfer of care, appointment/referral, discharge, treatment and medication. Improvement work is underway, including a review of dispensing controls following a look-alike/sound-alike medication error and strengthened escalation guidance. **Safeguarding:** During Q3, safeguarding activity focused on strengthening system intelligence and commissioning insight, particularly through the use of the Serious Violence Duty dataset. Progress was made through the continued development of the Families First Programme and the successful roll-out of CP-IS. This was supported by improved audit and workforce assurance and completion of the Child Death Overview Process internal audit, further strengthening governance and system learning. **Local Maternity and Neonatal System (LMNS)**: The interim findings of the National Maternity and Neonatal Investigation highlight significant systemic pressures across healthcare with further work underway to analyse past recommendations and gather national evidence to inform future improvement. All trusts have submitted their Maternity Incentive Scheme (MIS) declarations and where areas are not fully compliant appropriate action plans and mitigations are in place. **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):** Progress continued in Q3 to reduce reliance on inpatient care and strengthen quality and safety for people with a learning disability and autistic people through improved community services, governance, medicines optimisation and workforce capability. **Special Educational Needs and Disabilities (SEND)**: In response to the Schools White Paper and national SEND reforms, SEL partners are developing Local Area SEND Reform Plans, supported by national advisers, with SEL ICB required to formally agree and sign off these plans through the Chief Executive.				

<table>
<tr><td>Potential conflicts of Interest</td><td colspan="6">Nil known</td></tr>
<tr><td rowspan="2">Relevant to these boroughs</td><td>Bexley</td><td>X</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr>
<tr><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr>
<tr><td>Equalities Impact</td><td colspan="6">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.</td></tr>
<tr><td>Financial Impact</td><td colspan="6">There is no financial impact associated with this paper</td></tr>
<tr><td>Public Patient Engagement</td><td colspan="6">Patient engagement is outlined in the paper</td></tr>
<tr><td>Committee engagement</td><td colspan="6">Quality and Safeguarding Committe</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board are asked to note the content of the report</td></tr>
</table>

Quality and Nursing Report

NHS South East London Integrated Care Board (ICB) 8 April 2026

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 3. It covers essential areas, including Quality and Safety, Safeguarding, 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 Q3, a total of 19 Patient Safety Incident Investigations (PSIIs) were commissioned and 4 Never Events recorded. There have been 13 Never Events reported across the system year to date. Three of these Never Events related to wrong site surgery involving the removal of an incorrect lesion, the insertion of a ureteric stent at the incorrect side and inadvertent administration of a Botox injection to the bladder instead of to the urethral sphincter. The other Never Event was related to a retained foreign object (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. A recent thematic review completed by one of the providers using a systems-based analysis informed by incident data, investigations, clinical audit findings and national learning identified that retained foreign object events are rarely attributable to a single error and instead arise from multiple interacting system weaknesses. It also highlighted that there was variation in knowledge, practice and reliability of core safety processes, particularly in relation to surgical counts and the ‘sign-out’ stage of the WHO Surgical Safety Checklist. An improvement project is being undertaken to streamline the checklist and reduce the number of questions to improve engagement. The findings and results of the project will feed into the Themes and Concerns Group.

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 466 quality alerts were reported in Q3. The trending themes reported include transfer of care,

appointment/referral, treatment, discharge and medication. During Q3, a sustained 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. Themes and trends from QAs are also fed into the System Interface Group led by the ICB Medical Director. A new South East London (SEL) standard for discharge summaries has been proposed to help address known system issues. The team are also updating the current version of the Consensus Document to include reference to mental health.

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

- Following multiple administrative incidents resulting in delays in the completion of paperwork required after a death (Medical Certificate of Cause of Death, MCCD), a provider has introduced a new, clear protocol for responding to a death. This has been shared with all staff and now all death-related calls and emails are treated as urgent and dealt with on the same day by the Duty Doctor.
- Learning from a quality alert identified that initial triage did not escalate a patient with established cardiac disease and new chest pain directly to emergency care, this has resulted in a review of the process and strengthened escalation guidance.
- Issues with ongoing melatonin prescribing following discharge from paediatric services, led to a further review of the process within primary care resulting in improved communication of updated prescribing guidance that no longer requires a shared care agreement making the process clearer.
- Learning within community pharmacy led to strengthened dispensing controls following a look-alike/sound-alike medication error, including clearer stock separation, reinforced checking procedures, updated SOPs and targeted staff training to reduce the risk of recurrence.

The Patient Safety Incident Response Framework (PSIRF) pilot Phase 2 in General Practice, led by the Health Innovation Network (HiN) has come to an end. The pilot teams include five participants from SEL: one GP Federation, two Primary Care Networks, one GP practice, and one hospice. The local pilot group is focused on embedding PSIRF within general practice and aligning it with CQC preparedness. Key outputs include integrating primary care PSIRF requirements into the existing SEL PSIRF policy to support a consistent, system-wide approach. The team have also aligned the principles of PSIRF with the SEL CQC Support Tool and are supporting the development of resources on SEL.net. A practical flowchart is also being drafted to support implementation in day-to-day practice.

The CQC undertook inspection activity across two large providers in Q1 and Q2. The reports and findings have been published on the CQC website and the ICB quality team are working in collaboration with the providers on improvements and actions plans.

2.2 Safeguarding

The safeguarding update provides the Board with a summary update on the delivery of the ICB Safeguarding Workplan, outlining progress against key priorities and providing assurance on safeguarding activity and outcomes.

Serious Violence Duty (Including VAWG):

The ICB Serious Violence Dataset, drawing on Emergency Care Data Set (ECDS) and inpatient activity data, now provides partners with improved access to high-level intelligence on hospital contacts relating to serious violence across the SEL ICS. The availability of a comprehensive, shared dataset has strengthened system-wide insight and supports more informed commissioning and safeguarding decision-making.

Joint work between safeguarding and commissioning teams has strengthened the triangulation of serious violence data and how it fits with safeguarding statutory reviews. This enhanced alignment supports improved learning and more effective targeting of interventions. Further collaboration with the Vanguard service will strengthen this triangulation and directly inform service development, with emerging opportunities identified for a more prevention-focused approach.

Analysis of VAWG and domestic abuse data has improved system understanding of how services engage with hard-to-reach communities. This insight is informing place-based and system-level service development, supporting more responsive and equitable safeguarding approaches.

Families First Programme (FFP):

The Families First Programme aims to deliver an integrated, multi-agency health intervention by aligning existing resources, infrastructure, and partner capabilities. SELICB (Lewisham) has progressed as a pilot site, with learning from regional presentations and a Department for Education (DfE) pathfinder visit informing the emerging model. Progress across five boroughs has supported wider system discussions on Multi-Agency Child Protection Teams (MACPTs). Ongoing collaboration with the London region is shaping a sustainable approach, clarifying place-based planning, defining team models, and identifying commissioning and resourcing requirements to support future implementation and evaluation.

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

CP-IS enables secure information sharing between local authorities and NHS organisations to support the protection of vulnerable children. Phase 2 of CP-IS is progressing as planned, with roll-out underway across the system. Implementation is being tracked, and provider collaboration supported by shared learning from Lewisham has strengthened consistency, oversight, and safeguarding response across the SEL footprint.

Audit and Workforce Assurance:

An audit of the Serious Case Review Tracker (S-CRT) was undertaken to provide assurance on access arrangements, oversight, and the quality of recorded information. The audit is intended to strengthen the quality and consistency of statutory review inputting by place-based safeguarding leads and enhance system-level oversight. The internal audit of the Child Death Overview Process (CDOP) has been completed, resulting in a set of recommendations. These recommendations will be progressed during 2026 to further strengthen governance, learning, and system assurance.

2.3 Local Maternity and Neonatal System (LMNS)

The aim of the National Maternity and Neonatal Investigation, Baroness Amos interim report, is to develop national recommendations that will, once put into practice, help ensure that safe, compassionate care is consistently delivered everywhere. After sharing the terms of reference for the investigation Baroness Amos published some initial reflections (shared within the January 2026 LMNS Board report). The interim report was published in February. The investigation to date has heard from over 8,000 people, identified that the system is not working for women, babies, families, and staff and identified six factors that could be contributing to the pressures on maternity and neonatal services:

- Capacity pressures
- Culture and leadership
- Racism and discrimination
- Poor responses and lack of accountability when things go wrong
- The quality of estates
- Workforce

The next steps are to:

- Conclude the analysis of the previous investigation recommendations made to improve maternity and neonatal care
- Take evidence from national stakeholder organisations for insights into governance and organisational structures, training, regulation, and funding pathways for different elements of maternity and neonatal services.

- Convene further evidence panels focusing on inequalities, system wide working, and the relationship between trusts and families.

Maternity Outcomes Signal System (MOSS):
MOSS has been developed by NHSE in response to the East Kent ‘Reading the Signals’ report. The system is a near real time (data refreshes daily) safety tool that attempts to detect maternity safety issues in intrapartum care early through the generation of alerts if signals are raised. The system focuses on stillbirth and neonatal data up to 28 days. If a signal is triggered services conduct a mandatory critical safety check within eight days.

Maternity Incentive Scheme (MIS) Year 7:

The LMNS has been working across the three acute trusts on MIS year 7 submissions. All trusts have submitted their MIS declarations and where areas are not fully compliant appropriate action plans and mitigations are in place.

Transformation

Current transformation work taking place within the LMNS includes:

- A review of SEL tongue tie services to ensure the needs of women, birthing people, babies, and families are met. Feedback from service users is currently being sought via a questionnaire. We have received 64 responses to date. This feedback will inform any service improvements that are required.
- A preconception health pilot, led by an obstetric physician at a large provider, targeting childbearing age people with complex medical conditions is underway, recognising that early education and intervention supports better pregnancy, birth and long-term health outcomes. The pilot sits under the Women’s and Girls Health work and is overseen by the LMNS.
- The second stage of the SEL preconception health campaign is in progress, and we have seen sustained engagement with the messaging that started with our Tommy’s campaign. During January and February there has been over 15,000 search impressions and more that 746 clicks. Clickthrough improved over the two months and indicating that the ads continue to resonate with audiences. The themes that received the strongest interest were healthy diet, weight and physical activity, supplements, and general advice on what to do before trying for a baby.
- Cohort 1 of the Labour Ward Coordinator (LWC) programme is now complete. The programme has delivered on the specification with a focus on psychologically safe leadership, individual development, and culture. There will be two further cohorts which means that all LWCs across SEL will have received the same development. To ensure that change is embedded within the units we will also be providing a programme for the matrons (LWCs line managers) that will be complemented by the evaluation of the LWC Cohort 1 delivery and outcomes.

Issues:

GP prescribing for women and pregnant people has still not been resolved; therefore, pregnant women and birthing people still have to return to a hospital site to collect urgent

prescriptions. Further work is in progress to try and reach a consensus on how this can be avoided.

2.4 Infection Prevention and Control (IPC)

The NHS Standard Contract 2025/26 includes quality requirements for NHS foundation trusts and ICBs to minimise rates of both Clostridium difficile (C. difficile) and Gram-negative bloodstream infections to threshold levels set by NHS England. The SEL position to December 2025 shows SEL ICS is above trajectory for cases of E. coli, C. difficile, Klebsiella spp. and P. aeruginosa. This is in line with the overall London position year to date. There were 37 methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases across all settings against a threshold of zero.

Local improvement projects continue within individual trust organisations and in partnership with SEL ICB IPC team. The South East London Forum on Antimicrobial Stewardship continue to meet bi-monthly to update and review progress on systemwide workstreams. Other activities include ongoing general practice audits, outbreak management support and advice to SEL new build and refurbishment project teams. The IPC team supported Adult Social Care (ASC) Nurses Network meetings and hosted education and training sessions for SEL ASC and primary care staff.

2.5 Learning Disabilities and Autism (LDA)

Reducing reliance on inpatient beds:
During Q4, the increase in the number of admissions slowed in January and February, going up again in March. For adult admissions the majority (11 of 16) had previous admissions, often 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) remains essential to preventing admissions by intervening in the community and putting in place the right care and support needed. While during March the inpatient target number was not being achieved there were some key discharges of long stay patients planned by the end of March.

There has been a reduction in admissions for children and young people in Q4 2025/26. In the quarter 3, there were 8 Children and Young People (CYP) admissions. New admissions to hospital continue to be of new diagnoses of autism during an inpatient stay and often characterised by complex social and family circumstances.

Based on the number people with expected discharge dates (EDD) by the end of Q4 it is likely that we will be ending the year on or near to planned target given the level of unpredictability around admission and discharges. Boroughs continue to work on achieving complex discharges which may for example involve the Court of Protection and Ministry of Justice restrictions. One of the three (3) discharges expected of people

in hospital over ten (10) years was achieved during March and an achievement towards providing the least restrictive environment and quality of life in the community.

During Q4, newly commissioned services Community Autism Services and Intensive Support Teams (ISTs) for people with a learning disability in Lambeth and Lewisham, were actively working to recruit staff teams for mobilisation of services during Q1 2026/27.

Annual Health Checks (AHCs):
All boroughs in SEL at the end of January 2026 surpassed the operational target and are on track to exceed the 75% target by the end of 2025/26. By end of January 2026, 6332 checks were completed against a plan of 5190.
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). Completing and delivering a HAP is supportive of good quality AHCs if these are shared with people with a learning disability and their families as well as utilised by health and care professionals.

LeDeR:
Learning from the lives and deaths of people with a learning disability and autistic people (LeDeR), continues to find the learning from the reviews, A new strategic meeting has been developed within/alongside the structure of the SEL LDA Operational Borad for quarterly LeDeR strategic discussion to take place with boroughs and partners. Fixed term LeDeR reviewer role has been approved for and extension to December 2026 to ensure that the capacity for reviewers are maintained.

STOMP/STAMP:
The SEL One Stop STOMP Clinic (Stopping Overmedication in People with a Learning Disability or Autism) continues to operate with triaged referrals and clinical oversight from SLAM, Oxleas and SEL ICB, and during Q4 was rolled out across SEL. Plans to make service business as usual were explored in Q4.

Oliver Mc Gowan Mandatory Training:

The target for the Oliver McGowan Mandatory Training (OMMT) is 30% for both Tier 1 and 2. SEL is currently at **30% for Tier 1 and 28% for Tier 2.** The main reason for not meeting the 30% Tier 2 in-person training target was the lack of engagement of the two larger trusts with large numbers of staff to train alongside competing demands. Following guidance received from NHSE about the responsibility for the training falling to NHS organisations within the ICS, one of the Band 7 Programme Managers for Oliver's Training programme will have their contract extended and now be placed with South London and Maudsley Trust. This approach, to coordinate within a provider has been supported by SEL Human Resource Directors (HRDs) and Chief People Officer and will help with procurement of the training, operational management of the training and reporting to NHS England.

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2.6 Special Education Needs and Disabilities (SEND)

The SEL SEND Network has met and discussed the newly published Schools White paper which includes SEND Reforms and Local SEND Reform Plans that each Local area/borough must produce.

Joint SEND letter from the Department of Education (DfE) and NHSE has been issued to all Local Authority Chief Executives, Chief Finance Officers, Directors of Children's Services, ICB Chief Executives, and relevant ICB Leads. All Local Authorities have been provided with SEND Advisers and Financial Advisers to help prepare and plan for reform and all SEL meetings have taken place. SEL ICB will need to agree Local Area SEND Reform plans which need to be signed of the ICB Chief Executive for submission by 18 June 2026.

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.

ICB Board in Public

Title	**Month 11 ICS and ICB Financial Update**				
Meeting date	8 April 2026	Agenda item Number	9	Paper Enclosure Ref	I
Author	ICB Finance Team				
Executive lead	Mike Fox, ICB CFO				
Paper is for:	Update	x	Discussion	x	Decision
Purpose of paper	To provide an update to the Board of the financial position of the ICS and ICB as at month 11.				
Summary of main points	Two papers are being presented, covering the ICS and ICB financial positions as at month 11. The key headlines are: • The ICB is reporting a year to date (YTD) **break-even** position. • The ICS is reporting a YTD deficit of **£14.1m**, **£5.7m** ahead of plan. This represents an overall £0.1m improvement compared to month 10. At month 11, the ICS is forecasting a surplus of **£1.3m** for year-end. The surplus is being generated as a result of a lease reclassification benefit at Oxleas. The overall ICS position includes a forecast of **break-even** for the ICB.				
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.				
Recommendation	The Board is asked to note the reports and discuss any actions in relation to the financial position.				

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SEL ICB Finance Report

Month 11 2025/26

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9. MHIS Performance
10. MHIS Performance - continued

1. Key Financial Indicators

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 11, the ICB is reporting a year to date (YTD) and forecast out-turn (FOT) **break-even position** against its revenue resource limit (RRL) and financial plan. Within this reporting, the ICB has delivered **£56,500k** of savings YTD compared to the plan value of £54,700k.
- **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 **£7,610k** and forecast out-turn position of underspend of **£6,689k** against the **running cost allowance (RCA)**. This is primarily due to the full allocation received from NHSE in respect of redundancy costs **(£12,486k)** being badged as RCA whereas some costs will be programme costs. The full anticipated impact of the ICB change programme on redundancy costs has been included in the month 11 accounts as either a provision or an accrual as per accounting rules.
- All financial duties have been delivered for the year to month 11 period.

Key Indicator Performance

	Year to Date		Forecast	
	Target	Actual	Target	Actual
	£'000s	£'000s	£'000s	£'000s
Expenditure not to exceed income	5,406,971	5,406,971	5,901,043	5,901,043
Operating Under Resource Revenue Limit	5,406,971	5,406,971	5,901,043	5,901,043
Not to exceed Running Cost Allowance	43,247	35,637	46,819	40,130
Month End Cash Position (expected to be below target)	5,875	2,858		
Operating under Capital Resource Limit				
95% of NHS creditor payments within 30 days	95.0%	100.0%		
95% of non-NHS creditor payments within 30 days	95.0%	98.7%		
Mental Health Investment Standard (Annual)			537,494	550,242

2. Executive Summary

- This report sets out the month 11 financial position of the ICB. The financial reporting is based upon the final plan submission. This included a **planned break-even position** for the ICB. The ICB's financial allocation as at month 11 is **£5,901,043k**. In month, the ICB has received an additional **£13,848k** of allocations. These are as detailed on the following slide. **As at month 11, the ICB is reporting a year to date (YTD) break-even position.**
- Due to the routine time lag, the ICB has received nine months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,990k overspend YTD across PPA and non PPA** budgets. The overspend continues to be variable across the Places.
- The CHC financial position is **£1,301k underspent** at month 11, which is an improvement from last month's reported numbers. The boroughs which are most impacted are Lewisham and Bromley which is a continuation of the trend from last year. The YTD position for **Mental Health services** is an overall **overspend of £9,413k** 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 went live at the beginning of November but the impact is not yet known.
- 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.
- One place is reporting a material overspend YTD at month 11 – **Bromley (£398k – driven by MH and CHC overspends), with a break-even or better position being forecast by all.** All places have been tasked to identify additional mitigations to offset any financial risks, to ensure delivery of their financial plans.
- In reporting this month 11 position, the ICB has delivered the following financial duties:
  - Underspend of **£7,610k YTD** against its management costs allocation, primarily due to the allocation in respect of redundancy costs all being badged as running costs (RCA) whereas some costs will be programme costs. The full anticipated impact of the redundancy programme has been included as provisions and accruals this month, as the allocation has now been received.
  - 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 11 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. Revenue Resource Limit (RRL)

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	161,660	273,947	194,703	237,803	189,711	187,894	4,395,891	5,641,609
M2 internal adjustments	-	-	-	-	47		(47)	-
M2 Allocations	-	-	-	-	-	-	51,058	51,058
M2 Budget	161,660	273,947	194,703	237,803	189,758	187,894	4,446,902	5,692,667
M3 Internal Adjustments	261	396	300	599	136	149	(1,840)	0
M3 Allocations	-						26,788	26,788
M3 Budget	161,921	274,343	195,003	238,402	189,894	188,043	4,471,850	5,719,455
M4 Internal Adjustments	478	668	628	857	678	705	(4,013)	(0)
M4 Allocations	112	131					47,083	47,326
M4 Budget	162,510	275,142	195,631	239,259	190,571	188,748	4,514,920	5,766,781
M5 Internal Adjustments	72	114	51	111	93	124	(565)	(0)
M5 Allocations							5,044	5,044
M5 Budget	162,582	275,257	195,682	239,371	190,664	188,871	4,519,399	5,771,825
M6 Internal Adjustments	603	811	701	885	784	850	(4,634)	-
M6 Allocations	-	-	-	-	-	-	21,961	21,961
M6 Budget	163,185	276,068	196,383	240,256	191,448	189,721	4,536,726	5,793,786
M7 Internal Adjustments	-	(25)	-	-	-	-	25	-
M7 Allocations	-	-	-	-	-	-	-	-
M7 Budget	163,185	276,043	196,383	240,256	191,448	189,721	4,536,751	5,793,786
M8 Internal Adjustments	314	1,023	223	345	98	346	(2,348)	0
M8 Allocations							1,091	1,091
M8 Budget	163,498	277,066	196,605	240,600	191,546	190,068	4,535,494	5,794,877
M9 Internal Adjustments								-
M9 Allocations							26,317	26,317
M9 Budget	163,498	277,066	196,605	240,600	191,546	190,068	4,561,811	5,821,194
M10 Internal Adjustments	260	130	70	472	209	61	-1,203	-
M10 Allocations		63					65,938	66,001
M10 Budget	163,759	277,259	196,675	241,072	191,755	190,129	4,626,546	5,887,195
M11 Internal Adjustments								
Virements from PCD	91	224	87	41	15	148	-606	0
Virement re Asylum Seekers allocation		3		11	7	26	-46	0
M11 Allocations								
Winter Surge Funding							10,379	10,379
Elective Sprint - Outpatient Core							2,376	2,376
Elective Sprint - 52 week wait							200	200
Pre-referral Advice and Guidance GP Enhanced Service Q4							581	581
National Recovery Support							335	335
Mental Health SEMHIS Funding 25/26							200	200
Various Minor adjustments under £100k							142	142
2025/26 DOPS Hub Funding (transfer to NEL ICB)							(365)	(365)
M11 Budget	163,850	277,486	196,762	241,124	191,777	190,303	4,639,741	5,901,043

- The table sets out the Revenue Resource Limit (RRL) at month 11.
- The start allocation of **£5,641,609k** is consistent with the Operating Plan submissions.
- In month, the ICB has received an additional **£13,848k** of allocations, giving a total allocation of **£5,901,043k** at month 11**.**
- Allocations received in month 11 included Winter Surge funding of **£10,379k,** Elective Sprint funding totalling **£2,576k,** Pre-referral Advice and Guidance funding of **£581k**, National Recovery Support funding of **£335k,** Mental Health SEMHIS adjustment **£200k,** and other smaller adjustments totalling **£142k.**
- These additional allocations were offset by a negative allocation adjustment of **£365k,**in relation to SEL's contribution to the DOPS Hub.
- Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

4. Budget Overview

	M11 YTD								
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget									
Acute Services	4,854	7,648	6,500	592	809	222	3,083,071	-	**3,103,695**
Community Health Services	23,937	87,937	37,757	28,134	32,486	35,269	255,143	-	**500,664**
Mental Health Services	10,217	14,219	8,177	22,695	7,319	10,128	587,672	6,197	**666,622**
Continuing Care Services	24,484	25,792	27,781	32,918	23,300	18,807	-	-	**153,082**
Prescribing	35,798	48,155	35,176	40,247	40,178	33,122	-	2,215	**234,891**
Other Primary Care Services	1,406	1,862	1,769	3,667	1,969	893	-	16,237	**27,804**
Other Programme Services	1,123	-	1,645	-	-	799	18,106	4,109	**25,783**
Programme Wide Projects	(0)	-	-	-	23	237	-	9,803	**10,063**
Delegated Primary Care Services	45,525	65,205	58,259	88,417	66,582	71,105	-	(661)	**394,432**
Delegated Primary Care Services DPO	-	-	-	-	-	-	57,708	157,122	**214,831**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-	**-**
Corporate Budgets	2,776	3,444	3,229	4,277	3,048	3,795	-	54,533	**75,103**
Total Year to Date Budget	**150,121**	**254,263**	**180,293**	**220,948**	**175,714**	**174,378**	**4,001,699**	**249,555**	**5,406,971**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual									
Acute Services	4,776	7,190	6,508	525	835	267	3,082,696	-	**3,102,796**
Community Health Services	23,851	87,050	37,649	28,135	28,707	32,748	255,401	-	**493,542**
Mental Health Services	10,805	15,888	10,303	24,225	8,527	12,577	587,647	6,064	**676,035**
Continuing Care Services	23,600	26,700	27,347	31,253	24,830	18,050	-	-	**151,781**
Prescribing	36,846	47,719	36,648	40,893	41,511	34,793	-	471	**238,881**
Other Primary Care Services	1,439	1,679	1,665	2,960	1,742	866	-	16,080	**26,431**
Other Programme Services	750	-	-	-	-	-	18,106	15,257	**34,113**
Programme Wide Projects	-	-	(1,467)	-	23	163	-	9,697	**8,417**
Delegated Primary Care Services	45,311	64,456	59,056	88,505	66,266	71,313	-	(878)	**394,029**
Delegated Primary Care Services DPO	-	-	-	-	-	-	57,708	156,682	**214,391**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	(675)	**(675)**
Corporate Budgets	2,522	3,229	3,015	4,274	2,956	3,658	141	47,437	**67,230**
Total Year to Date Actual	**149,900**	**253,911**	**180,725**	**220,770**	**175,397**	**174,435**	**4,001,699**	**250,134**	**5,406,971**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	PCD Team	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance									
Acute Services	78	458	(8)	67	(27)	(45)	375	-	**899**
Community Health Services	86	887	107	(1)	3,779	2,521	(259)	-	**7,122**
Mental Health Services	(588)	(1,669)	(2,126)	(1,530)	(1,208)	(2,449)	24	133	**(9,413)**
Continuing Care Services	883	(908)	434	1,665	(1,530)	758	-	-	**1,301**
Prescribing	(1,048)	436	(1,472)	(646)	(1,333)	(1,671)	-	1,745	**(3,990)**
Other Primary Care Services	(33)	183	104	707	227	28	-	157	**1,373**
Other Programme Services	373	-	1,645	-	-	799	0	(11,147)	**(8,330)**
Programme Wide Projects	(0)	-	1,467	-	(0)	74	-	106	**1,647**
Delegated Primary Care Services	214	749	(797)	(88)	317	(208)	-	217	**403**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(0)	440	**440**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	675	**675**
Corporate Budgets	255	215	213	4	92	137	(141)	7,096	**7,872**
Total Year to Date Variance	**221**	**351**	**(432)**	**178**	**317**	**(56)**	**(0)**	**(579)**	**(0)**
Equalisation of Del P/Care	**(214)**	**(749)**	**797**	**88**	**(317)**	**208**		**187**	**-**
Revised YTD	**7**	**(398)**	**365**	**266**	**0**	**152**	**(0)**	**(392)**	**(0)**

- As at month 11, the ICB is reporting a YTD **break-even position**, albeit with **pressures in specific budgets.** Key areas of financial pressure are in **mental health services, CHC for some Places and prescribing.**
- Due to the routine time lag, the ICB has received nine months of 2526 prescribing data. After the usual accrual for two months of estimated prescribing expenditure, the ICB is reporting a **£3,990k overspend YTD** across PPA and non PPA budgets. The overspend continues to be variable across the Places.
- The CHC financial position is **£1,301k underspent** at month 11, which is an improvement from last month's reported numbers. The boroughs which are most impacted are Lewisham and Bromley which is a continuation of the trend from last year.
- The YTD position for Mental Health services is an overall **overspend of £9,413k** 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 went live at the beginning of November but the impact of this is not yet known.
- 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 still leaves a small number of impacted staff who remain at the ICB.
- One place is reporting a material overspend YTD at month 11 – **Bromley (£398k), with a break-even or better position being forecast by all.** Places have been tasked to identify additional mitigations to offset any financial risks, to ensure delivery of their financial plans.

5. Prescribing

- The table below presents the month 11 PPA Prescribing position and shows a YTD overspend of **£5,454k** and FOT overspend of **£5,001k**. The YTD position is calculated on 9 months of actual PPA data and 2 months of accruals which are estimated based upon a rolling average of data from previous months, multiplied by the number of dispensing days.
- The non-PPA prescribing budgets are underspent by **£1,464k YTD** and **£1,273k FOT** at month 11. Therefore, the overall month 11 Prescribing position is overspent by **£3,990k YTD** and **£3,728k FOT.**

M11 Prescribing	Total PMD (Excluding Cat M & NCSO) £	Central Drugs £	Flu Income £	Q4 24/25 Flu (Benefit)/Cost pressure £	Public Health Drug Recharge £	IPP Pharmacy First £	Total 25/26 PPA Spend £	M11 YTD Budget £	YTD Variance - (over)/under £	Annual Budget £	Forecast Outturn £	FOT Variance - (over)/under £
BEXLEY	35,916,555	1,185,246	(341,920)	(28,749)	(115,683)		36,615,448	35,521,005	(1,094,443)	38,831,403	39,677,529	(846,126)
BROMLEY	46,364,948	1,530,043	(472,190)	(3,940)	(53,849)		47,365,013	47,879,070	514,058	52,341,042	51,363,349	977,693
GREENWICH	36,035,482	1,189,171	(269,761)	(86,423)	0		36,868,469	34,910,512	(1,957,958)	38,163,821	40,161,682	(1,997,861)
LAMBETH	39,886,953	1,316,269	(299,274)	(60,319)	0		40,843,629	40,175,806	(667,824)	43,919,787	44,596,228	(676,441)
LEWISHAM	40,857,749	1,348,306	(223,991)	(49,435)	(440,213)		41,492,415	39,262,947	(2,229,468)	42,922,530	45,657,478	(2,734,948)
SOUTHWARK	33,750,537	1,113,768	(183,525)	(30,609)	0		34,650,171	32,886,525	(1,763,646)	35,951,219	38,001,101	(2,049,882)
SOUTH EAST LONDON	0	0	0	0	0	337,225	337,225	2,081,980	1,744,756	2,776,000	449,633	2,326,367
Grand Total	**232,812,224**	**7,682,803**	**(1,790,661)**	**(259,476)**	**(609,745)**	**337,225**	**238,172,370**	**232,717,845**	**(5,454,525)**	**254,905,802**	**259,907,000**	**(5,001,198)**

Prescribing
Comparison of April to December 2025 v April to December 2024

	2024/25 April to December	2025/26 April to December	Change £	Change %
South East London ICB:				
Expenditure (£'000)	184,184	192,308	8,124	**4.4%**
Number of Items ('000)	20,023	20,717	693	**3.5%**
£/Item	9.20	9.28	0.08	**0.9%**
London ICBs:				
Expenditure (£'000)	942,069	987,421	45,352	**4.8%**
Number of Items ('000)	114,374	119,108	4,733	**4.1%**
£/Item	8.24	8.29	0.05	**0.6%**
All England ICBs:				
Expenditure (£'000)	7,722,834	7,973,159	250,325	**3.2%**
Number of Items ('000)	935,758	957,081	21,323	**2.3%**
£/Item	8.25	8.33	0.08	**0.9%**

- Key areas of current pressures in the prescribing budget include endocrine systems, appliances and respiratory – reflecting the ICB's investment in the management of long-term conditions.
- The table to the left compares April to December prescribing data for 2024/25 and 2025/26. The headlines are that the trend in expenditure in the ICB is higher than nationally (**an increase of 4.4%**) but lower than the London average (**an increase of 4.8%**). This is driven primarily by a lower increase in the number of items **(3.5%)** – compared to an **increase of 4.1%** across London ICBs.

6. Dental, Optometry and Community Pharmacy

- In April 2023, ophthalmic, community pharmacy and dental services were delegated to ICBs from NHS England. The table below sets out the financial position of these budgets on both a month 11 YTD and forecast basis.

Service	YTD Budget £'000s	YTD Actual £'000s	YTD Variance - (over)/under £'000s	Annual Budget £'000s	Forecast £'000s	FOT Variance - (over)/under £'000s
Delegated Primary Dental	101,388	101,388	(0)	110,606	110,606	0
Delegated Community Dental	7,952	7,953	(0)	8,675	8,675	0
Delegated Secondary Dental	49,756	49,756	0	54,279	54,279	0
Total Dental	**159,096**	**159,096**	**(0)**	**173,560**	**173,560**	**0**
Dental Ring Fence	159,055	159,055	0	173,515	173,515	0
Dental Non Ring Fence	41	41	(0)	45	45	0
Total Dental	**159,096**	**159,096**	**(0)**	**173,560**	**173,560**	**0**
Delegated Ophthalmic	16,161	16,161	(0)	17,630	17,630	0
Delegated Pharmacy	38,893	38,453	440	44,289	43,808	480
Delegated Property Costs	680	680	0	742	742	0
Total Delegated DOPs	**214,831**	**214,391**	**440**	**236,221**	**235,741**	**480**

a) Delegated Dental

- The ICB has reported a break-even position for the year-to-date and the full year. There is an underlying full year underspend of circa £2,000k which is an unintended consequence of commissioning more activity as patient charge revenue has also increased. **The dental ringfence of £173,515k is expected to be delivered**. As per last year, the monthly accrual is based on the dental report downloaded from the national e-Den system. The delegated property costs relate to where the primary care dentists are working either in NHS PS or CHP sites, and rent is charged.

b) Delegated Ophthalmic

- ICB has reported a break-even position for the year-to-date and the full year, with arrears on the annual price uplift paid in February. The majority of the spend relates to Optician Sight Tests and Vouchers submitted by opticians within the SEL geography regardless of where the patient resides – claims are based upon location of provider not client/patient. The claims are as per a national framework arrangement, under which the ICB has a requirement to pay.

c) Delegated Community Pharmacy

- ICB has reported a **favourable £440k** variance for the **year-to-date** and **£480k** the **full year.** Information is generally received 2 months in arrears with an accrual then based upon the months average using the number of Prescribing days. Pharmacy First will be fully funded by non-recurrent allocations from NHS England which are received in arrears.

