South East London Integrated Care System

NHS South East London

Integrated Care Board – Meeting in Public

12.30 to 16.10 on 16 April 2025

Dulwich Room, Hambleden Wing,
King's College Hospital, Denmark Hill, SE5 9RS

Chair: Sir Richard Douglas Chair SEL ICB

Agenda

No.	Item	Paper	Presenter	Timing
	Opening Business and Introduction			
1	**Welcome** • **Apologies for absence** • **Declaration of Interest.** • **Minutes of previous meeting actions & matters arising**	 A B	RD	12.30
	Borough Showcase			
2	**Southwark – Borough Showcase**	-	DS	12.40
	ICB Corporate Business			
3	**Equality Diversity and Inclusion Reports**	C p20	TF	13.10
4	**Operational Plan 2025/26**	D p31	SC	13.20
	Report for Assurance and discussion of current issues			
5	**Chief Executive Officer's report**	E p40	AB	13.35
6	**Overall Report of the ICB Committees and Provider Collaboratives**	F p62	TF	13.45
7	**Board Assurance Framework**	G p111	TF	14.55
8	**Finance Report**	H p132	MF	14.05
9	**Performance Report**	I p155	SC	14.25
10	**Quality and Safeguarding Report**	J p172	EA	14.45

Delivering our Integrated Care Strategy				
11	**Development of Neighbourhoods and Integrated Neighbourhood teams in SEL - update**	K p179	CJ	15.05
Reducing Health Inequalities				
12	**Vaccination performance and approach**	L p207	ABh	15.30
Closing Business				
13	**Any other business**	-	RD	15.55
14	**Public Questions and Answers**	-	RD	16.00
CLOSE 16.10				

Presenters

RD	**Sir Richard Douglas**	**ICB Chair**
AB	**Andrew Bland**	**ICB CEO**
DS	**Darren Summers**	**Southwark Place Executive Lead**
SC	**Sarah Cottingham**	**ICB Director of Planning and Deputy CEO**
TF	**Tosca Fairchild**	**ICB Chief of Staff**
MF	**Mike Fox**	**ICB CFO**
EA	**Dr Elizabeth Aitken**	**Acting ICB Chief Nurse**
ABh	**Dr Angela Bhan**	**Bromley Place Executive Lead**
CJ	**Ceri Jacob**	**Lewisham Place Executive Lead**

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members and attendees
Date: 16/04/2025

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

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

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Ify Okocha	Partner member, Community	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 9. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2021 1996 1992 1992 1992 1985 1985 1985 1985	Current Current Current Current Current Current Current Current Current
Diana Braithwaite	Place Executive Lead, Bexley	none			
Debbie Warren	Partner member, local authority	1. Royal Borough of Greenwich salaried Chief Executive transacting financially with the SEL 2. Lead London Chief Executive on Finance, also contributing to the London Councils lobby on such matters including health.	Financial interest Non-financial professional interest	December 2018 (acting in role from July 2017) March 2020	Current Current
Dr. George Verghese	Partner member, primary care	1. GP partner Waterloo Health Centre 2. Lambeth Together training and development hub director 3. Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	2010 2022 2019	Current Current Current
Ranjeet Kaile	Director of Communications and Engagement	Non-executive Trustee - People's Health Trust Charity	Non-financial professional interest	April 2024	-
Dr Elizabeth Aitken	Acting ICB Chief Nurse	Consultant Physician in Elderly Medicine Clinical Lead for Community Diagnostic centres London Region	Non-financial professional interest Non-financial professional interest	1 Jan 2024 1 Jan 2024	Current Current
Philippa Kirkpatrick	CDIO	Director – inactive company Philippa Kirkpatrick Ltd in use prior to start of ICB role	Financial Interest	April 2022	-
Crystal Akass	CPO	Nothing to declare	-	-	-

Integrated Care Board meeting in public

Minutes of the meeting on 29 January 2025

Bexley Council Civic Offices

Present:

Name	**Title and organisation**
Richard Douglas [Chair]	ICB Chair
Dr Angela Bhan	Bromley Place Executive Lead
Andrew Bland	ICB Chief Executive Officer
David Bradley	Partner Member Mental Health Services
Diana Braithwaite	Bexley Place executive Lead
Andrew Eyres	Lambeth Place Executive Lead
Georgina Fekete	Non-Executive Member
Mike Fox	Chief Finance Officer
Dr Toby Garrood	ICB Joint Medical Director
Ceri Jacob	Lewisham Place Executive Lead
Prof Clive Kay	Partner Member Acute Care
Paul Larrisey	Chief Nurse
Peter Matthew	Non-Executive Member
Dr Ify Okocha	Partner Member Community Services
Anu Singh	Non-Executive Member
Darren Summers	Southwark Place Executive Lead
Dr George Verghese	Partner Member Primary Care
Debbie Warren	Partner Member Local Authority

In attendance:

Ben Travis	Chief Executive Lewisham and Greenwich Trust
Gabi Darby	Greenwich COO
Prof Ian Abbs	Chief Executive Guys and St Thomas NHSFT
Tosca Fairchild	Chief of Staff
Sarah Cottingham	Executive Director of Planning and Deputy CEO
Neil Kennett-Brown	System Sustainability Team
Philippa Kirkpatrick	ICB Chief Digital Information Officer
Crystal Akass	Chief People Officer Guys and St Thomas NHSFT
Meera Nair	Chief People Officer Lewisham and Greenwich NHS Trust
Yolanda Dennehy	Director for Adult Social Care and Health LB Bexley
Geraldine Russell	Age UK Bexley
Tara Piasetski	Public Health consultant
Debra Travers	Associate Director for Adult Social Care LB Bexley

1.	**Welcome and Apologies**
1.01	Sir Richard Douglas welcomed all to the meeting and apologies were noted from Ranjeet Kaile and Paul Najsarek.
1.02	Georgina Fekete was welcomed to the board as lay member to her first meeting.
1.03	The Board thanked Meera Nair for her work as south east London chief people officer and welcomed Crystal Akass who would now take on the role.
1.04	There were no additional declarations of interest in relation to matters in the

	meeting.
1.05	The minutes of the previous meeting were approved as a record of the meeting.
1.06	The action log was reviewed.
2.	**Mental Health**
2.01	Sir Richard Douglas explained that the Board had considered part of the paper at its November 2024 meeting and agreed to continue the discussion at its next meeting. Sarah Cottingham noted that at the last board a review intensive and assertive outreach services and an in-patient quality transformation plan had been presented. Actions in relation to the assertive outreach services were on track for completion April 2025 and the in-patient quality transformation plan had been shared publicly.
2.02	Sarah Cottingham presented focusing on prevention and early intervention in relation to adult mental health, an ICS's strategic priority and an important factor in reducing demand on secondary care services, freeing up capacity to help those who needed it most. Each borough was pursuing a range of different initiatives, but common themes across all six boroughs were: a focus on making sure prevention and early intervention work targeted population groups at particular risk of experiencing health inequalities, including Core20+5 ; building and growing partnerships across primary and secondary care and with the voluntary community and social enterprise sector; and including the voice of people with lived experience in the design of services to meet their needs.
2.03	Andrew Eyres introduced work by the Lambeth Living Well alliance to provide services in Lambeth's 14 Primary Care Networks. The *Primary Care Alliance Network* was a multidisciplinary clinical network including GPs, mental health practitioners, social prescribers providing additional support to people being looked after by general practice in a way that avoided them needing to be escalated to secondary care services. The *Staying Well team* offered non-clinical support in a range of other areas such as psychosocial, medications, housing, benefits or employment. The services had helped more people stay in their homes, reduced referrals and demand on mental health services and increased independent, supporting 1200 people and avoiding referrals to the single point of access for community health services for about 400 of these, and support through primary care (rather than community mental health) for 300 people.
2.04	Dr George Verghese and David Bradley shared examples of patients who it had been possible to help in general practice with the mental health practitioners and support with issues such as housing rather than emergency care.
2.05	Meera Nair welcomed the work across mental and physical health noting that implementing workforce models that crossed these boundaries was sometimes difficult and so good examples and a plan would be important.
2.06	Sarah Cottingham suggested work in boroughs on whole-person care and physical health checks for people with Serious Mental Illness were good examples of such work across boundaries. To improve care for people in emergency departments with mental health conditions, mental health advice was provided via psychiatric liaisons, and ED staff were offered training in mental health.
2.07	David Bradley added that the Mind and Body programme with Kings Health Partners had been successful in educating staff and building awareness of the benefits of mental and physical healthcare integration.

2.08	Ben Travis noted that high numbers attended emergency departments with mental health issues who were unknown to mental health services, and asked if there had been analysis of unmet need to allow the system to engage early and help prevent crisis for these patients
2.09	Sarah Cottingham responded that in Bromley Bexley and Greenwich those attending A&E with mental health tended to be unknown to services, compared to those in inner boroughs, despite equivalent community offers, and so the current focus was seeking to understand this variation.
2.10	Andrew Eyres added that central London A&Es often included significant numbers from outside south east London or outside London and may not be known to south east London services.
2.11	Georgina Fekete welcomed the presentation of examples but asked if there was quantitative target to reduce the 11% of south east Londoners with a long term mental health condition across south east London that the ICB was working towards.
2.12	Sarah Cottingham noted that it was important to be able to differentiate between different mental health populations in areas of south east London, and current targets tended to be process or access related, and so it was good to challenge ourselves whether there were ways to better define ambitions around outcomes.
2.13	Dr George Verghese suggested that there was an opportunity to integrate with 111 service option 2 to help describe need and was already identifying fragmentation in crisis service support.
2.14	Andrew Eyres commented that Council household surveys showed a fall in reported measures of happiness over recent years. The causes of need may sit well beyond health and care services for example in relation to housing, employment, poverty and racism, making setting a healthcare metric difficult. It was also sometimes difficult, for example in relation to homelessness and mental health, to disentangle cause and effect.
2.15	Peter Matthew asked about effective engagement with wider partners such as local authorities and others and in relation to homelessness, pointing out increasing numbers presenting to housing associations with mental health conditions.
2.16	Dr Toby Garrood noted that a consideration of the prevalence of mental health conditions in people using his own service found about 25% with conditions such as anxiety and depression which were known to predict poorer outcomes generally. Adapting care and being mindful of mental health conditions as well as treating the disorder itself was important.
2.17	Sir Richard Douglas reflected that quantification was one of the aims of the borough approach which aimed to measure within a borough and work with local partners, but there was a further challenge to track how interventions were tracked for effectiveness. Using 111 plus 2 may be an interesting route to pursue for more data**. Action to pursue through committee structure and work.**
2.18	The Board **noted** the updates provided on prevention and early intervention.
3.	**Sexual safety and domestic violence**
3.01	Tosca Fairchild outlined the guidance which had been issued in relation to sexual safety and domestic violence. Ten principles or commitments for organisations to make had been set out and the main partner organisations in south east London had signed up to charter. An additional amendment to the Equality Act of 2010

	required employers to take steps towards a proactive and preventative approach to sexual harassment. The ICB had signed the charter and developed a sexual misconduct policy based on the NHSE guidance; staff were being engaged on the policy and an equality impact assessment was being completed.
3.02	Peter Matthew noted that in presenting the implementation of national guidance the impression could often be given that organisations were starting from scratch, and it would be helpful to ensure that implementation built on existing work and policies.
3.03	Prof Clive Kay asked how the ICB would know that the system was being true to the principles of the charter and that they were being delivered.
3.04	Sir Richard Douglas noted that the ICB could put in place measures directly in respect of its own staff but through the Audit and Risk Committee would assure itself that governance was in place in the organisations, without re-doing the work within organisations. There was a question about how this might apply to primary care and VCSE parts of the system.
3.05	Anu Singh noted that organisations had signed up to the London Mayor's work on violence against women and girls as a visible piece of work aimed at culture, and so to focus only on process measures seemed a backwards step.
3.06	Sir Richard Douglas agreed that good organisations would already be addressing these areas, but and the guidance was aimed at trying to make sure this was the case – a useful test.
3.07	Andrew Bland noted that there was an obligation to ensure that the guidance was followed, but the system could also choose to take the opportunity to share across south east London some of the best practice. The ICB may also be able to add value by arranging through its INT work that smaller organisations within VCSE and primary care could be supported to meet these and other standards who may not have the resources otherwise.
3.08	The Board **noted** the national guidance and work set out under 'next steps' designed to ensure SEL ICB and its partners are aware of their responsibilities and compliant with all requirements.
4	**Specialised Services Delegation**
4.01	Sarah Cottingham presented a proposal for the delegation of some specialised services to the ICB in line with national policy for the board's endorsement. Work to prepare for delegation included a range of care pathway service transformation pilots to improve quality, equity of access and value. SEL ICB was part of the South London Pathfinder programme, working with NHSE London and other ICBs on a future operating model including flows into London from the South East region. Some legacy risks had been identified although thanks to good collaboration from all system partners in the work and the South London Office of Specialised Services the Board could be confident about the potential of delegation from 1 April, and were recommended to give approval to sign the agreements for delegation.
4.02	Prof Ian Abbs supported the delegation, pointing out that there were benefits for south east London by the location of large tertiary providers within the area, but also associated risks that needed to be mitigated. The population-based allocation model currently suggested that South East London were over-provided with

	specialised services and a convergence factor needed to be applied which created a financial risk to the ability to provide the specialist care needed by south east London residents. In addition to the £650m allocation direct to South east London, the health economy relied on spend from allocations from other integrated care boards with variation approaches to management of their allocation for example the treatment of growth.
4.03	Anu Singh expressed concern about convergence adjustments, given the financial context of the south east London systema and the risk of demand growth. Realising the opportunity presented by delegation to consider these services in a whole-pathway approach may have cost implications due to previous underfunding.
4.04	Sir Richard Douglas noted that with the chief executive he would continue to advocate for South east London in respect of the allocation formula calculations and the issue of payments from other ICBs. Andrew Bland noted that London ICBs were working together, and although convergence adjustments would happen irrespective of delegation, approving delegation offered the Board an increased level of control which may help it mitigate any risks and implement the shift from acute to community care.
4.05	The Board **noted** the Collaboration Agreement with all London ICBs and NHS England and its underpinning Host ICB agreement, which will be ready for review and Executive signature before 1 April 2025.
4.06	The Board **authorised** the ICB Chief Executive to sign the Delegation Agreement with NHS England before April 2025.
4.07	The Board **agreed** that internal ICB governance policies will be amended to support delegation - including the Scheme of Reservation, Delegation and Standing Financial Instructions.
5	**Chief Executive Officers report**
5.01	Andrew Bland referred the Board to the report, highlighting leadership moves including the announcement that Professor Ian Abbs would stand down from the role of Chief Executive Office at Guys and St Thomas NHSFT once a successor had been recruited. Although staff were still leaving the organisation, the management cost reduction programme had concluded and had been undertaken by the executive in an appropriate manner with due attention to taxpayers money. Efforts had been made to minimise the impact on staff, and this had involved trying to find opportunities within or outside the organisation resulting in a lower redundancy bill. Housing had a massive impact on the health and wellbeing of staff and residents and the ICB was joining the discussion through the South London Health and Housing Coalition. The agenda item on the neighbourhood health service item would launch a key element of the boards work in pursuing population health across the whole system.
5.02	Prof Clive Kay noted the conclusion in the report that GP collective action so far had a minimal negative impact on the system and asked if this was due to the mitigating actions taken by the ICB and primary care.
5.03	Andrew Bland pointed out that because it was not possible to determine practices or individuals taking part, there may be an increase in action in the future and some of the impact may become obvious only after some time. Dr George Verghese

	noted that due to the varied nature of the action there may be a 'long tail' to the action and some of the action may be hard to measure in a quantifiable way. Tosca Fairchild noted that calls at London level had largely been stood down for the time being.
5.04	Prof Clive Kay asked in relation to the reports on vaccination in Bromley and asked if there was information on uptake in other boroughs and any lessons which could be shared across Place and providers.
5.05	Dr Angela Bhan noted that reflecting a national trend each borough had seen about 5-10% lower uptake of vaccinations than previously. Huge efforts had been made by public health teams to improve uptake and increase the number of points at which people could access vaccinations for example in pharmacies. Uptake remained a concern however particularly for those under 65 years of age and vulnerable. The Board could be provided with a report at a future meeting.
5.06	Sir Richard Douglas suggested that a report be brought back as an agenda item outlining what had happened in Places and institutions, how this compared to other areas and whether the issues were local in origin. **Action**
5.03	The Board **noted** the CEO Report
6	**Board Assurance Framework**
6.01	Tosca Fairchild presented the Board assurance framework, noting that some risks had been de-escalated and three were recommended for closure as laid out in the paper. The risks had been subject to discussion in the committees of the Board.
6.02	The Board **approved** the Board Assurance Framework
7	**Overall report of committee and provider collaborative**
7.01	Tosca Fairchild referred to the report of the activities of committees and highlighted decisions escalated to the board in the paper, including acceptance of the outcome of the Emergency Planning Resilience and Response Annual report, a decision to delay 111 procurement, and terms of reference of board committees.
7.02	The Board **confirmed acceptance** of the outcome of the ICBs 2024 Emergency Planning, Resilience and Response core standards assurance assessment, which determined the ICB was fully compliant across all relevant standards.
7.03	The Board is asked to **noted** its decision to delay procurement of 111 services for South East London for one year, to enable national guidance to be released and assessed and any required changes to the ICB's draft commissioning proposals to be made.
7.04	The Board **approved** revised Quality and Safeguarding Committee Terms of Reference.
7.05	The Board **approved** revised Lambeth Together Care Partnership Board Terms of Reference.
	Quality and Safeguarding update
7.06	Paul Larrisey updated that

- No further safety incidents had been reported in quarter 3 of 2024/25 in relation to the Synnovis cyber-attack incident and the system continued to work through any reports of harm arising from the incident.
- The south east programme to review paediatric audiology services continued in response to the national policy, and next steps would be reported back to the Board.
- The ICB had signed up for phase two of the *child protection information system* roll out to help agencies involved in child safeguarding including primary care to share information, starting as a pilot in Lewisham before being extended to the rest of the system.
- All three south east London organisations providing maternity services reached compliance in relation to the *Maternity Incentive Scheme and Saving Babies Lives Care Bundle.*
- An improvement had been noted for King's College Hospital NHSFT in relation to maternity and they had been stepped down from the maternity safety programme.

7.07 Sir Richard Douglas noted that moderate harms had been identified in relation to the Synnovis incident and asked what 'moderate' entailed.

7.08 Prof Ian Abbs noted that it tended to be delays to operations absence of a test result. David Bradley noted that an example might be a patient with mental health issues whose test result had to be repeated and who found each blood taking a traumatic experience requiring restraint because of anxiety around the procedure.

Performance update

7.09 Sarah Cottingham noted that **A&E performance** had been challenged through winter pressures and the impact of higher levels of Covid-19, and other respiratory viruses. There was a huge system focus on maintaining the position and securing further improvement and there had been some sights of positive improvement over January.

7.10 The system had sought to improve access and reduce waiting times for **elective care and cancer**, with a key challenge being the legacy of the Synnovis incident, however there had been month-on-month improvement in elective long waits and positive cancer performance against plan although the 62 day target remained a challenge. Thanks to the work of acute trusts in improving these two areas, there had been in broad terms a reduction in the level of escalation the system was under in relation to these targets.

7.11 **Non-acute performance** over a range of targets was positive, except GP appointments which were on plan but with variation by borough within the aggregate position and work was underway with colleagues to address this.

7.12 A new target in relation to **out-of-area placements** for mental health was being agreed, but this continued to be monitored locally with a view to reduce the number, recognising the quality benefits of treating patients closer to their homes.

7.13 Prof Clive Kay reflected that despite continuing challenges in the current year, the acute trusts and the system seemed to have coped better than previous years and staff involved should be thanked for their efforts.

7.14 Ben Travis agreed that the planning for winter and the joined up working between partners had led to a better system response. This did not hide the significant pressure and risk which was being managed, for example with extra patients being

	put in wards.
7.15	Sarah Cottingham noted that performance was better than previous years, and there was good system working. There continued to be efforts to address variation across hospital sites, although there had been material improvements for example at both sites.
7.16	Peter Matthew asked about the definition of a GP appointment in the target and asked if there was a shift away from face-to-face appointments.
7.17	Ceri Jacob noted that access was one part however based on complaints from patients it was how access was provided and the triage process which concerned patients and so an area to follow up on.
7.18	Dr George Verghese noted that the number of appointments with the wider GP team had increased and data was available online.
7.19	Prof Clive Kay asked if there was an opportunity to learn from the positive improvements across all areas for the next year.
7.20	Sarah Cottingham suggested that with a precise scope an update could be brought, although system boards routinely showcased work in different parts of the system for mutual learning.
	Finance update
7.21	Mike Fox noted that the system was reporting a £69m deficit position, £6m adverse to plan. The main drivers of this position were the pathology incident and some slippage against delivery of the cost improvement programmes. Considered without the impact of the pathology incident, the system would be broadly on plan but still with a deficit to recover in the last part of the financial year. Factors to note and discussed by the integrated performance committee included an upward trend in the number of workforce despite the plans reliance on reductions in WTE. Against a CIPs amounting to £270m savings, £250m were delivered, but within this a large proportion were non-recurrent, leaving an impact on future sustainability. Additionally, two providers were experiencing significant challenge in meeting financial plan and the ICB was working with the providers and the whole system do ensure the financial plan was delivered.
7.22	Sir Richard Douglas asked how the impact of the synnovis pathology incident would be treated by NHS England for the current year.
7.23	Mike Fox noted that this was not yet clear but the system was not expecting to be able to close the gap created by the impact of the incident.
7.24	Sir Richard Douglas noted that there remained a further unmitigated gap of £20m which must be recovered in the remaining quarter as the system was already in deficit, but this challenge was important to see in the context of a £1.5bn quarterly spend. Any deficit in the current year would increase the challenge for the following year.
8	**Planning for 2025/26 and beyond**
8.01	Sarah Cottingham advised that a national NHS 10-Year Plan was being developed and planning guidance was still awaited. However, the planning context was already known and involved three priority shifts: sickness and treatment to prevention; hospital care to community care, and analogue to digital. In south east London there was a need for strategic improvement in population health and reducing inequalities, improving access performance and quality of services, and addressing the underlying financial deficit in the context of financial

	challenges across the system including in local government. It was important to focus on priority areas set in the strategic objectives of the ICS. Planning would need to address not just financial improvement but also population health and access, performance and quality, and the Medium Term Financial Strategy (MTFS) aimed at enabling this by achieving a sustainable breakeven position by 2027/28, target investment towards community based care and young people in particular, funding for population health and inequalities through re-orienting existing investment and recognition of the likely need for some invest-to-save funding to deliver cost improvements necessary for sustainability.
8.02	Mike Fox noted that the medium-term financial strategy (MTFS) set out the strategic intent for allocating resources, whilst the Medium Term Financial Plan showed the overall impact of resource allocation against existing and projected costs, as well as a 'do-nothing' scenario, and the impact of a 4% year on year CIP expectation. Delivering this would require significant effort and external support had been commissioned as well as work on system sustainability which drew a team of senior managers from across the system partners to look at wide-ranging transformational programmes. Some of the opportunities had been chosen as priorities and set out in the paper, and a rolling programme of identifying opportunities would run as well.
8.03	Sarah Cottingham outlined that the planning guidance was expected imminently but it was already known that the financial position was key, but also a range of operational and performance would need to be addressed as part of the national ambitions about improvement.
8.04	Anu Singh welcomed the paper addressed the ambitions for financial sustainability, doing things differently and transformation that the board had been discussing. Noting a lack of ambition called out by the public accounts committee as a challenge for the NHS, she asked if the Board was being as bold as it could be as some of the transformational work would need to shift from what was currently being done in a significant programme approach.
8.05	Debbie Warren asked if setting a 5% target across the board would result in more of the same overspending and missing the target, and whether a more detailed look on outlying areas was needed. Savings could not keep coming from the same areas, and so to achieve the innovation something would need to give. Although £20m was relatively small compared to £1.5bn, it was significant and would likely require looking at one off spending which would then add to the problem for the future year. The question was how to be more transformative and innovative without placing more demands on the same people who were dealing with the day-to-day management of the position.
8.06	Georgina Fekete asked recognising the financial situation why the 4% over two years had been chosen rather than 5%.
8.07	Ben Travis commented that the provider sector would be asked for an unprecedented level of change and efficiency but called for a recognition of the different starting points of organisations. A three-year plan to reach break felt the right balance between what was achievable but still maintained the requisite level of ambition. He supported the attempt to move to the neighbourhoods but suggested some investment in project costs would be needed. The financial challenge facing social care.
8.08	Prof Clive Kay noted that the system sustainability work was useful but as

	members had raised something quite radically different would need to be done in the next five years and asked how the Board could have this discussion, rather than work that tweaked current ways of working.
8.09	Ceri Jacob suggested that focus on health inequalities and the longer term was itself radical if it could be maintained. There was also a need for consistent implementation of agreed changes in every part of the system and further benchmarking may be helpful for the board.
8.10	Dr Toby Garrood suggested that the ICS should give attention to how wide and deep organisations were going with clinical engagement; without which significant sustainable solutions would not be achievable. Common measures of outcomes and a data infrastructure which was accessible to all would also be an enabler of the work.
8.11	Sarah Cottingham welcomed comments noting that although ideas had been generated by the senior teams across the system, new ideas were always welcomed, and there was some clinical engagement. It was right that health inequalities spending was radical and to preserve this funding would require board support. With the increase of investment in mental health it was important to address this at a borough level and particularly Lambeth and Southwark. The choice of 4% was based on it being accepted generally as the maximum achievable in terms of cash-out savings, although there would be a challenge to do more. The comments on shift to
8.12	Mike Fox noted that every effort would be made to secure recurrent savings, but given the short time available some non-recurrent may be needed. 4% was considered the maximum sustainable and safe reduction. He added that should the board support preserving inequalities funding it would also need to support the necessary steps to other areas of fund to achieve it and justify the spend given the system was effectively using money outside its allocation.
8.13	Sir Richard Douglas proposed that the level of ambition in the plan was radical given the shift of spending involved. The ideas were brought to the board who would need to help if they felt it was not ambitious enough, and some work on incentives or the 'how' would also be necessary. There was no option involving a longer time-period or larger deficit.
8.14	Andrew Bland suggested that the system was likely to be asked to achieve a higher level than 4%, and the ambition should be to have a CIP programme identified early enough to avoid an underlying problem for future years. It would be important also to consider greater prominence to the role of digital as part of planning.
8.15	The Board **noted** the update on planning.
9	**Developing our Neighbourhood health service**
9.01	Ceri Jacob presented an updated on the development of a neighbourhood service, noting that • Neighbourhoods were mentioned in the 2022 Fuller report and many parts of south east London had good foundations of integrated working on which to build. The success would be measured in a common way across the system, but it was important to recognise different start points for each of

the Borough.

- The changes involved would represent a significant cultural change from planning to operational colleagues. Key factors were the importance of joining up social care with proactive work, whilst working together with communities, and the importance of technology to enable the work.
- Neighbourhoods were a geography which made sense for local communities in which local organisations could come together to focus on individuals. Integrated Neighbourhood teams would be a significant part of Neighbourhood working, but the shift would also involve working with local communities and reflecting the local population health needs.
- Three initial areas of focus for approaching through a neighbourhood lens would be those with three or more long term conditions, those with frailty or approaching end of life, and children with complex needs. The economic impact of people affected by a long-term condition and chronic pain represented a real opportunity which would be particularly important for local authorities.
- Neighbourhoods would not happen automatically, and an 'integrator' function would support operational co-ordination, facilitate some of the population health management and work on issues of interfaces and provide some supporting infrastructure. A single population health management facility would be required across the ICS.

9.02 Andrew Bland asked for the Board to consider the work as the launch of neighbourhoods as a key priority, and not just an iteration of previous work. The changes would not happen by themselves, and residents would want to know what neighbourhoods were, where they were and how they could access services in them.

9.03 Ben Travis asked if there might be an explicit objective for the teams around reducing demand for acute services, which be necessary to achieve the shift in resources as well as engage colleagues in the acute sector to engage. It would be important to ensure that this was a coalition that everyone involved had to contribute to.

9.04 Prof Clive Kay emphasised his support for the approach, noting that the risk was that day-to-day pressures would take priority over redesigning and transforming care. Clinicians on the front line would be needed to work with neighbourhoods to transform care and were also needed in providers to deliver further and faster. There was no resource for double running, so the system would need to think differently about timescales and how processes were transformed.

9.05 Meera Nair welcomed the paper and a discussion at the People Committee about the work. There would need to be a consistent set of outcomes to give the newly formed teams direction as well as there would be resource implications for teams at borough level to address.

9.06 George Fekete welcomed the work and asked if there was ability to demonstrate change made on the financial side as well as health outcomes.

9.07 David Bradley noted that approaches of this kind in mental health to move from big mental health hospitals to community teams had driven positive change. It would be useful to set out how many people would be in the teams, who would presumably be existing staff from community, acute and mental health services.

9.08	Andrew Bland noted the optimism around the project and in anticipation of the planning guidance the teams would have to reduce demand for acute services, with colleagues help needed on how this would be executed.
9.09	Ceri Jacob noted that boroughs would plan locally, but for Lewisham around 6 to 7 people would be in local teams as a core with shifts to deal with particular topics as needed.
9.10	The Board **noted** the paper and supported the direction of travel.
10	**Showcase Bexley Neighbourhood working to Address frailty**
10.01	Diana Braithwaite presented a perspective on neighbourhood working in Bexley. The Bexley team had started by identifying the problem to fix, recognising that due to variation across Bexley, a single approach may not work everywhere. Work on neighbourhoods had been ongoing in Bexley for years as reflected in the health and wellbeing strategy, so the current work aimed to re-focus rather than re-invent this progress. Bexley had established geographical neighbourhoods in place since 2016 and aligned to three Primary Care Networks plus a fourth PCN across other local care networks but in collaboration with them. Local care networks included social housing, local authority as well as NHS representatives, who met regularly to talk about their neighbourhoods. *BexleyCare*, a partnership between London Borough of Bexley and Oxleas NHSFT was a great asset to the borough and an opportunity to build on as an integrator, importantly bringing in primary care GP services.
10.02	Introducing more detail on services for Frailty, Diana Braithwaite noted these were currently delivered at scale in Bexley replicating in each neighbourhood would be unaffordable.
10.03	Tara Piasetski outlined the data that had been gathered across Bexley Place focusing on frailty to provide a profile for use by the whole group. • Bexley had an older age profile than most London borough with around 40% of residents over the ago of 50 • Older people were more likely to live in the south of the borough, which also tended to be wealthier and less diverse. The north of the borough was younger, more diverse and with a higher Core20+ population. • Deprivation was concentrated in a large patch in the north of the borough, but also in Sidcup where some of the LSOAs were the most deprived nationally. • The electronic frailty index had been chosen to understand the cohort of frail residents as it was included data likely to be more completely recorded in EMIS. • 15,000 people in Bexley were found to have some kind of frailty and around 1500 over 50 years of age with severe frailty, 5000 with moderate frailty and 8882 with mild frailty. There were however also younger cohorts who were considerably under-recorded with the true number living with mild frailty estimated at 17000. • 848 admissions for fall-related injuries for those over 65 took place in 2023/24, and women were vastly overrepresented in emergency admissions. The south of the borough had the highest levels of emergency admissions for falls, with the highest in Sidcup. • After considering the current trends and costs, it was projected that by 2050 there would be an additional 10,000 people living with frailty in Bexley with an estimated cost of £20m

10.04	Debra Travers outlined work being done in local care networks. • There was close working with primary care, community and mental health, as well as the VCSE sector and local communities. • Eight of the large prevention and early intervention charities delivered Care Act assessments on behalf of adult social care, working with people early in their journey to identify and access support to maintain their independence. • Bexley Caer Partnership worked closely with people with moderate frailty and the re-ablement team of occupational therapists, physiotherapists, social workers and assistants working with care providers saw 1800 people in the moderate frailty group. • Of those who accessed support for the first time, 71% did not subsequently require support and a change their frailty index score was seen. • Frailty virtual wards were a way to pull in community support through Bexley Care partnership where providers identified a person slipping into severe frailty. • A functional fitness 'MOT' was delivered through Age UK and helped those starting to feel anxious about getting out to maintain their health and independence.
10.05	Diana Braithwaite noted that the support being piloted in Frognal cost around £83 per person compared to a very much more expensive emergency admission, and reflected that use of technology was an important enabler, and estates was a ongoing issue in Bexley, but that schemes such as Bexley Care had taken around 18 months to reach its current state, and so the neighbourhood working and inclusion of primary care in six months was a challenging timescale.
10.06	Dr Angela Bhan praised the work, and asked if there was any outcome data available, as well as tracking of the people following interventions as in Bromley a tendency had been found that people would deteriorate again and neighbourhoods may be able to help with this.
10.07	Dr Toby Garrood welcomed the work and asked in relation to data on prevention of deterioration whether there was an understanding of which interventions had the biggest impact relevant to the investment.
10.08	Diana Braithwaite suggested that the public health data was critical and recognised that there was a need to map the assets and assess performance, cost and impact. It was important to recognise that the population with frailty was getting bigger, so improvement in services was needed simply to keep pace with demand.
10.09	The Board **noted** the update.
11	**Any Other Business**
11.01	There was no other business
12	**Public Questions and Answers**
12.01	There were no questions asked by the public members present. Answers to questions asked in advance were posted on the ICB website.
	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	To be brought to May 2025 Informal Board session.
ICB 012	16-Oct-24	Work on Primary Secondary Care interface to be presented to a future board session	to be closed	TG	19-Mar-25	Scheduled for July 2025 Public Board
ICB 014	29-Jan-25	Executives to explore overall quantitative targets for reducing Mental Ill Health in south east London, and update on work to explore variation in numbers known to services in inner/outer London.	open	Executives	16-Apr-25	Ongoing via committees
ICB 015	29-Jan-25	Board to receive an update on vaccinations and immunisations for all boroughs, and any trends and lessons learned for the system.	to be closed	ABh	16-Apr-25	on agenda
ICB 016	29-Jan-25	Board to receive an update on UEC and system performance over winter 2024/25, to inform future planning with lessons learned.	to be closed	SC/AB	16-Apr-25	Scheduled for July 2025 Public Board
ICB 017	29-Jan-25	Chair and CEO to consider if the ICB's approach to the challenges facing the system in the medium term, particularly financial sustainability, is appropriately radical and ambitious.	to be closed	RD/AB	16-Apr-25	On agenda - plan submitted

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Equality, Diversity and Inclusion report**					
Meeting date	16 April 2025		Agenda item Number	**3**	Paper Enclosure Ref	**C**
Author	Wasia Shahain, Assistant Director of Equality, Diversity and Inclusion					
Executive lead	Tosca Fairchild, Chief of Staff and Equalities SRO					
Paper is for:	Update	**X**	Discussion		Decision	
Purpose of paper	To provide the SEL ICB Board with an update on the Equality, Diversity and Inclusion (EDI) programme.					
Summary of main points	This paper highlights the breadth of activities taking place in the ICB's EDI programme to improve access, experiences and outcomes for people and communities in south east London and the ICB's workforce. Updates on statutory requirements include: - Equalities governance - Equality Act 2010 - Public Sector Equality Duty (PSED) - Gender Pay Gap (GPG) - Equality Objectives Other EDI programmes covered are: - Equality Delivery System - Workforce Equality Standards - Anti-racism strategy - Equality Impact Assessments - EDI comms and engagement strategy					
Potential conflicts of Interest	None identified.					
Relevant to these boroughs	Bexley	**X**	Bromley	**X**	Lewisham	**X**
	Greenwich	**X**	Lambeth	**X**	Southwark	**X**
Equalities Impact	Positive impact: Provides assurance of compliance with the Equality Act 2010 and Health and Care Act 2022. Reports identify positive development and disparities within SEL ICB and outline action plans to address gaps.					
Financial Impact	Not applicable					
Public Patient Engagement	Public engagement has been undertaken where relevant.					
Committee engagement	Equalities Sub-Committee, September 2024, January and March 2025 Senior Management Team, November 2024, March 2025					

	Board, October 2024, January 2025 Executive Committee, March 2025
Recommendation	**The Board is asked to:** • Note progress made with core statutory and mandatory requirements • Note publication of SEL ICB's PSED, GPG and new set of Equality Objectives to meet statutory reporting requirements. • Note that action plans to address areas for improvement have been developed, and will be implemented and monitored through the Equalities Sub-Committee and progress periodically reported to the Executive Committee.

