Integrated Care Board – Meeting in Public

14.00 to 17.00 on 15 October 2025

Keith Peacock room Charlton Athletic FC SE7 8BL

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	14.00
	Borough Showcase			
2	**Socio-economic development and addressing the wider determinants of health**	-	RK	14.05
	ICB Corporate Business			
3	**NHS Planning update**	C	SC	14.35
4	**Green Plan**	D	TF	14.45
	Report for Assurance and discussion of current issues (90mins)			
5	**Chief Executive Officer's report**	E	AB	14.55
6	**Board Assurance Framework**	F	TF	15.00
7	**Overall Report of the ICB Committees and Provider Collaboratives**	G	TF	15.10
8	**Performance Report**	H	SC	15.20
9	**Quality and Safeguarding Report**	I	GK	15.40
10	**Finance Report**	J	MF	16.00
	Delivering our Integrated Care Strategy			
11	**Developing our Neighbourhood Health service**	K	HE	16.20

Closing Business				
12	Any other business	-	RD	16.45
13	Public Questions and Answers	-	RD	16.50
CLOSE 17.00				

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	Gwen Kennedy	ICB Chief Nurse
RK	Ranjeet Kaile	Director of communications and engagement
HE	Holly Eden	Director of Delivery - Neighbourhoods and Population Health

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members and attendees
Date: 15/10/2025

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Sir Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy 2. Trustee, Place2Be, an organisation providing mental health support in schools 3. Trustee, Demelza Hospice Care for Children, non-remunerated role. 4. Non Executive Member Department of Health and Social Care Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	March 2016 June 2022 August 2022 April 2024	Current Current Current Current
Crystal Akass	CPO	CPO Guys and St Thomas NHSFT	-	-	-
Dr. Angela Bhan	Place Executive Lead, Bromley	1. Undertake professional appraisals for consultants in public health professional public health appraiser for NHSE 2. Very occasional assessor for CESR applications for GMC, on behalf of Faculty of Public Health Faculty of Public Health 3. Professional Public health advise given when required London Borough of Bromley.	Non-Financial Professional Interest Financial Interest Non-Financial Professional Interest	July 2022 July 2022 July 2022	Current Current Current
David Bradley	Partner member, mental health	1. Unpaid advisor to Mindful Healthcare, a small start up providing digital therapy 2. Wife is an employee of NHS South West London ICS in a senior commissioning role 3. Chief Executive (employee) of South London and Maudsley NHS Foundation Trust	Non-financial profession interest Indirect interest Financial interest	April 2019 July 2019	Current Current Current
Diana Braithwaite	Place Executive Lead, Bexley	none	-	-	-
Andrew Bland	Chief Executive	1. Partner is an NHS Head of Primary Care for Ealing (a part of North West London ICB)	Indirect interest	1 April 2022	Current
Sarah Cottingham	Deputy Chief Executive and Director of Planning	none	-	-	-
Jennifer Daothong	Partner member, local authority	Chief Executive of Lewisham Council	-	-	-
Gabi Darby	Place Executive Lead Greenwich	none	-	-	-
Holly Eden	Director of Delivery – Neighbourhood and Population Health	none	-	-	-

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Andrew Eyres	Place Executive Lead, Lambeth	Director of Lambeth Southwark and Lewisham LIFTco. representing the class B shares on behalf of Community Health Partnerships Ltd with the aim of inputting local knowledge to the LSL LIFTco, for the following LIFT companies: Building Better Health Lambeth Southwark Lewisham Limited, Building Better Health Lambeth, Southwark Lewisham (Holdco 2) Limited, Building Better Health Lambeth Southwark Lewisham (Holdco 3) Limited, Building Better Health Lambeth Southwark Lewisham (Fundco 2) Limited, Building Better Health Lambeth Southwark Lewisham (Fundco 3) Limited, Building Better Health LSL (Fundco Tranche 1) Limited, Building Better Health LSL (Fundco Holdco Tranche 1) ,Limited Building Better Health LSL Bid Cost Holdco Limited Building Better Health LSL Bid Cost Limited, Building Better Health - LSL (Holdco 4) Limited, Building Better Health - LSL (Fundco4),	Non-financial professional interest	1 April 2013	Current
Tosca Fairchild	Chief of Staff	1. Partner is a Consultant in Emergency Medicine. Potential to undertake locum work. 2. Bale Crocker Associates Consultancy – Client Executive	Non-Financial Professional Interest Financial Interest	01 May 2022 03 May 2022	Current Current
Georgina Fekete	Non Executive Member	none	-	-	-
Mike Fox	Chief Finance Officer	1. Director and Shareholder of Moorside Court Management Ltd 2. Spouse is employed by London Regional team of NHS England 3. Treasurer of the PTA fo Friends of Green Lane Primary	Financial interest Indirect interest Non-Financial Personal Interest	May 2007 June 2014 16 June 2023	Current Current Current
Dr. Toby Garrood	Medical Director	1. Serac Healthare Shareholder 2. Guy's and St Thomas' NHS Foundation Trust Employed as a consultant rheumatologist 3. London Bridge Hospital Private medical practice 4. Guy's and St Thomas' NHS Foundation Trust In my role I have received research grant funding from Versus Arthritis, Pfizer, Gilead, Guy's and St Thomas' Charity and NHSx 5. Abbvie Speaking honorarium	Financial Interest Non-Financial Professional Interest Financial Interest Non-Financial Professional Interest Financial Interest	01/04/2020 07/10/2009 01/01/2012 01/01/2015 01/04/2020	Current Current Current Current Current
Ceri Jacob	Place Executive Lead, Lewisham	none	-	-	-
Ranjeet Kaile	Director of Communications and Engagement	Non-executive Trustee - People's Health Trust Charity	Non-financial professional interest	April 2024	Current
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists 2. Fellow of the Royal College of Physicians (Edinburgh) 3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Non-financial professional interest Non-financial professional interest Financial interest	1994 2000 April 2019	Current Current Current
Gwen Kennedy	Acting ICB Chief Nurse	A substantive employee of NHS England.	Non-Financial Professional Interest	30th Sep 2016	Current
Denis Lafitte	CDIO	none	-	-	-
Peter Matthew	Non executive director	none	-	-	-

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Paul Najsarek	Non executive director	1. Advisor to Care Quality Commission on their approach to local authority assurance 2. Board member, The Health Foundation 3. Chair of North Central London ICB 4. Trustee of Waythrough 5. Director, Paul Policy Practice Ltd 6. Advisor to DA Languages Ltd 7. Lead inspector on best value inspection, Warrington Council	Non-financial professional interest Non-financial professional interest Financial interest Non-Financial professional interest Financial interest Non-Financial professional interest Non-Financial professional interest	1 April 2022 1 March 2023 7 Oct 2024 1 June 2024 24 Dec 2021 1 July 2024 1 May 2024	Current Current Current Current Current Current 31 Jan 2025
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 4. Fellow of the Royal College of Psychiatrists 5. Fellow of the Royal Society of Medicine 6. International Fellow of the American Psychiatric Association 7. Member of the British Association of Psychopharmacology 8. Member of the Faculty of Medical Leadership and Management Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2021 1996 1992 1992 1992 1985 1985 1985 1985	Current Current Current Current Current Current Current Current Current
Amanda Pritchard	Chief Executive	Chief Executive of Guys and St Thomas NHSFT	-	-	-
Anu Singh	Non executive director	1. Chair, Leicester, Leicestershire and Rutland ICB 2. Non-executive director on Board of Birmingham and Solihull ICS. 3. Independent Chair of Lambeth Adult Safeguarding Board. 4. Member of the advisory committee on Fuel Poverty. 5. Non-executive director on the Parliamentary and Health Ombudsman.	Financial interest Financial interest Financial interest Financial interest Financial interest	Oct 2025 2020 April 2021 2020 April 2020	Current Current Current Current Current
Darren Summers	Place Executive Lead, Southwark	Member of Guys and St Thomas Trust Council of Governors	Non-financial professional interest	July 2024	Current
Ben Travis	Chief Executive	Chief Executive Lewisham and Greenwich Trust	-	-	-
Dr. George Verghese	Partner member, primary care	1. GP partner Waterloo Health Centre 2. Lambeth Together training and development hub director Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	2010 2022 2019	Current Current Current

Integrated Care Board meeting in public

Minutes of the meeting on 16 July 2025

Bromley Civic Centre Churchill Court, 2 Westmoreland Rd, Bromley BR1 1AS

Present:

Name	**Title and organisation**
Richard Douglas [Chair]	ICB Chair
Dr Angela Bhan	Bromley Place Executive Lead
Andrew Bland	ICB Chief Executive Officer
Diana Braithwaite	Bexley Place executive Lead
Andrew Eyres	Lambeth Place Executive Lead
Georgina Fekete	Non-Executive Member
Mike Fox	Chief Finance Officer
Paul Najsarek	Non-Executive Member
Dr Toby Garrood	ICB Joint Medical Director
Ceri Jacob	Lewisham Place Executive Lead
Prof Clive Kay	Partner Member Acute Care
Anu Singh	Non-Executive Member
Darren Summers	Southwark Place Executive Lead
Dr George Verghese	Partner Member Primary Care

In attendance:

Sarah Cottingham	Executive Director of Planning and Deputy CEO
Holly Eden	Director of Delivery - Neighbourhoods &Population Health
Ranjeet Kaile	Director of Communications and Engagement
Kieran Swann	AD of Assurance
Simon Beard	AD of Corporate Services
Dr Upaasna Garbharran (item 11)	Deputy Medical Director
Anthony Harris (item 2)	AD for Children's Commissioning at Bromley Place
Dr Shahid Karim (item 2)	Clinical Leader BCHIP
David Walker (item 2)	Chief Executive Bromley Third Sector Enterprise
Sophie Michael (item 2)	Penge Primary Care Network
Dr Agnes Marossy (item 2)	Consultant in Public Health One Bromley

1.	**Welcome and Opening Business**
1.01	Sir Richard Douglas welcomed all to the meeting and thanked Bromley Borough for hosting the event. He welcomed Gwen Kennedy as the ICB chief Nurse and Holly Eden as attendee in her role as Director of Delivery - Neighbourhoods and Population Health.
1.02	Apologies were noted from Prof Ian Abbs, David Bradley, Tosca Fairchild, Peter Matthew, Dr Ify Okocha, Ben Travis, Debbie Warren, and Philippa Kirkpatrick.
1.03	There were no additional declarations of interest in relation to matters in the meeting.

1.04	The minutes of the previous meeting were approved as a record of the meeting.
1.05	The action log was reviewed.
2.	**Bromley Borough showcase**
2.01	Dr Angela Bhan introduced presentations Bromley Children's Health Integrated Partnership (BCHIP) and on tackling health inequalities.
	BCHIP
2.02	Dr Shahid Karim and Anthony Harris explained that BCHIP had been based on a model used in Lambeth and Southwark for Children's health and had been adapted by One Bromley in response to an increase in demand. The model was based on integration, with paediatricians working with community nursing and GPs in a multidisciplinary team instead of being re-directed to a hospital setting. This allowed more information for example community nursing as well as GP information to be brought to bear to look at the whole system around the child as well as the child themselves.
2.03	Evaluating the system for impact on primary and secondary care attendances before and after using the service, based on data for two primary care networks (PCNs), showed a 20% reduction in primary care presentations after going through triage and a 60% reduction following use of the clinic. Secondary care data also showed a drop in caseload and an effect on referral to treatment performance. Compared to previous pathways children were seen on average 33 weeks sooner through the BCHIP service as well as being seen closer to home, with positive anonymous patient feedback, and cost savings across the system. The initiative was a learning opportunity for both paediatricians and GPs, and lunch-and-learn sessions shared learning across the system.
	Tackling Health inequalities
2.04	Dr Agnes Marossy outlined some of the inequalities work which had provided funding to key areas to develop work to address inequalities, including in Penge PCN where there was a high prevalence of risk factors for ill health. Sophie Michael outlined work which, instead of asking patients to come in to services, had involved going out and asking attendees of established community groups what services they wanted to receive locally. This had led to offering pre-natal and post-natal care to a young mums group, and offering BP checks and nutrition talks by dieticians to a group aiming to reduce isolation, with plans to increase an offer of vaccinations through these groups.
2.05	The one Bromley wellbeing hub, which had developed from a Covid vaccination centre situated int the Glades shopping centre, in collaboration with partners this centre took advantage of the accessible location to provide vital 5 checks, a stop smoking services, workshops and public health campaigns Sickle Cell, and childhood immunisation services.
2.06	David Walker added that the hub was an important in person site for Bromley Well to range of support for individuals including advice and guidance, support with long term health conditions, carer support, support back to employment, for those with learning difficulties, physical difficulties or experiencing isolation, with a drop in support every Wednesday which had seen 156 clients in its first six months.
2.07	Anu Singh remarked that the schemes had involved professionals such as paediatricians and general practitioners working together in new ways which may

	not be intuitive for them and asked if there were lessons from how this had been achieved.
2.08	Darren Summers asked how children and young people with mental health needs and neurodiversity were supported. Anthony Harris noted that the service was not yet extended to mental health and neurodiversity but had a direct line to the integrated single point of access in Bromley for CAMHS services.
2.09	Georgina Fekete asked if there had been a single factor which had made the biggest difference in achieving integration. Dr Angela Bhan note that cultural issues were important and that Covid had interfered rather than acted as the driver for these programmes, and people took time to become accustomed and there was still some scepticism. The One Bromley Partnership had been key in driving the work.
2.10	Dr Toby Garrood asked if it had been possible to realise any cost reductions or cost savings. Anthony Harris noted that outpatient tariffs and rates of follow-up had been compared to the service and it was estimated the model was a third of the cost of the existing pathway although it had not been possible to release cashable savings.
2.11	Dr Clive Kay asked if there were processes in place to ensure that children seen by the clinic were not coming to harm given that fewer went on to attend other services. Noting that the intervention had been developed since the pandemic he asked if there had been factors that had hindered such a scheme being developed before.
2.12	Dr Shahid Karim noted that a core part of why BCHIP worked was getting the right people with a similar mindset together. Challenges included political challenges, mitigated by the Bromley place executive lead, and the financial backing for the necessary double running of services. The cultural change was the co-production and genuine listening exercise, rather than implementing an approach from elsewhere.
2.13	Dr Shahid Karim noted that children who had visited the clinic had been seen by a paediatric consultant with reduction in GP attendance as a result but always with the option to go back to the GP for a referral. There had been a challenge.
2.14	Ranjeet Kaile referred to the metrics showing how many people visited the hubs asked if there were more metrics available on the impact such as avoiding ED attendances. Anthony Harris noted that many people attending the hub who may not attend other services, and it would be useful to understand more systematically which services these were and which geographical areas hub users were from. The key finding was that people appreciated a local neighbourhood service.
2.15	Sir Richard Douglas noted that the Penge work as with much similar work involved working through a range of other local organisations and with significant administration and asked what the obstacles were. Sophie Michael noted that engagement with local people was a challenge, and so by providing a place such as a community group where people would be attending anyway, as well as spending administrative time contacting individual people was a way to reach people and make the most of clinical time.
2.16	Prof Clive Kay asked if direct referrals were possible. Sophie Michael noted that there were no referrals yet but the PCN could help by following up and reminding

	people of their appointment.
2.17	The Board **noted** the Bromley Borough showcase.
3.	**ICB Annual report 2024/25**
3.01	Simon Beard introduced the annual report produced in line with guidance and the accounts to which a modified audit opinion had been added. A user-friendly summary of activities in the year had also been produced.
3.02	The Board **noted** the ICB 2024/25 annual report and accounts update.
4	**Chief Executive Officers report**
4.01	Andrew Bland referred to the report with inputs from all executives. The report welcomed the recently published ten-year health plan and the Board had started, and would continue, to consider the implications over the coming months. Despite the anxiety caused by the ICB change programme, staff had remained professional the ICB aimed to be ready for consultation in the next month although had been no further details of how redundancy costs could be covered or the approval process, and so a precise timetable would be developed when this information was available. The process was overseen by a Transition committee chaired by a Board Non-Executive member.
4.02	The board **noted** the CEO Report
5	**Overall report of committee and provider collaborative**
5.01	Simon Beard referred to the regular report of the activities of Board committees and drew attention to the three decisions escalated to the Board for its decision.
5.02	Sir Richard Douglas suggested deferring the Clinical and Care Professional Committee TOR to a future meeting to allow more time for members to read the document which had been circulated separately. **Action**
5.03	Georgina Fekete noted that the work of the Transition committee had started following its inauguration by the Board and would feed back to board as part of oversight of the change process.
5.04	Georgina Fekete reflected that taken together the work of committees seemed predominantly to be receiving information rather than decision-making. Prof Clive Kay added that the committees and membership may need to be revisited in light of the new purpose of the ICB. Andrew Bland noted that discussions had started on the governance the new arrangements would require but observed that until a change in the law ICBs would retain all their current responsibilities. Simon Beard suggested that a committee effectiveness review process would be a useful first step in assessing the committees and making any changes.
5.05	Andrew Eyres asked that Cllr Natalie Brown be listed as the Lambeth Together co-chair. **Action**
5.06	The Board noted the report and • **Endorsed** the 2025/26 start budgets for approval, as reviewed and recommended by the Executive Committee.

	• **Noted the work of the transition committee.**
6	**Board Assurance Framework**
6.01	Kieran Swann introduced the Board Assurance Framework, noting work by the risk and assurance team to review all risk registers to ensure risks were current and correctly scored, escalated or closed. The BAF listed 30 risks including new five new risks escalated to the BAF and two de-escalated.
6.02	Paul Najsarek noted risks related to completing the transition to the new ICB in terms of staff and structure and but noted that it may be necessary to widen the scope to consider risks to moving to the new strategic commissioning organisation and delivering the 10 year plan, as well as reviewing the risk appetite of the organisation. Sir Richard Douglas agreed noting that as the ICBs responsibilities changed it may be necessary to review for example strategic risks to ensure that they still related to areas of the ICBs responsibility.
6.03	Dr George Verghese paid tribute to the work being done to mitigate the impact of industrial action.
6.04	The Board **approved** the Board Assurance Framework
7	**Finance report**
7.01	Mike Fox noted that the ICB was reporting a break-even position at month 2 and were meeting with all teams to ensure they could deliver thier financial plans for the year. The ICS as a whole was reporting year to date deficit of £21.1m, an adverse variance to the planned deficit of £14.2m. All Organisations were on plan with the exception of Oxleas and the ICB. Organisations had collectively delivered £35.2m efficiency savings so far against a plan of £41.8m, corrolated to some extent with slippage in the delivery of Cost Improvement Plans. There remained a high number of unidentified efficiency saving but this was expected at an early point of the year.
7.02	Final budgets had been included and building on planning and the ICBs obligations in line with strategic intentions set out in the medium term financial strategy to spend a greater proportion on non-acute services.
7.03	Sir Richard Douglas noted that there was confidence in meeting the plan at year end after playing in deficit support, and that the budgets were moving in line with the medium term financial strategy.
7.04	Prof Clive Kay asked if the costs of industrial action had been included in the report. Mike Fox noted that the report did not include specific assumptions for the cost of industrial action.
7.05	Georgina Fekete welcomed the inclusion of information to enable the board to continue to measure the three shifts envisaged in the ten year plan. Asking about a consistent pattern of slippage in relation to continuing care and mental health spend she asked if actions were in place address the situation.
7.06	Darren Summers clarified that mental health spend was driven by complex placements and 'right to choose' pathways for ADHD, the latter driven by increased demand in society and a lack of comprehensive NHS offer which was being

	developed with Oxeas NHS FT. Work on complex placements was continuing with in boroughs working with mental health providers.
7.07	Ceri Jacob noted that continuing health care spend was driven by increased need in the population. Uplifts for providers also contributed to costs, which was being managed with local authority colleagues to ensure costs were consistent. Other work to keep processes tight included forecasting and regular reviews to ensure that CHC packages were correctly configured.
7.08	Dr Angela Bhan added that as the population aged in all boroughs need increased and in Bromley more care homes being built meant increased numbers of older people entering the borough. It was also important to carefully manage the ICB change programme with respect to CHC teams to ensure that reviews could continue to be delivered.
7.09	Andrew Bland noted that NHS England noted that there would be a national review of CHC spend variation, but that SEL was one of the lowest in spend.
	The Board **noted** the finance report.
8	**Performance report**
8.01	Sarah Cottingham referred to the performance report which summarised performance against the key performance targets for the ICB and system. The majority related to the assessments made in planning and a summary of the performance drivers and the current performance against plan had been included. • UEC performance was positive on 4-hour and 12-hour targets, meeting trajectory targets for the year. • Cancer performance was good on 28-day targets, although some challenge with 62-day performance which was improving but still behind trajectory. • Referral to Treatment showed positive trends but a recent increase in over 65-week waiters and challenges in specific specialties. • Diagnostics was a fundamental part of improving pathways and there were some very long waits with targeted actions to try to improve. • Non acute performance primary care access were doing well with some fluctuations. Mental health crisis pathways were still challenged as were out of • On CHC there was positive performance but with some variation by borough. • LD and Autism performance definition had changed but the ICB was confident it could continue to improve performance. • There had been good uptake of community pharmacy. There were some longer community waits in specific areas. There was good urgent community response and virtual ward performance.
8.02	Paul Najsarek suggested that in view of the long-term plan and the spending review there needed to be a longer-term view taken of performance.
8.03	Sir Richard Douglas noted in relation to diagnostics that non-obstetric ultrasound appeared to be a real issue and asked what specific actions were in place to address the target and what impact the issues had on other pathways.
8.04	Sarah Cottingham noted that there were fluctuations in performance on diagnostics but that it was recognised that south east London was an outlier in this area and

	that a more strategic look at capacity may become necessary. The impact was greatest in cancer pathways for particular tumour groups and on the 62 day performance.
8.05	Prof Clive Kay noted that there seemed to be a relative lack of capacity relative to demand particularly in the community. Ultrasound was increasingly being included more routinely in a range of tests to exclude cancer, leading to increases in ultrasound. At a national level there was work to consider what tests should be requested at each stage.
8.06	Dr George Verghese noted that the issue was related to best practice and choosing wisely but also an element related to patient safety and the regulatory landscape which impacted on the use of diagnostic tests more generally.
8.07	Dr Toby Garrood noted that studies of variations in practice in relation to ultrasound and also blood tests were being conducted.
8.08	Sir Richard Douglas asked if there was a link between financial spend on CHC and performance. Dr Angela Bhan suggested there was not a straightforward relationship. Andrew Eyres commented that some of the savings work had been about changing the nature of how the service was delivered and had also led to improvements in performance.
8.09	The Board **noted** the performance report.
9	**Quality and safeguarding report**
9.01	Gwen Kennedy referred the Board to the quality and safety report • the report provided good assurance that the team were looking at patient safety investigations and quality of care, looking at trends and making action plans to implement learning. In particular work on paediatric audiology had been positive. • Of particular note was safeguarding work with children who were care leavers and faced inequalities as a result. • Performance against the 28-day target for all-age continuing healthcare assessment had been improved but performance variation remained in this complex area. • South east London's local maternity and neonatal service provided strong oversight at a time of significant national concern over the quality of maternity services. • There had been good work on GP audits for infection prevention and control although the system was above trajectory for E.Coli and MRSA and so work was underway to understand and address this. • Greater number of annual health checks had been provided to Autistic people but there remained significant demand. A children and young people's neurodiversity hub would hopefully start to undertake needs assessments in coming weeks. • A SEND network had now be in place for a year and had been developing a data dashboard.
9.02	Anu Singh noted that the Quality and Safety committee had asked for information on the experiences of people in relation to continuing healthcare, as well as the data.

9.03	Georgina Fekete asked about the maternal and neonatal work and antimicrobial resistance trends. Gwen Kennedy noted that all trusts providing maternity services had been visited by the regional team and there had been good engagement by both trusts and the local maternity networks. A maternity improvement plan was in place for south east London and was well led. Antimicrobial risk was being monitored by pharmacists and there was a trend which may be an issue that needed more attention at a board level.
9.04	The Board **noted** the quality and safeguarding report.
10	**Development of South East London Neighbourhood health service**
10.01	Ceri Jacob noted that a south-east London models of care had now been developed for frailty and for people with multiple long-term conditions which local care partnerships were starting to implement. Plans were in place to start integrated neighbourhood teams in each local care partnership by the end of 2026/27. The BCHIP model, an expansion of work in Southwark and Lambeth, would be scaled up to all boroughs, with plans to develop this into a neighbourhood model for child health.
10.02	Holly Eden referred to integrated neighbourhood teams as the area thought to be able to deliver the biggest initial impact for patients and so the initial focus of the work. There were five other components of neighbourhood work, and a London Target Operating Model Case for Change for Neighbourhoods had been published in partnership across health, care and other key partners, setting out a clear set of deliverables. South east London's plans were being strengthened to enable it to deliver the full model.
10.03	The paper set out the approach to developing integrator arrangements in south east London. Integrators were intended to build strong local partnerships with a host organisation providing resourcing and capacity to enable delivery. Four local care partnerships had agreed arrangements, and it was proposed to provide £250k non recurrent funding to each integrator, once established, and agree spending plans to allow them to meet a set of developmental needs.
10.04	An outcomes framework included a high-level set of outcomes and a theory of change, which would then be applied to population to develop short, medium and long term metrics. The framework was still emergent and would be tested with a range of partners. A modelling and impact workstream would be informed by the outcomes and help to measure the activity shift and understand the costs and savings produced.
10.05	Ranjeet Kaile relayed a question from Peter Matthew about whether the plans were sufficiently ambitious and whether the system should go further, faster, and asked that the voice of VCSE should be included. Ceri Jacob noted that the VCSE sector were a big feature of many borough and local plans. The system were already progressing well compared to other areas but there was a need to bring along all partners in the process.
10.06	Darren Summers recognised the progress that had been made with a range of partners coming together, but observed the scale of the challenge should not be underestimated - for example in setting up Integrated Neighbourhood Teams - and it may be useful to reflect on what had prevented similar schemes being successful in the past or to implement a common change methodology. Holly Eden proposed that there were common skills and capacities across the system but there may be a need to maintain focus and grip rather than starting new schemes. Sir Richard Douglas suggested that in instituting a single change methodology there was a

	danger of spending too much time agreeing what the correct change methodology should be.
10.07	Crystal Akass asked how the opportunity to design hyperlocal services but without duplicating unnecessarily or increasing variation. Ceri Jacob noted that the Integrators in each borough had a role to address variation in each borough. Andrew Bland proposed that the assumption should be that any variation must be justified.
10.08	Georgina Fekete welcomed the work and the development of integrators and the developing outcomes, and asked if there was also a role on indicators of whether the three priorities were working.
10.09	Dr Toby Garrood emphasised the importance of looking at outcomes across the system and asked how co-ordinated the work need to be with other work across London and National.
10.10	Dr Angela Bhan noted that Bromley and Greenwich boroughs hoped to shortly bring their proposals and suggested that the Board might wish to approve them before the next meeting. Andrew Bland suggested that this could be possible provided that the proposals had the full agreement of the partners involved.
10.11	Andrew Bland suggested that south east London was progressing more quickly than many other areas although there may be other areas which had developed greater depth. He pointed out that the Integrator responses were important so that the contracts envisaged in the ten year health plan would be held by strong partnerships with working together built into the arrangements. The changes would need to be underpinned by a common approach to population health, and there was work was underway on a neighbourhood delivery board across London.
10.12	The Board **endorsed** integrator arrangements for Bexley, Lambeth, Lewisham and Southwark.
10.13	The Board **endorsed** the direction of travel and development of an outcomes framework.
10.14	The Board **agreed** in view that integrator arrangements in Bromley and Greenwich could be approved by the Board via correspondence to maintain pace of the programme.
11	**Primary and Secondary Care Interface**
11.01	Dr Toby Garrood reminded the board of the work on the primary and secondary care interface, noting reports that up to 30% of the work in primary care could be attributed to some kind of failure of the interface. NHS England had set out four areas it regarded as priorities in tackling this area. In south east London, there had been a good recognition by all involved that this was a shared problem with an impact on patients, who could be frustrated by repeating themselves, not knowing what to expect or who to contact. Interface groups representing all acute trusts as well as mental and community health and system interface groups met bi-monthly to discuss issues and share learning. A key area of work had been the development of an interface document in consultation with colleagues across the system with some principles for the interface.
11.02	

	Dr Upaasna Garbharran noted that patient engagement had been placed front and centre of the work on the primary secondary care interface. A review of the literature on the expectations of service users had led to four workstreams: including providing guidance, prescribing, clear points of contact, and communications. This would be followed by engagement with service users across four clinical settings in south east London including in depth one-to-one interviews with patients about their expectations. There would also be surveys sent out using existing patient engagement platforms.
11.03	Paul Najsarek noted that while there may not be large amounts of research within south east London, there was a large amount in relation to customer service and experience issues that might be transferable across industries.
11.04	Gabi Darby about the engagement with the clinical workforce using the example of fit-notes which were currently referred to a GP rather than issued at the point a clinician saw a patient, but changing the process would require behaviour change across a large number of people.
11.05	Prof Clive Kay asked about onward referral within trusts noting that previously trusts had prohibited this practice and that it may have led to some confusion. Noting the expectations on discharge letters he asked if these were monitored and auditing by trust and specialty. In relation to saving GP time he observed that there was a wider opportunity to save time across the system by reforming outpatients, and asked if this worked risked cutting across more significant outpatient reform.
11.06	Holly Eden suggested that in communications a shift from a direct communication between a GP and clinician to a web of GP and a range of clinicians. There was also an willingness to re-look at principles and approach of shared care arrangements and this could be included in a further phase of the work.
11.07	Dr Angela Bhan reflected from the Bromley experience suggested that direct engagement with residents would be helpful, as well as engagement with other professionals such as therapists and nurses. Audit work by junior registrars in specific specialities had been helpful in showing the impact of changes. There was also an opportunity in the development of Epic to make improvements.
11.08	Georgina Fekete observed that many of actions which could improve the interface had been described as relatively obvious and asked why therefore they were not already common practice; and whether this was due to a lack of performance management or lack of support.
11.09	Sir Richard Douglas asked if there was a way to adjust the financial incentives that it was in the interest of secondary care clinicians. Dr George Verghese noted that the incentives would need to be very sophisticated.
11.10	Prof Clive Kay suggested there may be potential to work through this issue within he neighbourhood teams.
11.11	The Board **noted** the report and the progress made in developing a response to primary and secondary care interface issues.
12	**Review of Winter 2024/25 – Urgent and Emergency Care**
12.01	Sarah Cottingham referred to the paper noting that with a interdependent and complex UEC system across a large geography benefiting from three local system

	UEC boards, but with a need to balance with system-wide work and achieve consistency.
12.02	The paper highlighted the overarching risks from local and south east work which were: • Demand with individual hotspots but also surges of demand over the winter period. • Capacity and flow management exacerbated by increased demand. • Quality and safety was of absolute importance, particularly in emergency departments and in relation to ambulance response times. • Resource constraints and the bandwidth of the workforce needed to be managed including less funding and a need to also focus on referral to treatment.
12.03	As well as local plans to mitigate these risks, south east London work included significant pilots on criteria to admit and a pilot single point of access in collaboration with London ambulance service, a communications campaign and focus on improving system wide management to co-ordinate with actions within borough. There was a year round improvement plan, as well as high impact actions to improve capacity such as the new UTC at Lewisham hospital and the new Same Day Emergency Care programme at Kings College Hospital Denmark Hill site. Planning actions for the coming winter would come to the board and there were a range of actions
12.04	Paul Najsarek asked about the knock-on effect of mental health issues for example in emergency settings and whether this had been addressed. Sarah Cottingham noted the work of the mental health task and finish group in this area but noted there were continuing issues in relation to developing community crisis support to reduce long waits in A&E, understanding differential trends across borough populations, including variation in whether patients were known to services, and inpatient flow, learning from acute physical health pathways.
12.05	Sir Richard Douglas noted that it was important to be clear on the impact of the each of the various actions so that the most effective actions could be prioritised. Sarah Cottingham noted that demonstrating cause and effect and impact had proved difficult in previous work, but it remained important to challenge what the impact was expected to be on each intervention.
12.06	Andrew Eyres noted that and there had been a drop in the uptake of flu vaccination and so this would be an important part of the overall effort to improve readiness for winter which would be through a number of incremental gains across the range of interventions. Sarah Cottingham noted that winter guidance also stressed the importance of vaccination and there had been an earlier start to the programme to try to address this.
12.07	Prof Clive Kay suggested that to some extent the current performance was being delivered and suggested that the Board may need to be more sighted on the degree and impact of corridor care and boarding from a south east London perspective. Sarah Cottingham noted that the challenge was that boarding had become almost BAU which had impact on flow and reduced the scope for escalation and a piece of work was in train to look at this. Gwen Kennedy acknowledged the challenge of this area which required looking across whole pathways.

12.08	The Board **noted** the report.
13 13.01	**Any Other Business** There was no other business.
14 14.01	**Public Questions and Answers** *A member of the public asked about the issue of corridor care and boarding which had been raised in the meeting.* Sarah Cottingham noted that corridor care was something that the system would need to track from a quality and safety perspective but was not currently a formal performance metric. Gwen Kennedy provided assurance that the issue was also being considered nationally as well as within the Royal College of Nursing in particular around the risks that could arise in relation to treating patients in escalation spaces.
	Close

NHS South East London Integrated Care Board
ACTION LOG

REFERENCE	DATE ACTION AROSE	ACTION DESCRIPTION	STATUS	ACTION OWNER	DATE FOR COMPLETION	UPDATE/NOTES
ICB 011	16-Oct-24	Consideration of how regular reporting received by the board might allow them to monitor inequalities in relation to performance items	to be closed	SC/AB	19-Mar-25	Report on annual health inequalities information brought to executive committee and discussion of feasibility of mapping data sources to local performance data.
ICB 014	29-Jan-25	Executives to explore overall quantitative targets for reducing Mental Ill Health in south east London, and update on work to explore variation in numbers known to services in inner/outer London.	to be closed	Executives	16-Apr-25	Focus to date has been on improving timely access to mental health services and supporting recovery of mental ill health as quantitative measures, however, greater focus now on preventing the development of mental health conditions in the first place with a particular focus on CYP mental health as demonstrated in the ICB's commissioning priorities. Known variation in levels of severe and enduring mental illness across the six boroughs in SEL with causal factors being wide ranging from biological (e.g. genes, physical health), psychological (trauma, stress) and environmental (poverty, stigma, social environment). Nationally known that there is a strong correlation between deprivation and mental illness which may therefore explain some of the patterns of demand across SEL.
ICB 018	29-Jan-25	For the ICB Audit committee to receive assurance on the governance in place in SEL organisations in relation to the Sexual safety and domestic violence charter.	to be closed	PM	15-Oct-25	The audit and risk committee discussed the assurance work in relation to this matter at the meeting on 9 October 2025
ICB 024	16-Jul-25	Amendments to the next committees report re lambeth chair and bring back CCPC ToR for approval	to be closed		15-Oct-25	Commitees report on agenda contains the amendments

Board meeting in Public

Title	**2026/27 Planning**					
Meeting date	15 October 2025	Agenda item Number	3	Paper Enclosure Ref	E	
Author	Sarah Cottingham, Director of Planning					
Executive lead	Sarah Cottingham, Director of Planning					
Paper is for:	Update	x	Discussion	x	Decision	
Purpose of paper	To provide an update on the key requirements for the 2026/27 planning process. To provide an update on progress to date and next steps.					
Summary of main points	The paper provides a summary of the planning requirements that have been set out by NHS England for 2026/27. These comprise several key planning outputs focussed on both medium-term strategic planning and annual operational planning, with requirements covering Integrated Care Boards, NHS providers and Health and Well Being Boards. ICBs have been asked to produce five-year strategic commissioning plans by end December 2025. To support this process ICB's have been asked to undertake foundational work to bring together insights and intelligence to inform the Plan and to then use this along with the national 10 Year Health Plan and existing strategic plans to develop the strategic commissioning plan. NHS providers have also been asked to produce their own strategic plans, linked to and reflective of the ICB plans, thereby ensuring alignment where appropriate and relevant. There is a further medium-term planning ask related to local neighbourhood improvement plans. These are to be coordinated on a multi neighbourhood footprint, aligned to Local Authority boundaries and overseen by Health and Well Being Boards. These plans will comprise a local population health improvement plan and a neighbourhood development and delivery plan. Finally, there will be a complimentary focus on operational planning for 2026/27, which we expected to major on our annual finance, activity, workforce and performance trajectories and commitments. The paper considers the expectations set in more detail, noting that we do not expect final and more detailed planning guidance or financial allocations until later in the autumn. The ICB has established various planning groups which will coordinate the planning outputs across our places, providers and system. We have also been working to complete the first phase of the planning process, namely the bringing together of a high level overview and set of actionable insights					

	across population health, performance, quality, productivity and efficiency and finance metrics, plus feedback from our communities and service users. The paper then highlights some key areas for consideration, opportunity or challenge as we shift our focus to the Phase 2 element of the process, the production of our December plans. These include: • Ambition – in the context of the tight timeframes we are working to, previous learning, scope and focus. • Timeframes and guidance – the shortened planning timeframes we are being asked to, the future receipt of final planning guidance and the multiple but interlinked plans we are working to produce. • Finance – the imperatives around financial sustainability, but also significant financial uncertainty around allocative methodologies and approaches that we will need to address as we refresh our Medium Term Financial Strategy. • Legacy position - our carry forward underlying challenges in relation to finance and performance particularly. • Strategic commissioning and system development – our strategic plan will inevitably reflect an element of work in progress and a plan for a plan in key areas of development for example around data, intelligence and insights, an outcomes and evaluation framework and the early stage of neighbourhood care development. We will be working through these issues as well as testing our strategic objectives, priorities and outcomes including with the ICB Board over the coming weeks.
Potential conflicts of Interest	None
Relevant to these boroughs	Bexley x, Bromley x, Lewisham x Greenwich x, Lambeth x, Southwark x
Equalities Impact	EIA will be completed as part of the planning process.
Financial Impact	Financial plans will be agreed as part of the planning process, with plans aligned to the ICB's allocation and refreshed Medium Term Financial Strategy.
Public Patient Engagement	Public and patient engagement feedback is being utilised as a key insight in our planning.
Committee engagement	Planning updates and oversight through the SEL ICB Executive Committee and SEL System Sustainability Group.
Recommendation	No recommendations. Paper is for update and discussion.

South East London Integrated Care System

2026/27 Planning

A summary of requirements

Draft Planning Framework – Overview of ICB requirements

- Draft planning guidance issued in August 2025
  - The guidance makes explicit the shift to strategic, multi year planning to support the effective delivery of the 10 Year Health Plan (TYHP), but frames expectations in terms of five year planning milestones/outcomes as expressed through the ICB's strategic commissioning plan and an annual planning process that will include the details of associated finance, activity, workforce and performance assumptions and deliverables.

- Final planning guidance, alongside more detailed supporting information on both planning outputs and enabling guidance such as the strategic commissioning framework is expected to be available in October 2025.

- In some ways the outputs are not fundamentally different to those of the previous three years, with ICB's having produced medium term (three year) Joint Forward Plans plus annual operational plans.
- However, there are some key differences around the what and the how:
  - **Strategic commissioning** – emphasis on population data and wider intelligence and insights to drive our planning, the need for clarity as to objectives, priorities, deliverables and outcomes and the use of commissioner levers to secure them.
  - **Service delivery** – focus on a new way of working within neighbourhoods to secure the key shift to prevention and community-based care, including through enhanced integration across health, LA and voluntary sector services. Focus on delivery, improvement, transformation and integration.
  - **Role of Place** – multi neighbourhood approaches secured through existing LA boundary footprints as serviced by a Health and Well Being Board. Key role in commissioning a population health plan and supporting neighbourhood delivery.
  - **System approaches** – greater separation of ICB/commissioner and provider planning outputs, but with a clear expectation around alignment in terms of relevant strategic priorities and planning assumptions across commissioners and providers.

Planning Framework – What do we need to produce? (1/3)

Plans are expected to:

- Build and align across time horizons, joining up strategic and operational planning
- Be coordinated and coherent across organisations and different spatial levels
- Demonstrate robust triangulation between finance, quality, activity and workforce

- And be:
- **Outcome focused** – tangible and measurable improvements in outcomes and value for the taxpayer with involvement of patients and the public in developing plans.
- **Accountable and transparent** – clear roles, responsibilities and accountabilities, supported by effective governance to enable transparent decision making, challenge and scrutiny/oversight of plans.
- **Evidence based** – plans are underpinned by robust analytical foundations including population health analysis, demand and capacity modelling, financial forecasts and workforce analytics.
- **Multi-disciplinary** – plans bring together teams from different functional areas to shape content.
- **Credible and deliverable** – ambitious yet achievable goals with robust triangulation.

Draft Planning Framework – What do we need to produce? (2/3)

Phase	Output
Phase 1 (To be completed by Sep 2025)	**Preparatory work – 'Foundational Elements'** Drawing together the **data, intelligence and insights that will drive our strategic planning**: • Population health needs assessment, identifying underserved communities and surfacing inequalities. • Identifying service and pathway redesign opportunities, including where services are vulnerable/unsustainable. • Demand and capacity analysis, including an assessment of demographic and technological changes (demand), plus productivity, workforce and estates factors (capacity). • Identifying opportunities to improve productivity and efficiency. • Financial analysis to establish a baseline underlying position and cost drivers. • Reviewing and refreshing the organisation's clinical strategy to ensure it is up to date and aligned to the 10YHP • Reviewing the organisation's improvement capability. • Reviewing strategic estates plans, opportunities for disposals and consolidation and where new additional or different estate is needed for transformation or performance improvement.

- We have worked to bring the above areas of data and intelligence together for end September.
- We are working to translate them into an assessment of actionable insights which will inform our strategic commissioning plans.
- We have submitted SEL responses to the national deconstructing block contract agreements exercise.
- We have also produced high level commissioning intentions for end September - building upon our existing medium-term priorities and the 10YHP requirements. whilst recognising the need for flexibility given our concurrent work on our strategic commissioning plan over Q3. Our commissioning intentions have been tested and shared with local NHS providers.

Draft Planning Framework – What do we need to produce? (3/3)

Phase	Output
Phase 2 (Due end of Dec 2025)	**Five year strategic commissioning plan** • ICB footprint integrated plan that cover service plans, workforce, finance, quality improvement and digital. • Will bring together local neighbourhood health plans into a system population health improvement plan (PHIP). • Plan will include details of overarching population health and commissioning strategy, new models of care and investment programmes aligned to the 10 YHP, how funding will be used to meet need/maximise value/deliver priorities, and how the ICB core strategic commissioning approaches and capabilities will be developed to secure our strategic objectives and outcomes.
	Local Neighbourhood Plan(s) (LNPs) • Part A: Population health improvement plan which includes social care, public health and BCF, co-ordinated by Health and Wellbeing Boards. • Part B: Delivery plan for neighbourhood health services. ○ LNPs will feed into and align with system PHIP, new models of care and investment programmes set out in the five year strategic commissioning plan.
	Operational plan return (annual) • Single ICB numerical return expected across finance, workforce, activity and performance (with triangulation with providers as required).

- Outside of operational plan returns for 2026/27, planning outputs and associated assurance is currently unknown - we would anticipate publishing and sharing widely our strategic commissioning and local neighbourhood plans.
- As part of our Phase 2 work we will be refreshing our Medium Term Financial Strategy.
- Agreed deliverables and outputs from our planning processes will need to be reflected in agreed contracts between commissioners and providers.

Planning Framework – How does it all fit together?

Commissioners

Foundational elements
- Supporting data, intelligence and actionable insights.

System Five Year Strategic Commissioning Plan
- Objectives, priorities, deliverables and outcomes across population health population health, service improvement and transformation.
- Underpinning enablers – including estates, workforce, finance and the use of commissioning approaches/levers.

Local Neighbourhood Health Plan (via HWBBs)
- Population health improvement plan & neighbourhood delivery plan.
- Covers NHS and LA, voluntary sector services and preventative services.

Operational plan
- Underpinning annual finance, activity, workforce and performance plans.

- *Joint working and coproduction to support alignment - for both strategic and operational plans.*
- *Agreed outcomes reflected in contracts between commissioners and providers.*

Providers

Provider five year strategic plans
- Take account of and reflect ICB strategic commissioning plans as relevant - across system and neighbourhood plans.

Provider operational plans
- Take account of and align with ICB operational plans as relevant.

Delivery
- Provider led - key focus on delivery of agreed objectives & outcomes, including service delivery, development, improvement and transformation.
  - Individual organisations – hospital care – working collaboratively with other providers and with neighbourhoods.
  - Neighbourhood providers – working together to integrate/join up care across care delivered outside of a hospital - underpinned by Place level coordination/borough integrator enabling action/support.

ICB Board meeting in Public

Title	**ICS Green Plan refresh 2025-2028: final draft for approval and publication**					
Meeting date	15 October 2025	Agenda item Number	4	Paper Enclosure Ref	D	
Author	**James Colley, Programme Manager Corporate Operations**					
Executive lead	**Tosca Fairchild, Chief of Staff and ICS SRO for Sustainability**					
Paper is for:	Update		Discussion		Decision	X
Purpose of paper	This paper is the final draft of the SEL ICS Green Plan refresh for 2025-2028 and is presented to the ICB Board: a) For approval so that it may be published on the ICB website by the [Greener NHS-set deadline of] end of October 2025.					
Summary of main points	• The NHS in England is to be carbon net zero by 2040 (for emissions within its control) and 2045 (for emissions it influence). • ICS Green Plans act as system-wide sustainability strategies that address the above requirements. System Green Plans are written and owned by respective ICBs. • In response to guidance from Greener NHS (a function of NHS England) the ICB has refreshed the SEL ICS Green Plan for the period 2025-2028. • The refreshed plan has been written with contributions and input from colleagues across SEL ICB, SEL Trusts, Bromley Healthcare CIC, SEL Primary Care, Greener NHS, NHS England, and wider system partners including (but not limited to) the GLA, the London Procurement Partnership and the London Air Quality Programme Office. It is influenced by multiple external net zero/sustainability frameworks and the 10-Year Health Plan for England. • Board members are invited to give any final feedback, amendments or additions so to move the attached to a final document for publication by the end of October 2025.					
Potential conflicts of Interest	None foreseen.					
Sharing and confidentiality	Can be shared more widely, if/as required but with the caveat that it is a final draft pending Board approval.					
Relevant to these boroughs	Bexley	X	Bromley	X	Lewisham	X
	Greenwich	X	Lambeth	X	Southwark	X
Equalities Impact	Environmental sustainabilty is an enabler to equality.					
Financial Impact	None arising directly from the plan as presented.					

Public Patient Engagement	None undertaken specifically for the ICS plan, but PPE and stakeholder engagement has informed SEL Trusts' individual Green Plans, which are reflected in the ICS plan.
Committee engagement	The ICB Executive Committee reviewed draft v5 of the ICS Green Plan in July 2025 and provided feedback. The Executive Committee received the final draft (amended to incorporate the July feedback) on 1 October 2025 and recommended it for publication, subject to the ICB Board's approval. Iterations of the refreshed Green Plan have regularly been shared with Green Plan contributor groups and with SEL ICS Sustainablity Programme governance groups for awareness and to provide opportunities to shape, feed back and input. The final draft plan was endorsed by the Greener SEL Oversight Committee on 30 September 2025.
Recommendation	The Board is asked: a) To approve the Green Plan so that it may be published on the ICB website by the [Greener NHS-set deadline of] end of October 2025.

South East London Integrated Care System

NHS

Healthier Planet Healthier People

South East London ICS
Green Plan 2025-2028

South East London ICS

Contents

Foreword

Tosca Fairchild, ICS Sustainability Senior Responsible Officer

The NHS in England is undergoing a transition, but the need to address the world's environment and climate challenges remain as urgent as ever. We must continue to accept our responsibility to be good stewards of the environment while we deliver safe, effective and high-quality NHS services.

I joined South East London Integrated Care Board (SEL ICB) as Chief of Staff in the summer of 2022, just after the first SEL Integrated Care System (ICS) Green Plan was published. In my capacity as Sustainability Senior Responsible Officer (SRO) I have provided executive leadership to the ICS sustainability programme for the three-year duration of the first plan.