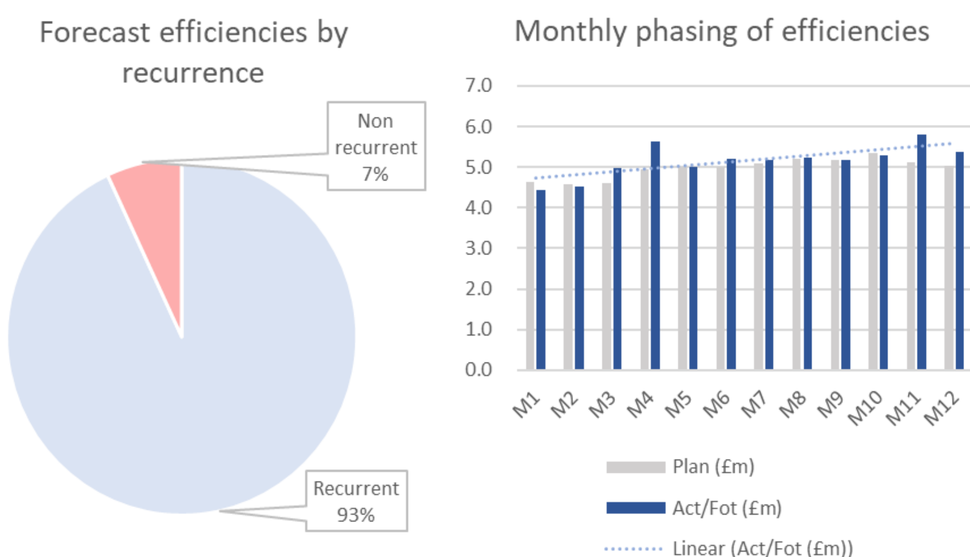
7. NHS Continuing Healthcare

- As of Month 11, the Continuing Healthcare (CHC) budget reflects an overall an **underspend of £1,301k YTD**, although cost pressures continue to vary across boroughs. **Lewisham and Bromley** are currently reporting material overspends.
- **Lewisham** remains the largest contributor to the overall overspend, reporting a variance YTD of **£1,530k above budget and a forecast outturn of £1,663k**. This is primarily driven by high costs associated with **palliative care clients, PHB Clients** and includes a **£254k full year provision** for anticipated increases in provider prices. This position is significant improvement on the overspend reported in the same period in the prior year 2024/25 (Month 11 YTD £3,105k and actual outturn £3,409k). The borough is continuing to hold twice monthly financial recovery meetings with the CHC team ensuring good progress on reviews and strengthening further financial controls and database integrity. Whilst the overspends remain high, the benefit of this work is reflected in over achievement of the 5% savings target. **Bromley** is reporting an **overspend of £908k** (Improved from last month's YTD reported overspend of **£1,156k**), mainly due to Funded Nursing Care, Personal Health Budgets and palliative care costs. Bromley's position includes all agreed provider price uplifts.
- To support a consistent management of provider price uplifts, an ICB-wide panel has been established to review all requests exceeding 1.5%. Most providers have now agreed to the proposed uplift, with only a small number still to be finalised. As a result, the uplift panel, which initially met weekly, now convenes monthly.
- In terms of **savings delivery**, all boroughs have identified and are actively progressing against their CHC savings plans. **Bexley,** and most materially **Lewisham** are forecasting to exceed their targets. The **forecast over delivery of £792k** in Lewisham reflects the focussed work outlined above and partially accounts for the improved position in 2025/26 compared to the prior year. In contrast, **Greenwich** is reporting an **under-delivery of £110k**. Despite this progress on savings, rising activity levels and the growing number of **high-cost clients** continue to place upward pressure on the CHC budget.
- In summary, the ICB's CHC financial position has improved in-month **(circa £1,400k overall),** driven primarily by reducing client numbers and package costs across **Bexley, Bromley, Lewisham, Greenwich, and Southwark**. However, despite improvements in both Bromley and Lewisham, their overall financial position remain the key concern due to **demand led cost pressures. Encouragingly, while average client numbers** increased year-on-year by **40** between October 2022 and October 2024, they have since **decreased by 23 this year**. This reduction demonstrates the boroughs' ongoing efforts to review and optimise clients' care packages to contain CHC expenditure within budget.

8. ICB Efficiency Schemes

	Year-to-Date			Forecast			Forecast (Risk)			Forecast (Recurrance)		Forecast (cash releasing)		Forecast
	Plan	Actual	Variance	Plan	Forecast	Variance	Low	Medium	High	Recurrent	Non-recurrent	Cash Releasing	Non-cash Releasing	FYE
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	7.1	7.3	0.2	7.7	7.9	0.2	7.9	0.0	0.0	7.9	0.0	4.9	3.1	7.9
Bromley	12.0	12.0	(0.0)	13.1	13.1	0.0	8.6	3.9	0.6	11.6	1.5	12.5	0.6	11.6
Greenwich	7.7	8.7	1.0	8.4	9.6	1.1	7.4	1.2	1.0	7.7	1.9	2.3	7.3	7.7
Lambeth	11.6	11.4	(0.2)	12.6	12.6	0.0	0.9	9.3	2.4	11.9	0.7	4.7	7.8	11.9
Lewisham	8.2	9.0	0.8	9.0	9.8	0.8	3.0	6.7	0.0	9.8	0.0	9.8	0.0	9.8
Southwark	8.0	8.0	(0.0)	8.9	8.9	(0.0)	8.7	0.1	0.1	8.6	0.2	8.6	0.3	8.6
SEL ICB Total	**54.7**	**56.5**	**1.8**	**59.7**	**61.8**	**2.1**	**36.5**	**21.2**	**4.1**	**57.5**	**4.3**	**42.8**	**19.1**	**57.5**

- The 6 places within the ICB have a total savings plan for 2025/26 of **£59,700k.** In common with the previous financial year, the key elements of the savings plans are in Primary Care, continuing healthcare and Community Healthcare.
- The table above sets out the YTD and forecast status of the ICB's efficiency scheme as at month 11.
- **As at month 11, overall, the ICB is reporting actual delivery of £56,500k which is ahead of plan by £1,800k.** At this stage in the financial year, the annual forecast is to exceed the efficiency plan **by £2,100k.**
- The current risk rating of the efficiency plan is also reported. At this stage in the year, **£4,100k** of the forecast outturn of has been assessed by the places as **high risk.**
- Most of the savings **(93%)** are forecast to be delivered on a recurrent basis.



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

Mental Health Investment Standard (excluding LD and Dementia) and delegated Specialised Commissioning Mental Health Investment Standard:	Expected Sign	2_1Achieve01 MHIS Achieved per plans submitted 09/05/2025 Desc 31/03/2026 Year Ending TEXT	2_1PLAN%01 2025/26 allocation growth Plan 31/03/2026 Year Ending %	2_1AuditedPY 2024/25 Outturn Actual 31/03/2025 Year Ending £'000	2_1TARGET01 Target MHIS spend 2025/26 Target 31/03/2026 Year Ending £'000	2_1ACT02 FOT 2025/26 Forecast 31/03/2026 Year Ending £'000	2_1VAR%01 Excess/Shortfall in 2025/26 MHIS Delivery % Actual 31/03/2026 Year Ending %	2_1VAR02 Excess/Shortfall in 2025/26 MHIS Delivery Actual 31/03/2026 Year Ending £'000	2_1Achieve02 MHIS Achieved in 2025/26? Desc 31/03/2026 Year Ending TEXT	2_1POP01 Projected Population 2025/26 YTD 31/03/2026 Year Ending Number	2_1Achieve03 SCMHIS Achieved per plans submitted 09/05/2025 Desc 31/03/2026 Year Ending TEXT	2_1SCMHISAuditedPY 2024/25 SCMHIS Outturn Actual 31/03/2025 Year Ending £'000	2_1TARGET02 Target SCMHIS spend 2025/26 Target 31/03/2026 Year Ending £'000	2_1ACT03 SCMHIS FOT 2025/26 Forecast 31/03/2026 Year Ending £'000	2_1SCMHISVAR%01 Excess/Shortfall in 2025/26 SCMHIS Delivery % Actual 31/03/2026 Year Ending %	2_1SCMHISVAR02 Excess/Shortfall in 2025/26 SCMHIS Delivery Actual 31/03/2026 Year Ending £'000	2_1SCMHISAchieve02 SCMHIS Achieved in 2025/26? Desc 31/03/2026 Year Ending TEXT	2_1COMM01 Commentary for Variances Desc 31/03/2026 Year Ending TEXT
MHIS Achievement	+/-	Yes	4.93%	471,495	537,494	550,242	2.37%	12,748	Yes	2,755,228	Yes		89,920	91,032	1.24%	1,112	Yes	

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2024/25 outturn by a **minimum of the growth uplift of 4.93%, a target of £537,494k. These figures were updated in month 4 to allow for the current year pay awards.** This spend is subject to the usual annual independent review.

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

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

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

- **As at Month 11 we are forecasting MHIS delivery of £550,242k, exceeding the target by £12,748k (2.37%). This is consistent with the planned over-delivery as described above. This is summarised in the above table.**

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

Risks and Mitigations

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

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

- ADHD is outside the MHIS definition and is therefore excluded from this reported position. There is, however, significant and increasing independent sector spend on both ADHD and ASD services, with expenditure exceeding £4,500k across a growing number of independent sector providers for Right to Choose referrals.

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

SEL ICS Finance Report

Month 11 2025/26

Contents

1. Executive Summary
2. ICS Financial Position
3. Analysis of the Year-to-Date Position
4. Provider run-rate analysis
5. Workforce and Finance Analysis
6. Efficiency Delivery
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8. System Capital
9. System National Capital Programmes for information only

1. Executive Summary

- This report sets out the month 11 financial position of the ICS. The ICS financial plan is to deliver a break-even position. This is after the receipt of non-recurrent deficit support funding of **£75.0m**. The full allocation has been received.
- At month 11, the ICS is reporting a **YTD deficit of (£14.1m), £5.7m ahead of plan,** reflecting a slight improvement of £0.1m compared to month 10. KCH remains £4.5m ahead of plan, though this represents a £0.6m deterioration from month 10. The KCH position continues to be supported by both industrial action (IA) funding and improved activity performance.
- Oxleas is **£1.3m ahead of plan** driven by a non-recurrent benefit from the reclassification of the Kidney Treatment Centre lease from an operating to finance lease. LGT and SLaM are each reporting £0.1m ahead of plan YTD while GSTT is £0.3m behind plan.
- At month 11, the **ICS forecast** has moved from breakeven to a **£1.3m surplus**, due to the lease reclassification benefit at Oxleas.
- The total system capital allocation for 2025/26 is **£228.0m**, including IFRS 16 impacts. This comprises £223.6m for providers and £4.4m for the ICB's primary care allocation. The allocation includes a £31.9m CDEL loan from SWL ICB, with repayment linked to the Lambeth Hospital site disposal agreed in principle with SWL ICB and SLaM, for deferral to 2026/27.
- Since the plan was set, further allocations totalling £39.4m have been received across the system adjusted by an agreed repayment of £7.4m to NHSE (brought forward to this year). This brings the total allocation to £260.0m. The system capital limit incorporates £56.2m for other national programmes allocations, for which MOUs have been confirmed during the financial year. This is in addition to the system allocation, bringing the overall capital limit to **£316.2m.** Capital expenditure YTD at month 11 is **£79.9m behind plan,** including **underspends** against **national programmes** of **£13.5m.** The current forecast is for a **£7.4m overspend at year-end** This includes a £10.0m pressure due to an NHSE reporting issue in recognising additional funding received by GSTT within the system allocation. This is partly offset by a £2.6m underspend in the national programme, following NHSE's agreement with providers to phase the return-to-constitutional-standards allocations across 2025/26 and 2026/27. The overall capital financial position has been discussed and agreed by CFOs.
- Applicable financial risks on the ICB's Risk Register are **606** (2526 Revenue Plan) and **607** (2526 Capital Plan). The score for risk 606 has been reduced to 9 (in line with the target rating) given the YTD financial position. This will be reviewed again at month 12. Risk 607 (the risk of an overspend against the capital allocation) has been closed, given the current financial position and CFO agreements on the forecast outturn.

2. ICS Financial Position – I & E Summary

- **As at month 11 SEL ICS is reporting a YTD deficit of (£14.1m), £5.7m ahead of plan, reflecting a slight improvement of £0.1m compared to month 10.**
- **KCH remains £4.5m ahead of plan, though this represents a £0.6m deterioration from month 10.** The position continues to be supported by both industrial action (IA) funding and improved activity performance.
- **Oxleas is £1.3m ahead of plan** driven by a non-recurrent benefit from the reclassification of the Kidney Treatment Centre lease from an operating to finance lease.
- **LGT and SLaM are each reporting £0.1m ahead of plan YTD** while GSTT is £0.3m behind plan.

Organisation	YTD					Forecast				
	Plan (pre Deficit Support Funding)	Plan Deficit Support Funding	Plan (incl. Deficit Support Funding)	Actual	Variance	Plan (pre Deficit Support Funding)	Plan Deficit Support Funding	Plan (incl. Deficit Support Funding)	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	(21.7)	0.0	(21.7)	(21.9)	(0.3)	0.0	0.0	0.0	0.0	0.0
Kings	(67.8)	68.8	0.9	5.5	4.5	(75.0)	75.0	0.0	0.0	0.0
LGT	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0
Oxleas	0.0	0.0	0.0	1.3	1.3	0.0	0.0	0.0	1.3	1.3
SLAM	1.0	0.0	1.0	1.0	0.1	0.0	0.0	0.0	0.0	0.0
Provider Total	**(88.5)**	**68.8**	**(19.8)**	**(14.1)**	**5.7**	**(75.0)**	**75.0**	**0.0**	**1.3**	**1.3**
ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
System Total	**(88.5)**	**68.8**	**(19.8)**	**(14.1)**	**5.7**	**(75.0)**	**75.0**	**0.0**	**1.3**	**1.3**

- To achieve the reported position, a total of £211.8m of non recurrent mitigations has been applied year to date. Of this, £95.8m was included in financial plans, with £115.9m deployed above planned levels.
- These mitigations have been used to offset:
    - £89.3m of efficiency slippages.
    - £68.7m YTD in-year pressures, including increased non- pay cost driven by inflation, pathology and winter pressures, the impact of the pay awards, and higher than planned sickness cover costs.
    - £26.5m unplanned shortfall on income; specialised commissioning, non-clinical income and other patient income.
    - £27.3m on other planned deficit mitigations, independent sector and prior year cyber attack legal costs.
- **At month 11, the ICS forecast has moved from breakeven to a £1.3m surplus, due to the lease reclassification benefit at Oxleas.**

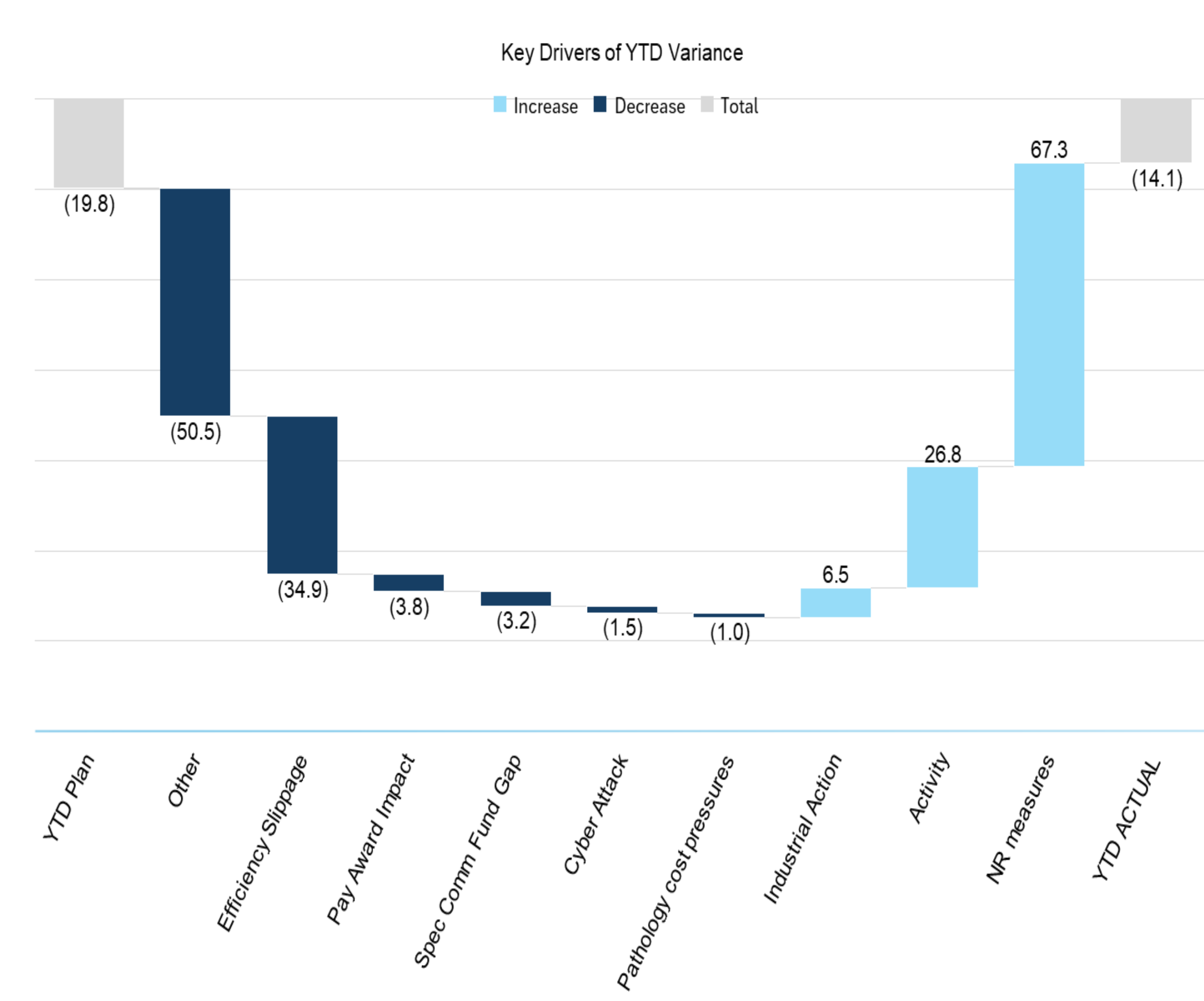
Non Recurrent Mitigations - YTD at Month 11 - £'M

Organisation	Planned	Actual	Variance/ Unplanned
GSTT	21.1	93.1	72.0
KCH	-	11.4	11.4
LGT	32.5	62.9	30.4
Oxleas	22.4	25.5	3.1
SLaM	19.8	18.9	(0.9)
SEL Providers	**95.8**	**211.8**	**115.9**

3. Analysis of month 11 YTD Position

At Month 11, SEL ICS is reporting a **year-to-date deficit of (£14.1m),** which is **£5.7m ahead of plan** reflecting an **improvement of £0.1m from month 10.** The position is driven by the following factors:

- Efficiency slippage across providers: £34.9m
  - LGT: £13.4m – Slippages across workforce, theatres consumables and procurement schemes, increasing unidentified schemes.
  - KCH: £12.3m – Mainly due to non-delivery of the workforce improvement schemes.
  - GSTT: £9.2m – Shortfall in planned efficiencies, partly offset by early sales of the Lexical subsidiary.
- Other impacts: £50.5m
  - Includes £30.5 on clinical supplies overspends driven by inflationary and activity pressures at GSTT.
  - £19.3m timing impact relating to balance sheet flexing at GSTT.
  - £0.8m additional mitigated pressures across Oxleas (£0.2m) and SLaM (£0.5m).
- Cost pressures at GSTT: £9.5m
  - £3.8m – Pay award impact.
  - £3.2m – Specialised commissioning funding gap.
  - £1.5m – Legal costs associated with the prior-year cyber incident.
  - £1.0m – Pathology year-to-date pressures due to delayed price reductions.
- Offsetting Benefits
  - £67.3m non-recurrent mitigations at GSTT.
  - £26.8m increased activity income above plan, shared equally between KCH and LGT.
  - £6.5m upside across providers for NHSE IA funding (Nov & Dec).

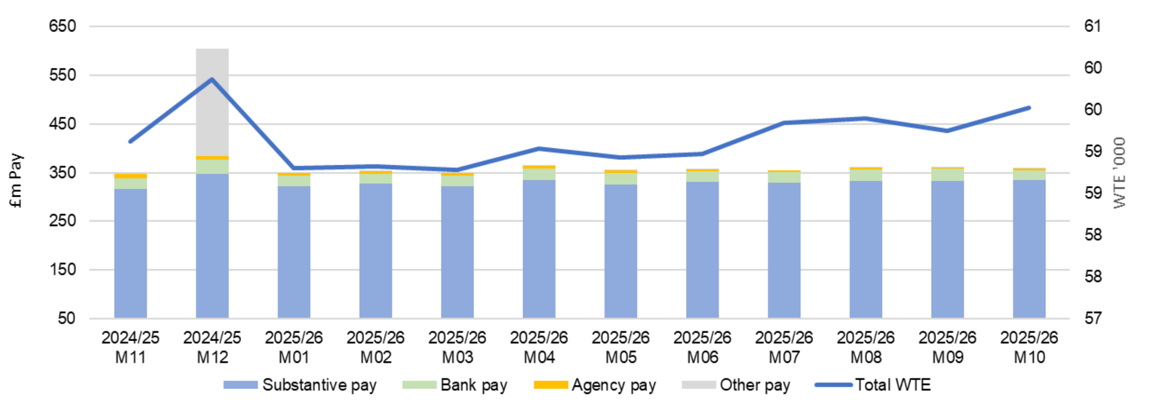


5. Workforce and Finance Analysis

Pay Type	2025/26 M08	2025/26 M09	2025/26 M10	Current month				Year-to-date				Analysis			
				Month 11 (in-month)				Month 11 (YTD)				Change from last month		Year-on-Year Change	
	Actual £m	Actual £m	Actual £m	Last year £m	Plan £m	Actual £m	Variance £m	Last year £m	Plan £m	Actual £m	Variance £m	£	%	£	%
Substantive	333.3	333.2	335.0	316.1	316.6	338.2	21.6	3,463.2	3,532.2	3,631.1	98.9	3.2	0.9%	167.9	4.8%
Bank	22.8	24.9	20.3	21.2	20.7	21.2	0.5	259.3	228.0	242.7	14.7	1.0	4.7%	(16.5)	(6.4%)
Agency	3.9	2.6	3.3	9.3	5.1	3.7	(1.4)	82.0	58.1	48.0	(10.1)	0.4	12.7%	(34.0)	(41.4%)
Other	0.2	0.4	0.7	1.2	0.2	0.1	(0.1)	3.9	2.3	2.9	0.5	(0.6)	(85.0%)	(1.1)	(26.8%)
Total Pay	**360.1**	**361.2**	**359.3**	**347.7**	**342.6**	**363.2**	**20.6**	**3,808.4**	**3,820.7**	**3,924.7**	**104.0**	**3.9**	**1.1%**	**116.4**	**3.1%**

Staff Type	M08	M09	M10	Current Month				Change from last month		Year-on-Year Change	
	Actual WTE	Actual WTE	Actual WTE	Last year WTE	Plan WTE	Actual WTE	Variance WTE	WTE	%	WTE	%
Substantive	54,689.5	54,651.6	54,773.4	53,547.6	52,624.8	54,875.9	2,251.1	102.5	0.2%	1,328.2	2.5%
Bank	4,278.4	4,176.1	4,324.0	4,653.0	4,163.2	4,255.5	92.3	(68.6)	(1.6%)	(397.5)	(8.5%)
Agency	436.5	422.0	430.2	926.7	587.7	375.5	(212.1)	(54.7)	(12.7%)	(551.2)	(59.5%)
Total WTE	**59,404.5**	**59,249.8**	**59,527.6**	**59,127.4**	**57,375.7**	**59,506.9**	**2,131.2**	**(20.7)**	**(0.0%)**	**379.5**	**0.6%**

- Month 11 pay increased marginally by £3.9m (1.1%) compared to Month 10, mainly due to higher medical and dental substantive staffing at LGT. Whilst expenditure on bank and agency staff has been reducing throughout the year as part of system-wide workforce transformation, there was a small in-month increase of £1.4m.
- Although there is an increase in pay costs compared to month 10, there are **20.7 less WTEs** in Month 11 mainly due to a marginal decrease in bank and agency staff.
- Compared to 2024/25, the system has seen a **59.5% (551 WTEs) reduction** in agency WTEs year to date. This represents a reduction in **agency spend of £34.0m (41.4%) year-on-year.**



6. Efficiency delivery and maturity

Organisation (£m)	Recurrent Efficiencies						Non Recurrent Efficiencies						Total Efficiencies						FYE
	YTD			FOT			YTD			FOT			YTD			FOT			
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Recurrent
GSTT	34.0	35.6	1.7	39.6	39.9	0.4	37.9	27.0	(10.9)	62.6	28.8	(33.8)	71.9	62.7	(9.2)	102.1	68.7	(33.4)	51.7
Kings	72.0	59.7	(12.3)	82.4	72.1	(10.3)	0.0	0.0	0.0	0.0	10.3	10.3	72.0	59.7	(12.3)	82.4	82.4	0.0	72.1
LGT	39.9	23.1	(16.8)	43.5	25.8	(17.7)	11.9	15.3	3.4	13.0	15.7	2.7	51.8	38.4	(13.4)	56.5	41.6	(14.9)	26.1
Oxleas	8.6	5.5	(3.1)	9.4	5.6	(3.8)	22.5	25.6	3.1	24.5	28.3	3.8	31.1	31.1	0.0	33.9	33.9	0.0	5.6
SLaM	34.1	25.6	(8.5)	37.1	28.2	(8.9)	0.0	8.5	8.5	0.0	8.9	8.9	34.1	34.1	0.0	37.1	37.1	0.0	31.7
Provider Total	188.6	149.6	(39.0)	212.0	171.6	(40.4)	72.3	76.4	4.1	100.1	92.1	(8.0)	260.9	226.0	(34.9)	312.1	263.7	(48.4)	187.2
SEL ICB	49.9	52.5	2.6	54.6	57.5	2.9	4.7	4.0	(0.7)	5.1	4.3	(0.8)	54.6	56.5	1.9	59.7	61.8	2.1	57.5
System Total	**238.5**	**202.1**	**(36.5)**	**266.6**	**229.1**	**(37.5)**	**76.9**	**80.4**	**3.4**	**105.2**	**96.4**	**(8.8)**	**315.5**	**282.4**	**(33.1)**	**371.8**	**325.5**	**(46.3)**	**244.7**

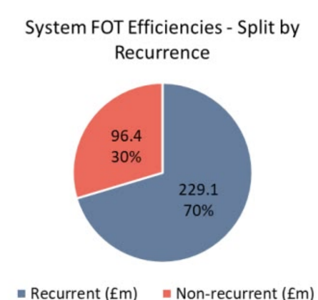
At Month 11, the system delivered £282.4m of efficiencies year-to-date, which is £33.1m (10.5%) behind plan.

The YTD plan comprised of £238.5m recurrent and £76.9m non-recurrent schemes. To date, £80.4m has been delivered from non-recurrent schemes (28.5% of year-to-date delivery, down 1.5% from month 10), while recurrent delivery is up by same rate, £202.1m (71.6% of total delivery).

The full year effect of the recurrent schemes is £244.7m, generating £15.6m recurrent benefit over and above the forecast actual delivery for this year.

Full-year efficiency plans **total £371.8m (£266.6m recurrent and £105.2m non-recurrent). The current forecast is £325.5m, comprising £229.1m recurrent and £96.4m non-recurrent, resulting in a £46.3m slippage against plan**. The shortfall sits within GSTT (£33.4m) and LGT (£14.9m). Achieving the full forecast will require an uplift in delivery compared with performance to date.

89.1% (£290.0m) of the forecast schemes are cash releasing. The remaining 10.9% (£35.5m) being non-cash releasing.



Organisation (£m)	Forecast				
	High Risk	Medium Risk	Low Risk	Cash Releasing	Non Cash Releasing
GSTT	0.5	2.8	65.5	68.7	0.0
Kings	0.0	10.3	72.1	82.4	0.0
LGT	1.2	0.2	40.2	41.6	0.0
Oxleas	0.0	0.0	33.9	17.5	16.5
SLaM	0.0	0.0	37.1	37.1	0.0
Provider Total	**1.6**	**13.3**	**248.8**	**247.2**	**16.5**
SEL ICB	**4.1**	**21.2**	**36.5**	**42.8**	**19.1**
System Total	**5.7**	**34.5**	**285.3**	**290.0**	**35.5**

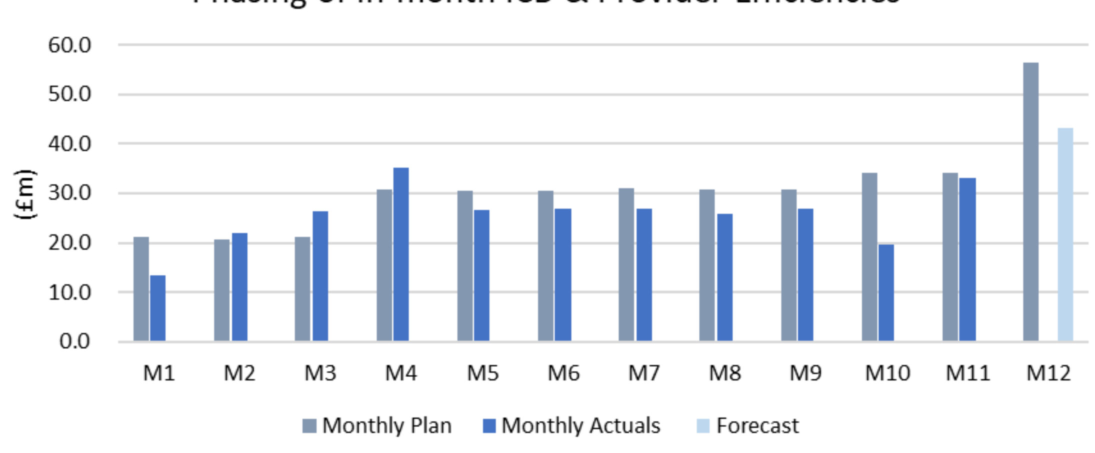
87.6% of the efficiency plan is assessed as low risk (£285.3m), a £6.8m (2.4%) improvement from Month 10.

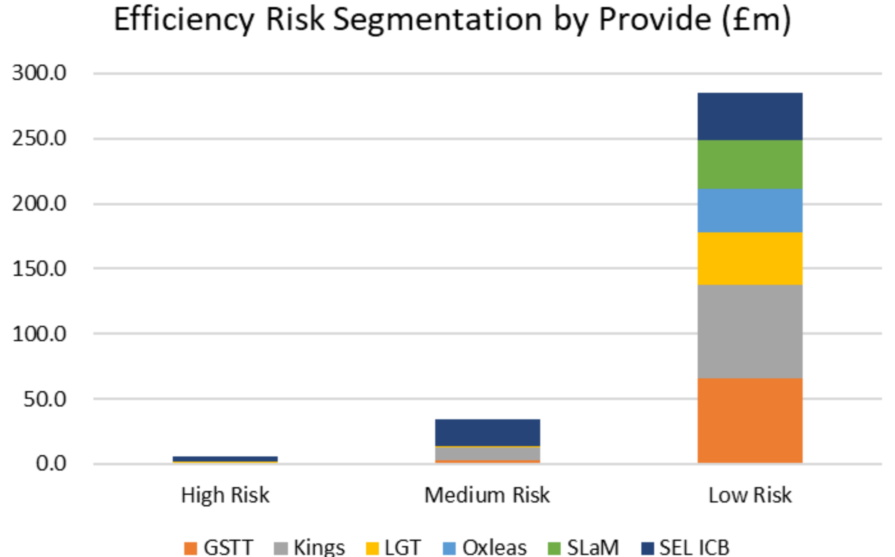
The high-risk category continues to decrease, £11.7m in Month 10 to £5.7m currently. This is mainly driven by delivery at Kings.

7. Efficiency delivery and maturity - cont'd

- The provider efficiency plan requires £37.7m to be delivered in the last month of the financial year. Providers are forecasting slippage of £48.4m against plan.

- Year-to-date slippage is £34.9m, driven mainly by recurrent schemes: non-pay **(-£33.9m)** and pay **(-£18.4m);** and non-recurrent pay **(-£30.4m).** This is partially offset by non-recurrent schemes; income **(+£18.7m)**, non-pay **(+£15.8m)** and recurrent income **(+£13.3m)**.





Provider Effeciencies by Scheme

Efficiency Category	YTD Plan £m	YTD Actual £m	Variance £m	FY Plan £m	Forecast £m	Variance £m
Recurrent	**188.6**	**149.6**	**(39.0)**	**212.0**	**171.6**	**(40.4)**
Pay - recurrent	85.1	66.7	(18.4)	95.2	79.7	(15.5)
Non-pay - recurrent	96.0	62.1	(33.9)	108.6	69.3	(39.3)
Income - recurrent	7.5	20.8	13.3	8.2	22.6	14.4
Non-Recrrent	**72.3**	**76.4**	**4.1**	**100.1**	**92.1**	**(8.0)**
Pay - Non-recurrent	59.1	28.7	(30.4)	65.7	41.0	(24.7)
Non-pay - Non-recurrent	10.3	26.1	15.8	31.2	28.9	(2.3)
Income - Non-recurrent	2.9	21.6	18.7	3.1	22.2	19.1
Total	**260.9**	**226.0**	**(34.9)**	**312.1**	**263.7**	**(48.4)**

8. System Capital Expenditure

System Capital Allocation

Organisation	Year-to-date Plan	Year-to-date Allocation	Year-to-date Actual	Year-to-date Variance against YTD allocation	Full Year Plan	Full Year Allocation	Full Year Forecast	Full Year Variance against allocation
	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	91.2	130.5	97.7	(32.8)	110.3	142.4	152.4	10.0
Kings	28.4	40.6	21.5	(19.1)	36.9	44.3	44.3	0.0
LGT	24.1	39.3	33.4	(5.8)	26.3	42.8	42.8	(0.0)
Oxleas	13.1	13.8	7.3	(6.4)	15.0	15.0	15.0	0.0
SLaM	25.2	10.2	8.0	(2.2)	35.1	11.1	11.1	0.0
Total Provider Charge Against Allocation	**181.9**	**234.3**	**167.9**	**(66.4)**	**223.6**	**255.6**	**265.6**	**10.0**
ICB	**3.4**	**3.4**	**3.4**	0.0	**4.4**	**4.4**	**4.4**	**0.0**
Total System Charge Against Allocation	**185.4**	**237.7**	**171.3**	**(66.4)**	**228.0**	**260.0**	**270.0**	**10.0**
National Programmes		49.2	35.7	(13.5)		56.2	53.6	(2.6)
Total System Capital	**185.4**	**286.9**	**207.0**	**(79.9)**	**228.0**	**316.2**	**323.6**	**7.4**

- The total system capital plan for 2025/26 is £228.0m, including the impact of IFRS 16. This comprises £223.6m for providers and £4.4m for the ICB's primary care allocation.
- The provider element includes a £31.9m CDEL loan from SWL ICB, with repayment linked to the disposal of the Lambeth Hospital site. This has been agreed in principle with SWL ICB and SLaM, with repayment deferred to 2026/27.
- Since the plan was set, further allocations totalling £39.4m have been received across the system, adjusted by an agreed repayment of £7.4m to NHSE (brought forward to this year). This brings the total allocation to £260.0m.
- The system capital allocation now incorporates £56.2m for other national programmes for which MOUs have been confirmed during the financial year. This is in addition to the system allocation, bringing the overall capital allocation to **£316.2m**. Further details are provided in the next slide.
- At Month 11, expenditure against the system capital allocation stands at £171.3m year to date, **£66.4m (27.9%) below allocation**, a deterioration compared to month 10. This variance is due to slippage on schemes. Expenditure against the national programmes is **£35.7m year to date**, **£13.5m below allocation,** a 9% improvement compared to month 10. **This brings the total year to date slippage on the system capital (including national programmes) to £79.9m below plan.**
- The current forecast shows a **£7.4m overspend.** This includes a **£10.0m pressure** due to NHSE reporting time delays in recognising additional funding received by GSTT within the system allocation. This is partly offset by a **£2.6m underspend** in the national programme, following NHSE's agreement with providers to phase the return-to-constitutional-standards allocations across 2025/26 and 2026/27.