Equality, Diversity and Inclusion Report

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

1 Context

1.1 NHS South East London Integrated Care Board (SEL ICB) is responsible for developing strategic plans to meet the health and care needs of the six south east London boroughs, as well as funding and coordinating services for the diverse community it serves.

1.2 SEL ICB, together with the wider South East London Integrated Care System (SEL ICS), aims to unite partner organisations to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

All the above core objectives are directly enabled by equality, diversity and inclusion.

1.3 This Board report is presented as an overview of the EDI programme and current progress and next steps on a range of workstreams which improve access, experiences and outcomes for people and communities in south east London and the ICB's workforce. The paper highlights the breadth of activities taking place covering core statutory requirements, key workforce standards and an update on other tools and mechanisms the ICB is implementing to embed equalities in all its functions. It is structured as follows:

a. Updates on statutory requirements: Equalities governance, Equality Act 2010, Public Sector Equality Duty (PSED), Gender Pay Gap (GPG) and Equality Objectives.

b. Other EDI programmes covered are: Equality Delivery System, Workforce Equality Standards, Anti-racism strategy, Equality Impact Assessments and EDI comms and engagement strategy.

2 Equalities governance

2.1 The ICB has a robust governance structure in place to ensure there is transparency and accountability for EDI at all levels:

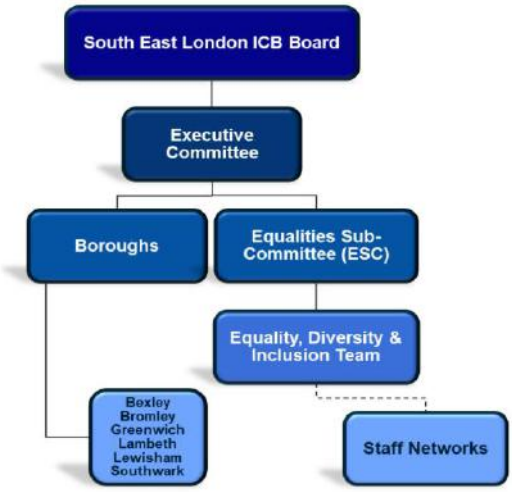


Diagram 1: SEL ICB EDI governance structure

2.2 Overall accountability sits with the Board, with key decision-making and approvals provided by the Executive Committee. The programme is overseen by the Equalities Sub-Committee, chaired by Chief of Staff and Equalities Senior Responsible Officer.

2.3 Equalities Sub-Committee drives meaningful improvements in Equality, Diversity and Inclusion for people, communities and the workforce. Following a recent review of membership, the sub-committee invited a broader range of leaders from across the ICB and ICS forging stronger links and fostering wider knowledge and collaboration. Deep dives have been conducted at Place, which have highlighted the breadth of equalities and health inequalities activity in the boroughs and strongly contributed to the highly positive feedback received on the ICBs Public Sector Equality Duty report from the Equality and Human Rights Commission following its audit of all ICBs last year.

2 Equality Act 2010

The Equality Act 2010 came into force on 1 October 2010, providing a legal framework to protect the rights of individuals and advance equality of opportunity for all, helping to protect individuals from unfair treatment, as well as promoting a fair and more equal society.

3.1 Protected characteristics

There are nine ‘protected characteristics’ identified under the Equality Act 2010:

Diagram 2: The nine 'protected characteristics' in the Equality Act 2010

In addition to these, SEL ICB also considers other key factors that impact health inequalities, covering socio-economic status/deprivation, carers, and digital inclusion.

3.2 Public Sector Equality Duty

The Public Sector Equality Duty (PSED), established under the Equality Act 2010, requires public authorities, including SEL ICB, to demonstrate 'due regard' in their operations. This means they must actively consider the following for both their workforce and the communities they serve through:

- Eliminating unlawful discrimination, harassment, and victimisation.
- Advancing equality of opportunity between people who share a protected characteristic and those who do not
- Encouraging good relations between people who share a protected characteristic and those who do not

Part of the specific duties under the Equality Act 2010 require public sector organisations like the ICB to:

- Publish information annually to demonstrate their compliance with the general equality duty.
- Prepare and publish equality objectives (see section 5).

The ICB (under the Health and Care Act 2022) also has duties to reduce inequalities within the communities it serves. Through the PSED, the ICB is able to be transparent and demonstrate the work being undertaken for equalities and health inequalities for patients and the workforce. It is designed as a showcase for the ICB's work therefore no benchmarking data is available.

3.3 Public Sector Equality Duty 2024/25 report

SEL ICB publishes its annual Public Sector Equality Duty (PSED) report in March each year, outlining how it is addressing equalities and health inequalities. The PSED 2024/25 report can be accessed here.

This year's PSED 24/25 report showcases a wide variety of patient and workforce activities which reflect a strong commitment to embedding equalities in all functions of the ICB, with strong representation from 'Place' regarding community interventions to tackle inequalities in boroughs, significant progress in population health, prevention, wellbeing and equity work, developing the digital inclusion programme, and a comprehensive suite of workforce initiatives.

3.4 Gender Pay Gap 2024/25

As part of the Equality Act (Gender Pay Gap Information) Regulations 2017, the ICB – as an organisation with more than 250 employees – is required to publish information for specific measures relating to the gender pay gap and develop action plans to address any variation. The report snapshot date is 31 March 2024.
The gender pay gap is the difference in average earnings between men and women. It reflects various factors, including differences in job roles, working hours, career progression, and discrimination.

There are two main measures: 1. Mean gender pay gap: the average difference in pay across all employees and 2. Median gender pay gap: the difference between the middle-earning man and the middle-earning woman. **In 2024/25, the ICB has seen an improvement in its average gender pay gap calculation. For every £1 a woman is paid, a man is paid £1.05 (last year this figure was £1.13).** The GPG 2024/25 report can be found here.

3.5 Equality Delivery System 2024/25

The Equality Delivery System (EDS) 2022 is a national NHS England (NHSE) quality improvement tool for all NHS systems and organisations. NHSE introduced this requirement in 2023/24, therefore this is SEL ICB's second year of implementing the framework. The ICB convenes system partners across the ICS to support, advise and monitor progress with the assessment. Annual NHSE reporting on EDS22 progress and outcomes is due by 28 February 2024.

There are three domains (consisting of 11 outcomes) which are assessed through engagement with a wide range of stakeholders based on robust evidence, as part of the EDS 2022:

- Domain 1: Commissioned and provided services.
- Domain 2: Staff health and well-being.
- Domain 3: Inclusive leadership.

For Domain 1, two services were assessed in 2024/25: SEL Paediatric Community Dental Service (partnering with Kings College Hospital and Bromley Healthcare) and Greenwich Integrated Therapies Service for children and young people (partnering with Oxleas and Royal Borough of Greenwich). Improvement plans for all three Domains have been developed, with the following key focus areas for 2025/26:

- Improving data quality
- Improving access and engagement
- Further building workplace culture
- Continuing to strengthen inclusive leadership

The ICB will work with partners across the ICS to implement these improvement plans with monitoring being undertaken through the Equalities Sub-Committee.

This year the ICB has seen an improvement in its overall rating and score, moving from 'Developing' (19) in 23/24 to 'Achieving' (22) in 24/25. The EDS22 2024/25 summary report can be found here.

3.6 Equality Objectives 2025/26

The ICBs current set of Equality Objectives 2020-2024 is due to expire, and a new set has been developed to meet requirements under the Equality Act 2010. The new Equality Objectives take into account advice from the Equality and Human Rights Commission in its 2023/24 PSED review for all ICBs in England.

The Equalities Sub-Committee endorsed the alignment of new Equality Objectives with the EDS22 assessment process, to provide a robust and evidence-based framework for development. A full mapping exercise was completed to ensure the new objectives synchronise with work being undertaken across the ICB. A new monitoring cycle has been agreed to ensure progress is delivered against objectives, with an annual refresh proposed in line with EDS22 requirements. SEL ICBs new Equality Objectives 2025/26 can be found here.

3.7 Equality and Human Rights Commission (EHRC)

Following two Public Sector Equality Duty (PSED) audits, the ICB received highly positive feedback from the Equality and Human Rights Commission (EHRC) from its review and benchmarking of all 42 ICBs in England. Two areas were highlighted, specifically, engagement with diverse people and communities, and the Public Sector Equality Duty report. Following this, two further areas were explored by the EHRC: tackling racial inequalities in maternity and neonatal services and taking action to address racial disparities in mental health detentions. As a result, the EHRC nationally spotlighted good practice being undertaken by the SEL Local Maternity and Neonatal System (LMNS) in a webinar series in March 2025.

4 Workforce Equality Standards

The Workforce Equality Standards were devised to address historic workforce disparities in the NHS, resulting from a complex set of factors including discrimination, lack of access to opportunities, poorer workplace experiences and social expectations. While these standards have not yet been mandated by NHSE England for ICBs, SEL ICB completes them as good practice as a measure of progress and commitment to EDI.

Each NHS organisation in south east London and across England has published workforce equality standards to the same timeline. SEL ICB will now look to work with partner organisations across the ICB to benchmark the standards outlined below.

4.1 Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) was developed to ensure employees from a Global Majority background have equal access to career opportunities and receive fair treatment in the workplace. The WRES has nine indicators, which include representation, recruitment, bullying and harassment, and training and development. Key findings include:

- Job applicants from a White background are four times more likely to be appointed after shortlisting (Indicator 4).
- Staff from a Global Majority background (23.5%) are more likely to experience harassment, bullying or abuse from staff compared with White staff (19%). Both percentages for SEL ICB are higher than the national average (Indicator 6).
- 42.9% of Global Majority staff and 54.3% of White staff believe the organisation provides equal opportunities for progression or promotion. The % for White staff is below the national average (Indicator 7).

The findings of the 2024/25 report show that improvements have been made in representation, however further work is required on a number of indicators and an action plan has been developed, with implementation supported by the Embracing Race and Diversity staff network and working closely with the HR and OD teams. The WRES report for 2024/25 can be found here.

4.2 Workforce Disability Equality Standard (WDES)

SEL ICB is committed to championing disability equality and improving the experience and everyday lives of its staff, or those seeking employment in the NHS, with disabilities. To help the ICB achieve this ambition, it adopted the Workforce Disability Equality Standard (WDES) - a set of ten metrics enabling NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. Key findings include:

- Metrics (4a and 4b) around harassment, bullying or abuse from manager or other colleagues highlighted significantly higher levels for disabled staff when compared with non-disabled staff, and higher under-reporting of incidents.
- Metric 5: A lower percentage of disabled staff (42.9%) believe the organisation provides equal opportunities for progression or promotion compared to non-disabled staff (54.4%).
- Metric 8: 56.5% of disabled staff have advised that reasonable adjustments were made to help them carry out their role which is a significant drop from the previous year.

The results for the 2024/25 report show some improvements however further work is required, and implementation of the action plan is underway with the support of the Age & Ability staff network and working closely with the HR and OD teams. For example, a new workplace adjustments policy is in development. The WDES report for 2024/25 can be found here.

4.3 Workforce Sexual Orientation Equality Standard (WSOES)

2024/25 marks the first time SEL ICB will be implementing the Workforce Sexual Orientation Equality Standard (WSOES). It forms part of SEL ICB's broader commitment to LGBTQIA+ staff, people and communities, linking closely with forthcoming work on the Health and Care LGBTQ+ Health Inclusion Framework, ensuring that all staff feel respected and valued, regardless of their sexual orientation. The WSOES is a framework to improve workplace equality for LGBTQ+ staff in the NHS. Using eight metrics, the framework is used to identify and address disparities in recruitment, progression, and staff experiences. Key findings include:

- Metric 5: 35.7% of Gay or Lesbian staff and 27.3% Bisexual staff believe that the organisation is providing equal opportunities for progression and promotion compared to 52.6% of heterosexual/straight staff.

- Gay or Lesbian staff are likely to experience higher levels of harassment, bullying, abuse or discrimination from managers and other colleagues compared with heterosexual/straight staff.

The action plan being implemented will be supported by the LGBTQ+ staff network and by working closely with the HR and OD teams. The WSOES report for 2024/25 can be found here.

4.4 Action Plans and Monitoring

Improvement plans have been developed for all our core statutory, mandatory and voluntary workstreams which will be monitored via the ICBs Equalities Sub-Committee. A refreshed Equalities Delivery Plan reflecting our new, consolidated ambitions is being developed to support this process. Progress will be fed back periodically through the Executive Committee and Board.

4.5 Staff Anti-racism Strategy

The ICB's Staff Anti-racism Strategy has now been in place for almost two years and following the UK riots last summer, and the decision to develop a new SEL ICB equality, diversity and inclusion strategy, it was time to check progress made so far. The review looked at how well the strategy had been implemented, assessed the current position and determined actions to take forward.

The strategy has been highlighted as a case study in Sir Michael Marmot's Structural Racism, Ethnicity and Health Inequalities in London report published in October 2024 by the Institute of Health Equity. SEL ICB was proud to be approached in late 2025 by the Race Equality Foundation to participate in a pilot programme called the 'Race Equality Maturity Index' (REMI) framework as part of work being carried out by the London Anti-racism Collaboration for Health (LARCH) to map organisations anti-racism journeys.

4.6 Equality Impact Assessment

In 2024/25 the EIA process underwent an extensive redesign to ensure the process was accessible and functional, including development of a comprehensive toolkit, a new screening form aligned with the ICB's risk management matrix, and a dedicated intranet space for staff. This has been soft launched and well received across SEL ICB covering areas such as the boroughs local care partnerships, workforce policy development and informing strategic changes. SEL-wide training is being developed for rollout in 2025/26 to improve quality, engagement and effectiveness of EIAs.

5 Engaging and awareness-raising

5.1 Staff networks

SEL ICB has four active staff networks covering Age and Ability; Embracing Race and Diversity; LGBTQ+ and Women, Parent and Carers. The networks act as a vital link ensuring that staff voice is a core aspect of workforce activities. The networks receive direct support from the Executive team and are well utilised, resulting in continually well attended and effective meetings. Achievements and highlights for 2024/25 include:

5.1.1 Age and Ability Staff Network

Worked closely with the EDI Team on the Workforce Disability Equality Standard. Following the release of the ICB's workplace adjustments guidance, network chairs are working with Human Resources to develop a workplace adjustments policy, ensuring all colleagues receive their adjustments in a timely way. The network has also participated in SEL ICB's Equalities Forum, where Thelma Stober, a survivor of the July 2007 bombings shared her experience; the EDI Mandate Team Lead from NHS England discussed the importance of mandatory reporting. Additionally, the network has formed supportive relationships with partner organisations across the wider SEL ICS.

5.1.2 Embracing Race and Diversity Staff Network

Delivered a themed book, film and music club and covered an array of Black History Month events in SEL ICB's Equalities Forum where Joyce Fraser and Dr Jan Etienne shared their lived experiences, alongside Black Thrive who presented their work within south east London. Embracing Race and Diversity staff network members have also inputted into the Workforce Race Equality Standard and NHS Staff Survey. The network has also provided a safe space to discuss topical issues and experiences surrounding race and discrimination.

5.1.3 LGBTQ+ Staff Network

Looked at the Health and Care LGBTQ+ Inclusion Framework, which is a practical framework enabling health and care leaders to create inclusive environments for LGBTQ+ staff and service users. The LGBTQ+ staff network is currently working on launching the Inclusion Framework survey to explore organisation-wide understanding of LGBTQ+ topics and issues and how embedded these considerations are across SEL ICB.

5.1.4 Women, Parent and Carers Staff Network

Focused on areas identified from SEL ICB's corporate objectives. This included uptake of cancer screening and raising awareness of cervical, breast and prostate screening, along with cardio risk factors such as hypertension. This network has also covered current issues within schools, such as Martha's rule, personal safety devices and possible amendments to the carers leave policy. There has also been a continued focus on the menopause policy and training to support its implementation.

5.2 Equalities Forum and Comms Campaign

The Equalities Forum is a safe space for colleagues within SEL ICB and the wider SEL ICS to come together to learn about and discuss different protected characteristics and to celebrate them. In 2024/25, SEL ICB held four main Equalities Forums which aligned to national campaigns and the ICB's four staff networks:

Age and Ability	Disability History Month
Embracing Race and Diversity	Black History Month
LGBTQ+	Pride Month
Women, Parent and Carers	International Women's Day

Table 1: Staff network alignment with national campaigns

To promote other protected characteristics, the ICB introduced additional ad-hoc webinars under the Equalities Forum banner, including sessions for Islamophobia Awareness Month and Time to Talk Day facilitated by SEL Mind.

The EDI team has led a robust communications campaign throughout the year to further spread awareness on other important topics with articles, thought-pieces,

videos and a newsletter for National Inclusion Week promoted widely through SEL Together, Sharepoint, the ICS website and social media.

6 Conclusion

SEL ICB has had another year of significant progress and achievement, reinforcing its dedication to the national equalities' agenda through both advocacy and action. The ICB's EDI efforts have been recognised locally by staff, the Board and within the ICS, and nationally by regulators and academic institutions. This reflects the ICB's deep-rooted commitment to shaping a more equitable and inclusive future for all patients and staff.

ICB Board Meeting in Public

Title	**2025/26 Operational Plan**						
Meeting date	16 April 2025		Agenda item Number	**4**	Paper Enclosure Ref	**D**	
Author	Sarah Cottingham, Deputy CEO, Executive Director of Planning						
Executive lead	Sarah Cottingham, Deputy CEO, Executive Director of Planning						
Paper is for:	Update	**x**	Discussion		Decision		
Purpose of paper	This paper provides an overview of our 2025/26 system operating plan which comprises seven aligned plan submissions covering the ICB, its five NHS providers plus an aggregated system plan, with plans encompassing a range of planning domains, including finance, workforce, performance, productivity and transformation, plus a board assurance template.						
Summary of main points	The key commitments and deliverables contained within our system operating plan are as follows, with further details set out in section 3 of this paper. • A financial plan for the SEL system that secures a year-end break-even position, underpinned by a cost improvement programme of approximately 5% and after taking account of the receipt of national deficit support funding totalling £74 million. • A workforce plan that secures an overall reduction in total workforce of 3.7%, inclusive of a substantive staffing reduction of 1.8% and a non-substantive staffing reduction of 20% (17% in bank staff and 37% in agency staff). • A performance and activity plan that supports national performance targets being met for Referral to Treatment Times, the Cancer Faster Diagnosis Standard and the 4 hour waiting times target for Accident and Emergency, plus compliance with the 62 day cancer referral to treatment target for pathways that are internal to SEL, alongside compliance or a year on year improvement for other performance measures across acute, mental health and learning disability services. • The delivery of 72% of the productivity opportunities identified for our system through a national opportunities identification exercise, with underpinning care pathway and efficiency improvement actions to support delivery.						
Potential conflicts of Interest	None identified						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**	
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**	
Equalities Impact	Addressed in the paper						
Financial Impact	Addressed in the paper						
Public Patient Engagement	The paper is presented to the public board						
Committee engagement	The ICBs committees have been engaged on operational planning leading up to the submission of the plan.						

Recommendation	To note the update on the 2025/26 operational plan

2025/26 Operational Plan

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

1. Background

Over Quarter 4 of 2025 the ICB has been working with its partners to develop our operating plan for 2025/26. Our final operating plan submission was made to NHS England on 27 March 2025, following an informal Board meeting the previous day where the detail of our plan submission was considered, reviewed and endorsed.

This paper provides an overview of our 2025/26 system operating plan which comprises seven aligned plan submissions covering the ICB, its five NHS providers plus an aggregated system plan, with plans encompassing a range of planning domains, including finance, workforce, performance, productivity and transformation, plus a board assurance template.

The operating plan represents a sub set of the ICB's overall planning and delivery work for the forthcoming year. It represents a local system response to the national priorities and deliverables set out in planning guidance for the year. A fuller picture of our overall strategic commissioning objectives and plans is set out in our Joint forward Plan, which will be refreshed for 2025/26 and published on our website during April 2025. This sets out borough plans, aligned to local Health and Well Being Plans, plus our plans in relation to key population cohorts e.g. mental health and children and young people and for key care pathways e.g. urgent and emergency care. It also sets out the details of our planned work in relation to enablers such as digital, workforce and finance.

2. Overarching Summary

As above the operating plan submission comprises a range of planning returns covering finance, workforce, performance, productivity and transformation. Boards were also asked to take in to account and assure themselves around a number of wider areas as part of signing off plan submissions, including the approach to improving the quality of services, key decisions that have been made as part of planning, including prioritisation and any Equity and Quality Impact Assessments that that have been completed in relation to these decisions, plus risks and mitigations.

The key commitments and deliverables contained within our system operating plan are as follows, with further details set out in section 3 of this paper.

- A financial plan for the SEL system that secures a year end break even position, underpinned by a cost improvement programme of approximately 5% and after taking account of the receipt of national deficit support funding totalling £74 million.

- A workforce plan that secures an overall reduction in total workforce of 3.7%, inclusive of a substantive staffing reduction of 1.8% and a non-substantive staffing reduction of 20% (17% in bank staff and 37% in agency staff).
- A performance and activity plan that supports national performance targets being met for Referral to Treatment Times, the Cancer Faster Diagnosis Standard and the 4 hour waiting times target for Accident and Emergency, plus compliance with the 62 day cancer referral to treatment target for pathways that are internal to SEL, alongside compliance or a year on year improvement for other performance measures across acute, mental health and learning disability services.
- The delivery of 72% of the productivity opportunities identified for our system through a national opportunities identification exercise, with underpinning care pathway and efficiency improvement actions to support delivery.

We have secured this start plan position through a focus on cost containment, cost improvement, productivity and efficiency, care pathway transformation and the use of non-recurrent flexibilities. This has meant we have not had to implement decommissioning or disinvestment proposals, although our up-front investment decisions for 2025/26 have resulted in opportunity costs in areas of potential forward investment such as prevention and inequalities.

Our plans are ambitious and challenging, with further work required to fully identify and assure the underpinning actions that will secure them and to derisk existing plans. We will also need to ensure robust and timely monitoring of delivery to ensure we are able to derisk plans and take remedial action where required during 2025/26. This will include the identification of in year recovery and contingency plans.

3. SEL operating plan objectives and commitments

The following section sets out in more detail the key commitments and deliverables within our system operating plan looking at each of the key planning domains in turn, including in relation to the national planning guidance objectives and requirements.

3.1. Finance

The national objective for 2025/26 is the delivery of break-even financial plans at a system level. In setting this objective the relative and underlying position of systems was considered and deficit support funding provided to some systems as an enabler to meet the national planning objective. The SEL received deficit support funding of £75m, a reduction to the £100m received in 2024/25.

We have worked as a system of secure a balanced plan for the year with our final plan submission reflecting a break-even position for each of our organisations and for the SEL system. This position relies upon the following:

- The agreed distribution of SEL's allocation across the system alongside income assumptions in relation to non-local commissioner and other sources of income.
- Work within each organisation to contain cost pressures for 2025/26 alongside the retention and further development of cost containment and control measures.
- The delivery of a material cost improvement programme (CIP) in each organisation, with an overall system CIP value of approximately 5% and an emphasis on recurrent CIP delivery.

- The embedding within the CIP of internal organisational CIPs, the benefit of planned workforce reductions and productivity improvements.
- The identification of non-recurrent funding as a contribution to the overall financial plan.

Whilst we have submitted a balanced financial plan, we have ongoing work to ensure we have fully identified cost improvement plans and have derisked existing identified plans. We are also working to ensure effective mechanisms are in place to track delivery of our overall financial position and CIP delivery as well as working up further initiatives that are not yet baked into our plans, including several system sustainability initiatives focused on securing collaborative savings for our system as a complement to organisational CIPs in areas such as medicines value.

3.2. Workforce

Our plans for 2025/26 include a set of ambitious workforce objectives and commitments, which align with and form part of our cost improvement and financial plans for the year. These are focussed on securing an overall reduction in workforce, thereby containing and reducing the level of post covid growth experienced across the NHS, plus targeting a reduction in bank and agency spend.

Our plans assume an overall reduction in our SEL system workforce establishment of 3.4% (2,011 WTE). This represents a net reduction in workforce (substantive and non-substantive) of 3.7% (2,174 WTE), with a substantive workforce reduction of reduction of 1.8% (974 WTE) and a non-substantive (bank and agency) reduction of 20.3% (1,199 WTE). Within this overall picture there are some planned staffing increases linked to specific capacity developments, such as our Community Diagnostic Centres and new surgical theatres.

Alongside our focus on workforce efficiency our system Chief People Officer network is overseeing a coordinated approach to workforce planning, delivery of our 2025/26 plans and in year monitoring, including ensuring effective workforce grip and control measures but also workforce transformation and development.

3.3. Performance

National planning guidance sets out a range of performance and associated activity targets and deliverables for 2025/26. These include priority measures focussed on acute targets for elective care, cancer and urgent and emergency care performance, plus priority targets for mental health and learning disability and autism services.

Our objective has been to secure overall compliance with national targets at a system level alongside demonstrable year on year improvement in performance from 2024/25 to 2025/26 at an organisational level. In most cases this has driven a compliant plan although there are a couple of exceptions to this, which are highlighted below.

Elective care – compliance at an organisational and system level with national targets, which focus on securing a 5% improvement in 18 week referral to treatment time performance, a 5% improvement in time to first appointment plus less than one % of patients waiting having waited for more than 52 weeks by March 2026.

Cancer care – delivery of 80% of patients being diagnosed within the 28 day Faster Diagnosis Standard by March 2026. The national cancer targets also include a target for 75% of patients receiving treatment for cancer within 62 days of referral. Our plan does not

secure full compliance against this standard for 2025/26, with a plan that gets us to performance of 73%. This position reflects case mix complexities within SEL and specifically the impact on our SEL cancer centres of referrals from outside of SEL. We expect to meet the national target for patients who start and finish their cancer diagnosis and treatment within SEL but do not believe we can also so do for patients referred in from elsewhere due to these referrals often arriving beyond the time periods required to secure treatment within the 62 day target.

Urgent and Emergency Care – delivery of the key target of 78% of patients attending Accident and Emergency (A&E) being seen and discharged from A&E within 4 hours at a system level, noting that our trajectories do assume a differentiated delivery against this standard by provider, although each provider is demonstrating a year on year improvement in performance. SEL has a number of stand alone Urgent Treatment Centres and it is therefore important to consider the 4 hour standard on the basis of system as well as provider performance. In addition plans include improvements to long waiters, with planned reductions in the % of patients waiting more than 12 hours in A&E.

Mental Health – systems have been asked to ensure improvements on length of stay plus in access for Children and Young People and SEL is showing delivery of both objectives with a clear improvement in planned in length of stay at both our mental health providers and increased access for children and young people as compared to 2024.

Learning disability and autism – our operating plan sets out plans to secure an improvement in our reliance on mental health inpatient care for adults with a learning disability and for autistic adults, with planned reductions for both patient cohorts.

Plans also include a range of other supporting metrics including:

- Diagnostic activity and performance, ambulance handover times, same day emergency care and 0 day length of stay for urgent and emergency care, discharge rates, length of stay and occupied bed days for acute services.
- Out of Area Placements, talking therapy access and recovery rates, access to perinatal mental health services, individual placement support access for mental health.
- Learning disability registers and annual health checks delivered by GPs and reliance on inpatient care for children with a learning disability or autism.

3.4. Productivity and Transformation

Productivity and transformation have been a larger focus in 2025/26 planning than previous years. National productivity packs, assessing opportunities at care pathway, corporate and provider level were developed, and systems were asked to use the opportunities identified to inform and drive the planning process.

We have worked to ensure a direct read across from the productivity packs to our wider plans, including for finance/cost improvement, workforce and performance. We have made positive progress in the planned level of productivity benefit that is embedded in our plans with 72% of the overall opportunity identified nationally included in our plans for 2025/26.

Alongside cash and non-cash releasing productivity benefit we were asked to identity key supporting process and care pathway improvements that we will take forward across our system to support overall delivery. Our plans therefore include key planned actions across primary care, outpatients, elective care, cancer, urgent and emergency care and mental

health – these will support improved care pathway value and efficiency, reduced cost and improvements to access and flow.

As for all other areas of the plan we are working to ensure we have concrete implementation and delivery plans in place, and we will track both delivery and impact.

4. Other key operational plan assurances

The ICB Board was asked to ensure Board awareness and consideration of a number of areas in signing off system operating plans for 2025/26 with reference to improving the quality of services, decision making and risks and mitigations. This section of the paper summarises the ICB approach in terms of 2025/26 planning across each of the areas.

4.1. Improving the quality of services, inequalities and prevention

An overarching system objective is ensuring high quality services for local residents and for those who access services at SEL providers. We have effective quality monitoring and surveillance governance at organisation and system level, which ensures an ability to understand our quality outcomes and to identify areas of learning or improvement. Our key objective for 2025/26 is to ensure a focus and drive around quality improvement, secured through timely quality monitoring and surveillance, a clear focus on safety, care pathway redesign, productivity and efficiency to optimise outcomes plus performance improvement, specifically around access, to reduce clinical risk and improve quality and outcomes. We will sponsor specific quality improvement programmes, with a specific focus for 2025/26 on maternity as part of this work.

A key objective is improving experience and outcomes for local residents and service users. In our engagement, including over the planning period in relation to the 10 Year Plan, access to services and support is a key issue, in terms of improving the ease and timeliness of access to services across all areas of provision. The focus on access improvement throughout our operational plan will help us address this key challenge and issue.

Improving population health and reducing inequalities in access, experience of care and outcomes is a vital focus that we are working to embed in all our programmes of care and service developments.

- We will continue to systematically apply the national Core20PLUS5 frameworks for adults and children and young people to support the system in identifying populations and cohorts of patients who are likely to experience health inequalities. This will be further supported by our development of population health management approaches to effectively identify and target population groups across our six boroughs.
- We recognise that at the heart of improving health inequalities is building and improving trust and confidence with our communities. We are seeking to do this through stronger engagement and feedback from patients, service users and residents, the development of an insights library to collate all the feedback and support the future planning and development of services and through working more closely with the voluntary and community sector.
- In 2025/26, we have increased our investment into mental health services, recognising the historic under-investment in these services particularly in Lambeth and Southwark.

Prevention is a crucial part of improving overall population health and reducing health inequalities. Our aim is to adopt ‘a prevention first’ approach across care pathways and across the life course. This includes an ongoing focus on delivering vaccination and immunisations, supporting children and young people with a particular focus on mental health and long term conditions (such as asthma and diabetes), and targeting known factors

that impact poor health such as the Vital 5 measures, diabetes and hypertension. The development of integrated neighbourhood care will provide us with an opportunity to provide more joined-up preventative care at a neighbourhood level.

4.2. Key decisions

ICBs were asked to ensure a clear approach to decision making, noting this requirement relates particularly to difficult decisions in relation to decommissioning to support systems in meeting financial target requirements.

As a system we collectively committed to optimising opportunities around cost improvement, productivity and efficiency before focussing on disinvestment of decommissioning. Our 2025/26 plan demonstrates a break-even system plan which is driven by a combination of challenging cost improvement plans, the receipt of national deficit support funding and non-recurrent flexibilities and as a result we have not had to disinvest or decommission existing services.

We have made some clear prioritisation decisions, which represent an opportunity cost rather than disinvestment or decommissioning. A key example relates to our Medium Term Financial Strategy objective of committing significant ring-fenced resource to support the delivery of our strategic objectives around prevention and inequalities. For 2025/26 we have instead earmarked this funding to support system sustainability, maximising the funding released to providers and securing the enabling investment to drive forward our system sustainability savings. This decision represents an opportunity cost as we would otherwise have invested this funding in new initiatives to support prevention and inequalities. Where we have invested growth, this has in several areas enabled underlying cost and services pressures to be managed. Again, this represents an opportunity cost as it means the funding available to support new service investment and associated improvement is reduced.

As part of planning each organisation has run a cost improvement plan process, and this includes multi-disciplinary and clinical input and the undertaking of Equity and Quality Impact Assessments (EQIA) as part of that process, recognising this process is not yet complete as organisations continue to identify their full cost improvement programmes. As this process is completed, we will be seeking to secure assurance that a robust EQIA process has been undertaken by each organisation. We will also identify any common themes around the CIPs and undertake a targeted review of the EQIA outputs through our system quality governance to provide further assurance around the clear identification and mitigation of risks associated with the CIPs in relation to protected characteristics. We will further assure ourselves that organisational actions will not impact adversely on system partners or on services that sit outside of that provider. To this end we have agreed that each organisation will confirm any CIPs that have potential wider impacts to enable a system wide consideration of the proposals, risk and mitigations in response.

4.3. Key risks and mitigations

As demonstrated in the rest of this paper our 2025/26 operating plan includes a number of ambitious commitments and deliverables. There is risk associated with delivery, and we continue to work to identify risks and derisk and mitigate them wherever possible.

A high level summary of key risks and mitigations is set out in the table below, noting this will be an area of on-going work, development and review over 2025/26, inclusive of a process to agree recovery and contingency plans in year as required.