It has been an honour and a privilege to work with committed colleagues across the system and seeing them rise to the challenge of reducing carbon emissions against a backdrop of system change, financial challenge and evolving priorities. I have seen incredible progress against our net zero objectives, knowledge and expertise flourishing across the system, networks being formed, learning being shared and the acceleration of partnership working. In many ways, sustainability is still a challenging area of NHS work, but we are learning and working together and consequently, we are stronger in our delivery. It is important that we maintain this, because the challenge of improving our environment is not going away any time soon and we know that it is linked to the health of our population.

2025 will see the beginning of a period of significant change for the NHS, with the 10 Year Health Plan setting new directions of travel for our health service. SEL ICB will restructure in support of this new vision and in doing so, will shift to align with the new ICB Blueprint.

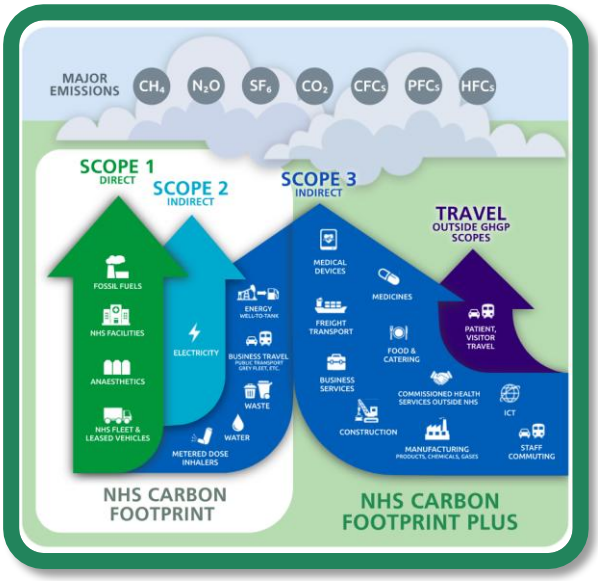
We must embrace and support this change, because it is about improving our health service and enabling every member of our population to be - and stay - healthier. This Green Plan does the same, because we recognise that a healthier planet is key to keeping our people healthier, and when our people are healthy, the NHS in south east London uses less resources and creates less waste that causes harm to our environment.

Thank you for reading.

Delivering a net zero NHS

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS.

The NHS was founded to provide high-quality care for all, now, and for future generations. Understanding that climate change and human health are inextricably linked, in October 2020, it became the first in the world to commit to delivering a net zero national health system. This means improving healthcare while reducing harmful carbon emissions and investing in efforts that remove greenhouse gases from the atmosphere.



With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act. The *Delivering a Net Zero Health Service* report sets out a clear ambition and two evidence-based targets:

1. **For the emissions we control directly (which we call the NHS Carbon Footprint – *see diagram above*) we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032**
2. **For the emissions we can influence (our NHS Carbon Footprint Plus - *see diagram above*), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.**

In 2022, the NHS became the first health system to embed net zero in legislation, through the Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to consider statutory emissions and environmental targets in their decisions. Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans.

The NHS's commitment to net zero was reinforced by Lord Darzi in his independent investigation of the NHS in England (September 2024).

Delivering a net zero south east London

The London boroughs of Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley are home to two million people, supported by the following net zero contributors:

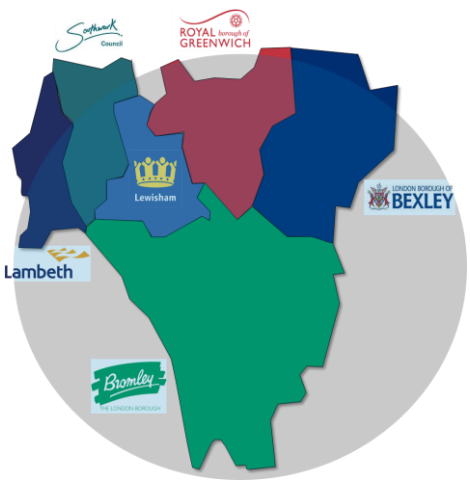
- **Five NHS trusts - Guy's and St Thomas', King's College Hospital, Lewisham and Greenwich, Oxleas and South London and Maudsley NHS Foundation Trusts** – all of which are members of the South East London Sustainability Network.
- **Bromley Healthcare CIC** – a member of the South East London Sustainability Network.
- **194 GP practices organised within 35 Primary Care Networks (PCNs) alongside community pharmacies, dentistry and optometry.** Primary care input to green planning is via the ICB-facilitated *Primary Care Green Group.*
- **The six south east London local authorities** – with whom the ICB is a longstanding partner across health and care services.

The care provided by these contributors to our population is organised around 25 neighbourhood health services, each of which has a shared plan for coordinated, local care that meets people's needs earlier and more effectively.

Using net zero to improve health inequalities

Our borough populations in south east London share some commonalities, but also have their own characteristics, complexities and needs.

Some of our boroughs experience high levels of deprivation, social and health inequality and inequity – which are all key determinants of health. The health (physical and mental) and social impacts of poor environment and climate change tend to fall disproportionately on those who are disadvantaged and most vulnerable.



By taking actions to bring carbon emissions down, the whole of the south east London population benefits, but our most deprived communities stand to benefit most.

Delivering a net zero south east London will also enable our 2025/2026 Joint Forward Plan. This five-year plan ensures the work we do improves population health, reduces health inequalities and ensures the sustainability of health provision.

The 2022-2025 Green Plan: Achievements from the last three years

Overview

Contributors to the ICS Sustainability Programme have learned, grown and achieved together throughout the duration of the first ICS Green Plan.

The 2022-2025 Green Plan set 122 objectives for delivery by system partners. The efforts of partners working to their own Green Plans and working in system-wide collaboration saw delivery against 90 of the planned objectives. This delivery positioned was supported notably by consistent delivery by expert colleagues working in hospital trusts and by colleagues leading system-wide workstreams, such as in Estates, Medicines and Digital Transformation.

A selection of our achievements across the 2022-2025 Green Plan include:

Workforce & System Leadership

We established a net zero learning catalogue for our workforce and leaders with the Centre for Sustainable Healthcare, provided net zero education and training through development sessions with ICB leaders, and through external sources, such as *NHS Collaborate*

Workforce & System Leadership

We have built networks of Green/ Sustainability Champions across the south east London system

Workforce & System Leadership

We hosted a Chief Sustainability Officer's Clinical Fellow, within the ICB Medicines Team *(see photo, right)*

SEL's Clinical Fellow Minna Eii (second from right) graduating with the CSO Clinical Fellow cohort of 2023-2024

Workforce & System Leadership

We co-designed and co-ran the London Green Celebration event with Greener NHS (London) in 2024 and 2025

Achievements from the last three years

Air Quality

We installed air quality monitoring nodes and used the data to drive improvements in air quality

Travel and Transport

We ran travel surveys and used the findings to help our people use sustainable travel to get to NHS sites

Travel and Transport

We commenced electrification of NHS fleet and supported this by installing electric vehicle charging infrastructure

Travel and Transport

We implemented a number and wide range of active travel initiatives

High security *Cyclepods* were installed in at GP practices to encourage active travel

Estates and Facilities

We switched to low energy LED lighting across our estates

Estates and Facilities

We made multiple successful bids for funding to support estates decarbonisation, incl. installation of solar panels

Estates and Facilities

We reviewed waste being disposed of through different waste streams and reduced the amount going to landfill; moving towards more recycling and exploring *energy-from-waste* solutions

Estates and Facilities

We reduced the use of single-use items, including medical instruments, theatre hats, cubicle curtains – and noting particular success in reduced use of vinyl gloves through *Gloves Off* campaigns

Green Space

We created green spaces at hospital sites to improve biodiversity and to allow patients' healing to be supported by nature

Achievements from the last three years

Medicines

We made significant progress on switching respiratory patients to low-carbon inhalers and we launched the first nationally-funded inhaler recycling pilot scheme across King's College Hospital sites and 20 south east London community pharmacies

SEL Pharmacy Leads launching the SEL inhaler recycling pilot scheme, July 2024

Medicines

We reduced the use of high-emission anaesthetic gases and reduced nitrous oxide waste

Medicines

We engaged with patients to understand how we can work together to reduce overprescribing

Digital transformation

We provided the technical support for staff to work from home, where appropriate – reducing staff journeys

Digital transformation

We moved towards higher energy efficiency IT equipment and cloud solutions

Digital transformation

We developed the *London Care Record;* an electronic health record which can be shared across care sectors. This integrates services across south east London; making our services more efficient and less wasteful by removing unnecessary patient contacts and travel.

Digital transformation

We have recycled c.400 items of IT equipment, of which 94 have been redistributed to digitally excluded communities in SEL

A volunteer at Community Tech Aid restoring laptops for donation to members of our community

Supply Chain

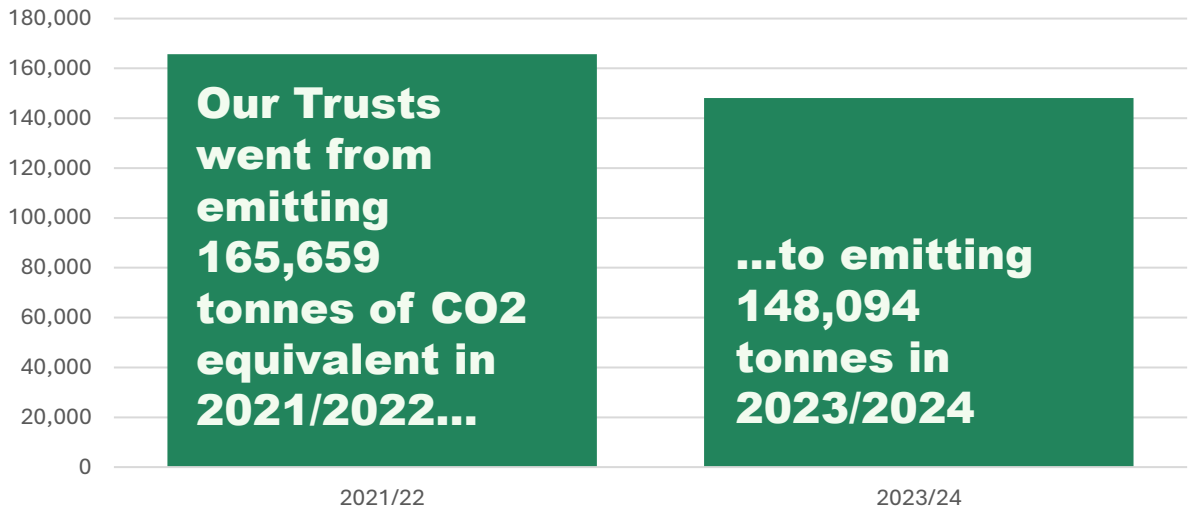
We started evaluating social value for the award of contracts, and suppliers must now have carbon reduction plans

Spotlight

Tracking progress in

Trust carbon emissions

In the two-year period since the first Green Plans were published (2022) to the latest available data (2024), NHS Trusts in south east London have lowered their NHS Carbon Footprints by 10.6%



The NHS Carbon Footprint are the emissions we control *directly* – emissions from building energy, waste, water, business travel and fleet. It also includes emissions from anaesthetic gases and the carbon-intense inhalers that are prescribed in secondary care. The table below shows how emissions in each of these categories have changed between 2022 and 2024.

Emissions from	2021/2022 (tonnes of CO2 equivalent)	2023/2024 (tonnes of CO2 equivalent)	% reduction
Anaesthetic gases	9,713	7,001	27.9
Building energy	129,179	119,192	7.7
Business travel and fleet	21,815	17,886	18
Metered dose inhalers	927	536	42.2
Waste	3,627	2,942	18.9
Water	398	537	35% *increase*

Data source: NHS England Green Plan Support Tool

Our 2025-2028 Green Plan

This Green Plan:

- Provides a system-level view of the net zero mission and objectives for south east London's NHS.
- Operates across the three-year period 2025-2028.
- Continues the work outlined in the 2022-2025 ICS Green Plan, whilst applying additional dimensions and/or outcomes.
- Invites contributions from every member of the NHS workforce and from our wider system partners in south east London
- Represents organisational objectives, whist recognising that we cannot deliver them without action at individual and collaborative levels.

Our mission

We will protect and improve our population's health and reduce health inequalities by mitigating our environmental impact and improving the quality of the environment in south east London.

We will achieve this by building awareness of net zero across our workforce - embedding sustainability into our 'business as usual' and supporting our colleagues and partners to minimise environmental harm in the design and delivery of our services.

To fulfil our mission, the objectives of this plan are designed to:

- **Recognise prevention as a key driver of sustainability, and sustainability as an enabler of prevention.** The single most effective way for the NHS to preserve resources and eliminate waste is to contribute to good public health and reduce the need for patients to attend our services for treatment. If we improve the environment around us, our population can enjoy healthier, happier, active lives that will help them stay in good physical and mental health.
- **Align with existing ICS priorities and the South East London Joint Forward Plan.** In our Joint Forward Plan, environmental sustainability is recognised as an enabler to population wellbeing, mental health and long-term conditions. The sustainability programme is also committed to developing leadership and our workforce; a key condition for change to deliver ICS priorities. The objectives of this Green Plan will raise the profile of sustainability and highlight the potential for further contribution to achievement of system objectives.

To fulfil our mission, the objectives of this plan are designed to:

- **Recognise the concept of the *sustainable value equation*** (also known as the '*triple aim*')

$$\text{Sustainable value} = \frac{\text{Outcomes for patient and populations}}{\text{Environmental + social + financial impacts}}$$
(the *'triple aim'*)

  This concept describes how sustainable value is achieved when better outcomes for patients and population are achieved without detriment to environmental, social or financial impacts. We will work towards assessing the environmental impacts of every significant discussion or decision in the same way that we currently consider financial and people impacts.
- **'Design out' emissions, waste, inefficiency and harm.** By undertaking environmental impact assessments of services, pathways and projects we can identify potential negative impacts and take opportunities to maximise efficiencies. Where there is inefficiency, there is inevitably waste and a negative impact for our environment. We must eliminate this.

  We must also recognise the additional resources required in exploring and using artificial intelligence (AI) to meet the *10 Year Health Plan for England's* aim of moving from an analogue to a digital health service and balance this with the benefits it can create for patients and staff.
- **Give greater support to clinician-led sustainability projects.** Previous Green Plan objectives have focused on lowering the carbon emissions from daily operations; buildings, waste, energy and water usage (the *NHS Carbon Footprint).* Over the next three years the system will be encouraged to place a greater focus on clinician-lead projects around sustainable models of care.
- **Embed net zero as an enabler and output of strategic commissioning.** The *10 Year Health Plan for England* requires ICBs to transform into strategic commissioners; strategically redistributing resource out of hospital and integrating care. Achievement of net zero should be both an enabler and an output of strategic commissioning, and this plan will seek to influence realisation of this.
- **Encourage full use of contracting levers in the delivery of net zero.** Delivery of net zero objectives and targets by trusts is included in the Service Conditions of the NHS Standard Contract. Where oversight of Green Plan delivery will transition away from the ICB, enforcement of contracting levers will be an essential mechanism for holding trusts to account on delivery.
- **Require and enhance collaboration** – within the existing South East London NHS sustainability network and with an increased breadth of system partners.

This plan is created with consideration of a number of contributors and influences, which include:

- **South East London NHS Trusts and their Green Plans.** Each Trust has refreshed its Green Plan for 2025, which sets out their strategy for sustainability and carbon reduction.
- **Bromley Healthcare CIC,** which is not held to Greener NHS guidance but works to its own Environmental, Social and Governance plan and actively participates in the ICS sustainability programme at multiple levels.
- **South East London ICB and Primary Care** – the ICB acting both in its capacity as commissioner and system convener in delivery of objectives.
- **Greener NHS;** the regional team of which convenes the London system and facilitates shared learning and the national team of which provides guidance, frameworks, tools and learning resources.
- **Collaboration and shared learning with/from wider system partners,** including (but not limited to) London Councils, the London Procurement Partnership, the Greater London Authority (GLA), and other ICBs across London.
- The **10 Year Health Plan for England**, which will promote three big shifts to address the changing needs of the UK population (from hospital to community care, from analogue to digital services, and from sickness to prevention) and direct changes to the purpose of ICBs.

With regards to these influences, this plan:

- **Serves as an overarching system-wide sustainability plan** encompassing and aligning with the green plans and inputs of the contributors listed above.
- **Is a continuation of the 2022-2025 SEL ICS Green Plan**, in that it recognises the work done over the last three years and requires the same work to continue, with adjustments for where we are now and what we have learned since 2022.
- **Recognises that responsibility for system-level oversight of net zero work will transition between NHS organisations.** To support this movement of responsibility, this plan confirms the system-wide sustainability themes and high-level delivery objectives but does not dictate the method of delivery or set delivery targets. This allows flexibility to be applied to delivery of this plan.
- **Is an enabling factor to the 10 Year Health Plan for England's focus on preventing sickness by keeping the SEL population healthy.** Keeping our environment in good health contributes to good public health – and the best way to increase sustainability and minimise waste is to promote good public health and to reduce the call on NHS services.

Spotlight

Delivering sustainability and net zero through

Neighbourhood working

The South East London system's move towards a neighbourhood health service connects directly with the system's resource and environmental sustainability programmes, acting to improve efficiency, design out waste and to implement effective and sustainable models of care.

The 10 Year Health Plan for England sets out a bold and ambitious vision to transform the NHS, ensuring it remains there for everyone who needs it, now and for generations to come. Neighbourhood care is central to this transformation, shifting care closer to home, strengthening prevention, and supporting more joined-up, personalised care for our diverse communities.

Neighbourhood working will transform how services work together at a local level, improving health outcomes and reducing inequalities by making care more personalised for the communities we serve and strengthening the role of communities in health and wellbeing through community-led approaches.

To ensure our transition remains on-track, and that we realise the benefits we expect from our transition to neighbourhood working, we have developed an outcomes framework. The framework sets a clear and succinct set of outcomes, inputs, outputs, and activities across four key outcome domains.

Population Health, Prevention and Inequalities

Resident experience and community impact

Workforce impact and staff experience

System resource and sustainability

Interwoven across the domains is an emphasis on environmental sustainability. Framework entries which relate explicitly to the environment are outlined on the next page. ***Note:*** *at the time of publication, the neighbourhood outcomes framework is in development and is subject to change as we continue to engage and refine the vision for neighbourhood working.*

South East London Neighbourhood outcomes framework entries which relate explicitly to the environment:

Resident experience and community impact

- *Activity:* active travel schemes are in place to support residents to access services
- *Activity:* population Health Management analytics and modelling are applied by neighbourhoods and Places to both planning and care delivery: to tailor resourcing and interventions, and to systematically and proactively flag and identify individuals vulnerable to health and social inequalities, rising risk, or the effects of climate change

Resident experience and community impact

- *Outcome:* communities are supported to thrive as local services are improved, more residents are supported to become or remain economically active and in employment, and environmental quality is improved
- *Output:* community and town centers are invigorated, with improved spaces for community collaboration, connection, and action
- *Activity:* there is greater grassroots action and community activation around the intersection of the environment and health and wellbeing outcomes
- *Input:* a cultural commitment to fostering healthy environments

System resource and sustainability

- *Outcome:* the system achieves environmental sustainability over the long term
- *Output:* reduced wastage and duplication of activity between individuals and within/between organisations
- *Output*: environmental sustainability and conscientiousness is embedded in our system-wide culture
- *Activity:* staff take up environmental training opportunities in sustainability in social care
- *Activity:* services are designed, commissioned and effectively evaluated on an outcomes basis, with an emphasis on reducing wastage.

Delivering our plan: governance, networks and assurance

Leadership, governance and strong assurance processes are needed to ensure that the net zero objectives in this green plan are delivered. This section focuses on oversight at an ICS level.

Leadership oversight and involvement

- NHS South East London Integrated Care Board's Chief of Staff is appointed as ICS Sustainability Senior Responsible Officer (SRO) and oversees Green Plan delivery.
- The ICB's Deputy Medical Director provides and promotes clinical leadership to Green Plan delivery. They also chair the Primary Care Green Group *(see below).*
- Each NHS Trust has appointed a designated board-level net zero lead (generally an existing executive director) to oversee delivery of its own Green Plan.
- Designated leads are responsible for ensuring that each contributor organisation has clearly identified operational support.

Key governance groups and networks

- The **Greener SEL Oversight Committee** provides system-level leadership, oversight and reviews the assurance submissions made to Greener NHS bi-annually. It is attended by board-level executive leads from the ICB, each of the Trusts and Primary Care. The committee meets bi-annually.
- The **Primary Care Green Group** is a forum through which primary care colleagues can contribute to and receive support from the ICB Sustainability Programme and its partners. It is attended by representatives from each of the six boroughs and leads for ICB workstreams relevant to primary care. The group meets quarterly.
- The **SEL Sustainability Network** takes updates on delivery of Green Plans, whilst also providing a forum to share best practice. It is attended by the operational sustainability leads from SEL provider Trusts. The network meets quarterly.

Assurance reporting requirements

- A full review of delivery against Green Plan objectives is undertaken bi-annually, in March and September. It is reported to the Greener SEL Oversight Committee and copied to the Primary Care Green Group and Sustainability Network.
- The system makes a bi-annual assurance submission to Greener NHS (NHS England). This is signed off by the Greener SEL Oversight Committee.
- SEL ICB and Trusts are required to make quarterly submissions on Greener NHS priority measures to Greener NHS. Sign-off of submissions is per organisation.
- Progress reports on actions in the green plan are included in the ICS Annual Report.

Workforce and System Leadership

Our opportunity:

If we can create and nurture a shift in culture where our people understand and consider the relationship between planetary health and population health, where system leaders visibly show their commitment to delivery of net zero by role-modelling positive action and enabling our workforce to participate, we can:

- **Drive effective change from the top of our organisations**
- **Integrate sustainability into our core business by showing our people how and where it can be effective in driving local health improvement**
- **Strengthen relationships for sustainable change with our system partners**
- **Create a 'movement', harnessing the collective power of staff, enabling and encouraging them to implement change on the ground and/or to become Green Champions**

Net zero cannot be achieved if we do not visibly lead, support and enable our workforce to participate.

Across our system, we will:

1. Continue to offer system-level opportunities for board-level sustainability leads to engage on net zero delivery; including via the Greener SEL Oversight Committee (see *Governance, networks and assurance,* page 15) and by making sustainability leadership training available and accessible.
2. Continue to promote our core training offer to our workforce and assess the skills requirements of staff groups who underpin the delivery of our Green Plan, to promote training offers that align with specialist requirements.
3. Seek opportunities to embed sustainability into job descriptions and staff performance objectives; openly demonstrating that good stewardship of the environment is everybody's responsibility.
4. Design and test approaches which integrate sustainability delivery into strategic commissioning processes and neighbourhood ways of working *(see Delivering net zero through Neighbourhood working,* pages 13-14*)*.
5. Continue to activate and grow our groups of Green Champions; providing members of our workforce with forums that they can connect with.
6. Champion our work, using communications channels to share case studies and successes, and to recognise key sustainability dates and events.
7. Continue to explore opportunities to offer sustainability-related apprenticeships and host clinical fellows; investing in leaders of the future.

Spotlight

Leading sustainable working in

Primary Care

Engaging primary care in the ICS Sustainability Programme provides a wide range of opportunities to unlock the mechanisms that can take us towards net zero. As small businesses and local community organisations, GP practices, dental and optometry clinics and community pharmacies can all have a direct influence on the actions and behaviours of their patients as well as the emissions produced by their own activity.

Over the last three years, primary care clinicians and colleagues have demonstrated a distinct will to make a difference. Whether by collaborating with the ICB Sustainability Team, by being active in the ICB Primary Care Green Group or by signing up to be an ICS Green Champion, the desire to move towards net zero is consistently shown.

"The concept of a healthier planet meaning healthier people resonates well with me and many primary care clinicians. Practices can also experience tangible benefits such as cheaper running costs and improved staff wellbeing from being greener'.

Over the last three years, we have established networks and created a movement towards greener practice. This means expertise and support are available to help embed sustainable practice into business as usual which is not just good for primary care organisations, but also for the patients they serve."

- Dr Nancy Kuchemann
GP, SEL ICB Deputy Medical Director and Primary Care Sustainability Lead

Primary care business obligations relating to the environment:

1. Working with ICB Digital, Medicines Optimisation and Primary Care estate teams to steer, develop and implement carbon reduction measures
2. Care Quality commission assessments – where leadership is required to support reducing our impact on the environment and supporting others to do the same
3. Business continuity planning – which must now include climate resilience, and an awareness of how extreme temperatures affect the health of vulnerable patients
4. Improving efficiency and reducing waste, leading to more cost-effective operations
5. Personalisation of care for patients – where providing more personalised and holistic care also supports improved efficiency

Opportunities to further promote sustainable practice in primary care:

- By raising awareness of the links between environment, climate, health and inequalities – and the benefits of adopting the sustainable value approach to neighbourhood care *(see the 'sustainable value equation' on page 11)*
- By growing sustainability leadership in primary care; and with it, growing the net zero knowledge base of leaders
- By putting primary care at the heart of, and to promote net-zero clinical transformation within neighbourhood development, and to play a key part in developing sustainable models of care
- By promoting primary care as key partners in the development of neighbourhoods as safe and healthy places, encouraging active travel and nature-based activity to influence patient health outcomes
- By promoting training opportunities, educational resources and good practice toolkits provided by external bodies, such as (but not limited to) the Centre for Sustainable Healthcare and the Royal College of General Practitioners through the Greener Practice
- By using the emergence of GP at-scale organisations to establish greater influence on green strategy and delivery; working collaboratively with the ICB (as commissioners of primary care) and providers
- By curating digital transformation to incorporate emissions reductions, recognising that primary care digital systems are some of the fastest changing and most innovative

Primary care priority objectives, 2025-2028

1. Support the decarbonisation of primary care estate
2. Reduce waste and emissions via use of existing systems to optimise medicines prescribing
3. Apply digital solutions to reduce emissions from travel and premises use
4. Support prevention and thereby avoid use of high carbon pathways. This can be realised through the neighbourhood approach to long term condition care
5. Educate leaders, colleagues and patients and develop networks that allow us to embed NHS net zero in everyday business
6. Recognise the impacts of climate change on patients and staff, and the emerging importance of climate adaptation and resilience

Air Quality

Our opportunity:

London has the highest percentage of deaths attributable to particulate air pollution of all English regions – 6.2% in 2023 compared to the national average of 5.2% If we can understand what puts pollution in the air and what causes air pollution levels and patterns to fluctuate – whether those pollutants come from NHS sites and services or from elsewhere – we can:

- **Take action to minimise the pollution the NHS puts into the air**
- **Actively communicate changes in air quality and pollution to our people, to help manage health conditions which are affected by changes in air quality**
- **Identify areas for collaborative work that spans health, social care and public health and determine which delivery partnerships will deliver it**
- **Provide appropriate training for NHS staff on the health impacts of air pollution, to support their treatment and management of our patients**

Objectives to address air quality fall mostly under the Areas of Focus concerning travel and transport, but additional actions in direct response to air quality monitoring data further support our efforts to improve air quality.

Across our system, we will:

1. Continue to use air quality data from the monitoring nodes we have installed across south east London and supplement it with admissions data and on-site observations to drive our action to reduce air pollutants.
2. Recognise the air quality improvements arising from initiatives across the other areas of focus in this Green Plan e.g. travel and transport
3. Seek points of entry into delivery partnerships with our councils to identify areas where we can work collaboratively on improvements to air quality.
4. Embed and consider local action to enhance the impact of the Air Quality alerts for healthcare professionals, which are circulated to GPs and EDs at times of high and very high air pollution.
5. Consider how key messages can be conveyed to healthcare professionals and patients on an ongoing basis.
6. Advocate for and champion action on air pollution; supporting key air quality events such as the annual Clean Air Day.
7. Continue motor vehicle anti-idling initiatives and zones across NHS sites.
8. Support patients with management of their respiratory conditions (see *Delivering Net Zero by Medicines Optimisation,* pages 30-32)

Travel and Transport

Our opportunity:

If we can understand how, where and why our people need to travel, and how they would like to travel, we can:

- **Promote and influence shifts to sustainable modes of transport**
- **Work to decarbonise our business fleet, moving towards an electric fleet supported by appropriate electric vehicle charging infrastructures**
- **Support staff to decarbonise their personal travel, through staff transport schemes, enhanced active travel facilities and staff benefits schemes, such as salary sacrifice lease car scheme or bicycle purchase schemes**
- **Can support our patients to travel more sustainably and actively; whether it is to reach NHS sites for treatment, or for their general health and wellbeing**

Net zero and cleaner air cannot be achieved if we do not minimise unnecessary and/or high emissions travel.

Across our system, we will:

1. Implement travel surveys to understand travel patterns and barriers to active travel and use the results of these to develop sustainable travel plans.
2. Work towards offering only zero-emissions vehicles through salary sacrifice lease car schemes from December 2026 and purchasing/leasing only zero-emissions vehicles for business use from December 2027.
3. Continue to promote and incentivise active travel for staff and patients; with the provision of facilities, information on safe and clean walking and cycling routes, confidence training and promotion of cycle hire schemes. We will also explore incentivisation of business travel by bicycle by increasing mileage reimbursement rates for cycling.
4. Continue our work to decarbonise (and ultimately electrify) the NHS business fleet. This will be supported by continued trials of e-bikes and cargo bikes and the rollout of innovative approaches (such as drone delivery) where shared learning and best practice signals value in these approaches.
5. Continue to expand and enhance the electric vehicle charging infrastructure across NHS sites, for patient, staff and fleet vehicles.
6. Recognise and promote the travel reduction benefits of hybrid and flexible working.
7. Form and strengthen partnerships with our local authorities and local transport authorities to drive modal shifts.

Estates and Facilities

Our opportunity:

If we optimise resource use in the construction and running of our buildings and the services housed in them – either by design or by retro-fitting solutions - we can:

- **Futureproof our estate by ensuring construction, facilities and maintenance are sustainable, efficient and adapted to our changing and volatile climate**
- **Ensure our buildings are fit-for-purpose and comfortable places to visit, work and receive NHS services**
- **Minimise carbon emissions from our running of buildings, including via decarbonisation and use of alternative and renewable energy sources**
- **Minimise waste and the environmental damage it does; including its emissions. This supports our legal duty to dispose of waste appropriately.**
- **Promote and increase re-use, recycling and energy recovery of/from waste as an alternative to disposal**

A considerable proportion of emissions within our direct control come from our estate (see *Tracking progress in Trust carbon emissions,* page 9) so there must be demonstrable reductions in resource consumption and emissions to deliver net zero.

Across our system, we will:

1. Continue to develop heat decarbonisation plans and develop roadmaps for decarbonisation of heating and hot water systems.
2. Ensure that all applicable new building and major refurbishment projects are compliant with sustainability standards and the NHS Net Zero Building Standard.
3. Continue our direction to zero-to-landfill and NHS targets for offensive waste. This will be supported by additional training, introduction of waste manager roles across the system (differential by organisation) and campaigns on recycling and reuse/circularity to further decrease waste disposal.
4. Develop an understanding of net zero opportunities and benefits from net zero adaptations within our general practice estate (see *Delivering net zero in Primary Care Estates*, pages 22-24)
5. Actively explore the opportunities for generation of electricity via installation of solar panels, with procurement support for Trusts who have successfully secured Great British Energy funding and support from the GLA's London Estates Delivery Unit (LEDU) for general practice.

Spotlight

Delivering net zero in

Primary Care Estates

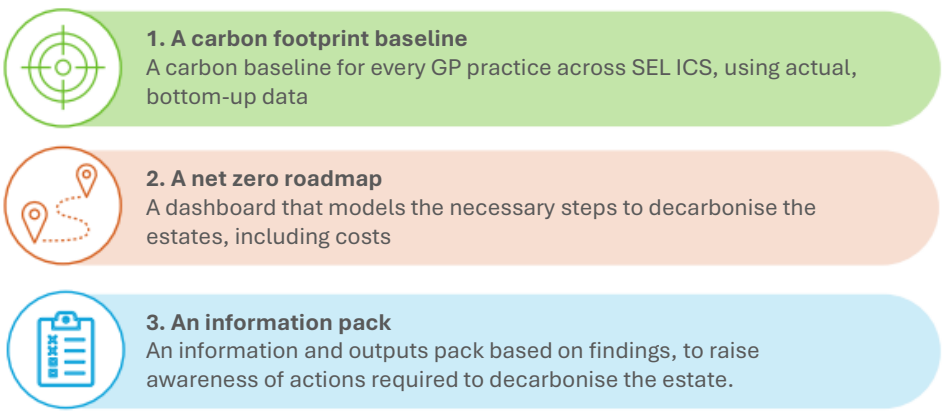
The SEL ICS Estates Strategy acknowledges the significant carbon emissions generated by NHS estates and approaches sustainability as a system-wide ambition, combining green design, digital innovation, resource efficiency, and place-based planning. It positions our estate as a key enabler in delivering environmentally sustainable, high-quality healthcare aligned with broader social and economic goals.

SEL ICS pledges to:

- Construct and maintain buildings to high environmental standards; adopting and exceeding the **NHS Net Zero Building Standard** for all new developments and major refurbishments.
- Use estate rationalisation and redesign to **reduce operational carbon emissions and improve efficiency.**
- Ensure estates are adapted for **climate risks** and incorporate **green space** and **biodiversity** into sites.

To meet these pledges, net zero is integrated into Integrated Care Systems (ICSs) governance and estate investment strategies.

South East London ICS includes 253 general practice sites. It is estimated that primary care accounts for c.25% of the NHS Carbon Footprint, with NHS estate accounting for similar. Through a programme led by the GLA London Estates Delivery Unit, in 2024 South East London ICB partnered with Turner & Townsend to develop three products/outputs:



The calculated footprint for the SEL primary care estate is an annual 7,184 tCO2e, with an annual energy bill of £4.04m. This demonstrates that energy efficiency and decarbonisation installations can reduce energy usage and costs. Reducing energy consumption can reduce energy costs, but it is important that energy demand is managed before installing more sustainable heating systems.

General Practice pilot study

Our work with Turner and Townsend – including the net zero roadmap and the recommendations from the information pack – has led SEL ICB to commission a detailed study of two GP Practices in South East London (Villa Street Medical Centre and Blackfriars Medical Practice) to understand current energy use and environmental performance and assess decarbonisation options.

Villa Street Medical Centre (top) and Blackfriars Medical Practice (bottom)

The study has recommended a package of interventions to decarbonise general Practice and lift energy performance:

1. **Comprehensive fabric upgrades** – roof and wall insulation and window replacement
2. **Heating System Replacement** – moving towards air source heat pumps
3. **Upgrades to high-efficiency LED lighting**
4. **Monitoring & Controls** – including sub-metering, thermographic surveys and air-tightness testing to verify performance.

The outcome of our case study/pilot work has confirmed a plan for supporting improvements to insulation and boiler replacement - as the main contribution to decarbonising general practice.

The ICB is now considering funding options to implement the improvements to our two pilot practices. This work means we are now in phase two of our 10-year implementation plan (see page 20) to achieve a 60–70% reduction in carbon emissions and EPC ratings of B across our GP estate.

Our 10-year implementation plan to achieve a 60-70% reduction in carbon emissions and EPC ratings of B across the south east London general practice estate (summarised for this plan)

Years 1-2: **Mobilise and prioritise**	
Key activities: • Baseline audits • Rank sites by scope • Secure funding	**Targets and outcomes:** • Site-specific roadmaps • Selection of pilot sites
Years 2-3: **Pilot and validate**	
Key activities: • Apply interventions at pilot sites • Implement metering and tests	**Targets and outcomes:** • Validate carbon reductions and energy improvements at pilots • Refine specifications
Years 4-7: **Scale-up and roll out**	
Key activities: • Bulk procure materials • Phase installations in waves • Delivery training to installers • Monitor performance [of roll out]	**Targets and outcomes:** • Energy use cuts evidenced • EPC ratings improvements across sites
Years 8-9: **Optimise and integrate**	
Key activities: • Investigate on-site renewables (solar panels, EV charging etc.) • Apply bespoke measures at high-energy sites	**Targets and outcomes:** • Additional carbon savings through optimisation • EPC ratings maintained or improved
Year 10: **Embed and report**	
Key activities: • Conduct final audits and EPC re-assessments • Publish a decarbonisation report • Develop a further net zero and technology refresh roadmap	**Targets and outcomes:** • Full GP estate at EPC rating B+ • Lessons learned reviewed and shared

Sustainable Models of Care

Our opportunity:

If we consider net zero principles in the design/re-design of patient services and pathways, we can:

- **Minimise emissions across patient pathways whilst improving quality of care, outcomes and patient satisfaction**
- **Engage with service users and local populations on how their health is linked to and influenced by the environment and invite service co-design – thereby improving social value**
- **Harness the benefits of organising the south east London system into neighbourhood health services, which will reduce duplication and inefficiency by bring joined-up care closer to patient's homes.**
- **Allow for tailored health services that support the reduction of health inequalities whilst reducing the financial impact of inefficient pathways**
- **Challenge ourselves to look at, evaluate and adopt modern, innovative approaches which may already incorporate net zero benefits**

Establishing strong clinical leadership for review of patient pathways will support the development of lean, low-carbon pathways where patients are empowered and prevention becomes a key objective.

Across our system, we will:

1. Identify clinical leads for oversight for net zero clinical transformation, who will be formally linked to board-level leadership and the Greener SEL Oversight Committee (see *Governance, networks and assurance,* page 15*).*
2. Continue to offer training in Sustainable Quality Improvement approaches to support staff to embed sustainability in service design and hold events to showcase quality improvement projects with an environmental focus.
3. Support initiatives within hospital theatres to improve efficiency, reduce waste and minimise reliance on single-use items. This is to be supported by identifying and adopting areas of good practice arising from clinical transformation work and frameworks developed elsewhere (e.g. *Greener ED*).
4. Reduce unnecessary clinical/patient activity, including (but not limited to) attendances, imaging and diagnostic testing.
5. Evaluate opportunities to switch to reusable and lower-carbon clinical instruments, personal protective equipment (PPE), textiles and consumables.
6. Engage the voluntary and community sector in the development of models of care and in the expansion of social prescribing services.

Digital Transformation

Our opportunity:

If we fully harness the benefits of digitally enabled care (for patients) and digital innovations and options for the NHS digital estate (for staff) we can:

- **Minimise our digital and energy-related carbon footprint**
- **Support clinical care and efficiency by offering remote attendance and monitoring to patients**
- **Improve co-ordination between care sectors by digitally joining them up**
- **Empower patients by giving them digital tools, apps and access to records**
- **Support healthcare staff by offering remote and hybrid working options, saving time and reducing the carbon footprint from business travel**
- **Enable a move away from paper correspondence and printed documents**

Digital improvements to the sustainability of healthcare must not come at a cost to the quality of care or by creating digital exclusion, as this exacerbates inequalities in access to care. We must also be mindful that increased use of Artificial Intelligence (AI), whilst essential to our digital development, can contribute to our carbon footprint.

Across our system, we will:

1. Continue to support and develop digital options to deliver NHS services flexibly, including evaluation of digital self-care and self-referral options for patients.
2. Increase the integration and uptake of the NHS App across all relevant services, enabling more digital-first, patient-centred care.
3. Continue to work with suppliers of IT equipment to identify high energy efficiency, low carbon hardware, software and services – including data centres, cloud computing solutions and the shipping packaging of hardware.
4. Incorporate circular economy principles into digital procurement, and work with suppliers and resellers to recycle obsolete and out-of-warranty equipment, for redistribution to our digitally excluded communities.
5. Continue to digitise patient records in general practice.
6. Reduce paper use in clinical processes and in back-office settings and continue to reduce printing.
7. Undertake digital maturity assessments and use outputs to inform how we can further embed sustainability in digital services.
8. Balance increased use of artificial intelligence with clinical and operational benefits, and sustainability impacts.

Spotlight

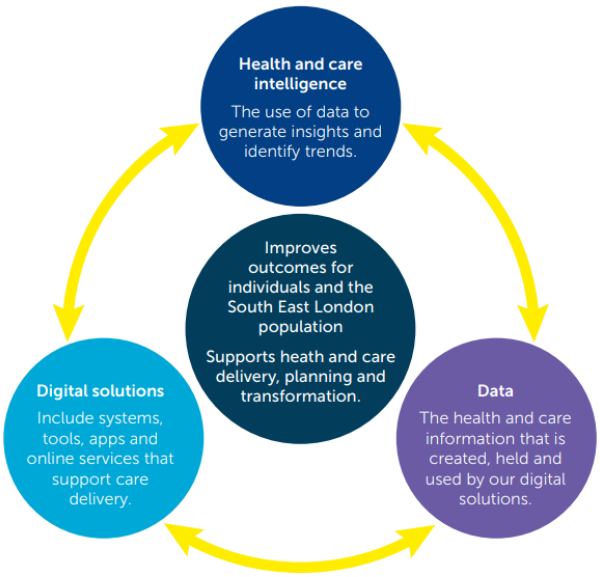
Delivering net zero through

Digital transformation

The South East London ICS Digital, Data and System Intelligence Strategy sets out our vision for how digital and data will enable the delivery of high quality, person-centred care in south east London.

Digital transformation is a key enabler in the delivery of safe and high-quality care as:

- **It unlocks access to data,** enabling generation of insights that can support the management of a person, as well as management of the health and care system
- **It supports collaboration** by making data needed for decision-making available at the point of care
- **It empowers people in our community** by allowing them to access health and care services from their own homes



Though these, digital transformation directly supports the Green Plan principles of **designing out emissions, waste, inefficiency and harm.**

Our digital programmes are designed to align closely with our Green Plan. By changing how we work with people and communities there are several ways in which the Strategy will help to make the NHS in south east London more environmentally sustainable:

1. Supporting care at home and remote monitoring (where appropriate) to reduce patient travel
2. Delivering digital transformation including digitisation of patient records to reduce the use of paper
3. Minimising duplication of testing, which can reduce patient travel time, consumable usage and logistics
4. Reusing and recycling IT hardware
5. Ensuring our suppliers consider sustainability by including net zero and social value measures in supplier contracts

How the digital transformation workstreams categorised in the SEL ICS Joint Forward Plan support good stewardship of our environment:

Joint Forward Plan category: **Digital solutions for connected care**	
Activity/aim: • We will use our digital platforms to support a shift from in-person contacts e.g. Accurx Web for messaging and remote consultation in Community Pharmacy	**Environmental benefit:** • Reduced carbon footprint associated with patient travel
Joint Forward Plan category: **Empowering people**	
Activity/aim: • We will support digital inclusion by expanding the Community TechAid donation/refurbishment scheme and through the Good Things Foundation hubs laptop donation programme.	**Environmental benefits:** • Reduction of waste through circular economy • Increased digital inclusion enhances access to care closer to home, further reducing carbon emissions from travel and resource use
Joint Forward Plan category: **Driving improvement and innovation**	
Activity/aim: • We will reduce paper consumption through changes to printing and Lloyd George digitisation • We will ensure our suppliers consider sustainability by including net zero and social value weightings • We will minimise duplication of testing via roll-out/use of the London Care Record; an electronic health record which can be shared across care sectors • We will mitigate the environmental impact of AI, as it's use grows, by undertaking environmental impact and ethical analyses	**Environmental benefits:** • Reduced consumption of paper/ natural resources • Reduced carbon footprint associated to the supply chain • Reduced patient travel, consumable usage and logistics • Mitigation of carbon footprint impact of AI usage

Medicines

Our opportunity:

If we optimise medicines prescribing and stock-keeping across our system, work with our patients to move to lower-carbon alternatives (where available) and educate our people on medicines disposal and recycling we can:

- **Minimise the carbon footprint of medicine use whilst providing high quality care where lower-carbon alternatives still support people to stay well and lead fulfilling lives**
- **Reduce the waste and potential harm of overprescribing/oversupply of medicines and in doing so, reduce spend**
- **Improve treatment adherence and effectiveness**
- **Move medicines waste away from landfill by providing (or signposting to) recycling options**

Medicines are a significant contributor to the NHS carbon footprint and an area where reduction of overprescribing and waste are within our direct influence. There is consensus on the work required with our patient populations and continued, concerted efforts are required to continue towards net zero.

Across our system, we will:

1. Minimise nitrous oxide waste by progressing the actions outlined in the NHS England nitrous oxide mitigation toolkit, supported by improvements to pipeline systems in trusts and decommissioning of manifold systems.
2. Continue our system-wide focus on the management of respiratory conditions (see *Delivering net zero by Medicines Optimisation*, page 30-32), reducing metered dose inhaler (MDI) prescribing and improving care of chronic obstructive pulmonary disease (COPD) by reviewing local formulary recommendations and associated guidelines.
3. Use data from patient surveys, studies and pilots to inform a programme of work on reducing overprescribing and minimising waste of medicines and medicines packaging.
4. Evaluate the success and cost-effectiveness of the SEL inhaler recycling scheme and seek to keep offering inhaler recycling across SEL trusts and community pharmacy.
5. Review options for switches between intravenous and oral medicines to increase efficacy with a secondary benefit of reducing use of consumables, where evidence indicates that it is safe, beneficial and effective to do so.

Spotlight

Delivering net zero by

Medicines Optimisation

Medicines account for approximately 25% of total NHS carbon emissions. It is estimated that for every £1 spent on medicines, 0.16kg of CO_2 equivalent emissions is generated. Medicines waste from overprescribing and usage non-adherence contributes to unnecessary environmental harm and resource use.

Reducing unnecessary prescribing and supporting adherence are therefore key enablers for improving clinical outcomes, reducing waste, and helping the NHS reach its Net Zero target.

The South East London Responsible Respiratory Prescribing Group (RRPG) provides a forum for healthcare professionals from across acute, community and primary care to work together to develop consistent, sustainable and cost-effective prescribing guidelines and strategies in respiratory disease for both adults and children. The RRPG supports moves to sustainable inhaler options, as outlined in the group's pledge to reduce the carbon footprint of inhalers:

1. Better patient education to support adherence with preventer use
2. Use combination inhalers where appropriate and where one is available
3. Improve asthma and chronic obstructive pulmonary disease (COPD) control and reduce short-acting beta agonist (SABA) use
4. "Make every puff count" – optimising inhaler technique
5. Increased utilisation of reusable inhaler device or their components
6. Choosing the most environmentally friendly inhalers where suitable
7. Monitor inhaler prescription requests and over-ordering
8. Used inhalers should not be placed in general waste

Additionally, the South East London ICB Overprescribing Group has, in line with national medicines optimisation opportunities, identified two aims:

1. To better understand the sources of medicines waste and support the safe disposal of unused medicines
2. To improve medicines sustainability by embedding best practice around prescribing into local guidance and formularies

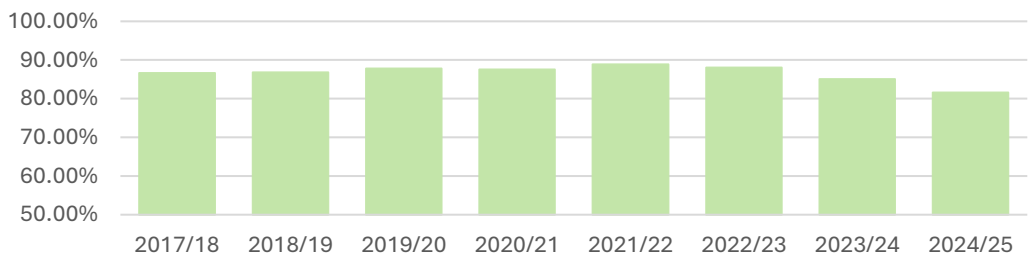
Progress on short-acting beta-agonist (SABA) free pathway uptake:

Although south east London is a high prescriber of SABA inhalers, significant progress has been made in promoting the uptake of SABA-free pathways:

- **A sustained and significant decrease in prescriptions for SABA**. The proportion of patients prescribed six or more SABA has decreased by 9% over the last three years. We have reduced carbon emissions from this category of inhaler by 5.76 kg CO2e per salbutamol item (a 25% reduction) - equivalent to travelling the circumference of the equator 69 times with an average sized car!
- **Improved adherence to preventer medications.** Adherence (number of preventer inhalers prescribed per person) has improved by 10% across both our asthma and COPD population, following patient education initiatives.
- **Improved uptake of SABA-free treatment.** Since the launch of the SEL asthma guide, prescribing of SABA-free treatments in the asthma population has increased from 8.5% to 15%.
- **Uptake of Dry Powder Inhalers (DPI).** Dry powder inhalers have several advantages over metered dose aerosol inhalers, including easier inhalation techniques, significantly lower carbon emissions, dose counters and other technologies to improve patient adherence and safety. The percentage of patient prescribed a higher-carbon metered dose inhaler (MDI) is consistently decreasing; evidencing gradual but sustained switches to DPI.
- **Training and support:** Working in partnership with our training hubs, healthcare professionals have received training on the benefits of SABA-free pathways and how to effectively communicate these to patients.
- **Monitoring and evaluation** – via development of the South East London respiratory dashboard, which provides useful insights and understanding of where to target our focus to improve prescribing and quality improvement.