9. System National Capital Programmes

for information only

- In addition to the system capital allocation is **£56.2m** allocated for national programmes. These include:
  - Estates safety - £38.7m
  - Return to constitutional standards - £16.0m and
  - Mental Health: Reducing Out of Area Placement - £1.5m.
- YTD expenditure is £35.7m, giving slippage against plan of **£13.5m, a 9% improvement compared to month 10**.
- The current forecast expenditure reported **in provider financial returns is £53.6m, reflecting an underspend of £2.6m**, mainly driven by the reforecasting of the return-to-constitutional-standards schemes. This results from NHSE's agreement with providers to phase these allocations across 2025/26 and 2026/27.
- The use of 2025/26 capital funding, together with agreement on the forecast outturn has been coordinated and discussed through the SEL CFO Group.

Estates Safety

Organisation	Year-to-date			Full Year			
	Allocation	Actual	Variance	Plan	Allocation	Forecast	Variance against allocation
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
GSTT	19.9	22.2	2.3	21.7	22.2	22.2	0.0
Kings	7.0	1.6	(5.5)	7.0	7.1	7.1	0.0
LGT	0.0	2.7	2.7	4.6	4.6	4.6	0.0
Oxleas	0.0	0.7	0.7	0.0	1.1	1.9	0.8
SLaM	3.5	1.9	(1.6)	3.8	3.8	3.8	0.0
Total Provider CDEL	**30.4**	**29.1**	**(1.3)**	**37.1**	**38.7**	**39.5**	**0.8**

Return to Constitutional Standards

Organisation	Year-to-date			Full Year			
	Allocation	Actual	Variance	Plan	Allocation	Forecast	Variance against allocation
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
GSTT	2.3	0.2	(2.2)	2.5	2.5	4.3	1.8
Kings	3.8	3.5	(0.3)	3.8	3.8	4.6	0.9
LGT	6.9	2.9	(4.0)	7.6	7.6	3.2	(4.4)
Oxleas	1.9	0.0	(1.9)	2.5	0.0	0.0	0.0
SLaM	1.4	0.0	(1.4)	1.6	2.2	0.3	(1.9)
Total Provider CDEL	**16.3**	**6.6**	**(9.8)**	**17.9**	**16.0**	**12.4**	**(3.6)**

Mental Health: Reducing Out of Area Placement

Organisation	Year-to-date			Full Year			
	Allocation	Actual	Variance	Plan	Allocation	Forecast	Variance against allocation
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Oxleas	0.0	0.0	0.0	0.0	0.5	0.5	0.0
SLaM	2.5	0.0	(2.5)	2.7	1.0	1.2	0.2
Total Provider CDEL	**2.5**	**0.0**	**(2.5)**	**2.7**	**1.5**	**1.7**	**0.2**
Total National Programmes	**49.2**	**35.7**	**(13.5)**	**57.7**	**56.2**	**53.6**	**(2.6)**

Board Meeting in Public

Title	Medicines Optimisation and Community Pharmacy				
Meeting date	8 April 2026	Agenda item Number	**10**	Paper Enclosure Ref	**J**
Author	Vanessa Burgess, Chief Pharmacist SEL ICB				
Executive lead	Sarah Cottingham, Director of Planning and Deputy Chief Executive				
Paper is for:	Update	x	Discussion	x	Decision	
Purpose of paper	To provide the Board with an update on medicines optimisation and community pharmacy across South East London, setting out how the system is maintaining a strong grip on medicines safety, value and affordability, while supporting neighbourhood-based care, prevention and access to innovation.				
Summary of main points	• Medicines are one of the NHS's largest, most volatile and most influential system levers, with c.£850m annual spend across South East London. Maintaining grip on safety, outcomes and affordability is critical to delivering neighbourhood health and sustaining access to innovation. • SEL is shifting from a cost-focused approach to a value-based medicines strategy, using prescribing quality, pathway design and workforce deployment to reduce avoidable harm, improve outcomes and release system capacity. Evidence from respiratory care, overprescribing and multimorbidity shows this delivers better outcomes while reducing pressure on GPs and hospitals. • Affordability pressures from NICE-approved innovation are accelerating, particularly in weight management and cardiometabolic disease. SEL is managing this through phased implementation, prioritisation and delivery of c.£22–25m medicines efficiencies in 2026/27 to create headroom for innovation. • Community pharmacy is a ready-to-scale neighbourhood asset, improving access, prevention and medicines safety, particularly for underserved populations. SEL data demonstrates strong delivery capability; system benefit now depends on consistent commissioning intent, GP referral behaviours, digital integration and workforce support. • Digital integration, medicines safety and workforce capability are critical enablers—but also current constraints. Fragmentation, shortages and variable capability increase risk and inefficiency, reinforcing the need for strong system leadership and coordination In summary, medicines optimisation and community pharmacy are central to balancing innovation, affordability and neighbourhood care. Without sustained system grip and delivery of planned efficiencies, access to new medicines and financial balance will be increasingly at risk.				
Potential conflicts of Interest	None declared.				
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	The work described supports equitable access to medicines and pharmacy services, particularly for underserved and higher-deprivation populations.				

CEO: Andrew Bland
Chair: Sir Richard Douglas CB

	Community pharmacy plays a key role in reaching groups less likely to access traditional NHS services, including working-age adults and ethnically diverse communities. Targeted approaches to medicines safety, prevention and overprescribing also reduce avoidable harm and health inequalities.
Financial Impact	The paper describes both cost pressures and mitigation. Rising affordability pressures from NICE-approved innovative medicines are being actively managed through prioritisation, pathway design and phased implementation. Significant savings are being delivered through medicines optimisation, including biosimilars and patent expiry, supporting delivery of QIPP while maintaining access to innovation. Medicines optimisation and waste reduction programmes contribute to system sustainability and NHS Net Zero objectives.
Public Patient Engagement	Community pharmacy-led services, prevention initiatives and medicines safety programmes are patient-facing and informed by patient experience and national best practice. No formal public consultation is required for this update paper.There has been extensive patient engagement in some programmes such as overprescribing, biosimilar switching and antimicrobial stewardship. A test and learn project in Lewisham is delivering a collaborative project between community pharmacy and the voluntary sector to improve the uptake of structured medicines review for older Black Afro-Caribbean residents particularly affected by overprescribing.
Committee engagement	The work described has been informed through established governance and professional forums, including the Integrated Medicines Optimisation Committee (IMOC), system clinical leadership groups, and relevant workforce and safety committees. The modern community pharmacy neighbourhood integration proposal has been discussed at the Neighbourhood Based Care Board in December 2025.
Recommendation	The Board is asked to: • Note the system position on medicines optimisation and community pharmacy, including progress, risks and opportunities. • Discuss the strategic implications for affordability, neighbourhood health and system productivity, including the role of community pharmacy and the pharmacy workforce. • Support the continued shift towards value-based medicines use and scaling neighbourhood pharmacy models as part of integrated neighbourhood teams.

Medicines Optimisation and Community Pharmacy

Vanessa Burgess	Chief Pharmacist SEL ICB
Keith Thompson	Chief Pharmacist and Clinical Director GSTT
Lelly Oboh	Consultant Pharmacist, Frailty GSTT and CCPL Overprescribing SEL ICB
Raj Matharu	Chair Community Pharmacy London Chief Executive Officer-Community Pharmacy South East London (LPC)

April 2026

Introduction and Contents

"Medicines optimisation is a person-centred approach ensuring patients get the best outcomes from their medicines, focusing on safe, effective, and evidence-based use. It aims to maximise health benefits, improve adherence, minimise waste, and involve patients in decisions, improving overall patient care quality."

Part 1 of this presentation updates the SEL ICB Board on our achievements and challenges in **medicines optimisation** against our priorities over the last year. It also identifies key priorities moving forwards in delivering medicines optimisation as set out in our 5 year strategic commissioning plan. **Part 2** highlights progress and challenges in the development of **community pharmacy** and the role of pharmacy in **neighbourhood health** giving some examples and areas of development**.** We will then finish with some key points and highlight the impact of our work on our population.

Contents:

Part 1

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Part 2

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Neighbourhood Care and Prevention – role of pharmacy 18-20.

Key Takeaways and Impact on our population 19-21

Links to the supporting data pack are given throughout 22-69

Keeping a "system grip" on medicines – why do medicines matter ?

Prescribing is the NHS's most common evidence-based intervention and one of the most volatile and controllable areas of spend at £850m annually for SEL ICS.

Primary care prescribing is £256m (5.7% of ICB allocation).

SEL hospitals spend £594m, £300m of which relates to medicines commissioned by NHS England specialised commissioning and £40m relates to SEL ICB commissioned medicines.

What good looks like (Model ICB expectations)

- Strategic commissioning pharmacy leadership, with medicines optimisation "delivery" functions previously undertaken by the ICB increasingly undertaken by providers (improving medicines quality, safety, outcomes and value in on the ground in primary care, and to deliver financial balance on the prescribing budget).
- Population health management, using prescribing and outcomes data and service commissioning to target unwarranted variation and inequality.
- Strong contractual levers, quality standards and financial accountability for medicines value and safety.
- Investment in data and analytics capability and system-wide partnerships to support innovation and improvement.

What this means for SEL

- A deliberate shift from delivery and cost control **to strategy and value** creation.
- Focus on **reducing avoidable harm, improving outcomes and productivity**, and ensuring the **pharmacy workforce, community pharmacy** and **medicines investment delivers maximum benefit** for patients and the system.

Productivity in medicines

We spend approximately £850m each year on medicines across the South East London ICS, making medicines one of our largest and most volatile and controllable areas of expenditure.

National Institute for Health and Care Excellence (NICE) are accelerating access to innovative but high-cost medicines. SEL ICS works collaboratively to plan for rapid implementation and access to NHS approved innovation, for more details see the supporting data pack at system level and for primary care. **System preparedness and affordability** are ongoing challenges. Weight-loss medicines illustrate this clearly, with NICE recommendations adopted by SEL requiring phased implementation in defined populations to manage cost, workforce capacity and system impact.

Other important developments

- Move towards a **single national formulary** over the next 2-5 years in line with the 10 year plan.
- Introduction of genomics into prescribing and pathways.
- Changes to Quality-Adjusted Life Year threshold are expected from April 2026 meaning **more medicines may be approved.** Pace of innovations is already faster than previous years reflecting faster appraisal processes (from 40 technology appraisals a year to a target of 100-120 a year) and a growing pipeline of new medicines
- **Left shift of services into community** is likely to increase primary care prescribing costs as pathways and services move.

SEL is on track to deliver 100% of the primary care 2025/26 medicines QIPP, with a planned **£13m QIPP** in 2026/27, enabling continued access to innovation while controlling growth in spend per patient.

Patent expiry and biosimilars are delivering significant savings without compromising clinical outcomes, see supporting data pack. Dapagliflozin (Forxiga loss of exclusivity) is already delivering £397k per month savings, with a planned switch programme increasing total savings to **£4.77m** in 2026/27.

Biosimilars: major savings delivered and planned across SEL, including:

- Ustekinumab: **£4.3m** savings in 2025/26 (largest contributor to biosimilar value).
- Aflibercept: **£6.9m** savings expected in 2026/27 across SEL Trusts following rapid uptake.
- Denosumab: **£0.6m** savings planned in 2026/27, subject to supply stabilisation

SEL has four **system sustainability programmes** (SSP) which are underway to ensure financial balance in prescribing. The SSP will deliver **£5m+ direct savings** for SEL over 3-5 years, while protecting substantially larger system-wide efficiencies and improving safety, resilience and productivity.

From Cost to Value : an example of optimising medicines for better care

Illustrative image generated using AI.

This is an example of the move from cost of medicines to the value of medicines with more detail given in the supporting data pack

High or frequent Short-acting beta-agonists (SABA) use is a marker of poor asthma control and has been consistently associated with higher risk of emergency attendance, hospital admission and avoidable harm. Reducing reliance on SABA, and shifting patients onto evidence-based maintenance or SABA-free regimens, reflects better quality care and is linked to improved outcomes despite higher upfront medicines costs.

High Value respiratory care and medicines optimisation:

- Current higher respiratory prescribing spend on SABA inhalers does not equate to better outcomes
- Over-use of SABA inhalers is linked to increased Emergency attendances and admissions
- Investment in best-practice, SABA-free treatment is associated with improved outcomes and lower system pressure
- Optimising prescribing choices delivers both clinical benefit and resource efficiency
- Medicines optimisation is a key lever for prevention and demand reduction

“Adopting clinical best practice improves outcomes and reduces emergency demand — even where individual medicines may cost more.

Short-acting beta-agonists (SABA) provide rapid symptom relief but do not treat the underlying airway inflammation that drives asthma.”

Critical pharmacy services: protecting safety, resilience and system value

The following examples illustrate the importance of robust commissioning for medicines services (using the London home oxygen service as an example) and also the importance of ongoing focus on medicines supply and delivery. Links are given in the titles below to more information in the supporting data pack.

Home Oxygen:

SEL leads the London Home Oxygen Service, delivering safe, equitable access for people with long-term and complex conditions. Contract reform and VAT optimisation have delivered prices 30–38% lower than the previous supplier, generating £2.1m savings in 2025/26 (part-year) and £3.9m recurrent savings from 2026/27. In parallel, VAT zero-rating has secured a £5–6m backdated VAT refund across London, with ongoing recurrent VAT savings embedded in the new contract.

Pharmacy Homecare:

Pharmacy homecare enables care closer to home for patients requiring high-cost specialist medicines and protects major VAT efficiencies. The Homecare System Sustainability Programme stabilises capacity and governance, delivering £454k recurrent annual savings for SEL ICB, while protecting much larger system-wide VAT benefits estimated at £60–70m per annum.

Aseptic Services Transformation:

Rising demand and fragmented, capacity-constrained aseptic services present increasing risks to safety, resilience and delivery of cancer and elective care. A **London hub-and-spoke** transformation programme is underway to standardise practice, improve productivity and strengthen supply resilience, securing a safe, sustainable and scalable model (financial benefits to be realised through reduced outsourcing, waste and improved productivity).

Digital & medicines : adoption of technology and data in medicines use to increase safety, productivity and patient experience

Digital integration is critical to the safe, efficient and person-centred use of medicines, particularly as care shifts into neighbourhood, community and virtual settings.

Progress in SEL:

Data – We are improving the quality, availability and use of medicines data to measure outcomes and improve safety. This involves integrating medicines data into population health and outcomes frameworks.

Giving people more control to get the best from their medicines. NHS App prescription ordering and pilots of digital transfer of hospital prescriptions to community pharmacy.

Developing safe digital capabilities in our workforce including AI-enabled tools are supporting clinical decision-making, risk identification, prescribing insight and administrative efficiency.

Using **connected technology** for example one third of community pharmacies in SEL now have access or are being onboarded to the London Care Record.

Robotics, centralised dispensing and digital workflows are reducing manual and administrative workload, allowing pharmacists to focus on prescribing, prevention and long-term condition management.

Key challenges

- Digital systems remain fragmented across primary, secondary and community care.
- Digital maturity is variable, particularly in community pharmacy.
- Medicines data and coding are inconsistent, limiting visibility of outcomes and risk.
- Workforce capability and confidence in new digital and AI-enabled tools varies.
- Legacy manual processes increase risk and consume clinical time at care transitions.

Photo of the robotic dispenser at Junction Pharmacy, Lambeth

Developing the Pharmacy Workforce to deliver the 10 year plan

This slide outlines why developing the pharmacy workforce is critical to delivering neighbourhood health and better outcomes with further information in the supporting data pack.

- Neighbourhood health models rely on having the right clinical workforce in the right place, and pharmacy professionals are central to delivering medicines-led prevention, long-term condition management and safer prescribing, closer to home.
- **From 2026 all new Pharmacists qualifying will be independent prescribers**. Independent prescribing in the pharmacy profession is a key enabler of neighbourhood care, allowing pharmacists to assess, initiate and optimise treatment, reduce delays, and improve continuity for patients with long-term conditions.
- Expanding the clinical scope, supervision and deployment of the pharmacy workforce supports a shift of care out of hospital and GP settings, helping to improve access, reduce system pressure and tackle health inequalities.
- Investment in pharmacy workforce development underpins better outcomes, productivity and safety, ensuring neighbourhood teams can deliver high-quality, integrated care at scale.

Progress in SEL

- SEL has a system-wide approach to convene our pharmacy leaders and teams under a “one pharmacy workforce” model and transformation programme. This is now aligning to support neighbourhood development and integrated neighbourhood teams, focusing on the SEL priority population groups.
- We are scaling implementation of pharmacist independent prescribing, supported by stronger supervision and governance. A test-and-learn approach is being used for delivery of independent prescribing in CVD and asthma in a community pharmacy setting, in collaboration with PCNs.
- We are working with the SEL Workforce Development Hub to support primary care pharmacy professional development including the 250+ working in PCNs and GP Practices in SEL

Key Challenges

- Change fatigue is affecting engagement and pace of delivery.
- Clinical supervision capacity is limited, particularly for prescribing roles.
- Community pharmacy is not consistently included in neighbourhood teams.
- Deployment of pharmacy roles varies widely across settings.
- Workforce capacity is stretched by day-to-day service pressures.
- Planning remains fragmented across organisations.
- Data on skills, capacity and impact is incomplete.

Medicines Shortages are now frequent

- Medicines shortages are now a chronic, structural issue, increasing significantly since 2021 rather than being isolated events
- Supply problem notifications have risen sharply, with a **67% increase between 2021–2023 and around 137 notifications per month in 2023**
- Manufacturing fragility is the main driver, including raw material shortages, quality failures and limited capacity, with demand shocks contributing to ~20% of issues
- Patient impact is significant: **almost half of UK adults report difficulty obtaining medicines and 8% report going without treatment**
- Service pressure is substantial, with pharmacies spending ~11 extra hours per week sourcing medicines and high levels of staff distress across pharmacy and general practice

What does this mean for SEL?

- Shortages increase clinical risk and generate significant workload across primary care, community pharmacy and providers, diverting capacity from patient care
- Use of higher-cost alternatives and imports increases prescribing costs, undermining QIPP delivery and creating volatility in ICB medicines budgets.
- Inconsistent local responses can widen unwarranted variation and health inequalities, reinforcing the need for strong ICB-led coordination, horizon scanning and consistent system messaging.

What have we done in SEL done to resolve this?

- SEL ICB has responded by working collaboratively across London and within our ICS to manage medicines shortages as a system risk. This included implementing a pan-London clinical and supply response to the pancreatic enzyme replacement therapy shortage to protect vulnerable patients, reduce unwarranted variation and stabilise frontline services.
- We also support collaboration in mutual aid and communication between community pharmacy and general practices in managing shortages.

Pharmacists warn drug shortage affecting cancer patients

GETTY IMAGES

Hugh Pym ›
Health editor

2 June 2025

Pharmacists have warned that "one of the worst" examples of medicine shortages is affecting cancer patients.

Creon, a pancreatic enzyme replacement therapy (Pert), helps digestion and is required by patients with pancreatic cancer, cystic fibrosis, and chronic pancreatitis. It is thought more than 61,000 patients in the UK need the medicine.

Some patients are said to be "skipping meals" to ration their medication due to a shortage of it, according to the National Pharmacy Association (NPA).

Pupils 'set up to fail' by ADHD medication shortage

Alice relied on her ADHD medication in the months before her exams

Zac Sherratt, BBC News, South East and **Ben Moore**, South East Investigations

5 September 2024

Some students starting new schools and colleges are being "set up to fail" due to an ongoing shortage of medication for ADHD, according to a charity chief.

There have been problems with the supply of proper medication because of manufacturing issues and an increase in demand, although the Department of Health and Social Care (DHSC) says recent supply issues with most ADHD medicines are resolved.

The shortage caused panic among a number of students who were forced to ration their tablets in the run up to this year's exam season.

Medicines safety, stewardship and sustainability

There is a public expectation that medicines will be **safe and that the NHS will prevent avoidable harm.**

In SEL we are working on local and national priority areas for **medicines safety** which include:

- Time-critical medicines
- Psychotropics in learning disability
- Opioids in chronic pain
- Valproate in pregnancy
- Polypharmacy,
- frailty and
- Acute Kidney Injury

This is system-wide, multidisciplinary work, led by pharmacy and quality colleagues.

Antimicrobial stewardship is embedded as a core patient safety and sustainability priority. SEL has demonstrated sustained improvement in antimicrobial prescribing quality:

- Lower overall antibiotic use.
- Rates of shorter courses of broad-spectrum amoxicillin prescribing have improved from 15.6% in April 2023 to 31.6% in April 2024, and further to 42.4% in April 2025.

SEL has also been successful in three NHSE leadership and digital funding bids to support SEL in delivery the UK AMR National Action Plan (NAP) 2024–2029.

Our challenges in medicines safety include provider capacity to reduce avoidable harm through medication review, growing clinical complexity and service pressures, and inconsistent digital systems, data quality and co-ordination to limit identification of risk and intervention.

Medicines account for around one-quarter of the NHS carbon footprint, most of which sit in the supply chain with inhalers and anaesthetic gases having a disproportionately high impact.

A SEL-led inhaler recycling pilot supporting NHS Net Zero, was delivered in 25/26 through community pharmacy and acute trusts, with growing national interest in replication.

Over 16,000 inhalers collected, with validated collection and carbon data now available.

This had a strong external profile, including national awards, poster presentations and 20+ enquiries from other NHS systems and internationally

There is now an NHSE-commissioned independent evaluation underway to support next steps.

Overprescribing

"The use of a medicine where there is a better non-medicine alternative, or where the medicine is no longer appropriate for the individual patient's circumstances, needs or wishes."

Overprescribing is a significant patient safety, quality and productivity issue, contributing to avoidable harm, medicines waste and health inequalities, particularly for older people, people with frailty and learning disability, and those living in deprivation. This is a **COMPLEX** problem requiring systems change and **shared decision making** with patients

What has SEL done ?

- SEL has a strong focus on overprescribing, with more information in the supporting data pack in using Structured Medication Reviews (SMRs) as a core clinical intervention. We have completed significant patient and public engagement to understand our population's challenges and how to best support people, focusing on reducing inequalities.
- SEL have established and led the London Region Overprescribing Group, coordinating pharmacy leadership across all five London ICBs. This has identified variation in SMRs, deprescribing practice, data capability and workforce capacity and agreed high impact "do once and share " priorities.
- Whilst we have made an impact in reducing polypharmacy in people over 65 years, the data in the supporting pack shows that it has been a challenge to reduce overprescribing in complex people over 75 years. Use of SMRs and the pharmacy workforce is embedded in our frailty model of care for integrated neighbourhood teams along with reductions in polypharmacy included as outcome measures which we hope will have a high impact.

Look out for the London wide "Only Order What You Need" campaign!

SEL led on the development of a London-wide medicines waste reduction campaign which is **live now for the next 3 months** across London and delivered jointly by all five London ICBs with NHS England support. This campaign:

- Aims to reduce unnecessary repeat prescription ordering by ~2%, focusing on habitual over-ordering rather than stopping clinically appropriate treatment
- Targeted at people aged 60–79 on 2+ repeat medicines (and carers), with additional focus on Bangladeshi, Pakistani and Black/Mixed communities where repeat prescribing rates are highest
- Delivered via a multi-channel communications approach, including GP and pharmacy engagement, NHS App and SMS prompts, community pharmacy materials, ethnic media, radio, digital and outdoor advertising
- Clear, patient-centred messages: check medicines at home before ordering, only order what is needed, request medication reviews, and return unused medicines to pharmacies
- Supports financial, environmental and patient-safety objectives, reducing waste, avoiding stockpiling and contributing to NHS Net Zero ambitions

The expected impact of this campaign is £2.15m London-wide savings from a targeted ~2% reduction in repeat prescriptions (≈£280k in SEL).
This will also empower patients, reduce medicines waste and reduce unnecessary medicines harm.

Community Pharmacy and Neighbourhood based Care

Community pharmacy as a neighbourhood health asset

South East London has a large (322) and diverse network of community pharmacies across all six boroughs, providing highly accessible, walk-in care on high streets and in neighbourhoods every day. Community pharmacy is often the **most frequently** used part of the NHS, particularly by working-age adults, people living in deprivation and those less likely to access other services. In SEL, community pharmacies dispense medicines, support self-care and deliver an expanding range of clinical services, while playing a growing role in prevention, medicines safety and neighbourhood-based care. The **SEL Community Pharmacy Alliance** is the collective vehicle for South East London community pharmacies that works with the ICB to provide, integrate and support consistent, high-quality community pharmacy services across neighbourhoods and Places.

Community pharmacy in South East London is operating under sustained pressure, reflecting challenges seen nationally. Pharmacies are managing rising workload and patient demand, ongoing medicines supply disruptions, and workforce shortages, alongside long-term real-terms funding challenges. These pressures are impacting staff wellbeing, limiting capacity to deliver new and expanded clinical services. This, along with financial challenges are increasing the risk of reduced opening hours and temporary/permanent closures, despite community pharmacy continuing to absorb demand and provide accessible care to local populations.

Part 2 highlights progress and challenges in the development of **community pharmacy** including delivery of nationally and locally commissioned services, and integration of community pharmacy into **neighbourhood health** as endorsed by the SEL Neighbourhood based care board .

The next slides take us through the highlights as follows:

Scaling pharmacy's role as a neighbourhood asset and developing the "modern community pharmacy 15
Community pharmacy clinical services data highlighting successes and opportunities 16-17
Neighbourhood Care and Prevention – role of pharmacy 18-20.

Links to the supporting data pack are given throughout.

Community Pharmacy: Modern Community Pharmacy as a Central Pillar of the Neighbourhood Health Service

As set out in the 10 Year Health Plan and Medium-Term Planning Guidance, pharmacy will transition from being focused on dispensing to becoming integral to neighbourhood health by:

Single Patient Record Integration Pharmacists access and update patient records in real time.

NHS App Connectivity Patients book pharmacy services, manage prescriptions, and receive advice.

Modernised Dispensing Automated dispensing and home delivery streamline operations.

Preventative Care & Screening Pharmacies support screening for CVD, diabetes and deliver vaccines

Taking on an expanded clinical role

- **Pharmacy First, Self Care & new clinical services** rolled out nationally
- Growth of **prescribing-based services**, expanding clinical scope.
- Expanding the Southwark-led **community pharmacy prescribing** service to include additional conditions and more pharmacies
- **Discharge Medicines Service** strengthened to reduce medicines harm and readmissions
- Workforce plans preparing all new pharmacists to qualify as **independent prescribers** from 2026
- **Oral contraception** services.

Supporting prevention and public health

- **Emergency contraception, smoking cessation, hypertension case finding** services
- **RSV, MMR, Flu and Covid vaccination** offered routinely through pharmacies
- Community pharmacy positioned to **improve access** in underserved groups through walk-in care
- Contribution to medicines safety, harm reduction and proactive follow-up after hospital discharge
- **SEL Health and Wellbeing (vital 5 service)** to support proactive care and action to tackle the vital 5 risk factors.

Integrating digitally

- Drive adoption of **Electronic Prescription Service (EPS), NHS App, and Federated Data Platform** for seamless medicines management.
- Support digital incident response frameworks as part of the NHS Patient Safety Strategy.
- All community pharmacies must enable patients to **track prescription status** via the NHS App
- All primary care services should allow patients **to request and manage medicines online**

System Challenges and Pharmacy Solutions

System Challenge	Community Pharmacy Contribution	System Impact Examples (non-exhaustive)
Access & GP pressure	Pharmacy First, independent prescribing, digital booking, self care services	Same-day care, freed GP time (NHS England estimates that, once fully implemented, Pharmacy First (alongside contraception and BP services) could free up around 10 million GP appointments per year.)
Hospital readmissions	Discharge Medicines Service (DMS) + follow-up	Fewer medicines-related readmissions. (Every 100 DMS interventions may save the NHS between £9,000 and £15,000 in avoided admission costs alone. In SEL Q1-Q3 2025-6 there were over 4700 DMS referrals)
Prevention gap	Vaccination, BP checks, weight & smoking support	Early intervention, inequality reduction (In South East London, community pharmacies have already delivered over 345,000 NHS flu vaccinations and 161,000 COVID-19 vaccinations ahead of 2025 winter)
Long Term Condition management	Pharmacist-led clinics (Hypertension, diabetes, asthma)	Improved control, fewer admissions (Pharmacist-led hypertension clinics have been running in community pharmacies in Southwark and multimorbidity kidney disease prevention clinics in Lewisham)
Workforce strain	Task-shift e.g. routine monitoring & reviews	Stabilises primary-care workload (Community pharmacies in England deliver ~69 million walk-in clinical advice consultations per year. This saves the NHS ~38 million GP appointments annually)
Digital fragmentation	Shared Record + NHS App integration	Seamless, safe patient journeys (The NHS App is now the first online GP service for 64% of users) (By September 2025, more than 10,000 community pharmacies have sent over 7,000,000 consultation summaries to general practices using Update Record.)
Focus on prevention	SEL Health and Wellbeing Vital 5 service	Identification and proactive care for risk factor reduction (Between January and October 2025, participating community pharmacies in SEL completed 3,718 Vital 5 Checks across all six SEL boroughs)

Community Pharmacy Clinical Services Uptake – data insights

Data from SEL on nationally commissioned community pharmacy service mobilisation is given in the supporting data pack. This includes comparison with other ICBs and nationally to demonstrate SEL's progress and remaining opportunities.

What's working well in SEL

- Very high community pharmacy opt-in and delivery capacity across all three national services
- Strong relative performance across London, particularly for blood pressure checks.
- Clear shift of activity from GP to community pharmacy– Oral contraception, EHC and uncomplicated UTIs.
- High Electronic Prescription Service utilization.
- Good access in deprived areas, aligning delivery with population need

What needs to improve / opportunities

- Under-utilised capacity in some services despite high pharmacy readiness.
- GP electronic referrals remain the key constraint as activity is driven mainly by self-referral rather than GP referral
- Inconsistent referral data sources (NHS BSA vs GP systems) limits system grip
- Lower Electronic Repeat Dispensing uptake than London average.
- Further scope to reduce GP self-care prescribing via Pharmacy First.
- Improving digital integration between community pharmacy and Urgent Care Centres.

Key messages

- SEL has strong delivery capability in community pharmacy.
- System benefit now depends on changing GP referral behaviour and using existing capacity more effectively.
- With consistent commissioned activity and referrals, community pharmacy can develop its workforce to support our population.

Integrated Pharmacy roles improve outcomes, experience and productivity in neighbourhood Care

- A pharmacy-led multimorbidity model improved **outcomes and experience** in the neighbourhood care in the Multimorbidity Model of Care pilot in South east London.
- Integrated pharmacy roles were successful in breaking down traditional care boundaries
- **Right care, earlier intervention**: medicines optimisation was embedded across prevention, case management and acute care. 292 holistic reviews were undertaken and 684 interventions made (54% medicines related). Pharmacy had input into 70 MDTs and 215 case discussions. High value prescribing for diabetes and CKD increased by 14% and 11% had dose adjustments in view of renal function.
- **Evidence of impact**: improved staff satisfaction, more holistic care, and strong patient endorsement
- A **scalable neighbourhood model** aligning with prevention, productivity and quality priorities

Further information is given in the supporting data pack and below:

Integrated neighbourhood working: multi-morbidity model of care – Francine's story

"Embedded multi-specialist pharmacists working alongside acute, PCN and community pharmacy roles within a single neighbourhood model delivered person-centred, preventative neighbourhood care with measurable impact."

Conclusion

What this means for our population

Safer use of medicines with fewer avoidable harms

Better access to care closer to home

Earlier identification of health problems, especially for under-served groups

More effective treatments that focus on outcomes, not just cost

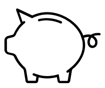
Fair and managed access to new medicines

A smoother, more joined-up experience across NHS services

Key Takeaways

SEL is balancing innovation, affordability and system grip.
We manage a large and volatile medicines budget of ~£850m, with ~£300m directly commissioned or managed by SEL ICB. Creating headroom for new NICE-approved innovation depends on delivering £22–£25m of medicines efficiencies in 2026/27, alongside wider indirect savings from reduced healthcare activity, underpinned by aligned commissioning, finance and planning.

So what?
Without strong system grip and delivery of planned efficiencies, SEL will be unable to fund timely access to new innovations or sustain financial balance.



Shifting from cost to value delivers better outcomes and system productivity.
Focusing on clinical value rather than unit cost improves outcomes, reduces avoidable harm and lowers pressure on acute and primary care services. Aligning prescribing budgets to pathways accelerates this shift.

So what?
Investing in high-value medicines use reduces emergency attendances, admissions and unwarranted variation, releasing capacity across the system.

Digital, workforce and medicines safety are critical enablers—and current constraints.
Fragmented digital systems, variable workforce capability and medicines shortages increase risk to patient safety and productivity, reinforcing the need for coordinated system leadership, data integration and strong pharmacy oversight.

So what?
If these enablers are not addressed, medicines-related harm, inefficiency and service pressure will continue to rise despite investment in innovation.

"Modern community pharmacy" and neighbourhood pharmacy models are ready to scale.
SEL evidence shows embedded pharmacy roles improve outcomes, experience and productivity—particularly in prevention, medicines safety, overprescribing and multimorbidity—but scaling requires clear commissioning intent, leadership, inclusion in integrator/Place partnerships and workforce support.

So what?
Scaling neighbourhood pharmacy models offers a rapid, cost-effective way to improve access, reduce inequalities and relieve pressure on GPs and hospitals.

Medicines Optimisation

Supporting Data Pack

April 2026

5 year Strategic Commissioning Plan : Medicines Optimisation

Medicines Optimisation and Pharmacy

What is our ambition for medicines optimisation and pharmacy?

Medicines are the most common therapeutic intervention in the NHS, and with £850 million spent annually in South East London, high-value prescribing is essential to improve outcomes and reduce health inequalities. Involving people in decisions about their treatment helps them use their medicines effectively and safely. When services work together, people are more likely to take the right medicines at the right time in a way that works for them.

What do we know about our commissioned services for this care pathway?

- We offer a wide range of pharmacy and medicines services across our system.
- Services are regularly checked and reviewed to improve consistency, quality and inequalities in access.
- There is a strong focus on developing new services from community pharmacies so people can access services and the right medicines more easily and equitably.
- Teams are working to get the best value from medicines, through improved pathways, purchasing, procurement and cutting waste.
- Pharmacy teams in different parts of the NHS are working together more effectively to provide care.
- Improvements are happening in how medicines are supplied, including specialist medicines supplied through home delivery and a focus on getting the best outcomes for patients who need these medicines.

What do we know about our residents who access or require access to these services?

- We serve 2 million people from many backgrounds, with big differences in health outcomes.
- People in poorer areas often have more than one health problem and therefore need more medicines, starting at a younger age.
- More people will need medicines and pharmacy services in the next five years, as people get older and have more health needs.
- Nearly everyone lives within a 20-minute walk of a community pharmacy, especially in poorer areas.
- Some people face barriers like language, low health knowledge, not using digital services, or money problems.
- Differences in ethnicity and poverty affect how people get and use medicines.
- Children and young people need help with conditions like asthma, epilepsy, ADHD, especially when moving to adult services.