Risk	Description	Mitigation

Finance	Plans contain significant risks: Level of unidentified or high risk CIPs. Potential in year cost and expenditure pressures. Potential income risks.	On going work to fully identify and de-risk CIP plans. Rigorous monitoring and management of spend and CIP delivery, inclusive of ensuring remedial action is taken in a robust and timely way. Realistic income assumptions as part of start plans, underpinned by consistent approaches to planning assumptions by commissioners.
Demand, capacity and flow.	Demand is over planning assumptions, flow, care pathway and length of stay improvements not secured.	Close monitoring of demand and care pathway improvement plans to enable timely and robust remedial action to manage demand and support flow. Robust system management approaches to real time risk management and mitigation.
Quality and outcomes	CIP/cost containment and/or operational pressures result in deteriorating quality and outcomes.	Quality surveillance and monitoring to enable investigation and remedial action as required. Robust system management processes to support quality and safety in real time.
Resourcing and bandwidth	Workforce reduction impact. Overall bandwidth given scale of commitments/requirements.	Mitigate risks around morale and reduced headcount through support for staff and prioritisation. Ensure delivery plans are prioritised alongside best use of system resource.
Lack of system/partnership working	Internal focus on asks/requirements. Delivery and improvement impacted by external factors and lack of collective working.	Ensure system asks targeted and value adding. Ensure plans are clear about respective deliverables, with collective accountability around implementation. Mutual aid and support to optimise outcomes.

5. Next steps

Having submitted our 2025/26 operating plan key next steps are:

- Regional and national review and assurance.
- Ensuring fully worked up delivery and implementation plans, including rapid work to identify currently unidentified or high risks plans or planning assumptions.
- Ensuring timely monitoring of delivery against plan to enable delivery and performance risks to be identified and early mitigating action to be taken.

We will report regularly to the ICB Board on our delivery progress during 2025/26.

Board meeting in Public

Title	**Chief Executive Officer's Report**						
Meeting date	16 April 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 29 January 2025						
Potential conflicts of Interest	None						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**	
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**	
Equalities Impact	Equality Impact Assessments are considered where applicable						
Financial Impact	N/A						
Public Patient Engagement	Public engagement takes place where appropriate and this report is presented to the Board meeting in public and published on the ICB website						
Committee engagement	N/A						
Recommendation	That the Board receive the Chief Executive Officer's Report						

Chief Executive Officer's Report

NHS South East London Integrated Care Board (ICB) 16 April 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 agree system wide plans for 2025/26 in an exceptionally challenged policy and economic context. As the planning round drew to a close we have also received national requirements to reduce running costs right across the system. NHS England's abolition and reduction in running costs will now be accompanied by a requirement for ICBs to reduce their running and programme costs by 50% in England and for NHS providers to half the growth in their corporate costs over the last five years. These requirements are hugely significant and sit alongside the known financial pressures felt by our local authorities colleagues.

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

1.1. Sir James (Jim) Mackey, Interim NHS Chief Executive Officer, has taken over from Amanda Pritchard as Chief Executive of NHS England with effect from 1 April 2025. Since the Board last met we have also learnt that Amanda will be returning to the role of Chief Executive Officer of Guy's & St Thomas' NHS Foundation Trust (GSTT), in September 2025, following the retirement of Professor Ian Abbs.

1.2. On Sir Jim's first day in the job, he wrote out at the first opportunity to provide further clarity upon his plans for reforming the NHS, which go beyond an adjustment in costs of NHS bodies and speak to a new operating model or way of working.

1.3. The hard work that has gone into the 2025/26 planning process has been recognised and praised. For context, the South East London ICB (SEL ICB) plan

was submitted with an adherence to the SEL ICB's control total of a deficit £74m plan. This is with all organisations planning for a balanced position, with the known exception of King's College Hospital NHS Foundation Trust. It will be incredibly challenging to deliver and the NHS CEO is sighted on this.

1.4. As well as discussing planning for this year (2025/26) the letter focuses on planning for next year (2026/27). The NHS CEO wishes to see a faster pace of change towards 'fair share' distribution of financial allocations.

1.5. The critical role of ICBs is reaffirmed, but equally refocused as the 'strategic commissioners' of the system. ICBs will change over time as well as reduce in cost.

1.6. On reductions, the NHS CEO is clear on the need for pace and sets some important considerations for the transition:

- the need to maintain some core staff, such as recently delegated commissioning staff and, in the short term, until further options are considered, continuing healthcare staff.
- the need to maintain or invest in core finance and contracting functions in the immediate term.
- the need to invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management and contracting.
- the need to commission and develop neighbourhood health, with the delivery being a provider function over time (GPs, PCNs, community and mental health Trusts, social care, acute Trusts or others).

1.7. Every indication is that specific reduction in cost targets will be available in April, and that the information is to be used to devise plans that live within those cost envelopes by the end of May. This is an exceptionally tight timetable that will then need to be implemented by the end of quarter three 2025/26

1.8. SEL provider Trusts have been asked to make reductions in corporate costs that have increased since the pandemic. This seeks a 50% in the reduction of the growth in corporate costs since 2018/19 (a circa 40% growth across the country, with significant variation).

1.9. Although there has been mention of a voluntary redundancy scheme being made available, no further news has been provided at this point.

2. Prevention, Wellbeing and Equity

2.1. Women and girls in Greenwich and Bexley now have better access to specialist support for menopause, heavy periods, contraception, and pre-conception advice through the Women and Girls' health hub.

2.2. Launched in March 2025, the virtual health hub allows for GP and self-referral for expert advice and care, reducing the need for hospital visits and improving access to timely support.

2.3. The service is part of South East London ICB's (SEL ICB) commitment to improving women's health and reducing inequalities, and is the first of two women's and girls'

health hubs, with a second hub due to launch in Lambeth in April. The model was informed by a south east London (SEL) wide needs assessment and co-designed with women and girls following a survey and engagement work with SEL residents that gathered insights from more than 1,000 people.

2.4. SEL ICB has launched an opportunity to partner with five voluntary, community and social enterprise (VCSE) organisations to co-develop ways to reduce health inequalities by supporting the Integrated Care System to re-imagine prevention and health creation in a way that is community-led and built on trust. This is a three-year funded partnership opportunity with organisations that are embedded in and hold relationships of trust with their communities, with an ambition to incorporate health into existing holistic community-based services and work together to transform health-led prevention.

2.5. This innovative approach has been led in conjunction with the SEL VCSE Alliance and has included leads representing the sector and communities that face the biggest health inequalities. We received over 140 applications, and following site visits in February and March, we have selected five Voluntary, Community and Social Enterprise groups that span the life course and deliver services to the following communities / groups: Black, African, and Caribbean adults, LGBTQ+ communities, People with learning disabilities, Children and young people (age 0-18).

3. Primary Care Access Delivery Plan

3.1. The Primary Care Access Delivery Plan Update outlines the ongoing work related to the planning and implementation of the Plan to recover access to primary care services. This marks the second year of the programme and the fourth update received by the Board. The previous update was presented in October 2024.

3.2. NHS England has asked Integrated Care Boards (ICBs) to deliver 10 nationally mandated actions for 2024/25. These actions are regularly RAG-rated. For any actions not completed by 31 March 2025, plans are in place to ensure continued progress into 2025/26.

3.3. There continues to be good coverage across south east London of pharmacies that are registered to provide clinical services. 95% of pharmacies are participating in the Pharmacy First scheme which delivered 64,412 clinical pathway consultations and 27,038 minor illness consultations between February 2024 and February 2025. 91% of community pharmacies offer hypertension screening services, delivering over 114,000 blood pressure checks and identifying 7,000 cases of high or very high blood pressure. Additionally, 9,700 ambulatory blood pressure monitoring (ABPM) checks were conducted, resulting in the identification of over 5,100 cases of hypertension.

3.4. The expansion of self-referral pathways and increasing the number of people self-referring into services where GP involvement is not clinically required, are key ambitions of the Delivery Plan for Recovering Access to Primary Care. In August, NHS England set London region a target of 15,746 self-referrals per month. SEL ICBs share of this target is 2,973 self-referrals a month. The latest published data (Dec 24) shows that ICBs in London continue to have lower self-referral rates than

elsewhere in the country. SEL performance is just under target. However, SEL's performance compares favourably to the standardised self-referral rate for London.

3.5. As the PCARP comes to an end in March 2025, the digital achievements in South East London's Digital Health have been significant and is rated green overall, indicating strong project delivery and a sound financial position. The NHS App aims to be the digital front door for SEL, with goals to increase awareness, enhance functionality, integrate more providers, and ensure digital inclusion. As of February 2025 registrations among those aged 13+ have risen to 60.8% - a 5% increase from 2023/24, with a target of 65% for 2025/26. Key KPIs show 60.8% aged 13+ registered with NHS App, 656,000 users enabled messaging notifications, 1.27 million logins in February 2025,94,000 repeat prescriptions ordered, 558,000 GP record views.

3.6. As part of Cloud telephony implementation all practices have accepted the data processing notice for advanced telephony other than one care home practice that has requested an exemption. SEL has a system-wide contract with Accurx for online consultation including digital triage for primary care. This system is used by 81% of practices.

3.7. Due to PCARP digital platform funding will no longer be available from in 2205/26, there is a need to transition to an ongoing funding arrangement for commissioning of the essential digital platforms such as Accurx remote consultation platform that provides online and video consultation, patient messaging services, appointment booking and health review questionnaires and Ardens Clinical Pro and Plus platform that supports practice level data/BI and search template.

3.8. The next phase of work to improve access will focus on supporting practices with implementation of practice list segmentation and total triage models. These initiatives are central to supporting more personalised, efficient, and appropriate care, ensuring patients are directed to the right service at the right time based on clinical need and complexity.

4. Independent Prescribing in Community Pharmacy Pathfinder

4.1. As part of a national programme, the medicines optimisation team have worked in partnership with Quay Health Solutions GP Federation and three community pharmacy sites in north Southwark, to develop an integrated model for improving access to care and outcomes for people living with hypertension and asthma.

4.2. As part of its extended access hub, Quay Health Solutions will identify people who are at risk of poor outcomes and invite them to book an appointment at one of the participating pharmacies.

4.3. The pharmacists provide all the usual high standards of care including prescribing, medicines supply and monitoring in line with local pathways from the community pharmacy site in the heart of their communities.

4.4. The pathfinder, which goes live in April, will be fully evaluated to assess its impact on improving outcomes, patient feedback and reducing inequalities in access to care.

5. Staff Survey Results 2024

5.1. In mid-March, the 2024 staff survey results were published and can be viewed on the NHS staff survey website. The website hosts an interactive dashboard, which contains results at a national, regional, ICS and organisational level. It also includes results for NHS Staff Survey indicators used in the Workforce Disability Equality Standard and the Workforce Race Equality Standard.

5.2. The purpose of the survey is to collect staff views about working in their NHS organisation and the data is used to identify areas for further development of local working conditions for staff, ultimately leading to improved patient care. The staff survey continues to be themed and aligned to the NHS People Promise.

5.3. South East London ICB (SEL ICB) saw an increase in its response rate (62%) and most of the People Promise scores are broadly in line with the medium score for ICBs. When looking at the People Promise scores in more detail, several of the sub-themes are significantly better, including compassionate culture and health and safety climate. The themes of morale and staff engagement remain key performance indicators for organisations. Staff engagement is significantly better than the ICB average, and both have improved significantly since 2023.

5.4. At question level, 23 scores are in the top 20% range of similar organisations. There are 77 scores that are in the intermediate 60% and seven in the bottom 20%. Where comparable to 2023, one question-level score has declined and there have been five significant improvements.

5.5. SEL ICB's organisational development team is currently engaging its staff networks to better understand the data related to protected characteristics, and working with its equality, diversity and inclusion team to triangulate the data to key equalities reporting such as the workforce race and equality standards, workforce disability and equality standards, workforce sexual orientation equality standards and EDS22 etc. SEL ICB's organisational development team is also engaging its executive team, staff partnership forum and staff more generally through staff briefings.

5.6. A series of recommendations will be developed based on the results and these will be progressed and acted on in early 2025. A 'you said, we did' document will be shared with staff ahead of the 2025 survey to demonstrate that staff have been listened to, and their comments have been acted on wherever possible.

6. Update on the Mental Health Intensive & Assertive Outreach Review

6.1. In November 2024, the Board was provided with a progress update of the system's review of the delivery of intensive and assertive community mental health services following the Nottingham attacks and the Valdo Calocane (VC) case.

6.2. This update shared the key findings of the initial review and the immediate actions that needed to be completed by the end of the year. This included:

- updating and streamlining Trust policies (including standard operational policies for individual teams) relating to access and discharge for this cohort of patients

- undertaking further audits of community caseloads
- developing clear and consistent engagement approaches across both South London and Maudlsey NHS Foundation Trust and Oxleas NHS Foundation Trust for clinical teams and
- seeking and building the view of wider partners, particularly those with Lived Experience, to help develop the wider and medium to long term actions for community mental health services.

6.3. Since the last update, it can be confirmed that both mental health trusts have:

- updated their individual trust policies relating to access and discharge
- completed additional caseload reviews and audits and
- have been engaging and working with staff to ensure they have consistent engagement approaches
- Work is also underway to use existing engagement routes and ways of working with people with Lived Experience, families and carers to further develop engagement and communication approaches.

6.4. Since the original action plan was developed, the independent investigation into the care and treatment provided to VC by NHS services has been published (February 2025). The report draws out several themes relating to the care and treatment of VC including risk assessment and management, diagnosis and medication, out of area placements, decision making, VC's capacity, assertive outreach and discharge to primary care. The report also identifies twelve actions which NHS Trusts need to take forward with underlying themes across all the recommendations relating to oversight, assurance, risk assessment and management.

6.5. SEL ICB is currently working with both mental health trusts to update their local action plans in line with the findings and recommendations from the independent investigation. Both Mental Health Trusts are in the process of updating their own Trust Boards on internal progress and actions linked to risk management, oversight and governance (South London and Maudsley NHS Foundation Trust briefed their Board in March 2025 and an equivalent Oxleas discussion is planned for 1 May 2025)

6.6. Following completion of these discussions, a revised action plan for the system will be developed. The updated action plan is expected to be developed by June 2025, in line with the national timetable and will be shared with SEL ICB Board members in accordance with the national ask. A fuller update on the revised action plan and its delivery will then be shared with the SEL ICB Board later in 2025.

7. Equalities Update

South East London ICS Equality Diversion & Inclusion (EDI) Awards and Conference

7.1. The first South East London ICS (SEL ICS) EDI Conference and Awards took place on 4 March with a keynote speech given by the South East London ICB (SEL ICB) Chief Executive Officer. The theme for the 2025 Conference and Wards was "Empowering our EDI Community". This theme reflects our commitment to fostering

and inclusive environment and advancing equality, diversity and inclusion across south east London. It also emphasises the importance of empowering and recognising those who are working tirelessly to make a difference in EDI. In total 107 nominations for the awards were received, 25 were shortlisted. The judges had a difficult job narrowing it down to the 6 winners from a very good variety of nominations. Each nomination was recognition of the tremendous EDI work being done and to all nominations and winners, their work is a reminder of the important contribution EDI is making across SEL ICS to improve access, experience and outcomes for staff, people and communities.

Statutory EDI duties

7.2. SEL ICB's Public Sector Equality Duty 2024/25 report has been published to meet statutory duties under the Equality Act 2010. In alignment with EDS22 commitments, a new set of statutory Equality objectives have also been developed and published. The Gender Pay Gap report has been collated showing a reduction in SEL ICBs' gender pay gap in 2024/25. Findings were reported to the Government Equalities Office in March 2025. More on these reports can be found under item 3: Equality report.

Equality Delivery System 2022 (EDS22)

7.3. A SEL ICS-wide programme for NHS organisations to assess their EDI performance on services they commission or provide, workforce health and wellbeing and inclusive leadership has now concluded for 2024/25. For SEL ICB, the EDI team worked with the Planning directorate, Place Executive Leads (PEL), and Chief of Staff directorate to ensure full coverage. Two services were selected and scored for the 2024/25 assessment: Integrated therapies for children and young people (Greenwich) and the Paediatric community dental service (SEL-wide). SEL ICB has moved from a rating of 'Developing' to 'Achieving', marking an improvement in 2024/25. Details of the assessment and findings can be found under item 3: Equality report.

Workforce Equality Standards

7.4. A new suite of reviews has been undertaken to understand the workplace experiences of SEL ICB staff through the lens of race, disability and sexual orientation. NHS providers are mandated to complete the Workforce Race and Disability Equality Standards (WRES and WDES) and as part of SEL ICB's commitment to equality, diversity and inclusion these are well established. SEL ICB has newly adopted the Workforce Sexual Orientation Equality Standard as part of a range of activities promoting LGBTQ+ inclusion. A multi-disciplinary action plan has been formulated, where disparities have been identified. The reports have been presented and discussed with the Senior Management Team and the Executive Committee and more detail on findings and actions can be found under item 3: Equality report.

EDI Strategy

7.5. Work is underway on developing a new 3-year EDI strategy for the ICB. This will unify and replace previous plans, covering workforce and services through an intersectional EDI lens. A programme of engagement has taken place including a roundtable with key leads, presentation and discussion with SMT, and a roadshow of staff networks to test key themes and deliverables.

8. Bexley Borough Update

Practice Merger

8.1. In December 2024, NHS South East London Integrated Care Board (SEL ICB) received a merger business case proposal from the Partners of Station Road Surgery and Sidcup Medical Centre. Both practices currently hold a Primary Medical Services (PMS) contract, a locally agreed contract agreed between SEL ICB and the practice. If a practice wishes to make changes to their PMS contract, they require the agreement of the ICB.

8.2. Both practices remain committed to working as part of the Local Care Network and the Frognal Primary Care Network, which includes two other practices, Woodlands Surgery and Barnard Medical Group. The merger would result in a reduction in the choice of GP Practices available for residents in the Sidcup locality from four to three GP Practices in addition to the respective branch sites associated with Sidcup Medical Centre and Barnard Medical Group.

8.3. The merged practice would adopt the two existing practice boundaries, and no patients would be de-registered. The merger patients would be able to attend any of the four additional practice sites as well the existing Station Road site.

Primary Care Access Recovery Plan

8.4. The second year of the access recovery plan (2024/25) has been focussed on building on the benefits to patients and staff from the foundations established in 2023/24. GP Practices, Primary Care Networks and the GP Federation have continued to deliver on improving access to core primary care and enhanced services for Bexley residents.

8.5. Bexley GPs have consistently offered the highest number of appointments per 1,000 registered patients in south east London; over 1 million GP appointments were offered in 2024/25. This has been through robust delivery of the Primary Care Access Recovery Plan, by addressing the 8:00am rush through implementing digital technology and platforms to enable easy access over the phone, online registrations and consultations. This has freed up GP practices to focus on delivering direct care to patients.

- 319,808 online consultations were submitted by Bexley residents
- There were 16,308 online registrations
- There are now 141,433 NHS App registrations in Bexley, a 10% increase on the previous year
- 14,781 repeat prescriptions were ordered using the NHS App in February 2025, a 63% increase on the previous year
- 109,783 GP medical records were viewed in the NHS App, a 93.9% increase on the previous year

NHS 10 Year Health Plan

8.6. A joint Department of Health & Social Care and NHS England team has been established to deliver a 10-Year Health Plan. This plan will be published in Spring

2025. The plan will set out how an NHS fit for the future is delivered, creating a truly modern health service designed to meet the changing needs of the changing population.

8.7. Working in partnership with the Bexley local health and care system, an engagement programme for residents was developed, which included promoting the consultation through social media channels (including via *Ask Bexley*), engaging community champions, patient participation groups (PPGs), voluntary organisations and online workshops and face to face sessions.

8.8. During January and February 2025 conversations took place with a range of groups and organisations including: the Bexley Pensioners Forum, Bexley Mencap, Bexley Deaf Centre and community champions. 77 people were involved from across Bexley; participants ranged from 16 to over 80 years old.

Workforce Development

8.9. Bexley is currently facing a shortage of paediatric Occupational Therapists. Whilst this is also a national concern, it has impacted on the number of individuals applying for roles or expressing an interest in pursuing it as a career.

8.10. Occupational Therapy is a vital profession that plays a key role in supporting individuals to live independently and improve their quality of life. To inspire the next generation, Bexley Wellbeing Partnership collaborated with two dedicated Occupational Therapists from the London Borough of Bexley, who attended a careers day at Harris Garrard Academy.

Neighbourhood Health Service

8.11. During quarter 4 2024/25 the Bexley Wellbeing Partnership has focused its efforts on developing integrated Neighbourhood Teams. Co-design and co-production workshops commenced with the local health and care system, voluntary sector and residents with lived experience developing neighbourhood models of care for multiple long-term conditions and integrated child health.

Men's Tackling Health, Welling United Football Club

8.12. On Saturday 1 March 2025, the Bexley Wellbeing Partnership teamed up with Welling United Football Club (FC) and Greenwich University for a 'Tackling Health' event at the Park View Road Stadium in Welling. The event targeted football fans and encouraged and focussed on health and wellbeing aspects, especially those which impact men.

8.13. Attendees were offered a blood pressure test as well as signposting and advice on subjects such as weight management, smoking cessation, prostate cancer awareness and managing mental health. Partners were available from the local pharmacy teams, Mind in Bexley and Gro Health, as well as representatives from Greenwich University who are working with Welling United FC on 'Talk Club', a mental health peer support initiative which began in January 2025.

8.14. 39 residents took up the offer of testing and advice, and two were referred to their GP due to hypertensive readings. Others were offered a loan of equipment to monitor their blood pressure at home. There are plans for another event in the

Autumn with more health partners including an offer of vaccinations for Flu and COVID.

9. Bromley Borough Update

Multiple Long Term Condition Management

9.1. Bromley is working on improving outcomes for people with three or more long term conditions. The work is focussed on people who have a rising risk of deterioration and use of unplanned care services. People who are identified as potentially frail will be transitioned to the frailty pathway.

9.2. The Bromley Clinical Advisory Group has recommended the work commence with people who have three or more long term conditions, at least one of which is cardiovascular disease. This maps well with international evidence for populations on drivers of high care and health utilisation. In Bromley that is 14,500 people under the age of 75, or 30,000 all age, recognising some of these groups will be living with frailty.

9.3. The work is further looking at the health inequalities experienced by a sub-set of this group, examining the overlap with living in a Core20 area, being a member of an ethnic minority group, or having another vulnerability. Resources will be targeted to deliver better outcomes and a 'left shift' towards prevention, on an INT basis.

Frailty and ICN Development

9.4. Integrated Care Networks (ICNs) in Bromley bring together a range of health and care services to work in a more joined up way to provide care for patients. There are currently three ICNs in Bromley, each covering around a third of the population that deliver weekly multi-disciplinary team meetings. This model of care aims to prevent ill health and unnecessary emergency admissions to hospital by proactively supporting patients who are frail, vulnerable or who have complex long-term conditions.

9.5. Between April 2024 and February 2025, 1,060 ICN multi-disciplinary team meetings were held for 1,021 patients with 1,020 medication reviews completed. The meetings included representatives attending from General Practice, Community Care, Mental Health, Social Services, St Christopher's and the voluntary sector. The approach is improving quality of care and outcomes for patients as well as reducing demand for emergency care at the Princess Royal University Hospital.

9.6. Recently, the following initiatives have been taken forward for frailty including:

- A case management pilot to support complex patients who need additional care for a short time after an ICN assessment. Case management has been expanded to four Primary Care Networks including Orpington, Crays, Mottingham, Downham & Chislehurst and Beckenham based on the highest number of referrals. From April 2024 to date, 125 patients have been through the case management pathway. There has been a 71% improvement in wellbeing scores which is recorded at the patients first visit and then their final visit before discharge.

- Multi-disciplinary, multi-organisational review process for care and nursing home residents most at risk of admission to hospital. This has resulted in the updating of patient universal care plans used by the London Ambulance Service and others so the health and care system can better ensure appropriate care and treatment for some of the most vulnerable patients. With greater care being provided in the community, there have been 24% fewer 999 calls and conveyances across the wider patient group in all care home settings involved in the pilot.
- The Acute Frailty Assessment unit at the Princess Royal University Hospital has expanded to take direct referrals from local community providers and the London Ambulance Service alongside referrals from the Emergency Department. This has enabled more individuals to be assessed before being discharged home with a care plan or transferred to the relevant medical service for further treatment.
- An anticipatory care dashboard has been developed to help identify the most complex patients who are greatest risk of hospitalisation.

9.7. During 2024/25 there was a continued focus on frailty in Bromley, two new frailty and older people clinical and professional leads were recruited and have taken the opportunity to review and refresh the frailty strategy. Several stakeholder events have been held which have informed immediate priority areas including:

- The use of consistent frailty recognition tools such as clinical frailty scores and universal care plans to drive pathway decisions and patient conversations
- The roll out of standardised frailty competency training to upskill the workforce
- Consistent health messaging and greater understanding of frailty provision to help drive the preventative agenda and wider use of community assets

9.8. One Bromley will continue to bring together providers, voluntary services and commissioners to build on the existing good work. For 2025/26, plans are underway to deliver frailty services using an Integrated Neighbourhood Team (INT) approach and geography. This will incorporate a wide range of frailty services currently being provided with a greater focus on prevention, coordinated proactive care and de-escalation of crisis.

Diabetes

9.9. Diabetes is a high priority long term condition within Bromley for which there is renewed focus. 18,871 people in the borough are living with diabetes: 1,314 people with Type 1 diabetes and 17,154 people with Type 2 or other diabetes diagnosis, giving a prevalence of 5.2% of the registered population of Bromley.

9.10. Nearly 30,000 people in Bromley are estimated to be at risk of developing diabetes. If obesity trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes. The Bromley Multiagency Diabetes Partnership Group works collaboratively to share best practice, resolve pathway issues and gain feedback from patients with lived experience of diabetes care.

9.11. A number of prevention, weight management and education initiatives are currently in place for Bromley residents:

- National Diabetes Prevention programme
- 9 Month and 3 month courses

- Walking Away from Diabetes
- Type 2 Diabetes total diet replacement

9.12. King's College Hospital (PRUH) has also developed several new initiatives including a 'D-Ward' to support the earlier discharge of people with diabetes. The hospital also provides best practice care for children with diabetes, transition services and antenatal care.

9.13. Working in partnership, several projects have also been delivered in 2024/25 as well as some that are being developed for delivery in 2025/26:

- Healthy.io – A 1 year project ending 2024, this project enabled home urine testing for cohorts of diabetes patients. This project led to increased coverage of ACR testing
- Diabetes Outcome scheme – A 2-year scheme, which worked with PCNs and the Health Innovation Network to improve the diabetes 8 care processes. Improvements were seen across practices and PCNs across all care processes along with improvements within variation amongst primary care
- SMI and LD Diabetes analytics – A project to investigate statistics of diabetes outcomes for SMI and LD patients. This is currently underway
- Early Onset Type 2 Diabetes – A new project currently being planned and set for delivery in 2025/26, will focus on extended appointments for a cohort of Type 2 diabetics with extended appointments
- Diabetes transformation – A wide-ranging review of the diabetes provision across the Bromley system. Planning commenced in 2024/25 and will continue into 2025/26 to ensure the Bromley diabetes is delivering the best practice it can, is sustainable and meets the changing needs of the population

Office Move to Bromley Civic Centre

9.14. Bromley staff are now based at Bromley Civic Centre, following the office move in mid-March, enabling further integrated working. This co-location is already facilitating joint working and has provided a much improved working environment for ICB staff.

10. Greenwich Borough Update

Neighbourhood working

10.1. In February 2025, The Healthier Greenwich Partnership (HGP) took a decision to focus on four neighbourhoods in Greenwich: Central-East Greenwich, East Greenwich, West Greenwich, and South Greenwich. This followed an options appraisal and engagement across all parties. The decision was determined according to the best fit against the South East London neighbourhood health framework criteria:

- Centre around populations and natural communities
- Build on existing networks and local assets

- Include population sized between 50-100k (one neighbourhood is slightly smaller but with a fast growing population)
- Enable, not hinder, joint working
- Adapt to specific challenges

10.2. A joint programme Board has been established across SEL ICB and the Royal Borough of Greenwich, with key workstreams on population health, the care model, the workforce and community engagement. These tailor with south east London-wide enabler workstreams, including on estates and digital.

Children and Young People - Child Health Teams Pilot

10.3. As part of the piloting, the Local Child Health teams in Greenwich, work has commenced to evaluate the impact it has been having over the past five months. The local team in Greenwich West Primary Care Network consists of two Lead GPs, the patch Paediatrician from Lewisham and Greenwich NHS Trust and a patch Community Nurse from Oxleas NHS Foundation NHS Trust. Further work is being undertaken to review the referral data, common presenting needs and impact.

Children and Young People - Continuing Care and Social Care

10.4. The introduction of the new patient level data set reporting requirements for Continuing Care has necessitated some changes to recording locally with a move onto Care Track. This aligns with the recording system utilised for Continuing Healthcare. The new recording and national requirements should help to support a better local and national understanding of trends within Continuing Care. Further discussions have also been taking place Pan-London to improving joint work between Continuing Care and Social Care, with a proposed approach outlined to support the gathering of data, identification of good practice and common challenges. This also includes planning around the development of joint training.

Children and Young People - Single Point of Access – Mental Health and Wellbeing

10.5. Greenwich has appointed PPL in partnership with Baxendale to be the design partner for the development of a Single Point of Access (SPA) for Children's Mental Health and Wellbeing. Work has already begun to develop the governance to take the work forward over the next 2 years. This will lead to the design and implementation of the new SPA helping to improve access for children to the right mental health and wellbeing support at the right time.

Integrated Commissioning – Adults - Staffing and team development

10.6. Collaboration across teams and with partners continues and there has been some good progress with teams setting up new ways of working across adults, public health, children and young people and primary care teams. Plans are in place to ensure this continues this year including leadership development across teams and with partners.

Integrated Commissioning – Adults - Digital Health & Care Service

10.7. Following contract award this service has been readying for go live as planned on 1 April. Staff have been trained and branding has been finalised. The Digital Health and Care service will now be offered proactively to eligible residents with health and care needs, supporting residents to stay independent for longer. This will complement the work on developing integrated neighbourhood team approaches and ensure the ability to better deliver preventative and proactive care. The approach taken will allow widening of the service beyond Greenwich in future if there are other interested Boroughs and south east London discussions around this and the use of data and insight to inform preventative and proactive care linked to neighbourhood developments continues.

Integrated Commissioning – Adults – Better Care Fund discharge programme

10.8. Greenwich and Bexley have been supported by the Better Care Fund (BCF) programme to review patient flow and discharge through the Queen Elizabeth Hospital in Woolwich. The BCF supports local health and social care systems to successfully deliver integration of services in a way that supports person-centred care, sustainability and better outcomes for people and carers. Leaders across health and social care in Greenwich and Bexley are now reviewing recommendations and will implement changes across three key areas: discharge and flow, demand and capacity and leadership.

Integrated Commissioning – Adults – CHC

10.9. Work continues on the areas of improvement which remain and have seen significant progress over the last period. The agreed actions from the MCR programme are being progressed and focus is on continuing to ensure better value care and support is commissioned, outstanding reviews are completed and that work with others across south east London continues to ensure consistent ways of working.

10.10. A new integrated brokerage team in Greenwich was launched in 2024 and is now supporting the CHC placements. The impact of the approach is hoped to be seen as awareness of gaps in provision is ensured which can be supported by commissioning teams, oversight of quality can be more aligned to Local Authority approaches and hopefully better value can be secured through enhanced negotiation and data driven approaches.

Integrated Commissioning – Adults – MSK

10.11. Recent work was undertaken to review the timeline for re-commissioning the service. The outcome of this has meant a direct award to the current provider has been put in place to ensure service continuity over the coming year. The new service will be commissioned to be in place for April 2026. This procurement process is now live.

Greenwich Healthier Communities Fund

10.12. Over the next four years, the Greenwich Healthier Communities Fund aims to prevent and respond to key health issues across Greenwich to ensure everyone has equal access to the health services and support they need. Two strands of funding for Voluntary, Community and Social Enterprise (VSCE) organisations were

launched in April 2024. The different funding strands support different kinds of work within Greenwich, all aligned to the agreed Health & Wellbeing Strategy. The enabling strand aims to increase organisational capacity building to better tackle health inequalities, whilst the delivery strand aims to fund projects that prevent and respond to key health inequalities. The programme will develop further in 2025, with plans to relaunch these strands in April 2025 with more targeted focus (set by local priorities), and further improvements based on stakeholder and grantee feedback.

10.13. The Enabling Strand has supported 31 organisations across three rounds, with a total of £245,726 awarded. 25 organisations have been supported through Round one the delivery strand totalling £542,189. In round three the committee funded 23 applications totalling £581,070.

10.14. For the next round of submissions, organisations will be asked to submit against a set of priority themes:

- Improving Health Outcomes for People with Learning Disabilities and/or Autism
- Tackling Isolation
- Long-Term Health Conditions
- Active Healthy Living for Children and Young People

10.15. For medium and large bids organisations will also be asked to demonstrate collaborative working within the neighbourhoods in Greenwich.

Connecting Greenwich

10.16. The Connecting Greenwich programme has been running since April 2024 and is actively working with two-thirds of Greenwich's general practices, including three primary care networks (PCNs). The programme works holistically with practice teams to identify areas for improving how practices provide proactive, accessible care to their local communities and/or target population cohorts. Through specific projects with the practices or PCNs, long term culture change is embedded through coaching, thinking councils, data analysis and trialling innovations. Many projects within the programme include a focus on reducing health inequalities, including engaging with Vietnamese, Nepalese and Somali older generations, improving hypertension control in black men, childhood immunisations outreach, integrated same day access, piloting Local Child Health teams and a community wellbeing café. The programme is being evaluated by DG Cities alongside delivery.

11. Lambeth Borough Update

Our Health, Our Lambeth

11.1. As we approach the third year of 'Our Health, Our Lambeth 2023-2028', Lambeth is undertaking the second annual review of the Health and Care Plan. This process is a key opportunity to take stock of what has been achieved, acknowledge the challenges faced, and refine priorities for the years ahead.

11.2. With increasing financial pressures across the system and the evolving national policy landscape, including a new 10-Year NHS Plan, Lambeth will be even more focused on how to plan and deliver health and care services in the borough within available resources.

11.3. The Annual Review and Action Plan for 2025-26 will be published following sign off at the May Lambeth Together Care Partnership Board meeting. In the past year, significant advances have been made in key areas of the plan as Lambeth has continued to develop and embed more proactive and integrated models of care, such as the multi-disciplinary Primary Care Alliance Network (PCAN) in adult mental health services and the Child Health Integrated Learning and Delivery System (CHILDS) framework.