Data insight

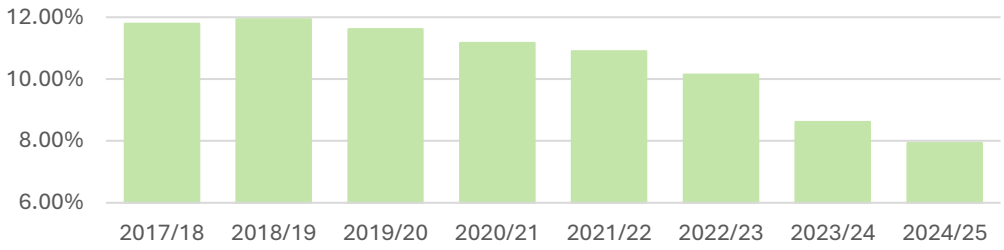
Trend #1: the percentage of patients prescribed a metered dose inhaler (MDI) peaked at 88.9% in in 2021/22 and has since fallen to 81.6% (graph below)



% of patients prescribed a metered dose inhaler, April 2017 - March 2025

Data insight

Trend #2: the percentage of patients prescribed a very high carbon MDI has fallen consistently since 2018/19, and is now less than 8%



% of patients prescribed a very high carbon metered dose inhaler, April 2017 - March 2025

Other medicines optimisation initiatives include:

- Implementation of the **Repeat Prescribing Self-Assessment Toolkit,** developed by the Royal Pharmaceutical Society and the Royal College of General Practitioners, to review and improve repeat prescribing processes. This helps align medicines supply with patient needs, reduce waste and improve patient safety within workflows.
- Increasing the uptake of **structured medications reviews** with a focus on high-need or high-risk patients. Reviewing medicines use alongside patients empowers them in shared decision-making to reduce avoidable prescribing and support safe deprescribing to reduce medicines waste.
- Development and roll-out of the **Only Order What You Need** public engagement campaign in London region. This campaign encourages patients to avoid medicines stockpiling, reduce unnecessary ordering on repeat, return unused medicines and understand the environmental cost of waste.
- Development of **targeted waste medicines pilot projects**. Pilot projects include *SEL Waste Medicines with Public Engagement* and *Care Home Medicines Waste*. These pilot projects and being developed to identify scalable models that can deliver measurable environmental benefits.

Spotlight

An example of net zero

Patient participation

Joanna, a Greenwich resident and patient participation group (PPG) member at the Eltham Medical Practice, contacted the SEL ICB sustainability team in June of 2023 offering to work with the ICB on exploring opportunities and options for medicines blister pack recycling in south east London. Joanna facilitated an introduction to the Circularity in Primary Pharmaceutical Packaging Accelerator (CiPPPA) - an initiative developing and deploying solutions for recycling medicines packaging. Below, Joanna describes why blister pack recycling is important to her, and how she has contributed to building networks in south east London.

"Finding sustainable solutions for everyday living is embedded in my DNA. My husband and I are both in our sixties and between us we collect c.500 medicine blister packs every six months. If you multiply that up across the UK, that equates to *billions* of blister packs!

Blister packs are formed of two main elements, the clear plastic coating on the front and the printed metal film at the back. This means they can't be recycled in normal plastic waste. I'd collect our empty packs and every six months I'd make the five-mile trip to the local collection point in a high street chemist. The collection box was always overflowing and often had carrier bags of empty blister packs piled around the base.

It was clear people were interested and happy to recycle their empty blister packs. I contacted the ICB in 2023 to see if a recycling point could be set up locally and since then I've been working with James to explore the options. My work has included writing, on behalf of my practice, to 35 pharmaceutical companies to enquire about sponsorship of a collection box. Whilst we haven't secured sponsorship, one respondent pointed me to the Circularity in Primary Pharmaceutical Packaging Accelerator (CiPPPA). At last, I had found an organisation not only interested in the issues but taking an active and positive step in finding solutions.

I've had discussions and correspondence with the CiPPPA team and have facilitated a meeting between CiPPPA and James, who has since introduced them to the wider London ICB network to explore what can be done.

I am a firm believer in doing my bit, and if we all do that, we can make a difference and enhance sustainability."

Supply Chain and Procurement

Our opportunity:

If we use our supplies more efficiently, consider low-carbon alternatives, embed circularity and work with our suppliers to decarbonise their processes, we:

- **Reduce emissions from the supply chain, which are mostly out of our direct control** (referred to as the *NHS Carbon Footprint Plus* – see page 4)
- **Create additional social value for our people in south east London and for our suppliers and their workforce – contributing to healthier, happier communities and helping tackle health inequalities**
- **Embed principles of circularity in our purchasing decisions, using refurbished equipment and engaging providers who re-use and recycle materials in the production and delivery of their goods and services**
- **Support suppliers to plan and demonstrate their own carbon reductions**
- **Create financial savings though sustainable and efficient solutions**

Our supply chain accounts for the majority of emissions not within our direct control, so we must make conscientious and measured decisions and work closely with our suppliers to deliver net zero.

Across our system, we will:

1. Adhere to procurement guidance requiring us to take account of social value and suppliers' carbon reduction in the award of contracts, developing processes to embed social value commitments in contract management, to ensure that they are delivered throughout the term of supplier contracts.
2. Embed NHS Net Zero Supplier Roadmap requirements into all relevant procurements and ensure they are monitored via key performance indicators (KPIs) across the term of supplier contracts.
3. Encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment.
4. Explore the development of a sustainable procurement policy, in collaboration with the London Procurement Partnership (LPP).
5. Develop guidance and recommendations on appropriate consideration of the circular economy and reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects.
6. Seek 'once for London' opportunities that will allow us to unlock the purchasing power of London to support decarbonisation of the supply chain.

Food and Nutrition

Our opportunity:

If we can support our people and service users to maintain a balanced diet and receive good nutrition via food that is appealing, seasonal, locally sourced and sustainably produced, we can:

- **Reduce emissions related to transport and agriculture**
- **Minimise food waste, and the emissions resulting from it**
- **Consider moves towards a greater range of lower carbon plant-based menu options for inpatient meals and staff canteens**
- **Support the recovery of patients with healthy meals offering good nutrition**
- **Increase the affordability of food at our sites, and in doing so, contributing to the reduction of food insecurity**

Achieving net zero in this area of focus relies on sourcing high quality, healthy, appealing food from sustainable suppliers, so that as much as possible is consumed and not sent to landfill.

Across our system, we will:

1. Continue to implement innovative food ordering systems to minimise the oversupply and preparation of food.
2. Measure and monitor food waste and use the data we collect to determine how we can go further with our net zero actions. Where food waste is unavoidable, we will use options that divert food waste from landfill, such as energy recovery, anaerobic digestion or to fertiliser.
3. Continue - with our catering suppliers - to explore a greater range of plant-based meals and menu options which use unprocessed foods.
4. Use procurement and contract levers to place greater weight on healthier, lower carbon, and locally sourced options when renewing catering contracts.
5. Move away from single use cutlery, cups and carry-out packaging at catering outlets and explore reusable, recyclable or compostable options.

Explainer: what do we mean by ‘climate adaptation’?

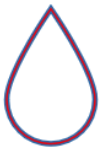
The climate is changing, and this has wide implications for health and care services. Adaptation is the process of adjusting our systems and infrastructure to continue to operate effectively whilst the climate changes and we experience a greater frequency of extreme weather events.

Climate adaptation is different to climate mitigation. Mitigation reduces the causes of climate change be cutting carbon emissions – which we must also do – but **climate adaptation** is about maintaining continuity of NHS services and ensuring a safe environment for patients and staff in even the most challenging times.

The risks of immediate concern for London, and examples of adaptation:

Heatwaves and overheating

We can adapt for this by installing efficient, passive cooling systems in our buildings, or by creating green spaces where trees create shade to protect our buildings from the heat of the sun. We provide our patients with advice on how to minimise the impact of heat.



Surface water flooding

We can adapt for this by making changes to our physical infrastructure; installing permeable property surfaces to manage water run-off or by creating green spaces which promote water drainage. We can also put water management strategies in place.

Thunderstorm asthma

Thunderstorm asthma is when wind and rain break up concentrations of airborne allergens into smaller particles which can trigger asthma symptoms. We can adapt for this by issuing health alerts and educating asthma patients on how to use their preventer inhalers before and during thunderstorms,

Adaptation measures are built into the business continuity and resilience plans of each NHS organisation in south east London. As the impacts of our changing climate become greater, our focus on climate risk grows and we move towards creating dedicated climate adaptation plans. NHS adaptation plans in London will respond to the recommendations raised by the London Climate Resilience Review – an independent review commissioned by the Mayor of London in 2023.

Climate Adaptation

Our opportunity:

If we can identify the full range of risks and impacts from climate change and climate events on our services, infrastructure and population and mitigate them via everyday discussions, decision-making and in our planning, we can:

- **Support our services to adapt to the changing climate and keep them running no matter what the weather or climatic conditions; reducing reliance on NHS business resilience processes**
- **Make our estates and services climate-resilient with financially viable long-term adaptations; moving away from costly reactive fixes and retrofit solutions**
- **Alert and educate our population to the impacts of our changing climate and use education and information to keep our people safe and well**
- **Deliver the recommendations from the London Climate Resilience Review**
- **Mainstream climate risk identification, so that the details and impacts of it are well understood and considered with equality to other corporate risks**

Without adapting to our changing climate, we can only be reactive to climate events, which risks the safety, security and wellbeing of our people, services and finances.

Across our system, we will:

1. Establish climate risk registers; first by organisation and then develop these into a system-wide register. This will allow us to recognise common risks and how we can collaboratively mitigate them.
2. Develop and publish climate adaptation plans.
3. Find as-yet-unrealised points of collaboration with wider system partners, including Local Authorities /Public Health and the Greater London Authority (GLA) and enter into delivery partnerships.
4. Facilitate the cascade of weather health alerts and relevant messaging
5. Continue to comply with the adverse weather standards within the Emergency preparedness, resilience and response (EPRR) core standards, and we will identify where action is required beyond the remit of EPRR teams. This will allow a greater focus on proactive, pre-emptive action
6. Identify actions (facilitated by London Region Greener NHS) to fulfil the recommendations of the London Climate Resilience Review, and in doing so, will identify which are best delivered ‘once for London’ and at-scale.

Green/Blue Space and Biodiversity

Our opportunity:

If we can expand green spaces (such as parks and gardens) and blue spaces (such as lakes and around rivers) at NHS sites and in our communities, we can:

- **Harness the healing power of nature in these spaces to improve physical and mental health and wellbeing**
- **Help reverse the loss of biodiversity**
- **Mitigate air pollution, noise and excessive heat**
- **Offer our workforce spaces to unwind to refresh and re-energise**
- **Offer our communities spaces for physical exercise and relaxation**

The loss of biodiversity is intrinsically linked to climate change. To mitigate climate change and contribute to the recovery of biodiversity we need to address them both, not just for planetary but also for human health.

Across the NHS estate in south east London, we have developed a number of innovative green spaces. Sharing our experiences and learning in creating natural healing spaces is key to continued innovation and biodiversification on our estate.

Across our system, we will:

1. Promote use of green spaces via social prescribing (also known as green prescribing).
2. Develop more green and biodiverse urban spaces at NHS sites, including incorporating them into new-build plans, to meet biodiversity requirements as per the Environment Act 2021.
3. Identify how increased and enhanced green and blue spaces can support the improvement of air quality and provide natural shading to support the climate resilience of our sites.
4. Continue to partner with horticulture experts and NHS Forest in the creation of biodiverse green spaces, to access free trees for planting and to take expert advice on planting methods for longevity and diversity of species and spaces.
5. Work with councils and find opportunities to partner with local voluntary and community sector organisations to develop healthier neighbourhoods where access to green space is easy and safe.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Chief Executive Officer's Report**						
Meeting date	15 October 2025		Agenda item Number	**5**	Paper Enclosure Ref	**E**	
Author	Andrew Bland, ICB Chief Executive Officer						
Executive lead	Andrew Bland, ICB Chief Executive Officer						
Paper is for:	Update	**x**	Discussion		Decision		
Purpose of paper	To receive the report from the Chief Executive Officer						
Summary of main points	This report updates the Board on matters of interest across NHS South East London since the last Board meeting on 16 July 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) 15 October 2025

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

Since the Board last met in public, our system has continued to manage high levels of demand and operational pressure, whilst coming together to progress local strategic priorities and the ambitions set in the NHS Ten Year Plan. In particular the board agenda highlights the progress we are making to establish a Neighbourhood Health service and we record the establishment of Integrator arrangements in all six south east London Boroughs, with Bromley and Greenwich achieving this milestone over August and September; and we were delighted to support three place based applications, covering four boroughs, for the National Neighbourhood Health Implementation Programme (NNHIP) and to learn that Lambeth and Southwark partnerships were awarded pilot status, as just one of five in London and 43 across the country.

The work progressed by our system occurs in a context of wider societal challenges. On several occasions since our last public meeting we have had cause to reiterate our commitments as an Anti-racist organisation and reassure staff and residents of our zero tolerance of discrimination in all its forms and our commitment as an inclusive organisation and system. As this report outlines, we are also seeking to support staff through a now prolonged period of organisational change as we take steps and make proposals to reduce our running costs in line with national direction in this area. As a Board and executive team we wish to place on record both our thanks for the professionalism and hard work of staff over this period.

When taken together our board papers today outline current system pressures, an incredibly challenging set of plans for the year, alongside cost reductions in the management resources we have to address them. The scale and pace of these challenges requires fundamentally different responses across our partnership and heightens the need for the reform and transformation activities we also have on the agenda for our meeting.

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. Management Change Update

1.1. SEL ICB has completed all Board approved activities in order to make proposals to restructure the ICB in response to the national requirement to make a reduction in running costs and deliver the Model ICB Blueprint.

1.2. SEL ICB, along with other ICBs in the country, is currently waiting to receive further national guidance which will include a consideration of redundancy cost management plus associated timetable and HR implications. All consultations upon change are paused pending receipt of this further guidance when informed decisions can be made in relation to future process in the context of affordability.

1.3. In the meantime, SEL ICB has received supplementary national best practice guidance in relation to four key functions: Medicines Optimisation, Continuing Healthcare, Safeguarding and Special Educational Needs and Disabilities (SEND). This guidance has been reviewed and assessed against the SEL ICB's proposals for these areas to test alignment and ensure the ability to meet any recommended approaches set out in the guidance.

1.4. A set of functions have been identified for transfer from SEL ICB to local partners, as set out in the ICB blueprint. These will be streamlined as part of the ICB restructure proposals ahead of any transfer. This workstream is overseen by a Transition Committee, reporting to the SEL ICB Board and chaired by a Non-Executive Director. Following an expression of interest and assessment process, work has begun to agree detailed service specifications and how and when functions will transfer. Transfers are expected to take place during 2026/27, subject to NHSE support and approval by the SEL ICB Board and receiving organisations' Boards.

1.5. As part of the change programme, SEL ICB has worked with other London ICBs to review functions that are currently provided once for London. These functions will either continue without change, continue but within a smaller financial envelope and amended remit or will cease entirely. This work is expected to conclude in the next month.

1.6. Weekly updates and Question and Answer sessions are continuing for staff. The support offer to staff remains available recognising the heightened stress and uncertainty staff are facing in the context of the paused consultation.

2. Equalities Update

Black History Month

2.1. A range of activities are planned for this year's Black History Month celebration including a newsletter focused on the 2025 theme of 'Standing Firm in Power and Pride' with contributions from members of the Embracing Race and Diversity staff network. Members are also organising a musical showcase for a related Book, Film and Music Club event which aims to highlight the powerful contributions of Black people and communities to society. The EDI Team has arranged an Equalities Forum with external speakers including Dame Joan Saddler, Director of Partnerships and Equality at NHS Confederation and the team behind the innovative work of enhanced community sickle cell services which is currently shortlisted for a Health Service Journal award. All ICB events have been shared across SEL ICS for wider engagement and collaboration.

Equalities Sub-Committee

2.2. The Equalities Sub-Committee (ESC), chaired by the Chief of Staff and Equalities SRO, met twice**,** in July and September**,** and considered a range of topics including: Black health and tackling inequalities through system change, digital inclusion, borough deep dives for Lewisham and Greenwich, south east London health inequalities statement and development of the new SEL ICB staff equality, diversity and inclusion strategy (detail below). The Committee has also completed an effectiveness review which yielded highly positive feedback, with minor feedback for improvement being addressed. The next ESC meeting will be held in November and will focus on deep dives for Southwark and population health, and updates on NHS England's workforce equality standards and Equality Delivery System 2022.

Staff Equality, Diversity and Inclusion Strategy

2.3. An intersectional and integrated Equalities, Diversity & Inclusion (EDI) strategy has been in development this year and a final draft has been prepared. At the September ESC discussion took place about publication and launch of the strategy, during this time of NHS change, with strong consensus, given the political and social climate, that this piece of work should go ahead. The strategy references the NHS changes and includes a section on equalities in a strategic commissioning organisation, to consider further as this work develops. The strategy mission statement is: 'We will build a fair and inclusive workforce culture at the heart of health services planning in south east London' and is organised around seven key workforce themes.

Supporting the ICB Change Programme

2.4. Consultation support and development: Over 120 staff have attended an exciting programme of wellbeing support and skills development being offered by the Equality, Diversity and Inclusion team to support staff through the ICB Change Programme. Topics are wide-ranging and focus on practical application in work settings to ensure that a culture of equity and fairness, compassion and solidarity is the bedrock of how staff navigate through this period. Sessions are being delivered from June to October and cover: Workplace Adjustments, LGBTQ+ Allyship, Being Compassionate Through Change, Micro-incivilities and Bias in the Workplace, EDI Awareness and Equality Impact Assessment training.

2.5. Equality impact assessments (EIA): A stage 1 EIA has been completed on the Change Programme which outlines the current staff demographic by protected characteristic and is accompanied by a proportionate and relevant EDI action plan being implemented by the HR Change Management Working Group. The stage 2 EIA will be conducted after ring-fenced interviews have taken place comparing pre and post change positions and identifying any disparities. An initial screening EIA has also been undertaken on the proposed voluntary redundancy scheme.

2.6. Inclusive recruitment: Discussions have taken place regarding how to make recruitment processes fair and equitable during ring-fenced interviews. Amongst other measures being finalised, an unconscious bias in recruitment training module has been refreshed and will be mandatory for all staff, band 4 and above. Interview panel members will have needed to complete this before participating.

3. Model Region Blueprint

3.1. The Model Region Blueprint was published on 8 September 2025 and begins to explain the role of the seven regions as the 'leadership interface between the centre and local health systems, overseeing strategy, managing performance and coordinating improvement and intervention'.

3.2. The 10-Year Health Plan for England (10YHP) commits to reshaping the NHS operating model to support its vision. A key part of the plan is the abolition of NHS England (NHSE), merging its functions into the Department of Health and Social Care (DHSC), and redesigning the centre to create a more agile, less bureaucratic NHS. The Blueprint sets out the regional role in implementing the 10YHP to work with Integrated Care Boards (ICBs), overseeing transformation at scale, supporting service configuration, and ensuring effective implementation of structures, functions and incentives. There is a strong emphasis on reducing duplication, using proportionate and streamlined regulation and oversight to minimise the burden on providers.

3.3. Key changes under the blueprint are:

- Enhanced regional role: The blueprint gives regions an expanded mandate, especially in performance management, a function that is being shifted away from ICBs.
- Abolition of NHS England: The functions of NHS England will be integrated into the Department of Health & Social Care (DHSC), which will lead to a 50% reduction in the combined headcount of the two central bodies.
- Reinforced ICB role: Integrated Care Boards will focus primarily on strategic commissioning to improve population health and address health inequalities. Their running costs are also being significantly reduced.
- New regional governance: Each of the seven regions will have a new governance model, including a chief executive and a Non-Executive chair.
- Commissioning functions transfer: The blueprint confirms that all specialised commissioning responsibilities will be transferred from regions to ICBs by April 2027. New "Offices of Pan-ICB Commissioning" will be established to manage this transition.

Core functions of NHS regions

3.4. The blueprint outlines three main functions for the newly defined NHS regions:

- Strategic Leadership: Developing and overseeing medium-term strategic plans that align with the 10YHP. This includes guiding investment, service changes, and workforce planning.
- Performance Management: Providing comprehensive oversight of provider and ICB performance against national standards, identifying risks, and monitoring the capability of local boards.
- Improvement and Intervention: Coordinating support for organisations that need to improve. Regions will facilitate the sharing of best practices and lead interventions where performance is challenged.

4. Planning Directorate Update

In year delivery and winter planning

4.1. Directorate leads continue to work with providers across the system to support the implementation of agreed commissioning priorities for 2025/26, including focussed work to support the delivery of agreed performance and care pathway improvement plans. There has been a specific focus on winter planning, including a south east London (SEL) wide winter planning workshop and the development of winter plans for 2025/26. The SEL ICB Board received an update and assurance in relation to the planning process and outputs at its informal meeting in September 2025, in support of the various submissions that the SEL system has made to the national team with respect to winter. This includes the completion of a SEL ICB Board Assurance Framework process. SEL organisations have also participated in regional winter planning and stress events as part of the planning and assurance process.

4.2. A national mid-year review process was initiated in mid-September 2025, including a review of progress against key operational plan commitments, with a specific focus on financial performance, Referral to Treatment Times, including progress in eliminating over 65 and 52 week waiters, the delivery of activity plans and progress in rolling out Advice and Guidance, Accident and Emergency performance in terms of the 4-hour standard, 12-hour and ambulance handover waits and primary care delivery of on line consultation access for general practice, dental and Pharmacy First activity. The review process includes the consideration and submission of revised performance trajectories for the second half of the year and underpinning recovery plans. The system Sustainability Group is overseeing the work required as part of this mid-year review process.

4.3. These processes, along with the publication of provider league tables and a relaunched oversight framework, demonstrate the huge focus and emphasis on ensuring the NHS demonstrably delivers the commitments it has made around delivery and improvement for 2025/26. In SEL some providers are subject to targeted enhanced oversight linked to areas of relative performance or financial challenge. Overall provider performance across a range of domains is also reflected in the national segmentation approach, with SEL provider segmentation ranging from Segment 1 high performing (Guy's and St Thomas' NHS Foundation Trust) through to Segment 3 where performance is off track across a number of domains (SEL's other four NHS providers).

2026/27 planning

4.4. The directorate has been focused on establishing the 2026/27 planning process, with a focus on both medium-term strategic planning and annual operational planning. This includes preparatory work that has been undertaken over the summer with leads from across the Planning and other directorates completing work around available data, insights and intelligence, the development of initial commissioning intentions for the year ahead and the development of agreed plans to produce the medium-term commissioning strategy and neighbourhood health plans.

Intensive and Assertive Outreach Mental Health Services

4.5. In early September 2025 SEL ICB, in collaboration with the two mental health trusts, submitted an updated self-assessment against a series of national Key Lines of Enquiry (KLoEs) regarding the delivery of intensive and assertive outreach services,

which form part of community mental health services. Broadly the return demonstrates improvements in some areas including:

- Policies and governance both within organisations but also system wide
- Overall approach to risk management in the providers supported by the expansion of multi-disciplinary approaches for complex cases
- Staff training and development to help in supporting this cohort of patients
- Pathway developments and enhancements, e.g. a new psychosis pathway at Oxleas NHS Foundation Trust and
- A stronger understanding of needs of this particular cohort of service users

4.6. However, the return also reflects ongoing challenges with:

- Consistent application of policies, protocols and risk management tools/approaches across all organisations and teams
- Overall caseloads in community mental health services and the mapping of resources to meet this need effectively across all six boroughs consistently and
- Recruitment and retention of staff within these services

4.7. The September return included a new KLoE on multi-disciplinary and multi-agency out of hours care. Although SEL ICB commissions out of hours care across both mental health trusts, this support is generic and is not tailored specifically for the needs of people who would fall within the intensive and assertive outreach cohort. This has therefore been flagged as an area of current non-compliance and development in SEL ICB's system return.

4.8. It is worth recognising that the updated self-assessment has been undertaken less than a year after the initial assessment, and therefore some of the challenges, which are long-standing and systemic, will take several different steps and time to address effectively. SEL ICB will continue to work with the two south east London mental health trusts to develop improvement plans and address the areas identified in the return, with areas of investment feeding into planning approaches and cycles as required.

Adult Attention Deficit Hyperactivity Disorder (ADHD)

4.9. Over the last 9 months, the Planning Directorate has been working with the two south east London mental health trusts to mobilise a new single point of access for all new Adult Attention Deficit Hyperactivity Disorder (ADHD) referrals. The Adult ADHD Referrals Triage Service will open on 3 November 2025 and will be hosted by Oxleas NHS Foundation Trust for all six boroughs in south east London.

4.10. The Referrals Triage Service is the first step towards wider pathway transformation for Adult ADHD services which have seen an exponential increase in demand since the Covid pandemic. Demand has grown not only locally but nationally and this has led to development of the independent sector market. Over recent years SEL ICB has seen an increase in the number of people opting to use patient choice and access care in the independent sector market. The Referrals Triage Service offers SEL ICB the ability to better understand patient need and demand to support the future development and commissioning of these services but will also support patients in being able to make a

more informed choice regarding their care (whether that be in the NHS or the independent sector).

4.11. Communication on the opening of the Referrals Triage Service has been shared with primary care and service providers, including independent sector providers, and SEL ICB will be sharing information with residents and members of the public via the ICS website.

Home Oxygen Service

4.12. The London Home Oxygen Service (HOS) contract for the London region was recently awarded to Baywater Healthcare, with the service commencing on 5 October 2025.

4.13. The new contract includes improvements for patients, healthcare services and commissioners. The service will be provided 7-days a week which will allow patients the flexibility to have their installations, services and/or refills at the weekend, as well as supporting acute providers with managing weekend discharges for patients requiring oxygen.

4.14. The addition of new equipment will further support the optimisation of treatment for patient groups such as those with a cluster headache diagnosis, providing a device that will allow more effective and rapid relief of cluster headache attacks.

4.15. The new contract also provides financial benefits, reducing the costs of home oxygen services across the region as well as being identified as a net zero-rated service for patients receiving the service in their homes.

4.16. The London HOS team, hosted by SEL ICB, has been working with the incumbent and new provider over the last nine months to ensure a smooth transition with minimal impact on patients and service delivery. The new provider is an experienced home oxygen provider, with five other regions across England and SEL ICB looks forward to collaborating with them to enhance the patient experience, maximise outcomes, and ensure spending remains within budget.

5. Maternity Update

5.1. The government has confirmed that 14 NHS hospital trusts across England are to be investigated as part of a 2025 National Maternity Investigation, reviewing maternity and neonatal care, led by Baroness Valerie Amos. The aim is to develop one set of national recommendations for improving maternity and neonatal care, drawing together lessons from past reviews and inquiries. Interim recommendations are expected by December 2025, with a full report following in the spring.

5.2. The selection of the 14 Trusts was informed by national audit data on stillbirths and perinatal outcomes, plus patient surveys and input from families among other factors. Investigators will conduct interviews, examine records and collect evidence from women, babies and family including fathers and non-birthing partners.

5.3. Key themes and challenges include:

- Patient & family voices front and centre
- Health inequalities and inclusion

- Systemic failures and cultural issues
- Integration of past reviews
- Support and scrutiny from medical voices

5.4. The investigation will run alongside a “national maternity and neonatal taskforce”, chaired by Wes Streeting, the health and social care secretary, and composed of experts and families. This taskforce aims to improve maternity and neonatal services in England through a rapid review process.

5.5. The Local Maternity and Neonatal System (LMNS) in south east London, which is a partnership between care providers, commissioners, service user representatives and other stakeholders including NHS England and public health representatives, will ensure learning from the investigations is fed into the south east London transformation of maternity services.

6. Bexley Borough Update

Integrated Urgent Care Services

6.1. In line with the NHS Provider Selection Regime competitive process under the Health & Care Act 2022 – NHS South East London Integrated Care Board, Bexley awarded the contract for the two Urgent Treatment Centres at Erith & District Hospital, Erith and Queen Mary’s Hospital, Sidcup, to Lewisham & Greenwich NHS Trust working in partnership with the local GP Federation, Bexley Health Neighbourhood Care CIC.

6.2. This partnership will enable and support delivery of integrated same day urgent care for residents in Bexley. An enhanced service model will connect and coordinate services across the local health and care system to ensure residents receive the right care, in the right place, at the right time. This service model will integrate:

- The two Urgent Treatment Centres
- Out-of-hours GP home visiting (via NHS 111)
- Urgent Community Response and mental health services
- Primary Care (general practice)
- Acute trusts (hospital services)
- Social Prescribing
- The Pharmacy First
- London Ambulance Service (via 999 and 111)

6.3. Lewisham & Greenwich NHS Trust and Bexley Health Neighbourhood Care CIC, working closely with the outgoing provider, have adopted a structured programme management approach, to ensure the safe transfer and transformation of the current services.

6.4. This approach supports national priorities set out in the Fuller Stocktake (2022), and NHS England’s Pharmacy First initiative (2024) and more recently the *Fit for the Future: 10 Year Health Plan for England* on integrated, community-based urgent care

that reduces pressure on hospitals and improves patient experience and outcomes. The official launch of the service is scheduled for 1 October 2025.

Supporting and engaging our communities through prevention

6.5. **Let's talk creative health:** On 24 July 2025, the Bexley Wellbeing Partnership held its *Let's talk* session on *Creative Health* – the power of creativity to improve health outcomes for residents. The Committee heard presentations from Matthew Couper from the Greater London Authority, and the Bexley Voluntary Services Council (BVSC). The BVSC are working with Bursted Wood Surgery on 'Bexley Buddies', a Creative Health initiative intended to empower individuals and reduce demand on primary care services. The committee also received a presentation on the *Music for Hospices* project, spearheaded by the Community Hospice.

6.6. **South Asian Heritage Month:** The annual Bexley Wellbeing Partnership *South Asian Heritage Month Health & Wellbeing* event took place on 29 July 2025. Around 100 residents attended to find out about aspects of health which disproportionately affect the borough's South Asian population. The Council Chamber at the Civic Offices hosted a marketplace of 25 stalls.

6.7. **Thamesmead Festival:** On 2 August 2025 Bexley Wellbeing Partnership was represented in the Community Zone at the Thamesmead Festival, Southmere Park. Over 10,000 visitors were at the festival this year and as part of the 'Connecting Thamesmead' stall the Bexley team had conversations with around 100 residents throughout the day. In partnership with staff from SEL ICB, Peabody and the Royal Borough of Greenwich Public Health team, photographs were taken to develop the Thamesmead Wall of residents' thoughts. Information was collected from residents on the type of creative health activities that would help to keep them fit and well and the support and services which might help to improve their lives including the type of services available across Thamesmead and beyond.

6.8. **Know Your Numbers Week:** This is a national campaign led by Blood Pressure UK to raise awareness of high blood pressure. High blood pressure usually has no symptoms but can lead to heart attacks, strokes, kidney disease and dementia. This year's theme is "Looking for the Missing Millions", highlighting the importance of identifying people with undiagnosed high blood pressure.

6.9. Between 8 and 10 September 2025, nearly 250 people attended the three venues across the borough: the Broadway Shopping Centre, the Nest Library in Thamesmead and the Bexley Civic Offices. The Hayshine Pharmacy provided testing and advice on lifestyle changes. People with more serious hypertensive readings were referred to their GP. Some were provided with a blood pressure (BP) monitor to continue testing at home.

7. Bromley Borough Update

Integrated Neighbourhoods Update – Integrator and Governance Development

7.1. On 31 July, the One Bromley Local Care Partnership Board approved the Borough arrangements for the Integrator. The One Bromley Partnership, set up as a neighbourhood provider group with members from the One Bromley Executive, will

serve as the integrator for Bromley Place. King's College Hospital NHS Foundation Trust will host the arrangement.

7.2. As in other boroughs, the integrator will provide the core infrastructure to support effective integrated neighbourhood team working as it develops, ensuring services are tailored to meet local community needs and operate smoothly across organisational boundaries. Their role is crucial in creating cohesive, proactive, targeted and sustainable services that place individuals and communities at the centre.

7.3. These proposed arrangements were subsequently approved by the South East London Integrated Commissioning (SEL ICB) Board and announced on 21 August by the ICB.

7.4. The next steps for the partnership will be to further develop the governance arrangements supporting the proposed place structure as set out below. This will include:

- Development of a Memorandum of Understanding and an Alliance Agreement, updating the existing agreements to reflect the proposed arrangements for the Bromley Integrator.
- Assessment of the local integrator arrangements against the south east London Maturity Framework to feed into a development plan for the partnership, supported by non-recurrent funding from south east London.

7.5. The One Bromley Partnership continues to progress on the three key areas of Integrated Neighbourhood Development set out by South-East London as the neighbourhood care priority population groups: multiple long terms conditions, frailty and children and young people.

7.6. Integrated pathways are currently live for frailty (through the Integrated Care Networks pro-active pathway) and Children and Young People (through the Bromley Child Health Integrated Partnership team (BCHIP) service), and these are being further developed to align further with integrated neighbourhood team working.

7.7. The development of the multiple long-term conditions management programme is progressing well with services planned to be live within the Borough by the end of 2025/26.

Bromley Learning Disabilities Strategy 2025 to 2030 and Bromley Mental Health and Wellbeing Strategy 2025 to 2030

7.8. SEL ICB (Bromley) and the London Borough of Bromley have jointly agreed new five-year strategies for learning disabilities and or mental health strategies. The new strategies were developed following an independent assessment of learning disability and mental health needs in the borough and were co-produced with local residents.

7.9. The Bromley Learning Disabilities Strategy (2025-30) sets out how SEL ICB and Bromley Council will work together with other key partners to enable people with learning disabilities in the borough to live fulfilling, independent lives. The plan sets out how the system will support young people to smoothly transition to adulthood, promote better health and wellbeing, increase housing options for people with learning disabilities, and help more people to access and sustain employment. This is the first time that SEL ICB and Bromley Council have come together around a single plan for

learning disabilities and sets out a common vision and approach which will deliver key changes in this area.

7.10. The Bromley Mental Health and Wellbeing Strategy (2025-30) is the second joint plan that SEL ICB and Bromley Council have put forward for the borough; it builds on a considerable track record of success from the last 5-year plan. The new strategy is an all-age approach, founded on a vision for improvements for people with mental health challenges. The strategy has five priorities: prevention and early intervention, helping children and young people to thrive, joined-up safe transitions from children's to adults' services, better recovery outcomes for people with long-term conditions and improved outcomes for older people with mental health challenges and dementia.

Childhood Asthma

7.11. The Children & Young People Asthma Working Group has recently been re-established to drive improvements for children with asthma across Bromley, notably the local delivery of the 'national asthma bundle,' supported by the join up of primary, secondary and community services. The group is actively engaged in mapping the existing asthma services across the borough, with the aim of identifying gaps, overlaps and opportunities, which include, though not exclusively, community provision, admission avoidance, 48-hour follow ups for patients, timely asthma plan reviews, and appropriate diagnostic capacity of asthma.

Quality Improvement Project – Improving Care Leavers' Access to Primary Care

7.12. Research consistently shows Care Leavers have significantly poorer health outcomes compared to their peers, across physical, mental and social domains. These can be compounded by difficulties navigating services due to limited support networks and the cessation of statutory health assessments at age 18, thus further widening disparities as children transition to adulthood. A project was established in Bromley as part of the wider Children Looked After work, to identify and address some of the issues.

7.13. A number of challenges were identified, for example:

- Care leavers are not identified or flagged on general practice lists, thus limiting opportunistic and proactive engagement in addressing their health needs. Consistent and accurate coding is required.
- Links between community health services and general practices could be strengthened to ensure that when someone leaves care, they can be offered physical and mental health checks and access to free prescriptions.
- Attitudes and awareness of the needs of care leavers in primary care could be enhanced so that young people are not misunderstood, and specific services can be offered.
- Moving from CAMHS to adult mental health services can be challenging for care leavers.

7.14. These issues are being addressed by all agencies. Practices are now more consistently being told when a young person is about to leave care and primary care staff are encouraged to code the person as a 'care leaver.' Awareness of the needs of care leavers and use of the Care Leaver code is being promoted through training events and Practice Bulletins and updates. Services are being earmarked for care

leavers such as designated sexual health clinic slots available twice a week for care leavers through Sexual Health Bromley.

7.15. Within mental health services, a pilot project is already in place, led by Bromley Children and Adolescent Mental Health Services (CAMHS) and Oxleas ADAPT, which includes the appointment of a Transition Worker to improve mental health pathways for 16-25 year olds.

7.16. Future work may consider the following initiatives:

- Establishing further links with care leavers and the Bromley Leaving Care team
- Developing clinician training focused on improving awareness and engagement
- Further work on coding
- Enhancing mental health pathways
- Supporting digital and healthcare literacy among care leavers
- Considering the further needs of under-represented groups such as unaccompanied asylum-seeking children, young mothers and homeless care leavers

8. Greenwich Borough Update

Neighbourhood working

8.1. Greenwich has established a central programme team, jointly with the Royal Borough of Greenwich, for delivery of Neighbourhood Health and Care. This programme of work is underpinned by co-design with communities and the wider Partnership. The work is split into three design areas: Preventing deterioration of health, Maintaining independence as long as possible, and Regaining independence after an admission to a residential setting and there are workshops happening in these areas to build a more detailed operating model.

8.2. In addition, Greenwich has been developing its structures to enable Neighbourhood delivery. The Healthier Greenwich Partnership has endorsed Oxleas NHS Foundation Trust to be the Health Host (Integrator) organisation in Greenwich. In September work will also begin to develop a Partnership Collaborative, first through a memorandum of understanding and then ultimately as a legal agreement. The goal of this is to enable the shift towards a more mature, democratically enabled and system led environment and aligned provider(s) operational response, to a more outcomes-based commissioning approach and may better position Greenwich to secure external social investment as well as getting collective best value and outcomes from the Greenwich pound.

8.3. Development of our proactive care pathway, which will encompass new approaches to preventative, proactive care of people with frailty and multiple LTCs, is progressing through the design phase through a collaborative approach with community services, general practice and other system partners. Building on and extending the existing frailty service, the proactive care pathway will benefit from upcoming requirements of general practices to risk stratify their patient lists and will be supported by the new Greenwich PMS Premium contract. Centred around the four Neighbourhoods and

working as multi-disciplinary 'wellbeing networks' that focus on both medical and wider determinants of health, a two stage roll-out will be progressed, starting with frailty and incorporating long term conditions' (LTCs) proactive care following learning from the Multi Morbidity Model of Care pilots across south east London.

Children and Young People

8.4. **Child Health Teams Pilot:** Greenwich is preparing to roll out its second Local Child Health Team based in Riverview Primary Care Network (PCN). This will build off the first team located in Greenwich West. A designated GP lead in the new PCN has been identified and is planning to shadow existing clinics in Greenwich West prior to the launch of the new team in the coming months.

8.5. **Families First:** To deliver on the national Social Care reforms, the Families First in Greenwich Programme is now well established, with joint governance including South East London ICB, local authority, education, health providers, police, voluntary sector and community partners. On 15 September a Partnership event was held, introduced by Greenwich's local Director of Children's Services, Place Executive Lead and Acting Detective Chief Inspector. The day was focused on our partnership working to deliver on the national Families First reforms across five workstreams: Universal Early Support, Family Help, Adolescent Safeguarding, Multi-agency Child Protection and Family Group Decision Making. As Families First is developed in Greenwich it is a chance to co-design services building on current strengths and identifying how the reforms support Local Care Plan ambitions and enable changes such as the development of Neighbourhood Teams.

8.6. **Single Point of Access:** Greenwich is continuing to develop its Single Point of Access for children's mental health and wellbeing. Extensive consultation has been undertaken with children, parents/carers and practitioners. This has informed the development of an initial options appraisal that is due to be considered by partners locally. This will inform a more detailed design stage with the aim to have a final proposal for consideration by Spring 2026.

Commissioning – Adults

8.7. Urgent and Emergency Care and winter planning – Greenwich has continued to work alongside local partners to deliver actions outlined in its Urgent & Emergency Care (UEC) recovery plan. Alongside this the new UEC Board across the Lewisham and Greenwich Trust footprint provides an opportunity for leaders to continue to work together and assure the impact local actions are having and where more needs to be done. Local forums continue to meet which feed in and out of the UEC board at place including Homefirst and Resplendent.

8.8. 2025/26 planning – as well as reviewing and contributing to system intentions letters being issued to providers, local work has been progressed to review outcomes, actions and progress against the Health and Wellbeing Strategy and the 5-year forward view.

8.9. Mental Health (MH) Vision and working alongside residents – In September the results of significant work to hear what matters to adults who have mental health needs in Greenwich was presented to Healthier Greenwich Partnership (HGP). This was alongside recommendations to ensure the work informs and is embedded across MH activity to continuously improve as well as transform local MH offers. HGP partners welcomed and valued the work so far and offered support to understand it more deeply through further discussions and the potential for a development session using the

outcomes for the vision work to think collectively as leaders about what more can be done locally. This work will also be shared with SEL ICB leaders at the October Board meeting alongside a wider MH related item.

Greenwich Healthier Communities Fund

8.10. The Greenwich Healthier Communities Fund aims to prevent and respond to health inequalities across Greenwich to ensure everyone has equal access to the health services and support needed, over the next four years. The Fund provides grants through various strands, all supporting work in Greenwich that aligns with the Health & Wellbeing Strategy.

8.11. Phase 1: Two strands of funding for Voluntary Community & Social Enterprise (VCSE) organisations were launched in April 2024. The Enabling strand aims to increase organisations' capacity building to better tackle health inequalities, whilst the Delivery strand aims to fund projects that prevent and respond to key health inequalities.

8.12. The Enabling Strand has supported 31 organisations across three rounds, with a total of £251,266 awarded. The Delivery Stand has supported 48 organisations across two rounds, totalling £1,122,701.

8.13. Phase 2: After a period of development, with stakeholder input and grantee feedback, the Fund relaunched in April 2025 with adaptations to existing strands and an additional strand; Micro Grants.

- Micro Grants funds the continuation or pilots of small projects, to encourage the trial of innovative projects on a smaller scale, before they are developed. Applications remain open and are reviewed as and when submitted. The budget is reviewed quarterly.
- The Enabling Strand now focuses on capacity building and one-off purchases. Applications remain open and are reviewed as and when submitted. The budget is reviewed quarterly.

8.14. The Delivery Strand was also split into Small, Medium and Large Awards. Small awards have two application deadlines and fund projects from £5,000 up to £20,000, medium awards have two application deadlines and fund £20,001 up to £50,000 (with partnership working encouraged), and large awards has one application deadline and fund partnership projects from £50,001 up to £200,000. The Delivery Strand large awards opened for applications week commencing 15 September 2025. Applicants must work in partnership/collaboratively to be eligible for this level of funding, demonstrate how the project will align with a priority theme (see below), and demonstrate collaborative working within the neighbourhoods in Greenwich.

Primary care

8.15. Primary Care access improvements and supporting the 'left shift' into community. Greenwich general practices offered over 1.7 million appointments in the 12 months up to June 2025, of which over 1 million were booked and used. Over half of Greenwich appointments were face-to-face (55%) and the remainder were by telephone (37%) or online (7%). Over half of all appointments (53%) were with a GP.

8.16. Greenwich Primary Care Networks (PCNs) are required to offer Extended Access appointments outside of their core hours (i.e. early morning, evenings or weekends).

Greenwich PCNs provided 14% more Extended Access appointments over the past year than they were contractually required to, including over 2,000 additional appointments being offered in Eltham PCN alone.

8.17. All 29 practices in Greenwich have now updated their telephony systems to provide call-back functions so that patients can hold their place in the queue and be called back without having to sit on hold whilst waiting for pick-up.

8.18. As of June 2025, 52 of the 57 pharmacies in Greenwich were participating in the Pharmacy First seven clinical pathways, which provide care for acute otitis media, sore throats, impetigo, shingles, sinusitis, infected insect bites and uncomplicated female urinary tract infections. Efforts continue to publicise the offer from community pharmacies to provide care for these symptoms as well as vaccinations, minor ailments advice and other care services.

New PMS Premium contract for Greenwich's 29 practices

8.19. Development of service specifications is progressing for five new PMS Premium services, utilising Greenwich's Premium allocation of £8.09 per patient. The new services have been identified and prioritised through engagement with Greenwich practices and the LMC and based on population health priorities for the borough. They are:

- Participation in the Proactive Care Pathway and INT
- Enhanced call/recall for childhood immunisations
- Enhanced call/recall for cervical screening
- Completion of Universal Care Plans with a focus on DNARs
- Shared Care Prescribing in general practice

9. Lambeth Borough Update

National 10 Year Health Plan and Neighbourhood Health Service Development

9.1. Convening of Integrated Neighbourhood Teams (INTs) of primary, community, acute and social care professionals, along with the voluntary and community sector, to enable collaborative working and provide person-centred care for people with complex needs in the community is a key-stone of the ICB's approach to Neighbourhood Health. Lambeth has been developing its approach to neighbourhood health at pace over recent months, including agreeing five neighbourhood geographies and the integrator model as a partnership between Guy's and St Thomas' NHS Foundation Trust and the Lambeth General Practice Provider Alliance. The Integrator will enable the delivery of INTs in Lambeth and work is underway to complete a 'maturity matrix' to understand the local strengths, opportunities and gaps for future working.

9.2. The Neighbourhood and Wellbeing Delivery Alliance (NWDA) is overseeing Lambeth's INT Delivery Plan, including establishing design meetings in each neighbourhood to review population health data and develop targeted interventions to inform the design of each INT between now and the end of December. Working with Healthwatch Lambeth, the NWDA has also started a wide-ranging public and community

engagement exercise to gain feedback and input to help shape the INT design, with two successful public events held in July.

9.3. Andrew Eyres, Lambeth Place Executive Lead, spoke about the NHS Plan alongside Louise Dark, Chief Executive of the Integrated and Specialist Medicine Clinical Group at Guy's and St Thomas', at the Lambeth Strategic Partnership (LSP) Summer Reception in July. The event reflected the many strengths of the LSP, aligning statutory and non-statutory partners around a clear set of shared values, aims and goals. The government's ambition for the NHS to play a fundamental role in driving local prosperity and social mobility through inclusive growth is directly aligned with the priorities of Lambeth's strategic partners. The recently published Lambeth Growth Plan highlights the opportunities in health and life sciences in Lambeth, including through assets like the Institute for Health Engineering and the SC1 Life Sciences Innovation District to attract inward investment, create jobs and upskill the local population. Lambeth's anchor institutions already employ thousands of local residents and are opening up new pathways into skills development and in health and life sciences careers.

Work in the Community

9.4. **Neighbourhood and Wellbeing Delivery Alliance:** The Discharge – Digital Approach Pathway Service (D-DAPS) is a volunteer-led programme funded by the UK Shared Prosperity Fund and delivered in partnership with Age UK Lambeth to support Lambeth residents in making a safe transition from hospital to home. Utilising the Careforme digital platform, the service delivers a 28-day personalised support plan for each patient, beginning with a "Ready for Return" home check, and works closely with our Thriving Communities and Guy's and St Thomas' to streamline discharge processes and connect patients with local resources. Since its launch in November 2024, D-DAPS has recruited over 98 volunteers, achieved volunteer matching within one hour of referral, and demonstrated early impact in enhancing patient safety, reducing isolation, and strengthening community engagement at the point of hospital discharge.

9.5. **Living Well Network Delivery Alliance (LWNA):** South London and Maudsley (SLaM) NHS Foundation Trust, along with Alliance partners, has undertaken a focused initiative to address the backlog in its Single Point of Access (SPA). Through the committed efforts of Lambeth's SPA team, supported by colleagues across Lambeth and other SLaM boroughs, the backlog of approximately 600 people at the end of June has been eliminated by mid-August. The SPA is being re-designed to prevent future backlogs, manage increased demand, and ensure the people of Lambeth receive timely access to necessary services. The Alliance continues to work to align targeted mental health support with the broader community redesign and Alliance priorities, including the development of neighbourhood working.