What might future access and care needs look like for our residents?

- Improved access to regular, high quality structured medicines reviews, particularly for those experiencing polypharmacy.
- People need joined-up, personal care from pharmacy teams that is easy to access and meets their needs and help in accessing the right medicines at the end of life.
- Community pharmacies will offer more clinical services, including prescribing, as part of neighbourhood health teams.
- Digital services will help people care for themselves and make it easier to get medicines and advice.
- Children and young people will need clear, joined up support as they move between different services and they should get the right medicines for conditions such as asthma.
- People will have access to medicines which have a lower impact on the environment and reduce waste.
- People will be offered cost-effective, approved medicines, following national guidance.

Medicines Optimisation and Pharmacy

Priority	What is the change we need to make?	What does success look like? [DN: What are the key outcomes?]	What will be different in five years?
1	**We need to develop our workforce, implement digital innovations and contribute to sustainability and net zero targets. We will do this by:** • We will continue to develop our "one pharmacy" workforce plan to enable pharmacy teams to work together and as part of wider teams, develop new prescribers and tackle equality and diversity challenges. • We will ensure that our pharmacy services can support new therapies, research and innovations, including aseptic and medicines homecare services. • We will adopt digital tools like enabling electronic prescriptions from acute care direct to community pharmacy and improve access to discharge medicines services. • We will reduce carbon emissions by reducing medicines waste and engaging with medicines recycling schemes.	• People are healthier with better controlled long term conditions because medicines are used safely and well. • Fewer people go to hospital because of side effects from medicines. • Less medicines waste • Smaller impact on the environment.	• People will get their medicines more quickly and easily from their pharmacist. • Care will feel smoother and safer because health information is shared securely. • Medicines and how they are supplied will be better for the environment with less waste.
2	**We need to integrate Community Pharmacy into the neighbourhood NHS. We will do this by :** • We will develop the "modern community pharmacy" model, embedding pharmacies as key partners in neighbourhood health care, supported by our wider pharmacy workforce. • We will support the transformation of community pharmacy, expanding clinical and prevention services to improve access. This may include transformation of medicines supply over time, maximising robotics and hub-and-spoke models. • We will mobilise national clinical and prevention services and develop community pharmacy workforce and capability to deliver new local services. • We will build a culture of co-operation and trust between community pharmacies and GP practices to ensure accessible, seamless primary care.	• More people get care including medicines and vaccinations quickly, especially those who find it hard to access healthcare. • Better care for long-term and urgent health needs. • Fewer gaps and delays in treatment.	• More care and advice from local pharmacies, close to home. • GP practices specialists and community pharmacy will work together, to join up care. • Improve access to medicines and urgent help, especially for people who usually face barriers.

Medicines Optimisation and Pharmacy

Priority	What is the change we need to make?	What does success look like? [DN: What are the key outcomes?]	What will be different in five years?
3	**We need to get the best value from medicines and continue improvements in medicines safety and antimicrobial stewardship. We will do this by:** • We will improve population health and maximise value from medicines by commissioning high-value prescribing pathways. • Through strong governance, we will adopt national best-practice prescribing and contribute to the single national formulary. • We will strengthen preparation for high-impact NICE medicines to support rapid uptake. • We will commission safe medicines optimisation services, implement safety alerts, and work with partners to advance antimicrobial stewardship.	• Safer prescribing and fewer medicine-related problems. • Lower rates of antibiotic use and resistance. • More people are offered effective medicines which are right for them. • Cost effective medicines are offered to people who need them faster.	• Taking medicines will feel safer, with clear safety checks in place. • New treatments recommended on the NHS will be accessible faster and more equitably. • Reduced use of medicines which are less effective and less waste. • Antibiotics will keep working.
4	**We need to prioritise prevention, personalised care for people with long term conditions and tackle overprescribing. We will do this by:** • We will find and treat long-term conditions early through strategic commissioning of proactive primary care, case finding and medicines optimisation services. • We will reduce the numbers of people unnecessarily taking multiple medicines through continued development of our overprescribing programme. • We will commission personalised care pathways including new innovations (eg **genomics**, weight management medicines). • We will promote prevention (vaccination, vital 5) and support self management through all pathways and services.	• Better control and prevention of long-term conditions • Fewer people take too many medicines. • More people have personal care plans and access to genomic medicine. • Proactively support clinical trials and innovation, particularly in primary care.	• More help for long-term conditions sooner with more focus on prevention. • Reduced unnecessary and inappropriate prescriptions. • Treatments will be more personalised, using the latest advances such as genomics.

Medicines Value

Asthma

Prescribing patterns mapped to Emergency Department attendance & admissions

- Prescribing costs variation across SEL is significant
- Correlation between over-prescribing of Short-Acting Beta-Agonist (SABA) medicines, prescribing costs and Emergency department attendance & admissions
- National Review of Asthma Deaths – reduce or eliminate SABA use to reduce risks of hospitalisation and death

Increased respiratory prescribing spend ≠ better outcomes

Spending **more** on medicines doesn't necessarily correlate with better outcomes in asthma (as defined by ED attendance and admissions data)

Focus should instead be on medicines **value**, prescribing **quality**, and improving medicines **optimisation** of drugs that are prescribed (eg inhaler adherence and inhaler technique)

Total respiratory prescribing cost vs ED and admissionsactivity, by PCN March 2025

£350
£300
£250
£200
£150
£100
£50
£0

7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%

prescrbing cost £ per asthma patient
% asthma ED and admissions of register
Linear (prescrbing cost £ per asthma patient)
Linear (% asthma ED and admissions of register)

Reduction in SABA prescribing linked to reduced ED & admissions?

Prescribing of 6+ SABA relative to ED attendance and admissions for asthma, by PCN March 2025

6+ SABA % | % asthma ED and admissions of register | Linear (% asthma ED and admissions of register)

As per the National Review, there is local data to support association of SABA prescribing with adverse outcomes as measured through ED attendance and admissions for asthma

SABA-free treatment linked to reduced ED & admissions

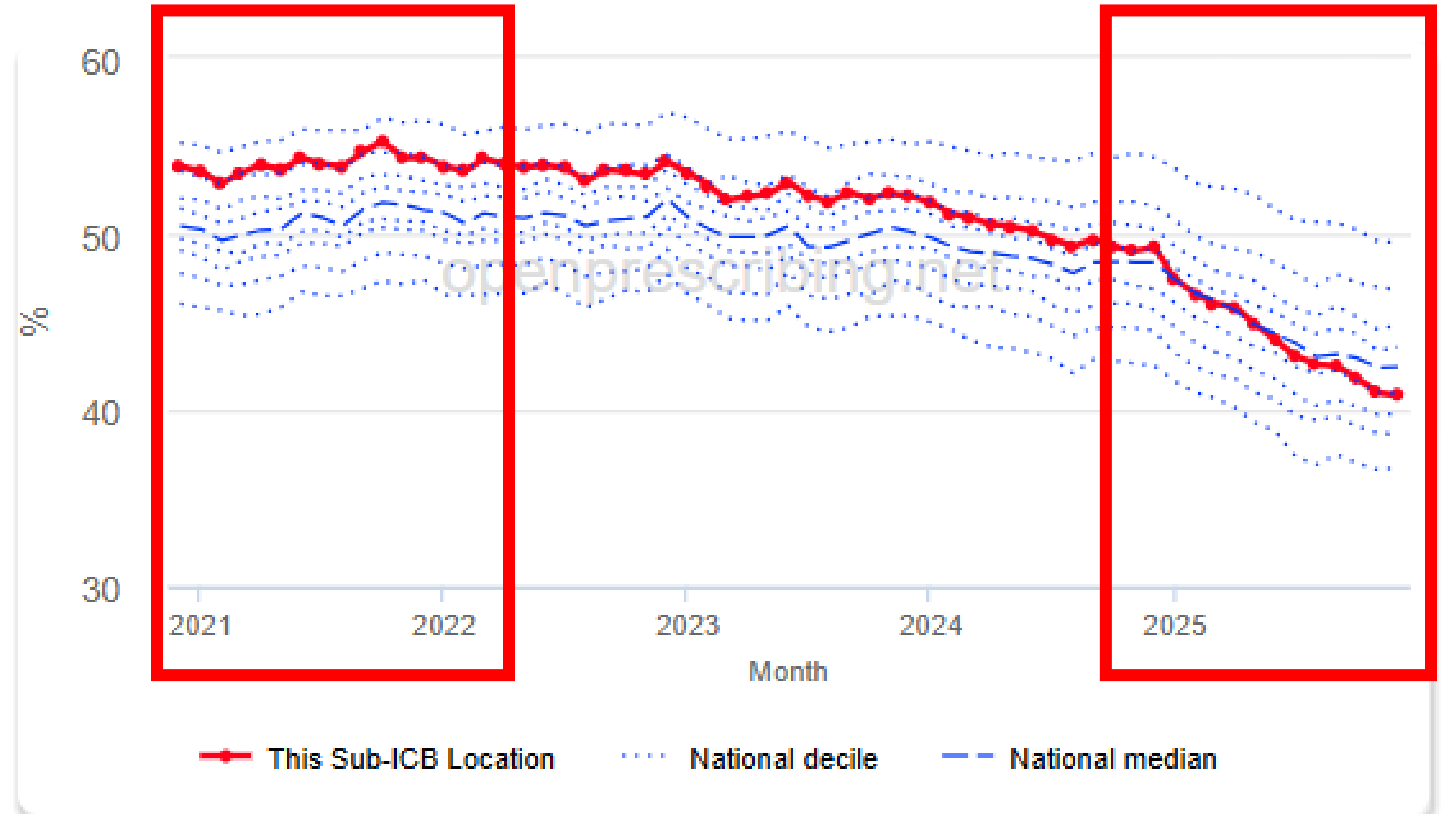
Prescribing of SABA-free treatment vs ED and admissions for asthma, by PCN March 2025

25%
20%
15%
10%
5%
0%

% SABA-free | % asthma ED and admissions of register | Linear (% SABA-free) | Linear (% asthma ED and admissions of register)

- Correlation between increasing uptake of SABA-free treatment and ED attendance or admissions
- This is aligned to the previous data showing the opposite with increasing use of SABA

Salbutamol prescribing



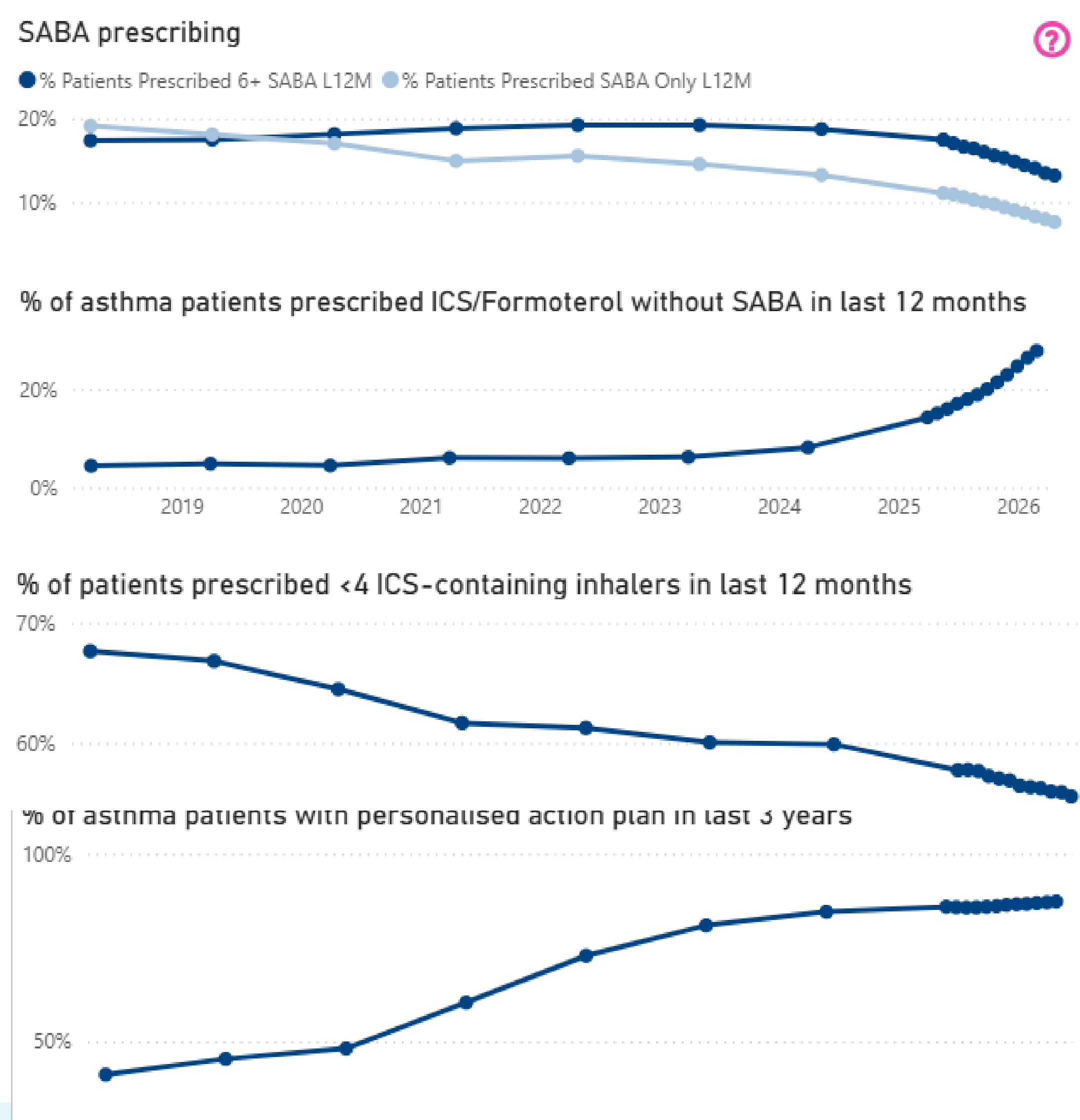
From OpenPrescribing www.openprescribing.net

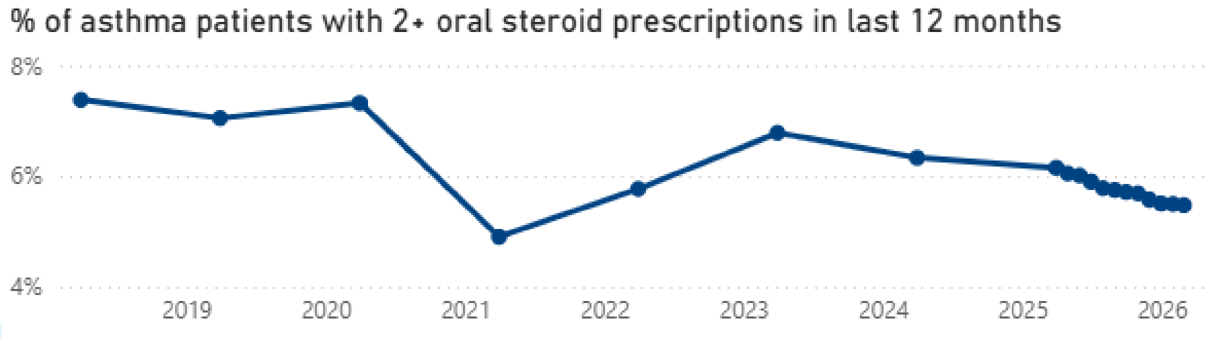
- **SE London was amongst the worst performing ICBs nationally for SABA prescribing**
- **Strong proxy indicator for poor asthma management**
- **Carbon impact**
- **National benchmarking**
- **What has driven change?**

Impact of new treatment approaches

Implementation of our SEL asthma guideline, incorporating SABA-free treatment pathways (ICS+Formoterol, without SABA) has:

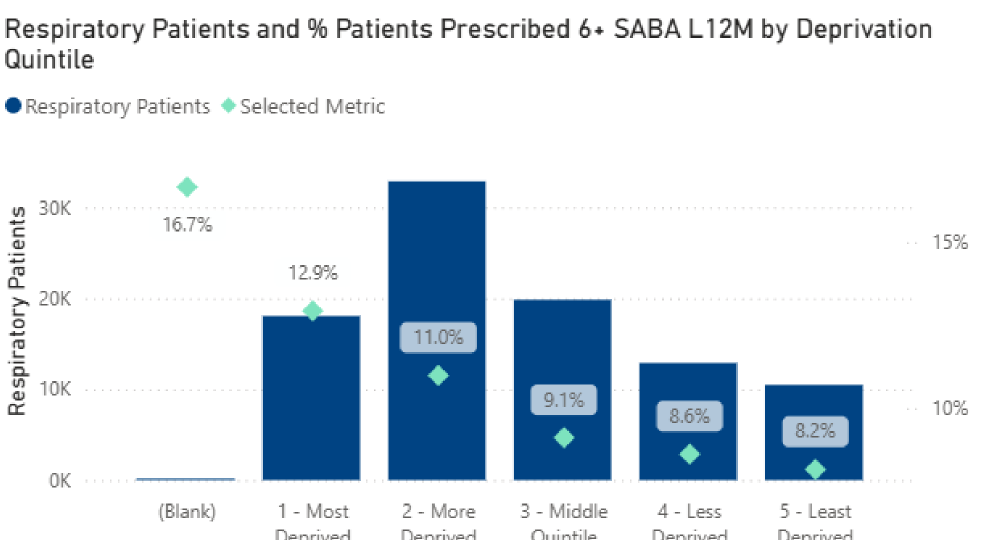
- Reduced SABA prescribing significantly, especially in SABA-only prescribing
- Improved adherence to inhaled corticosteroids
- Increased use of personalised asthma action plans
- Reduced need for oral corticosteroid rescue treatment

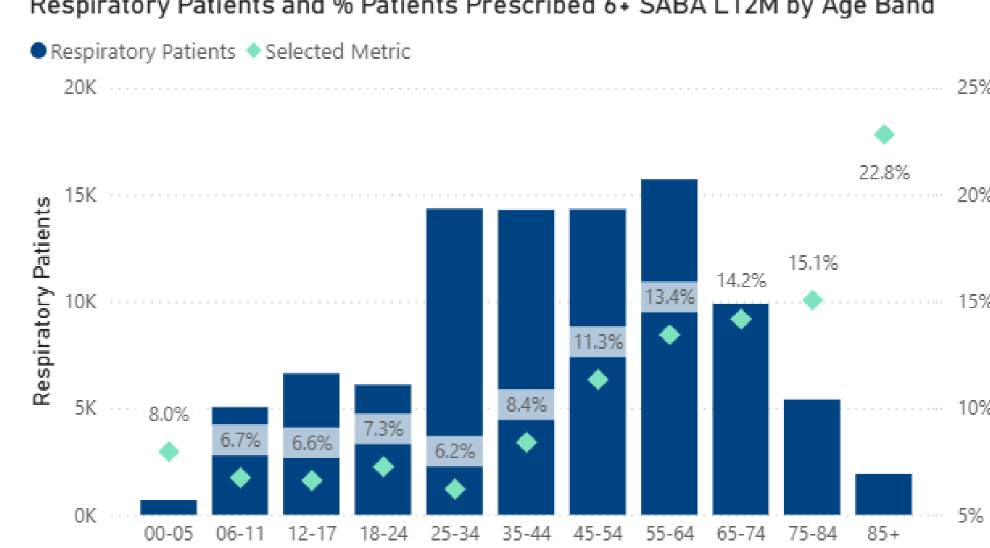




From NHS South East London asthma dashboard (internal data)

Inequalities lens





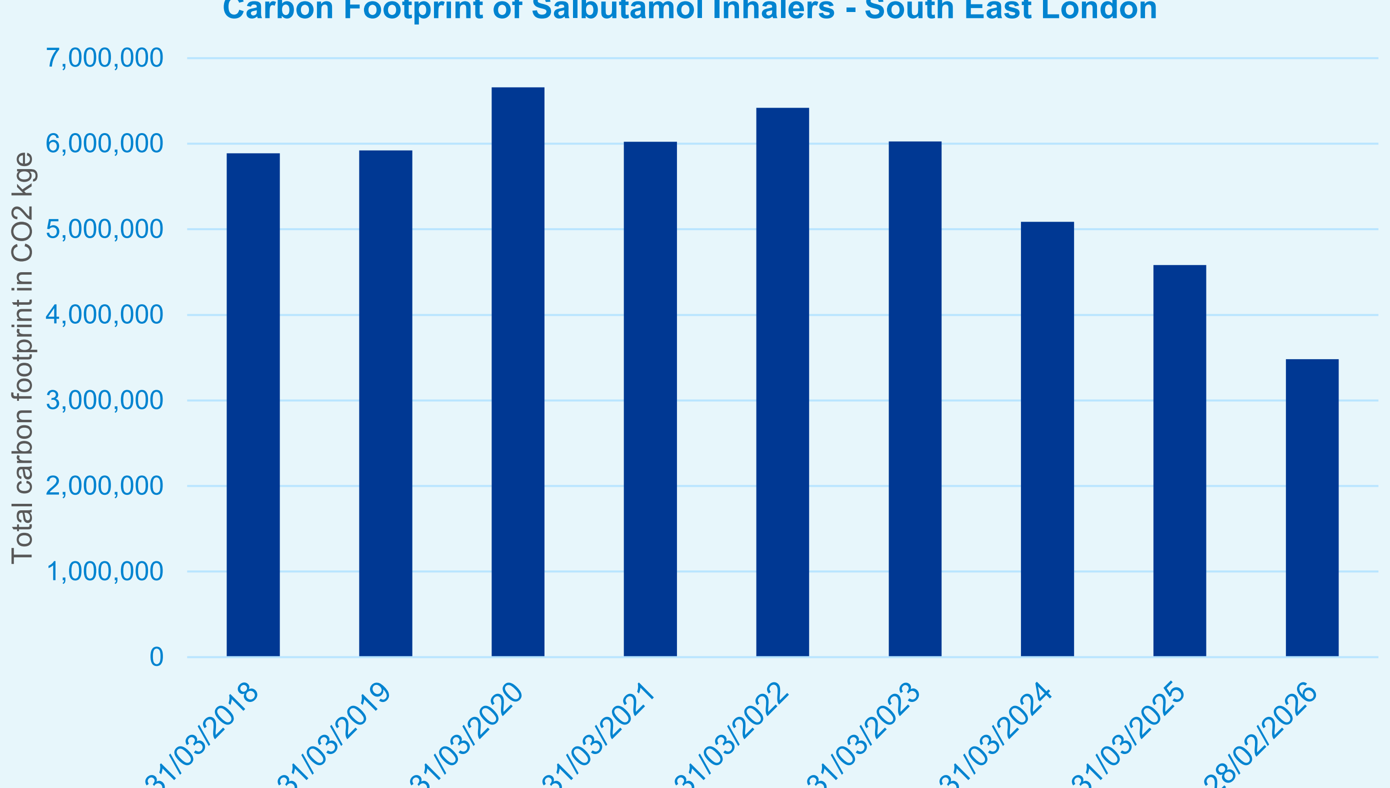
- Prescribing of SABA-free treatments is fairly uniform across deprivation quintiles and age bands
- However, if you’re older and / or experiencing higher deprivation, you are more likely to be over-reliant or over-prescribed SABA, and therefore at greater risk of poor asthma control and adverse outcomes

From NHS South East London asthma dashboard (internal data)

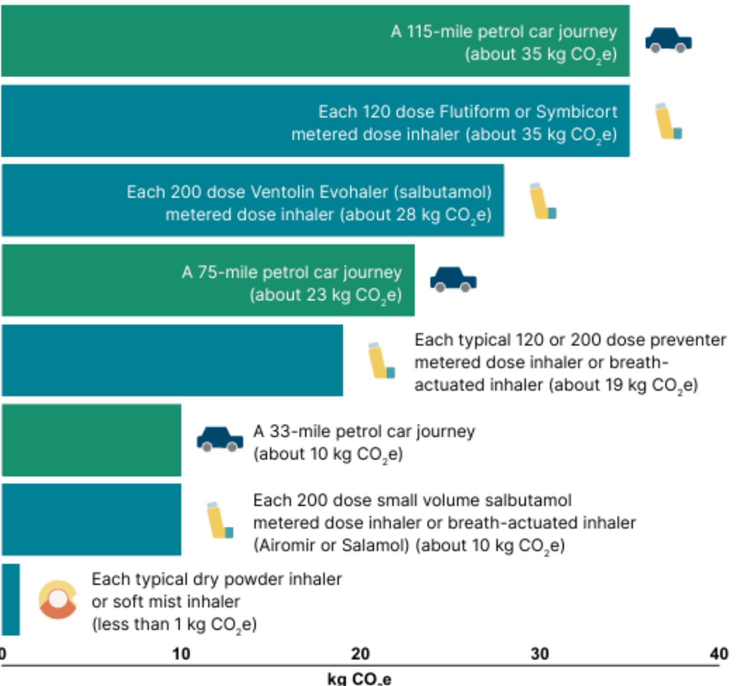
Environmental impact

Reducing inhaler use is not only good for patient outcomes, but for the planet too!

We have reduced CO_2 emissions from salbutamol alone by >2.5M kg



From NHS South East London asthma dashboard (internal data)



From NICE resource pack for asthma www.nice.org.uk

Adopt best practice to reduce impact on resource utilisation and improve outcomes

- Adopting clinical best practice is associated with reduced ED attendance and admissions for asthma
- Whilst SABA-free treatment is costlier than SABA therapy, moving away from treatments relying on SABA is associated with overall lower costs in respiratory drug treatment and reduced ED attendance and admissions
- Other factors such as promoting adherence and checking inhaler technique, use of personalised action plans and other interventions may be confounding factors
- We are working with data teams to further understand the links between pathway and treatment changes and impact on adverse outcomes, hospital ED attendance and admissions

Innovation in medicines

- Annual horizon scanning has identified key innovations to be considered by the National Institute for Health and Care Excellence (NICE) in 26/27. The likely cost impact of the top 5 innovations is highlighted below. System readiness to provide access to these medicines for our population involves financial and service capacity planning (e.g. staff, diagnostics, clinic appointments, shared care with primary care)
- In total, there is a cost pressure of up to £13.2million for acute Trusts and £12.1million for primary care due to upcoming NICE Technology Appraisals expected in 2026/27.

Acute Trust cost pressures		
Drug	**Indication**	**Cost pressure in 26/27**
Brensocatib	Non-CF bronchiectasis	£5,100,000
Dupilumab	COPD	£3,623,928
Resmetirom	Metabolic dysfunction-associated steatohepatitis	£1,640,000
Sibeprenlimab	Glomerulonephropathy	£1,313,760
Teplizumab	Type 1 diabetes	£918,888

Primary Care cost pressures		
Drug	**Indication**	**Cost pressure in 26/27**
GLP1 agents	Type 2 diabetes (earlier use)	£3,360,000
Semaglutide	Preventing major cardiovascular events in people with CVD and living with overweight or obesity	£2,615,725
SGLT2 inhibitors	Type 2 diabetes	£1,459,500
Tirzepatide, semaglutide and newer agents	Overweight and obesity	£836,010
Sacubitril valsartan	Heart failure (earlier use)	£785,211

26/27 Primary Care Medicines Horizon Scanning : £12.8m

Primary care cost pressures for SEL		
Drug	**Indication**	**Expected Costs in 26/27**
GLP1 agents	Type 2 diabetes (earlier use)	£3,360,000
Semaglutide	Preventing major cardiovascular events in people with CVD and living with overweight or obesity	£2,615,725
SGLT2 inhibitors	Type 2 diabetes	£1,459,500
Tirzepatide, semaglutide and newer agents	Overweight and obesity	£836,010
Sacubitril valsartan	Heart failure (earlier use)	£785,211
CGM	Type 2 diabetes	£582,750
Daridorexant	Insomnia	£372,330
Adrenaline intranasal	Anaphylaxis	£315,525
CGM	Type 1 diabetes - adults	£291,900
Linzagolix & relugolix	Endometriosis (pain associated with)	£257,397
Finerenone	Heart failure with preserved or midly reduced EF	£241,938
Gepotidacin	Urinary tract infections	£193,358
Rimegepant	Migraine - acute treatment	£192,675
deutetrabenazine	Tardive dyskinesia (moderate to severe in adults)	£179,603
Empagliflozin	CKD	£147,000
obicetrapib + ezetimibe	CVD - lipids	£131,250
Inclisiran	CVD - Lipid management	£126,000
atropine sulfate	Myopia (childen aged 3 - 14 years)	£125,843
Semaglutide	CKD in adults with type 2 diabetes	£123,375
Atogepant & rimegepant	Migraine prevention	£92,400
Glycopyrronium bromide	Hyperhidrosis - severe primary axillary in adults	£80,483
obicetrapib	CVD - lipids	£78,750
elinzanetant	Vasomotor symptoms associated with menopause (moderate - severe)	£59,525
insulin efsitora alfa	Type 2 diabetes - adults	£55,886
fezolinetant	Vasomotor symptoms associated with menopause (moderate - severe)	£54,154
Icosapent Eythyl	Lipid management	£42,000
Total		**£12,800,585**

These are new medicines or medicines with new indications which are being considered by NICE and their estimated costs if approved for 26/27.

Other important developments with an impact.

- Move towards a single national formulary over the next 2-5 years in line with the 10 year plan
- NICE – changes to QALY threshold are expected from April 2026 meaning more medicines may be approved. Pace already faster than previous years.
- Left shift of services into community is likely to increase primary care prescribing costs as pathways and services move

Patent Expiry and Biosimilars

Dapagliflozin

Generic dapagliflozin (following loss of exclusivity for Forxiga) is already delivering c.£397k per month savings in primary care prescribing

We have an active first-half 2026/27 switch programme planned to increase total savings by a further **£4.773m.**

Biosimilars are medicines that are highly similar to an existing biologic drug, with no clinical difference in safety or effectiveness, and are typically available at lower cost once patents expire.

They offer a major opportunity to improve medicines value, delivering clinically equivalent outcomes at lower cost and enabling reinvestment into patient care and service transformation. Realising benefits depends on timely switching, pathway alignment and supply stability, with delivery varying by molecule, market maturity and local implementation complexity.

Key biosimilars

🟢 Ustekinumab –High switching rates achieved across gastroenterology and dermatology. All new and existing patients initiated on biosimilars. Material in-year savings flowing, with the majority realised in 25/26. Largest single contributor to biosimilar medicines value savings.

Savings delivered indicate **£4.3m in** 25/26 with £2.7m delivered in H1 25/26

🟢 🟡 Aflibercept –Rapid uptake following market entry, with near-100% adoption in acute settings once stock available. Additional savings also possible as cost avoidance through best-value biologic use. Minor operational constraints (e.g. outsourced outpatient pathways) affect small volumes only.

Saving : **£6.9m** across SEL Trusts in 26/27

🟡 Denosumab –Patent expiry late 2025 with significant savings potential across primary and secondary care. Implementation readiness in place (systems, patient communications, clinical agreement). Savings delayed due to pricing confirmation, stock availability and cross-sector complexity. Delivery expected once supply stabilises.
Saving **£0.6m** across SEL Trusts in 26/27

Ustekinumab: delivered (🟢) | Aflibercept: delivering (🟢 🟡) | Denosumab: pending but planned (🟡)

Project report – Best Value Biologics: Aflibercept biosimilar

Metric	Benchmark	ICB performance
Accelerated adoption of best value biologics in *90% of new patients within 2 months of biologic launch.	90%	KCH: 95% up to 11th March GSTT: 100% up to 9th March
Adoption of best value biologics in 80% of existing patients within 5 months of a biologic launch.	80%	KCH: 95% up to 11th March GSTT: 100% up to 9th March

**The National target of 100% of new patients initiated within 3 months is recognised as the overall goal.*

Target savings in SEL 26/27	NHS E Productivity packs estimate savings of £6.9m across SEL Trusts
Savings to date (calculated as cost avoidance using biosimilar compared to originator usage)	GSTT: £43,092 KCH: £329,184 **Total: £372,276 (up to Feb 2026)**

Summary of key activities and progress to date:

- EPIC drug build, ongoing workflow transformation project
- Biosimilar aflibercept Vgenfli® available as staggered stock supply from Mid Jan 2026 (40% M1, 60% M2, 75% M3) – *now updated to 100% M3 via SPS procurement team*
- Depletion of originator stock mid Feb 2026
- New naïve starters from early Feb 2026 initiated on biosimilar. AT KCH stock initiation staggered over three sites to maximise usage of biosimilar in line with allocation
- Full switch will be completed mid march for all sites naïve and returning patients including insourcing

Escalations within organisation: Awaiting internal discussions on reporting mechanisms of expenditure based on reimbursement model from M1 26/27.

Key highlights with narrative on successes and/or blockers to delivery:

Successes:

- Stock received and switch initiated in line with allocation.
- Stock available from mid Jan 2026 –switch fully complete March 2026 for all patients and going forward only biosimilar will be stocked.

Blockers:

- Competing medicine launched (high dose aflibercept and pressure from Faricimab manufacturers to reduce prescribing).
- Biosimilar communicated as not fully available until April 2026, updated to March 2026 without sufficient notice to run down stocks.

Key risks that may impact delivery of milestones	Mitigations of risks and/or issues
Stock not fully available until M1 26-27	Roll out delayed for one month post availability to minimise drug selection confusion to allow for full switch within clinic (from 17th Feb 2026) at GSTT. At KCH, allocation used to maximum by rolling out site by site to reduce risk whilst using maximum biosimilar.
Growth of service to manage over capacity	Awaiting input from service management teams
Device is more challenging for staff to use	Escalated nationally and product redesign expected

Key actions for next month:

- Monitor for any adverse reactions compared to originator or switch back requests.
- To identify capacity expansion plans and expected service growth.