11.4. The expansion of the Hospital @Home service has helped reduce demand on hospital services, enabling more residents to receive care in their own homes. Lambeth Child and Adolescent Mental Health Services has made meaningful progress in improving access to mental health support for young people, reducing waiting times and ensuring that those in need are seen sooner. There has also been real impact in the work to improve access to care and in tackling health inequalities.

11.5. The recently launched Sexual Health Outreach Services, including the Sexual Health Empowerment & Reproductive Outreach (SHERO) initiative for women of black heritage, will be instrumental in breaking down barriers and making sexual health services more culturally appropriate and accessible.

Governance and Leadership

11.6. The Lambeth Together 'Board on the Bus' initiative has continued supporting Lambeth Together Care Partnership Board members to join Lambeth's Health and Wellbeing Bus as it visits community locations across the borough. The Bus reaches over a thousand residents and workers each month, providing essential health advice and support in community spaces.

11.7. This initiative extends the Board listening programme, enabling Board members to hear the thoughts and views of residents which are captured and reflected back with the wider Board. Each month, Board 'buddies' team up on a bus visit to talk to residents about what matters most to them about health and care for them and their families at a variety of locations across the borough. Residents connecting with Board members have raised a number of issues, including concerns around the cost of living, access to GP appointments and long waits for treatment, highlighting the difficulties around isolation and loneliness and the need for inexpensive leisure activities, especially for children to support their health and wellbeing.

11.8. Lambeth were pleased to welcome Ade Odunlade as the new South London and Maudsley NHS Foundation Trust (SLaM) nominated representative on the Lambeth Together Care Partnership Board, defining the integrator function.

Working with the Community

11.9. Neighbourhood and Wellbeing Delivery Alliance (NWDA) - The Alliance has continued to co-ordinate Lambeth's approach to developing Integrated Neighbourhood Teams (INTs). This has involved ongoing engagement with partners through the Lambeth Together Executive Group (LTEG), Guy's and St Thomas' Integrated Specialist Medicine Directorate, Primary Care and Lambeth Council, including Adult Social Care, Children's Services and Public Health. Through this work, Lambeth have established a new INT Working Group, bringing together cross-system partners to input into the proposed plans, with an initial focus on agreeing the five neighbourhood geographies, which was agreed at the March Lambeth Together Care Partnership Board meeting, and defining the integrator function.

11.10. Living Well Network Delivery Alliance (LWNA) - The LWNA has undertaken a rapid review commissioned by the Alliance Leadership team and led by Anu Singh to identify how the Alliance can ensure it continues to best function as it enters its three-year contract extension from April 2025, as agreed by the partners in 2024/25.

11.11. The Alliance has considered the findings of the review and will work with Alliance partners and other key stakeholders over the coming weeks to agree a plan to implement any changes to how they work and core priorities for the next phase of Alliance working to 2028. The LWNA has also been working with other colleagues in the Children and Young People and Neighbourhood and Wellbeing Delivery Alliances to develop a joint working approach to setting up Integrated Neighbourhood Teams in Lambeth, including building on the existing Primary Care Alliance Network (PCAN) service.

11.12. Children and Young People's Delivery Alliance (CYP) - Alongside the other Alliances, the Children and Young People Alliance continues to help develop work for Integrated Neighbourhood Teams, with a focus on children and young people, drawing on learning from the CHILDs model. CHILDs has already demonstrated the benefits of integrated and proactive care, improving access, reducing unnecessary hospital visits and strengthening service coordination. These principles are shaping how early intervention, multi-agency collaboration and population health approaches are embedded into Integrated Neighbourhood Teams, ensuring that care is joined up, responsive and accessible. The Alliance is actively involved in this work, engaging system partners to ensure services reflect the needs of children, young people and families in Lambeth.

11.13. Age-Friendly Lambeth Action Plan - To help guide Lambeth's approach to becoming an Age-Friendly Borough, Lambeth Council signed off its first Age-Friendly Lambeth Action Plan (2024-2027) at the Council Cabinet meeting on 24 February. In celebrating this milestone, Lambeth joins a growing number of boroughs in the UK and in London making commitments to support ageing well. The Age-Friendly Lambeth Action Plan will help guide efforts from the Council and partners to foster an age-friendly community and support older residents to age well. The Action Plan will be published online in the coming weeks.

Achievements and Recognition

11.14. The achievements of Lambeth teams and individuals was recognised at the first South East London Equality, Diversity, and Inclusion Conference and Awards.

11.15. The Sickle Cell Project led by the Council's Cost of Living Team, in partnership with a number of other council teams, Guy's and St Thomas', Primary Care Networks, and local Sickle Cell Support groups, won the Innovation in EDI Award. The project supports low-income residents with sickle cell disease by providing non-clinical cost and energy-saving interventions to improve their health and well-being during winter.

11.16. Juliet Amoa, Associate Director for Equity and Inclusion, Community Health and Engagement, was highly commended for the Inspirational Inclusive Leader award for her work collaborating to co-create programs that tackle social and health disparities, particularly with marginalized communities. The work of King's and Guy's and St Thomas' Staff Networks were also recognised in the Awards.

12. Lewisham Borough Update

Developing the Neighbourhood Model

12.1. Lewisham is actively advancing its Neighbourhood Model by refining the service model through an extensive co-design process. Five co-design sessions have been completed with individuals with lived experience, ensuring the model is shaped by those directly affected. The borough has also conducted 'Primary Care Networks (PCN) Roadshows', leading to the development of the model. PCNs have secured funding, enabling them to begin recruiting key roles, strengthening the foundation for integrated care. Additionally, the Outcomes and Evaluation Framework has been completed, providing a structured approach to measuring impact.

12.2. In parallel, Lewisham has identified funding for critical roles, with these proposals currently progressing through governance. Work is underway to develop a robust Voluntary and Community Sector (VCSE) offer, ensuring grassroots organisations play a key role in service delivery.

12.3. Key partner workshops have been hosted, involving mental health services, children and young people (CYP) services, and other stakeholders. The borough has also finalised the business case for the Integrated Neighbourhood Team (INT) Model, with a Return on Investment analysis in progress.

Engaging residents in the Neighbourhood Model

12.4. The development of INTs in Lewisham has been informed by a range of engagement activity undertaken with partners, local communities and other stakeholders.

12.5. A group of patients and residents with lived experience of health and care services, were recruited including those with a range of ages, religion, ethnicity, disabilities, and carer responsibilities. The group were invaluable in helping to gather insights and test ideas, shaping and refining the INT model based on real-life experiences.

12.6. Five sessions were delivered including a meet and greet, where it was agreed how the local system would work together, purpose, aims and values. Followed by four sessions, each focused on a separate element of the INT model:

- Patient/resident Communication
- Discharge Pathway
- Group Consultations
- Holistic Assessment Approach

12.7. The Co-design sessions proved a positive and enjoyable experience for all involved, and output from the codesign partners is now being integrated into the INT model.

Population Health

12.8. The Lewisham Population Health team has put together data packs on long-term conditions (LTCs) to help the new Health Equality teams, made up of GPs and local, Black-led community groups, to shape local interventions. These packs break down key information like demographics of people who are unoptimized from different

ethnic groups, and risk factors. By giving teams a clear picture of the local health landscape they can design solutions that are tailored to the community's needs. The goal is to make sure interventions are evidence-based, culturally appropriate, and truly benefit the people who need them most

Celebrating our people at the Lewisham General Practice Awards

12.9. The second annual Lewisham General Practice Awards saw colleagues from across the borough come together at the Rivoli Ballrooms to recognise peers and celebrate excellence. With growing demand and increasing patient needs, the awards provide a welcome opportunity to highlight the incredible contributions, hard work and dedication of primary care colleagues.

12.10. The awards recognised those working across a variety of roles and levels in primary care, with categories including GP Practice of the Year, Practice Manager of the Year, Administrator of the Year, the Innovation in Health Award, a System Collaboration award and, perhaps most importantly, a People's Choice Award which is chosen by residents.

Lewisham and Greenwich Trust (LGT) re-direct project

12.11. Work has commenced with the Lewisham GP Federation and LGT to pilot re-direction of patients presenting at the Urgent Treatment Centre who could more appropriately be treated elsewhere. The pilot will focus initially on redirects to Pharmacy First and MSK pathways. The project will test out use of the south east London developed patient leaflet 'Guide to Healthcare' as part of the communications plan for re-directing patients.

12.12. In the first two months of delivery, the pilot has re-directed 273 patients successfully, an average of six patients a day. 93% were re-directed to pharmacies participating in Pharmacy First, the remainder were supported to get booked appointments with their GPs. Three patients were supported to register with a GP. Feedback from patients has been positive, with no complaints.

Home First

12.13. The Home First team has completed a comprehensive analysis of capacity and demand across the Lewisham system looking at therapies and enablement resource and demand to inform current plans and longer-term strategy development. The analysis included a time and motion study which showed some variation in effective resource use across teams but indicated that current staff are working on average four hours more per week per person than contracted to meet demand. The Home First Steering Group approved a series of recommendations following the report, including establishment of a single Transfer of Care Hub, review of the enablement service, and improving interoperability in IT systems used by the discharge teams.

13. Southwark Borough Update

Partnership Southwark Strategic Board

13.1. The main discussion at the March meeting of the Partnership Southwark Strategic Board (PSSB) was on the development of Integrated Neighbourhood Teams (INT),

one of the five key priorities of Partnership Southwark, aligned with national and South East London ICB priorities. It was noted that the INT programme has been positively and enthusiastically supported by partners and has made significant progress towards establishing an agreed model. PSSB discussed the challenges and opportunities associated with the proposed approach, and key areas of focus to ensure a successful model is developed. The board agreed the South East London ICS INT framework, the proposed boundaries of five INTs for Southwark (aligned with local authority neighbourhood boundaries), and the roadmap/ implementation plan to establish teams. The programme will now move towards a detailed design and implementation phase, before an October 2025 launch date.

Partnership Southwark Board Development Session on Environmentally Sustainable Healthcare

13.2. In February the Board attended a development session led by Dr Matt Sawyer, a former GP who now runs an environmental sustainability consultancy (SEE Sustainability) working to improve human and planetary health. This was an educational session which aimed to inform Board members about the importance of environmentally sustainable healthcare and to provide some practical examples of what can be done as individuals and as leaders in health and care to contribute to this important agenda.

13.3. A key focus of the session was how the health of the planet is intrinsically linked to the health of humans, illustrated by examples such as there are more premature global deaths due to diseases attributed to air pollution than to AIDS, TB and malaria combined. Dr Sawyer shared examples of how good healthcare benefits individuals, society and the environment, as well as reducing cost of healthcare and inequality, such as the introduction of the HPV vaccination to 12-13 year old girls to prevent cervical cancer.

Southwark Health and Wellbeing Board 13th March

13.4. The Board received the Annual Public Health Report which this year has the theme of health inequalities. The report set out examples of key health inequalities in the borough between neighbourhoods and population groups and gave many examples of good work practice to tackle inequalities across Southwark which are being delivered by the Council, NHS and community and voluntary sector.

13.5. The Board approved the Southwark Joint Health and Wellbeing Strategy action plan which covers the final two years of the five-year strategy (2025-2027). The action plan has strong alignment with Southwark's vision for 2030 and the Partnership Southwark Health and Care Plan. The Health and Wellbeing Board is responsible for the strategic oversight of the plan and will be supported by the Partnership Southwark Delivery Executive for the relevant parts of the Strategy and actions.

13.6. The Southwark section of the SEL ICB Joint Forward Plan (which is the same content as the Partnership Southwark Health and Care Plan) was noted by the Board and confirmed that it takes proper account of the priorities and actions outlined within the Southwark Joint Health and Wellbeing Strategy.

Community Southwark Impact Report

13.7. Community Southwark have recently published an impact report on the 'Funding Differently' programme for 2024/25, the second year of the initiative. 30 grassroots

organisations, in the borough, received grants of either £5,000 or £10,000. Some of the key insights detailed in the report were the value of the tailored long-term support provided by small community-led groups, the importance of the power shift in this funding process to include the VCSE in the decision-making process, and the sustainability challenges faced by these organisations.

13.8. The report states that the recipients of the grants are directly supporting 3,000 individuals in the borough but also notes the 'impact beyond numbers' – the long-term change and preventative work done by these organisations that is difficult to quantify. Recommendations made by the report include multi-year funding to locally led VCSE groups to improve challenges around sustainability, keeping grant processes simple and adaptable, and strengthening the partnerships between VCSE groups, funders and statutory bodies. The full report can be accessed via the following link https://communitysouthwark.org/funding-differently-2024-25-impact-learning-report-now-available/

Better Care Fund Update

13.9. SEL ICB and the council have completed the process of drawing up Southwark's 2025/26 Better Care Fund (BCF) plans for submission to NHS England at the end of March. The BCF is a pooled budget of £57million which funds a range of core community-based health and social care services which are crucial to the objectives of supporting people to live independently and safely in their own home, avoiding admission to hospital and supporting timely and effective discharge from hospital.

13.10. Given the short turnaround in the planning process, it has been agreed to roll forward the vast bulk of funding for specific schemes, with an intention to review by mid-year to identify potential changes for implementing at the start of 2026/27.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Overall Committees Report**						
Meeting date	16 April 2025		Agenda item Number	6	Paper Enclosure Ref	F	
Author	Simon Beard, Associate Director for Corporate Operations						
Executive lead	Tosca Fairchild (Chief of Staff)						
Paper is for:	Update	x	Discussion		Decision	X	
Purpose of paper	The purpose of the paper is to highlight to the Board any DECISIONS referred to the Board from ICB Committees, to provide INFORMATION on any decisions made under derogation by those committees, and to provide INFORMATION on activity of the committee meetings.						
Summary of main points	The Overall Committees paper provides an overview to the Board members of the activity and decision making that has taken place at the ICB committees which report directly to the Board in the period since the last Board meeting held in public. In particular the Board is asked to note: • Decisions referred to the Board for approval, detailed in section 4. • Decisions made by committees, under their own delegated authority. The Board is asked to consider the decisions referred for approval and to note the other activity that has taken place during the period.						
Potential conflicts of Interest	Where conflicts have been identified with any items discussed at a committee, action has been taken to mitigate the conflict in line with the ICBs Standards of Business Conduct policy.						
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	No equality impacts identified						
Financial Impact	Any financial impacts are identified in the relevant papers.						
Public Patient Engagement	This paper is being presented to a Board meeting held in public for the purposes of transparency.						
Committee engagement	Discussions at other committees are detailed in the attached paper.						
Recommendation	The Board is asked to: • Approve the decisions recommended by its committees • Note the committee decisions and committee activities detailed.						

Overall Report of the ICB Committees

ICB Board 16 April 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 of the Board held in public which received this report, which was on 16 October 2024. In addition the ICS benefits from two provider collaboratives and one provider network and whilst no formal delegation has been made to them from the ICB the Board will receive updates upon their key activities through this report (and in anticipation of their future delegation).

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	22 January 2025	-	-	16 January 2025	6 March 2025	-	27 January 2025	11 March 2025	22 January 2025
	-	-	-	-	-	-	-	-	5 February 2025
	-	-	-	-	-	-	-	-	19 February 2025
	-	-	-	-	-	-	-	-	5 March 2025
	-	-	-	-	-	-	-	-	19 March 2025

	Local Care Partnerships					
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
Meeting date	23 January 2025	30 January 2025	22 January 2025	6 March 2025	30 January 2025	30 January 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 Paul Larrisey, Acting Chief Nursing Officer

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

4. Recommendations to the Board for Decision / Approval

4.1 The ICB Board is asked to consider the revised Terms of Reference for the Greenwich Charitable Funds Committee, which following consideration, the Committee RECOMMENDS to the Board for APPROVAL (appendix A).

4.2 The ICB Board is asked to APPROVE the revised Scheme of Reservation and Delegation (appendix B), which has been amended to reflect the ICBs assumption of responsibility for a defined list of specialised services delegated by NHS England.

4.3 The ICB Board is asked to APPROVE the revised Terms of Reference for the Integrated Performance Committee (appendix C), which reflect the amendment to the Schedule of Matters Delegated to Officers approved by the Executive Committee in relation to reporting to IPC on invoices in excess of SLAs, and the addition of a second Non-Executive Member.

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, or by sub-committees under delegation from the Committees.

No.	Committee name	Meeting date	Items for Board to note
1.	Remuneration Committee	16 January 2025	• The Remuneration Committee considered and approved two papers relating to redundancies associated with the management cost reduction programme.
2.	Executive Committee	22 January 2025	• The Executive Committee approved six policies for publication, being IT07 Change Management Policy, CG02 Freedom to Speak Up and Whistleblowing Policy, CG03 Security Management Policy, CG11 Public Access and Information Re-use Policy, CG17 Fit and Proper Persons Test Policy, FHS04 Lone Worker Policy.
3.	Executive Committee	22 January 2025	• The Executive Committee accepted the outcome of the annual EPRR Core Standards assessment completed for the ICB for 2024 – noting the outcome as **Substantially Compliant** and the proposed action plan.

4.	Executive Committee	5 February 2025	• The Executive Committee approved six policies for publication, being HR08 Bullying and Harassment Policy, HR09 Grievance Policy, HR11 management of stress and mental health in the workplace policy, HR13 Acting up guidelines, HRD01 Investigation guidelines, IT10 Disaster Recovery Plan.
5.	Executive Committee	19 February 2025	• The Executive Committee approved a technology appraisal for Ritlecitinib.
6.	Executive Committee	19 February 2025	• The Executive Committee approved a revised Schedule of Matters Delegated to Officers, updated to show changes to delegation of approval for business cases to reflect the ICBs new governance arrangements, and addition of the Medical Director as an approving executive for clinical trials.
7.	Executive Committee	19 March 2025	• The Executive Committee approved publication of the Public Sector Equality Duty 2024/25 report, Gender pay Gap 2024/25 report, Equality Delivery System 2024/25 report and the Equality Objectives 2025/26.
8.	Executive Committee	19 March 2025	• The Executive Committee approved four policies for publication, being IT11 ICT Acceptable Use Policy, QN03 HR Safer Recruitment Policy, PR01 Patient Choice Provider Accreditation Policy, QN11 Quality Impact Assessment Policy.
9.	Executive Committee	19 March 2025	• The Executive Committee approved proposals for investment of ringfenced funding for dental services during 2025/26 aimed to ensure plans were in place at the start of the year to achieve maximum benefit from the ringfenced budget.
10.	Executive Committee	19 March 2025	• The Executive Committee heard an update on a pilot scheme on recognising involvement from patients and public, agreeing to pause further investment pending greater financial certainty.
11.	Executive Committee	19 March 2025	• The Executive Committee approved updated terms of reference for the Integrated Pharmacy Stakeholder Group.

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.	Integrated Performance Committee	22 January 2025	• The members received a paper setting out the proposed framework for developing neighbourhood working and Integrated Neighbourhood Teams within SEL. • A presentation was received on the progress made in implementing the Bexley Wellbeing Partnership Integrated Forward Plan, noting the alignment to the ICBs Joint Forward Plan and the improvements being achieved. • The ICB CFO updated the Committee members on the finance position for the system and the work being undertaken to secure recovery to meet the year end plan.
2.	Executive Committee	22 January 2025	• The Committee members discussed the 2025/26 planning round, with the director of planning updating the members on expectations from the forthcoming planning guidance. • An outline on the progress made on development of an AI framework to support safe and effective use of AI in London was delivered, which the committee endorsed. A request to approve £150k investment in the AI Centre was declined. • The Committee considered the refresh of the plan for Children and Young Peoples Mental Health and Emotional Wellbeing services, noting the progress in delivery of waiting time standards, future ambitions, and the ongoing challenges faced by mental health trusts. • The group engaged in a deep dive discussion into programmes in place to address hypertension.
3.	People Committee	27 January 2025	• **Staff health and wellbeing update**: Members received an update on the Staff health and wellbeing programme, highlighting key achievements, including the launch of a refreshed strategy. Discussions focused on improving communication and engagement, particularly within primary and social care, addressing low event

			attendance, digital inclusion and the need for timely evaluation to demonstrate impact. • An update on **borough-level workforce groups** was provided. Discussions emphasised sustaining stakeholder momentum, building engagement through small wins and exploring collaborative approaches across boroughs, including the use of apprenticeships to support workforce development. • An overview of **the System Sustainability Programme** was presented. Members stressed the importance of staff engagement and cross-sector regulation in delivering cost-saving reforms without undermining motivation or care quality. • **Assisted Dying**: The Committee discussed the potential implications of the Assisted Dying Bill currently under review, including its operational, ethical and legal impact on staff and services. • A **spotlight on Integrated Neighbourhood Teams** was presented. The complexity of population health management, stakeholder engagement and alignment with the System Sustainability Programme were noted as key considerations for successful implementation. • **Workforce risk:** The Committee noted that overall workforce risk remains below the BAF tolerance level, with minimal change to controls, while highlighting two specific social care risks related to international recruitment and the impact of increases in employer national insurance contributions. • The **next People Committee** in March will focus on: ○ System leadership and Integrated Neighbourhood working ○ Oliver McGowan mandatory training ○ Voice of social care and collaborative working •
4.	Executive Committee	5 February 2025	• The members received an update from the ICB Chief Executive on the London Transformation Board, executive appointments and an ICP workshop on neighbourhoods. • An update on planning for 2025/26 was received and discussed.

			• A presentation was received on the strategic direction agreed for the Acute Provider Collaboration at its recent committee-in-common. • Proposals were considered and approved to invest £298k of ringfenced dental funding in additional units of activity. • Performance was discussed particularly in relation to Urgent and Emergency Care. • The Committee received and discussed a report on the Month 10 financial position for the ICB and ICS.
5.	Executive Committee	19 February 2025	• The members received an update from the ICB Chief Executive on the operating model, ICB ratings, spend review, NHS App and progress with integrated neighbourhood spend. • An update on planning for 2025/26 was noted. • A report on sub-committee activity was received and noted. • A report on performance was received and the benefits of a deep dive approach at future meetings discussed and agreed.
6.	Executive Committee	5 March 2025	• The members received an update on national and system senior leadership changes, the success of the recent SEL ICS EDI conference, and tQuest challenges. • An update on planning for 2025/26 was noted. • The Committee received an update on the move of the Bromley LCP corporate offices and agreed to the ICB entering the lease for space in Bromley Civic Centre. • WRES, WDES and WSOES reports were received and approved. • The Committee discussed the identification of a population health management tool to support the work on integrated neighbourhood teams, and agreed to a proposal for the ICB to hold patient identifiable data and to provision access to the AI Centre data scientists to the ICB Snowflake environment. • An update on the NHS App was noted, with an action for the Executive Committee to receive quarterly updates going forward. • The Executive Committee received and noted the full performance pack. • The Executive Committee discussed the ICS Vaccination Service, executive recruitment and the role of non-executive members.

7.	Greenwich Charitable Funds Committee	6 March 2025	• The Committee members considered a revised terms of reference aimed at clarifying each committee members role, which was recommended for approval to the ICB Board. • The members discussed the current and future strands of work to be supported with investment to deliver the boroughs health and wellbeing strategy via local groups. • An update on the charity's financial position was provided.
8.	Digital Committee	11 March 2025	• The Committee was provided with an assessment on the possible outcome of this years DSPT toolkit assessment. • Information governance structures and processes were discussed. • An updated was provided by the ICB Medical Director on the work underway to develop the Population Health Management function in SEL. • The priority workstreams for digital that were included in the Joint Forward Plan were discussed and noted. • The group received a briefing on the London Care Record Service Level Agreement and possible options going forward.
9.	Executive Committee	19 March 2025	• The Committee members received an update from the CEO on announcements regarding the future of ICBs, a recruitment freeze implemented in the ICB, and progress at KCH to support an overall plan to reach the planned deficit • Members noted progress on the submission of 2025/26 plans required by 27 March, noting improvement in some performance, finance and workforce areas, with work to do to incorporate recently released specialised commissioning information. • Conducted a deep dive into the corporate objective in relation to screening for cancer, noting improvements in many areas against targets as well as in reducing inequalities as a result of system working on the objective.

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.	23 January 2025	Station Road GP Practice and Sidcup Medical Centre: Merger proposal	The Bexley Wellbeing Partnership Committee received the summary business case and ICB assessment and review for the Station Road Surgery (G83047) and the Sidcup Medical Centre (G83066) merger proposal. The Bexley Wellbeing Partnership Committee *approved in principle* the merger with the following caveats and conditions: (i) A date for the enactment of the merger to be agreed by the Place Executive Lead once the pre-requisite criteria set out in the report has been satisfactorily addressed. • The submission of a Quality Improvement Plan by the Contractor and the Contractor's acceptance of the additional conditions set out in the report.

3. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	23 January 2025	Primary Care Delivery Group Business Update Report – Q3 2024/25	• Given the extended time required to review Agenda Item 4 (Station Road and Sidcup Medical Centre Merger proposal), the Bexley Wellbeing Committee noted the Primary Care Delivery Group Business Update Report for Q3, Month 8 Finance report, and risk register.
2.		Month 8 Finance Report	
3.		Risk Register	
4.	23 January 2025	Let's talk	• The *Let's talk* session heard from the Bexley Healthy Weight Partnership. The committee noted that 1 in 5 reception age children in Bexley are overweight or obese and third of children are overweight or obese in Bexley. This is higher than the London average. The session discussed some of the current services available and future challenges.

Appendix 2

Bromley Local Care Partnership – One Bromley

1. Recommendations to the Board for Decision/Approval

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

2. Decisions made by Bromley LCP Under Delegation

2.1 The LCP agreed the draft Bromley primary and secondary care interface consensus document.

2.2 The LCP has made the following contract awards within its delegation authority for commissioning of local services:

- Community Gynaecology Direct Access Ultrasound Service – Transvaginal Scanning (TVS)
- MSK and Orthotics
- GP Websites
- Winter Additional Transport for Transfer of Care Bureau
- Management of Prescribing Improvement Scheme 24/25
- Advocacy Services at the Princess Royal University Hospital

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.	30 January 2025	Item 6 – Bromley Primary and Secondary Care Interface Consensus	• The draft primary and secondary care interface consensus was presented and discussed. • The committee approved and endorsed the document.

2.	30 January 2025	Item 7 – Neighbourhood Working in Bromley – Update	• The paper was for information and was taken as read, providing an update on the work undertaken by the Executive. • There was a detailed discussion on progress with a number of comments raised. • The Committee noted the neighbourhood working update.
3.	30 January 2025	Item 8 - Partnership Report	• The report was taken as read, an additional update was raised regarding the decision to postpone the procurement of 111 services and Integrated Delivery Units in all six boroughs across SEL by a year. Guidance was awaited from NHS England on the shape of the 111 service. • The report was noted.
4.	30 January 2025	Item 9 - Month 8 SEL ICB Finance Report	• The SEL ICB and Bromley financial position at Month 8 was discussed and noted. SEL ICB was forecasting that it would deliver a year end position of break-even. • Planning guidance was expected by the end of January. The report was noted.
5.	30 January 2025	Item 10 – Primary Care Group Report	• The meeting received an overview of the feedback from stakeholder engagement on the proposed 2025/26 schemes (GP Premium and Locally Enhanced Schemes) and the considerations as a result. PCG had approved the 2025/26 specifications. • The report was taken as read and was noted.
6.	30 January 2025	Item 11 – Contracts and Procurement Group Report	• The group confirmed contracts had been awarded as noted above, with the contract award for Mental Health Hubs to be brought to the next meeting. The list outlining contracts due to expire before May 2026 was highlighted.
7.	30 January 2025	Item 12 – Performance, Quality and Safeguarding Group Report	• The meeting had included a deep dive item on Cyber-Security, to include a presentation from Michael Knight, Chief Information Security officer for SEL ICB. A brief update was given on implementation of the Patient Safety Incident Response Framework (PSIRF) within primary care. The updated Bromley risk register was presented to the committee. The report was noted.

Appendix 3

Greenwich Local Care Partnership – Healthier Greenwich Partnership (HGP)

1. Recommendations to the Board for Decision / Approval

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

2. Decisions made by Healthier Greenwich Partnership LCP Under Delegation

2.1 No decisions were taken in the reporting period by the Healthier Greenwich Partnership LCP under delegation from the Board.

3. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	22 January 2025	Agenda Item 3 Conflicts of Interest – relating to agenda items	• It was noted that four attendees had advised potential conflicts of interest relating to Agenda item 10: Live Well: MSK Procurement Update. • The potential conflict relates to all four attendees being part of organisations that could possibly be participating in the tender process as providers • The committee noted that as agenda item 10 was an update only and no decision making would be required the potential conflicts would be noted but would not affect the agenda item • The Chair advised that due to the potential COI, they would hand over chairing for that item to the Chief Operating Officer, Greenwich
2.	22 January 2025	Agenda Item 6	• The LCP received a report and presentation about Connecting Greenwich, which is creating environments that encourage people to connect and lead change to enable

		Positive Partnership Story: Connecting Greenwich	neighbourhood health in Greenwich, by changing the things are being done – not by what is being done; building trusting relationships across all parts of the system and local communities; and, challenging structures that are limiting and focussing on people • Noting some examples of the work relating to the number of practices that are participating, links to existing neighbourhood programmes, community leaders along with system partners and residents have been working together in their neighbourhoods to set priorities, the under-diagnosis and poorly managed hypertension in a specific cohort in one community, and how work is being tailored to each community • The committee noted that good information on projects was shared and all related or linked in to neighbourhood working
3.	22 January 2025	Agenda Item 7 Update on process of HGP refresh	• The LCP received an update on the process of the HGP refresh, relating to the established priorities of the Health and Wellbeing strategy published in 2023 • The committee noted that the priorities for the next year are being refreshed, alongside identifying priorities for the next year which were identified at a workshop held in November 2024 • The committee also noted that whilst all priorities are important, some have higher priorities that require the involvement of all partners
4.	22 January 2025	Agenda Item 8 Feedback from Public Forums	• The committee agreed to incorporate agenda item 8: Feedback from Public Forums into agenda item 7: Update on process of HGP refresh, as both items were aligned • The LCP received a comprehensive report on the public forum which focussed on the HGP refresh and tested emerging priorities with local residents • The committee noted that two forums were held; one was 'in person' and the other was hosted online, observing that this format worked well and allowed for good engagement • The committee also noted that knowledge of the Healthier Greenwich Partnership has increased from 3.2 to 4.3
5.	22 January 2025	Agenda Item 9	• The LCP received an update on Greenwich Neighbourhood planning

		Update on Greenwich Neighbourhood planning	• The committee were advised that the current progress includes good engagement with Connecting Greenwich, system partners who have identified neighbourhood deliverables, tackling health inequalities and taking a proactive approach • The proposed neighbourhood groupings were shared with the members
6.	22 January 2025	Agenda Item 10 Live Well: MSK Procurement update	• Note that this agenda item was chaired by Gabi Darby, Chief Operating Officer, Greenwich, due to potential conflicts of interest as noted in Item 1 of this report • The LCP received an updated which advised that the timeline for the procurement process had been changed to ensure that there was local engagement from patients, workforce and partners • The committee noted that due to the engagement activities, the procurement specification was amended • The members also noted that the formal procurement date was noted in the circulated papers
7.	22 January 2025	Agenda Item 11 Healthier Greenwich charity	• The LCP received an update on the current activities of the charitable fund • It was noted that the fund was launched in April 2024 and has two main funding strands of enabling and delivery, with 54 organisations having received funding • The members were advised that the fund would be re-launched in April 2025 and that this included plans to increase engagement with the south of the borough
8.	22 January 2025	Agenda Item 12 Healthier Greenwich Partnership – Quarterly Partner update	• Members received the quarterly partnership report, which included updates from partners
9.	22 January 2025	Agenda Item 14 Risk update	• The LCP Board reviewed the current Place based risk register, noting changes since the last update, and the work taking place at SEL level to consider system wide risk and agreed to accept the mitigations that have been put in place.

Appendix 4

Lambeth Local Care Partnership – Lambeth Together

1. Recommendations to the Board for Decision / Approval

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

2. Decisions made by Lambeth Together Care Partnership Under Delegation

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

No.	Meeting date	Agenda item	Items for Board to note
1.	6 March 2025	Lambeth Together Primary Care Commissioning Committee (PCCC)	Members of the Partnership Board noted the update on discussions held at the Primary Care Commissioning Committee on 22 January 2025 and ratified decisions made by the Committee at the meeting on 22 January 2025.

3. Agenda Items of Note

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

No.	Meeting dates	Agenda item	Items discussed
1.	6 March 2025	Lambeth Together Care Partnership - Place Executive Lead Report	Members of the Partnership Board received an update on key developments since the last formal Lambeth Together Care Partnership Board meeting in Public on 9 January 2025, reporting on key issues, achievements and developments from across the Lambeth Together Partnership.

2.	6 March 2025	Learning Disability & Autism Programme (LDA) – Deep Dive	Members of the Partnership Board noted and supported progress of the Learning Disabilities and Autism Programme and Lambeth All Age Autism Strategy throughout 2024/25. Members of the Partnership Board provided feedback to the team including commendation by the Chair as being a good demonstration of what can be achieved.
3.	6 March 2025	Lambeth Together Assurance Group (LTAG) Update	Members of the Partnership Board noted and supported the update from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented at the Sub-Group on 21 January 2025 which was centred around three outcomes which the partnership is aiming to achieve through delivery of the *Our Health, Our Lambeth*, as the Lambeth Together health and care plan, with detailed updates presented noted by Lambeth partners working in these areas discussing the interventions and impact measures being monitored to check that the outcomes are being achieved.
4.	6 March 2025	Lambeth Together Business Planning	Members of the Partnership Board noted the progress of the Lambeth Together 2025/26 business planning process, provided feedback on the Plan's development; and approved the next steps and timeline.
5.	6 March 2025	Neighbourhood and Wellbeing Delivery Alliance (NWDA) – Deep Dive	Members of the Partnership Board noted an update on the Integrated Neighbourhood Teams (INT) implementation and endorsed the proposed neighbourhood geographies for INTs in Lambeth. Members of the Partnership Board also noted and commented on the proposed integrator function for Lambeth and delegated final sign off on the neighbourhoods and integrator model to the Neighbourhood and Wellbeing Delivery Alliance, noting that a final model will return to the Lambeth Together Partnership Board seminar in April 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.	30 January 2025	(4). System Intentions	• The Board approved the system intentions for Lewisham, a joint approach with SLaM and LGT and in terms of delivery which will focus on: ○ LTC will focus on hypertension and especially around wait lists. ○ Older People - transformation programme is implementing the frailty project. Community and urgent care aim is to provide a reduction in ED and an increase in Home first and same day urgent care. ○ Mental health will focus on Autism and ADHD. ○ Community based care will focus on access to primary care and medicine management but will also improve the interface between primary and secondary care. ○ In progress is an improvement dashboard for wider system which is currently in progress. ○ CYP will focus on ADHD and access to diagnostics and family hub. •
2.	30 January 2025	(8). Take Home and Settle & Homeless Patients Legal Advocacy Service procurements.	• The Board approved the Take Home and Settle & Homeless Patients Legal Advocacy Service procurements. An update on the successful bidders will be announced at LCPSB March public meeting.