9.6. **Children and Young People's Delivery Alliance (CYPA):** continues to develop neighbourhood-based delivery of care for children and young people. Work is centred on Norwood, where the Alliance is working with the local delivery team to test pilots of integrated neighbourhood teams. These pilots will help Lambeth learn what works before expanding across all five neighbourhoods. A working group has been established with partners from the NHS, mental health services, primary care, and social care. This group will guide the development of INTs and make key decisions about how they are introduced. The Alliance is also supporting a health inequality review led by the South London Act Early Team, based at Evelina London. The review will give Lambeth a clearer view of the challenges faced by children, young people, and women using maternity services. It will help shape future plans for integrated care and

provide the basis for conversations with local communities about what matters most to them.

9.7. Lambeth Together Equality, Diversity and Inclusion (EDI) Group has continued to champion inclusive practice and amplify under-represented voices across the borough. The group has been actively preparing for the upcoming iNSPIRE event, on 25 October, which will promote equity, inclusion, and innovation in health and care for the borough's Black communities. The event will offer a mix of interactive workshops, lived experience panels, creative performances, and networking spaces, alongside access to support services including mental health, advocacy groups, career development advice, and wellbeing activities.

9.8. Lambeth is also making real strides in efforts to embed the Patient and Carer Race Equality Framework (PCREF) across the borough. All Delivery Alliances and Programme areas report into the Equality, Diversity & Inclusion Group to strengthen system-wide accountability and help drive consistent, anti-racist practice. The Children and Young People's Alliance, Mental Health Support teams and Children's Wellbeing Practitioners are providing early, practical support in schools and communities, shaped by data and insight from children and families. The Staying Healthy Programme is delivering initiatives like Fruit and Vegetables on Prescription, tailored physical activity for black women, and culturally specific weight management and mental health advice. The recently completed Mental Health Joint Strategic Needs Assessment strongly supports the continued rollout of PCREF in services across the borough. This is Lambeth showing leadership, rooted in its community voice.

9.9. The AT Beacon team was at Brixton market on Saturday 9 August as part of "*Our Health and Wellbeing Outreach".* The team interacted with over 400 individuals at the market. These included shoppers, market traders and residents. Health promotion advice and opportunities to talk about health and blood pressure checks was offered. The response was overwhelmingly positive, with appreciation expressed on the approach being inclusive and valuable to residents, particularly traders who, through the nature of their work, are less likely to be proactively looking after their health or taking up preventative services.

10. Lewisham Borough Update

Care Quality Commission (CQC) assessment of Adult Social Care (ASC)

10.1. Lewisham's ASC CQC inspection process is now underway, following an initial session on 18 September with London Borough of Lewisham's Senior Leadership Team, and the CQC team. This followed a provider survey and submission of key council documents. The on-site inspection begins the week of 13 October, with strategic partners expected to be interviewed beforehand. The process offers a valuable opportunity to showcase the integrated approach and identify areas for improvement in delivering better health and care outcomes.

Place system intentions

10.2. Lewisham Local Care Partnership (LCP) works with local partners each year to agree priorities for service development in the following year, which informs how any new funding for community-based care that may be available is utilised or how existing funding is repurposed. This work has commenced for 2026/27 and a system partners

session will be held on 2 October 2025 to review progress against the 2025/26 system intentions and to revise, as necessary, the local Place system intentions for 2026/27. This session is a vital component of the LCP's broader prioritisation process and underpins the collective focus on key developments and improvements for the year 2026/27.

Neighbourhood Development

10.3. Lewisham LCP partners continue to progress work to implement a neighbourhood health service. The current focus is on implementing the first Integrated Neighbourhood Teams (INTs) and establishing the Lewisham Integrator.

10.4. The first INTs to go live in Lewisham are those that will support people with multiple long-term conditions (LTCs). All 12 PCN-based INT roles have now been recruited to within the four neighbourhood teams. Nine new starters are already in post and working through a detailed induction plan, which is important given the different way of working expected from the posts. The Lewisham & Greenwich NHS Trust (LGT) Clinical Prescribers will join the teams by mid-October and will also provide management capacity.

10.5. A holistic "Getting to Know You" assessment has been developed and is being uploaded onto GP computer systems to support ease and consistency of use. Alongside this, population health dashboards will be ready for INT use by mid-October and work is underway to finalise the process for reporting and tracking outcome measures.

HSJ award nomination

10.6. The North Lewisham PCN and Red Ribbon Living Well Health Equity Partnership has been shortlisted in the Primary and Community Care Innovation of the Year category at the HSJ Awards 2025. This initiative is part of Lewisham's broader Health Inequalities and Health Equity Programme (2022–24), which is geared towards ensuring equitable access, experience, and outcomes, especially amongst racially minoritised and underserved communities. The programme includes several "Health Equity Teams," each pairing a GP health equity fellow with a community (often Black-led) voluntary or community organisation to co-produce hyperlocal interventions. The work undertaken through this project has helped Lewisham to build the INT model of LTCs.

Flu vaccination programme

10.7. This winter, the LCP is working with partners to increase flu vaccine uptake across Lewisham. Two new Vaccine Confidence VCS organisations are reaching out to residents and faith leaders in areas of low uptake, providing advice and building trust.

11. Southwark Borough Update

Harold Moody Health Centre Celebrates Official Opening on Aylesbury Estate

11.1. 29 July 2025 marked the official opening of the Harold Moody Health Centre with a ribbon-cutting ceremony attended by local leaders, NHS partners, and community members. The event celebrated the launch of a state-of-the-art facility that now

houses Aylesbury Medical Centre (Nexus Health Group) and East Street Surgery, alongside a range of community health services.

11.2. The centre also hosts services from Guy's and St Thomas's NHS Foundation Trust, including midwifery, speech and language therapy, and neighbourhood nursing alongside primary care services.

11.3. Named after civil rights pioneer Dr Harold Moody, the centre reflects years of collaborative planning between SEL ICB, NHS Property Services, Southwark Council, and local practices. Located at 60 Thurlow Street, it stands as a cornerstone of integrated, neighbourhood-based care.

Start Well Leadership Group INT workshop

11.4. In September, the Partnership Southwark Start Well Leadership Group held its second workshop to advance the development of Integrated Neighbourhood Teams (INTs) for children, young people, and families. Over 20 representatives from various partner organisations, including local authority children's services, NHS trusts (SLAM, GSTT, Evelina & Kings), primary care, public health, social prescribing, and the VCSE sector, collaborated to shape a shared vision for INTs centred on holistic, preventative, and responsive support.

11.5. Discussions focused on key priorities such as leadership, neighbourhood-level autonomy, early help, culturally appropriate services, and co-production. The group also identified barriers including capacity pressures, fragmented systems, and funding constraints, whilst proposing enablers like devolved decision-making, digital investment, and strengthened community engagement.

11.6. The session included mapping of local assets and explored how to define and support complex needs, placing greater emphasis on professional judgement and family-centred approaches rather than over-medicalising complexity.

Ageing Well Southwark Hosts Community Health Event for Older Residents

11.7. In September, Ageing Well Southwark, a collaborative alliance of health, care, and voluntary sector partners, held a community outreach event at Harriet Hardy House in Walworth to support older residents living with frailty. The initiative, focused on proactive and preventative care, brought together specialist doctors, an occupational therapist and social prescribing link workers to offer personalised advice, referrals, and support. Residents welcomed the opportunity to speak directly with professionals about their health and wellbeing, with many expressing appreciation for the time and attention given.

Southwark Health and Wellbeing Board Update

11.8. The Southwark Health and Wellbeing Board's September meeting focused on developing the South East London Integrated Care System Prevention Framework, aiming to embed prevention as a routine part of care, establish evidence-based offers, set priorities, and maximise investment, with INTs considered for delivering secondary and tertiary prevention. Progress was reviewed on the Joint Health and Wellbeing Strategy action plan 2025-27, especially the 'Support to stay well' theme, highlighting the launch of Southwark Hubs for Health under the 'Health on the High Street' programme to improve access to Vital 5 checks and health promotion for at-risk and

ethnic minority groups, alongside the introduction of a new outcomes dashboard. The Southwark Pharmaceutical Needs Assessment (PNA) 2025-28 confirmed adequate pharmaceutical provision except for limited weekend access in the south of the borough, and emphasized the role of local pharmacies in delivering preventative services aligned with the NHS 10-Year Plan and Southwark's neighbourhood health model.

Partnership Southwark Strategic Board Update

11.9. At the July Board meeting, key topics included a deep dive into immunisation and vaccination rates, which were found to be significantly below target; the board reviewed multi-agency governance and initiatives to address these challenges and discussed ways to reduce inequalities in uptake, noting that vaccination programme commissioning will transfer from NHS England to SEL ICB in April 2026. The Board also examined rising unplanned admissions for over-65s, with rates higher than similar boroughs, and reviewed data, current initiatives such as virtual wards and remote monitoring, and approved the south east London Ageing Well Framework, whilst suggesting further ideas for admission avoidance. Updates were provided on the appointment of the integrator for INTs, the successful NNHIP application, and the Place Executive Lead report, which covered: the Model ICB Blueprint, NHS 10-year plan, GP Patient Survey, Better Care Fund, maternity progress, and estates planning to support the shift to community care, alongside sub-group updates.

11.10. The September Board agenda covered several key topics, including a presentation and discussion on the implications of the NHS 10-Year Plan for Southwark residents and the development of local plans aligned with national priorities. The Board reviewed the impact of the new ICB model on Partnership Southwark and neighbourhood health initiatives and received a spotlight report on social prescribing services within the two Southwark PCNs, exploring their potential for greater integration in neighbourhood health care. Updates included the successful joint application for the National Neighbourhood Health Implementation Programme (NNHIP), progress on ICB reform, the CQC inspection of Adult Social Care and the official opening of the Harold Moody Health Centre. The Board also addressed the urgent award of a caretaking contract for Trafalgar Surgery following the sudden passing of its sole GP partner, ensuring uninterrupted patient services, and received the quarter 1 Integrated Assurance report, which provided a comprehensive overview of performance, quality, safeguarding, SEND, risk, finance, and CHC, with a recommendation for a deep dive report on delayed discharges to be presented in November.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**ICB Board Assurance Framework**					
Meeting date	15 October 2025	Agenda item Number	6	Paper Enclosure Ref	F	
Author	Kieran Swann (Associate Director of Assurance and Risk), Tara Patel (Head of Assurance - Risk)					
Executive lead	Tosca Fairchild (Chief of Staff)					
Paper is for:	Update		Discussion		Decision	X
Purpose of paper	The latest Board Assurance Framework (BAF) sets out 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 1 October 2025.					
Summary of main points	**1. Current position:** • There are 14 SEL risks and 5 LCP risks (Bromley, Greenwich, Lambeth, Lewisham and Southwark) which currently sit above risk tolerance thresholds. • There are no risks above threshold for Bexley. **2. Changes since last report:** The following changes to the BAF were made following review of the BAF at Executive Committee, 1 October 2025, and Place Executive Leads (PELs) on 6 October 2025: • **Increased risk scores:** SEL 386 (UEC pressures), SEL 601 (ICB change programme – capacity), SEL 602 (ICB change programme – impact on staff), Bromley 509, Lambeth 129, Lewisham 360, Southwark 520 (ADHD and autism diagnostic waiting times and associated financial impact).					

	• **Decreased risk scores** SEL 620 (resident doctors industrial action), SEL 385 (elective capacity pressures), SEL 632 and 633 (paediatric audiology services within SEL), Lewisham 612 & Greenwich 619 (population health platform), Bromley 467 (community equipment services provider), Greenwich 596 (achievement of financial balance 2025/26). • **New BAF risks:** SEL 628 (ICB redundancy financial impact), SEL 630 (SEL paediatric audiology service impact on patients), Greenwich 635 (ADHD and autism diagnostic waiting times and associated financial impact). **3. System risk development:** • SEL ICS Risk Leadership Group met in July 2025 to review NHSE-specialised commissioning transferred risks. The group met at the end of September 2025 to consider potential risks related to neighbourhood health services, risk governance for programme and corporate risks, and arrangements for the management of actualised risks or issues.
Potential conflicts of Interest	None identified
Relevant to these boroughs	Bexley **X** · Bromley **x** · Lewisham **x** Greenwich **x** · Lambeth **x** · Southwark **x**
Equalities Impact	Not directly applicable to the production of this paper.
Financial Impact	Not directly applicable to the production of this paper.
Public Patient Engagement	Not directly applicable to the production of this paper.
Committee engagement	PELs Group, 2 June 2025 SEL ICS System Risk Leadership Group, 29 April 2025 SEL ICB Risk Forum, 13 May 2025 ICB Executive Committee, 25 June 2025
Recommendation	The Board is asked to review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 25 June 2025.

South East London Integrated Care System

NHS South East London

SEL ICB Board Assurance Framework October 2025

Prepared for SEL ICB Board, 15 October 2025

Context and latest updates

- **The ICB's risk appetite matrix allows the Board to set tolerance levels for various categories of risk across the organisation**. This approach is designed to promote and support local ownership of risk across the ICB's governance and delegation arrangements. It also means that the Board will receive a view on those risks that have been assessed as exceeding the tolerance levels set.

- The **ICB's Audit and Risk Committee is responsible for review and approval of the ICB's risk management arrangements on behalf of the Board**. The Audit and Risk Committee approved an updated Risk Management Framework in July 2025 as per the agreed policy review schedule. Risk appetite thresholds were retained at their current level across all risk categories.

- The **Board Assurance Framework (BAF)** document represents the full range of ICB risks that sit above the permitted level of risk tolerance.

- The ICB's **risk register includes system risks** which are material and are assessed as having some likelihood of impacting system objectives or the ability of the system to deliver business objectives.

- The ICB risk and assurance team continue to **collaborate with risk leaders from ICS NHS partner organisations on areas of common risk** impacting integrated care system objectives in south east London **(see slide 4).**

Discussion of risks at key meetings / committees

A. Place Executive Leads (PELs) meeting

- On 18 August 2025, the ICB Risk and Assurance team attended the PELs meeting to discuss the comparative review of risks across the Local Care Partnerships (LCPs).
- The group examined potential areas of risk related to:
    - Provider selection regime (PSR) – discussion noted that there is variation in local contracting processes. The ICB will work to ensure a system-wide approach to assessing risks against all PSR requirements. A draft risk entry is being prepared to reflect this area of improvement.
    - Neighbourhood health - risks related to the delivery of plans for neighbourhood health services were considered with agreement that these would be reviewed by delivery teams and escalation governance from programme risk logs would be further considered.
    - Delegated performance targets – agreement that risks are recorded where a borough has identified variance from plan on key performance targets.

B. SEL Executive Committee (ExCo) and Further PELs discussion

- The ICB **Executive Committee met on 1 October 2025** 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 changes as outlined below, and following a **further PELs discussion on 6 October 2025.** ExCo proposed:
    - Increasing residual risk scores for current risks on urgent and emergency care; ICB workforce capacity and impact of ICB management change programme on staff; and place risk related to children and young people's neurodevelopment, autism and ADHD assessment pathways.
    - Reducing residual risk scores for risks on reputation and capacity regarding aetiological investigations in paediatric audiology services within SEL; resident doctors' industrial action; community equipment services in Bromley, and a risk to delivery of financial balance 2025/26 at Greenwich place.

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 includes:

- The most recent sessions, held on 8 July and 30 September 2025, focused on:
    - A 'teach-in' presentation from the associate director of South London Office Specialised Services (SLOSS) on key risk areas. In particular, those risks transferred over from NHSE were discussed and the team are in the process of liaising with key leads in all SEL ICS organisations to confirm which areas pose real risks to the system.
    - How SEL system partners will respond to risks relayed to the establishment of neighbourhood health services.
    - Risk governance approaches to management of major programme risks and mechanisms for transitioning risks between programme or project registers and corporate registers/BAFs.
    - Management of materialised risks and issues.
- The SEL system BAF comparison pack continues to be shared with the risk leads group for information. It has been shared with the Executive Committee to inform ICB risk analysis.

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 1 October 2025.

The current BAF

Key points to note:

- The risks included reflect the assessed position and risks were downloaded from **Datix on 15 September 2025, and incorporates recommended revisions agreed at Executive Committee** on 1 October 2025, and **further revisions agreed by PELs** on 6 October 2025.
- The current version of the BAF includes **14 SEL risks above threshold and 5 LCP risks (Bromley, Greenwich, Lambeth, Lewisham, Southwark).**
- There are **no risks above threshold** for **Bexley LCP.**

Summary of changes (1 of 2)

Newly added risks and escalation of risks onto the BAF

- **4 existing risks** and **1 new risk** related to **ADHD and autism waiting times** escalated onto the BAF:
    - PELs agreed that place risks relating to CYP diagnostic waiting times for autism and ADHD targets not being met and the subsequent financial impact of the increased number of referrals for assessments, should be increased to 16 for all boroughs. The following LCP risks were consequently added to the BAF: **Bro 509, Gre 635, Lam 129, Lew 360, Sou 520.**
- **1 existing risk** related to **ongoing pressures across SEL UEC services** has escalated onto the BAF:
    - **SEL risk 386 –** Given performance challenges, Executive Committee members agreed that this risk should be included on the BAF, and the score has subsequently been increased to 16.
- **2 existing** and **1 new risk** related to the **ICB change programme** have escalated onto the BAF:
    - **SEL risks 601 and 602** relate to the current change programme at the ICB (capacity and impact on staff). The Executive Committee agreed that risks relating to impact on staff, as well as ICB workforce capacity should be escalated to the BAF. The score for 601 (capacity) has been increased to 16, and the score for 602 (impact on staff) has been increased to 20.
    - **SEL 628** on the financial impact of ICB redundancies falls under the finance category with a score of 20, and so has been added to the BAF.
- **1 new risk** related to **paediatric audiology services** has been added to the BAF:
    - **SEL 630** relates to paediatric audiology services provided within SEL (potential quality of care and safety risk). This risk falls under the clinical, quality and safety category, and has a current score of 12.

Summary of changes (2 of 2)

De-escalation of BAF risks

- **SEL risk 385** relates to competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/ICS providers, with a consequent increase in waiting times for diagnosis and treatment. The likelihood score was reduced from 4 to 3, giving a current score of 12. This is due to recent reviews having provided further assurance on winter plans.

- **Lew 612 and Gre 619** relating to funding and contract position of a population health platform. The current score has been reduced to 9 for both risks as arrangements have been established to ensure continuity in access through to April 2026.

- **SEL risks 632, 633** both relating to paediatric audiology services within SEL (reputational risk for providers and ICB; lack of provider capacity in regarding aetiological investigations) were re-categorised to “strategic”. The Executive Committee agreed that this represented a more accurate classification of the risks. A related service risk on the quality of care (630), remains on the BAF.

- **SEL risk 620** relates to disruption caused by resident doctors industrial action on activities commissioned and assured by the ICB within SEL – the likelihood of risk has been reduced in score has been reduced from 4 to 3, given there are currently no dates announced for industrial action. The updated risk score of 12 de-escalates the risk from the BAF.

- **Bro risk 467**, relating to community equipment services was reduced to 9, which de-escalates the risk from the BAF.

- **Gre risk 596**, relating to achievement of financial balance 2025/26 – this risk had a current score of 16. It was agreed that the score could be reduced to 12, by reducing the likelihood to 3 to align the assessment with the other LCP finance risks. This risk has de-escalated from the BAF.

Closed BAF risks

- **No** previous BAF risks have been **closed.**

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

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	606	ICS revenue financial plan 2025/26.	12	25
	628	ICB Change Programme - financial impact of ICB redundancies		20
Data and Information Management	597	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services	9	12
Operational: relating to the effective day to day running of the ICB organisation (MCR)	601	ICB Change Programme – workforce capacity risks	15	16
	602	ICB Change Programme – impact on staff		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	Max tolerance score	Residual risk score
Clinical, Quality and Safety	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.		12
	437	Disruption to IT/Digital systems across provider settings due to external factors		15
	598	Post community pharmacy consultation messaging not returned to the GP practice (digital community pharmacy programme)		16
	630	Potential quality of care and safety risk in paediatric audiology services within SEL.		12

Key: Primarily system risk Primarily ICB risk

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

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**384**	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	12	16
	386	Ongoing pressures across SEL UEC services		16
	391	Increased waiting times for autism diagnostics assessments (adults and children)		16
	504	Cancer performance targets.		16

Key: Primarily system risk Primarily ICB risk

Summary of LCP risks exceeding tolerance levels

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**Bro 509**	CYP diagnostic waiting times for autism and ADHD targets not being met.	12	16
	Gre 635	Delayed diagnosis for autism and ADHD due to prolonged waiting time for assessment, and the subsequent financial impact of the increased number of referrals for assessments for autistic people and people with ADHD and other co-morbidities such as LD/MH.		
	Lam 129	Diagnostic waiting times for neurodiversity assessments - children and young people		
	Lew 360	Failure to deliver on statutory timescales for completion of ASD health assessments.		
	Sou 520	CYP diagnostic waiting times for autism and ADHD targets not being met.		

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 been differentiated between primarily ICB risks and primarily system risks.

ID	Summary risk descriptions
129	Diagnostic waiting times for neurodiversity assessments - children and young people
360	Failure to deliver on statutory timescales for completion of ASD health assessments.
384	Elective care transformation programmes
386	Ongoing pressures across SEL UEC services
391	Increased waiting times for autism diagnostics assessments (adults and children)
404	ICB oversight of new & emerging HCID & pandemics
437	Disruption to IT / digital systems
468	Variation in performance with funded nursing care
504	Cancer performance targets
509	CYP diagnostic waiting times for autism and ADHD targets not being met.
520	CYP diagnostic waiting times for autism and ADHD targets not being met.
597	Cyber Security or Technology Resilience Issue causing disruption to the operation of essential services
598	Digital Community Pharmacy programme
601	ICB change programme – capacity risks
602	ICB change programme – impact on staff
606	ICS Revenue financial plan 2025/26
628	ICB change programme - financial impact of ICB redundancies
630	Potential quality of care and safety risk in paediatric audiology services within SEL.
635	Delayed diagnosis due to prolonged waiting time for assessment, and the subsequent financial impact of the increased number of referrals for assessments for autistic people and people with ADHD

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.

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
384	Harriet Agyepong	Sarah Cottingham	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	There is a risk of non delivery in a range of elective care transformation programmes (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	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/ set 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	Ongoing pressures across SEL UEC services	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	There is a risk of making limited improvements in waiting times, pathway flow and timely transfer of care as a result of demand and flow challenges across the system. This impacts the ICB's ability to meet operational plan commitments, and impact on the service users affected by these services, affecting patient experience. Increased waits - for ambulance support, in the Emergency Department or for transfer of care (e.g. from a physical to a mental health facility) increases the risk of poorer clinical outcomes.	4	4	16	4	4	16	Robust daily intensive system support in place, led and coordinated by the SEL ICB System Control Centre, to review, manage and smooth pressures across the system, agree mutual aid and support site safety. SCC operates 24/7 providing in and out of hours system support. Operational plan for 2025/26 includes a number of performance improvement 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	Paul Larrisey	Increased waiting times for Autism diagnostic assessments (adults and children)	Clinical, Quality and Safety	7 - 9	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-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	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 (S256) to align with strategic framework. Core offer for CYP: Autism assessment developed and agreed with stakeholder. Set up of Community of practice to share best practice and find solutions to ongoing issues. Exploring options for assessment of 16/17 to 18 year olds before adulthood to prevent longer waits in adult services. - Piloting SEL CYP Neurodiversity Hub for diagnostic assessments and medication pathways. Implementation and sharing of learning from projected piloted using non-recurrent funding in 23/24 with each borough.	No gaps	SEL LDA Strategic Executive Group Agenda and Minutes 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	New and emerging High Consequence Infectious Diseases (HCID) & pandemics	Clinical, Quality and Safety	7 - 9	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more 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	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 (P). 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 (P). HCID plan reviewed and updated in 2024. Refreshed plan has been endorsed by ICB AEO and approved for publication by ICB Executive Committee (P). SEL ICB Head of EPRR and the Bromley PEL Angela Bhan, have been involved in the initial scoping discussion for the pan London MoU and are engaged in the ongoing development work.	No gaps in assurance
437	Nisha Wheeler, Michael Knight	Andrew Bland	DIGITAL - Disruption to IT/Digital systems	Clinical, Quality and Safety	7 - 9	There is a risk of significant disruptions to the IT and digital systems across our provider settings. This may be caused by external factors such as cyber attacks directly on our computer systems or servers, or those managed by our supply chain providers. It may also be caused by extreme weather conditions, fire or other events that result in system unavailability. The consequences of this risk occurring is significant disruption to the provision of clinical services, lack of access to historical information and lack of access to systems that support patient management such as waiting lists. In some events, patient and administrative data may be taken. These occurrences could result in patient harm or death, and may lead to significant financial loss. It could also lead to adverse public reaction and reputation damage.	2	5	10	3	5	15	Governance –DSPT compliance indicates relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk. Well established assurance plans are in place, including external assurance, and risk management framework that supports organisational risk management approaches., 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. Policy, Process and Procedures – DSPT compliance indicates that most policies, processes and procedures are clearly defined, integrate with broader organisational process and are well understood by users., Identity and Access Control – DSPT compliance indicates that processes to verify, authenticate and authorise users are in place. Multi Factor Authentication is widely adopted. DSPT Compliance indicates that Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity., Systems are designed to ensure appropriate levels of resilience and recovery plans are in place. Security Culture - DSPT compliance indicates that plans are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles. DSPT compliance indicates that monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures.	There are opportunities to further improve maturity of risk management practices by broadening the use of threat intelligence, There are opportunities to improve the depth of analysis regarding our supply chain and establish more stringent controls within the supply chain., There are opportunities to further improve the design and implementation of some policies, processes and procedures, There are opportunities to further improve technical controls., There are opportunities to further enhance our monitoring capability, There are opportunities to further enhance cyber incident response measures	DSPT Compliance Status of System Partners, Respective organisational assurance plans, to include: intrinsic assurance - process based assurance activities, primarily during design and procurement, Extrinsic assurance - external certification, such as cyber essentials, cyber essentials plus, ISO 27001 etc, or security evaluation, Operational assurance - activities necessary for maintenance, including plans for business continuity and cyber incident response, Implementation assurance - providing assurance that implementation has been conducted correctly, Some organisations hold additional information security certifications/accreditations.	Not all DSPT requirements are audited annually. Individual organisation assurance plans may include gaps that impact quality of assurance
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Lizzie Wallman - Deputy Chief Nurse	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	Clinical, Quality and Safety	7 - 9	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews. This is due to a significant number of reviews over the required time frames (National Standard). This is impacting on the ICB's ability to meet statutory requirements. This is a clinical risk which impacts on financial control across the system and patient experience.	4	4	16	3	4	12	This risk is monitored at the NHSE assurance meeting monthly. The SEL Head of CHC/CYPCC governance assurance and QIPP has oversight of this risk. There is a monthly assurance pack produced which goes to the CHC review meetings. The CHC monthly assurance report tracks FNC reviews. There are monthly meetings held at place level where this risk is discussed. There are individual borough plans setting out how boroughs will clear the overdue reviews.	No gaps in controls	There are minimal vacancies across the place based teams. Individual borough plans in place and teams are working towards reducing the backlogs	Place CHC leads have been asked to provide individual borough trajectories where necessary. The CHC monthly performance report shows that overdue FNC reviews have been increasing overall
504	Carl Glenister	Sarah Cottingham	Cancer Performance	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	This is a risk that the ICB does not meet the operational plan commitments it has made for 2025/26 with regards cancer access and wait times - including the Faster Diagnosis Standard and the 62-day treatment standard. Failure to meet agreed access and waiting times standards exacerbates the risk of poorer clinical outcomes due to diagnosis and treatment delays.	4	4	16	4	4	16	The 2025/26 operational plan includes agreed system-wide commitments to improve cancer performance, specifically access and waiting time standards, including the Faster Diagnosis Standard (FDS) and the 62-day treatment standard. Cancer performance has improved consistently across the system over the last financial year; however, the system has committed to further stretching targets for 2025/26. Cancer planning was embedded within broader operational and capacity planning to ensure requirements were modelled and prioritised appropriately. These plans underwent internal assurance and were also subject to external assurance through both regional and national processes., Ongoing oversight is maintained through the South East London (SEL) ICB Cancer Executive, with additional scrutiny through regional performance meetings. While GSTT Cancer remains under Tier 1 of the regional System Oversight Framework support process, neither GSTT nor LGT are currently subject to formal support measures. Quality and safety are monitored through continuous surveillance, including harm reviews for patients affected by delays. The system is on track to meet the Faster Diagnosis Standard, although meeting the 62-day standard remains more challenging.	No current gaps in controls identified.	Governance and Oversight: Robust governance structures are in place at both provider and system level, with regular reporting through minutes, papers, and performance dashboards. Progress is monitored against agreed trajectories and recovery plan milestones. System Collaboration: The ICB Planned Care and Cancer teams work closely with providers and the Cancer Alliance to support planning, delivery, and performance improvement. External Review and Assurance: Cancer plans are reviewed through regular Tier 1 meetings with NHS England (London Region), where the ICB participates in performance discussions and receives external scrutiny. Plan Assurance: Operational plans have been assured to confirm they address all necessary elements; however, delivery remains challenging due to the complexity of cancer pathways across multiple providers and specialties. Targeted support is in place to strengthen delivery capability where required.	No current gaps in assurance identified.
597	AD of IT - Piri Bhandal	Nisha Wheeler and Michael Knight	IG/IT (SEL-CORP) Cyber Security or Technology Resilience issue causing disruption to the operation of essential services	Data and Information Management	7 - 9	There is a risk that NHS SEL ICB could fall victim of a cyber attack. This could include unauthorised access to sensitive and/or patient identifiable data which could be illegally obtained, corrupted, encrypted and held to ransom. This could be due to gaps in security controls or human factors including phishing or social engineering. This could cause severely disrupt the day to day running of NHS SEL corporate systems and potentially affect clinical care systems, such as Continuing Health Care Systems. It may result in the loss or breach of personal data which could lead to the potential for financial and reputational damage, in addition to potential fines by the Information Commissioner.	4	3	12	4	3	12	Governance – Relevant committees oversee information risk. There is clear direction, roles and responsibilities, and decision making with respect to information risk., There is a well established assurance plan, including external assurance, and risk management framework that supports our risk management approach. Supply Chain - Processes to risk assess the supply chain are in place and there is an understanding of how suppliers may impact the delivery of our essential functions. Asset Management – assets that underpin our essential services are identified, prioritised and have clear ownership assigned. Policy, Process and Procedures – Most policies processes and procedures are clearly defined, integrate with broader organisational process and are well understood by users., Identity and Access Control – processes to verify, authenticate and authorise users are in place. Multi Factor Authentication is widely adopted. Secure design, configuration and management processes have been established. Vulnerability Management Processes are in place to track, manage and prioritise activity., Systems are designed to ensure appropriate levels of resilience and recovery plans are in place. Plans are in place to ensure staff have appropriate awareness, knowledge and skills to carry out their roles. Monitoring is in place to detect potential security problems and to track the ongoing effectiveness of protective security measures. A primary Cyber Incident Response Plan is in place, with accompanying scenario playbooks in development.	There are opportunities to further improve maturity of risk management practices by broadening the use of threat intelligence, There are opportunities to improve the depth of analysis regarding our supply chain and establish more stringent controls within the supply chain., There are opportunities to further improve the design and implementation of some policies, processes and procedures, There are opportunities to further improve technical controls., There are opportunities to further enhance our monitoring capability, There are opportunities to further enhance cyber incident response measures	Secure design and development practices. including security requirements and targets, Supply Chain Security, including Vendor/supplier use of standards, Application of Cloud security principles, Risk Management, User Training, Certification – CE+, Compliance – Secure Email Standard DCB 1596, Patching and maintenance, Internal Audit, Configuration mgmt. and change control, Security monitoring, Business Continuity and Disaster Recovery Exercises, Security Incident Management Processes	Data Security and Protection Toolkit Compliance - 2024/25. Scenario based cyber incident response testing to align with 2025/26 cyber incident response plan

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
598	Sharon Sheldon, Head of Digital Transformation /Clare Fernee, Associate Chief Pharmacist	Ananya Datta	DIGITAL - Digital Community Pharmacy programme	Clinical, Quality and Safety	7 - 9	There is risk that some post event messaging is not being returned to the GP practice from community pharmacy after a patient consultation. This is due to GP Connect update record not turned on for all SEL practices and PharmOutcomes software used by Pharmacies requiring an e-mail and email verification for the GP practice. The impact is that the GP record does not have the full detail of patient consultations where this has not been sent by the community pharmacy and poses a patient safety risk.	5	4	20	4	4	16	Liaising with GP practices to carry out task for programme of work - Regular monitoring and escalation to Primary Care Leads and supplier reviews, GP Practices contractually required to undertake programme of work	No gaps in control.	DIGITAL - Encouraging GP practice engagement, DIGITAL - Contractually required by GP practices with switch on GP Connect, DIGITAL - Raising issues to Local Pharmaceutical Committee and NHS England of any issues, DIGITAL - Ongoing liaising between supplier, pharmacists and GP practices	27th May update - 20 Practices with unverified email addresses. GP connect switch on October 2025
601	Sarah Cottingham/ Ceri Jacob	Andrew Bland	ICB Change Programme – Capacity risks	Operational relating to the effective day to day running of the ICB organisation (MCR)	13 - 15	Programme implementation will significantly change the shape and functioning of the organisation. Whilst the form of the resultant organisation will be follow function, there is a risk of significant disruption to BAU throughout both design and implementation stages of the programme where: a) capacity from across the organisation will need to be given to programme design and delivery b) the ICB is establishing and transitioning to new structures c) where the current vacancy freeze restricts the ability of the ICB to fulfil its current responsibilities in its current form (including where agency staff are lost from the structure and permission to recruit replacement agency staff may not be granted)	5	4	20	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.	None currently identified.	Change Programme Group with joint SROs meets weekly. Participation in London Transition Group to ensure safe transfer of functions.	None currently identified.
602	Sarah Cottingham/ Ceri Jacob	Andrew Bland	ICB Change Programme – Impact on staff	Operational relating to the effective day to day running of the ICB organisation (MCR)	13 - 15	There is a risk of low staff morale caused by the the ICB Change programme, owing to uncertainty around future structure, perceptions of job security and change fatigue where colleagues have been through (often multiple) change programmes before - and in recent memory. There may be a subsequent impact on: a) Staff health and wellbeing; potentially leading to sickness absence b) Delivery of BAU; either through distraction/anxiety or through loss of workforce where staff make the decision to leave the ICB c) Staff disengaging from the ICB Change Programme and consultation process; particularly , d) Staff disengaging from the wider organisation/their work; particularly i) for staff whose posts (or those of their friends and team-mates) are removed by the process and ii) where/if we do not uphold our values or our pledge to be open, honest and transparent throughout the MCR programme. The forward impact of this risk is disruption to BAU.	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 currently identified.	Change Programme Group with joint SROs in place – meeting weekly. Ongoing monitoring of staff feedback through HR channels.	None currently identified.
606	David Maloney	Mike Fox	ICS revenue financial plan 2025/26	Finance	10 - 12	There is a risk that Risk that ICS does not deliver its deficit revenue financial plan for 2025/26, due to: Inability to deliver requisite level of targeted savings. Under-delivery against elective recovery commitments. Inability to recover income in line with planning guidance.	5	5	25	5	5	25	Breakeven plan for 2025/26 agreed by ICS Executive and ICS SSG, subject to non recurrent deficit support funding of £75m from NHSE. Component parts of ICS plan to be agreed by SEL organisation Boards. Monthly review and reporting to ICB Executive and SEL System Sustainability Group on delivery against financial plans and risk of organisational efficiency plans. Oversight of revenue financial position and efficiency by SEL CFO group meeting fortnightly. Agency limit and monitoring of spend reported routinely each month. External review of SEL run rate and performance working with NHSE. Organisational control mechanisms. Monitoring of financial risks by SEL CFO group, Funding received from NHSE, KCH NOF 4 status. Quarterly review and reporting to ICB Integrated Performance Committee on delivery against financial plans and risk of organisational efficiency plans. Formal CFO in year review of trust year end forecasts and risks to delivery, Monitoring of risks and potential mitigations to achieve plan, Contracts agreed. Budgets agreed. Update at month 4 - ICS is off plan by £0.6m YTD, with a break-even forecast outturn	Identified CIPs and CIP forecasts do not currently meet targets.,	Non recurrent deficit funding received from NHSE, enabling a breakeven plan, Budgets agreed. SEL CFO group meeting fortnightly. SSG meeting monthly, Internal control totals agreed.	CIP plans do not meet targets. Monthly run rate forecasts do not yet show required improvement. Assurance on delivery of FYE of 2024/25 CIP schemes
628	Sarah Cottingham and Ceri Jacob	Andrew Bland	ICB Change Programme - Financial impact of redundancies	Finance	10 - 12	If there is no additional funding from the Treasury/other to cover the cost of staff redundancies, there will be an additional financial pressure estimated to be in the region of £25m (although includes some assumptions) in order to create the headcount reduction to meet the cost reduction requirement.	4	5	20	4	5	20	None currently identified.	Awaiting details of possible financial support from NHS England.	Change programme group, with joint SROs in place – meeting weekly	No gaps in assurance
630	Liz Aitken	Gwen Kennedy - Chief Nursing Officer	Paediatric audiology services within SEL - quality of care and safety	Clinical, Quality and Safety	7 - 9	Quality of care and safety risk to patients within SEL audiology services, as identified by site visits.	4	3	12	4	3	12	Provider lookback review completed by SME and capacity in place for patients to be seen. Alternative provider lookback review of patients seen by the clinician with clinical competency concerns are being reviewed in July and August by the same SME at the hospital provider. Once this has been completed the patients with high / moderate clinical need will be prioritised in the capacity available. The rest of the lookback patients whom were seen in the soundproofed room will then be reviewed with SME support. These patients have been noted by audiologists as lower risk given the risk associated with the ambient noise would be overdiagnosis rather than underdiagnosis.	SME capacity for commissioned provider ambient noise cohort and recall appointments needs to be identified	Patients identified as high or moderate risk to be prioritised with existing capacity.	No gaps in assurance

Appendix 2. LCP risks greater than risk appetite thresholds

Risk ID	Risk Owner	Risk Sponsor	Risk Title	Risk Type	Risk Appetite	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance
Bro 509	Sean Rafferty	James Postgate	CYP diagnostic waiting times for autism and ADHD targets not being met	Strategic commitments and delivery priorities; Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Across England, waiting times for the diagnosis of children and young people for Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD) are very long and have been growing. In Bromley, the average waiting time is over 2 years. This is clearly unacceptable and is causing a high level of dissatisfaction and complaints from families. In 2024/25, there were changes to the previous CYP ASD -ADHD diagnostic pathway in Bromley which resulted in a single approach led by a provider for patients in Bromley - with links to CAMHS .	3	3	9	4	4	16	CYP ASD/ADHD Project established led by a project manager with buy-in across providers and local authority.	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 providers on joint decision making
Gre 635	Jenny Lamprell, Rena Amin	Lisa Wilson	Risk of delayed diagnosis due to prolonged waiting time for assessment, and the subsequent financial impact of the increased number of referrals for assessments.	Strategic commitments and delivery priorities; Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Currently, there is no QOF requirement to maintain a register for autistic people and people with ADHD and with other co-morbidities such as LD/MH. There is a significant delay in diagnosis and post-diagnosis care, which has led to over -reliance on the private medical sector for prompt support. This has caused significant challenges for picking up care when there are no formalised processes for shared care, as patients have not been stabilised and yet require medication that often needs titration to suit the needs of the people. This variance in primary care, education system and the care setting is a challenge and hence a risk for poorer health outcomes and financial burden. The budget for this in the ICB is £350k. The spend in 2024/25 was £742k up from £230k in 23/24.	5	5	25	4	4	16	Greenwich is 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 the local provider for ADHD/ASD diagnosis to track the impact of these delays, as well as the financial impact.	Not aware of any standardised data analytics through the BI team. No Power BI dashboard is available. 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. Limited control over cost and quality of diagnosis. Cannot control GP shared care with private contractors.	Autism Partnership Board reporting into Learning Disability and Autism Oversight Board and Mental Health Oversight and Co-ordination Board when appropriate.	Once the BI Dashboard is operational, it will enable better performance visibility and this in return can enable the support that may be needed. However the budget gap is £550k and Place have no control over the national government Right to Choose policy
Lam 129	Laura M Griffin	Integrated Director for Children and Young People	Diagnostic waiting times for neurodiversity assessments - children and young people	Strategic commitments and delivery priorities; Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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	Transformation funding proposal from provider is going through contract management meetings route in order to build paediatric capacity to manage this. The additional capacity in place is overseen by provider 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 will be monitored monthly at place. 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 have 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 provider. Monthly ADHD meetings with providers. Monthly reporting of position now coming direct from provider to Place, Local authority 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 LCP Assurance Group	No Gaps in assurance at this time.
Lew 360	Paul Creech - Senior Commissioner	Sara Rahman - Director	Failure to deliver on statutory timescales for completion of ASD health assessments.	Strategic commitments and delivery priorities; Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Failure to deliver on statutory timescales for completion of Autism Spectrum Disorder health assessments. There is an 18 month waiting list. This is being driven by challenges in recruitment of community paediatricians. Impact on ICB - referral to treatment timescale, reputational risk, financial risk - ICB to pay for private assessments.	4	3	12	4	4	16	Quarterly review of ASD assessments with LCG, SEND and the DCO includes audit of initial assessments. GPs are being rotated from Primary Care into community paediatrics to free up capacity for ADOS assessments. Paediatric nurse in place to support medical work, SDIP in progress to increase capacity. There is the all aged autism service which provides advise and info without the need for a diagnosis. Recruitment ongoing, 1.2wte vacancies at present and another round of recruitment due. In terms of capacity, clinical staff assessing ECHP will prioritise where possible ASD assessments too to assist with work demands, Outsourced some assessment capacity for CYP waiting the longest to reduce the backlog (outsourced 200 assessments in progress), Assessment Pathway Transformation Programme underway with partners to identify and implement improvements to the current assessment process. This will inform the recruitment necessary to improve capacity and AHP required for the SDIP.	Availability of partners to undertake joint ASD assessments. Biggest control gap is staffing capacity and increasing demand.	Hospital provider quarterly contract and monitoring meetings ongoing to gauge impacts of controls. This includes outcome of outsourced assessments. Monthly Pathway Transformation Steering group meeting in place to monitor impact of transformation work. SDIP monitoring meeting in place to review implementation and impact.	There are no gaps in assurance at present.
Sou 520	Jubin Mama - Commissioning Manager, Social and Emotional Wellbeing, CYP Integrated Commissioning	Russell Jones - Assistant Director, Integrated Commissioning	Diagnostic waiting times for children and young people	Strategic commitments and delivery priorities; Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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. 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	Additional capacity purchased to reduce wait times, Wait list support implemented, Additional administrative support to bring additional capacity to wait list management, Regular monitoring meetings, Clear targets identified to reduce 52+week waiting times	Staffing capacity to meet demand. Delays in assessment time	SEL CYPMH Delivery Group, Emotional & Wellbeing Mental Health Steering Group, Start Well Leadership Group, Integrated Governance & Assurance Committee, LCP Delivery Executive, Deep dive by PSSIB in August 2024. CYP MH confirmed as key health and care plan priority in refresh.	No gaps in assurance

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Overall Committees Report**						
Meeting date	15 October 2025		Agenda item Number	7	Paper Enclosure Ref	G	
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 15 October 2025

1. Introduction

1.1 The purpose of this report is to provide a summary of the activity that has taken place within the Committees that report directly to the Board since the last meeting on 16 July 2025. In addition the ICS benefits from two provider collaboratives and whilst no formal delegation has been made to them from the ICB this paper provides an update on their key activities over this same period.

1.2 The report highlights:

- Decisions recommended to the Board from Committees, in line with the ICBs Scheme of Reservation and Delegation.
- A summary of items discussed at the Committees during the period being reported.
- Report of activities taking place in the Local Care Partnerships of South East London.
- Report of activities taking place in the South East London provider collaboratives and community services provider network.

2. Summary of Meetings

2.1 ICB Committees

	Committees								
	Integrated Performance Committee	**Quality and Safeguarding Committee**	**Audit & Risk Committee**	**Remuneration Committee**	**Greenwich Charitable Funds Committee**	**Clinical and Care Professional Committee**	**People Committee**	**Digital Committee**	**Executive Committee**
Meeting date	30 July 2025	2 July 2025	10 July 2025	8 September 2025	8 July 2025	30 April 2025	2 June 2025	8 July 2025	9 July 2025
	24 September 2025	1 October 2025	-	-	-	-	-	9 September 2025	23 July 2025
	-	-	-	-	-	-	-	-	6 August 2025
	-	-	-	-	-	-	-	-	20 August 2025
	-	-	-	-	-	-	-	-	3 September 2025
	-	-	-	-	-	-	-	-	17 September 2025
	-	-	-	-	-	-	-	-	1 October 2025

	Local Care Partnerships						
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**Transition Committee**
Meeting date	24 July 2025	31 July 2025	23 July 2025	3 July 2025	24 July 2025	24 July 2025	15 July 2025
	25 September 2025	-	11 September 2025	4 September 2025	-	25 September 2025	24 July 2025
	-	-	-	-	-	-	13 August 2025
	-	-	-	-	-	-	1 September 2025
	-	-	-	-	-	-	30 September 2025

3. Summary of the Principal Role of ICB Committees

Committee	Principal role of the committee	Chair
Integrated Performance Committee	Oversight and assurance of delivery of the ICS four aims through the objectives and deliverables set out in the range of ICP and ICB strategic plans. The Committee will monitor how delivery across different parts of the system contributes to the ICS's overall strategic work and direction, seeking to ensure efforts are aligned across the system.	Paul Najsarek, Non-Executive Member
Quality and Safeguarding Committee	Acts as a focal point for the collective oversight and strategic direction of safeguarding and quality matters across SEL Integrated Care System. Responsible for overseeing the delivery of high-quality care, ensuring compliance with safeguarding legislation, promoting the safety and wellbeing of vulnerable populations and fostering continuous improvement in health services. This is aimed at supporting improved health outcomes, reduced inequalities and enhanced patient experience.	Anu Singh, Non-Executive Member
Audit & Risk Committee	Responsible for delegated approval of annual accounts, providing an objective view of the ICB's compliance with statutory responsibilities, arranging appropriate audit, and oversight / assurance on the adequacy of governance, risk management and internal control processes across the ICB.	Peter Matthew, Non-Executive Member
Greenwich Charitable Funds Committee	Responsible for discharging its duties as a corporate trustee. Referred to as the Greenwich Healthier Communities Fund.	Peter Matthew, Non-Executive Member
Clinical and Care Professional Committee	Responsible for bringing together clinicians, care professionals and south east London residents to ensure the ICB has robust care, patient and public engagement, population health management, and leadership in place to shape and that the ICB's plans are demonstrably influenced by the outputs of its engagement work.	Dr Toby Garrood, 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.	David Bradley, Partner Member
Executive Committee	The Committee provides a platform for the executive directors of NHS South East London Integrated Care Board (SEL ICB) to discuss key issues relating to the strategy, operational delivery and performance of SEL ICB, and related Integrated Care System or wider issues upon which the executive team should be briefed or develop a proposed approach.	Andrew Bland, ICB Chief Executive
Transition Committee	The purpose of the Committee is to provide assurance and oversight of the ICB SEL Change Programme for the ICB Board, ensuring a safe and coherent transition, managing local risks, tracking progress and overseeing the development of organisational design and implementation of the change process, including the transfer of functions to providers over time.	Georgina Fekete, Non-Executive Member
Local Care Partnerships	Responsible for convening local system partners to develop plans to meet the needs of the local population, reduce inequalities and optimise integration opportunities. The ICB will delegate responsibility for the delivery of specified out of hospital care objectives and outcomes, including the management of the associated budget. A representative from each LCP will be a member of the ICB.	Dr Sid Deshmukh (Bexley) Dr Andrew Parson & Cllr Colin Smith (co-chairs, Bromley) Iain Dimond (Greenwich) Dr Di Aitken & Cllr Nanda Manley-Browne (co-chairs, Lambeth) Vanessa Smith & Fiona Derbyshire (co-chairs, Lewisham) Dr Nancy Kuchemann & Cllr Evelyn Akoto (co-chairs, Southwark)

4. Recommendations to the Board for Decision / Approval

4.1 The Board is asked to **NOTE** the attached annual governance review (Appendix A), which details the outcomes from the committee effectiveness reviews and confirmation of completion of the Fit and Proper Persons test for 2025, and **APPROVE** the following (attached as appendices to the report):

- Revised Audit and Risk Committee terms of reference (Appendix B)
- Reviewed Remuneration Committee terms of reference (Appendix C)
- Reviewed Clinical and Care Professionals terms of reference (Appendix D) – discussed at last Board but ToR not included

4.2 The Board is asked to **APPROVE** the revised terms of reference for the Healthier Greenwich Partnership (Appendix E), noting the amendments as detailed in the HGP section of this report.