ICS Medicines Value – System Sustainability Projects

Key areas	Aim is to	Key outputs	KPIs for 2025-26	2025-26 Milestones
1. Driving sustainable and cost-effective diabetes and weight management in the ICB	• Reducing health inequalities and improving equitable access to medicines	• Maximising medicines optimisation opportunities as indicated in national identified priorities • Increasing adoption of new generics and biosimilars for priority molecules to a minimum of 80% within 6–12 months	• ≥91.90% of patients prescribed a formulary approved DPP-4 inhibitor of all people prescribed any DPP-4 inhibitor OR ≥8% point increase compared to baseline • ≥52.63% of patients prescribed an NHSE or SEL preferred blood glucose testing strip (BGTS) costing • Adoption of biosimilar insulin to 50% within 12 months • 80% of generic prescribing of Dapagliflozin	• Q1 – Mainstream Lead SEL Integrated Diabetes & Obesity Pharmacist 0.5 WTE x 8b • Q4 – £4,206,000 savings
2. Rationalisation of unlicensed specials and ADHD medications	• Manage the exponential growth on ADHD medications • Implement evidence-based Pill School to empower children with lifelong self-care skills, improve cost savings and reduce environmental impact	• Pill School training sessions for healthcare professionals • Development melatonin choice for adults (paediatric is in place) • Development of ADHD transition pathway from children and young people to adults/from private to NHS	• 25% switch of melatonin/ methylphenidate MR to the most cost-effective preparation • 25% switch of Ritalin® to generic methylphenidate IR • 20% of unlicensed omeprazole specials liquid switch to oral solid dosage • 10% reduction of spend on unlicensed specials	• Q1 – Mainstream Paediatric Medicines Value Pharmacist 1 WTE x 8b and Highly Specialist Pharmacist SEL Paediatric 0.8 WTE x 8a • Q4 – £366,712 savings
3. Medical appliance prescribed in primary care	• Adopt a system-wide approach to optimise prescribing, procurement and patient pathway for medical appliances, with an initial focus on dialysis pouches and lower limb wound care, followed by stoma and continence products.	• Scope products that are above national/regional average. • Agreement of single formulary • Explore the most cost-effective and convenient supply routes for both patients and staff • Work in partnership with community providers network and dispensing appliance contractors (DAC)	• Bringing expenditure in line with the regional average presents an opportunity to release around £1.2 million in savings, supporting wider system sustainability. • Work collaboratively with regional and national colleagues, drawing on pharmacy and clinical expertise to inform and shape the procurement of medical appliances. • Standardise access across SEL, ensuring equity for patients while delivering greater value for the system.	• Develop a position statement for dialysis pouches aligning with SWL • Q1 – Appointment of a project manager to lead and drive the transformation work across system • Q4 - £33,000 savings
4. SEL Homecare Transformation	• Stabilise and transform SEL pharmacy homecare capacity, enabling timely onboarding of patients, safer prescribing, and consistent system-wide delivery.	• Collaborative, cross-trust stabilisation and transformation of homecare services, releasing capacity and improving efficiency across SEL.	• Deliver £454k recurrent annual savings for SEL ICB (c.£2.3m over 5 years) • Reduce invoice backlogs, interest charges, delayed treatments and patient safety incidents; improve resilience across tertiary and specialist services	• Establish a workplan to improve productivity through standardised processes, shared capacity across trusts, and removal of low-tech or low-value medicines from homecare where more appropriate supply routes exist.

Critical Pharmacy Services

Home Oxygen Contract and Services

The London Home Oxygen Service (HOS) is a pan-London commissioned service that provides oxygen therapy to patients in their own homes where clinically required.

It is commissioned jointly by the five London ICBs, with SEL ICB medicines team hosting and leading the service on behalf of the system.

HOS enables safe, equitable access to oxygen, supporting people with long-term and complex conditions and reducing avoidable hospital activity.

The London HOS team provides strategic commissioning, contract management and clinical oversight, ensuring consistent quality, safety and value across London.

Strong system leadership has enabled improved value for money and VAT-efficient delivery of oxygen as a prescribed medicine.

- The London Home Oxygen Service has delivered significant financial benefit through both contract reform and VAT optimisation.
- A new HOS contract commenced in October 2025 with prices around 30–38% lower than the previous supplier
- This delivered £2.1m savings in 2025/26 (part-year) and £3.9m recurrent savings from 2026/27, subject to activity levels.
- In parallel, the London HOS team secured HMRC agreement to zero-rate home oxygen for VAT.
- This is resulting in a backdated VAT refund of £5-6m across London and ongoing recurrent VAT savings embedded in the new contract.

Illustrative image generated using AI.

Pharmacy Homecare

- Pharmacy homecare is the supply of specialist, high-cost medicines directly to patients in their own homes, often with nursing support, training, and monitoring.
- It is used where medicines are unsuitable for GP prescribing and are best managed by hospital specialist teams.
- Homecare enables care closer to home, reducing the need for outpatient visits, day-case activity, or inpatient stays.
- Medicines supplied via homecare are VAT-exempt, delivering significant savings to the NHS compared with hospital supply routes.
- Effective homecare requires robust pharmacy oversight, including prescribing, governance, contract management, and capacity to manage growth in demand
- The Homecare System Sustainability Programme (SSP) focuses on protecting and releasing existing VAT efficiencies from homecare medicines by stabilising and transforming pharmacy homecare capacity across SEL.
- The SSP business case identifies a planned saving of £454k per annum, calculated as a conservative proportion of historic VAT savings that would otherwise be lost through growth-related diversion to non-VAT-efficient supply routes.
- In addition to this SSP saving, the programme protects significantly larger system-wide VAT benefits (c.£60–70m per annum) and supports future efficiencies through improved consistency, capacity and governance of homecare services

Pharmacy Aseptic Services Transformation

Why change is needed

Demand for aseptically prepared medicines (e.g. chemotherapy, parenteral nutrition, high-risk injectables) is growing rapidly across London, driven by cancer activity, advanced therapies and care closer to home.

London's aseptic provision is fragmented and capacity-constrained, with many units operating from ageing estates and relying increasingly on commercial outsourcing, creating risks to resilience, cost and timeliness.

Current arrangements limit the NHS's ability to standardise practice, reduce waste, support clinical trials and advanced therapies, and release nursing time through ready-to-administer products.

Without transformation, SEL and London region faces increasing risks to patient safety, workforce sustainability and delivery of elective and cancer priorities.

What action is being taken?

A London Aseptic Transformation Programme has been established, led by NHS England London with ICB and Trust partners, supported by a Strategic Outline Case.

The programme is developing a hub-and-spoke model, including one or more regional aseptic manufacturing hubs, alongside continued investment in essential local capacity.

Work is underway to standardise product portfolios, improve productivity, strengthen supply-chain resilience, and enable wider use of ready-to-administer medicines.

A formal governance structure is in place, including the London Aseptic Oversight Group and a London Aseptic Transformation Programme Board established in February 2026, providing clinical, operational and strategic assurance.

The programme aligns with national aseptic strategy, workforce transformation, and future capital investment opportunities to deliver a safe, sustainable and scalable London model.

Illustrative image generated using AI.

Pharmacy Workforce

Strategic Context

Pharmacy workforce pivotal to delivery of 10-year Health Plan, particularly the shift to neighbourhood health (NH) and LTC prescribing services in community pharmacy (CP).

Pharmacy education reforms: **all newly registered pharmacists to be prescribers on day 1, from summer 2026**

NHS reforms: ICB move to strategic commissioning and development of neighbourhood care.

SEL One Pharmacy Workforce Model has been developed, endorsed by the People Committee is driving collaborative workforce transformation across diversity and equality, general practice pharmacy deployment, training, and recruitment/retention.

We are also piloting clearer scopes of practice for newly qualified prescribers and strengthened prescribing governance along with pharmacy technicians clinically screening prescribed medicines in hospital settings.

Key challenges

- Workforce transformation fatigue and inconsistent inclusion of community pharmacy.
- Limited clinical supervision capacity to support community pharmacists delivering prescribing services.
- Variation in deployment of the pharmacy profession across general practice and neighbourhood medicines optimisation.

Plans for 2026/27

- Refocus on pharmacy support and leadership for **neighbourhood-based models of care.**
- Work with **SEL Workforce Training Hub** to support primary care pharmacy professional development.
- Implement a test-and-learn approach to sustainable community pharmacist prescribing training. Scale up Designated Prescribing Practitioner (DPP) training to grow community pharmacist prescribers.

PCN Pharmacy Workforce

Job Role FTE weighted PCN patients by Borough

Job Role FTE per 1,000 weighted PCN patients, by Borough

Borough: Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark

Job role	Values shown
Pharmacist	0.15, 0.11, 0.10, 0.12, 0.05, 0.09
Care Coordinator	0.21, 0.05, 0.12, 0.08, 0.07
Social Prescribing Link Worker	0.03, 0.04, 0.05, 0.05, 0.08
Other	0.03, 0.03, 0.03, 0.06
Physiotherapist	0.03
Physician Associate	0.06
General Practice Assistant	0.06
Pharmacy Technician	0.03
Paramedic	
Health and Wellbeing Coach	0.04
Mental Health and Wellbeing Prac...	
Trainee Nursing Associate	
Advanced Nurse Practitioner	
Nursing Associate	
Manager	
Digital and Transformation Lead	
Advanced Pharmacist Practitioner	
Community Mental Health Nurse (...	
Mental Health and Wellbeing Prac...	
Podiatrist	
Senior Manager	
Dietician	
Healthcare Assistant	

0.0 0.1 0.2 0.3 0.4 0.5 0.6 0.7

FTE per 1,000 weighted PCN patients

SEL pharmacy workforce funded through the ARRS* scheme is substantial in PCNs.

A 2025 survey of SEL PCN pharmacy professionals (n=53) showed:

- 30% felt they were not being utilised to their fullest
- concerns also raised around clinical space and estates with around one third disagreeing or strongly disagreeing that they had adequate clinical space for face-to-face care.

*The Additional Roles Reimbursement Scheme (ARRS) is an NHS England initiative launched in 2019 that provides funding for Primary Care Networks (PCNs) to hire 17+ diverse roles, such as pharmacists, mental health practitioners, and physiotherapists. It aims to reduce GP workload pressures, improve patient access, and expand the multidisciplinary team, with funding covering salaries and on-cost

Medicines Safety, Antimicrobial resistance and net zero

Reduce severe avoidable medication-related harm by 1/3 by 2027

Patients and the public
Health care professionals
Medicines
Systems and practices of medication
KEY ACTION AREAS
Polypharmacy
Transitions of care
High-risk situations
MEDICATION WITHOUT HARM
Global Patient Safety Challenge
World Health Organization
Public awareness & medication literacy
Patient engagement
Reporting by patients
Involvement of patient organizations
Education & training
Communication & teamwork
Capability at point of care
Incident reporting & learning
Product quality & safety
Naming, labelling & packaging
Logistics, storage & disposal
Right product at point of care
Leadership & governance
Prescribing, preparation & dispensing
Administration & patient monitoring
Monitoring & evaluation

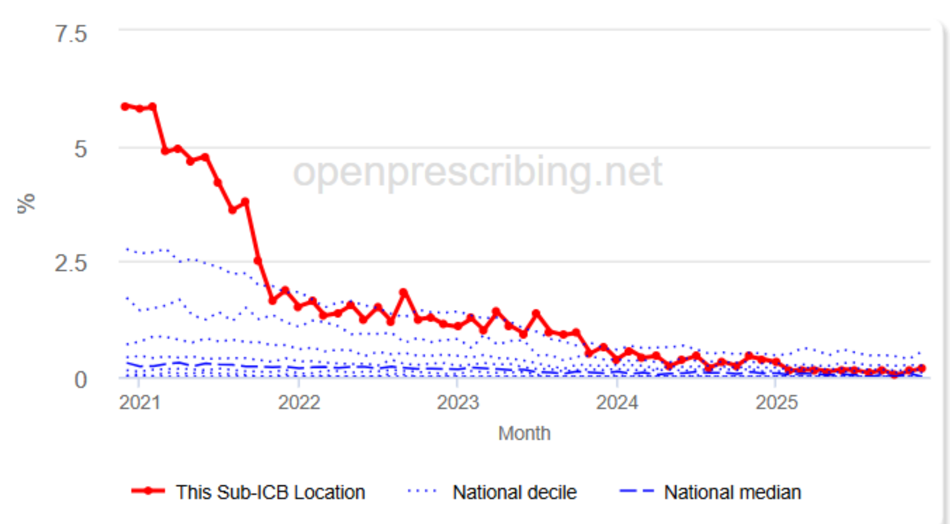
- **Productivity & Quality of Care**
- **Analogue to Digital**
  - **Empower the Medication Safety Officer workforce**
  - **Increase reliable administration of time critical medicines**
- **Hospital to Community / Neighbourhood**
  - **Reduce harm from psychotropics in learning disability**
  - **Reduce harm from opioids used in chronic pain**
- **Sickness to prevention**
  - **Reduce harm from valproate taken in pregnancy**
  - **Reduce acute kidney injury inducing polypharmacy**
  - **Perfect dosing of direct oral anticoagulants**
  - **Reduce harm from falls-risk inducing drugs in frailty**

Medicines Safety

The ICB Medicines Optimisation function provides system leadership, assurance and oversight to reduce medicines-related harm and ensure consistent patient safety across SEL.

- System leadership and assurance for safe, effective and value-based medicines use across primary care and system pathways, with escalation through IMOC to Quality & Safeguarding Committee.
- Coordinated delivery of national safety priorities, including compliance with patient safety alerts and medicines-related guidance, led through the Medication Safety Officer (MSO) function.
- Data-driven risk identification and harm reduction, using prescribing analytics and incident reporting to target high-risk medicines, polypharmacy, antimicrobial use and transitions of care.
- Strong system learning and collaboration, through the SEL Medicines Safety Network (bi-monthly MSO forum) reviewing PSIRF themes, Regulation 28 reports and safety incidents.
- Medicines shortage system responses and national alerts (14 in 2024; 20 in 2025 and 8 to date in 2026).

- Variation in care quality has a far greater impact on patient outcomes than marginal differences between drugs, meaning that standardising and improving how existing treatments are used offers more benefit than focusing solely on new therapies.
- Preventable medicines risk and inequity persist despite clear national guidance, illustrated by unsafe methotrexate prescribing, where local system factors — not lack of evidence — drive harm
- Data-driven transparency and cross-system collaboration can rapidly improve safety and equity, with OpenPrescribing enabling targeted local action that eliminated high-risk prescribing variation of methotrexate 10mg in South East London and nationally.



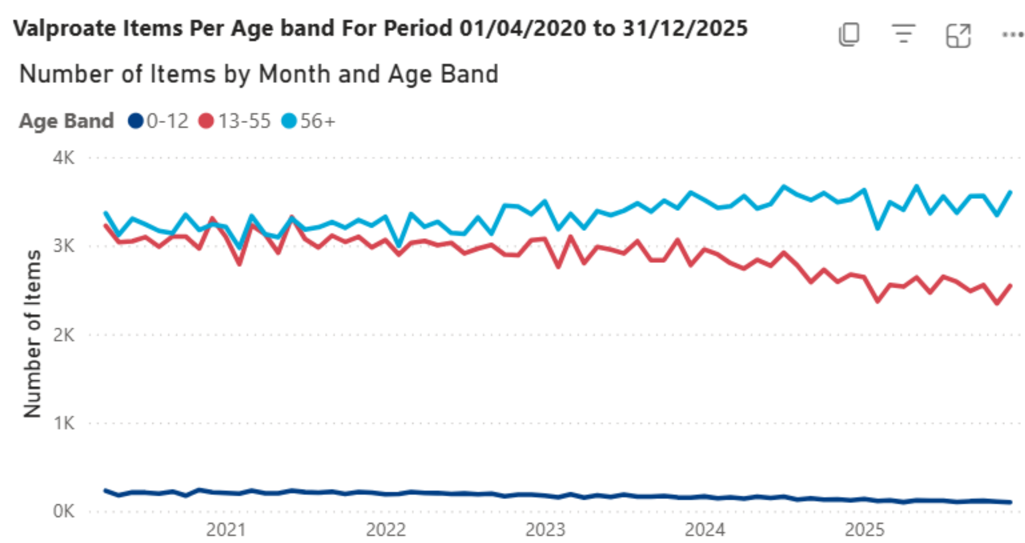
SEL (red line) significantly reduced potentially harmful prescribing of methotrexate 10mg by working across the system to embed safe prescribing.

Regional Response Medicines Safety System

London has established a coordinated, system-wide approach to implementing national medicines safety alerts, demonstrated through:

1. **NatPSA/2024/013/DHSC and NatPSA/2024/007/DHSC on Pancreatic Enzyme Replacement Therapy (PERT)**
   - The PERT plan prioritises patient safety, particularly for children, patients with cystic fibrosis and other clinically vulnerable groups. Licensed PERT remains first line, with prescribing and dispensing limited to one-month supplies to manage demand. Where licensed stock is unavailable, a London-approved route enables access to unlicensed imported Pangrol® via Oxford Pharmacy Stores, supported by clear prescribing, dispensing and patient communication arrangements across primary, secondary and community care.

2. **NatPSA/2023/013/MHRA on Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients**
   - The Valproate Integrated Quality Improvement (VIQI) Community of Practice provides national oversight and shared learning to support compliance with NPSA on valproate and topiramate use in people of childbearing potential.
   - The programme focuses on effective delivery of the Pregnancy Prevention Programme, digitisation and assurance of Annual Risk Acknowledgement Forms, and clarity of specialist, primary care and ICB responsibilities.



Prescribing data demonstrate sustained reductions in valproate use and very low pregnancy exposure, with residual risks managed through shared learning, ongoing assurance and transition to business-as-usual governance.

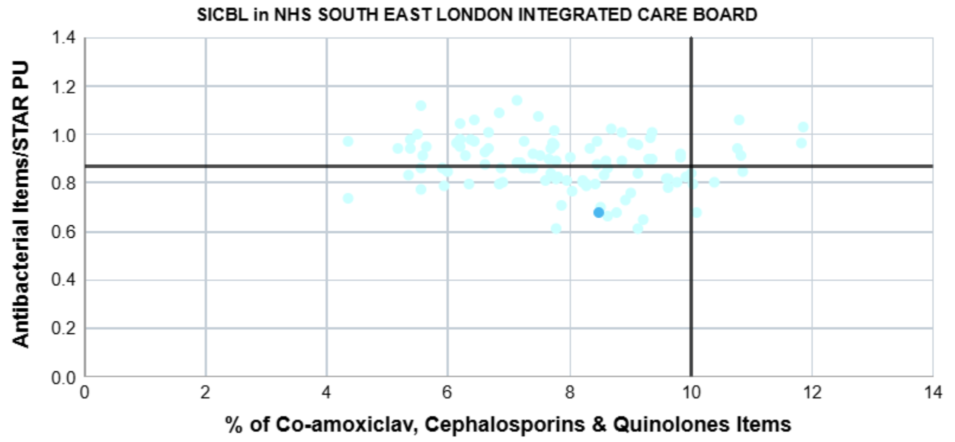
Medicines Optimisation Digital Enablement and Implementation:

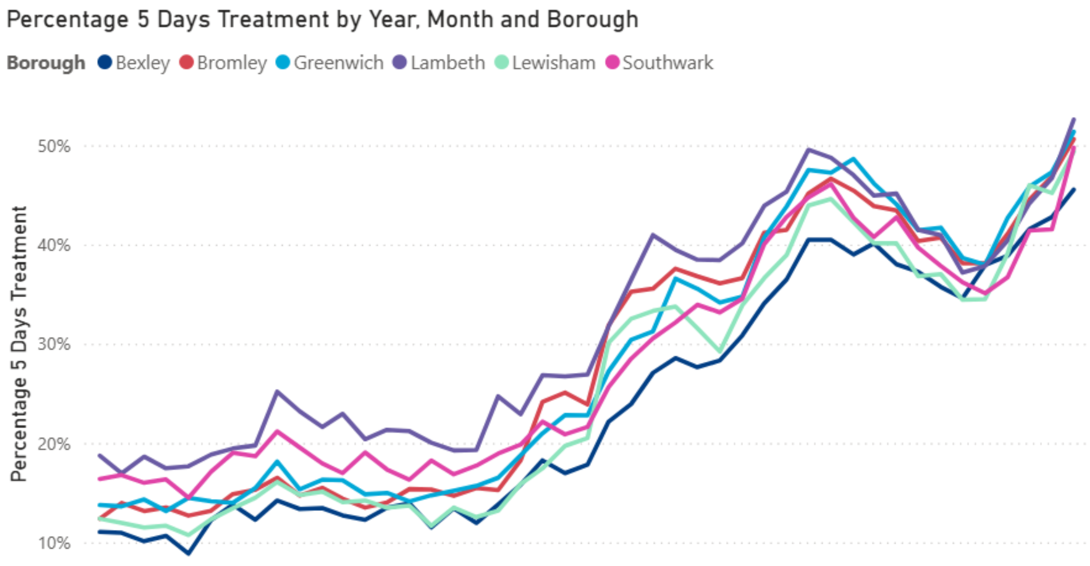
- Point-of-prescribing decision support through visible alerts or “hard stops” to ensure pregnancy prevention measures are confirmed
- Monitoring system and structured documentation to support clinical audits and quality improvement projects
- Digital recording of reproductive risk counselling and highly effective contraception
- Mandatory digital safety controls are required within EPRs, to be developed at national level with digital team.

Antimicrobial Stewardship

- The **Antimicrobial Prescribing & Medicines Optimisation (APMO) Workstream** aims to improve outcomes for patients with infections by promoting safe and effective antimicrobial use. Its objectives are to reduce unnecessary human exposure to antimicrobials, minimise selection pressure for antimicrobial resistance (AMR), and lower the environmental impact associated with antimicrobial use and waste.
- The workstream is led by the **SEL Forum of Antimicrobial Stewardship (SELFAS)**, which reports to the **Infection Prevention and Control (IPC)** and **Integrated Medicines Optimisation Committee (IMOC)**, and is ultimately accountable to the **Quality and Safeguarding Committee**.
- Delivery is enabled through collaborative approaches to AMR governance and digital leadership, alongside alignment with the **Medicines Optimisation Plan 2025/26** and implementation of digitally enabled **antimicrobial guidelines**.
- **Successes in SEL:**

1. Graph 1 shows that the ICB's position in the lower-left quadrant indicates comparatively low overall antibiotic prescribing and a lower reliance on broad-spectrum agents. This is consistent with good antimicrobial stewardship practice across both primary and secondary care, provided clinical outcomes remain appropriate.
2. Graph 2 shows that inclusion of a specific indicator within the Medicines Optimisation plan appears to have successfully increased adherence to 5-day amoxicillin prescribing. Rates improved from **15.6% in April 2023** to **31.6% in April 2024**, and further to **42.4% in April 2025**. This upward trend suggests that:
    - Raising awareness through targeted indicators can influence prescribing behaviour
    - There has been sustained improvement over time, rather than a short-term effect
    - Prescribing is becoming more aligned with antimicrobial stewardship guidance





NHS England Funding for UK Antimicrobial Resistance (AMR) National Action Plan (NAP) 2024-2029

SEL ICS was successful in all three bids for funding, that align with the NHS England digital vision for AMS and the UK AMR National Action Plan (NAP) 2024–2029.

Each project which will be delivered over the coming 2 years aim to embed lasting improvement in AMS/AMR through digital enablement, leadership, and governance.

Aims

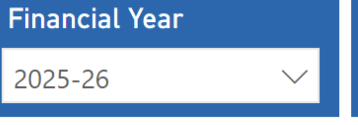
- Appoint a Single Operational Lead with authority across primary, secondary, and system-wide initiatives.
- Establish Combined Clinical Leadership for all 3 bids
- Create an Integrated Digital Workstream
- Harmonise Alerting and Messaging through a cross-system alert review panel.
- Embed Sustainability and Governance within existing ICB and provider structures.
- Develop Unified Monitoring and Reporting via a single dashboard accessible to all stakeholders.

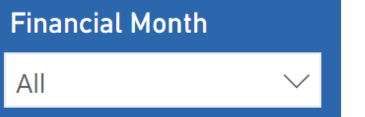
Overprescribing and Polypharmacy

1. Overprescribing

Summary | Practice | Savings

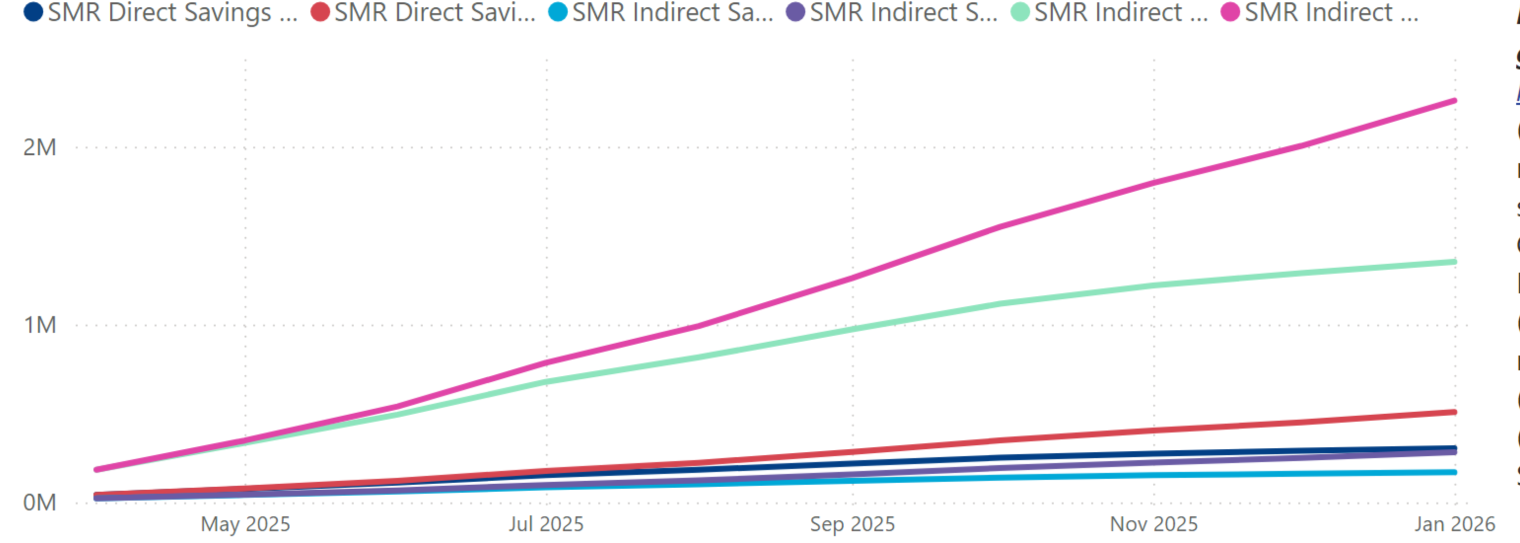
Borough › PCN › Practice: All





Please be aware that the SMR count and % of patients on SMR of all patients overprescribing Metrics are built using Primary Care data, and therefore data will only represent a rough approximation of the true value and should not be considered exact.

Monthly SMRs for patients 65+ being prescribed 10 or more unique medicines and associated savings for different methodologies



Savings are based on calculations from the iSYMPATHY study*.
The study costs were converted from Euros to GBP
Reference- *O'Mahony, C., Dalton, K., O'Hagan, L. et al. Economic cost-benefit analysis of person-centred medicines reviews by general practice pharmacists. Int J Clin Pharm (2024).
https://doi.org/10.1007/s11096-024-01732-y

(1a) Direct SMR savings - **£99** per SMR/ per annum (adjusted for 1 medicine stopped per SMR per annum and assuming that medicine will be stopped in 50% of SMRs to reflect the experience of our workforce) Calculated showing SMR Counts x 99 x Months till end of year (April is 12, May is 11, June is 10 etc.)

(1b) Direct SMR savings defined above, with each month showing a 12 month forecast (SMR Count x 99 x 12) instead of depreciating each month.

(2) The **indirect savings** from hospital avoidance -**£55** per SMR per annum

(3) The **indirect savings** from adverse drug reaction avoidance- **£441** per SMR per annum

Financial Year	2025-26										Total
	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	
SMR Counts over 65s	415	372	434	557	469	610	654	560	472	578	**5,121**
SMR Direct Savings Part Year (1a)	41,085	74,844	110,649	152,006	182,960	218,188	250,561	273,661	289,237	303,542	**303,542**
SMR Direct Savings Part Year (1b)	41,085	77,913	120,879	176,022	222,453	282,843	347,589	403,029	449,757	506,979	**506,979**
SMR Indirect Savings Part Year (2a)	22,825	41,580	61,472	84,448	101,645	121,215	139,200	152,034	160,687	168,635	**168,635**
SMR Indirect Savings Part Year (2b)	22,825	43,285	67,155	97,790	123,585	157,135	193,105	223,905	249,865	281,655	**281,655**
SMR Indirect Savings Part Year (3a)	183,015	333,396	492,891	677,119	815,005	971,927	1,116,134	1,219,034	1,288,418	1,352,143	**1,352,143**
SMR Indirect Savings Part Year (3b)	183,015	347,067	538,461	784,098	990,927	1,259,937	1,548,351	1,795,311	2,003,463	2,258,361	**2,258,361**

1. Overprescribing

Metric: % 75+ prescribed 10 or more unique medicines

Summary | Practice | Savings

South East London Integrated Care System

Please be aware that the SMR count and % of patients on SMR of all patients overprescribing Metrics are built using Primary Care data, and therefore data will only represent a rough approximation of the true value and should not be considered exact.

Please note the core-20 slicer will only affect the discovery metrics (65+ Overprescribing, 75+ Overprescribing and SMR metrics)

% 75+ prescribed 10 or more unique medicines by Date

11.0%
10.5%
10.0%
Jul 2023
Jan 2024
Jul 2024
Jan 2025
Jul 2025
Jan 2026
Date

Financial Year	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
2023-24	9.82%	9.95%	10.06%	9.94%	9.87%	9.77%	10.05%	10.07%	9.95%	10.32%	10.00%	9.95%	**9.98%**
2024-25	10.28%	10.18%	10.35%	10.32%	10.21%	10.15%	10.34%	10.22%	10.37%	10.48%	10.23%	10.33%	**10.28%**
2025-26	10.36%	10.54%	10.44%	10.77%	10.43%	10.73%	10.62%	10.42%	10.95%	10.75%			**10.60%**
Total	**10.16%**	**10.22%**	**10.29%**	**10.35%**	**10.18%**	**10.22%**	**10.34%**	**10.24%**	**10.43%**	**10.52%**	**10.11%**	**10.14%**	**10.27%**

% 75+ prescribed 10 or more unique medicines by Financial Quarter and Financial Year

10%
0%
2023-24 2024-25 2025-26
Q1
2023-24 2024-25 2025-26
Q2
2023-24 2024-25 2025-26
Q3
2023-24 2024-25 2025-26
Q4
Financial Year

1. Overprescribing

Metric

SMR Count for 75+ on 10 or more unique medi...

Summary | Practice | Savings

South East London Integrated Care System

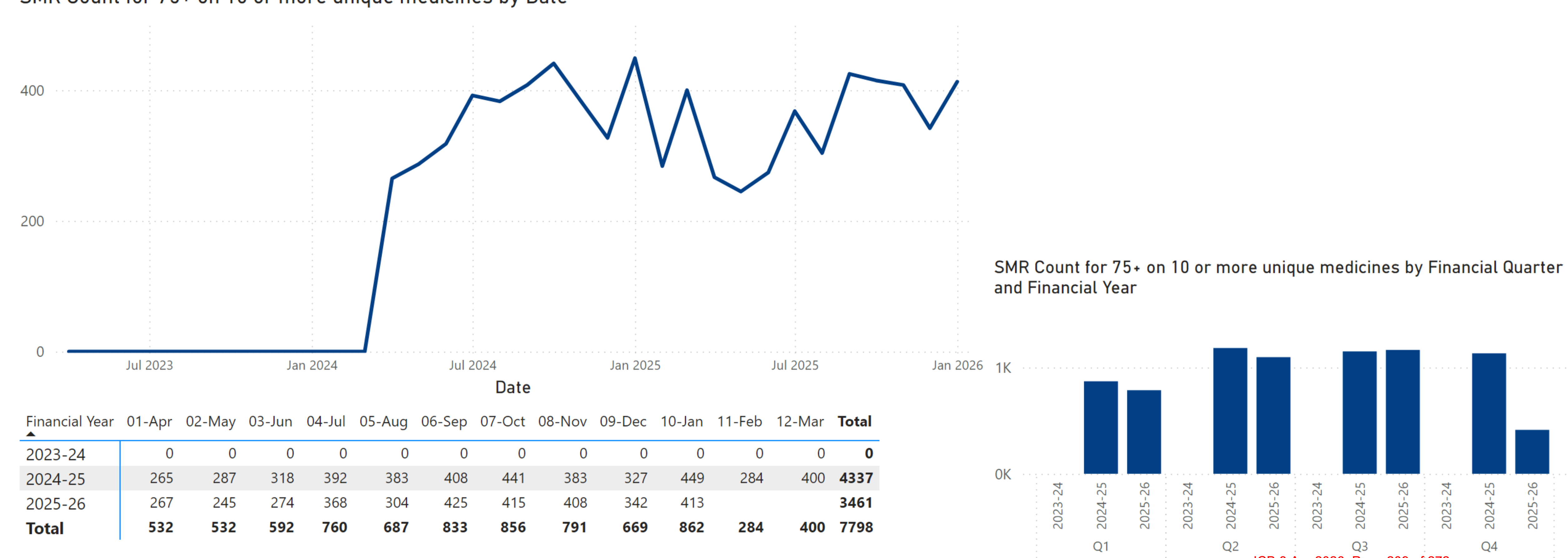
Borough › PCN › Practice: All

Core-20 Population: All

Financial Year › Month: All

Please be aware that the SMR count and % of patients on SMR of all patients overprescribing Metrics are built using Primary Care data, and therefore data will only represent a rough approximation of the true value and should not be considered exact.