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.	30 January 2025	(3). PEL Report	• The Board noted the PEL update from Ceri Jacob, Place Executive Lead, Lewisham. This included the 25/26 priorities and operational **Planning Guidance** which sets out a number of national priorities for 2025/26 with an emphasis on improving access to timely care for patients, increasing productivity and living within allocated budgets, and driving reform. • **SEL Overarching Neighbourhood Development Framework** – which will be discussed at a future LCPSB seminar. • **Waldron Centre Soft Launch** and that funding had been received for Neighbourhood 1 and a launch event was held in partnership with the VCSE colleagues to promote proactive selfcare.
2.	30 January 2025	(5). Health Inequalities	• Reports and updates on elective waiting list, Pharmacy First Plus, Heath Equity Fellows Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR).
3.	30 January 2025	(6). Hypertension VCSE award report	• Funding of £100k has been received by Lewisham split over 2 years. There were 3 bids received in total and **Africa Advocacy Foundation** was the successful bidder and have been awarded the contract.
4.	30 January 2025	(7). Interpreting Service procurement update	• Following on from the procurement (LCPSB, November 2024). The successful bidder for the service is **DA Languages Ltd.** As DA Languages are an incumbent provider the service will continue with no disruption to patients, service delivery or service pathways.
5.	30 January 2025	(9). Risk Register	• The Board noted the Risk Register update. Risks are regularly reviewed at key borough meetings as well as individual risk owner meetings. Key themes relate to financial, statutory and workforce limitations. A new risk raised relates to the Adults safeguarding team due to the designate safeguarding lead being on long term medical leave, although there is some acting up arrangements.

6.	30 January 2025	(10). Finance update	• MC reported that for Lewisham against the delegated ICB budget at M8 there is an overspend of £224K; and even though it is an overspend, it is the third consecutive month of improvement. In M9 we will return to a surplus of £176k. Key areas of overspend continue to be prescribing and CHC, but both teams within those areas have done a good job in in trying to recover their positions during the year. Lewisham is forecasting an outturn of break even. Although forecasting to achieve a break even position this year, a lot of the mitigations in place to deliver are non-recurrent in nature.

Appendix 6

Southwark Local Care Partnership – Partnership Southwark

1. Recommendations to the Board for Decision / Approval

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

2. Decisions made by Partnership Southwark Under Delegation

2.1 No decisions have been taken by Partnership Southwark under delegation from the Board during the period.

3. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	30 January 2025	Item 2. Community Spotlight: Adult Mental Health - How do we provide support for people with acute complex mental health needs?	• The board received a presentation from the Southwark SLAM team on current challenges faced by the system in responding to people with complex mental health needs. The focus is on addressing long waits in A&E, long lengths of stay in mental health wards, and delays in discharging patients clinically ready for discharge. The board discussed the issues raised and how collective action by partners in the community could help tackle the issues, for example through supported housing arrangements.
2.	30 January 2025	Item 3. Health and Care Plan Priorities Refresh – Focus on Adult and CYP Mental Health	• The board reviewed progress on delivering the Health and Care Plan priorities, with a focus on mental health.

3.	30 January 2025	Item 6: Strategic Director for Health and Care and Place Executive Lead Report	The Strategic Director for Health and Care and Place Executive Lead presented the report to the board including: • A summary of work being undertaken the Integrated Neighbourhood Teams (INTs) model as part of the five agreed Health and Care Plan priorities. • The ICB Joint Forward Plan refresh. • The current financial position and the 2025/26 planning round. • Health and Wellbeing Board meeting update • Winter pressures and discharge funding. • Southwark Council Peer Review • Lower Limb Wound Care • Contracts awarded Reports from sub-groups of the board (Primary Care Group, Integrated Governance and Assurance and the Partnership Southwark Delivery Executive) were noted.
4.	30 January 2025	Governance Review	• The board approved the revised terms of reference for sub-groups of the board (IGAC, PSDE, and Primary Care Committee, formerly PCG) reflecting the agreed reporting arrangements to the strategic board.

Appendix 7

Acute Provider Collaborative

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

1.1 No key decisions have been taken by the Acute Provider Collaborative under delegation from the Board between 9 January 2025 and 31 March 2025.

2. Decisions made by the Acute Provider Collaborative Under Delegation

2.1 Below is a summary of decisions taken by the Acute Provider Collaborative under delegation from the Board between 9 January 2025 and 31 March 2025.

No.	Meeting	Agenda item	Items for Board to note
1.	APC Executive 24 January	QMS Theatres – options review	Following the QMS "Round Table" discussion on 23 January, the APC Executive requested the Joint MDs to lead this work via APC governance, working with Dartford & Gravesham colleagues to agree a preferred way forward.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note from the APC for the period 9 January 2025 to 31 March 2025, for Board information.

No.	Meeting	Agenda item	Items discussed
1.	APC Executive and other APC Groups	System Sustainability Group work	The Trust strategy leads met with the System sustainability team, alongside SLOSS and SELCA and the APC Joint MDs to agree next steps including governance and project management for the next phase of development. The group concluded that the potential opportunities in stroke/neurorehab were already being explored via other routes and that further work via the SSG would risk being

			duplicative. Therefore, four priorities remain, of which three will be led via the relevant APC networks: Orthopaedic (incl. MSK); Gynaecology; Imaging.
2.	APC Executive, APC Ops & Strategy Group and sub-groups	Operational Performance including long waiters	Elective and diagnostic performance is regularly reviewed and remedial actions identified across several APC groups. There has been a strong focus on the trajectory to eliminate 65w week waits, with additional meetings held to identify and support initiatives within trusts and mutual aid between trusts to ensure patients can be treated sooner. As of 16th Feb 2025, all RTT long waiter cohorts showed improvement across the three Trusts. All trusts reported zero 104+w as of 16/02/2025. All three trusts have provided assurance that overdue surveillance for all modalities will be included in the monthly report (DM01) by March 2025.
3.	APC Executive, APC Ops & Strategy and other groups	APC Outline Strategic Direction	The APC Outline strategic direction was discussed at numerous APC meetings and also at the ICB Executive. Feedback has been incorporated into a revised version which will be reviewed by the Committee in Common in April.
4.	APC Ops & Strategy Group, 3 March	Pharmacy Aseptic Services Strategic Case	The Pharmacy Aseptic Services Strategic Case was also discussed, and it was agreed that given the system-wide implications it made sense for this to be considered via the APC governance structures.
5.	APC Finance & Estates Group 31 March	Constitutional standards - Capital bids prioritisation	The group noted the SEL submission requesting 2025/26 capital against “Constitutional Standards”, and the work of the APC delivery team in co-ordinating meetings between Trust and ICB ops and finance colleagues to prioritise schemes. The group aligned on a portfolio of schemes, consistently prioritised according to how effectively each scheme met the national criteria; known local challenges in terms of constitutional standards; and each trust’s own prioritisation. The Group also noted the benefits of this structured and multi-disciplinary approach.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 There have been no formal South London Partnership decisions to report to the Board in this quarter.

2. Items of Note

2.1 Below is a summary of other significant activity and items of note for Board information:

- A new community-based mental health rehabilitation unit opened in Lewisham in 2024 and is fully occupied. A potential location for a similar unit within Bexley, Bromley and Greenwich is being identified with the selected provider. The units support flow out of acute care services and offer intensive rehabilitation to support mental health service users return to the community as close to social networks as possible.

- South London Mental Health and Community Partnership (SLP) is working closely with SEL ICB ahead of NHS England formally delegating its strategic commissioning responsibilities for Specialised Mental Health, Learning Disability and Autism Services to ICBs from April 2025. Workshops have been held in early February and March to agree oversight approaches and transformation aims.

- SLP is engaging with the SEL ICS System Sustainability programme. The new NHS111 for Mental Health and NHS Police Mental Health Clinical Advice Line are fully operational across south London and being delivered from a central hub by staff from SL&M. Further opportunities to strengthen integration with existing adult and children and young people's mental health crisis lines are being taken forward by SLP.

NHS South East London Integrated Care Board
Charitable Funds Committee

Terms of Reference

~~Final – 21 June 2022~~Update 6 March 2025

1. Introduction

These Terms of Reference set out the role, responsibilities, membership, and reporting arrangements of the Charitable Funds Committee.

2. Purpose

NHS South East London Integrated Care Board (ICB) is the Corporate Trustee of NHS Greenwich Charitable Funds, Charity number: 1097722. The ICB Board serves as its agent in the administration of the charitable funds.

Declaration of Trust, dated 25 March 2003, as affected by Statutory Instrument 2004 No. 1643 as amended on 17 Apr 2020.

The charitable objects are 'For any charitable purpose or purposes relating to the National Health Service, for the Health & Wellbeing of the residents and staff in the population served by the Royal Borough of Greenwich.'

The Charitable Funds Committee has been established by the Board to make and monitor arrangements for the control and management of charitable funds.

The key purpose of the Committee is to govern, manage, regulate and plan the finances, accounts, investments, assets, business and all affairs of the charity, including the authorisation of expenditure.

3. Scope

The scope of the Committee will be the responsibility for charitable funds, where the NHS South East London Integrated Care Board (ICB) is the Corporate Trustee.

4. Duties

Within the budget, priorities and spending criteria determined by the ICB as Trustee and consistent with the requirements of the Charities Act 2016 (or any modification of that Act) to apply the charitable funds in accordance with their respective governing documents.

To ensure that the ICB policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way which both preserves their capital value and produces proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The Charities Act 2016
- Terms of the Funds' Governing documents

To ensure the approval and submission of the annual accounts and Trustees' report in accordance with the Charities Act.

To monitor the ICB's scheme of delegation for expenditure for the levels in accordance with policy and delegated limits.

To monitor income, expenditure and investments in relation to charitable funds.

To receive proposals for major expenditure and to approve charitable fund bids (over £5,000) in accordance with the relevant procedures.

To consider strategy in relation to the charity and charitable funds, with a view to making recommendations to the ICB Board as Corporate Trustee, ensuring that the outcomes are delivered against the charitable objects.

To ensure appropriate advice is sought in relation to the health & wellbeing needs of the population of Greenwich, so that this informs the strategy and evaluation of impact, being mindful of the inequalities within the borough.

The Committee will determine the strategy and policies for fundraising, including whether the ICB should undertake major fundraising appeals, establishing the appropriate framework to ensure that any appeal is properly managed. To monitor fundraising performance and compliance with fundraising regulations.

To identify and monitor risks in relation to the charity and charitable funds, including investments and grants made.

To ensure that training needs of Committee members are identified and met.

5. Accountabilities, authority and delegation

The Committee is a sub-committee of the ICB Board. The Committee will provide a report to the ICB Board a minimum of once each year.

The Committee shall have the authority to appoint an investment manager to advise it on investment matters and may delegate day-to-day management of some of all of the investments to that investment manager. In exercising this power the Committee must ensure that:

- The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
- There are in place adequate internal controls and procedures which ensure that the power is being exercised properly and prudently.
- It regularly reviews the performance of the person or person's exercising the delegated power.
- Where an investment manager is appointed, that the person is regulated under the Financial Services and Markets Act 2000.
- Acquisitions or disposal of a material nature always have written authority of the Committee or the Chair of the Committee in conjunction with the Chief Financial Officer.
- It establishes and maintains an approved list of counter parties for investment activities.
- It will obtain appropriate professional advice to support its investment activities.
- It will regularly review investments to see if other opportunities or investment managers offer a better return.

The Committee shall also have the authority to appoint a partner organisation that can support the Charity in the formation and implementation of a strategy to distribute funds held. In exercising this power the Committee must ensure that:

- The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.

- There are in place adequate internal controls and procedures which ensure that the power is being exercised properly and prudently.

- It regularly reviews the performance of the person or person's exercising the delegated power.

- It will obtain appropriate professional advice to support.

6. Membership and attendance

The core membership of the Committee will be:

- A Non-Executive Director (as Committee Chair)
- Chief Financial Officer
- Greenwich Place ~~Executive Director~~Chief Operating Officer
- Chief of Staff

In addition, the Committee will have the following in attendance:

- Charity Director (~~Greenwich Place Chief Operating Officer~~Nominated senior manager liaising on a regular basis with Charity Advisor~~,~~ to ensure delivery of agreed investment workstreams of the Fund)
- Charity Advisor (Charity partner supporting the ~~f~~Funds~~)~~)
- Representative (s) from Royal Borough of Greenwich Public Health
- Administrative support to take minutes
- Subject matter leads will be invited to the Committee as required

7. Chair of meeting

The Committee will be chaired by the Non-Executive Director. In the event that the Non-Executive Director is unable to attend, the Committee will be chaired by either the ICB Chair or another Non-Executive Director.

At any meeting of the Committee, the chair if present shall preside. If the chair is absent, the deputy chair shall preside. If the chair is temporarily absent on the grounds of conflict of interest, the deputy chair shall preside.

8. Quorum and conflict of interest

The quorum of the Committee is at least 50% of core members.

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 of the Committee.

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).

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.

9. Decision-making

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 core member may cast a single vote. In the event of equal votes, the chair will have a casting vote.

By exception and outside of formal meetings, decisions may be reached via email, for example approval of a funding bid, providing appropriate information is available to Committee members to consider the recommendation.

10. Frequency

The Committee will meet a minimum of two times over the course of a year.

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

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 to the meeting secretariat, in advance.

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

11. Reporting

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

Regular updates (at least annually) from the Committee will be provided to the Greenwich Local Care Partnership (Healthier Greenwich Partnership), so wider partners are able to contribute to and be informed on the charity's activity and plans.

12. Group support

The group will be supported by the Greenwich Place administration team, part of the Chief of Staff directorate.

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.

13. Review of Arrangements

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.

These terms of reference shall be reviewed by the Committee chair on an annual basis, in the context of the self-assessment and any changing business requirements.

NHS South East London Integrated Care Board
Scheme of Reservation & Delegation

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
REGULATION AND CONTROL	Prepare the ICB's overarching Scheme of Reservation and Delegation, which sets out those decisions of the ICB reserved to the Board and those delegated to the ○ Board ○ committees and sub-committees of the ICB, or ○ its employees		√		
REGULATION AND CONTROL	Approval of the group's overarching scheme of reservation and delegation	√			
REGULATION AND CONTROL	Prepare the ICB's operational scheme of delegation (schedule of matters delegated to officers), which sets out those key operational decisions delegated to individual employees of the ICB.		√		
REGULATION AND CONTROL	Approval of the ICB's operational scheme of delegation (schedule of matters delegated to officers) that underpins the ICB's Overarching Scheme of Reservation and Delegation.				Executive Committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
REGULATION AND CONTROL	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution	√			
REGULATION AND CONTROL	Prepare detailed financial policies that underpin the ICB's standing financial instructions			√	
REGULATION AND CONTROL	Approve detailed financial policies				Executive Committee
REGULATION AND CONTROL	Approve any changes to the ICB's committee structure	√			
REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests				Integrated Performance Committee
REGULATION AND CONTROL	Exercise or delegation of those functions of the ICB which have not been delegated to the board or other committee or sub-committee or [specified] employee		√		
STRATEGY AND PLANNING	Agree the vision and values of the ICB	√			
STRATEGY AND PLANNING	Agree the overall south east London integrated strategy				Integrated Heath and Care Partnership
STRATEGY AND PLANNING	Agree the overall strategic direction of the ICB	√			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
STRATEGY AND PLANNING	Approval of the ICB's annual corporate budgets	√			
STRATEGY AND PLANNING	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the ICB's ability to achieve its agreed strategic aims.	√			
ANNUAL REPORTS AND ACCOUNTS	Approval of the ICB's annual report and annual accounts				Audit and Risk Committee
ANNUAL REPORTS AND ACCOUNTS	Approval of the arrangements for discharging the ICB's statutory financial duties.	√			
HUMAN RESOURCES	Approval of the ICB's operating structure (in relation to organisational structures within the ICB)		√		
HUMAN RESOURCES	Approval of terms and conditions, pensions, remuneration, fees and allowances payable to board members, employees and to other persons providing services to the ICB outside of agenda for change				Remuneration committee
HUMAN RESOURCES	Approval of responsibility allowances payable to employees in Agenda for Change bands 2-7 which are less than £2,500 p.a.				Executive Committee
HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Chief Executive (where he/she is an ICB employee) and for other persons working on behalf of the ICB				Remuneration committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
HUMAN RESOURCES	Approval of the arrangements for discharging the ICB's statutory duties as an employer	√			
HUMAN RESOURCES	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers				People Committee
HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the ICB				Executive Committee
QUALITY AND SAFETY	Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes				Quality & Safeguarding committee
QUALITY AND SAFETY	Approve quality and safety policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes				Executive Committee
QUALITY AND SAFETY	Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.				Quality & Safeguarding committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's counter fraud and security management arrangements				Audit and Risk Committee
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's risk management arrangements.				Audit and Risk Committee
OPERATIONAL AND RISK MANAGEMENT	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Integrated Care Boards or pooled budget arrangements under section 75 of the NHS Act 2006).	√			
OPERATIONAL AND RISK MANAGEMENT	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB				Audit and Risk Committee
OPERATIONAL AND RISK MANAGEMENT	Approve proposals for action on litigation and claims handling against or on behalf of the ICB				Executive Committee
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's arrangements for business continuity and emergency planning				Executive Committee
OPERATIONAL AND RISK MANAGEMENT	Development of the ICB's Operational plans				Executive Committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
OPERATIONAL AND RISK MANAGEMENT	Authority to make decisions relating to operational matters, within the financial limits specified in the Schedule of Matters Delegated to Officers, where not explicitly delegated elsewhere or defined elsewhere in the Schedule of Matters				Executive Committee
GOVERNANCE	Approval of the ICB's arrangements for handling complaints				Quality & Safeguarding Committee
INFORMATION GOVERNANCE	Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data				Digital Committee
INFORMATION GOVERNANCE	Approval of Information Governance Policies				Executive Committee
TENDERING AND CONTRACTING	Approval of the ICB's contracts for any contracting / commissioning support including in respect of any commissioning functions delegated by NHSE		√		
TENDERING AND CONTRACTING	Approval of the ICB's contracts for corporate support (for example finance provision)		√		
TENDERING AND CONTRACTING	Approval of changes to the provision or delivery of assurance services to the ICB including internal audit, security management and counter fraud				Audit and Risk Committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
TENDERING AND CONTRACTING	Approve the appointment (and where necessary dismissal) of external auditors (and where necessary change/removal) of external audit				Auditor Panel
PARTNERSHIP WORKING	Approve decisions that individual members or employees of the ICB, participating in joint arrangements on behalf of the ICB, can make. Such delegated decisions must be formally recorded	√			
PARTNERSHIP WORKING	Approval of a new pooled budget, with a south east London local authority	√			
PARTNERSHIP WORKING	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.	√			
PRIMARY CARE COMMISSIONING	Approve primary care commissioning arrangements in south east London (Bexley, Bromley, Greenwich, Lambeth, Southwark, Lewisham)				Integrated Performance Committee
PRIMARY CARE COMMISSIONING	Approval of the arrangements for discharging the ICB's responsibilities and duties associated with its primary care commissioning functions for promoting improvement in the quality of services, reducing inequalities in relation to its primary care commissioning functions and promoting the involvement of each patient, patient choice, public engagement and consultation				Quality and Safeguarding Committee
PRIMARY CARE COMMISSIONING	Approval of the arrangements for discharging the ICB's responsibilities and duties associated with Pharmacy,				Quality and Safeguarding Committee via the joint

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
	Optometry & Dentistry (PODs) (delegated by NHS England) for promoting improvement in the quality of services, reducing inequalities in relation to its POD functions and promoting the involvement of each patient, patient choice, public engagement and consultation				London POD Commissioning Oversight Group
PARTNERSHIP WORKING	Approval of the arrangements for promoting integration and co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority/ies, where appropriate	√			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions for promoting improvement in the quality of services				Quality & Safeguarding Committee
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions including promoting the involvement of each patient, patient choice, public engagement and consultation				Engagement Assurance Committee
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions to promote reductions in inequalities	√			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority(ies), where appropriate	√			
DELEGATED COMMISSIONING ARRANGEMENTS	Decisions delegated by formal resolution of the board				√
DELEGATED COMMISSIONING ARRANGEMENTS	Overseeing the work of Pharmacy, Optometry & Dental, delegated by NHSE, via a Hub within NEL ICB to include: oversight of the POD Hub's contract management function and the commissioning activity and advice they undertake on behalf of the ICB, under the direction of the MoU (between NEL ICB and all other ICBs)				Integrated Performance Committee via the joint London POD Commissioning Oversight Group
DELEGATED COMMISSIONING ARRANGEMENTS	Integration of the responsibilities for a defined list of Specialised Services delegated by NHSE (as agreed on 1st April 2025 through a Delegation Agreement) with existing ICB commissioning functions taking decisions collectively with other ICBs where appropriate (London ICBs' Collaborative Agreement) and drawing on commissioning expertise of a London Shared Specialised Services Commissioning Team				Integrated Performance Committee via the London Specialised Services Partnership Board and South London Executive Management Board. Quality and Safeguarding Committee for any quality related issues.

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
DATA AND DIGITAL	Agree with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services, putting people at the centre of their care				Digital Committee
DATA AND DIGITAL	Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes				Digital Committee
SUSTAINABILITY	Agree joint working on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	√			

NHS
South East London

NHS South East London Integrated Care Board
Integrated Performance Committee
Terms of Reference
March 2025

1. Introduction

1.1. The Integrated Performance Committee (IPC) is established as a committee of the NHS South East London ICB (SELICB).

1.2. On behalf of the Board, the committee will consider NHS operational and financial performance with reference to the ICB's strategic commitments, providing the Board with assurance that these commitments are aligned across the ICS and on track for delivery. These strategic commitments are those of relevance to the whole system and as expressed in the ICP integrated care strategy, the Joint Forward Plan, Medium Term Financial Strategy and other strategic documents. In addition, the committee will provide an escalation route for the ICB Executive if enhanced review and assurance is required in relation to the in-year delivery of associated operational plans.

1.3. These Terms of Reference set out the role, duties, membership and reporting arrangements of the committee under its terms of delegation from the ICB Board. The committee's powers relate specifically to these terms of reference, which can only be amended by the ICB Board.

1.4. All members of staff of SELICB will be expected to co-operate with any requests made by the committee to further its agreed objectives and actions.

2. Purpose and Rationale

2.1. The four aims set out for all Integrated Care Systems describe ambitions that will require sustained collective effort over multiple years to:

a) Improve outcomes in population health and healthcare

b) Tackle inequalities in outcomes, experience and access

c) Enhance productivity and value for money

d) Help the NHS support broader social and economic development.

2.2. The aim of the IPC is to assure the Board that the NHS in SEL is in the best possible place to achieve these aims, through review, testing and assurance in relation to SELICB's strategic plans. It will achieve this through an agreed workplan which will allow the committee to consider a range of strategic objectives and outcomes, including recommending any changes in approach or delivery to the Board to secure agreed strategic plans.

2.3. The committee will not spend significant time at its meetings considering routine reports on finance and performance, although it will receive dashboard reports across key operational planning domains to maintain situational awareness and enable members to effectively carry out its more strategic role. It will also consider areas where the ICB is off track or at risk of non-delivery to provide further assurance to the Board as to recovery and mitigating actions.

2.4. The committee will provide recommendations to the Board around any proposed action to

mitigate risks or issues in relation to strategic delivery alongside wider learning around delivery of the ICB's strategic plans.

2.5. In summary the committee exists to oversee and assure the 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 also have a role to monitor how delivery across different parts of the system contributes to the ICS's overall strategic work and direction, including recommending to executives where correction needs to be made to ensure efforts are aligned.

3. Duties

3.1. The IPC will consider key areas of ICB strategic planning and delivery to provide assurance in relation to progress against agreed commitments and outcomes. The areas of focus will be driven by an agreed annual workplan setting out the areas for review and consideration by the committee.

3.2. The IPC will provide assurance to the Board that the strategic commitments of SELICB are on track for delivery and that where delivery is at risks clear actions and mitigations are in place to support recovery and ensure the successful delivery of plans.

3.3. The IPC will further consider material performance variations affecting the ability of the ICB to deliver its strategic commitments because of non-delivery of in year operational plans, as escalated by the ICB Executive (the IPC may also ask the ICB Executive to escalate a matter to it). It will provide assurance and direction or recommendations around the appropriate response by the ICB.

3.4. The IPC will support the work of the System Sustainability Group, providing Board Committee support, advice and feedback alongside assurance around delivery of agreed outcomes and commitments.

3.5. The committee will review the NHS contribution to borough plans as articulated in the Joint Forward Plan and Health and Well Being Plans, alongside the consideration of SEL wide plans. This does not constitute an additional mandatory approval step for local Places work and strategies but a mechanism through which there is ICB visibility around the NHS's contribution to the delivery of these plans alongside the identification of any system wide learning or enabling action required to optimise delivery.

3.6. The ICP may make recommendations to improve the metrics used to track progress against strategic aims.

3.7. Receive, for information, reports from the Deputy Chief Executive or Chief Financial Officer, when invoices in excess of agreed Service Level Agreements (SLAs) have been authorized (Section 8ii, Schedule of Matters delegated to Officers)

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. Formal decisions of the committee will need agreement from a majority of members present at the committee meeting.

4.3. The IPC will undertake an advisory function where a decision is required beyond the above stated levels of delegation. In this, the IPC will notify the ICB Board of items for decision.

4.4. The IPC may establish any working group or task and finish group to lead work under a

defined term of reference / engagement. The IPC must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

4.5. The Board may delegate to the group any decision within its scope by agreement of Board members.

5. Membership and attendance

5.1. The IPC will be constituted of the following members and attendees:

Members

- Non-Executive Member (Chair)
- ICB Chair
- Partner Member for Primary Care (x1) (Vice chair)
- Provider Non-Executive directors (x5)
- Acute provider Executive Director representative (x1)
- Community provider Executive Director representative (x1)
- Mental Health provider Executive Director representative (x1)
- ICB Chief Executive Officer
- ICB Chief Finance Officer
- ICB Executive Director of Planning
- ICB Chief of Staff
- ICB Place Executive Lead (x1)
- ICB Medical Director or ICB Chief Nurse
- Second ICB Non-Executive Member

5.2. Other individuals from across the Integrated Care System may be invited to attend as required.

5.3. The group is permitted, with the agreement of the ICB Chair 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 meeting will be chaired by the SELICB Non-Executive Member. The vice chair will be the Partner Member for Primary Care.

6.2. At any meeting of the group, the chair if present shall preside. If the chair is absent, the vice chair shall preside. If the chair is temporarily absent on the grounds of conflict of interest, the vice chair shall preside.

7. Quorum

7.1. The quorum of the group is 50% including at least

– The Non-Executive member (chair) or the Partner Member for Primary Care (vice chair)

– One provider member

– One ICB Executive Director member

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

7.3. Members are responsible for identifying a suitable deputy should they be unable to attend a group meeting which needs to be agreed with the IPC Chair, and notified to the meeting secretariat, in advance.

7.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the IPC Chair in advance.

7.5. The IPC 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 of the committee.

7.6. The IPC 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).

7.7. IPC 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.

8. Decision-making

8.1. 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 and decisions will require a simple majority. In the event of equal votes, the chair will have a casting vote.

9. Procedure of decisions made outside of formal meetings

9.1. The IPC 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 IPC Chair by a stated date. A decision made in this way will only be valid if the same minimum quorum, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

9.2. 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 that meeting.

10. Frequency

10.1. The IPC will normally meet once every two months, but the frequency may be changed by the chair with the agreement of members.

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

11. Reporting

11.1. IPC members will receive operational performance and finance reports, plus relevant board risk and assurance reports, to provide contextual information to support its work.

11.2. The IPC Chair will report to ICB public meetings of the board on the work of the committee and escalate any concerns relating to strategic and operational delivery.

11.3. The IPC shall, under the direction of its Chair, provide any information necessary to other committees or ICS groups conveying the advice, approval or view of the committee on areas within scope.

12. Committee support

12.1. The IPC will be supported by members of SELICB's governance team.

12.2. Papers will be made available at least 7 days in advance of the meeting.

12.3. 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.

13. Monitoring adherence to the Terms of Reference

13.1. The IPC Chair will be responsible for ensuring the committee abides by the terms of reference.

14. Review of Arrangements

14.1. The IPC shall undertake a self-assessment of its effectiveness and a review of its terms of reference on at least an annual basis.

14.2. These terms of reference shall be reviewed by the IPC Chair and ICB Chair on an annual basis, in the context of the self-assessment and any changing business requirements, with changes proposed for approval to the ICB Board.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**ICB Board Assurance Framework**					
Meeting date	16 April 2025	Agenda item Number	7	Paper Enclosure Ref	G	
Author	Kieran Swann (Associate Director of Assurance and Risk), Tara Patel (Head of Assurance - Risk)					
Executive lead	Tosca Fairchild (Chief of Staff)					
Paper is for:	Update		Discussion		Decision	X
Purpose of paper	This paper presents the latest Board Assurance Framework (BAF). The BAF sets out the main ICB risks and details controls and assurances which show how risks are being managed appropriately 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. ExCo met on 2 April 2025 to consider the current ICB BAF. The RMF states that the Board should be kept 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 Board is also responsible for formal approval of the BAF.					
Summary of main points	**Latest updates on BAF and key risks** This paper presents the current version of the SEL ICB BAF, reflecting all risks above the ICB's agreed risk appetite threshold as of 17 March 2025. It has been endorsed by the Executive Committee on 2 April 2025. The BAF includes 10 risks at system level and 2 LCP-level risks (both in Lewisham) that exceed agreed thresholds. There are no above-threshold risks for Bexley, Bromley, Greenwich, Lambeth, or Southwark LCPs. **Key changes since the previous report:** • No new or escalated risks have been added to the BAF. • One risk has de-escalated: Lewisham Risk 498 (financial balance) reduced from 15 to 9, following successful implementation of financial recovery actions.					

	• One risk has increased: SEL Risk 435 (all-age continuing care data submission) was re-escalated from 9 to 12 due to an IT system delay affecting CHC data reporting in Lewisham. **Additional updates following Executive Committee review:** Risk owners will re-profile all risks during April in the context of 2025/26 delivery planning, recognising the impact of challenging operational and financial conditions, including national directives to reduce ICB and provider management costs. SEL Risk 437 (disruption to IT systems) has been clearly reclassified as a clinical, quality and safety risk to reflect the direct impact on care delivery. The need to consider an emerging risk relating to the potential for industrial action was agreed, with this to be captured in the next BAF iteration. This and similar issues will form part of an emerging 'risk pipeline' approach to tracking and anticipating new threats. The ICB's BAF continues to align with risks to system objectives identified by ICS partners, with regular collaborative review, and sharing of thematic learnings completed together with ICS partners at bi-monthly SEL ICS System Risk Leadership Group meetings.
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	Risk and Audit Committee, 14 January 2025 PELs Group, 24 February 2025 SEL ICS Risk Leadership Group, 11 February 2025 SEL ICB Risk Forum, 11 February 2025 ICB Executive Committee, 2 April 2025
Recommendation	The Board is asked to: Review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 2 April 2025.

SEL ICB Board Assurance Framework 2024/25
April 2025

Prepared for SEL ICB Board, 16 April 2025

Context and latest updates

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

- The **ICB's Audit and Risk Committee is responsible for review and approval of the ICB's risk management arrangements on behalf of the Board**. The Audit and Risk Committee reviewed and endorsed the updated risk management framework and risk appetite statement on 11 July 2024, which was further updated in September 2024 to reflect changes in ICB governance arrangements. The Audit and Risk Committee also endorsed the recommendation that current risk appetite thresholds be retained to the point of next review in July 2025.

- 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 delivery business objectives.

- The ICB risk and assurance team continue to **collaborate with risk leaders from ICS NHS partner organisations on areas of common risk** impacting integrated care system objectives in south east London **(see slide 5).**

Discussion of risk at key committees / forums (1 of 2)

A. Place Executive Leads meeting and the SEL ICB Risk Forum

The LCP comparative risks review pack was updated in January 2025 and discussed at both the ICB's Risk Forum and at the place executive leads group on 24 February 2025. This resulted in the **following changes being made** to the LCP risk registers:

- Addition of a new risk against achievement of targets for the proportion of the **population vaccinated in Southwark** LCP, with a current score of 9.
- Reduction in score for all LCP risks relating to **GP collective action**. These risks were reduced from a 9 to 6, because this has not had a tangible impact on primary care services. Subsequently, it was confirmed that the BMA is 'no longer in dispute' with the Government and NHS England and the GPCE has therefore paused collective action after accepting a GP contract deal for 2025/26. Consequently, it was agreed that these risks should be closed on the respective borough risk registers.
- Closure of **community pharmacy collective action** risk from Bexley's risk register as discussions on this were still at very early stages and not considered a risk.

- The LCP comparative risk report showed a **decrease in scores in 20 out of a total 75 LCP risks,** since the previous quarter. This **demonstrates actions and controls put in place by LCP are taking effect** to mitigate these risks.

B. Risk and Audit Committee

The Risk and Audit Committee meeting on 14 January 2025 considered whether all **relevant primary care risks** were currently recorded on the LCP registers. The risk and assurance team subsequently met with the following to prompt review of current risks with the **expectation that a fuller set of risks in these areas would be considered** as part of a review of risks in the context of planning for delivery in 2025/26 and to be added to risk registers in April 2025:

- Place PELs, who indicated that they will be looking to add risks relating to primary care sustainability for the new financial year (2025/26).
- The ICB Chief Pharmacist and pharmacy risk lead to consider whether further pharmacy related risks (in particular, community pharmacy) should be considered for addition for the new financial year. The current pharmacy risks are being reviewed by the medicines optimisation senior management team.