4.3 The Board is asked to **NOTE** that the 2024/25 audited accounts for the Greenwich Charitable Fund have been signed off by the Committee Chair and Chief Finance Officer, and the annual return submitted to the Charities Commission, as required by the Charities Act 2011.

4.4 The 2025-2028 ICS Green Plan was considered by the Executive Committee on 1 October 2025 and recommended to the Board for approval – this is covered as a separate agenda item.

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.	Greenwich Charitable Funds Committee	8 July 2025	• Following external examiner recommendation, Committee members approved the formal submission of the annual accounts for 2024/25 and associated policies to the Charities Commission.
2.	Executive Committee	23 July 2025	• The Committee approved a business case for alarm devices aimed at improving safety for lone workers, for example ICB staff making clinical visits in the community.
3.	Executive Committee	23 July 2025	• The Committee approved revised policies in relation to change management and ICT equipment disposals.
4.	Executive Committee	6 August 2025	• The Committee approved the panel recommendation in relation to the accreditation of Innovate ADHD Ltd as a provider of adult ADHD services in south east London.
5.	Executive Committee	3 September	• The Committee approved policies in relation to Policy and Procedures Management, Violence and Aggression, Persistent and Unreasonable Contacts, Health and Safety, Fire Safety, Manual Handling and Emergency Planning and Business Continuity.
6.	Remuneration Committee	8 September 2025	• Remuneration Committee members approved the terms for a voluntary redundancy scheme, noting concerns about potential loss of workforce talent.
7.	Remuneration Committee	8 September 2025	• The Committee approved a redundancy business case for a VSM role.
8.	Remuneration Committee	8 September 2025	• The Committee considered a revised paper in relation to uplift of a role to VSM and approved the amended proposal which included a reduced percentage uplift.

9.	Executive Committee	17 September 2025	• The Committee approved a revised complaints policy.
10.	Executive Committee	17 September 2025	• The Committee approved a revised schedule of matters delegated to officers with changes made as part of the transfer to the new financial ledger system ISFE2.
11.	Executive Committee	17 September 2025	• The Committee approved an updated terms of reference for the ICB Equalities Committee.
12.	Executive Committee	17 September 2025	• The Committee approved Acute Service Specifications for medical and surgical services, which had been approved, which had been developed to help with existing as well as the accreditation processes for suppliers in relation to right to choose.

6. Agenda Items of Note

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

No.	Committee name	Meeting date	Items discussed
1.	People Committee	2 June 2025	• **ICB Change Management Programme**: Members discussed the ICB Change Management Programme, which follows national directives for cost reductions. The SEL ICB has submitted its draft plan, which aims for a 35% cost reduction. Discussions included the transfer of some functions to providers and retention of key talent within the system. • **Workforce Risks**: A new workforce risk has been added to the register in response to government-mandated cost reductions. It was noted that the rating for the two workforce risks might require adjustment after the publication of the workforce chapter of the NHS 10-year plan. • A presentation was given on the **SEL AI framework**, launched in February to ensure the safe and efficient use of AI. The discussion highlighted challenges for social care providers with data security requirements and the need for significant workforce engagement to ensure staff trust and are trained to use AI tools appropriately. • **Integrated Neighbourhood Health**: The committee received an update on the workforce plan to support Integrated Neighbourhood Teams (INTs), which was endorsed by the Neighbourhood Care Board. Immediate priorities include fostering a 'one team' ethos, launching leadership support offerings and developing a SEL-wide communications and engagement approach to support neighbourhood working. • The **2024 NHS Staff Survey** findings were shared with members, showing an improved response rate of 51.47% across SEL ICS. Three key system-wide themes were identified from the results: persistent discrimination, a decline in

			career development opportunities and elevated levels of burnout. The committee supported recommendations to agree on these three themes as shared ICS priorities and develop a SEL-wide action plan. • Committee members received an update on the **Bi-annual report**, which confirmed a total workforce of 132,000 across SEL as of March 2025. Key risks identified include specialist nursing shortages in community and social care, rising sickness absence and the impact of displaced international recruits. A growing mismatch between workforce supply and demand was noted, with four out of five trusts no longer offering guaranteed interviews for newly qualified nurses.
2.	Quality and Safeguarding Committee	2 July 2025	• The members discussed the outputs from the committee effectiveness review and agreed to review their terms of reference in six months time. • The Committee received comprehensive updates from: ○ **Safeguarding**: noting the statutory obligations on the ICB to report on this area, and discussing any implications from potential resourcing reductions. ○ **The quality team**, which included a review of work by the quality team, quality alert themes and trends, a review of never event and patient safety events reported in year, an update on progress against Marthas Law, and discussed on the Synnovis incident. ○ **The Local Maternity and Neonatal System** on work completed. ○ **All Age Continuing Care** noting the contribution to the Once for London and ICB reduction work, and improvements made to the management of CHC FOI requests. ○ **Infection Prevention and Control** on the activities of the group and current infection trends. ○ An end of year report was delivered on the key interventions and outcomes related to medicine safety and quality improvement in the year. ○ **Learning Disability, Autism and SEND** team on work ongoing in the LDA and SEND areas.

			○ **Patient Experience** on trends and themes from current patient experience contacts, also noting the submission of the annual KO41A return and expectation the KO41B return would be submitted that week. • The quality, safety and safeguarding risk register was discussed.
3.	Digital Committee	8 July 2025	• The Committee considered the outcome of its effectiveness review. • A presentation was delivered on the delivery of the London AI Framework, with contact details to be shared to enable input to the maturity assessment work and development of AI governance. • An update was provided on the information governance, technical and cyber security changes to the Data Security and Protection Toolkit and the implications on partners and their assessment outcomes. • The Committee considered the London Skills Development digital skills offering and associated funding and agreed other options should also be considered.
4.	Greenwich Charitable Funds Committee	8 July 2025	• Groundwork London provided an update on current applications and awards for the enabling and delivery strands of work. • Committee members were advised DG Cities have been appointed to create an evaluation framework, with an initial indication of outcomes report due in September to inform the next phase of awards • Committee members were reminded the original Groundwork London contract was for a 3 years + 3 years basis, with a decision on extension into the second 3 year period required in September.
5.	Executive Committee	9 July 2025	• The Committee considered a draft of the ICS Green Plan for the next three years and made suggestions for improvements and discussion on the need to measure progress, the challenge of capital investment, how to mitigates the climate change impacts already being felt by residents, and reflecting the direction of the recent ten year health plan in the document.

			• The Committee considered outstanding management actions advised by internal audit including in relation to continuing healthcare and were advised that these were on track for closure at the upcoming Audit committee. • The Committee received an update on the data and security protection toolkit, noting changes to the toolkit to align with the framework set out by the national cyber security centre, and actions to address risks identified to compliance by the internal audit report. Some actions had already been taken in relation to the more stringent requirement and the cyber security of the organisation had increased since previous years.
6.	Audit & Risk Committee	10 July 2025	• Grant Thornton noted completion of the 2024/25 annual accounts audit and were considering future audit plans in the light of the ICB reshaping work underway. • The Committee received the internal audit progress paper and a separate paper on follow up of management actions. Of particular discussion was the outcome of the DSPT review. • The Committee received an update report on progress against the anti-crime services annual workplan. • The Committee reviewed the Board Assurance Framework and corporate risk register and approved the current risk management framework and risk appetite for continued use. • The Committee noted a report on tender waivers and confirmation no special payments, losses or write offs had been transacted in the reporting period. • The Chief of Staff reported on gifts and hospitality declared and delivered the latest Freedom to Speak Up update report. • The Committee received an update on the progress made against management actions from the previous Safeguarding and CHC audits, noting closure of the outstanding CHC audit recommendations and a plan to re-audit safeguarding.
7.	Transition Committee	15 July 2025	• The Committee reviewed its terms of reference and purpose. Noting the operating model of the ICB had been described in the Model ICB blueprint, interpreted into

			proposals for the south east London ICB through the work of the ICB, but recognised that this would continue to be refined in response to the needs of the ten year plan. A role for the committee was identified to overseeing the process in relation to ICB functions proposed to be carried out on the ICBs behalf by providers. • The Committee received an update on progress including assurance processes and London wide discussions on the changing functions of ICBs. • The Committee were keen to be assured that the reductions proposed to every area did not compromise the ability of the ICB to be an effective strategic commissioner in the future in particular in relation to areas identified for growth in the ICB blueprint. • The Committee started a discussion on how to manage risks in the transition.
8.	Executive Committee	23 July 2025	• The Committee confirmed support for a move to a lead provider model in relation to paediatric audiology and recognised the work of an improvement programme for tier 2 services. • The Committee heard an update on a south east London review of children and young people's neurodiversity services, and a proposals to pilot a hub for neurodiversity support and assessment, initially covering two boroughs Greenwich and Bexley, and proposals to develop a medication pathway in coming months. • The Committee received a briefing on a complaint in relation to an accreditation process and discussed working with other ICBs on improvements to the process given common challenge. • The Committee received an update on the Data Protection Security Toolkit status and the organisations cybersecurity stance noting that the position in relation to cybersecurity had improved since the previous year, but some documentation tasks remained to be completed to provide assurance to internal auditors. • The Committee received an update on finance as at month 3.

			• The Committee considered a request for a research project on preparedness and learning from the cyber-attack incident.
9.	Transition Committee	24 July 2025	• The Committee received updates on the proposals noting that their comments in relation to the initial proposals had been addressed or incorporated. The committee expressed itself satisfied that the rationale for the change programme, and the design principles and insights of SMT work were reflected in the proposals. The new structure could also be delivered within the limit of £19 per head of population. • The Committee reviewed and endorsed a submission to NHS England on key lines of enquiry pointing out that key strategic commissioning resource had been protected rather than grown as previously suggested in the ICB blueprint, and that there would be a need for ongoing capability development as the organisation took on its future strategic commissioning goal. • The Committee reviewed a summary of the longer term and more strategic risks related to the programme, noting that day to day risks to the process were considered by an operations group.
10.	Integrated Performance Committee	30 July 2025	• Members discussed the outcomes of the committee effectiveness review and discussed changes to terms of reference. • A paper was presented on the digital enablers associated with the Ten Year Plan. • The current status of Electronic Patient Record business cases, and the financial risks associated, was discussed. • The Committee received a presentation on the One Bromley Strategy and Health and Wellbeing Board priorities, the Joint Forward view refresh and Bromley initiatives to develop neighbourhood working. • The month 3 ICB and ICS financial position was reported and noted.
11.	Executive Committee	6 August 2025	• The Committee received an update on the forthcoming transfer to the new IFSE 2 financial system for ICBs in October, noting that the ICB was not currently

			sufficient assured in relation to the readiness because of the need for more certainty on training or testing, and discussions taking place in mitigation. • The Committee conducted an in-depth discussion on challenges in ADHD provision including waiting times and increased demand, a dedicated group that was in place to address the issues, and the proposed work to develop a single point of access. • The Committee received an update on ICS performance.
12.	Transition Committee	13 August 2025	• The Committee received an update on guidance released including a blueprint for a model ICB region and positive feedback on the ICBs plans but uncertainty over funding for the necessary redundancies. They endorsed a list of issues for the committee to consider in future meetings. • The Committee received a paper setting out the process of appraisal and resultant recommendations for each functional area considered for transfer from the ICB. Questions sought assurance on the safety of the transfers and that the proposals made represented maximised the potential for these functions to be delivered in an innovative and transformational way.
13.	Executive Committee	20 August 2025	• The Committee received an update on recent planning guidance and discussed the guidance and the information to be collated across boroughs and providers as part of the foundational work.
14.	Transition Committee	1 September 2025	• The Committee received the draft consultation document, discussing proposed areas for sharing with other organisation, engagement with other organisation on areas such as safeguarding, the impact on staff and engagement with staff representatives. • The Committee reviewed an initial equalities impact assessment completed in relation to the proposed changes, suggesting areas for improvement, asking for additional data and approving the submission to NHS England. In particular the potential consequence of the greater proportion of posts at senior bands on staff currently in more junior bands was highlighted.

			• The Committee received an update on functions proposed for transfer asking questions about timescales and the treatment of cost.
15.	Executive Committee	3 September 2025	• The Committee received a planning update noting work on the foundational elements which were due by the end of September and the governance groups being identified to take forward phase 2. • The Committee received an update on ICS performance.
16.	Remuneration Committee	8 September 2025	• Remuneration Committee members considered and approved three papers, as detailed in the approvals section above, in line with the scope of their authority.
17.	Digital Committee	9 September 2025	• The Committee discussed proposals for the workplan and the need to review the terms of reference. • A discussion took place on the options available to ensure LGT retained access to a digital analytics platform to support ongoing population health work, given the March 2026 end of its notice period for Oracle Cerner. • The ICBs Chief Information Security Officer delivered a presentation on the lessons learned from the Synnovis cyber-attack. • The Committee discussed opportunities and challenges to delivering real digital transformation to pathway redesign work.
18.	Executive Committee	17 September 2025	• The Committee received an update on planning including a national exercise in block contract deconstruction as well as work on foundational elements and meetings planned with health and wellbeing briefings. • The Committee received and discussed a health inequalities report and welcomed improvements to its presentation but discussed the conclusions about continued health inequalities affecting people in south east London, noted the effort made in the medium term financial strategy to prioritise funding for areas such as inequalities and mental health, and discussed how to supplement the data and to ensure that it was informed decisions made in the forthcoming planning round.

19.	Integrated Performance Committee	24 September 2025	• The Committee received a briefing on the requirements, timeframes and approach for 2026/27 planning, including considerations for delivery of the 10 Year health Plan, requirements of for the medium-term financial strategy, and how to achieve financial stability. • An assessment on the work undertaken by the committee to date was delivered, and members discussed how to best deliver the core purpose going forward. • The month 5 ICB and ICS financial position was reported, noting efficiencies achieved in the year and the rollout of a new financial ledger system from 1 October 2025.
20.	Transition Committee	30 September 2025	• The Committee received a quality impact assessment in relation to proposed changes to the ICBs executive structure, asking questions about the risks and impact on stakeholders. • The Committee received an update the transition programme noting continuing uncertainty about the funding of redundancy. Consideration of guidance on CHC and Safeguarding, conversations with the London Region about respective roles for example monitoring and performance management. • The Committee received an update on work with functions to transfer as well as functions hosted by one London ICB on behalf of others and discussed the implications of changing timeframes for staff consultation.
21.	Executive Committee	1 October 2025	• The Committee were briefed on progress with the planning round including a national mid-year review of the system and 2026/27 planning. • The Committee received a cost impact model in relation to NICE recommendations including Sparsentan for treatment of primary IgA nephropathy in adults, and use of Nirmatrelvir plus Ritonavir, Sotrovimab and Tocilizumab for treating COVID-19 in adults. • The ICS Green Plan as revised was considered and recommended to the Board • The Board Assurance framework was considered by the committee and suggestions made in relation to ratings of emerging risks.

			• The Committee received an update on ICS performance. • The Committee received an update on ICB and ICS finance as at Month 5.

22.	Quality & Safeguarding Committee	1 October 2025	• The Committee formally noted the virtual approval for the PSII report and associated actions as a result of the last meeting not being quorate.
			• The Committee received comprehensive updates from:
			  ○ **Patient Experience**: Highlighting CHC complaints, increases in MP enquiries, impact to meeting KPIs due to significant reduction in team and capacity and delay in team receiving complaints from within the organisation.
			  ○ **Learning Disability, Autism and SEND**; noting the team were on track to meet targets, the launch of Dynamic Support Register (DSR) in August, and to note financial impact and regulation around diagnostic services
			  ○ **Local Maternity and Neonatal System** – note to delivery plan, data improvement, national reviews, MNVP non compliance, work around prescriptions and note to issues around infusion pumps.
			  ○ **All Age Continuing Care** – confirming strategic progress and actions, commending the CHC teams for their work with note to work around reducing complaints and training needs analysis
			  ○ **Infection, Prevention and Control** – note to impact from Blue print and limitations to any strategic work. Positive bid application in AMR/AMS funding.
			  ○ **Medicines Optimisation** – update on pathways, ADHD medications and note to controlled drugs work.
			  ○ **Quality and Safety** – decrease in quality alerts and new weekly reviews, progress in data analysis and updates from sub groups.
			  ○ **Safeguarding -** assurance around training compliance and supervision, workplan, NHSE assurance (S-CAT), safeguarding internal audit outcomes and exception report from Place.
			• Committee members received a report on the Blackheath Brain Injury peer review, led by the ICB, noting an improved CQC rating of Good following successful engagement.

			• Members received a BI presentation on Serious Violence Data (SVD) and offensive weapon review, highlighting themes and collaborative working. • The quality, safety and safeguarding risk register was reviewed.

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.	24 July 2025	4. Better Care Fund • 2025/26 Plan – Section 75 Schedule Update Q4 2024/25 End of Year Report (to note)	The Bexley Wellbeing Partnership Committee received a report of the Bexley Better Care Fund (BCF) 2025/26 Plan with a Section 75 Schedule update and the Q4 2024/25 End of Year report (to note). The Bexley Wellbeing Partnership Committee: • **Endorsed** the proposal to update the Section 75 agreement schedules for the Bexley BCF Plan 2025/26. • **Noted** the BCF Q4 2024/25 End of Year report
2.	24 July 2025	5. Developing Our Neighbourhood Health Service	The Bexley Wellbeing Partnership Committee received an update on the development of Neighbourhood Health Services in Bexley. The purpose of the report was to provide the Committee with the opportunity to note the Memorandum of Understanding, between the London Borough of Bexley, Oxleas NHS Foundation Trust, the Bexley Health & Neighbourhood Care CiC (local GP Federation) and the four Primary Care Networks, who have formed Bexley Care *Plus*, the local place '*integrator*'.

			The Bexley Wellbeing Partnership Committee: • **Noted** the progress of the report.
3.	25 September 2025	Developing Our Neighbourhood Health Service: Bexley Care *Plus* Memorandum of Understanding	The Bexley Wellbeing Partnership Committee were asked to endorse the Memorandum of Understanding, between the London Borough of Bexley, Oxleas NHS Foundation Trust, the Bexley Health & Neighbourhood Care CiC and the four Primary Care Networks, who have formed Bexley Care *Plus* the local place "*integrator*". The Bexley Wellbeing Partnership Committee: • **Endorsed** the Memorandum of Understanding.
4.	25 September 2025	Bexley Local Health & Care System Winter Resilience Plan	The Bexley Wellbeing Partnership Committee received a report on the preparedness of the local health and social care system for the forthcoming winter, including the risks and challenges faced and the actions to mitigate them. The Bexley Wellbeing Partnership Committee: • **Endorsed** the Bexley Local Health and Care System Winter Resilience Plan

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.	24 July 2025	Primary Care Quarterly Business Report (Q1 2025/26)	The Bexley Wellbeing Partnership Committee received the Quarterly Primary Care Delivery Sub-Committee Report (Q1 2025/26). The Bexley Wellbeing Partnership Committee: • **Noted** the report and the progress to date.

2.	24 July 2025	Local Care Partnership Performance Report	The Bexley Wellbeing Partnership Committee received the Local Care Partnership Performance Report. The report highlighted the latest position against key areas of=n local performance, highlighting achievements against national targets, agreed trajectories and other comparators. The Bexley Wellbeing Partnership Committee: • **Reviewed** the report and the mitigations/actions highlighted in Appendix 1 for each of the metrics RAG rated as red based on the latest reporting period.
3.	24 July 2025	*Let's Talk:* Creative Health	• The *Let's Talk* subject for the July 2025 committee was *Creative Health* - meaning creative approaches and activities, which can benefit health and wellbeing. Activities can include visual and performing arts, crafts, film, literature, cooking and creative activities in nature, such as gardening. • The committee heard evidence for *Creative Health* a preventative tool as well as the benefits for recovery from ill health. There were presentations from Bexley Voluntary Service Council (BVSC). BVSC have commissioned 'Bexley Buddies', a *Creative Health* project based at Bursted Wood Surgery. The committee also heard details on *Music for Hospices*, and inspiring initiative, which the Community Hospice have championed. There was also a presentation on the benefits of *Creative Health* and initiatives in the capital from Matthew Couper, from the Greater London Authority.
4.	25 September 2025	Better Care Fund: Quarter 1 Return 2025/26	The Bexley Wellbeing Partnership Committee received a report of the Bexley Better Care Fund (BCF) Quarter 1 Return 2025/26 (to note). The Bexley Wellbeing Partnership Committee: • **Noted** the report and the progress to date.
5.	25 September 2025	Primary Care Quarterly Business Report (Q3 2025/26)	The Bexley Wellbeing Partnership Committee received the Quarterly Primary Care Delivery Sub-Committee Report (Q3 2025/26).

			The Bexley Wellbeing Partnership Committee: • **Noted** the report and the progress to date.
6.	25 September 2025	*Let's Talk:* Dementia	• September's *Let's Talk* subject was about dementia, following World Alzheimer's Day on 21st September 2025. The committee heard from service providers who support those living with dementia in the borough, which includes those with a diagnosis and their carers, families and friends. Presentations from the local health and care system included Adult Social Care & Health and Oxleas NHS Foundation Trust who provide the Memory Service, the Alzheimer's Society and Bexley Carers Support, in addition to hearing from a carer with lived experience of caring for a relative with dementia.

Appendix 2

Bromley Local Care Partnership – One Bromley

1. Recommendations to the Board for Decision/Approval

1.1 The One Bromley Integrator proposal went to the Board for approval 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.	31 July 2025	6. Bromley Learning Disabilities Strategy (2025-2030)	• The One Bromley Local Care Partnership Board agreed and supported the Bromley Learning Disabilities Strategy 2025-2030. • The One Bromley Local Care Partnership Board supported the development of an action plan to deliver the strategy over the next five years.
2.	31 July 2025	7. Bromley Mental Health and Wellbeing Strategy (2025-2030)	• The One Bromley Local Care Partnership Board approved the Bromley Mental Health and Wellbeing Strategy – 2025 – 2030.
3.	31 July 2025	8. One Bromley Partnership Integrator Proposal	• For Bromley Place, it was proposed that the One Bromley Partnership will be the Integrator. Supporting the One Bromley Partnership will be King's College Hospital NHS Foundation Trust as the Integrator Host. • The One Bromley Local Care Partnership approved the proposal for submission to the SEL ICB.

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.	31 July 2025	9. SEL Ageing Well Strategy	• The One Bromley Local Care Partnership noted the alignment between the SEL Ageing Well Framework and the One Bromley Frailty Strategy and provided feedback on identified gaps and proposed next steps.
2.	31 July 2025	10. Partnership Report	• The report on partnership working was received, with an additional verbal update given on the status of the current community equipment provider, who had notified commissioners that they would stop delivering services from the end of the month. • The Inspire Community Trust had been appointed as the new provider for Bromley. • The local authority's onsite inspection of adult social care services by the Care Quality Commission would take place in September.
3.	31 July 2025	11. Finance Month 2 Update	• Initial forecasting was currently predicting that financial targets will be met for this year. There are however cost pressures in mental health placement and continuing healthcare budgets. The impact of the integrated community equipment service issue would also need to be factored in. Prescribing budgets were currently showing as within budget, along with primary care.
4.	31 July 2025	12. Primary Care Group Report	• The Board noted the Primary Care Group Report.
5.	31 July 2025	13. Procurement and Contracts Group	• The Board noted the Procurement and Contracts Group Report.

6.	25 September 2025	Meeting Summary	Items discussed: • Updates to the Bromley NHS Act 2006 s.75 Agreement for 2025-26 • One Bromley Winter Plan 2025-26 • Care Home Programme Successes • Homeless Service Update • Partnership Report • Finance Month 4 Update • Primary Care Group Report • Procurement and Contracts Group Report • Performance, Quality and Safeguarding Group Report • Any Other Business • As the meeting took place just before submission of this report, the minutes are pending approval at time of writing. A more detailed update will follow in the January report.

Appendix 3

Greenwich Local Care Partnership – Healthier Greenwich Partnership (HGP)

1. Recommendations to the Board for Decision / Approval

1.1 Healthier Greenwich Partnership Terms of Reference

The Healthier Greenwich Partnership Terms of Reference have been reviewed and updated to reflect the following:

- Additional clauses added to provide clarity on responsibilities of the partnership
- Financial clause added to make note of the delegation of budgets by the South East London ICB
- Membership and attendance updated to reflect:
- Core voting members
- Non-voting members
- Removal of Adult Social Care services member – noting that this may change once an organisation is identified
- Addition of nominated representative from Greenwich Local Pharmaceutical Committee as a non-voting member
- Clause appointing vice chair

The board is requested to approve the updated Terms of Reference for the Healthier Greenwich Partnership

1.2 To note for the purposes of this paper, the Board **APPROVED** in the reporting period the Healthier Greenwich Partnership recommendation that Oxleas NHS Foundation Trust are appointed to the role of Health Host Integrator for Greenwich

2 Decisions made by Healthier Greenwich Partnership LCP Under Delegation

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

No.	Meeting date	Agenda item	Items for Board to note
1.	25 July 2025	7.1 Integrator Identification – decision to endorse proposal	• The LCP members agreed to endorse and support the proposal that the appointment of the Integrator would be referred to the previously agreed SROs to undertake suitability assessments
2.	25 July 2025	7.2 Stone King	• The LCP members agreed to the appointment of Stone King for one year from September 2025 to focus on the cultural and OD development, helping to develop how the partnership operates and providing pathways on how to work changes and new ways of working
3.	25 July 2025	8. UTC Re-procurement	• The LCP members agreed to extend the UTC contract with Greenwich Health to 30 June 2028
4.	25 July 2025	9. Aging Well Frailty Framework	• The LCP members agreed to endorse the publication of the Aging Well Frailty Framework on the South East London website

3 Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	25 July 2025	6. Be Well	• The LCP members received a report on 'Be Well' engagement that focussed on work relating to the development of the physical sport strategy and the support being provided to residents to have better access to safe, affordable culturally appropriate healthier food

			• The LCP members were advised about what went well and what improvement opportunities had been identified
			• The LCP members noted that there was a commitment to deliver three High Impact Activities over the next year which were:
			  ○ To review, update and implement the Royal Greenwich Get Active physical activity and sports strategy
			  ○ To develop an approach to ensure food nutrition is included in all diet-related disease care pathways
			  ○ To improve food environments at neighbourhood, high-street and organisational levels, which HGP organisations would contribute to
			• The LCP members were advised Greenwich are the first borough that would be undertaking a whole system JSNA,

2.	25 July 2025	11. Risk update	• The LCP Board reviewed the current Place based risk register, noting changes since the last update, and the work taking place at SEL level to consider system wide risk and agreed to accept the mitigations that have been put in place.

Appendix 4

Lambeth Local Care Partnership – Lambeth Together

1. Recommendations to the Board for Decision / Approval

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

2. Decisions made by Lambeth Together Care Partnership Under Delegation

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

No.	Meeting date	Agenda item	Items for Board to note
1.	3 July 2025	Living Well Network Alliance (LWNA) Roadmap	Members of the Partnership Board endorsed the Alliance's agreed focus on outcomes and supported the implementation of the roadmap for the next 12 months
2.	3 July 2025	Neighbourhood Working Update	Members of the Partnership Board: • Ratified the proposed Lambeth Integrator Model. • Endorsed the use of £250k for integrator development in Lambeth. • Approved delegating final approval for the integrator memorandum of understanding and detail of the integrator development funding disbursement to the Neighbourhood & Wellbeing Delivery Alliance Leadership Board (with regular updates to the Lambeth Together Care Partnership Board). • Agreed the Integrated Neighbourhood Teams (INT) Delivery Plan (July–December 2025). • Supported the Ageing Well framework developed by South East London (SEL) as part of the ongoing development of integrated neighbourhood teams.

3.	3 July 2025	Lambeth Together Assurance Process Review for 2025/26	Members of the Partnership Board: • Approved the proposed changes to the Health and Care Plan impact measures for 2025/2026 • Agreed the forward view presentation timetable for 2025/2026.
4.	3 July 2025	Lambeth Together Primary Care Commissioning Committee (PCCC)	Members of the Partnership Board: • Ratified decisions made at the Primary Care Commissioning Committee on 14 May 2025 • Noted the update on discussions held at the Committee on 14 May 2025
5.	4 September 2025	Addressing Substance Misuse – Deep Dive	Members of the Partnership Board approved the progress report on the work of the Substance Misuse Programme against 'Our Health, Our Lambeth' activities and outcomes and supported the partnership efforts.
6.	4 September 2025	Primary Care Commissioning Committee (PCCC)	Members of the Partnership Board: • Ratified decisions made at the Primary Care Commissioning Committee on 23 July 2025. • Noted the update on discussions held at the Primary Care Commissioning Committee on 23 July 2025.

7.	4 September 2025	Universal Access Fund: All-Age Autism Fund (AAAF) - Q1 Monitoring Update (Apr–Jun 2025)	Members of the Partnership Board:
			• Noted the delivery and outcomes achieved in Quarter 1.
			• Endorsed the Quarter 2 priorities to strengthen equity and sustainability.
			• Supported cross-system enablers:
			  ○ Comms amplification via partners.
			  ○ Data-sharing to improve demographic and outcome completeness.
			  ○ Alignment with Oliver McGowan training rollout and leisure-centre sensory spaces.

3. Agenda Items of Note

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

1.	3 July 2025	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received an update on key developments since the last Lambeth Together Care Partnership Board meeting in public on 15 May 2025.
2.	3 July 2025	Lambeth Together Assurance Group (LTAG) Update	Members of the Partnership Board noted the update report from the Lambeth Together Assurance Sub-Group and the Integrated Assurance Report presented on 13 May 2025.
3.	3 July 2025	Healthwatch Lambeth Annual Update	Members of the Partnership Board received an update on Healthwatch Lambeth's impact, community engagement, and contribution to service improvements across 2024 – 2025.
4.	3 July 2025	Care Quality Commission (CQC) Assessment of Lambeth Adult (ASC)	Members of the Partnership Board: • Noted the commencement of the CQC assessment process of Lambeth Adult Social Care (ASC) in May 2025. • Reviewed the Lambeth Adult Social Care's Self-Assessment Executive Summary. • Agreed to engage with CQC assessors as part of the assessment fieldwork.
5.	4 September 2025	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received the update on key developments since the Lambeth Together Care Partnership Board meeting in public on 3 July 2025.
6.	4 September 2025	Lambeth Together Assurance Group (LTAG) Update	Members of the Partnership Board noted the update report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 15 July 2025.

Appendix 5

Lewisham Local Care Partnership – Lewisham Health & Care Partnership

1. Recommendations to the Board for Decision / Approval

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

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

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

No.	Meeting date	Agenda item	Items for Board to note
1.	24 July 2025	4. Lewisham Integrated Neighbourhood Model of Care	**The Board were asked to give formal approval on the Lewisham Integrated Neighbourhood Model of Care.** Members noted the model aims to deliver care closer to communities through multidisciplinary integrated neighbourhood teams (INTs) and neighbourhood hubs. Recruitment has been completed for key roles for the first INTs, which will be focused on Long Term Conditions (LTCs) and include clinical prescribers, case workers, link workers, and health and wellbeing coaches. These roles will commence between August and September 2025. The model had been co-designed with individuals with lived experience. Future phases would address frailty and complex children's services. The transformation is aligned with South London & Maudsley (SLaM) Neighbourhood 2 pilot. **The LCP Board approved Lewisham Integrated Neighbourhood model update.**
2.	24 July 2025	5. Better Care Fund (BCF) – updated S75 agreement	**The Board were asked to give formal approval on the Better Care Fund (BCF) – updated S75 agreement.** Members were asked to note the refreshed s75 agreement is due by September 2025. **The LCP Board approved updated S75 agreement (Better Care Fund).**

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.	24 July 2025	3. PEL Report	• **NHS change programme** was discussed noting the overall £21 million saving required for SEL, with Lewisham Place expected to deliver a 30.3% reduction, excluding Safeguarding, Continuing Health Care (CHC), and Clinical Care Professional Leads (CCPLs). Proposals had been submitted in June and reviewed in July to ensure consistency and coherence across directorates. • **10 Year Plan –** key aspects of the newly published 10-Year Plan were discussed noting that over the next three to four years, the proportion of NHS funding spent on acute care will fall and it should show a corresponding increase in primary care and community services. • The integrator functions detailed in the London target operating model were discussed to support neighbourhood working. In Lewisham a partnership approach was being taken that includes the local authority, NHS providers, general practice and the VCSE. Governance to underpin the Lewisham partnership was in development.
2.	24 July 2025	6. Lewisham Health Equity Team	• **Lewisham Health Equity Teams – Cycle 1 evaluation:** The evaluation of the first cycle of the Health Equity Teams pilot was an initiative that involved collaboration with six voluntary and community sector (VCS) groups to co-design projects addressing local health inequalities. Health Equity Fellows (HEFs) were recruited across Primary Care Networks (PCNs) to lead these efforts. The Health Innovation Network (HIN) conducted the evaluation, identifying opportunities for investment in Black-led organisations, development of Community Champions and improved accessibility of

			care. The pilot demonstrated the value of HEFs and reinforced the importance of targeted interventions for Black African and Black Caribbean communities.
3.	24 July 2025	7. Waldron Health and Wellbeing hub	• **Waldron Health and Wellbeing Hub:** The transformation of the Waldron Health Centre into a Health and Community Hub was discussed, which now offers a welcoming space for residents to access health and care services, receive advice, and engage with the community. It includes a community kitchen, bookable rooms, and pop-up spaces, and is actively used by VCSE groups such as Red Ribbon, Citizens Advice Lewisham, and others. Two Health Navigators support signposting, assisting approximately 1,500 people monthly and utilisation has increased. Plans are also underway to develop a frailty café. Additionally, the hub is part of a creative health demonstrator project funded by the Greater London Authority (GLA), aimed at evaluating the impact of creative approaches on health and wellbeing.
4.	24 July 2025	8. Risk Register update	• **Lewisham risk register.** The borough risk register was reviewed, noting the financial position remains stable early in the year, but there are persistent pressures in prescribing and Continuing Health Care (CHC). Concerns are around ADHD assessments and low vaccination uptake, particularly for flu. However, plans are being developed to improve vaccination rates and progress has been noted in autism spectrum disorder (ASD) health assessments. Risks are actively monitored and discussed at Senior Management Team (SMT) meetings.
5.	24 July 2025	9. Finance update	• **Finance update**: An update on the borough, ICB and ICS year to date financial position was presented, noting Lewisham had started the year with a small underspend of £24k and is forecasting a break-even position, though risks remain. CHC continued to be a pressure area, with a combined forecast overspend of £2.8m across adults and children, and mental health is showing a £700k overspend driven by rising ADHD assessment demand. Prescribing remained volatile, with early indications suggesting a repeat of last year's £2m overspend. Despite these pressures, the system was on track to deliver its 5% savings target of just under £9m.

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

No.	Meeting date	Agenda item	Items for Board to note
1.	24 July 2025	3.Unplanned Admissions for over 65 year olds	Partnership Southwark Strategic Board approved the SEL Ageing Well Framework.
2.	24 July 2025	4.Integrated Neighbourhood Teams Update	Partnership Southwark Strategic Board agreed that the partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and a new joint venture between Southwark GP Federations: Improving Health Limited (IHL) and Quay Health Solutions (QHS) is appointed as the integrator for Southwark

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.	24 July 2025	2. Deep Dive: Vaccinations and Immunisations	A deep dive review was conducted following the board's review of performance data in May, which showed immunisation and vaccination rates significantly below target. The presentation clarified multi-agency governance and assurance arrangements and outlined key initiatives to address challenges and improve coverage. The discussion focused on how board members and their organisations could help reduce inequalities in uptake. It was also noted that commissioning of vaccination programmes will transfer from NHSE to the ICB in April 2026.
2.	24 July 2025	3. Unplanned admissions for over 65 year olds	This deep dive report was requested as it is a key metrics in the frailty scorecard and Better Care Fund, and as admission rates are rising the target is not being met. The rate is higher than in similar boroughs. The report examined underlying data by condition type and reviewed current initiatives including virtual wards, @home, remote monitoring, schemes funded through the Better Care Fund such as Intermediate Care Southwark and the integrated frailty pathway. The SEL Ageing Well Framework was also summarised and was formally approved by the board. In the discussion a range of ideas for improved admission avoidance were suggested which will inform the gap analysis and next steps.
3.	24 July 2025	4.Integrated Neighbourhood teams update	The update included confirmation of the appointment of the integrator, a partnership between GSTT and the two GP Federations, which was agreed by the board. The meeting also discussed the potential application for the National Neighbourhood Health Implementation Programme (NNHIP) – the success of which was confirmed in September.

4.	24 July 2025	6.PEL report	The topics covered in the report included the Model ICB Blueprint and the local ICB reform process, the NHS 10-year plan, the GP Patient Survey, the Better Care Fund plan and progress by the Maternity Commission. The board also discussed a recent estates workshop focused on improving clinical building utilisation in line with the 10 Year Plan's shift from hospitals to community care, and the estates requirements of Integrated Neighbourhood Teams. Update reports from sub-groups of the board were also reviewed. The report included updates from the Integrated Governance and Assurance Committee including recent decisions made on contract extensions for the Care Home GP contract the PACT service and the Mental Health Wellbeing Hub. Updates were also provided from the Primary Care Committee and the Partnership Southwark Delivery Executive.
5.	24 July 2025	7. Integrated Assurance Report	A summary report was provided of the report received by the Integrated Governance and Assurance Committee highlighting key changes since the previous report.
6.	25 September 2025	2. NHS 10-year plan	The Board received a presentation and held a discussion on the implications of the NHS 10-Year Plan for Southwark residents, and the development of local plans aligned with the national vision
7.	25 September 2025	3. NHS changes and implications for Partnership Southwark	The impact of the new ICB model was reviewed, with particular attention to its effects on Partnership Southwark and neighbourhood health initiatives.
8.	25 September 2025	4.Integrated Neighbourhood Team update	The board received a presentation from the newly appointed Integrator on their plans for developing the function.
9.	25 September 2025	6.Community Spotlight: Social prescribing	A spotlight report outlined current social prescribing services within the two Southwark PCNs and explored the potential for these services to play a greater role in integrated neighbourhood health care

10.	25 September 2025	7. Place Executive Lead Report	Updates included the successful joint application by Southwark and Lambeth for the National Neighbourhood Health Implementation Programme (NNHIP), progress on ICB reform, the CQC inspection of Adult Social Care, and the official opening of the Harold Moody Health Centre and the urgent caretaking contract award for Trafalgar Surgery following the sudden passing of the sole GP partner. Reports from the Board's main sub-groups were also presented.
11.	25 September 2025	8. Integrated Assurance Report	The report, which had been discussed in detail at the Integrated Governance and Assurance Committee (IGAC), provides a comprehensive Q1 overview of performance metrics, quality, safeguarding, SEND, Risk, Finance and CHC for the board to note and discuss. Following concerns expressed at IGAC about performance, it was recommended that a deep dive report on delayed discharges be bought to the November board.

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 3 July 2025 to 30 September 2025.

No.	Meeting date	Items for Board to note
1.	July through to September 2025	The meetings of the APC Executive and Committee in Common have focused on considering and responding to the emerging context and its implications for the APC's strategic direction, but final decisions have not been reached. Meanwhile the APC delivery team has continued with the "business as usual" work of the APC networks in securing clinical transformation (eg implementing SEL MSK/Ortho Single Point of Access), and supporting the broader remit of the Executive Advisory Groups and the groups that report to them to facilitate streamlined and collaborative decision-making (eg decisions on capital prioritisation undertaken by the combined finance/ops group).

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 3 July 2025 to 30 September 2025, for Board information.

No.	Meeting	Agenda item	Items discussed
1.	APC executive and Committee in Common – July and August 2025	Changing policy and strategic context – implications for	Both the APC Executive and the Committee in Common have shared perspectives on the emerging and evolving NHS policy and strategic context for providers in general and for provider collaboratives. This will feed through into decisions on refreshing the outline strategic direction approved in December 2024.

		providers and provider collaboratives	
2.	APC executive and Committee in Common – July and August 2025	AOB	Acknowledgment and thanks to Ian Abbs on his retirement, reflecting his significant contribution to the APC and in particular in the last year as Lead CEO.
3.	Multiple executive advisory groups – July to September	Collaborative work with system sustainability group	Updates on ongoing Phase 1 service/specialty work to improve sustainability and address key challenges in orthopaedics, imaging, urogynaecology and breast services Updates on ongoing Phase 2 work exploring wider opportunities
4.	Multiple executive advisory groups – July to September	NHS Planning Framework	Reflection on emerging policy context and implications of the Planning Framework, including consideration of what work should be undertaken collaboratively and/or in an aligned way to minimise duplication/triplication of work.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 There were no key decisions made during the reporting period to advise to the Board.

2. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	September 2025	NHS 111 services	The programme of work to integrate the trusts' crisis lines into NHS 111 for Mental Health is progressing well. The transformation is currently focussed on finalising workforce and financial modelling for the new integrated service before integration timescales are agreed. Each crisis line will transfer activity in succession after a period of evaluation. This will be supported by a robust communication strategy to ensure all stakeholders are appropriately engaged and informed. This development will ensure easier access for all south London residents experiencing a mental health crisis, reducing duplication and confusion. Strengthened data collection of the integrated service, will also help identify trends and patterns which will help future service design in meeting local needs.

South East London Integrated Care System

NHS South East London

Annual Governance Review 2025

1. Introduction

The governance framework in place for the ICB reflects good governance practice and is in line with NHSE guidance and recommendations. This framework includes key governance documents including the Constitution, Scheme of Reservation and Delegation, Committee terms of reference, and the Governance Handbook, which incorporates key corporate policies, Standing Financial Instructions and the Schedule of Matters Delegated to Officers.

A number of these documents have been refreshed in year in proactive response to emerging issues. Approval has been provided in line with the Scheme of Reservation and Delegation, and changes are detailed in appendix A of this document.

Good practice also recommends an annual review of committee effectiveness, which was conducted in Q2 of this year following the refresh of the ICBs governance arrangements in August 2024.

The purpose of this paper is twofold:

1. To present to the Board the outcomes of the committee effectiveness review, and the resulting proposals to amend committee terms of reference and ways of working as these require Board approval specifically.
2. To provide the Board with oversight of the changes to other governance documents that have taken place in the year and approved by other committees.

While further in-year amendments to either sets of documents may be necessary as the ICB reshaping and national context evolves, this paper is being presented now to wrap up the outcomes of the committee effectiveness review, as well as addressing some specific terms of reference amendments following arrival at their annual review date.

2. Outcomes of review

Effectiveness reviews were conducted with members of the Boards direct committees, via completion of an MS Form asking a variety of questions covering four key areas of questioning:

i. Composition, establishment and duties
ii. How the committee meetings operate
iii. Governance, scrutiny and assurance
iv. Work plan arrangements
v. Administrative arrangements

The committees that were included in the review were Audit & Risk, Remuneration, Integrated Performance, Quality & Safeguarding, Digital and People committees. In addition, the Engagement Assurance Committee and Equalities Sub-Committee used the same review process to support development.

Following collation of the responses, committee chairs were asked to summarise the outcomes into an overall assessment for the committee, which has enabled identification of any areas of improvement in the way the committee works, or any changes needed in the relevant committee's terms of reference.

General themes

Whilst specific issues will be picked up with each committee, a range of general themes have been identified in the reviews which are highlighted here for the Boards awareness and assurance.

Positive feedback:

- Committee membership is appropriate, with the right skill mix and good levels of input received across the board.
- The committees have met their terms of reference requirements.
- Committee members work well as a team, providing the appropriate challenge between members and for agenda items discussed.
- Reporting is generally considered to be of a good standard, with information sufficiently broad and in the right form. It is worth noting a few exceptions were reported to this general consensus and they can be picked up in the relevant committees.
- Conflicts of interest were appropriately managed by all chairs.

- Generally, members considered the split between discussing operational and strategic issues, and between assurance and decision making activity, was generally right.

Areas of improvement broadly fell into two issues:

- Need for succession planning for committee members – in nearly all cases there was no succession plan in place
- More time should be allocated on agendas, particularly in the early part of the year, for workplan development, to ensure the committees can cover all areas of their terms of reference obligations in the year.

It is worth noting that both these issues relate to more medium to long-term planning arrangements, rather than how the committee operates. This may not be surprising given the recent review (in 2024) of the ICBs governance arrangements and the consequent changes to committee structures, with some terms of reference changing, other committees being disestablished (Quality & Performance and Planning & Finance) and new committees being established (Integrated Performance and Quality & Safeguarding).

3. Terms of reference

All committee terms of reference include a requirement for an annual review. As committees of the Board, any changes to the terms of reference for these committees require Board approval.

In the light of the feedback in the effectiveness reviews, committee chairs whose terms of reference are due annual review have considered and made amendments as they feel appropriate. These terms of reference are presented to the Board today for approval, as detailed in the table below.

Committee	Last review	Changes
Audit & Risk	September 2024	**4.20 include reference to new requirements around fraud prevention** in the Economic Crime and Corporate Transparency Act 2023

		4.24 Amend Security section to recognise the ICB no longer contracts a Local Security Management Specialist service, instead using locally obtained intelligence through resilience fora to inform its security strategy and communications.
Remuneration	July 2024	**No changes proposed** with the exception of minor changes to committee and role titles, and reporting processes.

The relevant terms of reference are attached to this report for reference:

Appendix B: Audit and Risk Committee

Appendix C: Remuneration Committee

The Board is asked to consider and approve the revised terms of reference for immediate implementation.

People Committee terms of reference also fall due for a 12-month review in September. However, after consideration the Committee has decided to defer a review until after the current ICB change management programme has progressed further and the new structure of the People Programme team becomes clear.

Likewise, the Digital Committee terms of reference are due for review. Following the recent change in Chief Digital Information Officer, a full review of membership of the committee is underway with the CDIO and committee chair and any amendments to the terms of reference will be presented to the Board at a future meeting.

4. Fit and Proper Persons Test (FPPT)

The ICB is obliged to carry out an annual assessment that its directors hold the necessary skills and knowledge to fulfil their roles and meet the requirements of the Fit and Proper Person Regulations (FPPR). By way of formal assessment, ICBs are required to demonstrate compliance with the FPPR to NHS England on an annual basis. For the purpose of this process, “directors” have been deemed to be those senior executive and non-executive directors, who are members of the Board.

In line with section 4.4 of the NHS England Fit and Proper Persons Test Framework, the Board should receive a report on the outcome of the annual FPPT process. This section of the report intends to meet that governance obligations.

With the exception of partner members who are assessed under the FPPT processes within their own Trusts, all Board members (including non-executive directors) and other executive directors have completed an annual self-attestation, confirming they still meet the core elements to be considered a fit and proper person to perform a board role:

- Good character
- Possessing the qualifications, competence, skills required and experience
- Financial soundness.

This process is further supported by the completion of additional searches, such as the Companies House register, Charity Commission register of removed trustees, and professional body checks.

All requirements were met and the Chair was able to successfully submit a return to NHS England by the deadline of 30 June 2025 to confirm no issues had been identified.

5. Recommendation

The Board is asked to APPROVE the amended terms of reference for Audit & Risk Committee and Remuneration Committee.

The Board is asked to NOTE the completion of the Fit and Proper Persons Test requirements for 2024/25 and that no issues were identified.