Please note the core-20 slicer will only affect the discovery metrics (65+ Overprescribing, 75+ Overprescribing and SMR metrics)



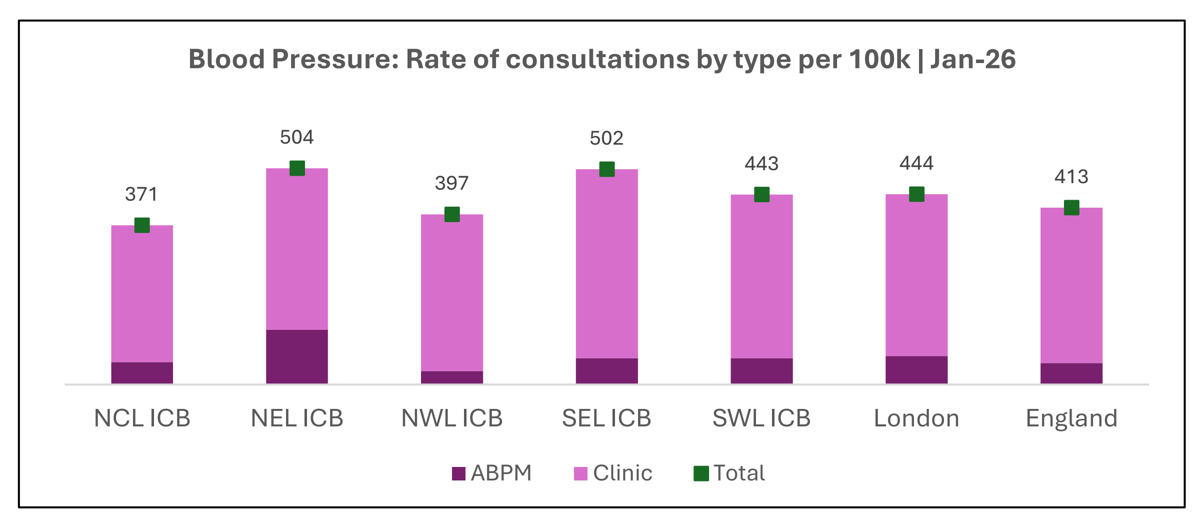
Financial Year	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	**Total**
2023-24	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2024-25	265	287	318	392	383	408	441	383	327	449	284	400	**4337**
2025-26	267	245	274	368	304	425	415	408	342	413			**3461**
Total	**532**	**532**	**592**	**760**	**687**	**833**	**856**	**791**	**669**	**862**	**284**	**400**	**7798**

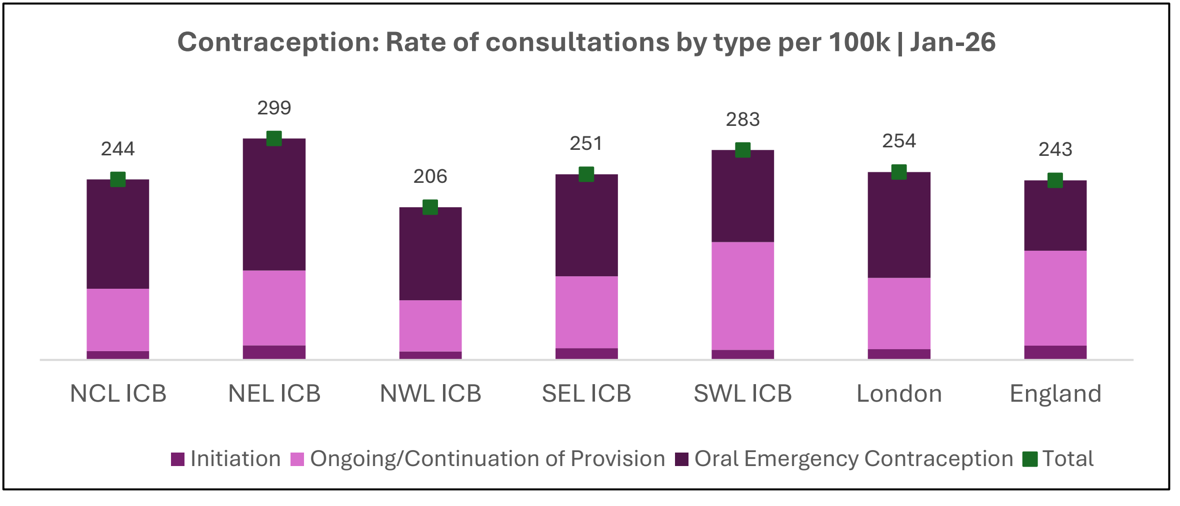
Neighbourhood Health and Community Pharmacy

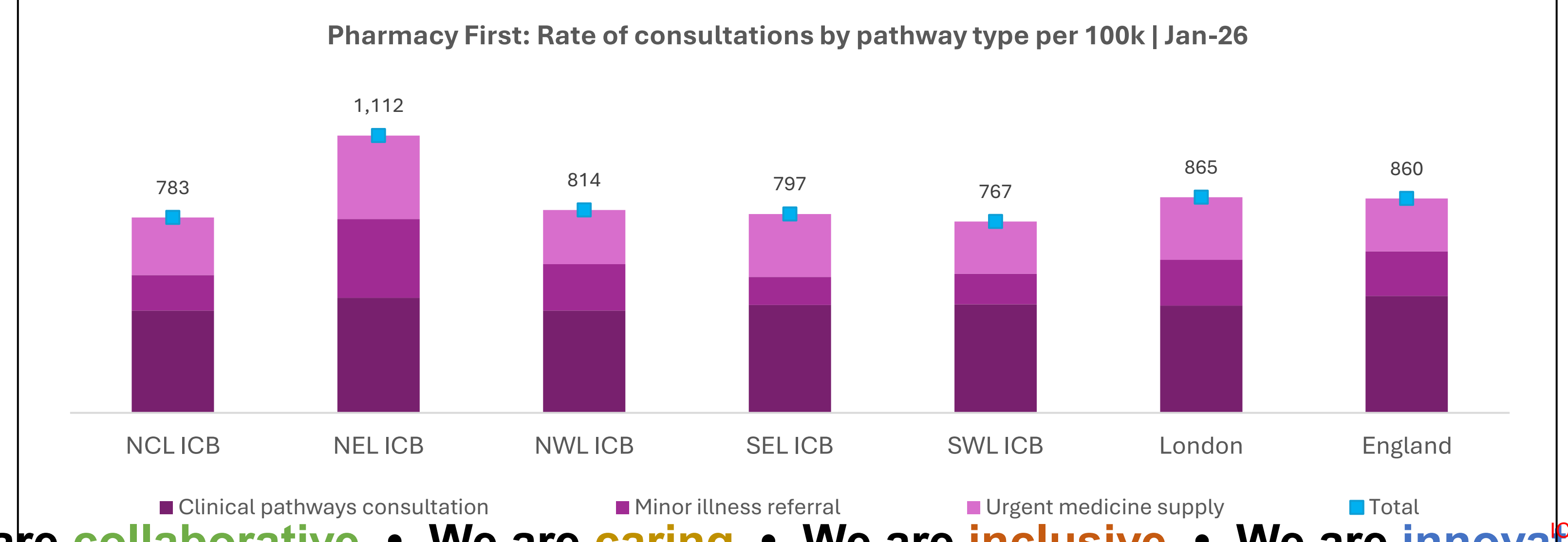
Supporting Data Pack

April 2026

Community Pharmacy: 3 national services rates of consultations per 100k – Upto Jan 26







Community Pharmacy: 3 national services element breakdown rates of consultations per 100k

Metric & Breakdown	NCL ICB	NEL ICB	NWL ICB	SEL ICB	SWL ICB	London	England
Blood Pressure: Rate of consultations by type per 100k | Jan-26							
ABPM	52.5	127.6	31.8	61.1	61.5	66.9	50.3
Clinic	318.8	376.4	364.8	441.1	381.2	376.9	362.3
Total	371.3	503.9	396.6	502.1	442.7	443.8	412.6
Contraception: Rate of consultations by type per 100k | Jan-26							
Initiation	11.9	19.8	11.3	15.9	13.6	14.5	19.5
Ongoing/Continuation of Provision	84.5	101.1	69.2	97.0	145.4	96.2	128.3
Oral Emergency Contraception	147.4	178.2	125.9	137.9	124.4	143.1	95.0
Total	243.8	299.0	206.4	250.8	283.5	253.9	242.8
Pharmacy First: Rate of consultations by pathway type per 100k | Jan-26							
Clinical pathways consultation	409.7	462.0	409.7	433.0	435.6	429.9	468.8
Minor illness referral	143.6	315.9	186.2	111.9	122.5	183.9	179.5
Urgent medicine supply	229.9	334.0	217.9	252.4	209.2	250.9	211.4
Total	783.2	1111.9	813.8	797.3	767.3	864.7	859.6

Percentage of Pharmacies Opted in to provide all 3 services (Jan 26)

Percentage of pharmacies opted in to provide all three services (Pharmacy First, blood pressure and contraception)

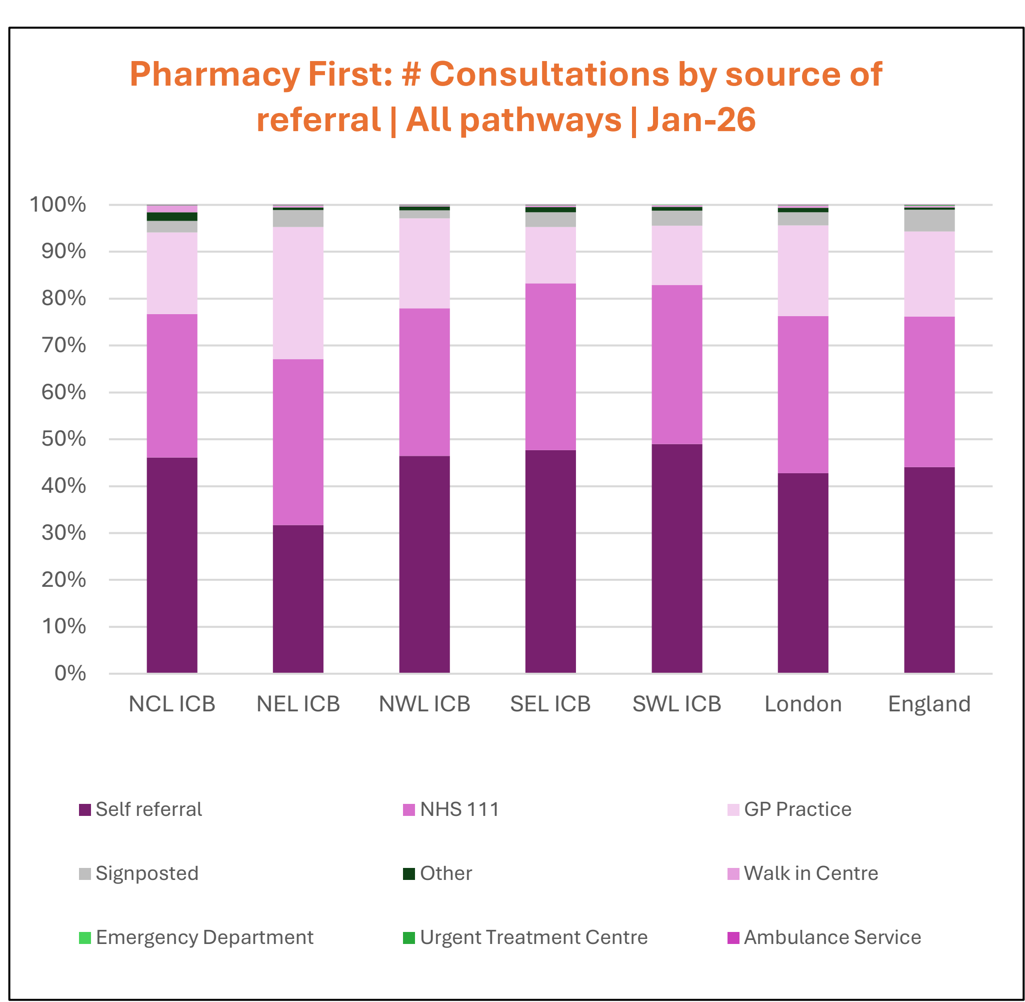
Geography	Jan-26	Dec-25	Nov-25
ENGLAND	**94%**	**94%**	**94%**
LONDON	90%	91%	90%
NHS NORTH CENTRAL LONDON ICB	90%	90%	90%
NHS NORTH EAST LONDON ICB	96%	96%	96%
NHS NORTH WEST LONDON ICB	85%	85%	85%
NHS SOUTH EAST LONDON ICB	93%	93%	92%
NHS SOUTH WEST LONDON ICB	91%	91%	90%

Percentage of pharmacies (out of total 322 CP for SEL) that delivered at least one consultation in each of the clinical pathways, blood pressure, ABPM, and contraception services

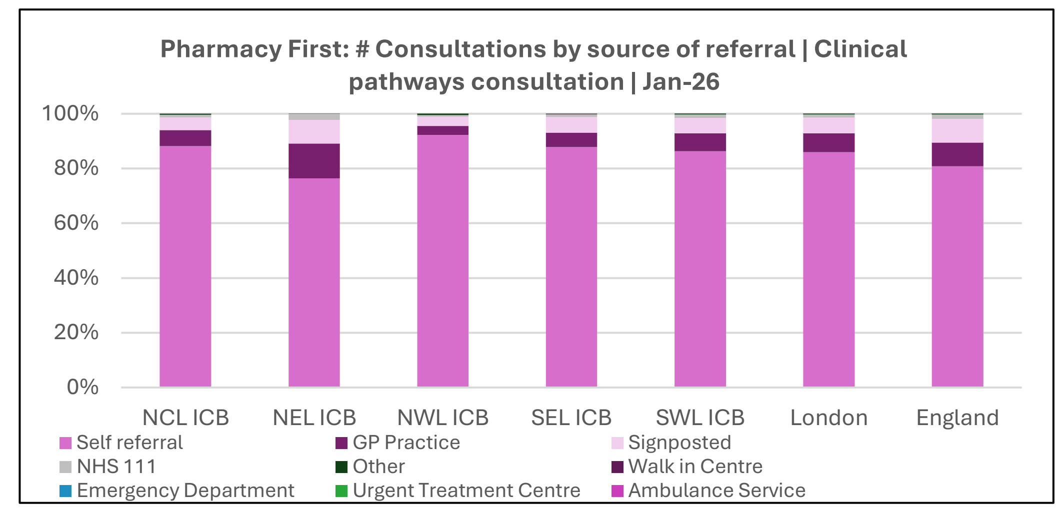
Geography	Jan-26	Dec-25	Nov-25
ENGLAND	**56%**	**56%**	**56%**
LONDON	60%	61%	61%
NHS NORTH CENTRAL LONDON ICB	58%	60%	60%
NHS NORTH EAST LONDON ICB	79%	80%	80%
NHS NORTH WEST LONDON ICB	40%	42%	42%
NHS SOUTH EAST LONDON ICB	63%	62%	63%
NHS SOUTH WEST LONDON ICB	67%	65%	68%

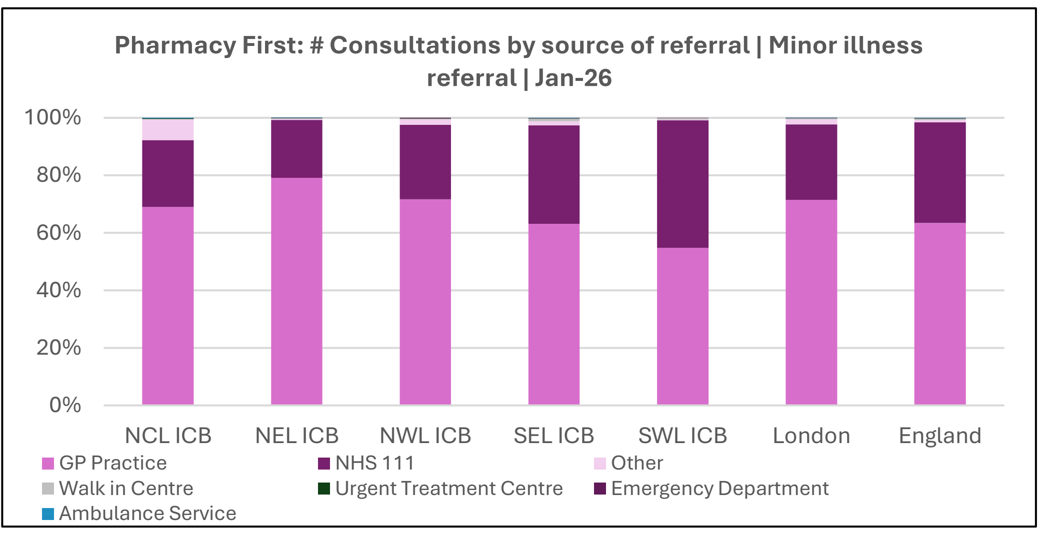
- Data shows across SEL ICB, 298 out of 322 community pharmacies were opted in to provide all 3 national services (Jan 26)
- Out of the 298 community pharmacies opted in, 202 pharmacies delivered at least one consultation in EACH of the services (clinical pathways, blood pressure, ABPM, and contraception services).

Pharmacy First: Source of referral national and regional outlook



Split into clinical pathways and Minor Illness





Pharmacy First Outcomes

- From the NHSBSA data Jan 25-Jan 26, it was noted the most common first alternative choice would have been to contact/go to GP practice, if the patient had not been seen in a community pharmacy for a clinical pathway consultation

Row Labels	Sum of Ambulance	Sum of Emergency Department	Sum of GP Practice	Sum of NHS 111	Sum of Other	Sum of Urgent Treatment Centre	Sum of Walk in Centre	Sum of Total
Grand Total	40	479	42756	10605	882	4704	30229	89695

Community Pharmacy is identifying unmet needs in communities least likely to access other health services

- Community pharmacy is identifying unmet vital 5 including mental health need early, at scale through a **prevention pilot in SEL as part of our vital 5 approach.**
- Between January and October 2025, participating community pharmacies in SEL completed **3,718** Vital 5 Checks across all six SEL boroughs
- Around 12% of people receiving Vital 5 Checks screened positive for mental wellbeing concerns, triggering advice and signposting to appropriate support. This demonstrates pharmacy's role as an accessible point for early identification of vital 5 and mental health problems, particularly for people not routinely accessing GP or specialist services.
- Mental wellbeing screening is embedded within a wider prevention check (blood pressure, BMI, smoking and alcohol), enabling holistic identification of co-existing mental and physical health risk.
- Community pharmacy disproportionately engages working-age adults, people living in higher deprivation, and ethnically diverse communities — populations that are often under-represented in NHS prevention and mental health programmes.
- High levels of satisfaction and trust indicate that pharmacy offers a non-stigmatising, walk-in environment where people are willing to disclose mental wellbeing issues they may not raise elsewhere.
- Pharmacy staff provide immediate advice and signposting, and (with patient consent) share a Vital 5 summary with GP practices to support follow-up and continuity of care. Improving consistency of coding, data flows and outcomes are a key opportunity for the 2026/27 phase.

What does this mean for SEL?

- Pharmacy enables early, equitable Vital 5 identification at scale
- Reaches underserved populations and reduces inequalities
- Offers a trusted, non-stigmatising route into mental wellbeing support
- Digital integration and data consistency are the critical next step in for 2026/27

Our response to improving CKD outcomes

In early 2023, modelling of in-centre haemodialysis growth in London showed that demand would exceed capacity by 2030

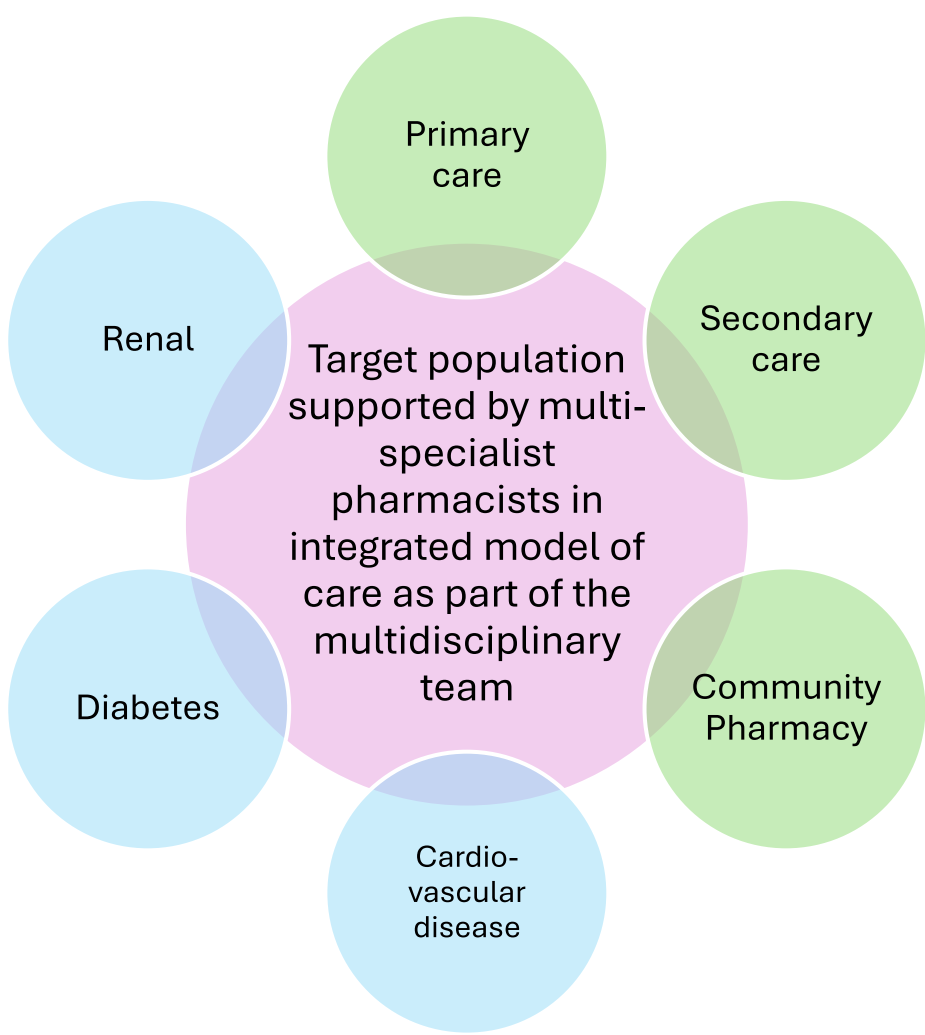
Working collaboratively, the five London ICSs developed a Renal 3Ps transformation programme (funded by NHSE) with a:

Proactive, Predictive, Preventative approach to reduce long-term costs, improve quality of life, and reduce pressure on services

South East London developed the **Multimorbidity model of care (MMMoC) project**

MMMoC - Opportunity for pharmacy

- Experts in medicines
- Traditionally segregated pharmacist roles exist across the care interface
- Novel model of care to support the people targeted for interventions with multi-specialist pharmacists in an integrated neighbourhood team
  - Medicines optimisation at the heart of optimising care
  - Opportunity to build on successes of local integrated multiple long term condition roles
  - Experience of :
    - Redesigning clinical pathways and embedding evidence based prognostic therapies
    - Reducing unwanted variation in care
    - Ensuring equitable access to medicines
    - Embedded within the three MMMoC pillars of care



MMMoC three pillars

Pillar 1: Prevention and targeted testing

- **Proactive testing** (uACR) **in community** outreach setting
- **Digital remote testing** targeted to patients with no uACR in the last 5 years and a diagnosis of hypertension
- Using **point of care (POC) test machines** to identify and medically optimise CKD
- **Notes review, appropriate tests, diagnosis and medicines optimisation** for coded and uncoded CKD patients

Pillar 2: Clinical case management of complex patients in community

- **Holistic, patient centred care** led by senior nurse/pharmacist
- **Initial 30 minute holistic assessment with care co-ordinator** to assess social and healthcare needs
- Aim to identify and **unblock barriers to receiving care**
- **Scope for referral** onto appropriate members of the integrated neighbourhood team where required
- Regular **multi-disciplinary team meeting (MDM)** with primary and secondary care colleagues for complex case discussions

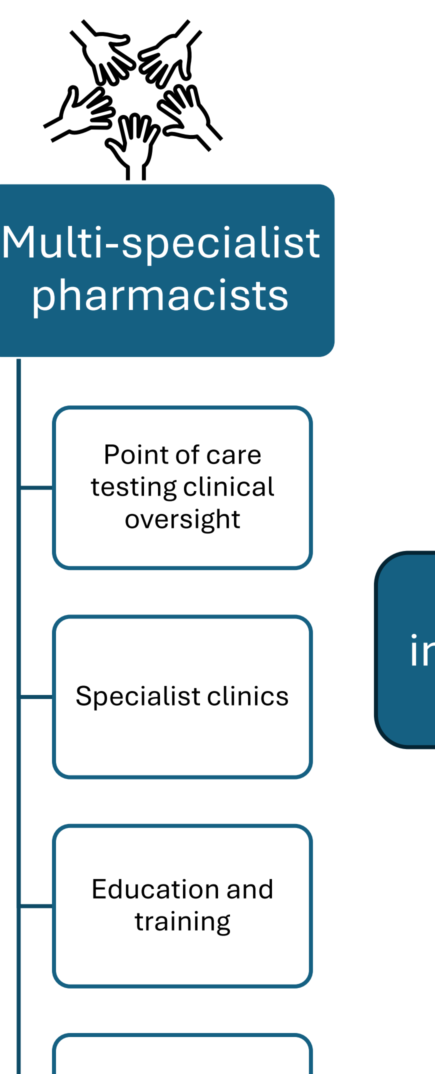
Pillar 3: Integrated acute care

- Renal, diabetes and cardiology **consultant input**
- Two full-time multi-specialist pharmacists working across SEL to enable **vertical and horizontal integration**
- **Supportive care workstream** with **geriatrician input** for patients with advanced kidney disease for supportive care only

Pharmacist input

MMMoC pilot: the role of the pharmacist

South East London Integrated Care System



Community Pharmacists
- Point of care testing clinics
- Raising awareness of CKD
- New medicines service

Practice Pharmacists
- Case finding, notes review, coding and medicines optimisation
- Complex case management
- Multidisciplinary team meetings

Service improvement projects
- Right Care Pathway
- Medicines safety in reduced renal function
- Redesign of complex renal and diabetes clinic
- Review of renal advice and guidance requests
- Embedding evidence based medicines in pathways

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

Early project outcomes

This is the only model. We must see the patients health as whole.
Gone are the days of one appointment, one problem, we need to be linking them together.

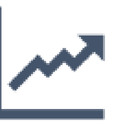
7 in 10 staff members report increased job satisfaction

85% of staff feel that care is more holistic

No one has ever explained properly to me about my kidney and last week, **the pharmacist explained [it] well to me, talked to me like a person**, not just staring at the computer. [We] **talked about my pension and finance[s]** and [they] asked someone to call me and explained all to me.

88% of patients said that they would recommend this service

81% of patients said that they feel involved in decisions about their care



4% rise

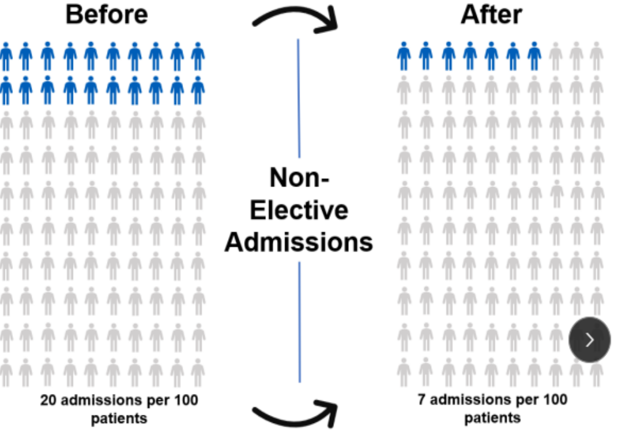
in chronic kidney disease (CKD) prevalence in MMMoC sites

6x improvement

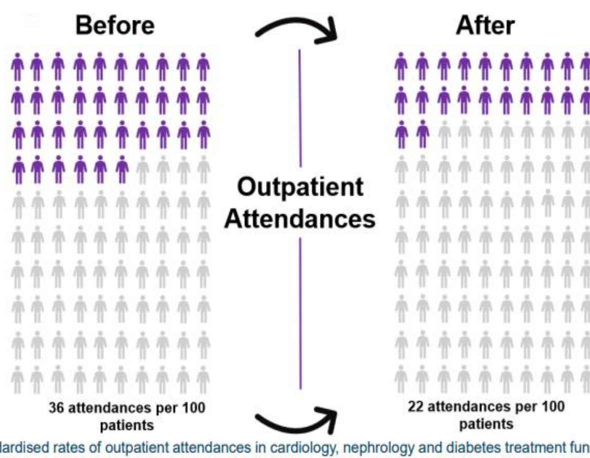
in blood pressure control in our cardiorenal metabolic (CRM) cohort vs CKD register population

14% increased

SGLT2i prescribing for service users with diabetes and CKD



Age-standardised rates of non-elective admissions in long list cohort



Age-standardised rates of outpatient attendances in cardiology, nephrology and diabetes treatment functio long list

Community Pharmacy Prescribing

National Independent Prescribing Pathfinder

Aim: To establish a framework for the future commissioning of NHS community pharmacy clinical services, incorporating independent prescribing (IP) for patients in primary care

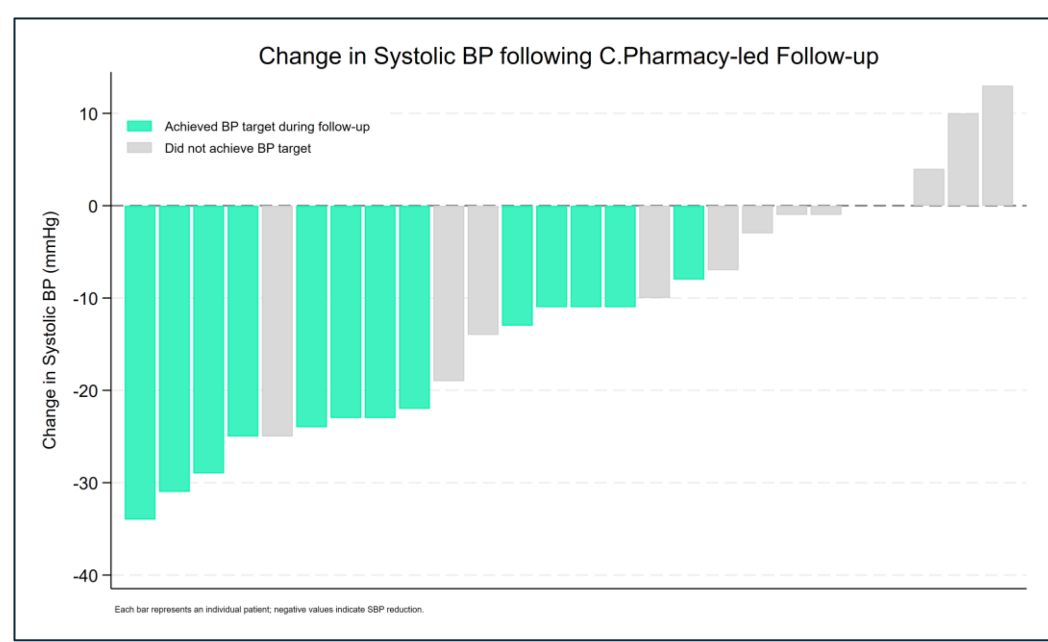
Objectives:

- Test the delivery of IP in community pharmacy settings, and develop pathways for implementation locally;
- Identify the optimal processes (including governance, reimbursement and IT requirements) required to support IP in community pharmacy;
- Inform the development of assurance processes for professional and clinical service standards;
- Contribute to the wider pharmacy workforce strategy, including training and development needs;
- Support the evolution of community pharmacy contractual framework beyond 2024;
- Undertake evaluation / research, including patient experience

Our experience and learning

- Community Pharmacist IP Pathfinder Programme launched in 3 North Southwark pharmacies in April 2025
- Our **integrated model** was established as a collaboration between the pharmacies and the local GP Federation
- **Hypertension** management pathway with **Lipid primary prevention** added to the pathway in October – significant under-treatment across SE London, including in deprived and underserved communities
- Pathfinder sites in North Southwark - extension of the Federation's **enhanced access service**
- Initial evaluation indicates **positive clinical outcomes** for patients including significant improvement in blood pressure control – potentially up to
- **Adherence and lifestyle advice** key to improving outcomes
- Patient feedback **positive** from 'friends and family' questionnaires, reflecting improved access and patient experience

Outcomes



For every 5mmHg reduction in blood pressure, a reduced risk is seen in:

- major cardiovascular events (10%),
- stroke (15%),
- heart failure (17%)

In this service, systolic BP fell on average by 6.4 mmHg, and within 2-3 appointments

Baseline Systolic BP, mmHg median (IQR)	
Initial consultation	156 (146 to 161)
Average change in Systolic BP, mmHg (SD)	
Overall	-6.4 (11)

Impact on accessibility and acceptability

The service reached cohorts of residents who are known to be at higher risk:

- 75% from black, asian and other non-white ethnicities
- 42% from CORE20 postcodes
- Where primary language known, 25% didn't speak English as a first language

Patient feedback was universally positive, with 96% likely, or extremely likely to recommend the service to friends and family

- The service has been successful, with significant impact on achieving blood pressure control to target in the majority of patients, all of whom were known to have uncontrolled hypertension
- The service is welcomed and used by patients, with high uptake, which may be influenced by increased availability at weekends and evenings
- For every 100 patients seen, the direct NHS cost savings equate to approximately £500,000 over 10 years, for an upfront cost of £25,000
- The service is continuing with further sites planned in 2026-27 to continue learning, and align to broader prevention activity through Community Pharmacy

Board Meeting in Public

Title	Primary Secondary Care Interface				
Meeting date	8 April 2026	Agenda item Number	11	Paper Enclosure Ref	K
Author	Toby Garrood, Nancy Kuchemann, Dominic Norton, Jessica Arnold				
Executive lead	Toby Garrood, Medical Director				
Paper is for:	Update x	Discussion		Decision	
Purpose of paper	To update the Public Board with an update on improvement work at the primary and secondary care interface				
Summary of main points	The interface between primary and secondary care is one of the key channels through which patients and their care flow. In July 2025, a newly published consensus document was brought to the Public Board for information – the co-produced document describes agreement around ways of working across the interface and provides clear guidance with a view to simplifying processes, minimising uncertainty, reducing unnecessary workload and improving patient experience. Here we describe updates to this consensus document since last summer, and progress on a related programme of work • The consensus document set out what good interface working should look like, along with some more tangible guidelines around e.g. timelines for document transfers and communications. Following further stakeholder engagement this has been adapted to include guidance for mental health and community providers. We have also worked with patients to develop patient-facing principles. • Local interface groups are now established for all our acute providers and have broad membership, supported by the System Interface Group • Further workstream outputs include guidance on discharge summaries and outpatient letters, updated prescribing guidelines, guidance on improving non-clinical communications, a document detailing how to make best use of community phlebotomy capacity and updated prescribing guidelines. In this paper we will also discuss how impact can be assessed and how we ensure sustainability of the programme.				
Potential conflicts of Interest	none				
Relevant to these boroughs	Bexley x	Bromley	x	Lewisham	x
	Greenwich x	Lambeth	x	Southwark	x
Equalities Impact	The principles are intended to improve patient pathways and experience of care and reduce some of the impacts of health inequalities				

Financial Impact	More efficient cross-system work is expected to improve cost-effectiveness of clinical pathways
Public Patient Engagement	Patient engagement has informed this work. A dedicated workstream to test the document with patients is now complete.
Committee engagement	Finalised documents in the appendices have been agreed at appropriate committees including the CCP Committee and System Interface Group
Recommendation	The board is asked to note progress and to support ongoing work across the system

Primary Secondary Care Interface

NHS South East London Integrated Care Board (ICB) 8 April 2026

1. Background and recent progress

1.1 The primary and secondary care interface (PSCI) is one of the key channels through which patients and their care flow. It needs to be patient focussed, delivering the best possible experience of care and clinical outcomes whilst ensuring that there is efficient use of resources. However, frustrations are common with all stakeholders having to contend with complex processes, multiple touch points and duplication, at times inadequate communication with poor transfer of information, failure to make use of all the expertise in the system at the right time and poor use of patients' and clinicians' time. It is not always clear to patients where to seek help and how to access advice at the right time and it may be unclear where responsibilities should be, for instance around prescribing and drug monitoring.

1.2 In May 2023 NHSE stipulated 4 areas for particular focus in its delivery plan for recovering access to primary care (onward referrals, complete care, call and recall and clear points of contact), and asked ICBs to establish local mechanisms to address high priority issues.

1.3 In 2023 we undertook discovery work including stakeholder engagement in primary and secondary care. This validated the national priorities and highlighted a number of other areas identified as areas of particular challenge, many of which impact on patient experience and, potentially, outcomes which have informed subsequent work.

1.4 In parallel to this, NHS England has completed its Red Tape Challenge review, many of the outputs of which address interface challenges. These are summarised in the referenced GIRFT report and Escape the Tape guidance recently published by the Academy of Medical Royal Colleges.

1.5 Over the last 24 months local interface groups have been established with representation from all acute provider sites and boroughs, the four groups being as follows:

- Lambeth and Southwark/GSTT/KCH (Denmark Hill)
- Bromley/PRUH
- Lewisham/ UHL
- Greenwich and Bexley/QEH

1.6 All four groups are represented in the System Interface Group which brings together learning and identifies system-wide priorities requiring a collaborative approach. This meets bi-monthly and is chaired by the ICB Medical Director.

1.7 Over the last year we have worked with the Health Innovation Network South London on development of the interface groups as well as a number of subprogrammes of work which will be detailed in the following sections. Alongside this, we have produced a maturity matrix against which interface groups can assess maturity (appendix 1).