Discussion of risk at key committees / forums (2 of 2)

C. SEL ICB Executive Committee

- The ICB **Executive Committee met on 2 April 2025** to consider the draft BAF, as well as updates on 'place' risk register and 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 **supported its submission to the ICB Board**.
- As part of the discussion, **ExCo confirmed that all risk owners will be asked to re-profile risks during April 2025** in the context of delivery of plans for 2025/26 in a significantly challenging operational and financial environment. This includes recognising the **major risks to the delivery of core system commitments for 2025/26, the ICB's and ICS's financial plan, and the national requirement for reductions to running and management costs** across both the ICB and provider sector.
- ExCo asked that **SEL Risk 437 (disruption to IT systems) be classified from a data and information risk to a clinical, quality and safety risk**, reflecting the operational impact of digital system disruption on direct care delivery. This risk was noted to be included in different categories across the main paper and detailed appendix, so the change ensures clarity and alignment between the BAF on Datix and the summary presentation of risks within the report.
- In addition, the **Committee considered emerging and pipeline risks,** particularly those related to the above referenced management expenditure change programmes, and key LCP delivery commitments. It was additionally agreed that a new risk will be drafted for the next version of the BAF to capture the potential for future industrial action to impact the resilience of both the ICB and ICS partners.

SEL ICS System Risk Development

- In July 2024, the ICB's risk and assurance team **set up a SEL ICS risk leadership group**, attended by all ICS acute and mental health trusts as a first step towards improving collaboration and coordination of risk management across the health system in SEL.

- The medium-term objectives of this collaboration are to **improve pan-system awareness of joint commitments / objectives (e.g. delivery of the ICS strategic plan), and to ensure that risks against these are considered collectively** rather than by each partner in isolation.

- The most recent meeting of this group took place on **11 February 2025**, where:
  - risks recorded across the **system partner BAFs were collectively considered** and discussed.
  - a 'teach-in' presentation took place into the requirements and related risks to delivery of **system and trust sustainability / net zero** targets.

- The next meeting is on **29 April 2025**. The agenda for this meeting includes a similar 'teach-in' and plenary session to look at the following areas of development and risk:
  - the ICB's Chief Nurse and team on **patient safety risks,** with a focus on objectives related to system working in this area.
  - the ICB's Chief Information Security Officer, on **cyber and IT risks.**

- The ICS risk leads group collectively agreed further similar sessions on:
  - Elective care transformation
  - The process of managing programme and corporate risks
  - Areas of risk that exist across the interface of providers, e.g., patient transport.

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 10-11). **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 12). The **detailed descriptions of risks in the appendices**, include the following information:
  - risk owners and sponsors
  - the risk category that the risk falls into
  - the risk appetite for that category of risk
  - a description of the risk
  - controls that are in place to mitigate the risk
  - assurances
  - initial and residual risk scores

System versus ICB risks

- As the ICB develops its system risk approach, relevant risks in the appendices have been differentiated into two categories as below:
  - **Primarily ICB risks** – those that have the potential to impact on the legal and statutory obligations of the ICB and / or primarily relate mainly to the operational running of the organisation. Controls for these risks are primarily within the ICB's scope to be able to resolve. The risk numbers have been highlighted in **green**.
  - **Primarily system risks** – those that relate to the successful delivery of the aims and objectives of the ICS as are defined in the ICB's strategic, operational, financial plans, corporate objectives and which impact on and are impacted by multiple partners in the integrated care system. Controls for these risks require a contribution from both the ICB and other ICS system partners to be able to resolve. The risk numbers have been highlighted in **blue**.
- A **risk heatmap showing the likelihood and impact of the BAF risks**, differentiated by these areas is included on **slide 13.**

Role of the Board and recommendation

The ICB Board:

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

Recommendation to the Board

- **Approve** the ICB BAF endorsed by the Executive Committee on 2 April 2025.

The current BAF

Key points to note:

- The risks included reflect the assessed position and risks were downloaded from **Datix on 17 March 2025**.
- The current version of the BAF includes 10 **SEL risks above threshold and 2 LCP risks (Lewisham).**
- There are **no risks above threshold** for **Bexley, Bromley, Greenwich, Lambeth and Southwark LCPs**.
- The report **incorporates recommendations provided at Executive Committee**, 2 April 20205.

Summary of changes since the last quarterly report

Summary of changes

- **No new risks** with a score greater than the risk appetite thresholds have been **added** to the BAF.
- **No risks** have **escalated** onto the BAF.
- **None** of the previous BAF risks have been **closed**.

- **One risk** has **de-escalated** off the BAF:
    - **Lewisham risk 498** relates to achievement of financial balance in the borough for 2024/25. The current score was reduced from 15 to 9, because Lewisham borough has implemented robust financial recovery actions during 2024/25 resulting in a reduced expenditure run rate for continuing healthcare and prescribing, enabling the risk assessment to be reduced.

- **One** increase in risk score:
    - **SEL risk 435**, relating to a single data submission for all age continuing care (AACC) by April 2025, was reduced in score in January 2025 from 12 to 9, because it was expected that the single data submission would go live in February 2025. This is no longer expected to be achieved as there is an additional application development to address the specific IT system challenge for the CHC team in Lewisham, and so the score has been increased again to 12.

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

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	**543**	ICS revenue financial plan 2024/25.	12	25
Data and Information Management	**435**	Variation in CHC digitalisation means that SEL will not meet the all age continuing care patient level dataset submission.	9	12
Clinical, Quality and Safety	**437**	Disruption to IT/Digital systems across provider settings due to external factors	9	15
	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics.		12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.		12

Key: Primarily system risk Primarily ICB risk

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

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

Key: Primarily system risk Primarily ICB risk

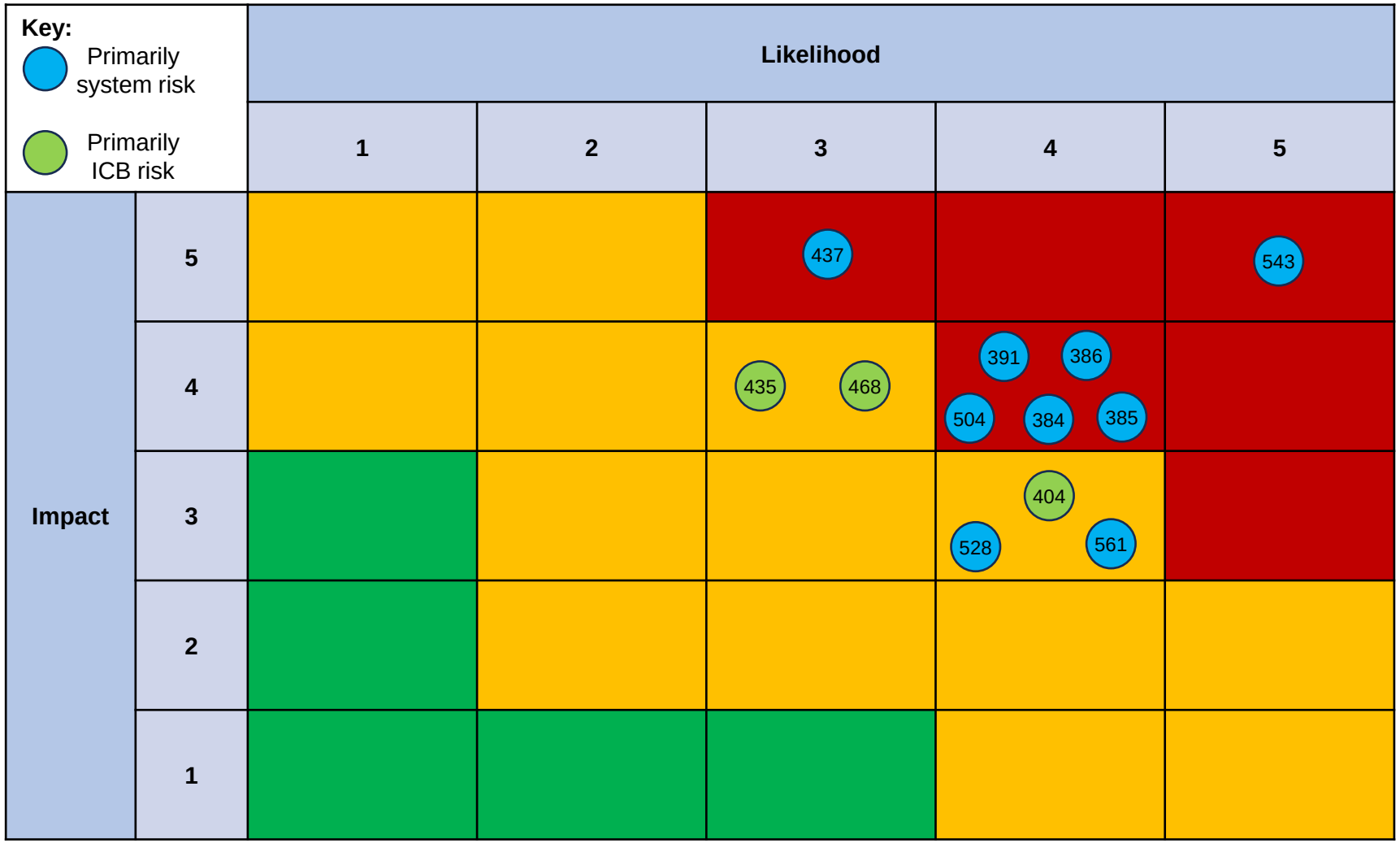
Summary of **Place/LCP** risks exceeding tolerance levels

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Clinical, quality and safety	**Lewisham 528**	Access to primary care services.	9	12
	Lewisham 561	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations.		12

Key: Primarily system risk Primarily ICB risk

‘Heat Map’ of BAF risks

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



ID	Summary risk descriptions
384	Elective care transformation programmes
385	Elective recoveries across the ICB/its providers
386	Ongoing pressures across SEL UEC services
391	Increased waiting times for autism diagnostics assessments
404	ICB oversight of new & emerging HCID & pandemics
435	AACC patient level dataset submission
437	Disruption to IT / digital systems
468	Variation in performance with funded nursing care
504	Cancer performance targets
528	Access to primary care services in Lewisham
543	ICS Revenue financial plan 2024/25
561	Increase in vaccine preventable diseases

Appendices: risk scoring matrices

Risk scoring matrices (1 of 3)

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

Likelihood x Severity = Risk Score

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

Likelihood Matrix:

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

Risk scoring matrices (2 of 3)

Severity matrix

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

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

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

Appendix 1. SEL risks greater than risk appetite thresholds

Risk ID	Risk Owner	Risk Sponsor	Risk Category	Risk Appetite	Risk Title	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
394	Harriet Agyepong	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	There is a risk of non delivery in a range of elective care transformation programmes (theatres, admitted, non admitted) led by the Acute Provider Collaborative. This is caused by the limited bandwidth of clinical and operational teams due to: Multiple asks of the same clinical and operational teams (e.g. a single specialty is asked to introduce a range of initiatives simultaneously). This could result in confusion over priorities, teams being overwhelmed or lacking the resource and support required to secure impactful and sustainable delivery. Inadequate capacity for clinical and other leads to engage and co-design initiatives with partners across primary and secondary care, leading to lack of awareness, buy-in and adherence to new pathways/ways of working with consequent inconsistency and inefficiency of care pathways. Insufficient oversight and awareness of the range of asks on teams (e.g. elective, cancer, urgent care), and what support might be needed to enable delivery. This will impact on the ICB's ability to meet statutory obligations and will impact on the waiting times for services that residents receive, with resulting potential impacts on patient experience, quality of life and outcomes alongside broader socioeconomic impact. It will also impact delivery of optimal care for those with long-term conditions if patients requiring treatment cannot be seen in a timely way in the most appropriate setting.	3	4	12	4	4	16	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. This risk has been increased in June'24 as a result of the Synnovis incident at GSTT & KCH. The system oversight of this incident is managed by the ICB, the acute trusts are involved directly in these meetings. The impact is shared across APC partners where relevant so there is a system understanding of the impact and risks. The impact of Synnovis is an agenda item at APC Ops & Strategy meeting to enable an understanding of direct impacts and mitigations on elective recovery & waiting time objectives.	No gaps	Minutes of APC Executive meetings, and key workstreams (e.g. Non-Admitted, Theatres), noting ICB participation in the APC led workstreams. In addition regular performance reporting across key standards and metrics. Regional review and enhanced assurance measures as part of national system oversight framework for challenged providers and services, including for SEL on elective delivery. Joint work and approaches across the ICB and APC, providing ICB visibility of actions and progress. Operational Plan commitments and agreed actions in elective recovery plan. Regular reporting and review against these - including monthly ICB/provider performance meetings plus monthly System Focus Meetings with the regional team, and a range of other Regional meetings.	No gaps
395	Harriet Agyepong	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a consequence increase in waiting times for diagnosis and treatment.	There is a risk of decreased capacity available for elective work which could lead to a consequent reduction in elective activity and ability to meet targets to reduce patients waiting a very long time for appointments / treatment. This is caused by competing pressures in the system e.g. urgent and cancer demand in relation to finite available capacity and resource. This will impact on the ICB's ability to meet statutory obligations and targets set out in the 24/25 operational plan, and will further impact on the length of time patients are required to wait for these services, affecting patient experience, plus potentially quality of life, clinical and psychosocial outcomes as a result of suboptimal waits.	3	4	12	4	4	16	In year plan refresh and winter plans (planning templates and recovery narratives) - inclusive of internal Board sign off and external/regulatory assurance and sign off. Regular review including through System Focus Meetings with the regional team. Minutes of APC Meetings – particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery, noting ICB participaton and representation as part of ICB governance. Regional assurance and review elective meetings. APC system level and internal trust work on theatre productivity to maximise activity that is carried out in the capacity available for non-urgent elective work and to optimise the use of day case and outpatient procedure capacity. All areas are regularly monitored and reviewed. APC work on non-admitted care and specialist advice. Annual work on winter planning to minimise disruption on elective care by planning for likely increases in non-elective activity over the winter period and wider transformation work in UEC. PIFU and use of community services to make best use of outpatient capacity available. This risk has been increased in June'24 as a result of the Synnovis incident at GSTT & KCH. The system oversight of this incident is managed by the ICB,, the acute trusts are involved directly in these meetings. The impact is shared across APC partners where relevant so there is a system understanding of the impact and risks. The impact of Synnovis is an agenda item at APC Ops & Strategy meeting to enable an understanding of direct impacts and mitigations on elective recovery & waiting time objectives.	No gaps	Operational plan for 2024/25, in year plan refresh and winter plans (planning templates and recovery narratives) - inclusive of internal Board sign off and external/regulatory assurance and sign off. Regular review including through System Focus Meetings with the regional team. Minutes of APC Meetings – particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery, noting ICB participaton and representation as part of ICB governance. Regional assurance and review elective meetings, including Tier 2 (LGT, KCH). Assurance also monitored through monthly Performance Report to the APC Ops & Strategy Group, fortnightly reports to the Operational Delivery Group. Weekly updated SEL NHSE dashboards. And monthly Trust specific Performance Meetings by the ICB Acute Performance Team. Notes and actions written for all NHSE, APC and ICB meetings.	No gaps
396	Kelly Hudson and Sara White	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Ongoing pressures across SEL UEC services	There is a risk of not being to make improvements in waiting times, pathway flow and timely transfer of care as a result of demand and flow challenges across the system. This will impact the ICB's ability to meet operational plan commitments and impact on the service users affected by these services, affecting patient experience. Increased waits - for ambulance support, in the Emergency Department or for transfer of care (e.g. from a physical to a mental health facility) increases the risk of poorer clinical outcomes. Cyber attacks in 2024 have had system-wide impact and have exacerbated existing issues and complicated efforts to streamline services which, in turn, impacts on system recovery of UEC performance. Whilst the system has largely recovered operationally from the last attack, the risk of future attacks remain.	4	4	16	4	4	16	Robust daily intensive system support in place, led and coordinated by the SEL ICB System Control Centre, to review, manage and smooth pressures across the system, agree mutual aid and support site safety. SCC operates 24/7 providing in and out of hours system support. Operational plan for 2024/25 includes a SEL system Urgent and Emergency Care r a number of performance improvement trajectories. Local system actions: each local system has an action plan to support urgent and emergency care pathway improvement including reviewing and making best use of available assets/capacity, workforce, care pathway changes (aligned to recommended best practice), 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. SEL System actions: SEL improvement work across the system to develop and implement supportive measures, for example, increasing direct access to and the further development of Same Day Emergency Care, direct booking from 111, increasing crisis support for Mental Health. In response to cyber attacks system went into Major Incident and Gold Command, these have since been stood down. Ongoing management of impact for UEC via recovery process including monthly recovery meetings with UEC SROs and local UEC leads in place and acute.	Reporting from some sites remains incomplete due to the implementation of EPIC. This does impact on having full and reliable data on which to measure performance and sites continue to work with the provider to bring full reporting back on line as soon as possible.	The daily SCC calls are providing the immediate system support to retain site safety across all SEL sites, with assurance having been completed regional and nationally of SEL's SCC arrangements. Review of revised OPEL (escalation) framework through SCC, aligned to national expectations, to ensure parity of escalation and system response. SEL operational plan for 2024/25 is being further assured this year by means of the SEL UEC Recovery Plans and monthly review meetings with each local system to review plans, impact and progress against trajectory. Each local system will manage their recovery plan through their local UEC Board with SEL UEC Board having oversight. Monthly call with UEC local system leaders to review current performance issues, challenges and successes; to understand key issues driving local performance and planned solutions; to understand key successes and opportunities for spread - plus formal local and SEL Urgent and Emergency Care Boards overseeing progress and performance with a supporting UEC performance dashboard. Further assurance through London UEC and MH UEC Boards.	None - no known at time of reporting
391	Carol-Ann Murray	Paul Lamsley	Clinical, quality and safety	7 - 9	Increased waiting times for Autism diagnostic assessments	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory obligations and increased spend due to non-contracted activity. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.	3	4	12	4	4	16	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. 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. Minutes from 6-8 weekly Joint Region and System LDA health Partnership meeting. Minutes from Monthly monitoring of ASD Support services and workforce with providers (Oxleas and SLaM).	No gaps on assurances
404	Simon Beard - Associate Director Corporate Governance	Tosca Fairchild - Chief of Staff	Clinical, quality and safety	7 - 9	New and emerging High Consequence Infections Diseases (HCID) & pandemics	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more waves. This could cause disruption to the operation of the ICB with staff illnesses/absence and reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	4	4	16	4	3	12	Staff are offered flu and covid-19 vaccines to mitigate as far as possible the impact on the workforce. HCID & pandemic plan is in place. Antiviral plan in place for SEL system. Collaboration with organisations across the system through forums such as Borough Resilience Forums enables the ICB to horizon scan for potential emerging HCID issues and put mitigating actions in place early to minimise impact to the workforce and ICB operations., Hybrid working arrangements are in place, supported by cloud-based access to IT systems, which enables the ICB to reduce face to face interactions between staff should this be necessary as a measure to reduce spread of infections. The ICB has an established process for considering staff redeployment to focus on business critical services. Employee assistance is available - e.g. mental health first aiders; occupational health and employee assistance programme. During the 2024-25 year there are plan to run tabletop and workbook exercises with the primary care teams and GPs to test and exercise the ICB plans for HCIDs, A national exercise - Op Pegasus - is planned to be run in 2025 to test plans.	UK HSA have published updated communicable disease outbreak management guidance which will be used in London to develop a pan London MoU for managing complex infectious disease outbreaks. Once completed, the ICB HCID response plan will need to be reviewed for alignment.	SEL ICB - System approach utilised and implemented for HCIDs. EPRR Practitioners network is in place enabling early sharing of information/ horizon scanning in relation to HCIDs, which will ensure organisations can take early mitigating actions. HCID plan reviewed and updated in 2024. Refreshed plan has been endorsed by ICB AEO and approved for publication by ICB Executive Committee. SEL ICB Head of EPRR and the Bromley PEL Angela Ithan, 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
435	Jane Waite - Head of CHC/CYPCC	Paul Lamsley - Acting Chief Nursing Officer	Data and information management	7 - 9	There is a risk that SEL will not meet the AACC (All Age Continuing Care) Patient Level Dataset submission due to variation in CYPCC digitalisation across the six boroughs by the deadline of 1st April 2025 to coincide with month 1 of 25/26	There is a risk that SEL will not meet the AACC (All Age Continuing Care) Data Set submission due to variation in digitalisation across the six boroughs by the deadline of 1st April 2025 to coincide with month 1 of 25/26.	5	4	20	3	4	12	Project in place working with SEL CHC and CYPCC teams to ensure readiness for the 01 April deadline. Heatmap maintained showing progress in each borough with opportunity to escalate to the PELS on a weekly basis if needed. All boroughs have plans in place to progress their local solution. Lewisham PEL approval obtained for additional application development by the IT system provider to address specific IT system challenge for the CHC team in Lewisham.	Timeline and costs yet to be confirmed by the Lewisham IT system provider	Borough heatmaps in place	Meetings with Lewisham IT system provider
437	Philippa Kirkpatrick, Michael Knight	Andrew Bland	Clinical, quality and safety	7 - 9	DIGITAL - Disruption to IT/Digital systems	There is a risk of significant disruptions to the IT and digital systems across our provider settings. This may be caused by external factors such as cyber attacks directly on our computer systems or servers, or those managed by our supply chain providers. It may also be caused by extreme weather conditions, fire or other events that result in system unavailability. The consequences of this risk occurring is significant disruption to the provision of clinical services, lack of access to historical information and lack of access to systems that support patient management such as waiting lists. In some events, patient and administrative data may be taken (see risk 32) . 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	Individual organisations accountable to their own boards to demonstrate sustainability of their digital and IT infrastructure, and actions put in place to move to greater third party hosting rather than relying on on-premise data centre. GPIT services are mostly 3rd party managed cloud-based solutions. GP services are required to have business continuity, including for their IT services, built into their contracts. A paper on the 2022 cyber and resilience incidents provided to the Board in July 2023, including lessons learnt and actions taken following the incident. Capturing lessons learnt from the Synnovis incident is underway. A senior Chief Information Security Officer for the ICB has been recruited. This role is responsible for identifying risks and will support partnership working to mitigate those risks. An external cyber and resilience maturity assessment has been completed by EY. Management responses to the review have been agreed by the Board and progress of agreed actions are being tracked by the Digital Board and the Audit and Risk Committee. MFA provides a second line of defence with regard to accessing systems where a password has been breached. All trusts in our system are now required to be compliant with MFA as per the national policy, and we are undertaking standards based configuration reviews before the end of the financial year to identify residual risks associated to local implementation. Organisations that handle personal identifiable data must complete the annual Data Security and Protection Toolkit, which includes assurance against Business continuity and resilience planning, information technology security, data management and due diligence with supply chains/third-party suppliers. A deep dive review of essential services and the associated supply chain has started, to help identify specific risks and support mitigation of specific risks within the supply chain.	The quantum of funding required to mitigate risks to an acceptable level has not yet been determined. It will be necessary to do this as part of the strategy development and provide advice to the Board if there are gaps in funding on controls following this process. A cyber and resilience strategy has been drafted and will be finalised in 2025 (in accordance with national timeframes). This will reflect the recommendations of the EY cyber and resilience maturity assessment. There is currently no central tracking of MFA status of all organisations in our system. This is best managed through commissioning arrangements where expectations and reporting on these can be established. The ICS Cyber Strategy will need to address this. Some components within technology platforms are aged, which impacts the extent to which desired controls can be applied to mitigate the likelihood of a cyber security incident. The supply chain supporting SEL is vast and diverse. Assurance of suppliers at point of procurement exists, but ongoing assurance is not consistently undertaken., Platforms and systems are not consistently configured in line with recognised frameworks to optimise security, There are gaps in identification and monitoring of assets, in particular those not supported by IT teams, There is currently limited reporting of system-wide cyber security status at committees. This is due for implementation in Q1 2025/26.	The Digital Board is responsible for overseeing the cyber status of our system. They are able to do this as they are guided by the external EY review, as well as an expert community of practice that has been established. Board cyber training held on 26 January 2024 to support members understand risks and mitigations. An external review was conducted by EY into the cyber and resilience maturity of Trusts and boroughs in our system. A management response to the review has been agreed by the Board, and agreed actions will be tracked by the Digital Board and the Audit and Risk Committee. Annual Completion of DSPT	No gaps
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Paul Lamsley - Acting Chief Nursing Officer	Clinical, quality and safety	7 - 9	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews. This is due to a significant number of reviews over the required time frames (National Standard). This is impacting on the ICB's ability to meet statutory requirements. This is a clinical risk which impacts on financial control across the system and patient experience.	4	4	16	3	4	12	This risk is monitored at the NHSE assurance meeting monthly, and locally at CHC/CYPCC oversight group 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. PELs and the CNO have taken a decision to pause a plan to reduce the backlog of reviews via an Independent provider. PELS are co-ordinating and overseeing a plan of additional internal support to deliver on this action and reduce the risk.	The Place Executive Leads (10/04/24) have been requested to provide revised trajectories and a collective improvement plan to address the remaining backlog of reviews (CHC Standard, fast track).	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	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Cancer Performance	This is a risk that the ICB does not meet the operational plan commitments it has made for 2024/25 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	2024/25 operational plan included agreed commitments in relation to cancer performance in relation to access and waiting time standards and the system Cancer Recovery Plan set out the planned actions that would support delivery. Cancer planning took place as part of overall operational and capacity planning to ensure cancer requirements were modelled and considered as part of overall planning and prioritisation. Plans were assured internally and externally, through regional and national processes. Plans regularly reviewed and monitored through the SEL ICB Cancer Executive, plus further review through regional meetings - further recovery actions developed and agreed through these processes. In January 2024 SEL entered into the system oversight framework support process (at Tier 1 - the highest level of support) in the context of a very challenged year to date position driven by overall operational pressures and the impact of Epic and industrial action. The performance position for the system has improved dramatically from this point with the system meeting all of its 23/24 performance commitments. However, the tiering set out in January has continued into the start of 24/25 financial year. Recovery actions considered through this process to be the right actions to support recovery, with a focus on both short term recovery actions and medium term sustainability plans. On quality and safety on going quality monitoring and surveillance including identifying potential and actual harm as a result of waits. It is expected the system will meet the FDS standard with the 62 day standard remaining challenging.	No current gaps in controls identified.	Governance - and associated minutes, papers and reports e.g. monitoring against trajectories and recovery plan actions - at a provider and SEL system level. ICB team works alongside providers and the Cancer Alliance to support planning and delivery. Plans/delivery are further reviewed in regional and national meetings - ICB co chairs Tier 1 meetings with Regional team. Plans have been assured in terms of covering the right areas - challenge is operational delivery across a complex range of services/pathways and providers - support being given to better secure delivery.	No current gaps in assurance identified.
543	Tony Read	Mike Fox	Finance	10 - 12	ICS revenue financial plan 2024/25	There is a risk that Risk that ICS does not deliver its deficit revenue financial plan for 2024/25, due to: Inability to deliver required level of targeted savings Uncertainty over closing £15m gap between plan and control total Under-delivery against elective recovery commitments Impact of industrial action Inability to recover income in line with planning guidance from non SEL ICBs Impact of cyber attack	5	5	25	5	5	25	£100m deficit plan for 2024/25 set as a control total by NHSE. To be agreed by ICS Executive and ICB Planning and Finance Committee. £100m non recurrent deficit support funding received in year, enabling a breakeven plan. Component parts of ICS plan to be agreed by SEL organisation Boards. Monthly review and reporting to ICB Executive, 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 plan and performance working with NHSE. Increased organisational control mechanisms. Monitoring of financial impact of industrial action by 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 review of trust year end forecasts and risks to delivery at M5, M7 and monthly thereafter. Monitoring of risks and potential mitigations to achieve plan, Review of underlying positions. Analysis of trust income vs cost. Budgets agreed. Financial Improvement Support from KPMG completed.	The impact of cyber crime means that the risk of missing our financial plan by a larger value than contained in the start risk is now greater than before. Identified CIPs and CIP forecasts do not currently meet targets. Funding for the financial impact of the pathology Cyber crime not yet received. Recovery plans to deliver plan in two organisations	£100m non recurrent deficit funding received from NHSE, enabling a breakeven plan, Budgets agreed. SEL CFO group meeting fortnightly, SSG meeting monthly, IA funding received, Internal control totals agreed, Additional support allocation received from NHSE in M12 Internal control totals agreed, Collectivley all 6 SEL organisations forecasting to deliver system financial plan and control totals. Trusts pursuing improvements targeted by KPMG I&T work	CIP plans do not meet targets. M11 run rate forecasts show an adverse variance to plan.

Appendix 2. LCP risks greater than risk appetite thresholds

Risk ID	Risk Owner	Risk Sponsor	Risk Category	Risk Appetite	Risk Title	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
528	Ashley O'Shaughnessy, Associate Director of Community Based Care and Primary Care	Ceri Jacob - Place Executive Lead	Clinical, quality and safety	7 - 9	Access to Primary Care Services	There is a risk that patients may experience an inequality (and inequity) in access to primary care services. The inequality in access may be caused by: 1.Patients not understanding the various routes to access primary care services and the appropriate alternatives that are available 2.GP Practices operating different access and triage models 3.Digital exclusion 4.Workforce challenges 5.Increasing demand It could lead to: Poor patient outcomes A decline of continuity of patient care Avoidable activity including A&E attendances and NHS 111 calls	4	4	16	4	3	12	Local implementation of the national "Delivery plan for recovering access to primary care". The Modern General Practice model is being implemented across practices supported through the national transition and transformation funding. All practices have telephone and digital access options in place to support and maximise patient access. All 6 PCNs have developed and implemented Capacity and Access Improvement Plans for 23/24 which focus on patient experience, ease of access, demand management and appointment coding. The PCN Additional Roles Recruitment Scheme is fully operational to support use of a diverse skill mix and provide additional workforce capacity. The PCN Enhanced Access service is operational to provide additional capacity between 6.30pm and 8pm, Monday – Friday, and 9am – 5pm on Saturday. Launch of the national Pharmacy First scheme to support the management of minor ailments and supply of prescription only medicines for specific conditions,. Community self-referral pathways have been developed to empower patients manage their own health, Continued promotion of the NHS APP so patients can directly book appointments, request repeat prescriptions and access their own medical record., Ongoing review of practice websites to ensure up to date and consistent to support patient navigation, Continued support for PCN digital inclusion hubs to support patients who are willing and able to maximise use of digital tools, Focused work on the primary/secondary care interface to free up capacity in General Practice, Oversight through the Lewisham Primary Care Group	Need an effective public-facing communications and engagement plan to educate and inform the public on the new ways of working in general practice and wider primary care to improve understanding of services and manage expectations. Ongoing industrial action may have an impact on patient access.	Working in conjunction with the Lewisham Peoples Partnership, develop and implement a Lewisham Primary Care Communications and Engagement Plan. As outlined in controls	None known at present
561	Mervlyn Clarke - CBC Development Manager	Ashley O' Shaughnessy - AD for Community Based Care and Primary Care	Clinical, quality and safety	7 - 9	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations	There is a risk that Lewisham may see an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. Low vaccine uptake may occur when: 1.Misinformation and lack of knowledge and education about vaccinations and organisms responsible for diseases is widely circulated and reinforced. 2.Cultural beliefs may inform decisions. 3.There is negative lived experience. 4.There is a lack of trust with professionals and wider establishment. 5.There are concerns around safety. 6.Patients find it difficult to access vaccines. It could lead to: 1.Severe and harmful disease outbreaks. 2.Increased pressure on Primary Care. 3.Increased A&E attendances and emergency admissions. 4. Poor patient outcomes, including disability and mortality.	3	4	12	3	4	12	All practices administer vaccinations and where clinically appropriate and operationally feasible, make co-administration of seasonal vaccinations the default model and have robust patient call and recall systems in place. Lewisham has a dedicated flu and immunisations coordinator who supports general practice, The ICB works with the local authority (Public Health) to take responsibility for planning outreach services that meet the needs of underserved populations and address wider health inequalities. There is vaccination delivery in convenient local places, with targeted outreach to support uptake in undersened populations. Also, a universal, core offer in a consistent location/setting to increase efficiency and capitalise on public understanding of 'where to go' for vaccinations., Vulnerable populations, such as asylum seekers,refugees, and rough sleepers, are opportunistically offered vaccinations in different settings to ensure they are given the best chance of protection. Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes i.e. MMR/Covid/polio.	no gaps currently	Oversight through the Lewisham Immunisation Partnership Group with focussed task and finish sub-groups convened to support specific programmes i.e. MMR/Covid/flu/polio. Lewisham representation at SEL immunisation and Vaccination board. Regular oversight through the Lewisham SMT. Regular review of the LCP performance data report. Production of local comparative performance dashboards at practice level which are regularly shared with practices.	no gaps currently

ICB Board Meeting in Public

Title	**2024/25 Month 11 ICS and ICB Financial update**						
Meeting date	16 April 2025		Agenda item Number	**8**	Paper Enclosure Ref		**H**
Author	ICB Finance Team						
Executive lead	Mike Fox, ICB CFO						
Paper is for:	Update	**x**	Discussion	**x**	Decision		
Purpose of paper	To provide an update to the Board of the financial position of the ICS and ICB as at month 11.						
Summary of main points	Two financial papers are being presented, covering both the ICS and ICB positions as at month 11. **SEL ICS** For month 11 SEL ICS is reporting a YTD deficit of (£27.0m), £5.4m adverse to plan. The main drivers are the impact of the Synnovis cyber-attack (£34.9m), and slippage in efficiency programmes (£23.8m). **Forecast Outturn** As at month 11, the SEL ICS system is forecasting to deliver a break-even position, in line with its financial plan. As part of month 11 reporting, the individual organisations have re-forecasted. The ICB has moved to a break-even forecast. King's have improved their forecast outturn but are still forecasting a deficit. This is offset by surplus positions across the other four providers. **SEL ICB** The ICB is reporting a year to date (YTD) break-even position against its revenue resource limit (RRL) at month 11. This represents £16.9m adverse against its surplus plan.						
Potential conflicts of Interest	Not applicable						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham		**x**
	Greenwich	**x**	Lambeth	**x**	Southwark		**x**
Equalities Impact	Not applicable						
Financial Impact	As set out in the attached finance reports.						
Public Patient Engagement	Not applicable						
Committee engagement	ICB committees, including the System Sustainability Group, receive regular updates on the financial position.						

Recommendation	The Board are asked to note the report and discuss any actions in relation to the financial position.

South East London
Integrated Care System

South East London ICS Finance Report – Month 11

16th April 2025

Executive Summary

- At month 11 the **system is forecasting to deliver breakeven,** in line with the plan.
- **At month 11 individual organisations have re-forecasted.** The ICB has moved to a break-even forecast. King's have improved their forecast outturn but are still forecasting a deficit. This is offset by surplus across the other four providers.
- At month 11 SEL ICS is reporting a YTD deficit of (£27.0m), £5.4m adverse to plan. The main drivers are **the impact of the Synnovis cyber-attack** (£34.9m), and **slippage in efficiency programmes** (£23.8m).
- At month 11 the **system is forecasting to under-spend its capital allocation by £32.5m**. £20.0m of the underspend is related to the consolidation of Sexual Assault Referral Centre (SARC) service onto one site at King's, which the system was given allocation for but has since been confirmed this will not happen in 2024/25.