Appendix A – Updates to key governance documents since August 2024 (last full governance review)

Date	Document	Changes made	Approved by
16.10.24	Greenwich LCP Terms of Reference	1. Membership changes 2. Introduction of annual rotation of chair 3. Increase in frequency of meetings held in public.	Board
16.10.24	Southwark LCP Terms of Reference	1. Added clarification on accountabilities, authority and delegation 2. Membership changes 3. Flexibility added to frequency	Board
29.01.25	Quality and Safeguarding Terms of Reference	1. Membership changes 2. Quoracy changes	Board
29.01.25	Lambeth LCP Terms of Reference	1. Explicitly reference commitment to tackle health inequalities and ensure equitable access to care 2. Add clarity to clause on delegation 3. Add explanations for acronyms and term “place”.	Board
19.02.25	Schedule of Matters Delegated to Officers	1. Delegation of approval for business cases amended in light of new governance arrangements 2. Medical Director added as an approving executive for clinical trials.	Executive Committee
16.04.25	Greenwich Charitable Funds Committee Terms of Reference	1. Membership and “in attendance” changes	Board
16.04.25	Scheme of Reservation and Delegation	1. Addition of delegation of commissioning arrangements for Specialised Services delegated by NHS England.	Board
16.04.25	Integrated Performance Committee Terms of Reference	1. Add receipt of reports where invoices in excess of agreed SLAs have been authorised 2. Add second non-executive member to membership	Board
16.07.25	Clinical and Care Professional Committee Terms of Reference	1. Add emphasis to role in delivering population health management and engagement assurance. 2. Membership changes, including recognition of ICB Deputy Medical Director roles 3. Amendment to quoracy provisions 4. Change of frequency of meetings to quarterly (from minimum of six times per year).	Board

South East London

NHS South East London Integrated Care Board

Audit & Risk Committee

Terms of Reference

September 2025

1. Introduction

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

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

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

2. Authority

2.1. The Audit & Risk Committee is authorised by the Board to:

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

2.2. For the avoidance of doubt, the committee and its members will comply with the ICB Standing Orders, Standing Financial Instructions and the Schedule of Reservation and Delegation (SoRD).

3. Purpose

3.1. To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and

internal control processes within the ICB.

3.2. The duties of the committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.3. The Audit & Risk Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Duties

4.1. The committee's duties can be categorised as follows.

Integrated governance and internal control

4.2. To review the adequacy and effectiveness of the system of integrated governance and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

4.3. To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

4.4. To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives and the effectiveness of the management of principal risks.

4.5. To ensure that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

4.6. To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance and internal control, together with indicators of their effectiveness.

4.7. To identify opportunities to improve governance and internal control processes across the ICB.

Internal audit

4.8. To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion (and management's response) and ensure coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

- Monitoring the effectiveness of internal audit and carrying out an annual review

External audit

4.9. To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the performance of the external auditors, as far as the rules governing the appointment permit
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

4.10. The Audit & Risk Committee shall not have responsibility for appointment or selection of the external auditors. This will be the responsibility of the Auditor Panel.

Risk Management

4.11. To maintain oversight of the ICB's Risk Management Framework, recommending the Framework to the Board for approval.

4.12. To review the adequacy and effectiveness of risk processes across the entirety of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

4.13. To receive regular updates on the ICB's risk register.

4.14. To have oversight of system risks where they relate to the achievement of the ICB's objectives.

4.15. To consider opportunities to improve risk management processes across the ICB and in relation to management of system risk.

Other assurance functions

4.16. To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

4.17. To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit & Risk Committee's own areas of responsibility.

4.18. To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

4.19. To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution and CQC.
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

4.20. To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet the NHS Counter Fraud Authority's (NHSCFA) Requirements for the Counter Fraud Functional Standard and review the outcome of work in these areas. This should include assurance that the ICB has the appropriate "reasonable procedures to prevent the occurrence of fraud" to mitigate the exposure of the ICB to the Failure to Prevent Fraud offence governed by the Economic Crime and Corporate Transparency Act 2023.

4.21. To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss the outcomes of the annual Counter Fraud functional Standard Return (CFFSR).

4.22. To be responsible for ensuring that the counter fraud service submits an Annual Report and CFFSR, outlining work undertaken during each financial year to meet the Requirements of the NHSCFA Counter Fraud Functional Standard.

4.23. To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining work undertaken during each financial year to meet the NHS Standards for Commissioners, Fraud, Bribery and Corruption.

Security

4.24. To assure itself that the ICB has adequate security management arrangements in place internally to identify any specific risks and take mitigating action..

4.25. To receive appropriate update reports and provide scrutiny and challenge where appropriate.

Freedom to Speak Up

4.26. To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical, management, or other matters. The committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

4.27. To receive regular updates from the information Governance Sub-Committee on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

4.28. To provide assurance to the Board that there is an effective framework in place for

the management of risks associated with information governance.

Financial reporting

4.29. To monitor the integrity of the annual financial statements of the ICB and any formal announcements relating to its financial performance.

4.30. To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.31. To approve the annual report and annual financial statements (including accounting policies) for submission, and reporting to the Board, focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the committee
- Changes in accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the Financial Statements
- Significant judgements and estimates made in the preparation of the Financial Statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

Conflicts of Interest

4.32. The chair of the committee will be the nominated Conflicts of Interest Guardian.

4.33. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective, including receiving reports relating to non-compliance with the ICB's policy and procedures relating to conflicts of interest.

Management

4.34. To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.35. The committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

4.36. To receive reports of breaches of policy and normal procedure or proceedings including suspensions of the ICB's standing orders in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

4.37. To receive regular reports on tender waivers approved within the ICB.

Communication

4.38. To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

4.39. To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

5. Membership and attendance

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

5.2. The Board will appoint four members of the committee including two non-executive members of the Board and two partner members of the ICB board (who are not the usual members of the remuneration committee).

5.3. Neither the chair of the Board, nor employees of the ICB will be members of the committee.

5.4. Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit and technical or specialist issues pertinent to the ICB's business. When determining the membership of the committee, active consideration will be made to diversity and equality.

5.5. Only members of the committee have the right to attend committee meetings, however all meetings of the committee will also be attended by the following individuals who are not members of the committee:

- Chief Financial Officer or their nominated deputy
- Representatives of both internal and external audit
- The Chief of Staff or their nominated deputy
- Individuals who lead on corporate governance, risk management, counter fraud and security matters
- Other relevant attendees as requested by the Audit & Risk Committee chair

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

5.7. The chair may ask for a meeting in private with the external and internal auditors at the end of any meeting.

5.8. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), secondary and community providers.

5.9. The ICB Chair and Chief Executive should be invited to attend the meeting at least annually, with an open invitation to attend meetings as they require.

5.10. Where an attendee of the committee (who is not a member of the committee) is unable to attend a meeting, a suitable alternative may be agreed with the chair.

5.11. Regardless of attendance, external audit, internal audit, and local counter fraud providers will have full and unrestricted rights of access to the Audit & Risk Committee.

6. Chair and Vice Chair

6.1. In accordance with the constitution, the committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the committee.

6.2. The chair of the committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

6.3. The Vice Chair will be the second Non-Executive Member.

6.4. The chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

7. Meetings Quoracy and Decisions

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

7.2. The Board, Chair or Chief Executive may ask the committee to convene further meetings to discuss particular issues on which they want the committee's advice.

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

7.4. For a meeting to be quorate 75% of members are required including one Non-Executive Member of the Board.

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

7.6. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

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

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

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

7.10. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Behaviours and Conduct

8.1. Members will be expected to conduct business in line with the ICB values and objectives.

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

8.3. Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and reporting

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

9.2. The minutes of the meetings shall be formally recorded by the secretary and key discussions and decisions will be submitted to each meeting of the Board in accordance with the Standing Orders.

9.3. The Audit & Risk Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements and
- The robustness of the processes behind the quality accounts
- The effectiveness of the committee.

10. Secretariat and Administration

10.1. The committee shall be supported with a secretariat function which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the chair those meetings that do not meet the minimum quoracy requirements
- Records of members' appointments and renewal dates are kept and the Board is prompted to renew membership and identify new members where necessary

- Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The chair is supported to prepare and deliver reports to the Board
- Action points are taken forward between meetings and progress against those actions is monitored.

11. Review

11.1. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
South East London

NHS South East London Integrated Care Board

Remuneration Committee

Terms of Reference

30 September 2025

1. Introduction

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

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

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

2. Authority

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

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

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

3. Purpose

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

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

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

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

4. Duties

4.1. The committee's duties are as follows:

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

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

4.3. For all staff:

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

4.4. For clinical and professional leads:

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

5. Membership and attendance

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

constitution.

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

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

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

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

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

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

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

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

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

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

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

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

6. Chair and Vice Chair

6.1. In accordance with the constitution, the committee will be chaired by a non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the committee.

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

the chair, the vice chair will chair the meeting.

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

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

7. Meeting Quoracy and Decisions

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

7.2. The committee will meet in private.

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

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

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

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

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

8. Decision making and voting

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

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

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

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

9. Procedure of decisions made outside of formal meetings

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

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

10. Behaviours and Conduct

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

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

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

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

11. Accountability and reporting

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

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

11.3. The Remuneration Committee will submit a report on activity as part of the Boards committee summary ~~to part 2 of the Board following each of its meetings~~. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

12. Secretariat and Administration

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

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

13. Review

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

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

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

Integrated Care Board

Clinical and Care Professional Committee (CCPC)

Terms of Reference

[XX] March 2025

1. Introduction

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

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

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

2. Purpose

2.1. It is recognised that ensuring clinical and care professional leadership is integral to the way we work as a system and will require a distributed approach across the health and care partnership.

2.2. The committee has responsibility for providing clinical leadership in support of ICB decision making and for convening a broader network of clinical and care leaders to support existing leadership in the system.

2.3. The ICB and Integrated Care Partnership have committed to clinical and care professional leadership and alignment with the five ICS clinical and care professional leadership design principles included within national ICS implementation guidance[1]:

1. Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

2. Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf

3. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.

4. Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (e.g. managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).

5. Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

2.4. This committee is designed to operate in a way that interlinks to other key decision-making parts of the ICB and broader system's governance arrangements. The CCPC creates a forum in which decisions with a direct clinical impact can be considered and recommendations made to the ICB; it is additive and complementary - where a single conversation with representatives across the SEL system is required.

2.5. The CCPC will support ICB decision making and enable change through its recommendations and by escalation and influence. It will ensure a multi-professional perspective, establish a more systematic improvement and transformation method linked to population health, and share learning and best practice through ICB and regional channels.

2.6. In addition, the CCPC will provide a senior clinical forum for discussion of clinical matters requiring a system-level decision (e.g., regarding Patient Group Directions). In these cases the CCPC will determine if a formal decision is required by the ICB, or if a decision can be made by the CCPC as a clinical leadership group.

2.7. The CCPC will, together with other relevant ICB committees and groups, undertake the following functions on behalf of the ICB:

2.8. **Learning system** – lead coordination of the ICB's approach to becoming a learning system, including a population health management approach, transformation, improvement, evaluation and other components of learning system culture across the full scope of the ICB's activities. This will support the ICS-wide focus on tackling health inequalities.

2.9. **Health inequalities** – to promote and support clinically-led work to tackle health inequalities in southeast London.

2.10. **System-wide clinical and care strategy** – to review and provide clinical advice and guidance in relation to the development of operational and strategic plans

2.11. **Care pathway transformation and innovation** – routine review of new or proposed clinical pathways to understand and advise on clinical impact, workforce implications, key messages and implementation requirements.

2.12. **Patient and public engagement** – to support the ICB's approach to patient and public engagement as part of our People and Communities strategic framework and take assurance on the organisation's engagement activities and processes from the Engagement Assurance Committee (EAC).

2.13. **Sustainability** – to support work which improves the sustainability of clinical and care services across southeast London.

2.14. **Continuous improvement and innovation** – to drive forward the improvement and innovation agenda across the partnership, ensuring learnings and good practice are disseminated and embedded and that innovation in other areas are harnessed and enacted in south east London.

2.15. **Clinical and care professional development** – together with ICB workforce leaders to lead an on-going development and support offer for clinicians and care professional leaders within the ICS and ensure leaders maximise their impact their respective areas of interest and across the partnership more broadly.

2.16. **Establishing a broad-based and multi-disciplinary ICB clinical senate** – with the aim of significantly enhancing the breath of clinical input and expertise in the development of clinical strategy and proposals for clinical transformation.

2.17. **General clinical advice and input into other ICB functions** – to receive requests from other key ICB functions where clinical advice and input is required. This will include the below functions as a minimum:

- Workforce resilience linked to the ICB Workforce programme.
- Quality assurance and safety linked with IBC Quality & Performance Committee, System Quality Group and CNO and CMO membership.
- Professional leadership support and development linked to the ICB Workforce programme and workforce lead role membership.
- ICB care pathway and enabler work programmes.
- Leadership in research and evidence.
- Care standards as requested by ICB, ICS or regional programmes.

3. Duties

3.1. The committee is an integral part of the wider ICB governance arrangements and will maximise its impact by working in close alignment with other parts of the organisation's governance: key committees, ICB clinical transformation programmes and enabler programmes. The CCPC will operate with the following distinct responsibilities:

3.2. To oversee the ICB's approach to becoming a learning system in support of the ICS's focus on tackling health inequalities, including population health management.

3.3. To oversee the ICS's approach to patient and public engagement as part of our People and Communities strategic framework. This includes receiving the minutes of the Engagement Assurance Committee with reports by exception.

3.4. To provide clinical and care professional input into ICB / ICS programmes and other key functions. This will involve detailed consideration of information on clinical strategy, service and pathway changes and will involve the committee considering impacts and making recommendations to inform the proposed change. The committee may also consider information on risks or issues which have been identified with a potential clinical impact and advise on these accordingly.

3.5. To direct cross-system clinical work where there is not a programme established to own that activity.

3.6. To offer a review and constructive challenge of clinical proposals or cases for change developed within the ICB or broader ICS partnership, and to provide commentary and, where it supports ICB decision making, recommendations to the ICB regarding the direct clinical impact of proposals, projects and other changes.

3.7. Interact with region and other partners outside of the ICS in order to input from a clinical perspective to regional programmes and to understand and adopt learning and innovation from other places.

3.8. To convene a broad-based, multi-disciplinary clinical and care professional leaders' forum with broader representation from system clinical and care clinical leadership to engage a broader cohort of clinical leaders on matters related to clinical strategy, transformation and programmes of change.

4. Accountabilities, authority, and delegation

4.1. The authority delegated to the committee is set out in the ICB's Scheme of Reservation and Delegation.

4.2. The committee will act to agree and report against all duties within its scope as recorded in section 3 (above). It will report on its activities to the ICB Board on a minimum annual basis.

4.3. The committee is responsible for overseeing activities related to becoming a learning system, including population health management, and engagement assurance.

4.4. The committee will receive the minutes, and reports by exception, from the Engagement Assurance Committee and any sub-committees created.

4.5. The committee will be provided with a regular opportunity to hear from representatives of its sub-committees. It will be able to act on recommendations or proposals that arise at its sub-committees in line with the ICB Scheme of Reservation and Delegation.

4.6. The committee will, together with the ICB Planning and Finance Committee, operate dual reporting lines from ICB care pathway programme boards and key enabler programme boards and workstreams where appropriate. The CCPC will receive updates on progress from clinical leaders in these programmes and offer its support and clinical input as requested.

4.7. The committee may establish a working group or task and finish group to lead work under a defined term of reference/ engagement. The committee must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

5. Membership and attendance

5.1. The committee members shall be appointed by the Board in accordance with the ICB Constitution. When determining the membership of the committee, active consideration will be made to equality, diversity and inclusion.

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

5.3. The membership seeks to incorporate a broad clinical representation from across the health and care system in south east London; including representation from acute trusts, community providers, mental health providers, general practice, nursing, the ICB executive leadership team, and social care.

5.4. ICS partners must nominate appropriate clinical representatives. Representatives are responsible for discussing papers with relevant colleagues prior to the meeting and must be able to provide input into the discussion. Representative members may change between postholders on a meeting-by-meeting basis to suit the topics being discussed.

5.5. The committee will be constituted of the following postholders:

- ICB Medical Director (Co-Chair)
- ICB Chief Nurse (Co-Chair)
- ICB Deputy Medical Directors
- 1 x SEL Director of Public Health or Consultant in Public Health
- Clinical Representative (MD or CNO, or delegate)
    - Guy's & St. Thomas' NHSFT
    - King's College Hospital NHSFT
    - Lewisham and Greenwich NHS Trust
    - Oxleas NHSFT
    - South London and Maudsley NHSFT
    - Bromley Healthcare
- 1 x Clinical Lead ICB Primary Care Group
- ICB Chief Pharmacist

- CCPL lead from each Borough
- Clinical lead for Digital
- SEL ICS Director of Voluntary Sector Collaboration and Partnerships

5.6. Committee members will be responsible for ensuring relevant issues or activities within their own organisation are discussed where they are relevant to the work of the committee. Intelligence should be shared with the committee from other discussions held within organisations, partnerships or at a regional level.

5.7. It is expected that members can make decisions on behalf of their organisations (up to the limits delegated to them) and do so within any set timeframe, securing sign off and cascade from own organisations where applicable.

5.8. In addition to the standing membership, other individuals from across the Integrated Care System may be invited to attend as required. It is anticipated that representation from ICS clinical networks / collaboratives and transformation programmes will be requested by the committee on a regular basis. It will also be ensured that a representative of the ICB Quality Directorate is present, if no attending members fulfil this role.

5.9. The committee is permitted with agreement of the chair and a majority of members to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary.

6. Chair of meeting

6.1. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

6.2. The meeting will be co-chaired by the ICB Medical Director and ICB Chief Nurse Officer. These post-holders will chair the meeting in sequence.

6.3. At any meeting of the committee, the designated chair for that meeting if present shall preside. If the chair is absent, the co-chair shall preside. If the designated co-chair is temporarily absent on the grounds of conflict of interest, the other co-chair shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of members of which the following must be present:

a. The ICB Medical Director or ICB Chief Nurse

b. 3 x representatives of partner organisations

c. 3 x CCPL Borough representatives

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

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

7.4. Committee members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

4. Decision-making

7.5. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote. In the event of equal votes, the chair will have a casting vote.

8. Procedure of decisions made outside of formal meetings

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

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

9. Frequency

9.1. The committee will meet every three months

9.2. All members will be expected to attend all meetings or to provide their apologies, or an alternative representative where appropriate, in advance should they be unable to attend.

9.3. Members are responsible for identifying a suitable deputy should they be unable to attend a committee meeting which needs to be agreed with the chair and notified in advance.

9.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the committee chair.

9.5. Members and staff from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the committee.

10. Reporting

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

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

10.3. The committee will also provide reports as requested to other relevant ICS committees and/ or bodies (e.g., the Neighbourhood Based Care Board, the Acute Provider Collaborative, etc.)

10.4. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

11. Committee support

11.1. The committee will be supported by members of the ICB's governance team.

11.2. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Monitoring adherence to the Terms of Reference

12.1. The co-chairs of the committee will be responsible for ensuring the committee abides by the terms of reference.

13. Review of Arrangements

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

13.2. These terms of reference shall be reviewed by the committee chair and ICB chair on an annual basis, with changes proposed for approval to the ICB Board.

NHS
South East London

Integrated Care Board

Greenwich Local Care Partnership Committee (Healthier Greenwich Partnership)

Terms of Reference

11 September 2025

1. Introduction

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

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

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

2. Purpose

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

a. The place contribution to the ICB's agreed overall planning processes including the effective planning and delivery of place based services to meet the needs of the local population, with a specific focus on community based care and integration across primary care, community services and social care, managing the place delegated budget, taking action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local Care Partnership to ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider ICS.

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

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

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

d. The Healthier Greenwich Partnership will ensure representation and participation in the wider work of the ICS and Integrated Care Board, contributing to the wider objectives and work of the ICS as part of the overall ICS leadership community.
e. The Healthier Greenwich Partnership will be the prime committee for discussion and agreement for its agreed specific local funding and functions and will work as part of the South East London ICB
f. The committee is responsible for managing the annual plan, budget and performance to ensure best value and optimal outcomes. It must oversee delivery and escalate material risks to the South East London ICB as needed.

3. Duties

3.1. **Place-based leadership and development:** Responsibility for the overall leadership and development of the Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes, development and relationship building activities and meaningful local community and resident engagement. This will include developing relationship with other parts of the system that may operate at place including the acute provider collaborative, the mental health collaborative and community networks to ensure the join up of services at place. The LCP also needs to support the Place Executive lead to ensure they can represent LCP views effectively whilst also considering the needs of the wider ICS.

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

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

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

To review and process decisions referred to the partnership by programme boards when those decisions directly impact local population, health, care and wellbeing.

3.5. **Finance:** The South East London ICB has delegated budgets to the Healthier Greenwich Partnership committee, including running costs, with responsibility resting with the Place Executive Lead. Decision making and further delegation follow the Standing Financial Instructions, Standing Orders and Delegated Matters outline in the ICBs constitution.

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

4. Accountabilities, authority and delegation

4.1. The LCP Committee is accountable to the Integrated Care Board of the SEL Integrated Care System.

4.2. The LCP Committee will provide regular updates to the Health and Wellbeing Board ensuring the alignment of work.

5. Membership and attendance

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

a. Place Executive Lead, ICB
b. LCP Clinical & Care Professional Lead, ICB
c. 1 x Local authority adult social care - Director of Adult Social care, RBG
d. 1 x Local authority children's services - Director of Children's Services, RBG
e. 1 x Local authority public health - Director of Public Health, RBG
f. 2 x Primary care (Nominated PCN Directors)
g. 1 x Community services provider –Director of Children & Young People's Services, Oxleas
h. 1 x Mental health services provider, Chief Operating Officer- Oxleas
i. 1 x Acute services provider – Board Director, LGT
j. VCSE sector –METROGAVS
k. VCSE sector – large commissioned VSCE provider representative

5.2. In addition to the core membership, the following non-voting members will be members of the Healthier Greenwich Partnership

a. 1 x Healthwatch - Chief Executive
b. 1 x LMC Representation (Greenwich) - Chair LMC
c. 1 x GP Federation Representative - Director, Greenwich Health
d. 2 x Integrated Commissioning Directors - joint postholders RBG/SEL ICB
e. Director of Primary Care & Neighbourhoods
f. 1 x Nominated representative from Greenwich Local Pharmaceutical Committee
g. Clinical and Care Professional Leads (as appropriate for agenda) ICB nominated - Non-Executive Director

6. Chair of meeting

6.1. The committee would have a rotational chairing arrangement. The chair would be appointed by the committee on a rotational basis from the membership. The committee would also appoint a vice chair who would be from a different organisation.

6.2. The committee will appoint the outgoing chair as the vice chair on a rotational basis.

6.3. At any meeting of the committee the chair or vice chair if present shall preside.

6.4. If the presiding chair is temporarily absent on the grounds of conflict of interest, the vice chair shall preside, or, in the case that they also may not, then a person chosen by the committee members shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of voting members of which the following must be present (or their nominated deputies):

- Chair
- Two of the following:
  - Place Executive Lead,
  - Director of Adult Social care, RBG
  - Director of Children's Services, RBG
  - Director of Public Health, RBG
- 1 x Primary care
- Either Director of Children & Young People's Services, Oxleas or Chief Operating Officer- Oxleas
- Board Director, LGT
- Director of Strategy, METROGAVs

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

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

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

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

8. Decision-making

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

9. Frequency

9.1. The committee will meet once every quarter (in public) with ability to have closed session as Part B in addition to this.

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

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

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

10. Reporting

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

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

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

11. Committee support

11.1. The LCP will provide business support to the committee. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Review of Arrangements

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

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Performance Report**					
Meeting date	15 October 2025	Agenda item Number	8	Paper Enclosure Ref	H	
Author	ICB Risk and Assurance and ICB Performance teams					
Executive lead	Sarah Cottingham, Executive Director of Planning					
Paper is for:	Update	x	Discussion		Decision	
Purpose of paper	The report provides the Board with a summary of current system performance across a range of national performance metrics. It is intended to ensure Board members are appraised of progress against key operational planning commitments for 2025/26 and understand the areas of challenge, risk and improvement focus. The report supports the Board's oversight and assurance of delivery by setting out the latest available data and together with a summary analysis across a range of key performance areas, including urgent and emergency care, cancer, referral to treatment, diagnostics, primary care, mental health, community services and continuing healthcare. Where performance is below trajectory, the paper outlines the agreed recovery actions and improvement trajectories					
Summary of main points	The report shows encouraging progress in a number of areas. SEL combined trust performance against the 4-hour A&E performance target has broadly been in line with improvement trajectories during 2025/26, though has narrowly missed the month 5 target. System level performance against the faster diagnosis standard has improved during 25/26 and is above the agreed trajectory to achieve the 80% target by year end. GP appointment volumes remain above plan, with good uptake of Pharmacy First clinical conditions and hypertension services in community pharmacy. The inpatient and health check targets for people with a learning disability and autistic people are also above planned trajectories to meet the year end targets. At the same time, significant pressures remain. These include in urgent and emergency care, mental health crisis presentations and demand for admissions, waits for community paediatrics and diagnostics. Referral to					

	treatment long waits (65 week +) have continued to increase, and some challenges persist in securing mental health access targets. The paper outlines the recovery actions underway across these areas and notes changes to future reporting to reflect updated 2025/26 operational plan requirements. It should also be noted that the Chief Executive of the NHS recently wrote to ICBs and NHS trusts about the mid-year review process. This will take stock of progress against key priorities, look at where there might be risks that need mitigation, and work through opportunities that could be expedited in the second half of the financial year. The review will cover a range of related priorities across finance, quality and performance. Recovery trajectories will be developed for key performance areas identified as being off track.						
Potential conflicts of Interest	None						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	Not directly applicable to the production of this paper.						
Financial Impact	Not directly applicable to the production of this paper.						
Public Patient Engagement	Not directly applicable to the production of this paper.						
Committee engagement	ICB Executive Committee, 1 October 2025						
Recommendation	The Board is asked to note the update and consider any implications for system assurance and delivery oversight.						

South East London Integrated Care System

NHS South East London

SEL System Performance Summary October 2025

SEL ICB Board - 15 October 2025

South East London Integrated Care System

Contents

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

Area	YTD summary and key issues

Urgent & Emergency Care (UEC)	• Performance across 25/26 has remained broadly in line with improvement trajectories for the 4-hour performance standard, and there has been some gains in handover delays.
	  ○ SEL trusts combined view of 4-hour performance in August was 72.2% (based on SitRep data), which narrowly missed the month 5 trajectory for combined trust performance.
	  ○ SEL 'footprint' performance, which includes activity from stand alone Urgent Treatment Centres, was 76.8%.
	• The new target for the percentage of 12-hour delays (from arrival) has not been met year to date
	• Demand, capacity and flow challenges continue across physical and mental health, with ongoing improvement work across the care pathway. This includes embedding discharge and admission avoidance models. There continues to be a focus on reducing the number of delayed days post-discharge ready date (DRD) and the number of patients with a length of stay of over 7 days.

Cancer	• System level performance against the faster diagnosis standard has improved during 25/26 and is above the agreed trajectory to achieve the 80% target by year end. • The proportion of lower gastrointestinal referrals accompaniment by a faecal immunochemical test (FIT) result has increased each month during 25/26 and remains above the planned trajectory. • The treatment backlog position has also remained low through the year. • 62 day performance, however, has remained a challenge for the system. The system focus continues to be improving pathway efficiency, inter-trust transfers, treatment capacity. Focused support is being provided to address service and provider level specialty challenges, with a focus on urology, lung and breast services.
Referral to Treatment Times (RTT)	• While there has been significant focus on RTT performance, including a renewed emphasis and focus on the implementation of transformation initiatives, 65-week-waits have recently risen following a period of downward movement at the end of 24/25. There is an enhanced focus in SEL on the system and process changes needed to optimise the management of long waiters. • Urology, ENT and gynaecology are the most challenged specialties for long waiters and remain priority areas for recovery. Progress in outpatient transformation and demand management is expected to support system performance improvement in the second half of 25/26.
Diagnostics	• Diagnostic performance remains an area of significant system challenge. Year-to-date performance has been affected by sustained pressure on key modalities such as non-obstetric ultrasound, 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. SEL wide demand and capacity reviews for imagining are underway as part of syst sustainability.

Summary of YTD position – October 2025 (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. Crisis services have seen high levels of Emergency Department (ED) presentations and demands for admission. The number of inappropriate out of area placements has, however, remained stable and below the planned trajectory during 2025/26. • All providers are delivering internal flow improvement plans, and system-wide work is underway to reduce ED delays and support timely discharge. Data quality improvements and updated trajectories are in place as part of 2025/26 plans. • Urgent Children and Young People (CYP) eating disorder targets have been met and the number of people with SMI receiving physical health checks was inline with internal trajectories for quarter one of 24/25. The Talking Therapies reliable recovery and improvement rate targets were met during quarter one of the year. However, these were narrowly missed in July. The number of people completing a course of Talking Therapies has been increasing during the year but remains below the planned trajectory. As does the number of people accessing perinatal services. Actions are in place to support improvement in these areas
Primary care access	• Appointment levels have exceeded plan year-to-date with the growing adoption of digital services and enhanced access models. Appointments totalled 826,297 in July 2025 against an operating plan target of 762,051. • Borough-level improvement plans are now in place, and all boroughs are engaged in actions to better understand and target support for practices showing variation in access levels. Capacity pressures and rising demand continue to impact patient experience in some areas. Boroughs are also planning for expected winter pressures. • All 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 91% of SEL community pharmacies providing all three services as of June 2025. Since the start of the *Pharmacy First* service across community pharmacy in SEL in February 2024, there have been approximately 120k consultations for the seven clinical conditions, approximately 195k for hypertension consultations (blood pressure and ambulatory monitoring), and 21k oral contraception consultations (both initiation and ongoing supply) up to July 2025. • Ongoing work is focused on improving referral pathways, data quality and promoting services in community pharmacy.

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

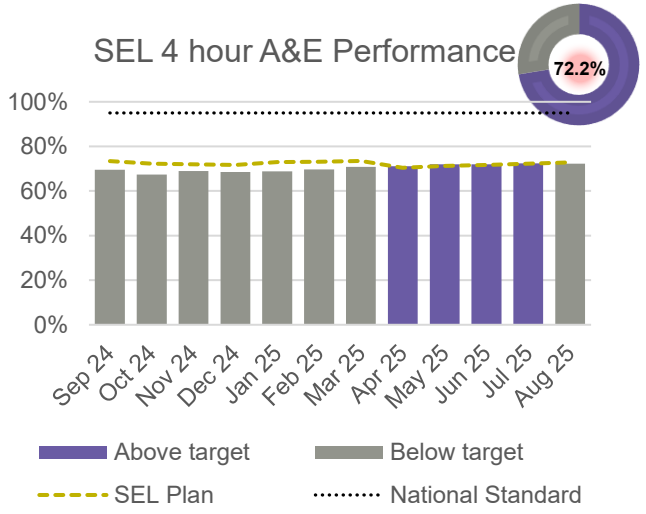
Area	YTD summary and key issues
Community waits and urgent community response (UCT)	• Long community waits have decreased in children's services and have stayed consistently low in adult services. The number of people waiting over 52 weeks, however, remains above trajectory and this continues to be a significant challenge particularly in community paediatrics. Demand continues to exceed capacity in key services, and system-wide recovery planning is underway to support backlog reduction and improved reporting. • SEL is not meeting the national UCR rate of referrals per 100,000 population target of 180. This has been a relatively consistent position during 2025/26. Workforce capacity within UCR services is a significant reason for referrals not being accepted. Work has commenced with providers to better understand this and develop options for change utilising learning from other systems in London.
Virtual ward	• Virtual ward capacity has exceeded plan year to date, though utilisation has varied due to data and operational challenges. Support is being offered to improve data submission rates. Workshops are taking place with key stakeholders to build a joint vision for urgent community-based care that will optimise existing pathways and resources.
Continuing healthcare (CHC)	• CHC performance improved across 2024/25 and into 2025/26, with delivery of the national 28-day standard in most months and a reduction in backlogs for reviews. There is variation in the number of overdue standard CHC and fast track reviews across the 6 boroughs. There has been a general trend of improvement though this remains a pressure in some areas. • August 2025 performance (local reporting) against the number of referrals completed within the 28-day timeframe was 90% which remains above the national target of 80%. The number of incomplete referrals over 12 weeks remained at zero which is inline with the national standard.
Learning disability and autism	• At the end of Q1 the inpatient target trajectory was being achieved and, two months into Q2, is on track to achieve the end of Q2 target despite a significant increase in admissions. • Increasing demand for all age autism assessments remains a system-wide challenge. Work is progressing on CYP Neurodiversity Hub and diagnostic pathway redesign, community development and Right to Choose accreditation for providers to support further improvement in 2025/26. • All boroughs in south east London are achieving the annual health check (AHC) trajectory to achieve the agreed 75% target for 2025/26

Urgent & Emergency Care

South East London Integrated Care System

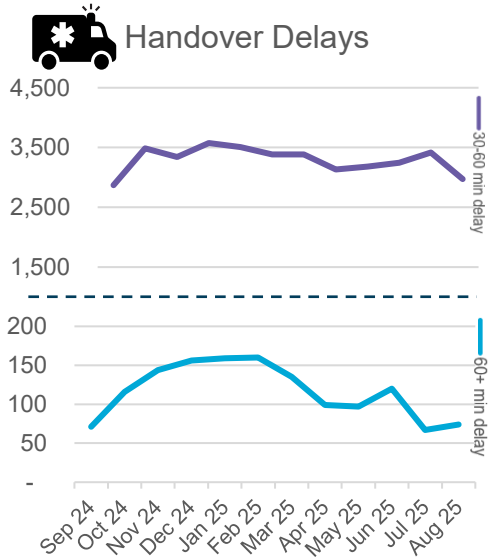
Notes and Issues

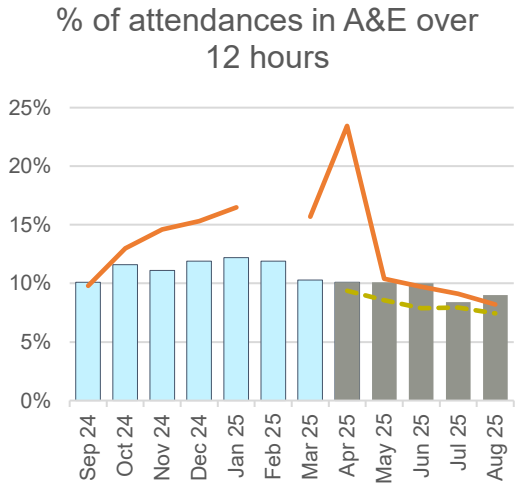
- ED performance – August SitRep data showed performance of 72.2% across the three acute trusts. Published performance for SEL in August (including standalone UTC activity) was **76.8%**, a small deterioration on the 76.9% reported in July.
- Ambulance handover delays decreased in August. However, there was a small increase in the number of delays over 60 minutes.
- Bed occupancy levels decreased with overall occupancy of 94%.
- The new target for the percentage of 12 hours waits (from arrival) has not been met so far this year. Performance in August was 9.0% compared to a trajectory of 7.4%.
- The target for the percentage of patients discharged on their discharge ready date (DRD) was not achieved in south east London. A higher than planned average length of stay post DRD was also reported.

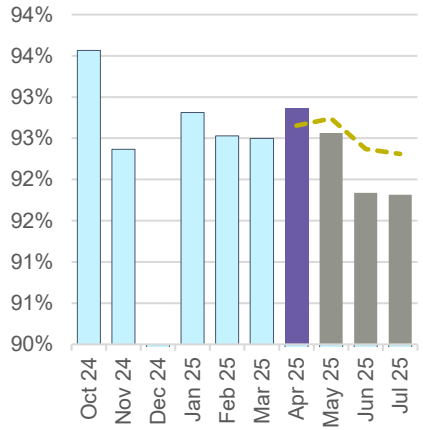


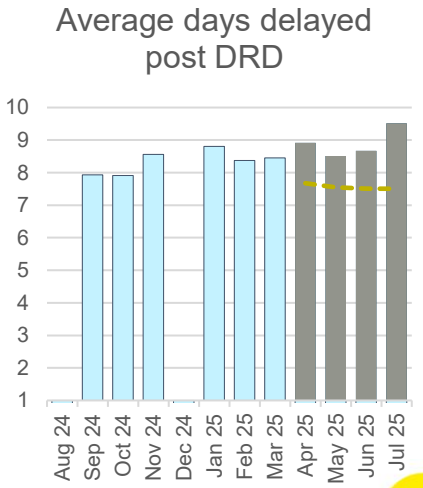
Recovery Actions

- Local systems and providers are implementing plans for 2025/26 to help deliver agreed improvement trajectories. Improvement actions 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.
- There is a regional/national focus on reducing delays beyond discharge ready date (DRD) and the number of patients with a length of stay greater than seven day.
- The new BI dashboard to support UEC recovery and new areas of focus highlighted in the new Urgent & Emergency Care Plan was published in July.









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

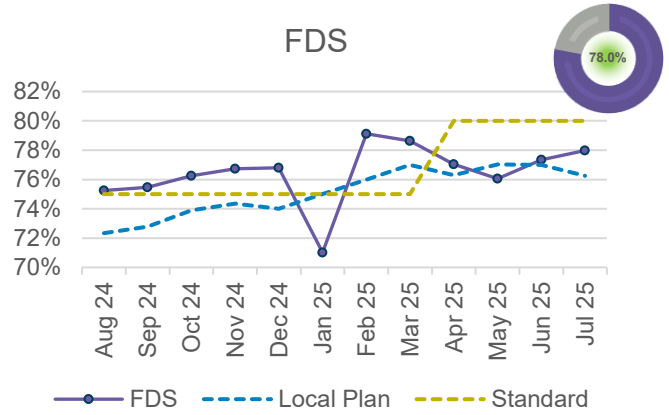
Linked to Risk: 386

Cancer

Actual
Standard Target
Operational Plan

Notes and Issues

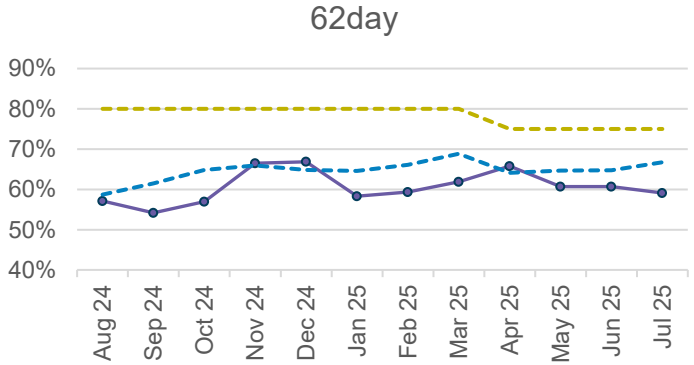
- Faster Diagnosis Standard (FDS) performance remains robust at a system level and trajectories have been agreed to meet the national aim of reaching 80% by year end.
- 62 day performance remains a challenge for the system. Timely and effective Inter-Trust Transfer are a critical focus to improve performance. Focussed support is being provided to address service and provider level specialty challenges, with a focus on urology, lung and breast services.
- Backlog position has remained low although is now not required to be formally monitored vs a planned trajectory
- The system continues to perform well against the Faecal Immunochemical Test (FIT) targets. FIT is used to support referral for suspected lower gastrointestinal cancer.



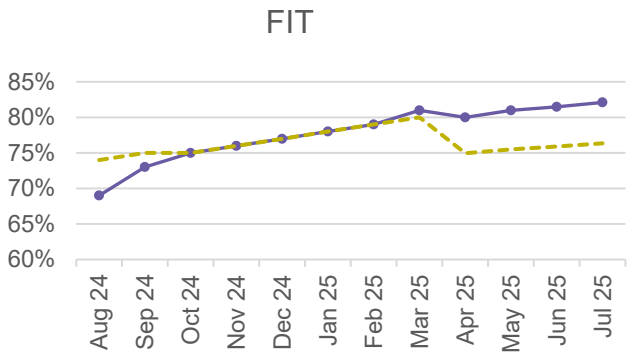
Faster Diagnosis Standard (Standard Target 80%)
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days

Recovery Actions

- Streamline cancer pathways and optimise diagnostics.
- Ensure timely communication of diagnoses and cancer rule-outs within 28 days.
- Promote utilisation of rapid diagnostic clinics, FIT testing, teledermatology, and personalised stratified follow-up.
- Improve early diagnosis, patient experience, and resource utilisation.
- Participate in national trials and programs to contribute to advancements in cancer detection and management
- Waiting list validation and review including clinical review.
- Increased theatre capacity
- Cancer is recognised as a priority pathway within capacity planning.

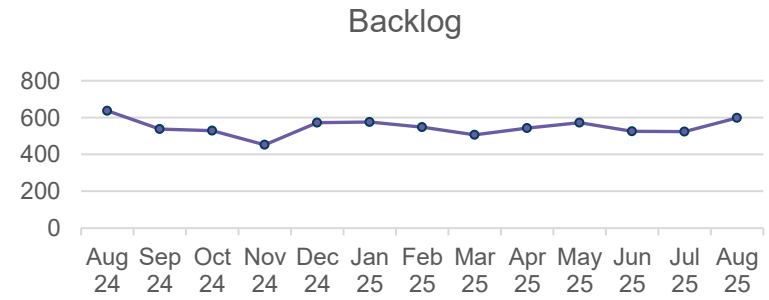


(Standard target 75%)
% of patients with first treatment within 62 days of urgent GP referral



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. We have included this for information purposes at this time.



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

Linked to Risk: SEL 504

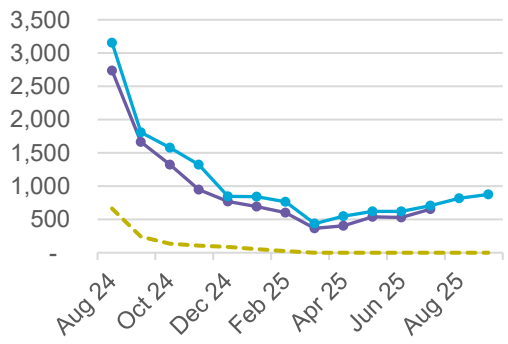
Referral to Treatment: Long Waiters

Latest Published month	Jul 25
Previous Published month	Jun 25
Latest weekly data	07/09/25
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

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

65 week waits

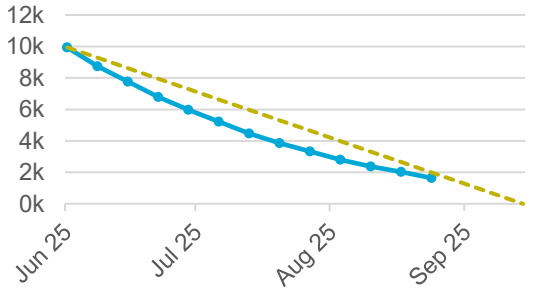


There are currently **876** patients at SEL Trusts who have been waiting more than 78 weeks to start treatment.