1.8 The acute/community interface is one of the core delivery domains within the ICB neighbourhood development roadmap and communication standards, operating models for specialist advice and leadership and culture around workforce development can all be informed by the PCSI work to date. The local interface forums have been built on relationships which have matured to support local integrator development and it is important that the consensus agreement principles continue to inform behaviours within integrated neighbourhood teams.

1.9 This is a period of change for the NHS, including prioritisation of national priorities related to the Three Shifts outlined in the Ten Year Plan, the establishment of integrators at place to support neighbourhood working, clustering of SEL and SWL ICBs, and changes to the GP advice and guidance process as part of wider changes in the new GP contract. Anticipating these changes to the system, we have been engaging in conversations with senior leadership to understand how the guiding principles of the PSCI will be taken forward in the new structures. We are now in the process of ensuring sustained change and identifying the key parts of the system to continue to take this work forwards.

2. The SEL primary and secondary care interface document

2.1 In the summer of 2025, following extensive engagement across the interface as well as with patient representation, we published an interface consensus document which set out agreed ways of working in priority areas. This has been disseminated via our interface groups, webinars, the SEL ICB website and engagement events at provider organisations. In early 2026 we ran further workshops to explore how the document should be adapted for mental health and community working. A revised version of the document is in appendix 2 and will shortly be published on our website.

2.2 In addition to this, we wanted to adapt the principles of the interface document to ensure that they represented the needs of patients. We have kept patient experience at the forefront of this work, our ambition being to publish a document which sets out what patients can expect as they move between primary and secondary care. We recently delivered a workshop attended by patients as well as representatives from primary and secondary care to test patient-facing principles. A draft patient-facing document is presented in appendix 3.

2.3 We will continue to update these documents to ensure they reflect best practice and ongoing feedback. As we move into a restructured ICB, the intention is that over time this work will be taken on by integrators at place. We believe there is a need to ensure consistency, retaining a single document for SEL (or even South London) and for this reason there will need to be clear ownership.

2.4 A key priority is ensuring visibility, awareness and, by extension, impact of the document. Our principles for interface working are being built into consultant and junior doctor inductions and the medical directorate will continue to act as an ambassador for this work. We are finalising a video, shortly to be made available on our website, to act as a brief introduction to the principles and which can be included in induction programmes in secondary and primary care.

2.5 We have recently completed an appendix providing guidance as to where patients can attend for blood tests in the community when these are requested in secondary care. This will facilitate the ordering of follow up tests by reducing the need for patients to travel back to the hospital.

3. Patient communications: discharge summaries and outpatient letters.

3.1 Our initial scoping work and subsequent stakeholder engagement identified consistency of communication as a priority. The format and quality of discharge summaries and outpatient letters can be variable, and this can lead to confusion for patients and GPs, particularly when there is a lot of information to assimilate. We have worked with stakeholders across the system to develop guidance for these communications, taking into account the views of patients.

3.2 This discharge summary guidance is now published on the SEL website and is presented in appendix 4. Trusts are being encouraged to explore how this can be adopted and to ensure that those producing discharge summaries are aware of the guidance and principles therein. Similar guidance for outpatient letters is currently in draft form and presented in appendix 5.

3.3 The key components of discharge summary guidance are:

- communicate the diagnosis/reason for admission and what happened in hospital
- clearly state actions required and who is responsible
- provide a patient-facing, plain-English summary of next steps
- support safe handover and medicines reconciliation.

4. Prescribing

4.1 The ICS already has a SEL Interface Prescribing Policy which was developed via the SEL Integrated Pharmacy Stakeholder Group and SEL IMOC and last reviewed in April 2024. Prescribing issues were frequently referenced by staff and patients during all stages of the PSCI engagement and so one of the priority workstreams gave focus to updating the policy and promoting it alongside the other workstreams.

4.2 Key themes impacting prescribing included communication and clear point of contact to resolve issues. Much of the general feedback via earlier patient and staff engagement influenced the draft section of the consensus agreement and the priority areas for the updated policy.

4.3 Prescribing leads and other stakeholders were invited to co-produce the updated document via virtual engagement sessions and an in-person workshop. The resulting draft (appendix 6) is due to be shared for final review and sign off by the IPSG and IMOC during Q1 2026/7. Key additions to this document include the importance of a minimum data set of information to be shared by the initiating prescriber, refreshed messaging about formulary and guideline adherence, adaptations for specific care settings and the importance of de-prescribing when appropriate.

4.4 Two additional pieces of work on prescribing have also been sponsored via the PSCI programme which demonstrate both the importance of targeting work to areas of clinical risk and the opportunities for development of neighbourhood models of care via the interface community. These are improving the safety of prescribing for common medical conditions during pregnancy and offering long-acting injectable antipsychotic medications to stable people with SMI in neighbourhood settings.

5. Points of contact for primary and secondary care

5.1 This priority was identified through our local mapping work as well as being an area of focus identified in the original PCARP report. Patients can be frustrated

by lack of clarity as to when their next appointment might be or how results might be communicated. It is not always clear who to contact, and how, meaning that many will return to their GP practice for help; GPs then find themselves chasing referrals on behalf of patients.

5.2 We engaged widely across the system, including with provider patient advice and liaison services (PALS), Healthwatch, clinicians and care coordinators to better understand these challenges and opportunities. Key findings included:

- Patients may be uncertain whether to contact their GP or hospital leading to repeated redirection.
- Patients often seek confirmation from their GPs that referrals are received, estimated waiting times, and guidance on escalation if symptoms worsen. Patients would like more clarity that their position on referral waiting lists is clinically appropriate.
- Patients are utilising secondary care call lines to receive information that should be available to them online or in patient letters, which causes unnecessary work for administrative teams.
- There may be ambiguity around who communicates results (GP vs. hospital) and this causes delays, anxiety, and duplicate contacts. This specific issue was also highlighted by GPs and their admin teams.
- Patients report difficulty finding hospital numbers; unanswered calls and automated menus add barriers.
- Patients without reliable internet access, housebound patients, or those with limited English proficiency, face disproportionate challenges. Translation services and accessible alternatives are inconsistent.
- Where patients receive clear written updates, translated information, or a single named contact, satisfaction and confidence improve significantly.
- GPs often must chase referrals, with the only way to check progress being direct contact with secondary care providers. If a referral is rejected, GPs are often not notified or provided with a reason.
- Some GPs are not confident in using the e-Referral Service (e-RS), particularly around offering patients a range of options.
- Communication pathways within hospital trusts, which are used to assist with referrals, test results, and care record queries, are inconsistent, fragmented and difficult to navigate.
- There is a lack of clarity around who is responsible for managing referrals after submission and for communicating test results generated in secondary care.
- When effectively used, shared care record systems improve communication and reduce challenges by giving GPs access to consistent, up-to-date information.

5.3 These findings and principles have been incorporated into our interface documents and have informed other work referenced here. Recommendations will be fed back to provider organisations. Furthermore, we are providing ongoing support to develop Advice and Guidance capability and capacity, and support for these and the newly-mandated Advice and Refer principles will be provided by local interface groups.

6. Impact assessment

6.1 This work requires significant changes in ways of working and organisational culture. It is therefore essential that we maintain visibility through our interface groups and more widely in the system. Due to the disparate nature of the specific

challenges and the lack of systematic data it can be difficult to demonstrate short-term impact; however, we expect to see change over time and this will be reflected in patient and staff experience. Each of these areas is specifically addressed in our interface consensus document, in addition to which specific measures are highlighted below.

6.2 Greenwich, Bexley and Lewisham Interface leads have implemented a process for feeding back to hospital clinicians, via the respective LGT Medical Directors, when inappropriate requests are made of general practice (appendix 7). A breakdown of the cases of inappropriate requests that were re-directed back to secondary care is below.

Reason for report	Number
Requested GP to do an onward referral to a specialist team	80
Request GP to order investigations and forward results	37
Requested GP to follow-up results of investigations requested by secondary care	27
Requested GP to commence a medication that is not in line with the South East London prescribing guidance	17
Request to arrange a follow-up	4
Request GP to issue Fit Note for patient	1
Individual funding request	1
Appointment escalation request	1
Grand Total	**168**

6.3 Further potential data sources for some of the key priorities are as follows:

6.3.1 **Onward referral** (where appropriate, referrals being made within provider organisations rather than via the GP). Guidance has been issued and disseminated in all acute providers trusts to make clinicians aware of best practice. We have explored whether this can reliably be captured within electronic record systems but so far this has not been achievable. We therefore need to rely on feedback through local interface groups, feedback channels such as that developed in Lewisham and Greenwich (to be presented at the Board meeting) and quality alerts.

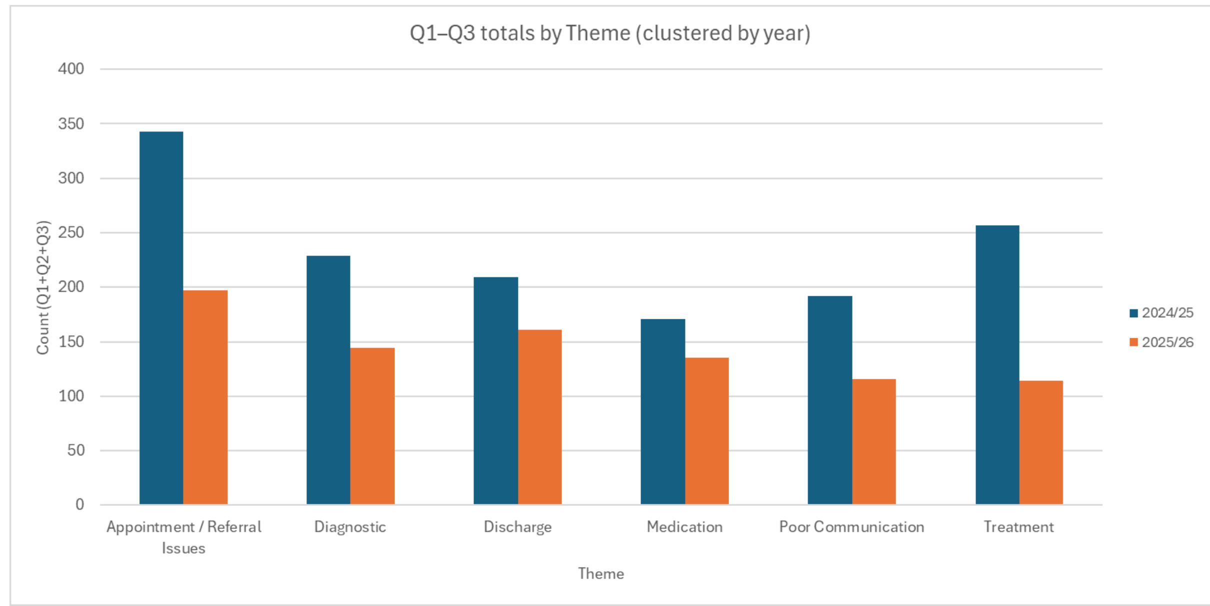
6.3.2 **Call and recall** (ensuring follow up tests and appointments are made in the most appropriate setting). Potential data sources include: quality alerts, patient experience (e.g. PALS contacts, complaints).

6.3.3 **Complete care** (issuing of fit notes and discharge summaries). Guidance for issuing of fit notes has been disseminated in all acute provider trusts. Discharge summary guidance has been published as described. GPs are asked to provide feedback via quality alerts.

6.3.4 **Clear points of contact**. GPs are asked to feedback via quality alerts. Patient experience can be tracked through PALS reports and complaints.

6.4 Quality alerts are the system whereby GPs and secondary care clinicians can raise concerns about issues affecting patient pathways or other concerns across the interface. These rely on clinicians taking the time to complete them and so can only be a partial record, and hence may not give a clear picture of incremental changes in practice in the short-term. Throughout this project we have encouraged clinicians to use the system to raise concerns, and we have also built a dedicated form on the SELnet website for GPs to do this in a simplified form.

6.5 Thematic analysis has revealed that appointment and referral issues, concerns related to treatment and diagnosis, discharge processes, communication and medication issues make up the majority of these. An overall summary of these with year-on-year comparison is presented below. The data has been presented for quarter 1-3 for 2024/25 and 2025/26 so is comparable. There has been an overall reduction in quality alert reporting over this period, possible due to additional reporting systems, and it is not possible to directly attribute these reductions to the programme at this stage. However, as we embed the principles we would expect to see a year-on-year fall in reports directly related to interface working.



6.6 In addition to local implementation of this, work in south east London has been presented at the national forums as exemplars of best practice.

7. Future work

7.1 As the ICB moves to its new structure, is it essential that ownership of work at the primary and secondary care interface is clearly defined. ICB capacity will reduce, and it is expected that much of this will move into our place integrators as they mature, but during this transition phase we anticipate that the ICB will continue to lead this work. As this is absorbed by integrators it will remain important that some components are maintained at ICB level, including maintenance and iteration of the interface document.

7.2 Embedding these principles requires long-term culture change, necessitating strong leadership and board-level support in provider organisations. We will continue to encourage organisations to build this into induction programmes, to disseminate updates to the principles, and to use feedback from quality alerts and other sources to provide ongoing feedback to clinicians.

7.3 The ICB board is asked to continue to support this programme and resourcing to ensure full benefits realisation for patients and staff.

Appendix 1: maturity matrix

South East London Interface Working Maturity Matrix

1. Introduction

The South East London (SEL) maturity matrix is designed to define and measure progress in interface improvement projects, as well as to assess the extent to which the principles outlined in the SEL Interface Consensus document[1] have been embedded in practice. The matrix works alongside the South east London primary and secondary care interface consensus document and is aligned with the priorities of the National Neighbourhood Health Implementation Programme (NNHIP) and other initiatives across South East London that aim to optimise interface working. By providing a structured framework, the tool enables local interface teams within the South East London Integrated Care System (SEL ICB) to identify current strengths, measure adoption of agreed principles, highlight gaps, and prioritise areas for further improvement.

2. Aims and purpose

The purpose of this maturity matrix is to:

- Assess readiness for process improvement across PSCI structures.
- Enable targeted action for operational improvement within local PSCI teams.
- Provide a common framework for evaluating governance, engagement, communication, integration, and sustainability.
- Support strategic planning by aligning local work with national priorities (Red tape challenge, GIRFT), integrators. NNHIP and the SEL neighbourhood development programme.

3. Instruction for use

Scope of Assessment

- In scope: South East London place-based Interface Groups and associated forums

Maturity Levels

- Level 1 - Initial: Ad hoc processes, improvement work not started, guidance is not adopted
- Level 2 - Developing: Some structures and processes in place, early adoption of improvements and guidance

[1] South east London primary and secondary care interface consensus document

- Level 3 - Established: Structures and processes are fully adopted, guidance and improvement projects are now business as usual.

Scoring

- For each dimension, assign a level (1-3) based on evidence from forums, reports, and stakeholder feedback.
- Use qualitative notes to capture context and examples.

Next Steps

- Develop an action plan - Use the identified gaps between current and target maturity levels to plan specific actions for development
- Integrate and monitor progress - Revisit the matrix regularly (e.g., annually) to review improvements, update your assessment, and maintain alignment with the wider system.
- Engage stakeholders - Use the results to support discussion between stakeholders and ensuring a shared understanding of progress and priorities.

Table 1 - Dimensions of access

Dimension	Indicator of maturity	Source/alignment
Governance	Clear, proportionate governance arrangements that define scope, accountability, decision-making authority, and reporting lines for PSCI work.	NHS England, Working Together at Scale[2] (provider collaboratives): *"The 'right' form and governance arrangements should flow from the shared purpose and objectives of the provider collaborative… governance arrangements that are proportionate."*
Leadership and Agency	Named leadership and coordination capacity to own PSCI improvement, manage workstreams, and resolve interface issues.	GIRFT[3] : "All NHS secondary, community and mental health care providers [should] identify an individual or team to act as an 'interface liaison officer' to manage local issues." Integrators: "Building trust, resolving conflicts, and embedding community leadership." INT/Integrators[4]: Building trust, resolving conflicts, and embedding community leadership in INT development.
Engagement/culture	Active, balanced participation from primary and secondary care with a shared improvement culture and mutual accountability.	GIRFT: *"Providers, primary care networks, local medical committees (LMCs) and ICBs to fully participate in local strategic and operational interface groups to resolve local issues."* Integrators: *"Enabling shared learning."* INT/Integrators: Enabling shared learning Facilitating cross-borough dissemination of best practices and scalable integrated models. L&S forum: shared education and cultural alignment opportunities
Integration & Digital	Digital and pathway integration that enables shared working across organisations and settings.	GIRFT: Improve IT by adopting the electronic prescribing service (EPS) in secondary care and increasing access to shared care records. This should include greater interoperability of electronic patient records (EPRs), starting with the sharing of structured medication information. Integrators/INT[5]: Aligning workforce, governance, risk, finance, estates, and digital

[2] Provider Collaboratives guidance
[3] GIRFT – Bridging the Interface Report

[4] Neighbourhoods INT: (NHS England » Neighbourhood health guidelines 2025/26)

[5] Neighbourhood team development: Neighbourhood healthcare maturity matrix | Good Governance

		systems across sectors to operationalise neighbourhood-level integration. Ensuring a standard core community offer across all neighbourhoods that aligns with consistent integration functions. NNHIP[6]: Leveraging technology and data to improve care coordination and outcomes.
Performance monitoring & KPIs	Use of agreed metrics to monitor interface performance, variation, and improvement impact.	GIRFT: "All secondary, community and mental health care providers to continue collecting and collating relevant data for 6-monthly self-assessments… using the GIRFT checklist."
Advice & Guidance (A&G)	Consistent, timely, high-quality use of A&G that supports appropriate referral, facilitates shared care, and meets agreed SEL KPIs for responsiveness, quality, and outcomes.	7.0 South east London primary and secondary care interface consensus document
Clear point of contact	Clear points of contact between primary and secondary care, with defined responsibilities, escalation routes, and response expectations, as set out in SEL RACI matrix for roles and responsibilities across the interface.	3.0-6.0 South east London primary and secondary care interface consensus document
Prescribing	Safe, consistent prescribing across the interface with clear responsibility for initiation, continuation and monitoring; adherence to shared care agreements; and alignment with SEL interface prescribing policy	8.0 South east London primary and secondary care interface consensus document
Communication (Discharge summaries, clinic letters and fit notes)	High-quality, timely clinical communication between care settings (including discharge summaries, clinic letters and fit notes) meeting SEL communication standards for content.	2.0 South east London primary and secondary care interface consensus document
Sustainability and continuous improvement	Capacity to sustain PSCI improvement through workforce planning, funding, learning, and scaling of effective models.	L&S interface objectives: "Evaluate impact and review KPIs; embed shared health promotion agenda; scale successful models." Integrators: "Improving sustainability… offering targeted support to practices or teams under strain."

[6] NNHIP : https://neighbourhood-health.co.uk/about

4. PSCI Maturity matrix

Dimension	Level 1- Initial	Level 2- Developing	Level 3 – Established
Governance	• PSCI activity occurs through ad-hoc forums with no scope or decision-making authority • Governance arrangements are informal	• Purpose and scope for PSCI activity are partially defined • governance arrangements exist but are inconsistently applied • Variable membership and unclear reporting lines.	• Governance arrangements are clearly defined and documented • PSCI forums meet regularly, with agreed membership, delegated authority, and clear reporting into place and system governance structures.
Leadership & Coordination	• No named individual or team is responsible for coordinating PSCI activity or managing interface issues • Escalation is informal and inconsistent.	• Named local leads or teams exist for PSCI, but roles, authority, or coverage of key workstreams are incomplete or inconsistently applied.	• Named PSCI leads or liaison roles are in place with clear authority to coordinate work, manage escalation, resolve interface issues, and oversee all agreed PSCI workstreams captured within the SEL consensus document.
Engagement/ Culture	• Engagement from primary and secondary care is sporadic • Participation is limited and/or unbalanced in representation from both sides of the interface	• More regular engagement is evident, but participation is unbalanced across the interface and dependent on individuals rather than organisational commitment.	• Consistent, balanced engagement from primary and secondary care organisations • Evidence of shared learning, joint problem-solving, and collective ownership of PSCI improvement.
Integration & Digital	• Pathways and systems are fragmented, with limited digital enablement and minimal sharing of information across the interface.	• Shared care protocols and digital tools are implemented in some pathways or services, with partial interoperability or reliance on local workarounds.	• Shared care protocols and interoperable digital systems (e.g. EPS, shared care records) are embedded across the interface.
Performance monitoring & KPIs	• PSCI performance is not routinely measured • data is not collated or used to inform improvement.	• Some PSCI metrics are collected locally or intermittently, but reporting is inconsistent and rarely informs decision-making.	• Agreed PSCI KPIs are routinely collected, reported, and reviewed • data is used to identify variation, support GIRFT self-assessments, and drive continuous improvement.
Advice & Guidance	• A&G is available inconsistently • Response times are unreliable and often outside agreed standards • Poor-quality responses or redirection back to referral is common • Little monitoring or a lack of adoption of the SEL A&G KPIs	• A&G is in regular use across most specialties • Response times and quality are variable but improving • Early adoption of SEL A&G KPIs and feedback mechanisms	• A&G is the standard, embedded route for appropriate clinical queries • All specialties meet agreed SEL A&G KPIs on timeliness and quality • Data is routinely reviewed and informs service redesign and education
Clear point of Contact	• SEL RACI for roles and responsibilities across the interface not implemented • No consistent or reliable mechanism for contact between sectors • Escalation routes and accountability unclear	• SEL RACI for roles and responsibilities across the interface is partially implemented • Contact mechanisms in place but variably used or understood • Some defined response expectations but not consistently met	• SEL RACI for roles and responsibilities across the interface is fully implemented and understood across organisations • Clear contact points consistently used by primary and secondary care
Prescribing	• Limited adoption of SEL prescribing principles from the consensus document	• Partial adoption of SEL prescribing principles and shared care agreements • Increasing clarity on initiation vs. continuation responsibilities • Shared care arrangements are in place for some medicines/conditions • Ongoing work to reduce inappropriate transfer of workload	• Full adoption of SEL prescribing consensus principles across pathways • Shared care agreements are routinely applied and reviewed • Initiation, continuation and monitoring responsibilities are clear and accepted • Minimal escalation or conflict regarding prescribing responsibility
Communication (Discharge summaries, clinic letters and fit notes)	• Limited adoption of SEL communication standards • Quality and content are inconsistent	• Partial implementation of SEL communication standards • Standardised templates or minimum datasets used inconsistently	• Full adoption of SEL communication standards • Discharge summaries, clinic letters and fit notes are consistently clear on responsibility and timeframes, and all fields in the standards are completed for each letter • Regular audit and feedback cycles sustain compliance with standards
Sustainability	• No plans or resources are in place to sustain PSCI improvement	• Time-limited or non-recurrent support exists for PSCI roles or initiatives, with limited evaluation or scaling of learning.	• PSCI improvement is sustained through recurrent funding, embedded improvement cycles, regular evaluation of impact, and scaling of effective models across SEL.

Appendix 2: Revised SEL primary and secondary care interface consensus document

South East London Primary and Secondary Care Interface Consensus

General Principles

1. Keep the patient at the centre of all we do. All interactions with patients should add value.

2. Treat all colleagues with respect.

3. Clinicians should seek to undertake any required clinically appropriate actions themselves, within the limits of their professional competency.

4. Ensure patients are kept fully informed of their care and next steps in their pathway. Patients should know who is responsible for the next stage of their care, when their next appointment is, and who to contact in the event of delays.

5. Where possible, speak to colleagues directly if in doubt. A clinical conversation could enable a real-time solution for patients which may avoid onward referral.

6. Take appropriate responsibility for tests or actions that may need to be done in the future

7. There should be a shared health promotion agenda across the primary and secondary care interface.

Specific domains

1. Onward referral

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

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

2.1. All clinical and patient communications will comply with agreed standards and service-specific guidelines (for example mental health service discharge summary guidance).

2.2. All services will issue fit notes when needed, covering the period of any episode of care. Extensions will be issued by the patient’s own GP team.

2.3. For patients who self-discharge or leave a clinical pathway against advice, secondary care will produce clinical communication to conclude that episode of care.

2.4. If a patient does not attend an outpatient appointment, the clinician will attempt to reach them by telephone before recording as DNA.

2.5. All services will ensure clear and timely communication to the GP following each relevant patient contact, using the most appropriate method (such as updating the patient record or sending a formal letter where required.)

2.6. All services should send discharge summaries at point of discharge, with a maximum timeframe of 24 hours,

2.7. All services should send outpatient clinic letters within 10 days of the episode of care.

2.8. Additional consideration and acknowledgement may be required for fluctuating engagement, complex needs (for example mental capacity) and multi-agency involvement (for example, a non-attendance or self-discharge may trigger a multi-agency risk review).

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

3.1. Clinicians who organise tests are clinically accountable for acting on the results and for communication of results and next steps to patients. Local variation in practice may require a coordinated approach across care settings, but the steps and reasons for them should be made clear in correspondence.

3.2. Where patients are under shared care, any existing guidance should be followed with regards to surveillance such as blood monitoring. Where there is lack of clarity, guidelines should be developed or adapted.

3.3. In the case of home visits for monitoring, community teams need explicit agreements regarding responsibility for recall, when GPs must take over and when escalation to acute care is necessary.

4. Points of contact (in both directions)

4.1 All services will provide a simple, clear and equitable point of contact for queries from patients and carers, hospitals, primary care and other services.

5. Principles of referral (including rejection and advice and guidance)

5.1. GPs will make the intended outcomes clear, including patient expectations, when referring patients to any other service.

5.2. Primary care assessments should be completed when referring to any other service.

5.3. Patients must have consented to, and be clear on, the reasons for referral.

5.4. When patients are referred for surgical intervention, GPs will continue to optimise long-term conditions management.

5.5. Up to date, simple and easy to navigate directories of services and management guidelines will be available across the system.

5.6. Referrals from community care may come from non-medical staff; in these cases the referral should go via the GP for review and onward referral.

5.7. Before making a referral from primary care, GPs will consider whether existing clinical guidelines, written advice and guidance, or a telephone call could avoid a referral.

5.8. Secondary care will always provide clear guidance on their reasons for declining a referral and advise on an alternative clinical pathway.

6. Supporting patient expectations whilst waiting

6.1. For patients referred to any service, an approach of 'Waiting Well' will be taken.

6.2. On receipt of a referral, all services will send the patient an appointment as quickly as possible, agreeing a time or letting the patient know about the waiting time.

6.3. Whilst waiting for a first appointment, it will be clear to patients who they should contact for general information and in the case of any deterioration.

6.4. Provider services will have publicly accessible data regarding waiting times.

6.5. Patients will be offered a simple way to make changes to appointments taking into account reasonable adjustments and without delaying access to care.

6.6. Further sources of useful information should also be made available, for example voluntary, community and social enterprise sector resources.

7. Prescribing and discharge medicines

7.1. The clinician who wishes to prescribe a new medication for the patient, will undertake appropriate pre-treatment assessment and counselling with the patient and outline the need for ongoing prescription and review to the GP.

7.2. Medications that are required immediately will be prescribed during that clinical consultation.

7.3. New medications prescribed during a clinic consultation, or discharge medications after hospital admission, will cover an initial period of at least 14 days, or longer as locally agreed.

7.4. Primary care, secondary care and mental health teams will use the SEL Interface prescribing policy, SEL formulary, and Discharge Medicines Service to support efficient prescribing of medications.

7.5. When recommending ongoing prescribing from the GP, secondary care and mental health services will first check locally agreed prescribing formulary and reference relevant shared care agreements.

Considerations for Mental Health Services

7.6. Mental health services must retain prescribing responsibility until the GP has explicitly agreed for handover of care.

Appendix 3: Patient-facing document DRAFT statements

General Principles

1. **We will see you as a whole person and join up your care across all your conditions and the services you use.**
We will consider how tests, treatments, and advice interact across your different conditions, avoid unnecessary duplication, and share information so you don't have to repeat yourself. When we write to you, we will explain the purpose of tests or appointments so you understand how everything fits together.

2. **We will explain what happens next, why it is happening, who is responsible, and when you should expect to be next contacted.**
We will communicate with care and compassion, make reasonable adjustments, and involve the people who support you - including carers, family, or others you trust - when you want us to. We will think about the other services and teams you are dealing with, so you feel supported rather than left to manage the system alone. If you are waiting for an appointment we will ensure you know you are on a waiting list. If we are unable to confirm a date we will tell you how long you can expect to wait and when you will be contacted.

3. **We will work together with you making reasonable adjustments and involving carers and family when you want us to.**
When your care moves from one team to another - for example during referral or discharge - we will tell you what to expect, why the change is being made, when you are likely to hear from someone, and what you should do if your condition changes while you wait.

4. **We will explain results, medications and your management plan plainly during consultations (and in writing in some cases) avoiding medical jargon.**
We will use straightforward language wherever possible, explain medical terms, and respect your preferred way of receiving information (such as phone, text, email, letter, or mixed formats). We will confirm important conversations in writing in a way that's easy to find and understand, and we will tailor the amount and style of communication so it doesn't feel overwhelming.

5. **We will support you whilst you are waiting for tests, procedures, next appointment by giving you practical advice and contact details for when things do not go as planned.**
We will tell you when and how your test results will arrive, what they mean, and who will explain them. We will make medication changes clear - when they are expected, why they have changed, and how to get your medicines. We will avoid jargon, let you know if a care plan is needed or needs updating, and tell you who to contact if something is unclear.

Behaviours

1. **We will be honest with each other and communicate openly about what we are doing and what we need.**

Staff will be transparent about pressures and limits, and patients will be honest if they are struggling with, or not following, treatment plans, medications or self-management instructions. Both sides recognise that illness affects emotions, and that staff are also working under intense pressure. Everyone commits to empathy, respect and avoiding blame-shifting.

2. **We will take shared responsibility for preparing for appointments and making good use of the time.**

Patients will come prepared with questions, information or concerns, and staff will ensure complex information is backed up with a written record that patients can understand and keep. Both sides recognise that some information may need repeating and that asking for help is always acceptable.

3. **Patients will attend appointments or cancel in good time, and the NHS system will make it easier to do so.**

Patients commit to attending appointments wherever possible or letting services know promptly if they cannot. Staff commit to providing clear contact details and systems that allow cancellations or changes without unnecessary barriers. Both acknowledge that missed appointments cause delays and impact care for others.

4. **We will follow agreed care plans, treatments and tests, and tell each other when this isn't happening.**

Patients will let clinicians know if they have stopped taking medications, missed tests, or chosen not to follow advice, so care can be safely adjusted. Staff will respect patient choice and avoid judgement, focusing instead on understanding what is getting in the way and what support might help.

5. **We will take appropriate action if expected timelines have passed and something hasn't happened.**

Patients commit to getting in touch when a timeframe has elapsed or if they are worried something has been missed. Staff commit to providing clear, realistic timeframes and acknowledging when a delay has occurred. Both sides aim to avoid the feeling of being "lost in the system."

6. **We will give and receive feedback respectfully and routinely, not only when things go badly wrong.**

Patients are encouraged to share feedback early, including when things feel unclear or could work better, and staff commit to listening and using that insight to improve care. Both recognise that constructive feedback helps prevent bigger problems later.

Appendix 4: SEL discharge summary standards

South East London Discharge Summary: Proposed Standards

1. Purpose & definition

A South East London (SEL) discharge summary is a single standardised communication from secondary care to primary care produced after a hospital attendance or admission. Its purpose is to:

- communicate the diagnosis/reason for admission and what happened in hospital,
- clearly state actions required and who is responsible,
- provide a patient-facing, plain-English summary of next steps, and
- support safe handover and medicines reconciliation.

(Aligned with Professional Record Standards Bosy (PRSB) intent that one single discharge summary should contain all pertinent information and be sent to GP and patient.)

2. Structure: required headings

Implementations must support all PRSB headings, but local display order may vary. Below are the *minimum* clinical headings that must be completed (or explicitly stated as “None / Not applicable”):

1. **Patient identifiers**: Include NHS number (or “Not known”), name, DOB, NHS organisation that generated record. (PRSB mandatory demographics.)
2. **Reason for admission**: List symptoms and severity of symptoms experienced requiring admission and dates associated with symptoms
3. **Diagnosis**: Provide diagnosis; date(s) of diagnosis. (PRSB: record primary/secondary diagnosis guidance.)
4. **Investigation results & outstanding tests**: Include only the clinically important results and provide **clear ownership for follow up (who arranges action). If tests are pending, state who is to follow up and by when.**
5. **Medication summary**: Acknowledge which medications are to continue, identify new medication(s), include medication(s) changes with reasons for change, record whether supplied and quantity/duration. Indicate whether the patient has been counselled on changes to the medications. (Follow PRSB medicines guidance.)

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Chair: Sir Richard Douglas CB

6. **Allergies & adverse reactions**: Provide explicit statement if none known, or "Information not available" where relevant.

7. **GP Actions box (MANDATORY, visible and separate)**: Provide explicit, *actionable* items for GP (or "None") with due dates where relevant and the named responsible party for each action (hospital team, GP, patient).

8. **Patient actions / Advice (patient-facing)**: Provide plain English instructions for patient, including counselling to changes in medications, follow-up steps and expected symptoms to watch for.

9. **Follow-up / Next steps**: Include named responsible team/person, timeframe, who arranges (GP or hospital/secondary care).

10. **Contact details for queries**: Include named contact, team, phone/email, and times available. (Essential for patients & primary care.)

11. **Person completing record**: Provide name, role and date/time stamp.

Why: Feedback from clinician reference group valued consistent placement of actions, and named responsibility to avoid workload shifting to primary care. PRSB requires these data models/fields exist and be supported by systems.

3. Presentation & language rules

- **Single summary only:** One patient-friendly discharge summary is produced and distributed (no separate AVS + discharge summary duplication).

- **Dedicated GP Actions box:** Always shown prominently and cannot be removed or hidden by default in the EPR. If there are no actions, explicitly state "None".

- **Plain language for patients:** Each summary must include a short patient-facing paragraph (2- 4 lines) in non-technical language summarising reason for admission, what was done, and next steps. PRSB notes patient should get a copy and communications should be as understandable as possible.

- **Avoid duplication & avoid irrelevant raw data:** Only clinically pertinent investigation results should be included.

- **Template enforcement:** EPR templates should prompt completion of minimum fields and prevent sending unless the *mandatory sections* (including GP Actions box) are completed.

4. Coding & computable data

- **To be considered alongside digital teams-** follow PBRS standards, FHIR technical specification[1]

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[1] Transfer of Care message specifications - NHS England Digital

5. Distribution & timing

- **Send at discharge:** The single discharge summary must be sent electronically to the registered GP *and* given to the patient at or immediately after discharge. PRSB and clinician group both stress timely, single summary delivery.
- **Other recipients:** Community teams / care homes / pharmacies per local trading agreements; all recipients listed on the distribution list.