I&E summary

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
South East London ICB	16,907	(0)	(16,907)	(0.4%)	38,958	(0)	(38,958)	(0.8%)
Guy'S And St Thomas' NHS Foundation Trust	(1,000)	(10,227)	(9,227)	(0.4%)	0	12,573	12,573	0.4%
King'S College Hospital NHS Foundation Trust	(38,129)	(15,411)	22,718	1.3%	(40,004)	(34,238)	5,766	0.3%
Lewisham And Greenwich NHS Trust	-	(10,628)	(10,628)	(1.4%)	-	9,560	9,560	1.2%
Oxleas NHS Foundation Trust	939	942	3	0.0%	1,036	2,536	1,500	0.3%
South London And Maudsley NHS Foundation Trust	(340)	8,329	8,669	1.5%	10	9,569	9,559	1.5%
ICS Total	(21,623)	(26,995)	(5,372)	(0.1%)	0	(0)	(0)	(0.0%)

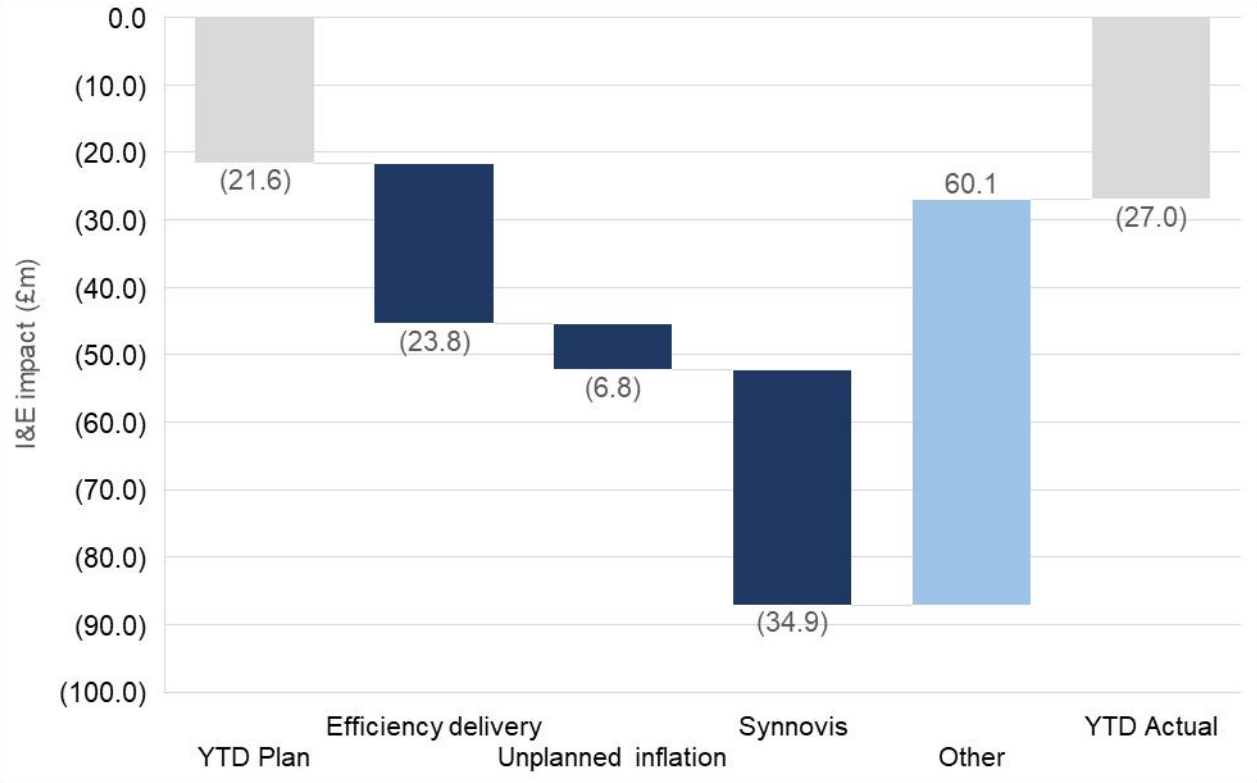
- At month 11 SEL ICS is reporting a YTD deficit of (£27.0m), £5.4m adverse to plan. The main drivers are **the impact of the Synnovis cyber-attack** (£34.9m), and **slippage in efficiency programmes** (£23.8m).
- The month 11 CIP shortfall is forecast to translate to a **full year under-delivery of £18.1m**. Every ICS organisation except GSTT is forecasting to deliver its efficiency plan.
- **At month 11 the system forecast remains breakeven but individual organisations have re-forecasted.** The ICB has moved to a break-even forecast. King's have improved their forecast outturn but are still forecasting a deficit. This is offset by surplus across the other four providers.

Analysis of month 11 system YTD position

At month 11 SEL ICS is reporting a YTD deficit of (£27.0m), £5.4m adverse to plan. The main drivers are:

- **The Synnovis cyber-attack incident is reported to have an adverse impact on the I&E of £34.9m.** The biggest impact is on the loss of income due to the impact on activity. This is marginally offset by a reduction in pathology related costs.
- The **under-delivery of the efficiency programme is a driver of £23.8m of the variance**.
- **Inflationary pressure of £6.8m YTD** related to the pay award.
- These adverse pressures are **off-set by a variety of prior year benefits and non-recurrent underspends**.

Drivers of month 11 variance to plan



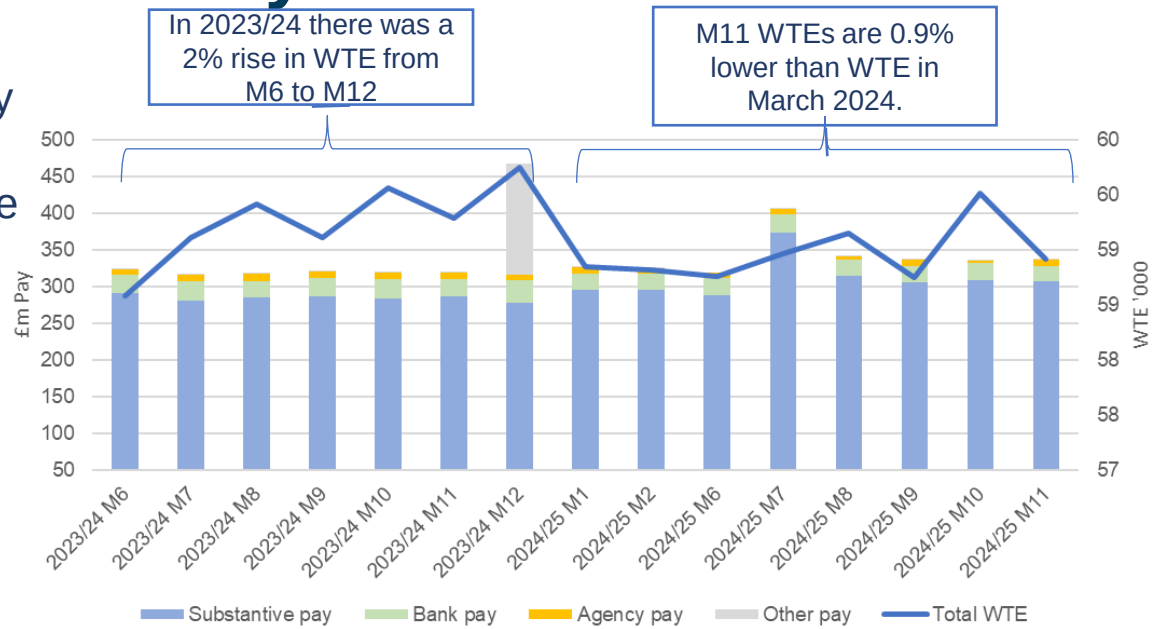
Provider run-rate analysis

	Last 5 months					Current month				Year-to-date				Analysis			
	2024/25 M6	2024/25 M7	2024/25 M8	2024/25 M9	2024/25 M10	Month 11 (in-month)				Month 11 (YTD)				Change from last month		Year-on-year change	
Key data category	Actual	Actual	Actual	Actual	Actual	Last year	Plan	Actual	Variance	Last year	Plan	Actual	Variance	£	%	£	%
Income	539.9	725.0	587.2	574.4	588.0	524.7	555.6	615.8	60.2	5,852.7	6,109.1	6,318.1	209.1	27.9	4.7%	465.4	8.0%
Agency	*(7.9)*	*(6.8)*	*(5.1)*	*(8.5)*	*(4.1)*	*(8.5)*	*(9.1)*	*(9.0)*	*0.1*	*(97.2)*	*(95.2)*	*(79.7)*	*15.5*	*(5.0)*	*123.0%*	*17.5*	*(18.0%)*
Other pay	*(310.2)*	*(398.5)*	*(336.0)*	*(329.1)*	*(332.5)*	*(310.3)*	*(320.5)*	*(329.1)*	*(8.6)*	*(3,371.0)*	*(3,546.0)*	*(3,623.8)*	*(77.8)*	*3.4*	*(1.0%)*	*(252.8)*	*7.5%*
Pay	(318.0)	(405.3)	(341.1)	(337.6)	(336.5)	(318.7)	(329.6)	(338.2)	(8.6)	(3,468.2)	(3,641.3)	(3,703.5)	(62.3)	(1.6)	0.5%	(235.4)	6.8%
Non-Pay	(233.1)	(253.9)	(234.4)	(228.0)	(238.6)	(220.9)	(218.4)	(234.7)	(16.3)	(2,398.0)	(2,418.8)	(2,563.6)	(144.8)	4.0	(1.7%)	(165.7)	6.9%
Non Operating Items	(7.2)	(7.3)	(7.6)	(6.2)	(8.0)	(7.7)	(7.9)	(5.7)	2.3	(95.1)	(87.5)	(77.9)	9.5	2.4	(29.7%)	17.2	(18.0%)
Surplus/(Deficit)	**(18.4)**	**58.5**	**4.1**	**2.6**	**4.8**	**(22.5)**	**(0.4)**	**37.3**	**37.7**	**(108.5)**	**(38.5)**	**(27.0)**	**11.5**	**32.6**		**81.5**	

- **Providers delivered a run-rate surplus of £37.3m in month 11, up from a £4.8m surplus in month 10.**
- **YTD Pay is up 6.8% year on year,** in line with the national pay inflation assumption of 6.8%.
- **YTD Non-pay is up 6.9% year on year** and the in-month actuals are 1.7% lower than month 10.
- **YTD Income is up 8.0% year on year** and an increase of £27.9m (4.7%) in income compared to month 10

Pay run-rate and WTE analysis

- Month 11 pay is £1.5m (0.5%) higher than month 10. This is driven by a large (£5.0m (123.0%)) increase in agency.
- Plans for 2024/25 were based on a 3.7% reduction in WTE across the system. **In month 11 there are 0.9% fewer WTE than month 12 of 2023/2024.** *NB at time of reporting LGT workforce data is missing and M11 has been assumed to equal M10 for LGT*
- The system has seen a 22.8% reduction in agency average WTE YTD compared to 2023/24. This reduction of 286 average WTE has resulted in a **reduction in agency spend of £17.5m (18.0%) year-on-year.**



	Last 5 months					Current month				Year-to-date				Analysis			
	2024/25 M6	2024/25 M7	2024/25 M8	2024/25 M9	2024/25 M10	Month 11 (in-month)				Month 11 (YTD)				Change from last month		Year-on-year change	
	Actual	Actual	Actual	Actual	Actual	Last year	Plan	Actual	Variance	Last year	Plan	Actual	Variance	£/WTE	%	£/WTE	%
Substantive	287.5	373.0	314.3	304.9	308.2	285.8	295.3	307.4	12.2	3,085.2	3,266.7	3,367.9	101.1	(0.8)	(0.3%)	282.6	9.2%
Bank	23.5	25.2	21.6	22.8	23.2	24.0	25.0	20.6	(4.5)	283.7	277.1	252.1	(25.0)	(2.7)	(11.5%)	(31.6)	(11.1%)
Agency	7.9	6.8	5.1	8.5	4.1	8.5	9.1	9.0	(0.1)	97.2	95.2	79.7	(15.5)	5.0	123.0%	(17.5)	(18.0%)
Other	(0.7)	0.3	0.1	1.5	1.0	0.5	0.2	1.1	0.9	2.1	2.2	3.8	1.7	0.1	12.2%	1.8	85.8%
Total Pay	**318.0**	**405.3**	**341.1**	**337.6**	**336.5**	**318.7**	**329.6**	**338.2**	**8.6**	**3,468.2**	**3,641.3**	**3,703.5**	**62.3**	**1.6**	**0.5%**	**235.4**	**6.8%**
Substantive	52,755	53,097	53,329	53,319	53,585	53,052	51,536	53,534	1,997	52,369	52,208	53,060	852	(51)	(0.1%)	690	1.3%
Bank	5,012	4,883	4,847	4,457	5,038	5,222	4,918	4,781	(138)	5,258	5,092	4,883	(209)	(258)	(5.1%)	(375)	(7.1%)
Agency	992	981	971	974	885	1,008	1,088	872	(216)	1,255	1,135	969	(165)	(14)	(1.5%)	(286)	(22.8%)
Total WTE	**58,759**	**58,960**	**59,147**	**58,750**	**59,508**	**59,282**	**57,543**	**59,186**	**1,643**	**58,883**	**58,435**	**58,913**	**478**	**(322)**	**(0.5%)**	**30**	**0.1%**

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

Efficiency delivery and maturity

	M11 year-to-date			Full-year 2024/25			Full Year Forecast - Scheme Risk			Full-year	
	Plan	Actual	Variance	Plan	Forecast	Variance	Low	Medium	High	Recurrent (FOT)	% of FOT
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
GSTT	85.0	64.1	(20.9)	93.8	72.0	(21.8)	59.7	9.3	3.0	58.6	81%
KCH	45.1	43.6	(1.5)	50.0	50.0	0.0	50.0	0.0	0.0	43.3	87%
LGT	40.8	35.4	(5.4)	44.5	44.5	0.0	36.6	0.8	7.1	26.7	60%
Oxleas	21.9	21.9	(0.0)	23.9	23.9	(0.0)	13.5	0.0	10.4	2.3	10%
SLaM	26.8	26.8	0.0	32.3	32.3	0.0	3.0	2.7	26.7	12.2	38%
Provider total	**219.6**	**191.8**	**(27.7)**	**244.5**	**222.6**	**(21.8)**	**162.7**	**12.8**	**47.1**	**143.0**	**64%**
SEL ICB total	**23.0**	**26.9**	**3.9**	**25.5**	**29.2**	**3.7**	**20.2**	**9.0**	**0.0**	**26.8**	**92%**
System total	**242.6**	**218.8**	**(23.8)**	**270.0**	**251.9**	**(18.1)**	**183.0**	**21.7**	**47.1**	**169.8**	**67%**

- At month 11 the system is reporting YTD efficiency delivery of £218.8m, £23.8m (9.8%) behind the YTD plan of £242.6m
- At month 11 the system is forecasting to under-deliver its efficiency plan by £18.1m (6.7%). Every organisation, except for GSTT, in the system is forecasting to deliver or exceed its efficiency plan.
- At month 11 £183.0m (67.8%) of the full year efficiencies is reported as at low risk of not being delivered.

System capital expenditure

- The **total system capital allocation for 2024/25, including impacts of IFRS 16, is £327.3m**, made up of £323.9m provider allocation and £3.4m ICB primary care allocation.
- At month 11 the **system is forecasting to under-spend its allocation by £32.5m**. £20.0m of the underspend is related to the consolidation of Sexual Assault Referral Centre (SARC) service onto one site at King's, which the system was given allocation for but has since been confirmed this will not happen in 2024/25.
- At **month 11 the system has spent £153.7m YTD, £66.8m less than plan.**

Capital spend against system capital allocation

	Year to date (YTD)			Full-year (FY)		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
GSTT	112.9	78.3	34.6	124.7	121.4	3.3
KCH	42.3	22.6	19.7	50.4	48.3	2.1
LGT	41.1	36.4	4.7	44.9	44.6	0.3
Oxleas	14.0	5.5	8.5	17.2	11.1	6.1
SLAM	9.5	10.2	(0.8)	63.4	66.0	(2.7)
SEL Providers	**219.8**	**153.1**	**66.8**	**300.5**	**291.5**	**9.1**
SEL ICB	**0.6**	**0.6**	**0.0**	**3.3**	**3.3**	**0.0**
Total	**220.5**	**153.7**	**66.8**	**303.8**	**294.7**	**9.1**
Capital envelope analysis						
Provider allocation				**323.9**		**32.4**
ICB allocation				**3.4**		**0.1**
System allocation				**327.3**		**32.5**

NHS
South East London

SEL ICB Finance Report

Month 11 2024/25

Contents

NHS South East London

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 11, the ICB is reporting a year to date (YTD) break-even position against its revenue resource limit (RRL). This represents an overspend of **£16,907k** against the ICB's planned surplus. Agreement has been reached across all NHS organisations in SEL regarding the achievement of the 24/25 ICS control total, and the month 11 position reflects this. Within this reporting, the ICB has delivered in full the YTD element of its savings requirement.
- **All boroughs are reporting that they will deliver a minimum of financial balance at the year end.**
- ICB is showing a YTD underspend of **£1,771k** against the running cost budget, which is largely due to vacancies within the ICB's staff establishment. These are in the process of being recruited to. The stranded costs (of staff at risk) following the MCR process to deliver 30% savings on administrative costs as per the NHSE directive, are being charged to programme costs in line with the definitions given for running costs versus programme costs.
- All other financial duties have been delivered for the year to month 11 period.
- As at month 11 the ICB is reporting a forecast break-even position against its RRL, representing an adverse variance against plan of £38,958k. As referenced above, the month 11 report reflects the agreed ICB position in delivering the overall ICS control total.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	4,368,589	4,385,496	4,795,817	4,834,775	
Operating Under Resource Revenue Limit	4,431,877	4,431,877	4,834,775	4,834,775	
Not to exceed Running Cost Allowance	33,422	31,651	36,121	36,121	
Month End Cash Position (expected to be below target)	4,500	1,261			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	100.0%			
95% of non-NHS creditor payments within 30 days	95.0%	99.1%			
Mental Health Investment Standard (Annual)			469,778	470,742	

2. Executive Summary

NHS South East London

- This report sets out the month 11 financial position of the ICB. The financial reporting is based upon the final June plan submission. This included a **planned surplus of £40,769k** for the ICB which has now been adjusted due to the impact of the deficit support funding by £1,811k, to give a revised surplus of **£38,958k.**
- The ICB's financial allocation as at month 11 is **£4,834,775k.** In month, the ICB has received an additional **£20,311k** of allocations. These are as detailed on the following slide.
- As at month 11, the ICB is reporting a year to date (YTD) break-even position against its revenue resource limit (RRL). This represents an overspend of **£16,907k** against the ICB's planned surplus. Agreement has been reached across all NHS organisations in SEL regarding the achievement of the 24/25 ICS control total, and the month 11 position reflects this. Within this reporting, the ICB has delivered in full the YTD element of its savings requirement.
- Due to the usual time lag in receiving current year information from the PPA, the ICB has received nine months of prescribing data, with an estimate made for the last two months. The ICB is reporting an overspend YTD of **£4,783k** at month 11 which is an adverse movement in month for all boroughs. Details of the drivers and actions are set out later in the report.
- The current expenditure run-rate for continuing healthcare (CHC) services is above budget **(£2,406k YTD),** a small improvement from last month. Lewisham **(£3,105k),** Bromley **(£612k)** and Greenwich **(£35k)** boroughs are particularly impacted, with the other boroughs reporting small underspends.
- The ICB continues to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and so the ICB has started the process of issuing notice to affected staff. This delay has generated additional costs for the ICB of **circa £4,725k YTD.** The first redundancy payments were made in December 2024, with the majority paid in January 2025.
- Only one place is reporting an overspend position YTD at month 11 **(Bromley, £572k),** which is a deterioration in the position compared to that reported last month. However, **a break-even position is being forecasted**. Financial focus meetings were held with all places and the CFO/Deputy CEO in December.
- In reporting this month 11 position, the ICB has delivered the following financial duties:
    - Underspending **(£1,771k YTD)** against its management costs allocation, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions;
    - Delivering all targets under the **Better Practice Payments code**;
    - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance.
- As at month 11 the ICB is reporting a **forecast break-even position** against its RRL, representing an adverse variance against plan of £38,958k. As referenced above, the month 11 report reflects the agreed ICB position in delivering the overall ICS control total. More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

3. Revenue Resource Limit (RRL)

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	**147,630**	**249,631**	**177,025**	**214,455**	**170,943**	**167,786**	**3,333,394**	**4,460,864**
M2 Internal Adjustments	1,049	3,464	2,037	2,146	901	2,431	(12,028)	-
M2 Allocations							11,975	**11,975**
M2 Budget	**148,679**	**253,095**	**179,062**	**216,601**	**171,844**	**170,217**	**3,333,341**	**4,472,839**
M3 Internal Adjustments	1,286	1,666	812	1,770	1,512	1,541	(8,587)	-
M3 Allocations				128			7,831	**7,959**
M3 Budget	**149,965**	**254,761**	**179,874**	**218,499**	**173,356**	**171,758**	**3,332,585**	**4,480,798**
M4 Internal Adjustments	33	33	125	128	120	128	(567)	-
M4 Allocations	106	177			75		17,952	**18,310**
M4 Budget	**150,104**	**254,971**	**180,000**	**218,627**	**173,551**	**171,886**	**3,349,969**	**4,499,108**
M5 Internal Adjustments	127	296	165	230	184	189	(1,191)	-
M5 Allocations						20	2,685	**2,705**
M5 Budget	**150,231**	**255,267**	**180,165**	**218,858**	**173,734**	**172,095**	**3,351,463**	**4,501,813**
M6 Internal Adjustments	578	290	804	1,021	660	891	(4,244)	-
M6 Allocations	1,137	1,635	1,489	2,124	1,694	1,756	110,442	**120,277**
M6 Budget	**151,946**	**257,191**	**182,459**	**222,003**	**176,088**	**174,741**	**3,457,662**	**4,622,090**
M7 Internal Adjustments	277	425	372	442	325	414	(2,256)	-
M7 Allocations	1,346	3,400	1,913	1,883	1,557	1,588	109,347	**121,034**
M7 Budget	**153,569**	**261,017**	**184,744**	**224,328**	**177,971**	**176,743**	**3,564,753**	**4,743,124**
M8 Internal Adjustments	243	158	240	531	149	425	(1,746)	-
M8 Allocations	110	114					31,516	**31,739**
M8 Budget	**153,922**	**261,288**	**184,983**	**224,860**	**178,120**	**177,168**	**3,594,523**	**4,774,864**
M9 Internal Adjustments	52	234	107	148	38	107	(687)	**0**
M9 Allocations							3,635	**3,634**
M9 Budgets	**153,973**	**261,521**	**185,090**	**225,009**	**178,158**	**177,275**	**3,597,471**	**4,778,497**
M10 Internal Adjustments	70	233	89	104	147	105	(748)	-
M10 Allocations							35,967	**35,967**
M10 Budgets								**4,814,464**
M11 Internal Adjustments								
In month internal movements	910	1,339	1,011	1,813	1,447	1,480	(8,000)	-
M11 Allocations								
PCT ARRS Final Full Year 24/25	-	-	-	-	-	-	7,849	**7,849**
PCT GP ARRS Final Full Year 24/25	-	-	-	-	-	-	1,214	**1,214**
PCT - Pharmacy First (Clinical Pathways Service)	-	-	-	-	-	-	805	**805**
PCT - Pharmacy First Funding Top Up	-	-	-	-	-	-	1,447	**1,447**
PCT - Community Pharmacy Contractual Framework	-	-	-	-	-	-	2,728	**2,728**
ERF Overperformance	-	-	-	-	-	-	3,055	**3,055**
FD 24/25 Q3&Q4 LPP Funding - Guy's	-	-	-	-	-	-	1,015	**1,015**
DOAC 24/25 Q2	-	-	-	-	-	-	431	**431**
Kings College Hosp - National Recovery Programme	-	-	-	-	-	-	1,066	**1,066**
Other minor allocations	-	-	-	-	-	-	701	**701**
M11 Budget	**154,953**	**263,093**	**186,190**	**226,926**	**179,752**	**178,860**	**3,645,001**	**4,834,775**

- The table sets out the Revenue Resource Limit (RRL) at month 11.
- The start allocation of **£4,460,864k** is consistent with the Operating Plan submissions.
- During month 11, internal adjustments were actioned to ensure allocations were aligned to the correct agreed budgets. These had no overall impact on the overall allocation.
- In month, the ICB has received an additional **£20,311k** of allocations, giving the ICB a total allocation of **£4,834,775k** at month 11**.** The additional allocations received in month were in respect of ARRS **£7,849k**, GP ARRS **£1,214k**, 2 allocations for Pharmacy First of **£805k** and **£1,447k**, Community Pharmacy **£2,728k**, ERF overperformance **£3,055k**, DOAC **£431k**, National Recovery Programme for Kings **£1,066k** plus some smaller value allocations.
- Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

4. Budget Overview

NHS South East London

	M11 YTD							
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	4,587	6,929	6,618	1,089	1,212	78	2,259,012	**2,279,525**
Community Health Services	20,687	83,738	35,865	25,878	26,898	33,389	240,783	**467,237**
Mental Health Services	9,772	13,624	7,877	21,235	7,054	9,402	507,554	**576,517**
Continuing Care Services	23,960	24,868	26,785	31,732	21,135	18,114	-	**146,593**
Prescribing	34,266	46,710	34,122	39,041	38,980	32,130	930	**226,179**
Other Primary Care Services	3,096	2,109	2,093	3,687	2,179	1,243	18,100	**32,507**
Other Programme Services	1,099	-	917	-	3,051	730	58,686	**64,483**
Programme Wide Projects	-	-	-	-	23	237	(16,536)	**(16,276)**
Delegated Primary Care Services	36,798	52,931	46,868	72,568	54,114	58,140	5,461	**326,880**
Delegated Primary Care Services DPO	-	-	-	-	-	-	202,655	**202,655**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	**-**
Corporate Budgets	2,782	3,193	3,215	3,638	2,885	3,159	43,415	**62,288**
Total Year to Date Budget	**137,048**	**234,101**	**164,360**	**198,867**	**157,532**	**156,622**	**3,320,059**	**4,368,589**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	4,594	6,743	6,571	796	718	82	2,257,206	**2,276,711**
Community Health Services	20,464	83,240	35,033	25,852	25,402	32,256	242,701	**464,947**
Mental Health Services	9,634	14,281	8,683	21,807	7,080	10,617	507,515	**579,618**
Continuing Care Services	23,541	25,480	26,820	31,349	24,240	17,570	-	**148,999**
Prescribing	35,021	47,045	35,298	38,836	40,673	33,049	1,039	**230,962**
Other Primary Care Services	3,096	2,109	2,084	3,313	1,732	1,260	18,203	**31,796**
Other Programme Services	1,099	-	-	-	0	-	54,232	**55,331**
Programme Wide Projects	-	-	(6)	-	820	268	2,756	**3,838**
Delegated Primary Care Services	36,798	52,931	46,878	73,268	54,032	58,350	5,461	**327,718**
Delegated Primary Care Services DPO	-	-	-	-	-	-	203,271	**203,271**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	4,725	**4,725**
Corporate Budgets	2,532	2,844	2,907	3,279	2,791	2,939	40,289	**57,581**
Total Year to Date Actual	**136,779**	**234,673**	**164,266**	**198,499**	**157,489**	**156,392**	**3,337,397**	**4,385,496**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	(7)	186	47	293	494	(4)	1,806	**2,814**
Community Health Services	223	498	832	26	1,496	1,133	(1,918)	**2,290**
Mental Health Services	138	(658)	(806)	(571)	(26)	(1,215)	39	**(3,100)**
Continuing Care Services	420	(612)	(35)	383	(3,105)	544	-	**(2,406)**
Prescribing	(755)	(336)	(1,176)	205	(1,693)	(919)	(109)	**(4,783)**
Other Primary Care Services	-	-	9	374	447	(17)	(102)	**711**
Other Programme Services	0	-	917	-	3,051	730	4,454	**9,152**
Programme Wide Projects	-	-	6	-	(797)	(30)	(19,292)	**(20,113)**
Delegated Primary Care Services	-	-	(9)	(700)	82	(210)	-	**(838)**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(616)	**(616)**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	(4,725)	**(4,725)**
Corporate Budgets	250	350	309	359	94	220	3,126	**4,707**
Total Year to Date Variance	**268**	**(572)**	**94**	**368**	**43**	**230**	**(17,338)**	**(16,907)**

- As at month 11, the ICB is reporting a year to date (YTD) break-even position against its revenue resource limit (RRL). This represents an overspend of **£16,907k** against the ICB's planned surplus. Agreement has been reached across all NHS organisations in SEL regarding the achievement of the 24/25 ICS control total, and the month 11 position reflects this. Within this reporting, the ICB has delivered in full the YTD element of its savings requirement.
- Due to the usual time lag, the ICB has received nine months of prescribing data. Using an estimate for January and February based on prescribing days, the ICB is reporting an overall YTD overspend of **£4,783k**, which was an adverse movement in month. This impacted all boroughs; further details are included in this report.
- The continuing care financial position is £2,406k overspent which is an improvement on last month. Lewisham continues to have the largest overspend (£3,105k) which is predominantly driven by the full year effect of activity pressures seen in the second half of last year. However, **the run-rate in Lewisham has improved in-month.** This is as set out in this report.
- As described previously, the ICB is continuing to incur pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and the ICB has issued notice and has now made most of the redundancy payments. The additional cost YTD is **£4,725k.**
- The MH/LD cost per case (CPC) budgets across the ICB are highlighting a cost pressure, with MH budgets reporting an overall overspend of **£3,100k,** a deterioration from last month. The CPC issue is differential across boroughs with Bromley, Greenwich, Lambeth and Southwark being the most impacted. ADHD and ASD assessments are a pressure in all boroughs.
- Only one place is overspending YTD at month 11 **– Bromley (£572k**), which is an adverse movement from last month. **However, a break-even position is forecast.** More detail regarding the individual place financial positions is provided later in this report.

5. Prescribing – Overview as at Month 11

NHS South East London

- The table below shows the month 11 prescribing position. Due to the usual lag in receiving information from the PPA, the ICB has received nine months of 2024/25 prescribing data. Based upon a prescribing days methodology to estimate spend for January and February, the ICB is reporting an overall YTD overspend on **PPA prescribing of £4,851k.**

M11 Prescribing	Total PMD (Excluding Cat M & NCSO) £	Cat M & NCSO £	Central Drugs £	Flu Income £	PY Flu (Benefit)/Cost Pressure £	Cat M Clawback £	Total 24/25 PPA Spend £	M11 YTD Budget £	YTD Variance - (over)/under £
BEXLEY	33,846,252	213,608	1,129,794	(313,756)	3,336		34,879,234	34,043,807	(835,426)
BROMLEY	45,439,850	348,397	1,515,431	(547,652)	(31,432)		46,724,594	46,487,853	(236,742)
GREENWICH	33,887,222	261,747	1,131,559	(190,615)	(1,687)		35,088,227	33,856,210	(1,232,017)
LAMBETH	37,521,292	376,237	1,253,376	(291,406)	(23,696)		38,835,803	38,969,577	133,774
LEWISHAM	38,460,099	479,009	1,292,025	(259,053)	(6,642)		39,965,438	38,352,023	(1,613,416)
SOUTHWARK	31,690,375	351,140	1,063,198	(302,043)	(45,179)		32,757,490	31,799,284	(958,206)
SOUTH EAST LONDON						218,964	218,964	110,000	(108,964)
Grand Total	**220,845,091**	**2,030,137**	**7,385,384**	**(1,904,526)**	**(105,300)**	**218,964**	**228,469,750**	**223,618,755**	**(4,850,996)**

- This position is variable across the boroughs, with significant overspends in Lewisham, Greenwich and Southwark. There has been a significant movement in month due to seasonal increase in prescribing spend by day in December, high number of repeats prescriptions, impact of NICE approved tech such as Mounjaro, price concensions impact higher in December compared to November. Key drivers of the overspend continue to be Cat M and NCO price impacts, plus significant activity growth in medicines to support the management of long-term conditions. Other drivers of increased expenditure include increased prescribing of central nervous system drugs (especially ADHD drugs and migraine drugs), female sex hormones and nutrition and blood products. All these items are showing a higher % increase than is being seen nationally. The boroughs continue to reviewing how each of these issues has impacted them specifically.
- Lewisham place is seeing the largest cost pressure **(£1,613k YTD).** Actions being undertaken taken to address the position include the review of additional savings opportunities including the patent expiry on key drugs such as Rivaroxaban, and additionally drugs and other items which are recommended not to be prescribed in primary care are being reviewed to ensure they are not prescribed by practices. An audit has been undertaken of patients being managed under the Monitored Dosage System (MDS) and Medication Administration Records (MARS). This sets out a basis for ensuring that patients are reassessed as required on an annual basis and has been committed to by the Local Pharmaceutical Committee (LPC) and the Lewisham Medical Committee (LMC). Through ensuring an annual review of patient needs, recurrent savings against the annual budget of circa £626k are planned.
- Non PPA budgets are underspent by **£67k** giving an overall YTD overspend of **£4,783k,** an adverse movement in-month which has been seen across all boroughs, other London ICBs, and nationally this month.

5. Prescribing – Comparison of 2425 v 2324

NHS South East London

- The table below compares April to December prescribing data for 2023 and 2024. The headlines are that expenditure in the ICB is increasing marginally faster **(2.4%)** than nationally **(2.2%)** although slower than the London average **(3.1%).** This is driven by a combination of the cost per item falling more slowly **(1.8%)**, together with a rise in activity **(4.2%)** albeit at a significantly slower rate than across London **(6.1%)**.

Prescribing
Comparison of April to December 2024 v 2023

	2023 April to December	2024 April to December	Change £	Change %
South East London ICB:				
Expenditure (£'000)	179,872	184,184	4,312	**2.4%**
Number of Items ('000)	19,211	20,023	813	**4.2%**
£/Item	9.36	9.20	-0.16	**-1.8%**
London ICBs:				
Expenditure (£'000)	913,729	942,069	28,340	**3.1%**
Number of Items ('000)	107,812	114,374	6,563	**6.1%**
£/Item	8.48	8.24	-0.24	**-2.8%**
All England ICBs:				
Expenditure (£'000)	7,559,074	7,722,834	163,760	**2.2%**
Number of Items ('000)	896,208	935,758	39,549	**4.4%**
£/Item	8.43	8.25	-0.18	**-2.2%**

- It is unrepresentative to base judgements solely on nine months of information, but the key factors explaining the SEL position and the movement this month include:
  - Infections, CVD, CNS, Respiratory and Endocrine are the largest drivers.
  - Seasonal increase in prescribing spend by day in December.
  - High number of repeats prescriptions.
  - Impact of NICE approved tech such as Mounjaro.
  - Price concessions impact higher in December compared to November.
  - Impact of NCSO remains a factor.