Recovery Actions

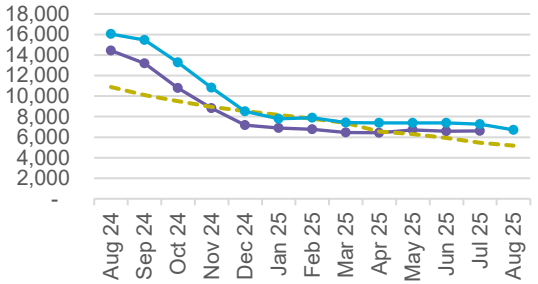
- Waiting list validation including the sprint programme. This includes additional funding for trusts who can validate waiting lists at levels above those achieved in previous years.
- Introduction of straight to test, patient initiated follow up (PIFU) to release more capacity for first outpatient appointment
- Addressing cross-site disparity in waiting times by equalising waits
- 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

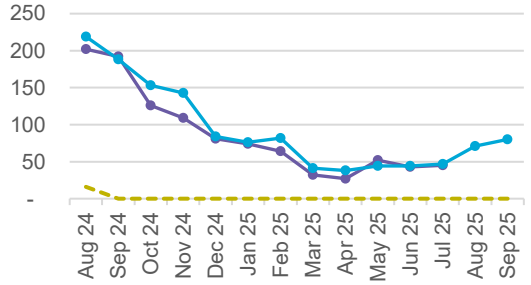


(total pathways which will breach 65+ weeks by 30/09/2025 if not seen)

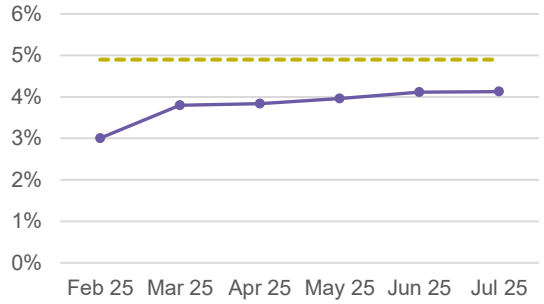
52 week waits



78 week waits



PIFU



RTT Patients still waiting Jul 25

	52+	65+	78+	104+
This month	**6,609**	**656**	**45**	**3**
Plan	× 5,467	× -	× 0	× 0
Last month	▲ 36 (0.5%)	▲ 125 (19.1%)	▲ 2 (4.4%)	▲ 2 (66.7%)
Latest week	**6,494**	**876**	**80**	**12**

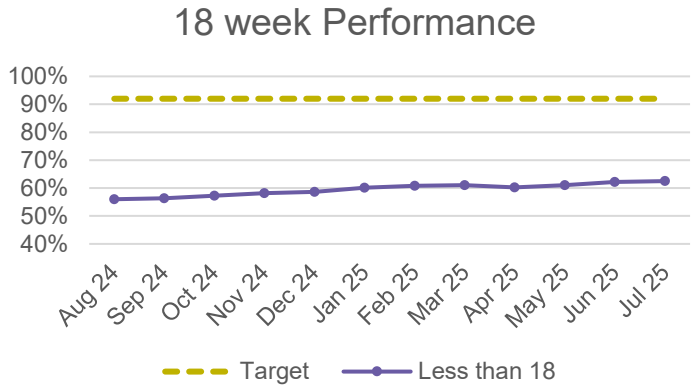
Linked to Risk: 384, 385

Referral to Treatment: Demand Management

Latest Published month	Jun 25
Previous Published month	May 25
Latest weekly data	10/08/25
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

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

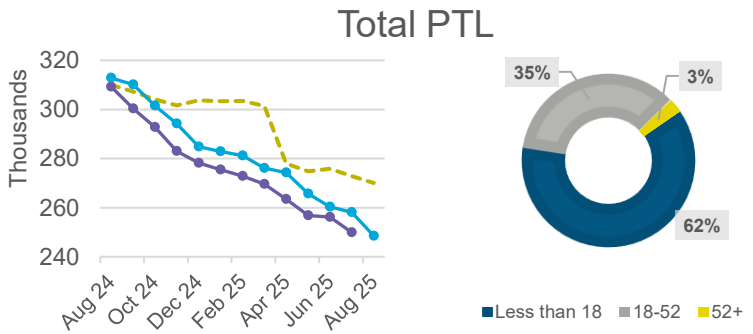


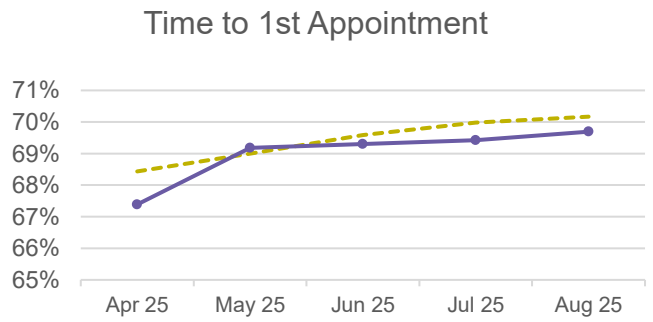
Recovery Actions

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

RTT Patients still waiting Jul 25

	Total	<18 ww	18 week perf
This month	**249,877**	**156,159**	**62.49%**
Plan	✓ 310,010		× 92%
Last month	▼ -6274 (-2.5%)	▼ -3036 (-1.9%)	▲ 0.3% (0.6%)
Latest week	**248,400**	**151,683**	**61.06%**





Demand Management Metrics

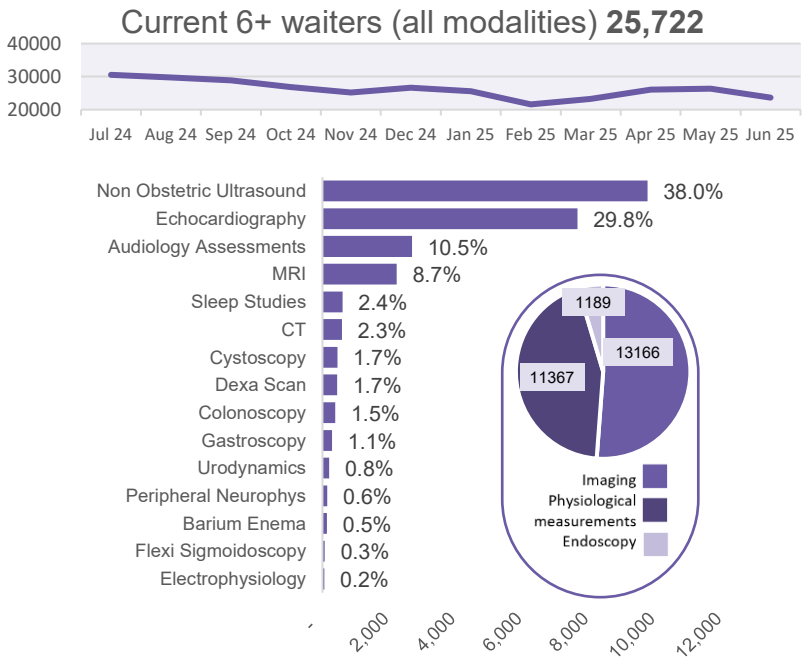
	Current (Jun-25)	Previous (May-25)	Trend
e-RS Advice & Guidance			
Provision	40%	39%	▲
Turn Around Time	65%	62%	▲
Diversion Rate	77%	79%	▼
Referral Triage			
Provision	34%	33%	▲
Turn Around Time	61%	60%	▬
Diversion Rate	13%	13%	▬

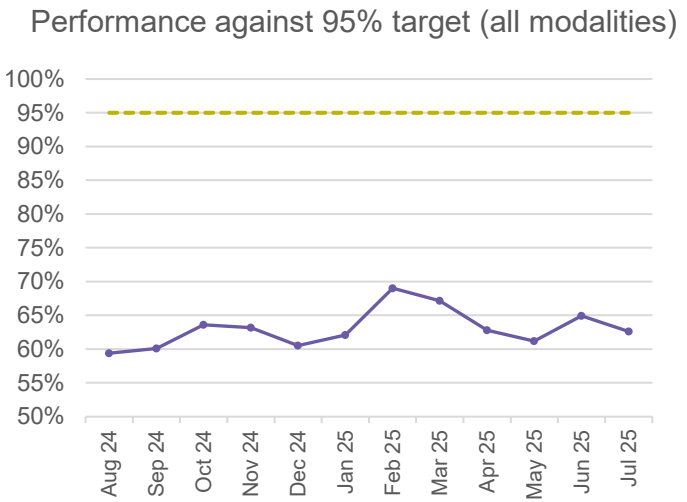
Linked to Risk: 384, 385

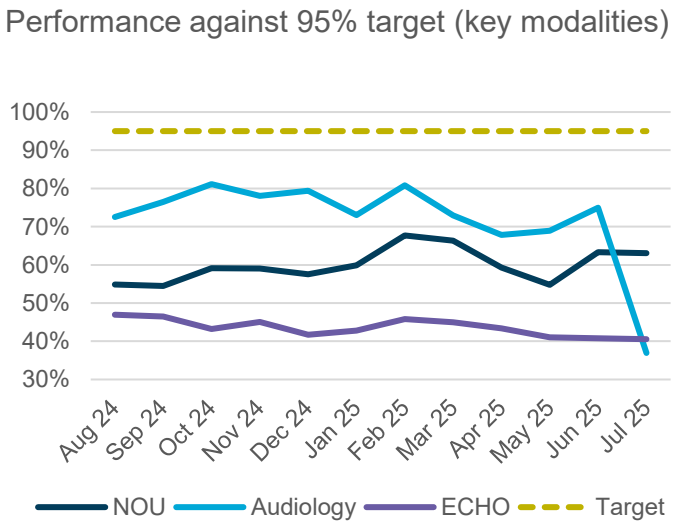
Diagnostics

Notes and Issues

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

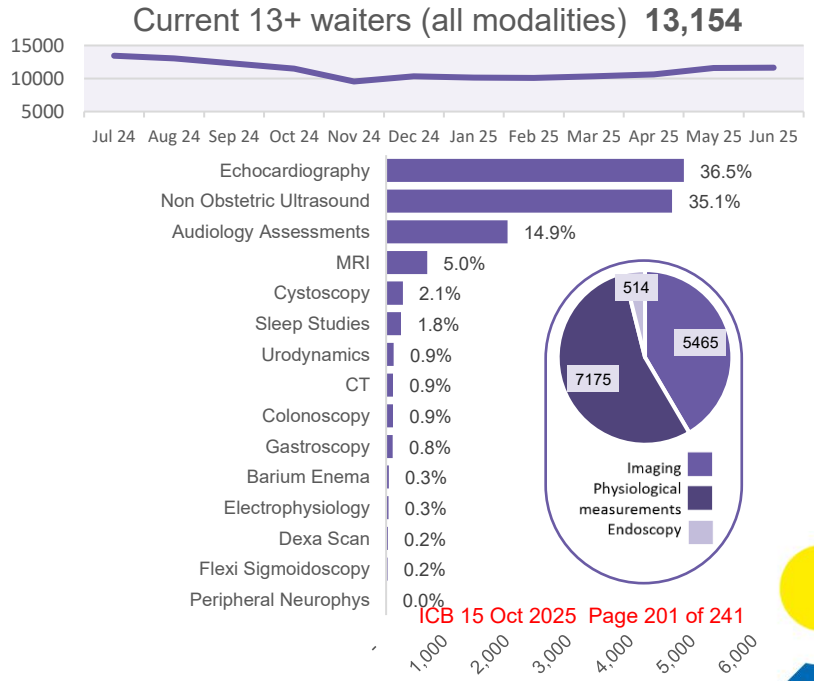






Recovery Actions

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



Mental Health

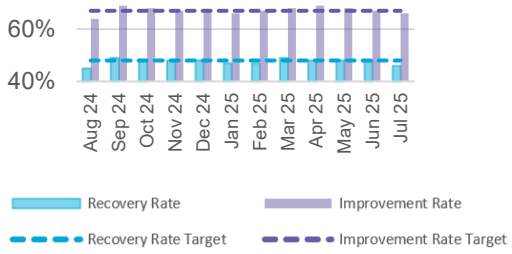
Actual
Target

Notes and Issues

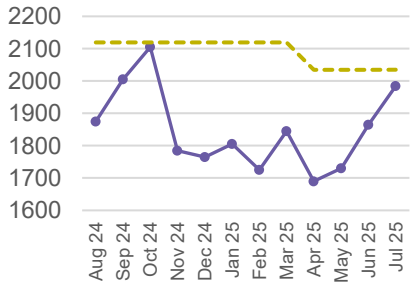
- The waiting times target for urgent children and young people (CYP) eating disorder referrals was met in July. The target for routine referrals was, however, not met.
- CYP access performance remains below target in July. Performance is expected to improve over the coming months as data issues are rectified.
- The number of patients completing a course of Talking Therapies has been increasing since May in SEL. However, it is still below planned trajectory. The targets for reliable recovery and improvement rates were narrowly missed in July. Noting that they were achieved in all months during quarter one of this year.
- Perinatal access is also narrowly below planned trajectory with a reported performance of 1,655 vs a target of 1,742 in July 2025.
- The number of physical health checks for people with SMI, which is a corporate objective, reduced in quarter 1 2025/26 but is aligned with internal planned trajectories. Performance remains variable by borough.

Talking Therapies (IAPT)

Improvement[1] & Recovery[2] Rates



Numbers Discharged

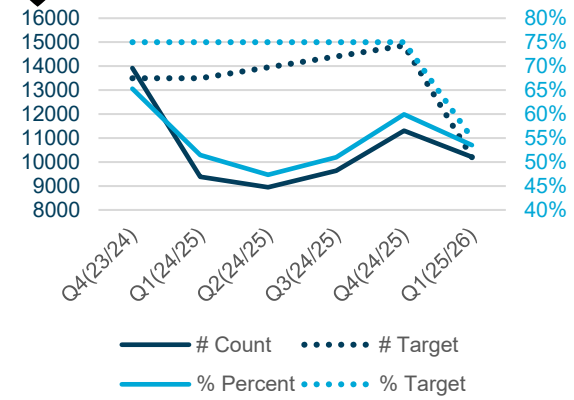


1. Reliable improvement rate for those completing a course of treatment.

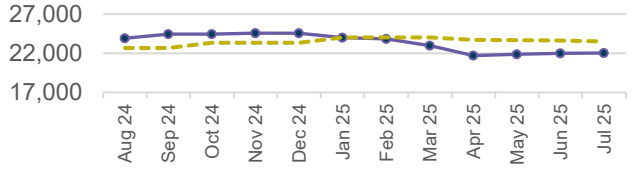
2. Reliable recovery rate for those completing a course of treatment and meeting caseness

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

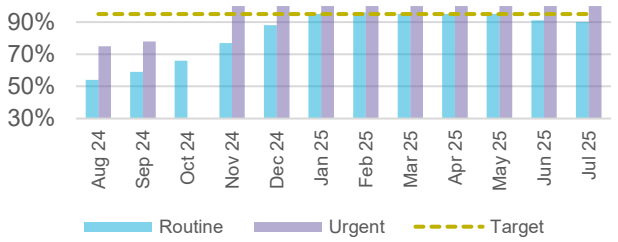
SMI Physical Health Checks



No. young people accessing NHS funded MH services



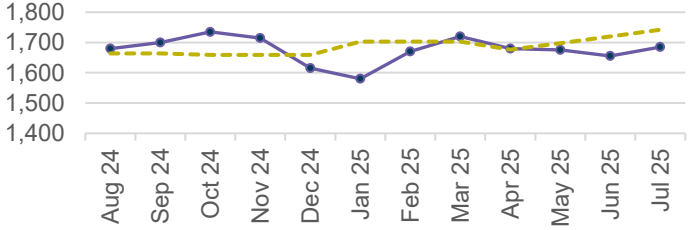
CYP Eating Disorders: percentage achieving standard



Recovery Actions

- Continued support available to ensure all providers can submit data.
- Data Quality Improvement Plans embedded in the contracts for both Oxleas and SLAM. Plans are being revised following a review of the refreshed 2024/25 MHSDS submissions
- 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.

Number of people in contact with perinatal services

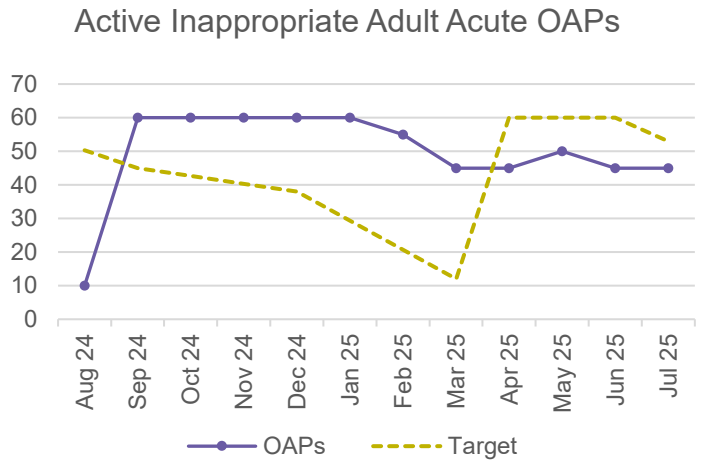


Linked to Risk: 387

Mental Health Crisis & Flow

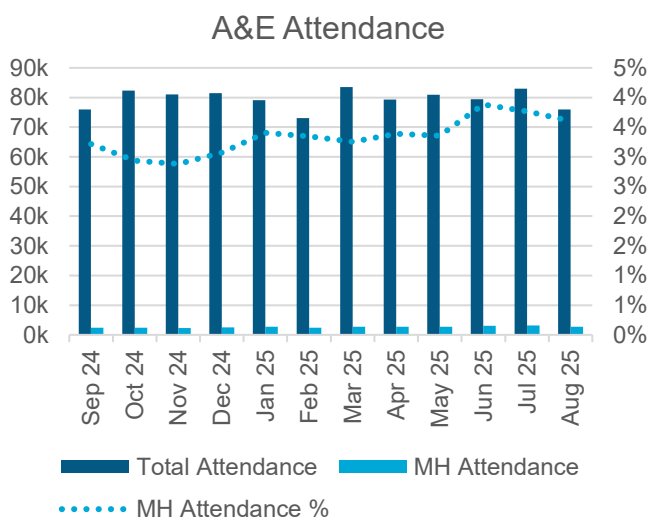
Notes and Issues

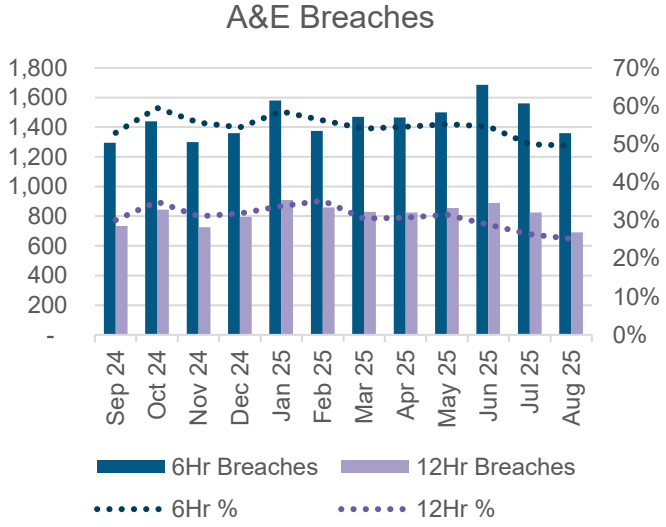
- Mental Health emergency pressures continue with challenges with regards crisis presentations to our Emergency Departments (ED) and demand for admissions.
- The number of inappropriate out of area placements (OAPs) has remained stable in July with 45 active placements reported against a plan of 53.
- A&E data shows that the proportion of MH presentations in ED in August was around 4%. 50% of MH patients waited more than 6 hours in ED and 25% more than 12 hours.
- A&E breaches are disproportionately high for MH patients. SEL's operational plan for 2025/26 give a commitment to reduce the number of MH breaches.
- SEL is delivering against the average LoS target set with performance of 51 days against a target of 55.

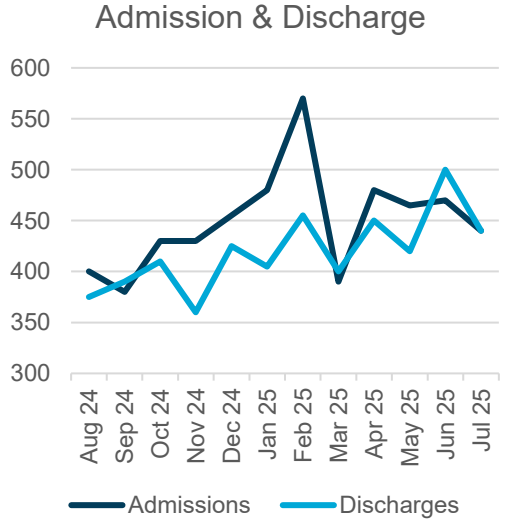


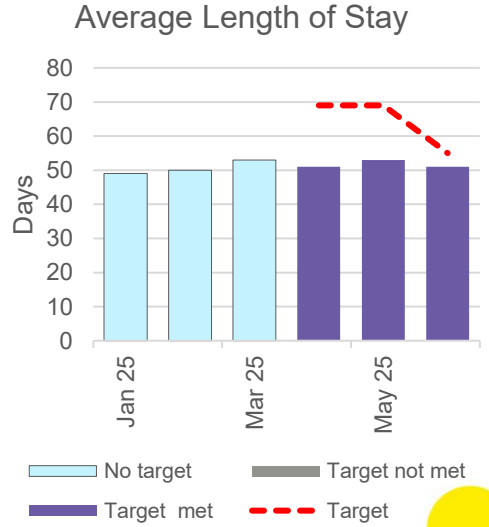
Recovery Actions

- 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 826,297 in July 2025 against the operating plan target of 762,051.

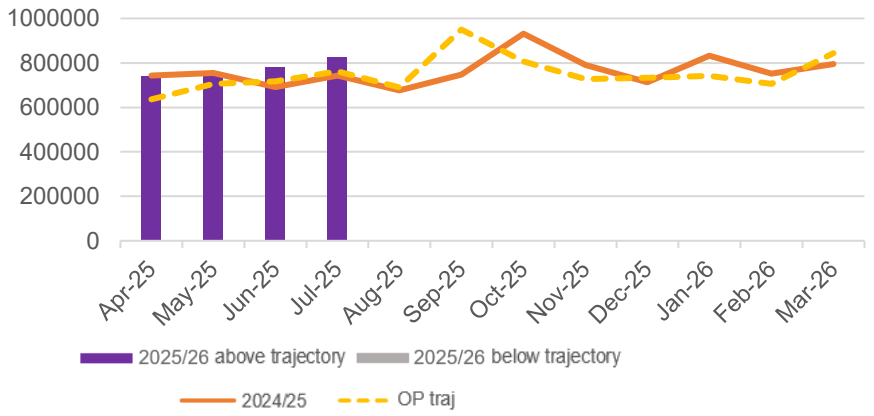
General Practice Action Plan

- SEL ICB has developed its action plan to improve general practice in line with NHS England's requirement for all ICBs to have such plans now in place.
- The plan sets out a coordinated approach to contract oversight, commissioning, transformation, and addressing unwarranted variation.
- Work is underway to triangulate practice level data—appointments per 1,000 patients, GP staffing levels, appointment wait times, and GPPS access results, to identify practices that may be struggling. Practices can then be prioritised for support.
- A practical support offer for general practice resilience, building on the sector's views of what is needed now and in the future, has been developed. The offer aims to promote equity of provision, access, experience, and outcomes across general practice, taking into account the two main drivers of this work.

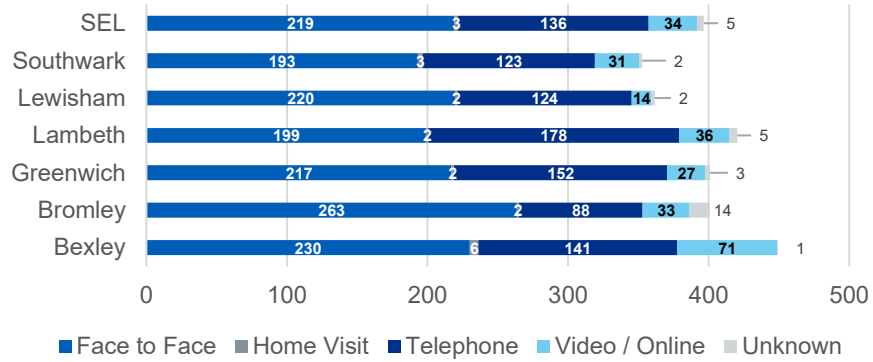
ICB and Borough Level Recovery Actions

- Work across our six borough Local Care Partnerships to develop schemes to encourage more staff into primary care and support retention and maximise the use of investment in additional roles.
- The ICB has purchased software for analytics at practice, PCN and federation level providing a better understanding of capacity and demand, population health insight, future forecasting of demand and trend analysis.
- Commenced a campaign to help residents understand how general practice works and the different roles of staff.
- Borough-level improvement plans are now in place, and all boroughs are engaged in actions to better understand and target support for practices showing variation in access levels. Capacity pressures and rising demand continue to impact patient experience in some areas. Boroughs are also planning for expected winter pressures.
- All 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.

Primary care access: appointments
National data vs Operational plan trajectory



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



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

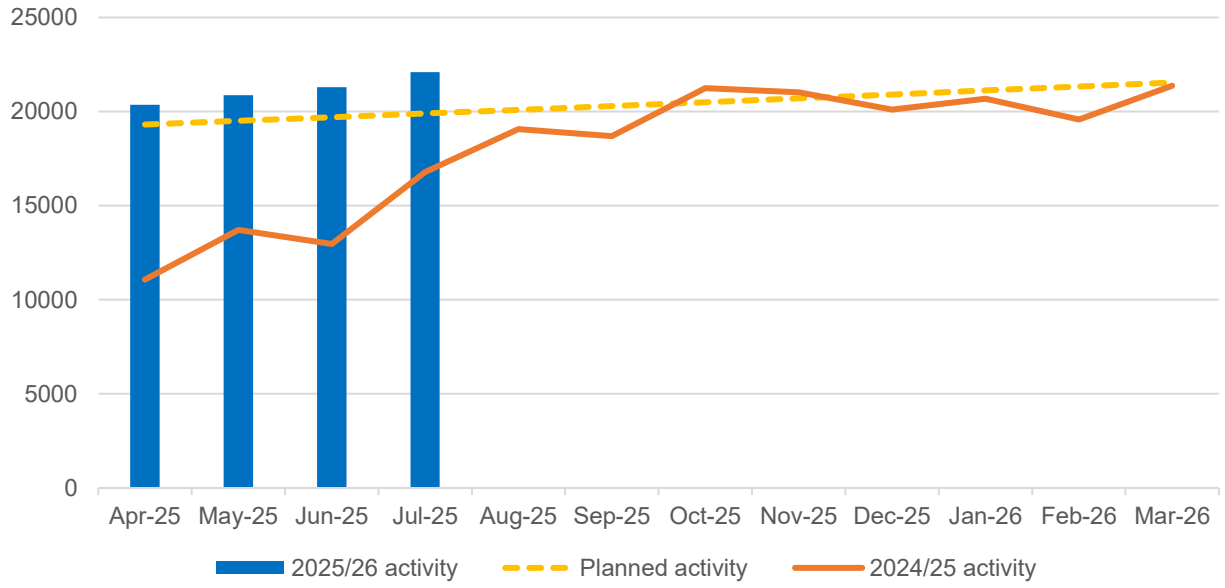
Linked risk: Lew 528, Gre 621

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

Notes and Issues

- In June 2025 311 (of 324) pharmacies were providing Pharmacy First services, with 306 providing hypertension screening and 302 providing oral contraception.
- As of June 2025, pharmacies must be registered to provide all three services to qualify for threshold payments
- From Feb 24 to July 25, approximately 102,000 clinical pathway consultations have been conducted by SEL community pharmacies
- Pharmacy First clinical pathways consultations total per 100,000 in June 25 have improved from the previous month and are almost in line with the London average.
- Oral contraception: gradual increase in consultations in community pharmacy for both initiations and ongoing supply across all boroughs. SEL ICB is above the London average for consultations per 100,000 population
- Hypertension: Total consultations appear to have plateaued slightly in recent months. SEL ICB has the highest rate of consultations per 100,000 population in the London region and is also above England average.
- Issues regarding post-event messaging (PEM) and coding have been identified and are being reviewed.

SEL: Total number of consultations (hypertension, oral contraception & Pharmacy First clinical pathways)



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

Recovery Actions

- Digital team supporting in contacting pharmacies who are not registered, supported by Medicines Optimisation team and SEL Local Pharmaceutical Committee (LPC).
- Sharing of resources, webinars and toolkit roll out for practices and pharmacies to improve referrals to community pharmacy for all three services.
- Improving data sharing across teams, to drive referrals from practices.
- Digital resources being promoted to increase uptake for contraception consultations in community pharmacy e.g. messaging from GP practices.
- Working closely with SEL LPC to support services in community pharmacy.
- Refresh of Community Pharmacy Neighbourhood Leads (CPNL) programme, part of which role will be supporting in driving services available in community pharmacy.
- Encouraging sharing learning from each other, with most boroughs having Pharmacy Network Meetings.
- The National Pharmacy First campaign starts in October 2025.

Linked to Risks: SEL 598, Bex 585

UCR and community waits

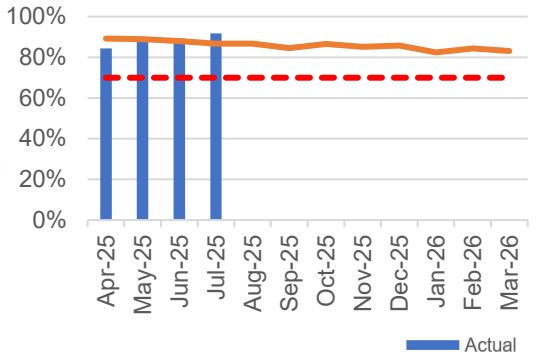
Notes and Issues

- July UCR performance data shows SEL providers exceeding the 2- hour and 2-day response standards.
- UCR 2-hour and 2-day referral numbers increased. Compliance improved for 2-hour referrals compared to June but show a slight reduction on 2-day referrals, with performance down from 95% to 93%.
- Provisional July performance against the standardised rate of referral target is 75 against a target of 180.
- The total number of patients reported on the Community Services waiting list for services in scope in SEL was 27,798 - a decrease of 1,958 on the previous month. This was primarily due to reductions in patients waiting at the 4-12 and 12-18 week intervals.
- Of the total number of patients waiting, 16,224 (58%) have been waiting less than 12 weeks for a first appointment. Services contributing most to overall wait numbers are: MSK (6%) and Community Paediatrics (37%).

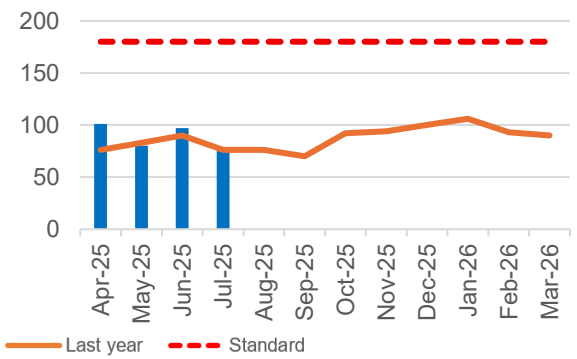
Long waiters:

- The number of patients waiting over 52 weeks for a first appointment decreased from 2,160 to 2,122. Of the 2,122 patients waiting 52-104 weeks 2,099 (99%) were in Community Paediatrics, with small numbers across a range of other services.
- The number of patients waiting over 104 weeks increased from 0 to 2.

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



Standardised rate of referral per 100,000 population



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

Community waits >52 weeks***

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

SEL Waiting List Breakdown (July 25)

Weeks	Number of waiters
0-1 weeks	**1,997**
>1-2 weeks	**2,365**
>2-4 weeks	**3,419**
>4-12 weeks	**8,443**
>12-18 weeks	**3,373**
>18-52 weeks	**6,077**
>52-104 weeks	**2,122**
>104 weeks	**2**

Recovery Actions

UCR:

- Data reporting improvement plans for challenged providers.
- The ICB is currently reviewing all of the UCR services to look at opportunities to maximise referrals to the services. This has also identified some variation in reported data.
- Collaborative working with LAS and UCR providers to improve triaging of referrals. This includes a pilot placing an ED consultant in the LAS call centre supporting clinical decision making for category 2 and 3 calls.
- Working with UCR providers via the Community Provider Network on the management of referrals with a view to mitigating barriers to acceptance and increasing overall referral numbers. Reasons for non-acceptance are primarily due to lack of capacity and patients requiring home visits.
- Exploration of digital options and tools to support greater efficiency and productivity in UCR teams.

Community wait list:

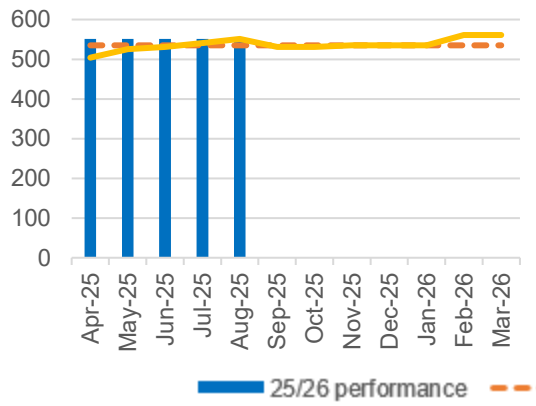
- Actions have been taken by providers to improve data quality and ensure that reporting is accurate across different services.
- Actions including additional professional recruitment and outsourcing of assessments are being taken to improve services with the largest >52 week waits.

Virtual Wards

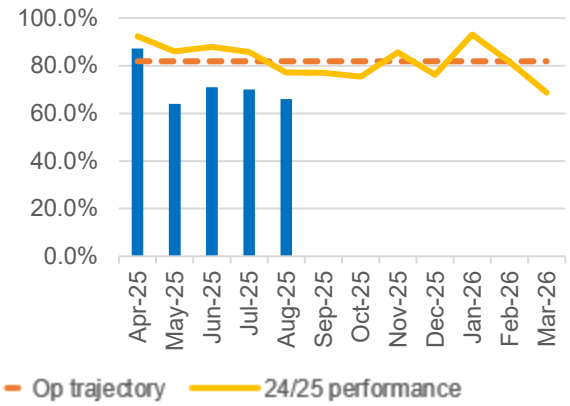
Notes and Issues

- SEL Virtual Ward capacity is above plan at 554 beds against a target of 535.
- The monthly average utilisation for August was 66% (which was below plan at 82%), noting that the incomplete submission of occupancy data from one of the SEL providers has negatively impacted the reported position. Where this occurs, support is being offered to enable the provider to meet the submission deadline

Capacity (beds) vs plan



Occupancy vs plan



Average of snapshots August 2025

	Av. Capacity	Average Utilisation
SEL actuals	554	66%*
SEL Plan	535	82%

*Occupancy data incomplete for one provider during August 2025

2025/26 Plans and Actions

- Starting in quarter 2, a series of strategic workshops, facilitated by the South London Health Innovate Network and the ICB Community Based Care Team, are being held with stakeholders across SEL including providers of Virtual Ward, Urgent Community Response (UCR), Same Day Emergency Care (SDEC), London Ambulance Service (LAS), VCSE and system leaders.
- The key output expected is to build a joint vision for urgent community-based care that will optimise our existing pathways and resources. This will inform the strategic vision for SEL to reduce duplication and variation in pathways, and support increasing activity in alternative care pathways and reduce unnecessary ambulance conveyances.

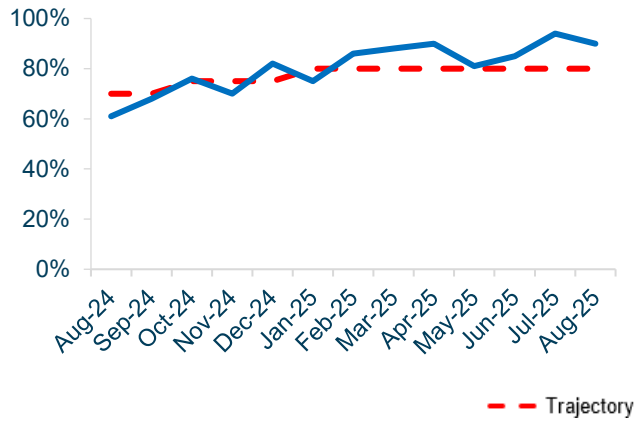
Linked to Risk: Gre 474

NHS Continuing Healthcare

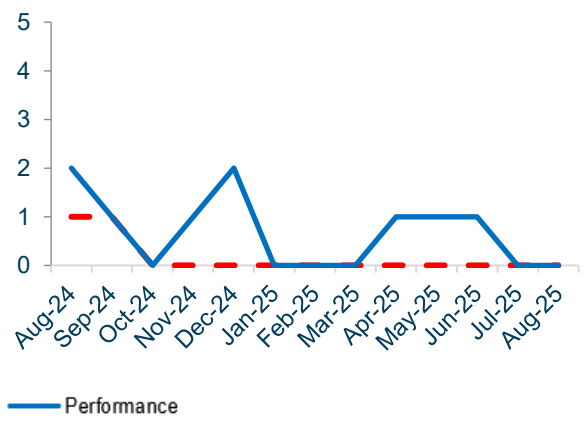
Notes and Issues

- 28 day performance: August performance (local reporting) against the number of referrals completed within the 28-day timeframe was 90%. This is a decrease from the July performance of 94% but remains above the national target of 80%.
- Incomplete referrals over 12 weeks: SEL reported zero 'long wait' over 12 weeks in August which meets the national requirement.
- The quarter 1 statutory reported position for SEL was 87% for 28-day performance which is above the national target. There was one incomplete referral over 12 weeks which is above the expected national standard of zero.
- Standard CHC and Fast Track Reviews: There is variation in the number of overdue standard CHC and fast track reviews across the six boroughs. The number of individuals waiting for a Standard CHC reviews is 109. This is a slight increase from the previous month of 101.
- There are 54 overdue fast track reviews. This is an increase from the previous month of 47.
- Funded Nursing Care Reviews: The number of Funded Nursing Care Reviews has been decreasing since October 2024 (807) and is now 676.

CHC assessments completed within 28 days
Local monthly tracking



Incomplete referrals over 12 weeks
Local monthly tracking



Quarterly statutory reported position

	CHC assessments in an acute setting			% assessments completed in 28 days			Incomplete referrals over 12 weeks		
	Q1	Trajectory	Target	Q1	Trajectory	Target	Q1	Trajectory	Target
Bexley	2%	-	0%	82%	80%	80%	0	0	0
Bromley	0%	-	0%	93%	80%	80%	1	0	0
Greenwich	0%	-	0%	100%	80%	80%	0	0	0
Lambeth	7%	-	0%	88%	80%	80%	0	0	0
Lewisham	2%	-	0%	86%	80%	80%	0	0	0
Southwark	0%	-	0%	71%	80%	80%	0	0	0
SEL	3%	-	0%	87%	80%	80%	1	0	0

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

Recovery Actions

- The ICB recovered performance against the assessment targets during 2024/25. 28 day performance has continued to be achieved during 2025/26 and remains above the national target of 80%.
- Boroughs are continuing to work to locally agreed trajectories to reduce to number of patients waiting for Standard CHC, fast track and Funded Nursing Care Reviews
- Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities and where expected performance is not achieved at a borough level, including when CHC assessments are reported as occurring in acute settings.

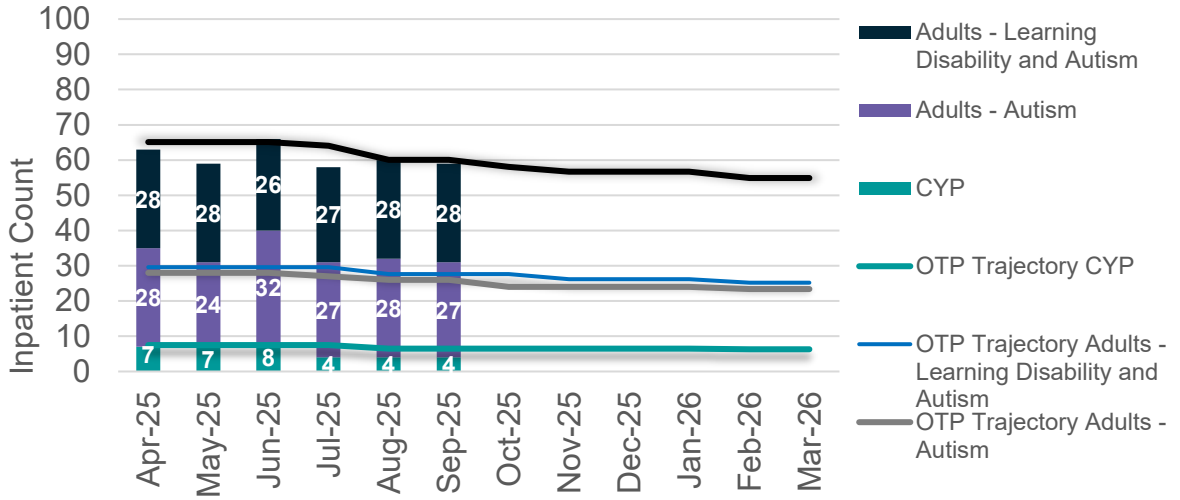
Linked to Risk: SEL 468

Learning disability and autism (LDA)

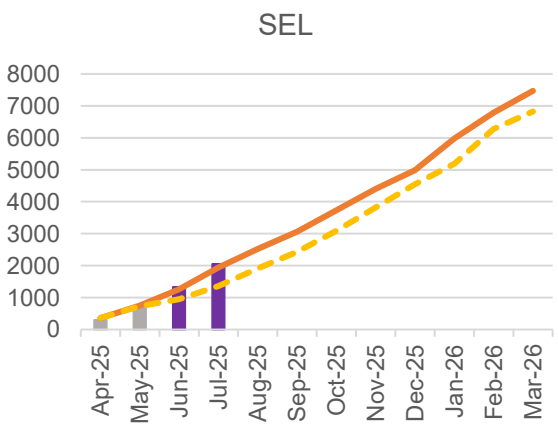
Notes and Issues

- At the end of August 2025, the target LDA inpatient position was met. There were 60 inpatients, which is in line with the Q2 target. There were 56 adults (28 autism only diagnoses) in non-secure and secure units, and 4 children and young people. 8 people were due for discharge by end of Q2 2025.
- The target for 2025/26 is 48 adults – (25 with a learning disability and/or autistic adults and 23 autistic adults) and six young people.
- There continues to be an increase in demand for autism assessments for both adults and children and young people across all boroughs.
- The trajectory to achieve the year end target of 75% completion of Learning Disability Annual Health Checks was on track at the end of Q1. The focus in all boroughs will continue to be around assuring AHCs are of a good quality and on improving peoples experience of AHCs.
- Continued roll out of The Oliver McGowan mandatory training to provide essential skills and knowledge to ensure safe and compassionate care for autistic people and individuals with a learning disability.

LDA Inpatient Position



LD AHCs: SEL and Borough Level Position



	July 25 performance		July-25 Trajectory	2025/26 Plan
	%	Count		
Bexley	23%	290	182	908
Bromley	20%	255	188	938
Greenwich	20%	346	250	1248
Lambeth	20%	348	256	1279
Lewisham	21%	436	294	1472
Southwark	29%	375	195	975
SEL	22%	2050	1365	6825

Recovery Actions

- Operational planning trajectories for 2025/26 consider the number of adults aged 18 and over from the ICB who have a learning disability (including those who may also be autistic) and the number of adults aged 18 and over from the ICB who are autistic (with no learning disability) who are in mental health inpatient care.
- Community autism specialist services to support autistic only people are in development to prevent admission and support community placements. Along with existing services commissioned from MH providers these services will support the continued reduction in admission rate.
- Housing, care and support work in development to support discharge and prevent admissions.
- Working with providers to identify an action plan to address the high numbers of people on waiting lists/long waiting times for autism assessment as well as requirements to meet demand in the longer term, includes work on Right to Choose and accreditation of services.
- **Digital Dynamic Support Registers (DSRs) launched 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

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Quality and Nursing**					
Meeting date	15 October 2025	Agenda item Number	9	Paper Enclosure Ref	I	
Author	**Elizabeth Aitken, Deputy Medical Director and CCPL Quality**					
Executive lead	**Gwen Kennedy, Interim Chief Nursing Officer**					
Paper is for:	Update	X	Discussion		Decision	
Purpose of paper	To provide an overview of quality and nursing across the ICS for Quarter 1					
Summary of main points	**Quality and Patient Safety:** In Q1, 24 Patient Safety Incident Investigations and 7 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. 427 Quality Alerts were raised, with the trending themes reported include appointment/referral, transfer of care, discharge and poor. Improvement work is underway, including better discharge summaries and digital solutions. **Safeguarding**: The London Boroughs of Lambeth and Southwark are two of the pilot sites for Offensive Weapons Homicide Review (OWHR) which are new statutory reviews aimed at understanding if partners could have worked more effectively to prevent deaths involving an offensive weapon. The Child Protection Information System (CP-IS) helps health and social care staff to share information securely between local authorities and NHS organisations to better protect society's most vulnerable children and the work is advancing as planned. Good progress has been made in meeting the safeguarding internal audit actions with one outstanding action remaining **All Age Continuing Care (AACC)**: The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, CHC teams have exceeded their savings targets. Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities. **Local Maternity and Neonatal System (LMNS)**: Maternity services are anticipating challenges in offering posts to the 2026 March/September cohort of student midwives – this is a regional issue and NHSE is supporting the system across London. There has been an increase in cases of women and birthing people presenting with current or newly diagnosed cancer during pregnancy with work ongoing with the cancer alliance. There is ongoing work looking at community midwifery prescribing pathways to promote equitable and improved access to prescribed medications across the hospital and community interface **Infection Prevention and Control (IPC)**: The most recent surveillance data shows a rise E. coli bacteraemia in keeping with national trends. In SEL 67% of these cases were attributed to community cases and work is ongoing with partners to identify improvements in catheter care in the community. **Learning Disabilities and Autism (LDA)**: At the end of Q1 June 2025, the Q1 target was not achieved due to a significant number of new admissions and late notifications of admissions. The One Stop STOMP Clinic was piloted during Q1. The clinic seeks to ensure optimised care and enhanced patient outcomes by addressing the overprescribing of psychotropic medication.					

	Special Educational Needs and Disabilities (SEND): The SEL SEND Network established since September 2024 is seeking to review its Terms of Reference and membership to ensure that the network remains useful and effective					
Potential conflicts of Interest	Nil known					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	This paper has considered the potential impact on individuals and groups with protected characteristics. No adverse impacts have been identified, and the proposed quality improvements are expected to promote equitable access and outcomes for all service users.					
Financial Impact	There is no financial impact associated with this paper					
Public Patient Engagement	Patient engagement is outlined in the paper					
Committee engagement	Quality and Safeguarding Committee					
Recommendation	The Board are asked to note the content of the report					

South East London Integrated Care System

NHS South East London

Quality and Nursing directorate Report

October 2025

1. Introduction

This report provides an overview of key performance updates from the Quality and Nursing Directorate across South East London Integrated Care Board (SEL ICB) for Quarter 1. It covers essential areas, including Quality and Safety, Safeguarding, All Age Continuing Care (AACC), the Local Maternity and Neonatal System (LMNS), Infection Prevention and Control (IPC), Learning Disabilities and Autism (LDA), and Special Education Needs and Disabilities (SEND).

2. Quality and Nursing Updates

2.1 Quality and Patient Safety

During Q1, a total of 24 Patient Safety Incident Investigations (PSIIs) were reported, along with 7 Never Events. Five of these Never Events related to retained foreign objects post-procedure. Specifically, one incident involved a retained swab, two involved retained guidewires, and the remaining two involved a retained bulldog clip and an oral prop. There is ongoing work through quality improvement projects across the Trusts that have reported Never Events linked to Patient Safety Incident Response Plans.

Quality Alerts (QAs) have been closely monitored, and the quality team meet on a weekly basis to review and theme the QAs reported across the system. A total of 427 quality alerts were reported in Q1. The trending themes reported include appointment/referral, transfer of care, discharge and poor communication.

During Q1, an increase in QAs was noted in relation to healthcare staff phoning 111 to request an ambulance rather than following the correct process within Primary Care. As a result, the London Ambulance Service (LAS) protocol has been disseminated across SEL through various forums, and webinars have been held by 111 to outline the correct process.

There has been targeted improvement work made in South London and Maudsley (SLaM) from closed QAs:

Digital Improvements:

- Review of digital discharge systems to ensure correct GP registration and delivery of discharge letters
- Plan to include clear prescribing responsibilities in discharge summaries

Service Coordination:

- Agreement to keep patients open to Anxiety, Depression, Affective, Personality Disorders & Trauma (ADAPT) services to facilitate access to tertiary services
- Joint management plans to be developed between services to avoid placing burden on primary care

The Patient Safety Incident Response Framework (PSIRF) pilot Phase 2 in General Practice, led by the Health Innovation Network (HiN), has commenced. The pilot teams

include five participants from SEL: one GP Federation, two Primary Care Networks, one GP practice, and one hospice. The pilot is reviewing four different phases of PSIRF within General Practice. The quality team holds monthly stakeholder meetings and is working to establish a sustainable method of recording and responding to patient safety incidents that will meet the requirements of the pilot.

2.2 Safeguarding

The safeguarding function continues to progress a number of deliverables and quality improvement programmes. The following is not an exhaustive list:

- The London Boroughs of Lambeth and Southwark are two of the pilot sites for Offensive Weapons Homicide Review (OWHR) which are new statutory reviews aimed at understanding if partners could have worked more effectively to prevent deaths involving an offensive weapon. The ICB has contributed to the pilot through being a Relevant Review Partner. Review reports are currently proceeding through the respective OWHR governance processes. A thematic report will potentially be available by end of Q3.

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

- The Child Protection Information System (CP-IS) helps health and social care staff to share information securely between local authorities and NHS organisations to better protect society's most vulnerable children. Phase 2 of CP-IS is advancing as planned. SELICB are waiting for confirmation from NHSE digital on IT system integration before proceeding to the next phase in Primary Care.

- The ICS Safeguarding System Group has met for the third time. The group brings together the representatives from the SEL health system to identify themes, trends, learning and risk across the SEL health economy, sharing solutions, ideas and innovations. This quarter focus has been on CP-IS, developing a consistent Children Looked After performance dataset and using the ICB Serious Violence dataset to inform operational and strategic approaches.

- The ICB / Kings Fund Safeguarding Leadership Programme has completed with a high satisfaction rate from delegates of 4.7 out of 5. The programme has supported various practitioner projects, for example: *Access to domestic abuse services through an Equality, Diversity and Inclusion Lens*. The programme will be formally evaluated in Q3 to as ascertain whether it could be repeated.

- The ICB central Safeguarding team has significantly improved the statutory requirements for safeguarding training across the ICB through a safeguarding competency strategy, delivering on all levels of safeguarding training. Compliance rates are reported through the Quality and Safeguarding Committee.

- Good progress has been made in meeting the safeguarding internal audit actions with one outstanding action remaining. This is related to the Safeguarding Case Review Tracker (S-CRT) and the quality of data inputted. Further auditing and feedback to Designates working at place is in progress.

- There are 3 safeguarding risks:
    - There remain challenges in relation to EPIC implementation for both GSTT and KCH, the system originally having some deficits in relation to recording safeguarding case information. Both GSTT and KCH advise they are in production stage to rectify the issue
    - Workforce challenges remain in some Provider safeguarding teams across the sector, caused through either sickness or continued vacancies. This has an impact on service delivery. Ongoing discussion and support are in progress with the relevant Provider.
    - Increased numbers of out of borough Children Looked After placed in south east London heightens challenges to deliver on timely health assessments. Ongoing delays regarding late notification and incomplete paperwork from local authorities exacerbate these issues. There is ongoing partnership working to solve these risks.

3.3 All Age Continuing Care (AACC)

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

The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, CHC teams have exceeded their savings targets. Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities. There is variation in the number of overdue Standard CHC and fast track reviews across the six boroughs, however the overall position continues to improve. The total number of individuals waiting for a Standard CHC review is 109. This is a slight increase from the previous month of 101. Overall performance has improved recently with no incomplete referrals over 12 weeks. The 28-day performance has continued to be achieved during 2025/26 and remains above the national target of 80%.

2.4 Local Maternity and Neonatal System (LMNS)

Maternity services are anticipating challenges in offering posts to the 2026 March/September cohort of student midwives. At present the issues does not extend to neonatal nursing where vacancies remain across the system. This is a regional issue. NHSE is supporting the nursing and midwifery system across London with the coordination of intelligence and data with regards to nursing and midwifery vacancies to highlight opportunities for student deployment, this includes utilising, where feasible, maternity support worker roles.

There is continued collaboration across the LMNS and ICB to strengthen shared learning from perinatal mortality cases. This includes liaison with the tri-borough CDOPs scoping where collaboration and reducing duplication can be improved.

There has been an increase in cases of women and birthing people presenting with current or newly diagnosed cancer during pregnancy. Work has commenced with Cancer Alliance colleagues to ensure there is involvement of the Maternal Medicine Network and Obstetric Medicine teams in care planning. The initial focus is on breast cancer, with plans to expand to other tumour groups.

The LMNS Quality Surveillance Group has highlighted inconsistencies in clinical methodologies used across the system to estimate fetal weight, particularly in identifying small or growth restricted babies. These variations are causing some confusion for families, especially those receiving care from multiple trusts. A stakeholder meeting is scheduled for October to address the issue.