6. Governance, training & implementation

- **Local PSCI oversight:** Place-based Primary–Secondary Care Interface group to own adoption, mapping and trading agreements (clinician group recommendation).
- **Training:** Include discharge-summary standards in inductions and registrar training; focus on purpose and how to write succinct, action-oriented summaries. (Local PSCI teams to manage)
- **EPR configuration:** Configure Epic/EPR templates to enforce mandatory fields (esp. GP Actions), make GP Actions box non-deletable, and provide a patient plain-lang paragraph generator or template suggestions.
  - Primary care digital collaboration group

7. Example SEL discharge summary

Patient name

NHS No

DOB

Discharge date | Completed by (name, role):
Patient summary (2–4 lines, plain English): “You were admitted for X. While in hospital we did Y. You should expect Z and need to do A. If you get symptom B contact …”

Diagnosis / reason for admission: [SNOMED code] & short text.

Medications (discharge list):

- [Medicine name (dm+d if available)] & Status: Indication for *New Drug / Changed / Continued / Stopped*; Dose directions; Reason for change; Quantity supplied (e.g., 28 tablets / 30 days).

Allergies: [List or “No known drug allergies” / “Information not available”].

GP Actions (boxed & prominent):

1. [Action text] - Responsible: [Hospital team / GP / Patient]; By: [date or timeframe].
   (If none: “No GP actions required”.)

Patient actions / Advice: [Plain English bullet points].

Pending investigations / Results to follow up: [test] - Responsible: [Hospital / GP] By: [date].

Follow up appointment: [Team / clinician], Date/How arranged (if arranged).

Contact for queries: [Name / Team / Tel / Email / times].

8. Minimum dataset

For each discharge summary the system should capture these structured elements (these form the auditable fields):

- ☐ Patient NHS number, name, DOB, contact.
- ☐ Date/time of discharge & name of person completing summary.
- ☐ Primary diagnosis (SNOMED) + secondary diagnoses (SNOMED) or symptom if diagnosis not yet confirmed.
- ☐ Medications: for each med - name (dm+d if possible), status (continued/new/changed/stopped), reason for change, directions, quantity/duration, whether supplied.
- ☐ Allergies/adverse reactions (or explicit “None known” / “Information not available”).
- ☐ GP Actions: text of action, due date (if applicable), responsible party (hospital/GP/patient).
- ☐ Patient actions/advice (plain English snippet).
- ☐ Pending investigations with ownership.
- ☐ Distribution list.

9. Key Performance Indicators (KPIs)

Governance: Governance: audit reviewed by borough-based PSCI group. Quarterly audit reports submitted to SEL-wide PSCI interface leads.

1. **Completion of GP Actions box (%)** - numerator: summaries sent with GP Actions box completed (or explicitly “None”), denominator: total discharge summaries. *Target*: ≥ 95%. (Clinician group emphasised this as key quality metric.)

2. **Single summary delivered to GP within 24 hours (%)** - target ≥ 95%. (PRSB: timely single summary.)

3. **Patient copy provided at discharge (%)** - target ≥ 95%.

4. **Medication reconciliation completeness (%)** - discharge meds coded with status (continued/new/changed/stopped) and reason for change present. *Target*: ≥ 95%.

5. **Plain-English patient summary present (%)** - patient-facing plain language paragraph included. *Target*: ≥ 90%. (Clinician group priority.)

6. **Outstanding test ownership (100%)** – Origin of investigation dictates responsibility for follow up. Follow up plans clearly stated. *Target*: ≥ 95%.

10. References for development

1. PBRS e-discharge summary guides[2]

2. Reference group meeting 24, September 2024

3. Health Innovation Network (HIN) led rapid literature review

4. UnBoxed patient user research report

11. Discharge summary audit performance audit scorecard

KPI	Definition/Calculation	Target	Current performance	RAG rating
Completion of GP Actions box	summaries sent with GP Actions box completed (or N/A if no actions are required).	≥ 95%.		
Single summary delivered to GP within 24	As stated,	≥ 95%.		
Patient copy provided at discharge	As stated,	≥ 95%.		
Medication reconciliation completeness	discharge meds coded with status (continued/new/changed/stopped) and **reason for change present.**	≥ 95%.		
Plain-English patient summary present	patient-facing plain language paragraph included.	≥ 90%.		

[2] eDischarge Summary Standard - PRSB

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London
Integrated Care System

NHS
South East London

Appendix 5: DRAFT SEL outpatient letter guidance

SEL Outpatient Letters: Proposed Standards

1. Purpose & definition

A SEL Outpatient Letter is a single, standardised communication from secondary care to primary care, produced following a hospital outpatient attendance. Its purpose is to:

- Communicate the reason for the referral, clinical findings, and outcomes of the consultation.
- Clearly state any actions required, including who is responsible for each action.
- Provide a patient-facing, plain-English summary of next steps and follow-up plans.
- Support safe handover and medicines reconciliation, where applicable.

(Aligned with PRSB intent that one single Outpatient letter should contain all pertinent information and be sent to GP and patient.)

2. Structure: required headings

Implementations must support all PRSB headings, but local display order may vary. Below are the *minimum* clinical headings that must be completed (or explicitly stated as "None / Not applicable"):

1. **Patient identifiers**: NHS number (or "Not known"), name, DOB, NHS organisation that generated record. (PRSB mandatory demographics.)
2. **Reason for referral**: symptoms and severity of symptoms experienced requiring referral and dates associated with symptoms
3. **Diagnosis**: diagnosis; date(s) of diagnosis. (PRSB: record primary/secondary diagnosis guidance.)
4. **Investigation results & outstanding tests**: only the clinically important results and clear ownership for follow up (who arranges action). If tests are pending, state who is to follow up and by when.
5. **Medication summary**: medications to continue, new meds, changed meds, stopped meds, with *reason* for change and directions; record whether supplied and quantity/duration. (Follow PRSB medicines guidance.)
6. **Allergies & adverse reactions**: explicit statement if none known, or "Information not available" where relevant.

7. **GP Actions box (MANDATORY, visible and separate)**: explicit, *actionable* items for GP (or "None") with due dates where relevant and the named responsible party for each action (hospital team, GP, patient).
8. **Patient actions / Advice (patient-facing)**: plain English instructions for patient, including follow-up steps and expected symptoms to watch for.
9. **Follow-up / Next steps**: named responsible team/person, timeframe, who arranges (GP or hospital/secondary care).
10. **Contact details for queries**: named contact, team, phone/email, and times available. (Essential for patients & primary care.)
11. **Person completing record**: name, role and date/time stamp.

Why: Feedback from clinician reference group valued consistent placement of actions and named responsibility to avoid workload shifting to primary care. PRSB requires these data models/fields exist and be supported by systems.

3. Presentation & language rules

- **Single summary only:** One patient-friendly Outpatient letter is produced and distributed (no separate AVS + Outpatient letter duplication).
- **Dedicated GP Actions box:** Always shown prominently and cannot be removed or hidden by default in the EPR. If there are no actions, explicitly state "None".
- **Plain language for patients:** Each summary must include a short patient-facing paragraph (2–4 lines) in non-technical language summarising the reason for the appointment, what was done, and next steps. PRSB notes the patient should get a copy and communications should be as understandable as possible.
- **Avoid duplication & avoid irrelevant raw data:** Only clinically pertinent investigation results should be included.
- **Template enforcement:** EPR templates should prompt completion of minimum fields and prevent sending unless the *mandatory sections* (including GP Actions box) are completed.

4. Coding & computable data

- **To be considered alongside digital teams –** follow PBRS standards, FHIR technical specification[1]

5. Distribution & timing

- **Send after consultation:** The outpatient letter must be sent electronically to the registered GP *and* given to the patient at or before 10 days of the consultation. PRSB and clinician group both stress timely, single summary delivery.
- **Other recipients:** Community teams / care homes / pharmacies per local trading agreements; all recipients listed on the distribution list.

6. Governance, training & implementation

- Describe audit process
- **Local PSCI oversight:** Place-based Primary–Secondary Care Interface group to own adoption, mapping and trading agreements (clinician group recommendation).
- **Training:** Include outpatient letter standards in inductions and registrar training; focus on purpose and how to write succinct, action-oriented letters. (Local PSCI teams to manage)
- **EPR configuration:** Configure Epic/EPR templates to enforce mandatory fields (esp. GP Actions), make GP Actions box non-deletable, and provide a patient plain-lang paragraph generator or template suggestions.
    - Primary care digital collaboration group

7. Example SEL Outpatient letter

Patient name

NHS No

DOB

Appointment date | Completed by (name, role):
Patient summary (2–4 lines, plain English): "You were seen in (insert outpatient service) for (insert symptoms/reason appointment was made). While in our care, we did Y. You were given a diagnosis of Z. You should expect A and need to do B. If you get symptom C contact …"

Diagnosis / reason for appointment: [SNOMED code] & short text.

Medications (prescription list):

- [Medicine name (dm+d if available)] & Status: *New / Changed / Continued / Stopped*; Dose directions; Reason for change; Quantity supplied (e.g., 28 tablets / 30 days).

Allergies: [List or "No known drug allergies" / "Information not available"].

GP Actions (boxed & prominent):

1. [Action text] - Responsible: [Hospital team / GP / Patient]; By: [date or timeframe]. (If none: "No GP actions required".)

Patient actions / Advice: [Plain English bullet points].

Pending investigations / Results to follow up: [test] - Responsible: [Hospital / GP] By: [date].

Follow up appointment: [Team / clinician], Date/How arranged (if arranged).

Contact for queries: [Name / Team / Tel / Email / times].

8. Minimum dataset

For each Outpatient letter the system should capture these structured elements (these form the auditable fields):

- ☐ Patient NHS number, name, DOB, contact.
- ☐ Date/time of discharge & name of person completing summary.
- ☐ Primary diagnosis (SNOMED) + secondary diagnoses (SNOMED) or symptom if diagnosis not yet confirmed.
- ☐ Medications: for each med - name (dm+d if possible), status (continued/new/changed/stopped), reason for change, directions, quantity/duration, whether supplied.
- ☐ Allergies/adverse reactions (or explicit "None known" / "Information not available").
- ☐ GP Actions: text of action, due date (if applicable), responsible party (hospital/GP/patient).
- ☐ Patient actions/advice (plain English snippet).
- ☐ Pending investigations with ownership.
- ☐ Distribution list.

9. Key Performance Indicators

Governance: audit reviewed by borough-based PSCI group. Quarterly audit reports submitted to SEL-wide PSCI interface leads.

1. **Completion of GP Actions box (%)** - summaries sent with GP Actions box completed (or N/A if no actions are required). *Target*: ≥ 95%. (Clinician group emphasised this as key quality metric.)
2. **Single letter delivered to GP within 10 days(%)** - target ≥ 95%. (PRSB: timely single summary.)
3. **Patient copy provided (%)** - target ≥ 95%.
4. **Medication reconciliation completeness (%)** - discharge meds coded with status (continued/new/changed/stopped) and reason for change present. *Target*: ≥ 95%.
5. **Plain-English patient letter present (%)** - patient-facing plain language paragraph included. *Target*: ≥ 90%. (Clinician group priority.)
6. **Outstanding test ownership present (%)** - pending investigations with clearly assigned responsible organisation. *Target*: ≥ 95%.

10. References for development

1. PBRS e-Outpatient letter guides[1]
2. Reference group meeting 24, September 2024
3. HIN led rapid literature review
4. UnBoxed patient user research report

11. Outpatient letter performance scorecard

KPI	Definition/Calculation	Target	Current performance	RAG rating
Completion of GP Actions box	Letters sent with GP Actions box completed (or N/A if no actions are required).	≥ 95%.		
Letter delivered to	As stated,	≥ 95%.		

[1] Outpatient letter Standard - PRSB

GP within 10 days				
Patient copy provided	As stated,	≥ 95%.		
Medication reconciliation completeness	discharge meds coded with status (continued/new/changed/stopped) and **reason for change present.**	≥ 95%.		
Plain-English patient letter present	patient-facing plain language paragraph included.	≥ 90%.		
Outstanding tests and ownership present	pending investigations with clearly assigned responsible organisation. *Note: clinician responsible for ordering the investigation dictates follow up.*	≥ 95%.		

Appendix 6: DRAFT updated SEL Interface Prescribing Policy

South East London Interface Prescribing Policy

Introduction

This policy has been jointly developed by the Medicines Optimisation leads within the NHS organisations in South East London Integrated Care System (SEL ICS). It has undergone consultation with the Medicines Management/Drug and Therapeutics Committees for Acute and Mental Health Trusts and boroughs forming South East London Integrated Care Board (ICB). The policy has been approved by the SEL Integrated Pharmacy Stakeholder Group (a cross-sector Pharmacy Leadership Group) and the SEL Integrated Medicines Optimisation Committee. This document has undergone revisions following reengagement with the above groups and stakeholders involved in the south east London Primary / Secondary Care Interface work programme, in order to address gaps and better account for the diversity of clinical and non-clinical prescribing roles, and with a view to the impending system changes with the development of neighbourhoods.

The policy clarifies the role of GPs, Acute Hospital clinicians, Mental Health clinicians, community consultants and other prescribers, and aims to facilitate consistent prescribing across SEL through better communication between clinicians. For the avoidance of doubt, devices are not included in this policy.

This is a policy document and cannot override national or out-of-area formulary decisions. It provides SEL standards for communication, safety and accountability, even where cross-boundary prescribing creates constraints. All clinicians – medical and non-medical – should comply with this policy wherever possible and record clear reasons if unable to do so. It is the responsibility of all providers to embed this policy into their induction, clinical governance and digital systems.

All prescribing decisions must consider patient safety and provide high value care.

Implementation and monitoring of this policy is the responsibility of each Trust and ICB with exceptions reports to be highlighted in contract meetings.

General Principles

2.1. The South East London Integrated Medicines Optimisation Committee (SEL IMOC), the South East London Joint Medicines Formulary Committee (JFC), and the Evelina Medicines Committee should maintain an up-to-date formulary/prescribing guidelines and treatment pathways for common and high cost drugs with the involvement of GPs and SEL ICB MO team. These pathways should have embedded within them drug choice, RED, AMBER, GREEN, GREY (RAGG) category and signpost to shared care where appropriate.

2.2. The majority of prescribing by hospital clinicians should be in line with the SEL Joint Medicines Formulary and SEL Paediatric Formulary, or prescribing guidelines/position statements. Where, exceptionally, a patient’s treatment necessitates the prescribing of a non-formulary drug, the hospital clinician should first obtain in-house approval via Trust non-formulary processes. The hospital clinician should then discuss the choice of drugs and reasons for prescribing outside the formulary with the individual GP and agree who will continue prescribing.

2.3. Advisory Committee Borderline Substances (ACBS) products, dressings, appliances, and devices will have their local prescribing arrangements in place, but the general principles of good prescribing for medicines can also be applied to these products. Drug tariff ACBS criteria should be followed.

2.4. Legal responsibility for prescribing lies with the prescriber (doctor/Non-Medical Prescriber (NMP)) who signs the prescription.

2.5. All patients should continue to receive the most appropriate drug therapy when necessary and in the most appropriate setting.

2.6. Prescribing responsibility must be based on clinical responsibility. Responsibility for prescribing lies with the clinician who, at the time, has clinical responsibility for a patient and is able to monitor treatment and adjust dose as necessary. This is in the best interest of patients.

2.7. When carrying out shared decision-making with patients on the choice of treatment, the impact of sustainability and overprescribing should form part of these decisions.

2.8. OTC/self-care medicines should not be prescribed routinely in any setting. Clinics must avoid recommending OTC items that conflict with NHSE guidance. IMOC will provide specialty-specific examples. Epic should prompt prescribers about OTC/low-value status at point of prescription.

2.9. Clinicians should always consider when it might be appropriate to de-prescribe a medication particularly when a patient is frail, is on short-term behaviour modifying drugs or drugs with high anti-cholingeric burden.

Technical Guidance on Prescribing

Trusts within the ICS must adhere to the guidance contained within the following circulars (not an exhaustive list – compliance with all relevant circulars and guidance is required):

- Responsibility for Prescribing Between Primary, Secondary and Tertiary Care, NHS England 29 January 2018.
- Commercial sponsorship in the NHS, Dept of Health Nov 2000.
- Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs, NHS England March 2018

Trusts should have a discharge policy in place that includes arrangements for the transfer of prescribing information to GPs including standards of 6.2 of this policy.

Trusts should notify ideally within 24 hours but no longer than 72 hours of discharge to GPs for ongoing management including any changes in prescribing especially if prescribing was initiated during investigation of unconfirmed condition or awaiting formal diagnosis.

Trusts to carry out medicines reconciliation as set out in the NICE guideline NG5 Medicines optimisation.

Where a medicine is urgent, high-risk or RED-listed, the secondary care prescriber must complete the episode: prescribe, counsel the patient, and arrange the initial supply via the hospital trust pharmacy.

When requesting GP initiation or continuation of any medicine, secondary care must document the counselling provided to the patient - including indication, benefit, risks, side effects, monitoring, duration and reasonable timeframes for medicines to be prescribed as well as de-prescribed.

Prescriber must recommend or prescribe treatment by generic name except where it is clinically inappropriate. Pharmacies must dispense and label by generic name unless clinically appropriate to use the brand name.

The hospital will dispense medicines routinely as patient packs unless there are clinical reasons not to, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients.

Valproate products must always be dispensed in original packs in line with MHRA guidance, January 2024

In-patients (person admitted to hospital for the purpose of observation, care, diagnosis and treatment)

All drugs, enteral nutrition, dressings and appliances prescribed for administration pre-procedure or for whilst an in-patient are the responsibility of the consultant concerned. All necessary drugs and dressings will be supplied by the Hospital Trust.

All healthcare professionals should encourage patients (e.g., via the ‘green bag’ scheme) to bring their medications into the hospital on admission. These can be checked to aid medication history completion and initial inpatient prescribing. The 'green bag' scheme is where on admission to hospital all the medicines being taken by the patient will be placed in a green, easy to identify, reusable bag, with the right dosage information.

Patient’s own drugs remain their own property and should be returned to them on discharge from hospital, providing such therapy is still appropriate. Patient’s own drugs, with the agreement of the patient, may be used while the patient is in hospital until a supply is made by the hospital pharmacy or where a policy exists regarding the use of patient’s own drugs. They may be used to fulfil discharge medicine requirements. Local Trusts Medicines Policies should be followed.

When a patient is discharged from hospital, ensure that patients have a minimum of 14 days of drugs including patient’s own supply at home (unless trust maintaining responsibility for supply).

- This should be supplied in the form of a patient pack wherever possible.
- Full course of antibiotics and steroids should be given if duration known and is less than 2 weeks.
- If compliance aids are to be supplied this should be for 7 days where appropriate, or via FP10HP to community pharmacy for compliance aids where appropriate.

- For dressings 5 days should be supplied (subject to paragraph 2.2) unless the full course of treatment calls for a shorter supply.
- The amount should be sufficient to ensure safe continuation of treatment prior to GPs taking over prescribing responsibility.
- Where there is an agreed national tariff charge such that the tariff paid from an inpatient episode includes that the Trust retain responsibility for patients for a period of rehabilitation (which may be less or more than 30 days post discharge), then in accordance with guidance, provision of drug therapy for this period will be part of the Trust responsibility.

Trusts should have in place a policy for use of Patients' Own Drugs, Self-Administration of Medication, Dispensing Medicines for Discharge, Discharge Medicines Service referrals and the use of Compliance aids (including monitored dosage systems), this should include liaison between primary care (including community pharmacy) and secondary care and appropriate arrangements for continuity of care after discharge, supply of amber/red medicines supplied by the Trusts and work towards a sector approach.

Emergency Department, Urgent Care Centres

A minimum 5 days supply of drugs and/or dressings needed should be given unless the full course of treatment requires a shorter supply. Self-care should be encouraged for self-limiting conditions, in line with national guidance, for example with OTC analgesia. Full course of antibiotics and steroids should be given if duration known and is less than 2 weeks.

Patient's own drugs should remain with the patient during the time of their assessment (unless unsafe to do so when e.g. safe storage of medicines is unavailable) and transferred with them if they are admitted or sent home, unless clinically inappropriate.

Outpatients (A person who is not an inpatient, not hospitalised)

Drugs and dressings and appliances prescribed for administration during a hospital outpatient consultation should be provided by the Trust.

If immediate treatment is required following an outpatient consultation, a minimum of 14 days of drugs (supplied in the form of a patient pack wherever possible) and a minimum of 5 days of dressings should be supplied by the hospital, unless the full course of treatment requires a shorter supply. Patients should be advised on the importance of a hospital supply for urgent treatment rather than a delayed supply from their GP.

When the patient does not require an immediate supply, the patient should be informed that their treatment is not urgent. The clinician must fill out all relevant sections (including diagnosis, allergies, prescribing information and contact details of prescriber) of the Out-Patient paper/electronic prescriptions and tick or select the 'Non-Urgent' box. All relevant information enabling the GP to prescribe, should reach the practice as soon as possible but no longer than 7 working days. Patients

should be advised that it can take up to 3 working days once information received for a GP to process requests for new medication and to issue an FP10.

In the case of urgent / RED listed / safety-critical initiations, the hospital must supply at least 14 days, preferably 28 days, and provide counselling at initiation.

In the case of non-urgent starts, GPs may be asked to prescribe if the **minimum medicines dataset** is fully included in the discharge or clinic letter, and the medications change is labelled as 'non-urgent'.

When medicine changes are recommended by a non-prescribing clinician, a prescriber must have oversight over the initial prescription

There may be instances where the patient may not require an immediate supply of medication but the drug being recommended requires specialist initiation. *Either all* prescribing of the treatment is hospital only (i.e. RED drugs,) or initial supplies are from the hospital (i.e Amber 2) where the hospital supplies an initial portion of treatment, and Amber 3, where the initial supplies are by the hospital and SEL shared care arrangements are followed. In these instances the initial supply should be made by the hospital and, if necessary, the shared care process outlined in section 7 of this document should be implemented.

If formulary differences in out-of-area patient cases delay or prevent GP continuation, secondary care retains prescribing responsibility. Letters must explicitly state formulary mismatches and interim supply arrangements

Day Case Patients (a person that requires an intervention to be performed in hospital but doesn't need to stay overnight)

Drugs and dressings prescribed for administration during day case treatments are the responsibility of the consultant concerned (subject to paragraph 2.2). All necessary drugs and dressings for administration pre-procedure or for a day case will be supplied by the Trust (subject to paragraph 2.2).

Discharge medication for day case patients are subject to prescription charges as per out-patients. A minimum of 14 days of drugs (supplied in the form of a patient pack wherever possible) and a minimum of 5 days of dressings should be supplied, unless the full course of treatment requires a shorter supply.

Virtual wards (Patients who would otherwise be in hospital to receive the acute care, monitoring and treatment in their own home.)

All patients should be provided with sufficient medicines during their virtual episode of care. Arrangements should be in place for prescribing and continuation of medicines when they are discharged including consideration of referral to the Discharge Medicines Service.

Healthcare professionals must satisfy themselves that they can make an adequate assessment before prescribing for a patient via telephone, video, online or face-to-face consultations.

Where available, non-medical prescribers (NMPs) should be embedded in virtual ward services to allow for timely prescribing, medicines optimisation and deprescribing.

The prescribing and medicines ordering processes in virtual wards should be integrated to ensure continuity of supply, avoidance of missed doses, efficiency, and avoidance of wastage. Various prescribing and supply routes for medicines have been utilised in different settings depending on the organisation providing the service. Local guidance should be followed.

For those medicines not normally sourced from community pharmacies, collaboration with other providers across the system is key to ensuring timely access to medicines. Alternatively, agreements can be set up locally with community pharmacies to hold stock of medicines that may not be routinely stocked but may be required regularly in the specific virtual ward pathway setting. Patients in virtual wards should be encouraged to self-administer their medicines, where possible, with the support of family and/or carers where needed

Transfer of Information

On referral to a hospital consultant for a planned attendance, it is the responsibility of the GP to give comprehensive details of a patient's relevant medical history, drug treatment, previous adverse reactions, allergies and any use of compliance aids. Electronic records such as London Care Records could be used for this purpose.

On discharge from hospital or the community, clinicians must provide the patient's GP with information on diagnosis and reason for admission, patient's medication on discharge including hospital supply medications, including whether to continue or stop, any medication changes and reasons for the changes, and recommended next review timeframe. In addition, any relevant clinical or biochemical monitoring parameters should be communicated highlighting further monitoring to be undertaken by the GP. The information provided should include the recommended core content of records for medicines when patients transfer between care providers as outlined in the RPS guidance "keeping patients safe when they transfer between care providers- getting the medicines right" and NICE guideline NG5 Medicines optimisation. This information must be made available to the patient's GP ideally within 24 hours but no longer than 72 hours of discharge to allow ongoing treatment to be maintained. If this cannot be guaranteed, then the hospital should prescribe for as long a period as necessary.

Where there is uncertainty or lack of clarity about prescribing, clinicians should be able to seek advice and guidance from the lead prescriber via a department, team, or individual point of contact such as an email address.

Minimum Medicines dataset to be included in discharge and clinic letters where the GP is being asked to initiate or change a medication:

- Indication / diagnosis.

- Full list of medicines (new, changed, stopped, continued).
- Reason for each change (aligned to PRSB standards).
- Named responsible secondary care prescriber and contact details.
- Monitoring requirements (what, when, who; thresholds for action).
- Summary of patient counselling (benefits/risks/side-effects; self-care advice; expected timelines).
- Supply provided (14/28 days) OR reason no supply was given.
- Out-of-area considerations (formulary conflicts or funding differences).
- Shared care status and links to relevant IMOC documents.
- Next review date and responsible team.
- Whether it would be good practice to de-prescribe when appropriate.
- Use of patient-friendly language.
- Documentation in Epic (until structured fields exist, all dataset information must be included clearly in free text).

Shared Care

The process for agreeing and implementing shared care guidelines in SEL and shared care guidelines approved by the SEL IMOC can be found at the Committee's website.

GP prescribing under a shared care arrangement should only be considered when the patient's condition is stable, the GP has confirmed agreement to accept prescribing under the shared care arrangement, and the GP has sufficient information to safely prescribe for the patient. The criteria for transfer of care prescribing via shared care must be fulfilled before counselling the patient to request item from the GP. The shared care agreement should include clear expectations about monitoring, prescribing and when they can expect a review.

The ICB may require Trusts to work within locally agreed Shared/Transfer of Care document although this may not be necessary for all drugs and an individual management plan may suffice (See sections 7 and 8). Trusts retain the responsibility for prescribing until the GP has agreed to take over. Financial incentives for GPs to take on shared care in primary care is expected in 2027. Further information on shared care arrangements on SEL IMOC website.

Special considerations

Responsibility for prescribing will remain with the hospital consultant where:

- Drugs are undergoing or included in a hospital based clinical trial, or for compassionate use including early access schemes

- The consultant considers that only they are able to monitor the patient's response to medication because, for example, of the need for specialised investigations
- A drug or appliance is not available on a FP10 or is only available through the hospital
- Drugs subject to High-tech Hospital at Home guidance, EL(95)5
- GP does not feel confident taking on clinical responsibility for prescribing of specialist drugs. Where agreements have been made at IMOC meetings, GPs should be encouraged to prescribe in line with these.
- When patient becomes unsuitable for shared care, the hospital must repatriate prescribing responsibility promptly.
- For RED/ high-risk drugs, primary care may contact the specialist clinic directly, and Trusts must publish a clear point of contact.
- Red or Grey drug from RAGG list of drugs. Exceptional circumstances to be discussed between consultant and GP as per RAGG list definitions

GPs should record all medications (including red-listed (hospital only) medicines) on the patient medication list regardless of if they are not responsible for prescribing them. This is to ensure a comprehensive medication history is maintained and should be updated on a regular basis.

GPs are encouraged to continue to prescribe medicines for off-label indications where such use is approved in evidence-based guidelines or is established practice (e.g approved on Formulary as green or amber).

Unlicensed drugs remain the responsibility of the hospital consultant except where evidence exists to support the use of an unlicensed medicine (e.g SEL IMOC Amber recommendation).

Where a treatment that is not listed in 9.1 and is not on the SEL formulary please follow process described in 2.2.

A separate policy exists for the supply of medicines for end-of-life care. Please check local Trust policies

New Drugs and Clinical Trials

The process for managing the entry of new drugs or indications must consider clinical and cost-effectiveness and the impact on Primary Care prescribing. In South East London, the process for managing the entry of new drugs that will impact on primary care or are tariff excluded (high cost drugs), and are ICB attributed is through the SEL IMOC after initial review by the triage panel. Submissions will be considered through the SEL IMOC. Submissions for hospital only, in tariff drugs will be considered through the SEL JFC or Evelina medicines committee.

Clinicians should refer to the Terms of Reference for the SEL IMOC for detail on how New Drug applications should be submitted; these can be accessed via the Committee's website. Individual SEL

ICB Boroughs will need to ensure that a process is in place by which GPs are informed of decisions for new drugs, approved or rejected, by the SEL IMOC.

Trust Formulary pharmacists will need to ensure that a process is in place by which Trust clinicians are informed of decisions for new drugs, approved or rejected, by the SEL IMOC.

All clinical trials must have been subject to Ethical Committee approval. The hospital clinician is responsible for informing the GP if a patient is participating in a clinical trial

Prescribing and supply of clinical trial, compassionate or patient access scheme material is the responsibility of the Hospital Trust. The ICB will not automatically continue compassionate or clinical trial medicine funding once the compassionate funding or clinical trial ends. Trusts must discuss on-going treatment with appropriate commissioners.

Patients should be made aware that funding for clinical trial medication may not be available once the trial comes to an end.

Commissioning of NICE technology appraisals

SEL ICB will fund treatments that fall within local commissioning responsibilities which are recommended by a NICE Technology Appraisal. Funding will be within the time frame stipulated in the NICE guidance (usually within 3 months of the final NICE publication, or 1 month for TAs designated as "fast-track" appraisals). Trusts supplying such treatments prior to the formal commissioning date stipulated in the NICE Technology Appraisal (e.g. under an early access scheme) are required to ensure that separate arrangements for funding are in place up to the stipulated date for formal commissioning.

National shortage of medicines

Where a medication is initiated in a Trust and continued in Primary Care and there is a national shortage, NHS organisations within the ICS will work together to ensure patients' care is not adversely affected and will provide advice on alternative options during the shortage. In these scenarios it may be necessary to temporarily amend formulary restrictions or make non-formulary products available if this is the most appropriate clinical course of action.

National medicines value programme

Trusts and the ICB will work collaboratively across the ICS to promote and implement the national Medicines Value Programme (MVP), which aims to improve health outcomes and ensure the best value from medicines. Initiatives covered by the MVP include:

- Decreasing or stopping the use of medicines which are neither clinically- or cost-effective
- Promoting the self-care agenda, including associated SEL IMOC resources
- Increasing the use of best value biological and generic medicines, including biosimilar medicines where appropriate

- Supporting antimicrobial stewardship
- National Medicines Optimisation Opportunities

Responsible ICS Rules

Trusts and the ICB will work collaboratively across the ICS to jointly agree on commissioning policies and formulary recommendations. To operate to the NHS Contract these are classified as responsible commissioner rules. Therefore, Trusts will apply these policies and recommendations to all patients undergoing treatment irrespective of the ICS area they are referred from.

This includes referring to the Trust's local formulary position on medicines used in the service, red list status and prescribing arrangements.

Patients being treated in an out of sector Trust should be treated the same as a patient who is registered with a GP practice within that ICB i.e., out-of-area patients should not be treated in line with another ICB's pathway.

Contacts

SEL ICB Borough Medicines Management Team Contact Details

Bexley	Bexley.MMT@SELondonICS.nhs.uk
Bromley	Bromley.Medicinesmanagement@SELondonICS.nhs.uk
Greenwich	Greenwich.Pharmacy@SELondonICS.nhs.uk
Lambeth	Lambethmedicines@selondonics.nhs.uk
Lewisham	Lewisham.medsopteam@SELondonICS.nhs.uk
Southwark	Southwark.medicine-optimisation@SELondonICS.nhs.uk

Glossary

In order of appearance:

Abbreviation	**Definition**
SEL	South East London
ICS	Integrated care system
ICB	Integrated care board
GP	General Practitioner
NMP	Non-medical prescriber
MHRA	Medicines and Healthcare products Regulatory Agency

EEC	European Economic Community
NHS	National Health Service
CCG	Clinical Commissioning Group
NICE	National Institute for Health & Care Excellence
NG	NICE guideline
IMOC	Integrated Medicines Optimisation Committee
JFC	Joint Formulary Committee
MO	Medicines Optimisation
RAGG	Red, Amber, Green or Grey formulary rating
ACBS	Advisory Committee Borderline Substances
FP10HP	FP10 Hospital prescription
OTC	Over the counter medicines
RPS	Royal Pharmaceutical Society
MVP	Medicines Value Programme

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Appendix 7: Greenwich, Bexley and Lewisham Inappropriate Requests letter

14th February 2025

Dear

Patient Name:

Patient Hospital/NHS Number:

GP practice:

A key initiative within South East London is improving communication and relationships between primary and secondary care. One component of this is reducing the burden of work we place on each other by following agreed local pathways and policies.

Following a recent clinical encounter with a patient at Lewisham and Greenwich NHS Trust, you or a member of your team requested that the patient's GP undertake a task which, according to Trust policy, you should have undertaken, namely (tick as appropriate):

A. **Requested GP to follow-up results of investigations requested by you or your team [ ]**

Hospital clinicians are responsible for reviewing and actioning the results of tests that they or their team have requested.

B. **Requested GP to organise investigations pertaining to the referral/admission and forward the results/action [ ]**

Hospital clinicians are responsible for organising tests that they or their team have requested and then action them as required.

C. **Requested the GP to do an onward referral to a specialist team [ ]**

Hospital clinicians should do onward referrals if the problem is related to the initial reason for referral, OR a problem identified during an admission or outpatient appointment that clearly requires a specialty referral OR is urgent/potentially serious (e.g. 2 week wait).

D. **Requested the GP to commence a medication that is not in line with the South East London prescribing guidance [ ]**

Hospital clinicians are responsible for prescribing in line with South East London prescribing guidance and arranging appropriate speciality follow up as required by the guidance. Guidance available here: https://selondonjointmedicinesformulary.nhs.uk

E. **Requested the GP to arrange an Individual Funding Request for a treatment recommended or offered by you or your team [ ]**

Hospital clinicians are responsible for making the request themselves for a treatment they recommend or offer. Guidance available here: https://www.selondonics.org/our-residents/your-health/care-and-support/individual-funding-requests/

F. Requested the GP to issue a Fit Note for the patient [ ]

Hospital clinicians should issue a Fit Note for the entire period (up to three months) that they feel a patient will be unable to work following an inpatient or outpatient encounter.

G. Requested the GP to arrange recall of the patient for future follow up [ ]

Hospital clinicians are responsible for recalling patients for future appointments that they or their team deem necessary.

H. Details of other inappropriate request:

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The response of the GP is as follows:

1. The action requested has not been completed and by return of this letter, we ask you to take action promptly. **[ ]**

2. Due to high clinical risk such as 2ww, the GP has undertaken the requested action on this occasion. **[ ]**

3. The GP has copied this letter to the Deputy Chief Medical Officer, Waqas Khaliq, via wkhaliq@nhs.net to monitor trends in inappropriate referral and request behaviours within the Bexley and Greenwich system, to enable all parties to understand where improvements and efficiencies in patient care can be made. **[ ]**

In future, please kindly ensure you and your team follow Trust policy.

Yours sincerely,

Vanessa Purday
Chief Medical Officer
Lewisham and Greenwich NHS Trust