There is ongoing work looking at community midwifery prescribing pathways to promote equitable and improved access to prescribed medications across the hospital and community interface. This work will help to mitigate risks to women who have difficulty accessing their medications in local community pharmacies.

Work is ongoing to implement Maternity and Neonatal Voices Partnership (MNVPs) guidance across SEL. Both the guidance and NHSR Maternity incentive Scheme Year 7 expect ICBs to provide funding and infrastructure to support MNVPs, including the employment of MNVP leads. Currently there are leads aligning with the footprint of the LMNS, but they work in a remunerated volunteer capacity.

Progress to date includes:

- Gap analysis against national guidance
- Draft job descriptions agreed across LMNS and borough leads
- Provision of laptops, training and development
- Peer network support, including psychological support exploration

Areas of non-compliance:

Expectation	Current position
Commissioned and appropriately funded MNVPs across SEL footprint to deliver on the national ask	MNVPs are funded by the ICB boroughs and the LMNS but not to level required to deliver on the national ask. NHSE funding received to date is non-recurrent.
ICB employment of MNVP leads or commission a third party (not trusts). National examples include hosting arrangements with Healthwatch.	MNVP leads currently work in a volunteer capacity. Examples of hosting contracts via other ICBs are available, these models require significant funding. Approximately £65k budget per one MNVP.
MNVP leads as quorate members at trust meetings.	Current infrastructure does not provide the capacity required for the MNVPs to deliver on the national guidance and attend the meetings required and ensure continued engagement with SEL communities. There is concern within the partnerships regarding attendance at perinatal mortality review meetings due to the voluntary nature of the lead role, the often-traumatic content of the meetings on the leads and insufficient governance structures in place to support.

2.5 Infection Prevention and Control (IPC)

Activities include ongoing general practice audits, Lambeth primary care new build reviews prior to opening, moderating IPC elements in bids submitted for two Southwark practices, and contributing to SEL ICB leadership and governance for antimicrobial resistance bid to NHSE. The team worked with Bexley local authority Environmental Health Team to inspect IPC standards in a high street premises carrying out invasive cosmetic procedures. The outputs of these were shared with Public Health Teams through the IPC Collaborative and Provider Trust Colleagues at Themes and Concern Meeting.

In July, there were 119 cases of Escherichia coli (E.coli) recorded in South-East London, which is the highest monthly total for the previous four years. It reflects the national increase where E. coli bacteraemia incidence rose by 17.0% between 2020-2021 and 2024-2025. The increase has been primarily driven by additional community-onset cases, which represented 80.8% of cases in 2024-2025.

In South-East London, 67% of E.coli bacteraemia cases were attributed as community cases in July 2025. A singular source or risk has not been identified but SEL ICB has

initiated a programme of work to reduce known patient risk factors. SEL ICB IPC Team is working with GSTT, Partnership Southwark, Lambeth and Southwark LA Commissioning leads to review community services for individuals with a urinary catheter to identify gaps and improve access. The IPC team also works with SEL ICB Core Catheter Offer Group and NHSE London Regional Catheter Group to ensure workstreams are aligned and avoid duplication

2.6 Learning Disabilities and Autism (LDA)

At the end of Q1 June 2025, the Q1 target was not achieved due to a significant number of new admissions and late notifications of admissions. There were 66 inpatients one over the Q1 target of 65. At the time of writing this report the Q2 position is markedly improved with discharges of new and long stay patients. The end of Q2 target of 60 is expected to be achieved with the current position of 59 inpatients, one below the target position for the end of Q2. The number of children and young people at the end of Q1 was eight (8) against a target of eight (8), at time of report there are four (4) children and young people in hospital, which if maintained will see the end of Q2 target of seven (7) being surpassed. As was seen during 2024/25 SEL continues to achieve the discharges of long stay patients.

All boroughs in SEL at the end of Q1 surpassed the operational target and are on track to exceed the 75% target by the end of 2025/26. By end of July 2025, 2049, checks were completed against a plan of 1365. The focus in all boroughs continues to be around assuring AHCs are of a good quality and on improving peoples experience of AHCs.

There is continued increase in demand for autism assessments for both adults and children and young people across all boroughs. Work is in progress to develop an accreditation process for Right to Choose providers and information for GP referrers about providers to aid their decision making.

Learning from the lives and deaths of people with a learning disability and autistic people – LeDeR, continues to find the learning from the reviews and in July published the first SEL LeDeR Newsletter which had a focus on the LeDeR theme of Improving the Application of the Mental Capacity Act in SE London.

The One Stop STOMP Clinic was piloted during Q1. The clinic seeks to ensure optimised care and enhanced patient outcomes by addressing the overprescribing of psychotropic medication. Based on the learning from the pilot the clinic will be offered across the wider SEL footprint.

The roll out of The Oliver McGowan Mandatory Training continued during Q1 but with fewer sessions being available while funding and delivery model was developed. A plan to buying additional training has now been approved to allow SEL the possibility of achieving 30% coverage during 2025/26 and receiving a share of 2025/26 funding.

2.7 Special Education Needs and Disabilities (SEND)

The SEND system continues to face persistent challenges. These pressures are compounded by scrutiny from inspection outcomes to date, national inquiry reports such as *Solving the SEND Crisis*, and other publications, alongside ongoing media interest. In this complex and demanding context, the SEL SEND Network, established since September 2024, is seeking to review its Terms of Reference and membership to ensure that the network remains useful and effective.

The SEL SEND priority actions currently are:

- Strengthening ICB Governance, Relationship to Place Partnership Groups for SEND and Risk Escalation – strengthening assurance that statutory duties are being met
- Sharing learning to support improvement of health outcomes – systematically gather and share learning, and mapping of health provision across the 6 boroughs
- Strategic commissioning, in collaboration with Place commissioners – identify opportunities for more effective commissioning / funding arrangements
- Workforce capability and capacity – raise awareness of SEND workforce, standardised opportunities for training and development
- Data and Intelligence – develop meaningful metrics to gather a 6-borough view of service access and outcomes

3. Conclusion

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

Board Meeting in Public

Title	**Finance Report**						
Meeting date	15 October 2025		Agenda item Number	10	Paper Enclosure Ref	J	
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 as at month 5.						
Summary of main points	The South East London ICS has an agreed financial plan for 2025/26 of a break-even position. This is inclusive of non-recurrent deficit support funding of £75.0m, for which the allocations for both quarter 1 and quarter 2 totalling £37.5m have been received. As at month 5, the key headlines are: • The ICB is reporting a year to date break-even position. • The ICS is reporting a year to date deficit of **£22.0m** against a planned deficit of **£22.6m**, **a favourable variance of £0.6m**. GSTT is **£0.6m** ahead of plan at month 5. All other organisations are broadly on plan. • The ICS has delivered YTD **£123.2m** of efficiencies against a plan of £124.1m, **slippage** of **£0.9m**. **£42.1m (34%)** of the savings delivered YTD have been on a **non-recurrent basis.** This is compared to a planned value of **£27.8m.** • The forecast underlying exit position for this financial year is a **deficit** of **£298.0m.** This is a worsening of **£43.0m** against the 2025/26 plan submission of **£255.0m**. This is driven by adverse movements at **GSTT (£33.2m)** and **KCH (£11.4m).** Underlying financial positions were discussed with provider Chief Finance Officers at the regular ICS CFO meeting on 19 September, with an emphasis on mitigating actions being implemented. • At month 5, the ICS is forecasting a break-even financial position at year-end. • Overall capital expenditure at month 5 is **£45.7m behind plan** (underspend against **capital allocation** of **£28.6m** and **£17.1m** against **national programmes**). Providers have been asked to review their likely forecast outturn positions for capital projects.						
Potential conflicts of Interest	Not applicable						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	Not applicable						
Financial Impact	As set out in the attached finance report.						
Public Patient Engagement	Not applicable						

Committee engagement	ICB committees, including the Integrated Performance Committee, receive regular updates on the financial position.
Recommendation	The Board is asked to note the report and discuss any actions in relation to the financial position.

NHS
South East London

SEL ICS Finance Report

Month 5 - 2025/26

Contents

1. Executive Summary

- This report sets out the month 5 financial position of the ICS. The ICS financial plan is to deliver a **break-even position**. This is after the receipt of non-recurrent **deficit support funding** of **£75.0m**. The Q1 and Q2 allocations (£18.75m each quarter) were received in months 2 and 3.
- At month 5, the ICS is reporting a **YTD deficit** of **(£22.0m), £0.6m ahead of plan**; an improvement of £1.2m compared to month 4. GSTT reports a favourable position of **£0.6m** due to recognising the sales (£12.4m) of their subsidiary Lexica in month to mitigate the slippage in planned efficiencies (£5.1m), non utilisation of the planned balance sheet flex (£8.8m) and £2.1m favourable net effect of mitigating inflationary pressures including Industrial Action (£0.6m). All other organisations are reporting broadly in line with their YTD plan values.
- As at month 5, all organisations are **forecasting a break-even year-end position** in line with the ICS financial plan submitted on 30 April.
- The forecast underlying position included in the 2025/26 planning submission was **£255.0m**. As at month 5, the forecast is for an underlying deficit of **£298.0m**, an adverse movement of **£43.0m**. This is driven by adverse movements at both GSTT **(£33.2m)** and Kings **(£11.4m).**
- 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** totaling **£36.0m** have been received across the system, an increase of £5.3m compared to month 4. This brings the total allocation to **£264.0m**. 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 **£320.2m**. Overall capital expenditure at month 5 is **£45.7m behind plan** (underspend against **capital allocation** of **£28.6m** and **£17.1m** against **national programmes**). Providers have been asked to review their likely forecast outturn positions for capital projects.
- There are currently no additional cash requirements within the system.

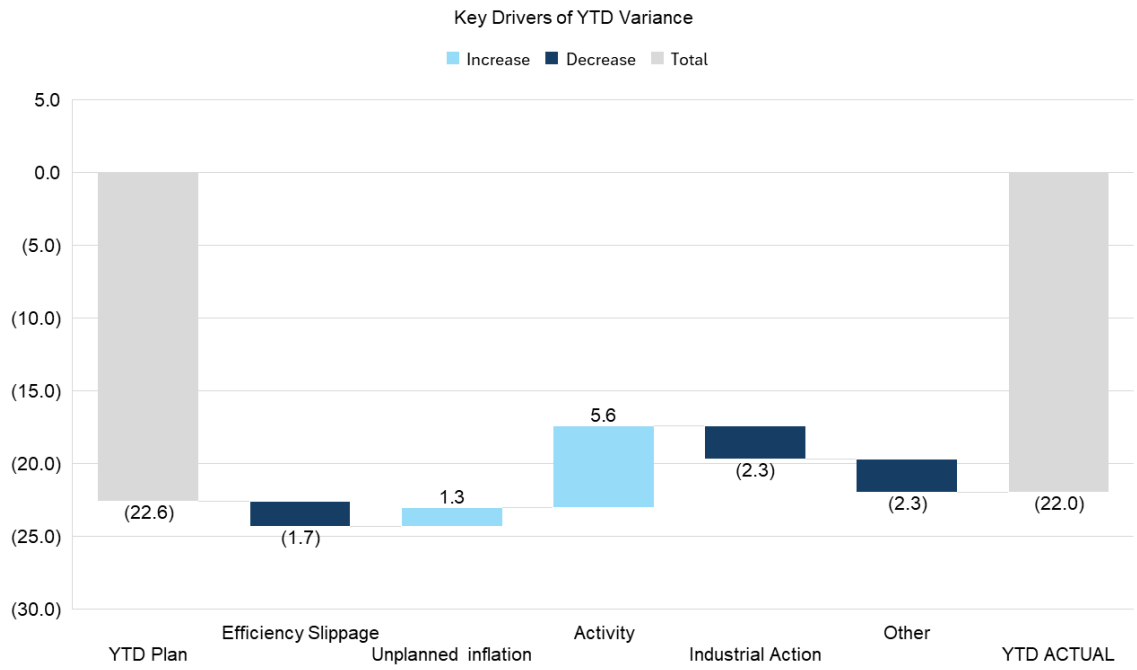
2. ICS Financial Position – I & E Summary

- This slide provides an overview of the financial position across the ICS and the individual organisations as of month 5, including both year-to-date and forecast. It is intended to support informed discussion around the collective financial outlook and progress towards the agreed control total. The slide also reflects the impact of deficit support funding received by the Integrated Care Board (ICB), offering insight into how this additional resource is helping to stabilise the system and support continued delivery of services.
- As at month 5, SEL ICS is reporting a YTD deficit of (£22.0m), **£0.6m ahead** of plan, this is an **improvement of £1.2m** compared to M4.
- GSTT reports a favourable position of **£0.6m** due to recognising the sales (£12.4m) of their subsidiary Lexica in month to mitigate the slippage in planned efficiencies (£5.1m), non utilisation of the planned balance sheet flex (£8.8m) and £2.1m favourable net effect of mitigating inflationary pressures including the IA (Industrial Action - £0.6m).
- All other organisations are reporting broadly in line with their YTD plan values.
- To achieve the reported position, a total of £33.4m risks were fully mitigated recurrently using inflationary reserves :
  - £19.2m unplanned shortfall on income; specialised commissioning, non-clinical income and other patient income.
  - £6.4m YTD increase in pathology costs at GSTT due to delayed expected price reductions. This pressure is expected to be non recurrent.
  - £5.5m YTD increase in non pay expenditure including the effect of inflation and impact of the pay awards.
  - Industrial Action (IA) – £2.3m total impact: £1.0m at KCH, £0.6m at GSTT, £0.7m at LGT, and £0.03m at Oxleas.
  - **At month 5, the ICS system forecast remains at a break-even financial position.**

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	(23.7)	0.0	(23.7)	(23.1)	0.6	0.0	0.0	0.0	0.0	0.0
Kings	(31.1)	31.3	0.2	0.1	(0.1)	(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	0.1	0.1	0.0	0.0	0.0	0.0	0.0
SLAM	1.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Provider Total	**(53.8)**	**31.3**	**(22.6)**	**(22.0)**	**0.6**	**(75.0)**	**75.0**	**0.0**	**0.0**	**0.0**
ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
System Total	**(53.8)**	**31.3**	**(22.6)**	**(22.0)**	**0.6**	**(75.0)**	**75.0**	**0.0**	**0.0**	**0.0**

3. Analysis of month 5 YTD Position

- At Month 5, SEL ICS is reporting a year-to-date deficit of **(£22.0m),** which is **£0.6m** ahead of plan. This is an improvement of £1.2m compared to M4, primarily driven by a favourable variance at GSTT of £0.6m. Key drivers of the position are as follows:
  - Income - £5.6m increase against plan at Kings is driven by activity catch up and run rate improvement. This partially offsets the organisation's CIP slippage, IA impact and inflationary pressures.
  - Inflation mitigation upside - £1.3m favourable net position across the providers. Benefit of £2.7m at GSTT, reduced by pressure at Kings of £1.4m.
  - Industrial Action (IA) - £2.3m impact: £1.0m at KCH, £0.6m at GSTT (gross, net impact under review), £0.7m at LGT, and £0.03m at Oxleas.
  - Provider efficiency £1.7m under delivery. Slippages: £3.9m SLaM, £3.3m KCH, £1.8m LGT. Partially offset by +£7.3m over-delivery at GSTT (Lexica sale). The slippages are driven by timing of the recurrent plans, especially on MH complex placement reviews, work force improvement, and clinical transformation schemes.
  - Other drivers - £2.3 net: Non utilisation of the balance sheet flex of £8.8m at GSTT partially offset by £3.9m usage of same at SLaM and £2.6m cost pressure mitigations at LGT.



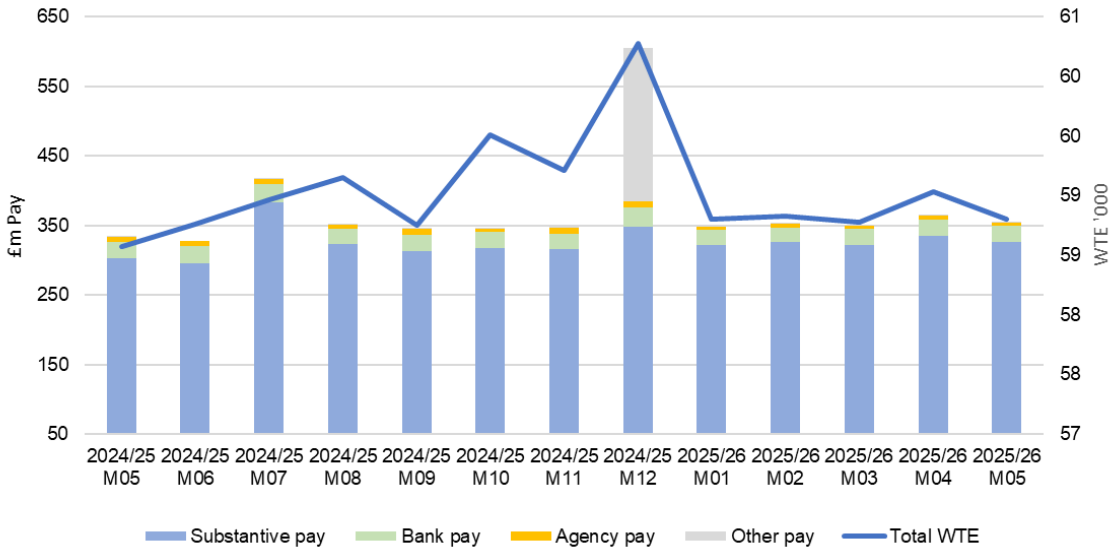
4. Provider Run-rate Analysis

Key data category	2025/26 M01	2025/26 M02	2025/26 M03	2025/26 M04	Current month				Year-to-date				Analysis			
					Month 5 (in-month)				Month 5 (YTD)				Change from last month		Year-on-Year Change	
	Actual £m	Actual £m	Actual £m	Actual £m	Last year £m	Plan £m	Actual £m	Variance £m	Last year £m	Plan £m	Actual £m	Variance £m	£m	%	£m	%
Income	580.5	584.9	590.1	602.5	558.2	590.3	583.3	(7.0)	2,764.0	2,921.6	2,941.4	19.8	(19.2)	(3.2%)	177.4	6.4%
Pay	(348.6)	(353.2)	(349.8)	(364.5)	(333.5)	(349.2)	(354.2)	(5.1)	(1,672.9)	(1,750.0)	(1,770.4)	(20.4)	(10.3)	(2.8%)	97.5	5.8%
Non-Pay	(238.9)	(232.4)	(235.1)	(245.5)	(239.5)	(232.8)	(219.6)	13.2	(1,173.3)	(1,155.2)	(1,171.5)	(16.3)	(25.9)	(10.5%)	(1.8)	(0.2%)
Non Operating Items	(6.9)	(6.6)	(7.7)	7.4	(7.1)	(7.8)	(7.8)	0.1	(37.1)	(39.0)	(21.5)	17.5	(15.1)	(205.2%)	(15.6)	(42.0%)
Surplus/(Deficit)	**(13.9)**	**(7.2)**	**(2.5)**	**(0.1)**	**(22.0)**	**0.5**	**1.7**	**1.2**	**(119.3)**	**(22.6)**	**(22.0)**	**0.6**	**1.9**		**97.3**	

- Providers delivered a **run-rate surplus** of £1.2m in month 5, an improvement of £1.3m compared to month 4. This is driven by the following:
  - YTD **income** up 6.4% year-on-year, but **down** £19.2m (–3.2%) compared to M4. Key movements are:
    - GSTT: –£12.5m (–£6.6m specialised commissioning; –£5.9m non-clinical income; NIHR/NHSE R&D –£3.3m, private patients –£2.6m)
    - KCH: –£5.8m (specialised commissioning)
    - SLaM: –£3.3m (other patient activity)
    - Oxleas: +£2.4m (income increase for agreed contract adjustments)
  - YTD **pay up 5.8% year-on-year**, **but down 2.8% (£10.3m) since M4**. Key drivers are:
    - GSTT: –£4.6m (prior month inflation adjustment)
    - KCH & Oxleas: –£3.8m and £0.8m respectively on admin cost reduction
    - SLaM: –£2.5m (–£1.3m non-medical, –£0.9m medical, –£0.3m admin)
    - LGT: Increased by £1.5m (+£2.1m medical, partly offset –£0.6m admin)
  - YTD **non-pay** is **down** by 0.2% year on year. The in-month actuals are **10.5% lower than month 4**. The movement is mainly at GSTT- £25m for adjusting and recognising the sales of their subsidiary Lexica in month that was previously backed out.
  - The £15.6m movement in non-operating items is the contra adjustment and recognition of the Lexica sales at GSTT.

5. Pay Run-rate and WTE Analysis

- Month 5 pay is **£10.3m (2.8%) lower** than month 4. This is mainly driven by a £9.3m (2.8%) decrease in substantive staff mainly within admin and non-medical staffing.
- There are **0.4% (233)** fewer WTE in Month 5 than Month 4, mainly due to reduction in bank & agency staff.
- Compared to 2024/25, the system has seen a **29.4% reduction** in agency average WTEs YTD, **a 1% improvement** from month 4. This is a reduction of 294 average WTEs, resulting in a reduction in **agency spend of £12.6m (31.8%) year-on-year.**



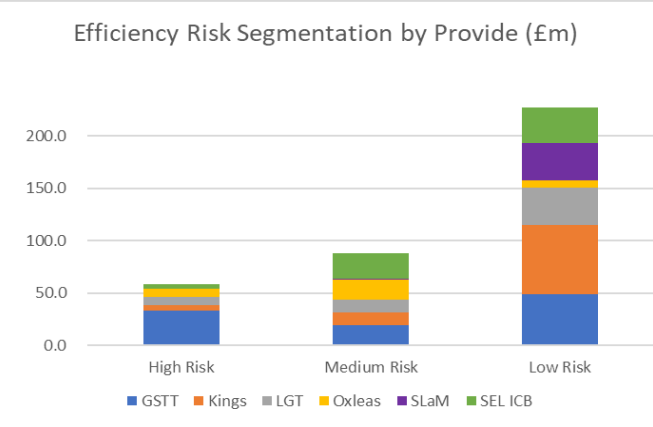
Pay Type	2025/26 M01	2025/26 M02	2025/26 M03	2025/26 M04	Current month				Year-to-date				Analysis			
					Month 5 (in-month)				Month 5 (YTD)				Change from last month		Year-on-year change	
	Actual £m	Actual £m	Actual £m	Actual £m	Last year £m	Plan £m	Actual £m	Variance £m	Last year £m	Plan £m	Actual £m	Variance £m	£	%	£	%
Substantive	321.6	326.7	322.1	335.4	302.2	322.9	326.0	(3.2)	1,514.3	1,618.5	1,631.8	(13.3)	(9.3)	(2.8%)	117.5	7.8%
Bank	21.3	20.5	22.4	23.1	23.9	20.7	23.0	(2.3)	118.6	103.6	110.2	(6.6)	(0.0)	(0.2%)	(8.4)	(7.1%)
Agency	5.6	5.8	4.9	5.8	7.4	5.3	4.8	0.5	39.5	26.8	26.9	(0.1)	(1.0)	(16.9%)	(12.6)	(31.8%)
Other	0.2	0.2	0.4	0.3	0.1	0.2	0.4	(0.2)	0.5	1.1	1.4	(0.4)	0.1	22.0%	0.9	178.8%
Total Pay	**348.6**	**353.2**	**349.8**	**364.5**	**333.5**	**349.2**	**354.2**	**(5.1)**	**1,672.9**	**1,750.0**	**1,770.4**	**(20.4)**	**(10.3)**	**(2.8%)**	**97.5**	**5.8%**

	Actual WTE	Actual WTE	Actual WTE	Actual WTE	Last year WTE	Plan WTE	Actual WTE	Variance WTE	Last year WTE	Plan WTE	Actual WTE	Variance WTE	WTE	%	WTE	%
Substantive	53,736	53,727	53,892	53,796	52,615	53,011	53,951	(940)	52,808	53,374	53,820	(446)	155	0.3%	1,012	1.9%
Bank	4,328	4,346	4,206	4,498	5,021	4,497	4,250	248	4,940	4,547	4,325	221	(248)	(5.5%)	(614)	(12.4%)
Agency	738	757	682	742	934	722	602	120	998	775	704	71	(140)	(18.9%)	(294)	(29.4%)
Total WTE	**58,802**	**58,830**	**58,780**	**59,036**	**58,570**	**58,230**	**58,803**	**(572)**	**58,746**	**58,696**	**58,850**	**(154)**	**(233)**	**(0.4%)**	**105**	**0.2%**

6. Efficiency Delivery and Maturity

- **At Month 5, the system delivered £123.2m of efficiencies year-to-date, which is £0.9m (0.7%) behind the £124.1m plan.**
- The YTD plan comprised of **£96.3m recurrent and £27.8m non-recurrent schemes.** To date, **£42.1m** has been **delivered from non-recurrent** schemes (34% of year-to-date delivery, down 3% from month 4), while recurrent delivery is £81.1m (66%).
- At plan, the recurrent efficiency FOT was 72%, (£266.6m) and 28% non recurrent (£105.2m). The recurrent FOT has improved to 76% £284.8m with the non recurrent schemes reducing to 24% £88.6m.
- 89.5% (£334.3m) of the forecast schemes are classed as cash releasing, an 11% improvement from month 4. The remaining 10.5% (£39.2m) being non-cash releasing.
- The system is forecasting a full delivery of CIP plans.

£m	Year-to-date					Forecast								
				Actual Split		Plan			FOT			Variance		
Organisation	Plan	Actual	Variance	Recurrent	Non Recurrent	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent	Total
GSTT	22.9	30.2	7.3	13.0	17.2	39.6	62.6	102.1	70.3	31.9	102.1	30.7	(30.7)	0.0
Kings	24.2	20.9	(3.3)	20.9	0.0	82.4	0.0	82.4	82.4	0.0	82.4	0.0	0.0	0.0
LGT	23.6	21.8	(1.8)	13.2	8.7	43.5	13.0	56.5	42.2	14.3	56.5	(1.3)	1.3	0.0
Oxleas	14.1	14.1	0.0	0.8	13.4	9.4	24.5	33.9	3.7	30.2	33.9	(5.7)	5.7	0.0
SLaM	15.5	11.6	(3.9)	10.5	1.0	37.1	0.0	37.1	29.7	7.5	37.1	(7.5)	7.5	0.0
Provider Total	**100.4**	**98.7**	**(1.7)**	**58.4**	**40.2**	**212.0**	**100.1**	312.1	**228.3**	**83.8**	**312.1**	**16.3**	**(16.3)**	**0.0**
SEL ICB	**23.8**	**24.6**	**0.8**	**22.7**	**1.9**	**54.6**	**5.1**	59.7	**56.5**	**4.8**	**61.3**	**1.9**	**(0.3)**	**1.6**
System Total	**124.1**	**123.2**	**(0.9)**	**81.1**	**42.1**	**266.6**	**105.2**	**371.8**	**284.8**	**88.6**	**373.4**	**18.2**	**(16.6)**	**1.6**



Organisation	Forecast							
	Plan	Identified	Unidentified	High Risk	Medium Risk	Low Risk	Cash Releasing	Non Cash Releasing
	£m	£m	£m	£m	£m	£m	£m	£m
GSTT	102.1	102.1	0.0	33.7	19.4	49.0	102.1	0.0
Kings	82.4	82.4	0.0	4.7	11.9	65.8	82.4	0.0
LGT	56.5	56.5	0.0	7.7	12.8	36.0	56.5	0.0
Oxleas	33.9	33.9	0.0	8.2	18.7	7.0	14.1	19.9
SLaM	37.1	37.1	0.0	0.0	1.3	35.8	37.1	0.0
Provider Total	**312.1**	**312.1**	**0.0**	**54.4**	**64.2**	**193.5**	**292.2**	**19.9**
SEL ICB	**59.7**	**61.3**	**0.0**	**4.2**	**23.9**	**33.2**	**42.0**	**19.3**
System Total	**371.8**	**373.4**	**0.0**	**58.6**	**88.0**	**226.8**	**334.3**	**39.2**

- 61% of the efficiency plan is now assessed as low risk (£226.8m), a £17.7m (5%) improvement from Month 4.
- All schemes have now been fully identified, an improvement mainly at GSTT of £29.1m compared to month 4.
- High-risk category has decreased by 6.4% from £62.6m in Month 4 to £58.6m. This is mainly driven by certainty on scheme delivery spread across all providers.

7. System Capital Expenditure

System Capital Allocation							
	Year-to-date			Full Year			
Organisation	Plan	Actual	Variance	Plan	Allocation	Forecast	Variance against allocation
	£m	£m	£m	£m	£m	£m	£m
GSTT	35.8	19.2	(16.5)	110.3	142.4	142.4	0.0
Kings	9.6	6.0	(3.6)	36.9	40.8	40.8	0.0
LGT	11.0	11.5	0.5	26.3	26.3	26.3	0.0
Oxleas	6.2	8.1	1.9	15.0	15.0	15.0	0.0
SLaM	12.9	2.0	(10.9)	35.1	35.1	35.1	0.0
Total Provider Charge Against Allocation	**75.4**	**46.8**	**(28.6)**	**223.6**	**259.6**	**259.6**	**0.0**
ICB	**0.0**	**0.0**	**0.0**	**4.4**	**4.4**	**4.4**	**0.0**
Total System Charge Against Allocation	**75.4**	**46.8**	**(28.6)**	**228.0**	**264.0**	**264.0**	**0.0**
National Programmes					56.2	55.9	0.3
Total System Capital Allocation				**228.0**	**320.2**	**319.9**	**0.3**

- The total system capital plan for 2025/26 is £228m, 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 totaling £36m have been received across the system, an increase of £5.3m compared to month 4. This brings the total allocation to £264m.
- 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 £320.2m. Further details are provided in the next slide.
- **At Month 5, expenditure against the capital allocation stands at £46.8m year to date, £28.6m below plan**. This variance is due to slippage on schemes. However, all organisations are currently forecasting to fully spend their allocations. We continue to work with the Deputies to ensure that expenditure is aligned against the individual capital schemes.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Development of our South East London Neighbourhood Health Service**						
Meeting date	15 October 2025		Agenda item Number	**11**	Paper Enclosure Ref		**K**
Author	Holly Eden, Director of Delivery – Neighbourhoods and Population Health						
Executive lead	Holly Eden, Director of Delivery – Neighbourhoods and Population Health						
Paper is for:	Update	**x**	Discussion		Decision		**x**
Purpose of paper	To receive the report from the Chief Executive Officer						
Summary of main points	The attached presentation outlines the progress being made across South East London to develop our Neighbourhood Health Service, providing updates on delivery to date and planned activity against the five main deliverables reflected in the national Neighbourhoods approach: • The Model Neighbourhood • Model System Architypes • Model Neighbourhood Health Centre Archetypes • The National Framework for Neighbourhood Health Plans • The National Neighbourhood Health Implementation Programme •						
Potential conflicts of Interest	None						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham		**x**
	Greenwich	**x**	Lambeth	**x**	Southwark		**x**
Equalities Impact	Neighbourhoods is expected to reduce health inequalities through proactive and preventative care models and integrated care delivery supported by population health approaches						
Financial Impact	A cost and impact modelling workstream for the neighbourhood health service is in place initially focussing on Integrated Neighbourhood Teams						
Public Patient Engagement	A range of public engagement exercises have been undertaken over the last 3 years which have contributed to the development of the SEL Neighbourhoods Programme. Local Care Partnerships will continued to engage with the public during the detailed development and implementation of their local neighbourhood plans.						
Committee engagement	ICB Executive, Local Care Partnerships, Neighbourhood Based Care Board						
Recommendation	It is recommended that the Board note progress across all areas.						

South East London Integrated Care System

NHS South East London

SEL ICB: Neighbourhoods Update

October 2025

National context

The National Neighbourhoods approach has been structured around five key deliverables for which there will be national guidance/ expectations that local systems will wish to respond to:

- **Model Neighbourhood**: to include the definition, scope and expected services within a neighbourhood, what is more likely to be coordinated across multiple neighbourhoods and how we see the leadership, planning and performance management of neighbourhoods evolving
- **Model System Archetypes**: to include how contracts can fit together in different archetypes of an overall system provider landscape
- **Model Neighbourhood Health Centre Archetypes**: to include the main archetypes and the supporting logic of what services should be ideally co-located together, depending on the topography of a local community, and the approach ICBs can take to maximise their assets to support neighbourhood health.
- **National Framework for Neighbourhood Health Plans**: a joint NHSE/DHSC/LGA framework document to be published alongside NHS planning guidance which will cover the strategic element of local planning
- **National Neighbourhood Health Implementation Programme**: A national programme aims at accelerating work across places by learning together, sharing solutions, tackling challenges and delivering improvement

To support the ICB Board we have structured our Neighbourhoods update to align with this national structure:

Slide	Theme	Update
3	The model neighbourhood	**Progress to date:** Implementation of INTs, Tactical Population Health Management approach; General Practice Sustainability
4		**Planned Activity:** Staff Activation; Modern Pharmacy; Evolving the CYP model
5	The model system archetype	**Progress to date:** Outcomes framework; Integrator Partnerships; Maturity Matrix
6		**Planned Activity:** Impact modelling; Metrics; Strategic Commissioning Framework
7	The national framework for neighbourhood planning	**Progress to date:** Initial Neighbourhood Planning; SEL Engine Room
8		**Planned Activity:** Medium to Long-term Neighbourhoods Planning
9	The model neighbourhood health centre	**Progress to date:** Spotlight on Greenwich **Planned Activity**: Identifying Neighbourhood Hubs
10	NNHIP and the London Delivery Board	

The "model neighbourhood"

Progress to Date

1. Implementation of INTs

- Continued progress in the implementation of **Integrated Neighbourhood Teams (INTs) for our** three priority cohorts – multiple long-term conditions (mLTCs), frailty/ageing well, and children/young people (CYP).
- Places are **putting core enablers in pl**ace, including integrator governance and leadership groups, targeted recruitment and induction, estates readiness, and digital pathways with information governance and EMIS access.

	Children and Young People with Complex Needs	Multiple long term conditions	Frailty and end of life
Bexley	• First neighbourhood to go live Oct 25 • All live by end of Q3 25/26	• First neighbourhood live • All live - End of Q3 25/26	• First neigbourhood to go live Oct 25 • All live - TBC
Bromley	• All live	• All live by end of 2025/26	• All live
Greenwich	• To be confirmed	• Testing Q3/Q4 2025/26	• Testing Q3/Q4 2025/26
Lambeth	• All Live	• All live from April 2026	• First Neighbourhood live April 2026
Lewisham	• Planning underway	• All Live	• Expansion to frailty by Mar 26
Southwark	• All live	• Pilot live • All live from April 2026	• Pilot live • Planning underway for expansion

2. Tactical Population Health Management (PHM) approach

- **Introduction of new PHM capabilities for neighbourhood working via Ardens**, whilst work remains ongoing on the future PHM function for the system.
- This includes universal access for general practice and Integrated Neighbourhood Teams (INTs) to tools to **support identification and case management of our INT priority populations** based on the **Bridges to Health population segmentation approach.**
- Also access to the **Frimley segmentation model**, which applies a RAG (red, amber, green) rating to people's conditions and needs with real-time data tools that enable **more efficient triage and streamlined flow** across general practice

3. General Practice Sustainability: Co-developing a support offer

- **South East London has taken a co-designed, evidence-based approach to developing a refreshed GP support offer,** ensuring it reflects both the realities of frontline general practice and system priorities, while recognising the central role of practices in neighbourhood health.
- **A focused Sprint process (Aug–Sept 2025) brought together frontline staff** – GPs, nurses, practice managers and PC+ representatives – alongside SEL ICB colleagues, borough teams, training hubs and LMCs**.** This process combined local insight, national best practice and workforce intelligence to create an offer that is both practical and scalable.
- **The support offer has been signed off by the NBCB, providing a clear mandate for delivery and ongoing iteration with practices.** A second Sprint in October, led by the PC Exec and PC+ Group, is now focusing on implementation and on how SEL ICB can adopt a more strategic commissioning approach, embedding collaboration with providers in the delivery of commissioned support.

The "model neighbourhood"

Planned Activity

4. Staff activation

Workforce and Communications workstreams have recently been collaborating on developing a staff activation plan which will be rolled out in this financial year. The aim is to activate and empower the workforce across SEL (particularly those working in INTs) so that they feel ownership of neighbourhood-based care, understand their role, are equipped with the knowledge and skills they need to lead local change, and have access to the training and support they need to develop.

Activation will adopt a phased approach:

- Pre-activation baseline: Mapping each place's readiness, staff groups affected, and INT progress.
- **Phase 1 - Awareness (6 months):** Campaigns, FAQs, case studies, leadership endorsement.
- **Phase 2 - Educate and empower (12–18 months):** Training, leadership development, digital literacy, learning forums.
- **Phase 3 - Enable and embed (18+ months):** Ongoing staff forums, champions network, recognition, feedback loops.

5. Modern Community Pharmacy

- Community Pharmacy South East London (LPC) are collaborating with the ICB to develop a vision for modern community pharmacy as part of neighbourhood care.
- This will develop a Modern Community Pharmacy document which can act as a strategic template to engage with community pharmacy around their role in neighbourhoods across four key care domains – preventative care, acute care, planned care and chronic care

6. Evolving the Children and Young People model

- All places have made progress in implementing INTs to support children and young people with complex needs, based on the existing CHILDs model.
- Work is now underway across South East London to collaborative design the evolution of this model into a broader neighbourhood model for children and young people, working closely with local authority colleagues to ensure this reflects the Family First ethos.
- This is people jointly sponsored by the Babies, Children and Young People Strategic Partnership Board and the Neighbourhood Based Care Board and aims to report in Q4 25/26 for implementation within 26/27

The "model system archetype”

Progress to Date

7. The SEL Neighbourhoods Outcomes Framework

The SEL Neighbourhoods Working outcomes framework, presented to the ICB Board in July, was developed through engagement with colleagues from across the system, and **aims to reflect the impact we anticipate for all partners and residents.**

Crucially, this cannot stop with health; the impact will be felt across social care, the voluntary and community sector, and those working within the wider determinants – only with everyone in the system participating and realising this impact can the neighbourhood model achieve its holistic ambitions for transforming how we deliver services. This outcomes framework attempts to capture the full scope of this ambition reflected by neighbourhood working**.**

8. Integrator Partnerships

All six places across South East London have now established their integrator partnerships that bring together NHS trusts, primary care, social care and the VCSFE within a place, supported by a host organisation. Integrator Partnerships will drive forward Neighbourhood working and is a critically important preparatory phase for partners in each Place to ensure they are best placed to respond to future development and to make progress on Neighbourhood working.

9. The SEL Neighbourhood Maturity Matrix

A SEL Neighbourhood Maturity Matrix has been developed to help partnerships and their integrator host organisations **understand how neighbourhood-based care develops over time.** It sets out both functional domains (e.g. operational coordination, infrastructure, PHM) and relational domains (e.g. trust, partnerships, culture) that need to mature to enable effective neighbourhood working.

The maturity approach is intended to be supportive but not exhaustive. It is not a blueprint or specification. The intention is to:

- Provide prompts that promote open discussion, debate and deep reflection within and across place partnership arrangements supported by host integrator organisations on what the role of local partners and the integrator host is in enabling neighbourhood health.
- Enable local partners to reach a common view as to the current level of maturity of local functions; and
- Jointly identify key developmental priorities

Each integrator is now being using the matrix to inform initial developmental priorities and ensure these are reflected in local plans This will also be reported into the ICB Board for their continued oversight.

The "model system archetype”

Planned Activity

10. Impact Modelling

The SEL BI team, Lewisham PHM team, and PPL are working as a blended team to develop what will be **the most systematic attempt to model the impact of the shift to Neighbourhood working to-date**, with an initial focus on the Frailty and Multiple LTC INTs.

The team built on the Theory of Change and Outcomes Framework to develop **logic models** setting out the mechanisms through which INTs are expected to impact the distribution of demand across the system and therefore the associated (theoretical) financial implications

The initial modelling exercise, whose timeline is set out on this slide, will produce an initial set of results on the impact of INT rollout on demand and the associated theoretical financial impact. The intention is to **work with providers to build on the initial financial modelling** to account for their real cost bases to inform discussions on funding flows and future contracting.

The core impact model and the associated dataset have a **wide range of use cases beyond financial modelling**, including workforce modelling, evaluating future business cases for neighbourhood working, and identifying opportunities for preventative care

11. Metrics

Building on the Outcomes Framework & Theory of Change, work is now taking place to **identify key metrics associated with the initial priority cohorts to enable the effective measurement of impact/ benefits realisation.** Once agreed, these metrics will inform the development of a dashboard that will support monitoring and reporting into the NBCB.

12. Strategic Commissioning

Work is underway to develop **a strategic commissioning framework for neighbourhoods** which aligns with the ICB’s Five Year Strategic Commissioning Plan and national policy development, particularly around model system archetypes. This work will consider how we shift towards **population and outcomes-based commissioning approaches** and maximise **new financial incentives and contract forms** that may emerge. The work will be developed in partnership with the ICB’s Strategic Commissioning Directorate and place leadership.

Milestone	Date
Finalise patient-level data request for acute, primary, and community care with SEL BI team	Sept 25
Agree approach and assumptions for financial model (acute, primary, community cost implications)	Sept 25
Start modelling using patient level data	Oct 25
Interim report summarising finalised approach, available data, and key assumptions	Nov 25
First run data analysis complete	Oct 25
First draft set of results shared for feedback with key stakeholders	Nov 25
Share final report including next steps to develop modelling approach, toolkit, and engagement with providers	Dec 25

The "national framework for planning”

Progress to Date

13. Initial Neighbourhood Planning

All places in South East London have undertaken **local planning** to enable the delivery of Neighbourhood working. These plans reflect both local health improvement priorities identified with Joint Health and Wellbeing Strategies as well as system-wide priorities reflected in our Joint Forward Plan and our Neighbourhoods Framework. Planning to date has been focused predominantly on the 2025/26 financial year.

As part of the broader SEL Neighbourhood Programme there are **six established enabling workstreams** responsible for delivering the key tools and infrastructure required across the system to enable Neighbourhood working. Again, planning to date has been focused predominantly on the 2025/26 financial year.

	Workstream (sub-workstream)	
1	Delivery of INTs and Neighbourhoods	INT delivery
		Models of care for priority areas
2	Population Health Management approach & data	
3	Flexible workforce models and culture change	
4	Comms and Engagement	
5	Strategic planning and resource allocation	Strategic commissioning
		Estates
		Modelling and impact
6	Digital	

14.The SEL Engine Room

Given the complexity and interdependencies of SEL's Neighbourhood programme, a **central Engine Room has been established**. The Engine Room acts as a **programme management and coordination function** at SEL level, providing oversight, aligning activities, facilitating shared learning, and maintaining momentum. It supports the Neighbourhood Based Care Board (NBCB) by synthesising information from workstreams and Places, escalating risks and issues, and ensuring decisions are informed by accurate and timely data.

The Engine Room also **aims to increasingly foster a ‘test and learn’ culture**, encouraging continuous improvement and iteration of models based on emerging evidence and local experience.

NBCB Highlight reports

These aim to provide a valuable single point of clarity and visibility for both the Board and for Place and workstream leads. In a highly interconnected and changing programme context, this will support leads to maintain a view of all relevant activity, plan ahead and manage dependencies, and make connections across the system.

The “national framework for planning”

Planned Activity

15. Medium to Long-term Neighbourhoods Planning

Delivering the shift to neighbourhood working requires **a long-term approach and a complex and multi-faceted change programme** with significant alignment between activities delivered and coordinated across places, providers, system and enabler functions.

Our initial focus has been on establishing INTs for specific populations, but we need to widen this out to **reflect the broader paradigm shift in how and where care is delivered, recognising the underpinning community assets, prevention and targeted interventions**. We will also need to be ready to instigate work that has not yet come online but is signalled in the 10 year plan, such as genomics.

With this context in mind SEL is developing a system-wide roadmap that:

- Provides a common framework and language for neighbourhood development and delivery against the 10 Year Plan.
- Shows clear alignment between and across local, regional, and national policy and implementation.
- Brings together related workstreams, such as digital, workforce, commissioning, and estates.
- Recognises that different places are at different levels of readiness and maturity.
- Supports sequencing of activity in line with national funding cycles and procurement windows
- Gives visibility to workstream leads and wider partners, helping them plan ahead within a shared system framework.

The development of our long-term road map for neighbourhoods within South East London will assist with and compliment the development of our **broader planning requirements set out within the draft planning guidance issues in August 2025**.

Five-year strategic commissioning plan

- Integrated plan that cover service plans, workforce, finance, quality improvement and digital.
- Will bring together local neighbourhood plans into a population health improvement plan (PHIP).
- Plan will include details on overarching population health and commissioning strategy, new models of care and investment programmes aligned to the 10 YP, how funding will be used to meet need/maximise value/deliver priorities, and how the ICB core capabilities will be delivered.

Local Neighbourhood Plan(s)

- Part A: Population health improvement plan which includes social care, public health and BCF, co-ordinated by Health and Wellbeing Boards.
- Part B: Delivery plan for neighbourhood health services.

Model neighbourhood health centre archetype

16. Progress to Date: Spotlight on Greenwich

Greenwich has recently explored how it can **navigate the longstanding estate challenges** it faces (limited capital investment, constrained capacity, complex approval processes) by rethinking how spaces can **better support neighbourhood-based health and care**, namely by **identifying Neighbourhood hubs**. The approach:

- A Local Estates Forum is now in place, with members drawn from across the system. This is working alongside the GP Estates Strategy to guide transparent and system-wide decision making.
- A structured process has been undertaken to explore challenges and build consensus around Neighbourhood Hub options – this involved a desk review, borough-wide workshops, and validation through the Estates Forum.
- Hub preferred options have been identified for each of Greenwich's four neighbourhood clusters/geographies

17. Planned Activity – Delivering Neighbourhood Hubs

Across South East London, work is already underway at Place level **to identify prospective neighbourhood hubs**, supported by the SEL Estates workstream. Initial mapping activity is in progress, but further structured support is required to build a coherent and consistent view across the system.

The work planned for the next quarter includes:

- Supporting Places to understand and explore the current challenges and opportunities around current estates.
- Understanding available estates and agreeing which hubs to prioritise
- Establishing what is needed to bring each hub into operation, including capital works, IT infrastructure, and other enablers, so that they are functional and able to support neighbourhood working.

Neighbourhood hub identification

To achieve this the Estates team is currently developing a support offer based on the recent Greenwich approach. This covers four key stages:

1. **Diagnostic** – provide a light touch overview of the current position for each Place.
2. **Design a flexible engagement offer** that meets each Place where it is at. It will include agreeing the shared principles of what is required from a neighbourhood hub, built from the 10 year plan, London TOM etc Drawing on the recent Greenwich example.
3. **Carry out the engagement** – likely in the form of cross-system workshops and 1:1s.
4. **Mapping and consolidation** – map the outputs from the engagement in a structured and consistent way.

Where do we hope to get to?

The consolidation activity aims to provide:

- A clear view of the current status of hub identification across all six Places.
- A comparison of where Places are aligned and where variation remains.
- A system-wide picture of what is needed to progress the establishment of functional neighbourhood hubs, including enablers such as capital investment, IT infrastructure, and programme support.

NNHIP and the London Neighbourhood Delivery Board

SEL is actively engaged in both the **National Neighbourhood Health Implementation Programme (NNHIP)** and the newly established **London Neighbourhood Delivery Board**. Together, these programmes represent a significant opportunity for SEL to accelerate neighbourhood working, influence national policy, and strengthen the infrastructure needed to deliver the 10-Year Health Plan through local, place-led action.

- **The National Neighbourhood Health Implementation Programme (NNHIP)** is supporting 43 Places across the UK to strengthen neighbourhood-based health and care.
- **Southwark and Lambeth are part of Wave One**, working with national and local coaches to test new approaches for people with long-term conditions and those at rising risk.
- **The programme aims to accelerate integrated working**, share learning rapidly, and influence national policy on key enablers such as funding and digital.
- **The London Delivery Board coordinates neighbourhood implementation across the capital**, grouping shared enablers into five project boards (Digital, Commissioning and Contracting, People, Infrastructure, and Implementation/Community of Practice).
- **For SEL, this provides structured support while retaining flexibility to shape delivery locally.** Early focus is on workforce development, digital interoperability, commissioning reform, and embedding shared learning across neighbourhoods.