6. Dental, Optometry and Community Pharmacy

NHS South East London

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

Service	YTD Budget £'000s	YTD Actual £'000s	YTD Variance - (over)/under £'000s	Annual Budget £'000s	Forecast £'000s	FOT Variance - (over)/under £'000s
Delegated Primary Dental	97,710	95,610	2,101	106,593	104,272	2,321
Delegated Community Dental	7,219	7,219	(0)	8,053	8,053	0
Delegated Secondary Dental	51,239	51,239	(0)	55,553	55,553	(0)
Total Dental	**156,168**	**154,068**	**2,100**	**170,199**	**167,878**	**2,321**
Dental Ring Fence	152,828	152,828	0	166,722	166,722	0
Dental Non Ring Fence	3,340	1,239	2,100	3,477	1,157	2,321
Total Dental	**156,168**	**154,068**	**2,100**	**170,199**	**167,878**	**2,321**
Delegated Ophthalmic	14,212	16,101	(1,889)	15,504	17,564	(2,060)
Delegated Pharmacy	31,928	32,756	(828)	36,281	37,370	(1,089)
Delegated Property Costs	662	662	0	722	722	0
Total Delegated DOPs	**202,970**	**203,586**	**(616)**	**222,706**	**223,535**	**(828)**

a) Delegated Dental

- Overall, Dental is showing a YTD underspend against budget of £2,100k, and a forecast of £2,321k for the full year. The underspend is forecast to partially mitigate the overspends within Ophthalmic and Community Pharmacy. **The dental ringfence of £166,722k is expected to be delivered in 24/25, with full year expenditure forecast to be £167,878k.** Due to the volatility of dental activity the 2425 budget was set greater than the ringfenced value. The month 11 accrual is based January's dental report downloaded from the national e-Den system. The year-to-date level of dental activity is 80.6% and the forecast is 89.4%, with activity levels expected to pick up as the year progresses. The delegated property costs relate to where the primary care dentists are working either in NHS PS or CHP sites and rent is charged.

b) Delegated Ophthalmic

- The YTD position is an **overspend of £1,889k**. The spend largely relates to Optician Sight Tests and Vouchers submitted by high street opticians within the SEL geography regardless of where the patient resides – claims are based upon location of provider not client/patient. The claims are as per a national framework arrangement, under which the ICB has a requirement to pay.

c) Delegated Community Pharmacy

- The YTD position is an **overspend of £828k**, noting that information is received 2 months in arrears with an accrual then based upon the 9 months average using the number of Prescribing days. The overspend is driven by the costs associated with professional fees and advanced services. Pharmacy First will be fully funded by non-recurrent allocations from NHS England which are received in arrears.

7. NHS Continuing Healthcare

NHS South East London

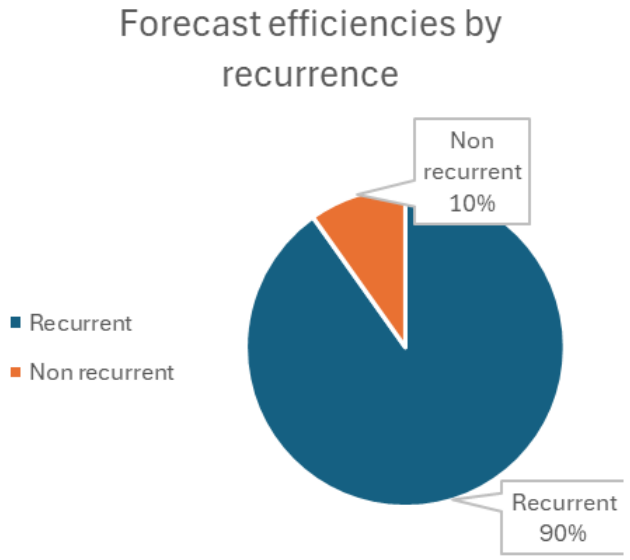
- **As of Month 11**, the Continuing Healthcare (CHC) financial position reflects a **£2,406k overspend**, showing a **£134k improvement** from the previous month. Cost pressures remain uneven across boroughs, with **Lewisham, Bromley, and Greenwich reporting overspends**, while the **other three boroughs** collectively show an **underspend of £1,346k.**
- **Lewisham (£3,105k overspend)** remains the largest contributor, primarily due to the full-year impact of late 2023 activity pressures (£1,445k), particularly among Learning Disability (LD) clients. Efforts to address this include weekly meetings led by the Place Executive Lead to monitor savings plans and an ongoing client database review, which has further improved the monthly run rate as of Month 11.
- **Bromley (£623k overspend)** continues to face financial pressure due to expanded bed capacity, higher staff costs from new contracting arrangements, and settlements for retrospective cases, which are under review to assess why Bromley remains an outlier compared to other local boroughs.
- **Greenwich (£36k overspend)** has improved its position, primarily due to database updates and regular client reviews by CHC teams, bringing the borough close to breakeven. Additionally, all funds allocated for inflationary pressures were released this month, further supporting financial improvement. Other boroughs have strengthened their financial positions through ongoing service and database reviews.
- **To address provider price increases**, an ICB panel continues to review requests exceeding 1.8%, meeting weekly to maintain consistency across SE London and mitigate significant cost escalations. Boroughs initially budgeted for a 4% inflationary uplift, and reserves were released in Month 7 where agreements were below budget. This process has been repeated this month to further optimise financial reporting.
- **On savings initiatives,** all boroughs have made progress on CHC savings plans, with three exceeding their targets. However, rising activity levels and high-cost patients continue to exert financial pressure on the CHC budget.

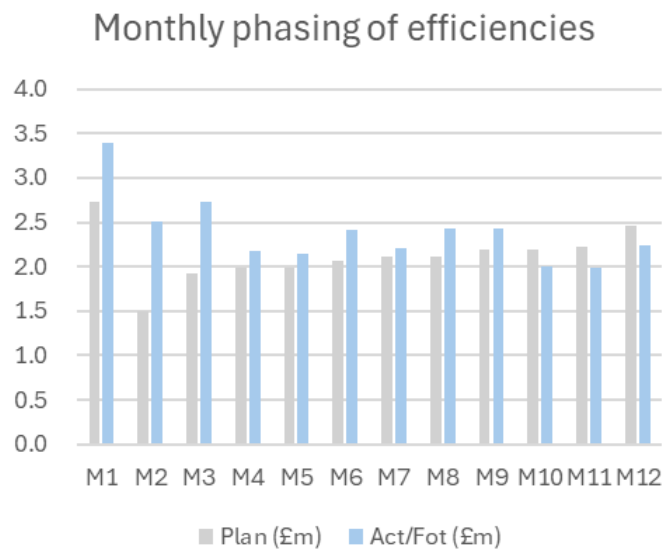
7. ICB Efficiency Schemes at as Month 11

NHS South East London

- The 6 places within the ICB have a total savings plan for 2024/25 of **£25.5m.** In common with the previous financial year, the key elements of the savings plans are in continuing healthcare (CHC) and prescribing.
- The table to the right sets out the YTD and forecast status of the ICB's efficiency scheme as at month 11.
- **As at month 11, overall, the ICB is reporting actual delivery ahead of plan (£3.9m).** At this stage in the financial year, the annual forecast is to slightly exceed the efficiency plan **(by £3.7m).**
- The current risk rating of the efficiency plan is also reported. At this stage in the year, none of the forecast outturn of **£29.2m** has been assessed by the places as **high risk.**
- Most of the savings **(90%)** are forecast to be delivered on a recurrent basis.

	M11 year-to-date			Full-year 2024/25			Full Year - Identified			Full Year Forecast - Scheme Risk		
	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	FOT	Change	Low	Medium	High
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	3.2	4.2	0.9	3.5	4.4	0.9	3.5	4.4	0.9	4.4	0.0	0.0
Bromley	5.5	5.6	0.1	6.3	6.4	0.1	6.3	6.4	0.1	4.2	2.2	0.0
Greenwich	3.2	4.2	1.0	3.5	4.6	1.1	3.5	4.6	1.1	2.6	2.0	0.0
Lambeth	4.8	6.0	1.3	5.2	6.2	1.0	5.2	6.2	1.0	2.2	4.1	0.0
Lewisham	2.9	3.3	0.4	3.2	3.6	0.4	3.2	3.6	0.4	2.9	0.7	0.0
Southwark	3.4	3.7	0.3	3.8	4.0	0.2	3.8	4.0	0.2	3.9	0.1	0.0
SEL ICB Total	23.0	26.9	3.9	25.5	29.2	3.7	25.5	29.2	3.7	20.2	9.0	0.0





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

NHS South East London

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2023/24 outturn by a **minimum of the growth uplift of 6.85%, a target of £469,778k.** This spend is subject to annual independent review. The 2023/24 review is currently being finalised.

- MHIS excludes:
  - spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
  - Spend on Service Development Fund (SDF) and other non-recurrent allocations

- Slide 2 summarises the 2024/25 SEL ICB MHIS Plan. As at Month 11 we are forecasting MHIS delivery of **£470,742k**, exceeding the target by **£964k** (0.20%). This is largely made up of over-delivery against the plan on prescribing of approximately £2.0m, noting that prescribing spend can be volatile because of the supply and cost of drugs. Slide 3 sets out the position by ICB budget area.

Risks

- We continue to see growth in mental health cost per case spend, in terms of client numbers, cost and complexity, for example on S117 placements. Mitigating actions include ensuring that timely client reviews are undertaken, reviewing and strengthening joint funding panel arrangements and developing new services and pathways.

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

- ADHD is outside the MHIS definition and is therefore excluded from this reported position. There is, however, significant and increasing independent sector spend on both ADHD and ASD services, with a forecast of £3.5m across a growing number of independent sector providers for Right to Choose referrals.

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

8. Summary MHIS Position – Month 11 (February) 2024/25

NHS South East London

Mental Health Spend By Category	Category	Total Mental Health Plan 31/03/2025 Year Ending £'000	Mental Health - NHS Actual 28/02/2025 YTD £'000	Mental Health - Non-NHS Actual 28/02/2025 YTD £'000	Total Mental Health Actual 28/02/2025 YTD £'000	Mental Health - NHS Forecast 31/03/2025 Year Ending £'000	Mental Health - Non-NHS Forecast 31/03/2025 Year Ending £'000	Total Mental Health Forecast 31/03/2025 Year Ending £'000	Total Mental Health Variance 31/03/2025 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	45,046	37,146	3,994	41,140	40,523	4,357	44,880	166
Children & Young People's Eating Disorders	2	2,841	2,604	0	2,604	2,841	0	2,841	0
Perinatal Mental Health (Community)	3	9,749	8,937	0	8,937	9,749	0	9,749	0
NHS Talking Therapies, for anxiety and depression	4	35,799	27,030	6,213	33,243	29,487	6,778	36,265	(466)
A and E and Ward Liaison mental health services (adult and older adult)	5	19,376	17,761	0	17,761	19,376	0	19,376	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	13,205	12,105	0	12,105	13,205	0	13,205	0
Adult community-based mental health crisis care (adult and older adult)	7	35,639	32,528	400	32,928	35,485	436	35,921	(282)
Ambulance response services	8	1,173	1,075	0	1,075	1,173	0	1,173	0
Community A – community services that are not bed-based / not placements	9a	122,258	101,797	9,237	111,034	111,051	10,118	121,169	1,089
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	25,758	13,430	9,414	22,844	14,651	10,283	24,934	824
Mental Health Placements in Hospitals	20	4,454	3,057	1,009	4,066	3,335	1,110	4,445	9
Mental Health Act	10	6,189	0	5,889	5,889	0	6,466	6,466	(277)
SMI Physical health checks	11	865	638	109	747	696	119	815	50
Suicide Prevention	12	0	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	128,232	117,860	0	117,860	128,575	0	128,575	(343)
Adult and older adult acute mental health out of area placements	14	9,762	8,595	91	8,686	9,376	100	9,476	286
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**460,346**	**384,563**	**36,356**	**420,919**	**419,523**	**39,767**	**459,290**	**1,056**
Mental health prescribing	16	9,190	0	10,234	10,234	0	11,164	11,164	(1,974)
Mental health in continuing care (CHC)	17	242	0	264	264	0	288	288	(46)
Sub-total - MHIS (inc CHC, Prescribing)		**469,778**	**384,563**	**46,854**	**431,417**	**419,523**	**51,219**	**470,742**	**(964)**
Learning Disability	18a	16,917	14,163	2,722	16,885	15,451	2,987	18,438	(1,521)
Autism	18b	3,837	2,674	95	2,769	2,917	104	3,021	816
Learning Disability & Autism - not separately identified	18c	48,399	4,428	42,601	47,029	4,830	46,603	51,433	(3,034)
Sub-total - LD&A (not included in MHIS)		**69,153**	**21,265**	**45,418**	**66,683**	**23,198**	**49,694**	**72,892**	**(3,739)**
Dementia	19	14,936	12,128	1,574	13,702	13,230	1,717	14,947	(11)
Sub-total - Dementia (not included in MHIS)		**14,936**	**12,128**	**1,574**	**13,702**	**13,230**	**1,717**	**14,947**	**(11)**
Total - Mental Health Services		**553,867**	**417,956**	**93,846**	**511,802**	**455,951**	**102,630**	**558,581**	**(4,714)**

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**SEL System Performance update**						
Meeting date	16 April 2025		Agenda item Number	**9**	Paper Enclosure Ref	**I**	
Author	Sarah Cottingham, Deputy CEO, Executive Director of Planning						
Executive lead	Sarah Cottingham, Deputy CEO, Executive Director of Planning						
Paper is for:	Update	**X**	Discussion		Decision		
Purpose of paper	To provide an overview of key performance areas.						
Summary of main points	The paper provides an update on performance including key messages on • Urgent and Emergency care • Cancer • Referral to Treatment • Diagnostics • Mental Health • Crisis and Flow • Learning Disabilities • Primary Care Access • NHS Continuing Healthcare • UCR and Community Waits • Virtual Wards						
Potential conflicts of Interest	Nil known						
Relevant to these boroughs	Bexley	**X**	Bromley	**x**	Lewisham	**x**	
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**	
Equalities Impact	Work continues on better incorporating equalities information into performance metrics.						
Financial Impact	As part of planning processes the ICB seeks to align performance with the financial context.						
Public Patient Engagement	The report is intended for the Board meeting in Public						
Committee engagement	Executive Committee receive regular reports and updates by exception on performance.						
Recommendation	The Board are asked to note the content of the report						

South East London Integrated Care System

NHS South East London

SEL System performance

Overview of delivery against national performance standards

- Acute services
- Mental health, learning disability and autism service
- Community based care

April 2025

South East London Integrated Care System

Contents

Key messages : Acute Services

South East London Integrated Care System

Urgent & Emergency Care

- SEL Trust combined view of 4-hour performance in February was 74.7 % (based on SitRep data) against the 2024/25 national expectation of 78%, noting this includes performance at our three acute providers and in our stand-alone Urgent Treatment Centres. There is variation across our A&Es in terms of performance.
- The unvalidated 4-hour performance position (trust combined) for March was 70.8%. As a system, SEL is likely to achieve performance of around 75.2% after the estimated adjustment for standalone UTC activity.
- Infection prevention control issues negatively impacting on bed availability and flow at some SEL sites alongside wider environmental, demand and flow pressures.
- We are continuing to progress service and pathway improvement actions to improve performance and flow, in and out of hospital.

Cancer

- Christmas and New Year often brings a dip in performance in cancer due to reduced capacity and patient availability. Despite this performance remains strong for the several Faster Diagnosis Standard and the dip in January is expected to recover in February. 62 day performance is below trajectory with Quarter 4 expected to be challenging in terms of meeting the target with by provider variance.
- There are a number of pathway and service improvement actions underway at organisational and system level.

Referral to Treatment

- 104 week waiters have been virtually eliminated and low numbers are also forecast for 78 week waiters. Reductions in 65ww are occurring at a slower pace than expected, and the number of over 65 week waiters at SEL trusts remain among the highest in London. Again, the position does vary, with some Trusts challenged others having seen a significant reduction in long waiters over Quarters 3 and 4. .
- The new Community ENT service is having a significant impact - over 4,500 long wait patients have been transferred from acute providers and all clinically appropriate new routine ENT referrals are now either going directly to Communitas or being redirected from our acute providers at the point of referral.

Diagnostics

- Plans to deliver our diagnostic trajectories include increased activity, demand management, validation and the use of clinical support tools. Despite this waits are long, and we are a significant distance from national targets, with variance by diagnostic test - MRI, ECHO & NOUS remain the most challenged modalities – and provider.
- All trusts are focused on ensuring overdue surveillance patients are being monitored and accurately reflected in their waiting lists.

Key messages : Mental Health & Learning Disabilities

South East London Integrated Care System

Mental Health – core targets

- Performance for both routine and urgent Children and Young People (CYP) Eating Disorders waits have improved , with both now delivering against the 95% standard.
- The number of completed Serious Mental Illness (SMI) physical health checks remains significantly below target – further work is taking place on improvement actions for 2025/26 and will be completed in April.
- SEL continues to under-perform against the Talking Therapies completed treatments target. This is, in part, due to the shift in focus this year from access to completion of treatment. In addition, services are reporting increased acuity which can increase the pathway to treatment completion.
- Some performance areas are still impacted by missing data/data quality issues, most notably provider OAPs with work on going to resolve these issues going forward.

Crisis & Flow

- Mental Health emergency pressures continue with high numbers of presentation in A&Es and demand for admissions.
- The proportion of MH patients attending EDs remains below 3.5% of the total attendances. However, in January 59% of MH patients waited more than 6 hours in the department and 34% more than 12 hours. SEL's operational plan reflects the intention of all system partners to reduce delays for this cohort in 2025/26.
- SEL is reporting significant numbers of out of area placements (OAPs). Both mental health providers have flow improvement plans in place with actions to support a reduction in the use of OAPs over the coming year.

Learning Disabilities

- SEL is currently on track to achieve the end of year target inpatient position of 61. Delivering the planned discharges of two or three long stay patients will be key to achieving the target as, while numbers may increase, many new admissions are appropriate and shorter. Admissions from prison to secure care are unpredictable.
- Increased referrals for autism assessment remains a challenge across all boroughs particularly our inner London boroughs. Work is taking place to better manage demand and capacity and access alongside the accreditation of Right to Choose Providers for Autism assessments.
- Annual Health Checks (AHCs) performance is on track.

Key messages : primary care & community services

South East London Integrated Care System

Primary care access

- Appointments totalled 832,324 in January against the operating plan of 727,247. The percentage of patients seen within two weeks was below trajectory at 89.2% (vs 91.0% for January 2025 plan)

NHS continuing healthcare

- February local reporting shows 28 day performance increased to 86%, above the national target of 80. There is continued variation in performance for reviews across SEL, with significant numbers of overdue reviews reported. Reducing the number of outstanding reviews is a key areas of focus alongside addressing borough variation.

UCR and community waits

- Community waits have seen a further decrease. Long waiters in adult services has remained consistent and is driven by increased referral demand in Podiatry / Podiatric Surgery. Community Paediatrics and CYP Therapies are driving long waits in children's services.
- Waits over 52 weeks remain challenging to reduce for all providers but mainly relate to community paediatrics. Work is taking place to improve our long waiter position.
  .
- SEL performance on the national trajectory for UCR referrals is below trajectory. Although an improvement on the previous month, performance is skewed by missing data at one provider.

Virtual Ward

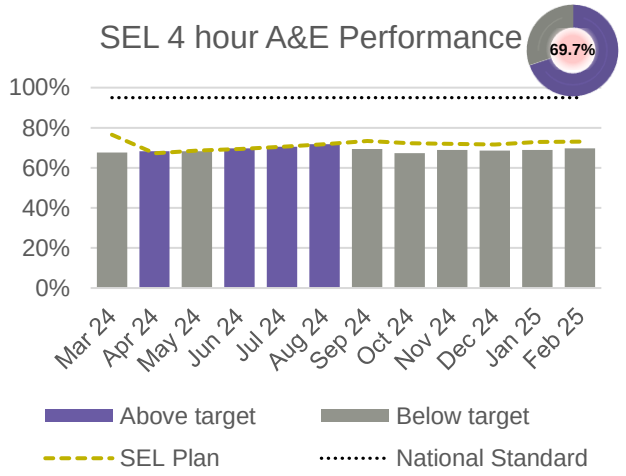
- SEL virtual ward capacity is below plan although occupancy is exceeding national and local performance targets at 81%. A workshop has taken place to consider learning from our work on virtual wards to date and the use of tech enabled monitoring.

Urgent & Emergency Care

South East London Integrated Care System

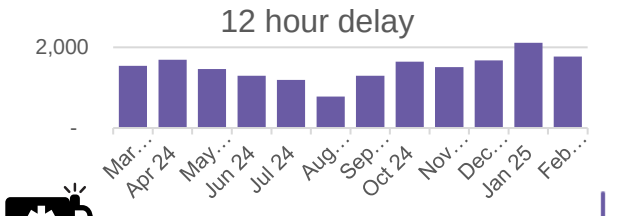
Notes and Issues

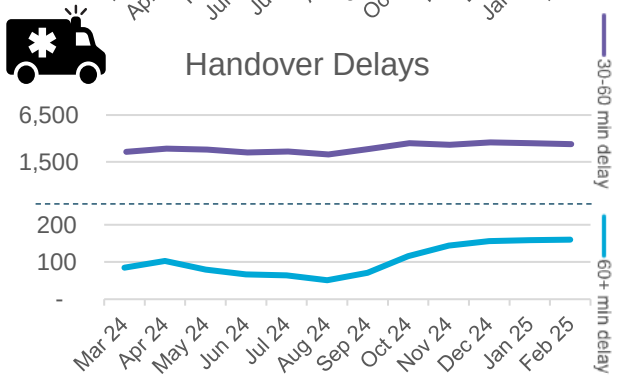
- ED performance – improved performance position reported over the summer months. February (SitRep data) showed performance of 69.7%. Published performance for SEL in January (including standalone UTC activity) was **74.7%**, an improvement on the 74.0% reported in January.
- Mental health pressures continue, leading to some long delays.
- The number of 12-hour delays reduced in February.
- Infection prevention control issues continue at some SEL sites which is impacting negatively on flow.
- Ambulance handover delays remained high in February with a similar number of delays reported compared to January.
- Bed occupancy levels increased with overall occupancy of over 95%.
- The percentage of beds occupied by patients not meeting the criteria to reside (CTR) remains above plan at 21%.

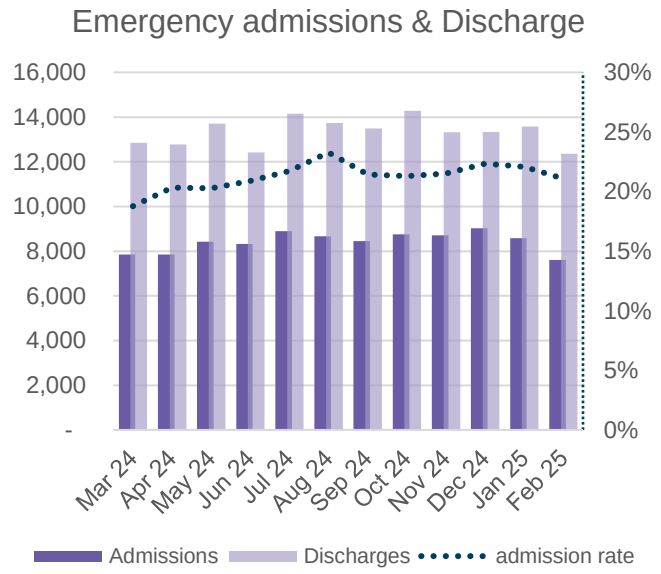


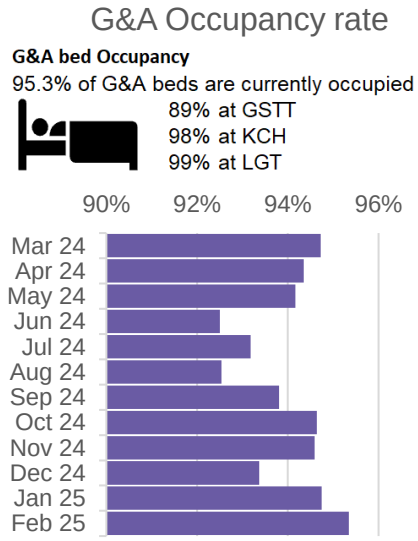
Recovery Actions

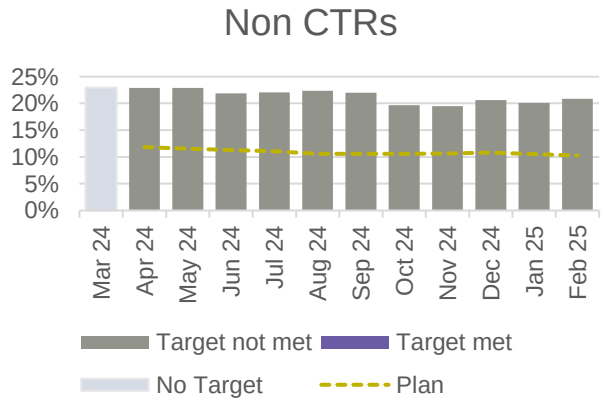
- Continued focus on improving ED performance and flow through:
  - Local system UEC improvement plans implemented with regular review of actions to assess impact and delivery.
  - Front door management – use of alternatives to ED, ED triage and streaming, redirection, use of admission avoidance, MH crisis pathway, hospital handovers.
  - In hospital management – same day emergency care, length of stay improvement.
- Continued national/regional focus on increasing the number of early discharges and delays beyond discharge ready date.
- Additional improvement actions in place to support improved performance during March to ensure optimal performance against the year-end target.











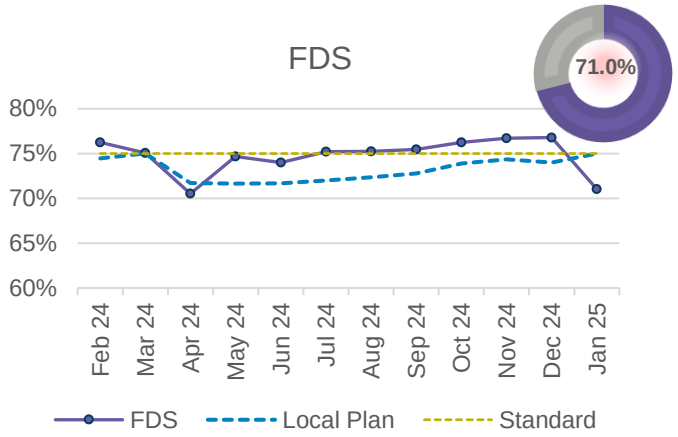
New target: Percentage of beds occupied by patients no longer meeting the criteria to reside

Cancer

Actual
Standard Target
Operational Plan

Notes and Issues

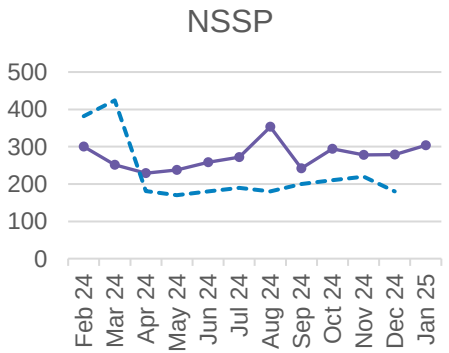
- FDS performance remains strong at a system level despite issues at LGT. This is expected to recover in February
- GSTT remain in tier 1 for Cancer but KCH have been formally removed.
- From April 2024 national focus changed from backlog recovery to 62 day performance. This improved in November/December to be on trajectory however performance is expected to reduce in January. Timely and effective Inter-Trust Transfer are a critical focus to improve performance, plus treatment capacity at the Cancer Centre.
- Backlog position has remained low although is now not formally monitored,
- The system continues to perform well on NSSP and FIT and these remain operating plan targets for 24/25 although may be removed for 25/26



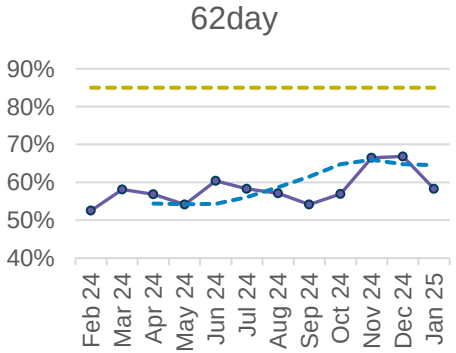
Faster Diagnosis Standard (Standard Target 75%)
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days

Recovery Actions

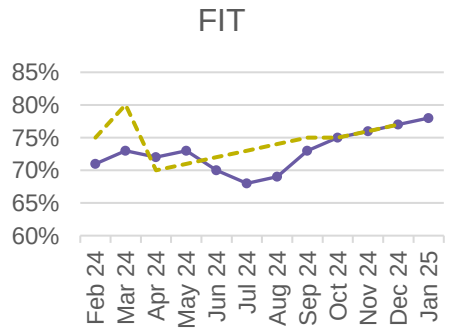
- Streamline cancer pathways and optimize diagnostics.
- Ensure timely communication of diagnoses and rule-outs within 28 days.
- Promote utilisation of rapid diagnostic clinics, FIT testing, tele-dermatology, and personalised stratified follow-up.
- Improve early diagnosis, patient experience, and resource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



The number of patients with suspected cancer seen on a **non-specific symptoms pathway**, following GP referral or referral from another service.

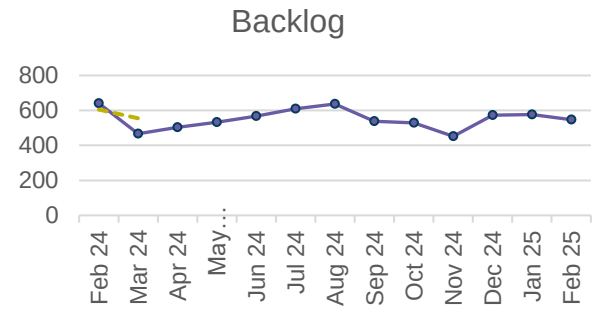


(Standard Target 85%)
% of patients with first treatment within 62 days of urgent GP referral
From Oct 23 metric changed to 62 Day (Combined). This merges the urgent, screening and consultant upgrade standards that were in effect before.



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

Please note that this is the only metric on this page that is not included in the Systems operational plan for 24/25. We have included this for information purposes at this time.



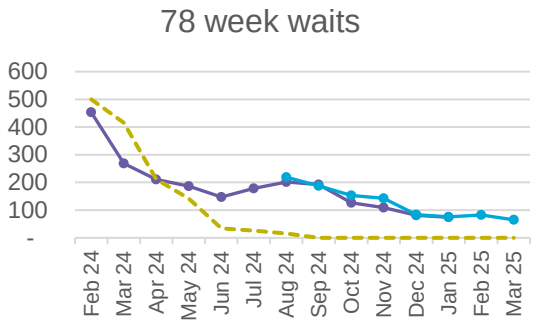
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period

Referral to Treatment

Latest Published month	Jan 25
Previous Published month	Dec 24
Latest weekly data	09/03/25
Reporting on:	SEL Trusts
Plan	-------

Notes and Issues

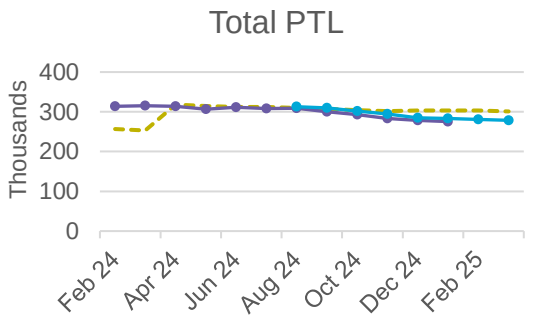
- NHSE (London) set each system a target achievement for 65 ww breaches for 22nd December which wasn't met by any system in London.
- The 65 week cohort continues to reduce but the rate of reduction has slowed.
- 52 ww continue to decrease which will reduce the level of future 65ww tip ins.
- Focus will shift to include 18-week delivery in 2025/26
- Low levels of 78 week waiters are forecast for year end.

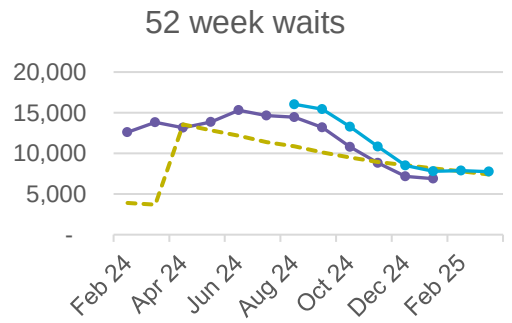


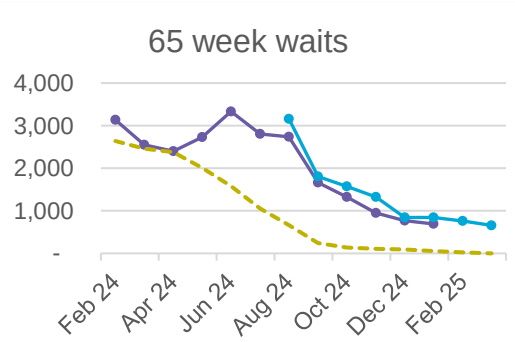
There are currently **65** patients at SEL Trusts who have been waiting more than 78 weeks to start treatment.

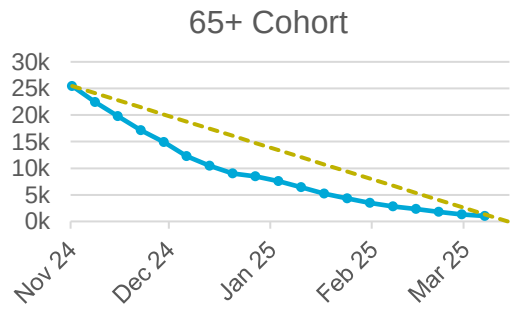
Recovery Actions

- Recovery includes:
  - Additional in house capacity targeted and challenged specialties
  - additional mutual aid within SEL and to other London trusts.
  - ISP insourcing and outsourcing
  - For ENT one of the most challenged specialties, the community provider is triaging non-admitted patients to maximise redirection to alternative community provision in line with the new pathway
  - Administrative and clinical PTL validation

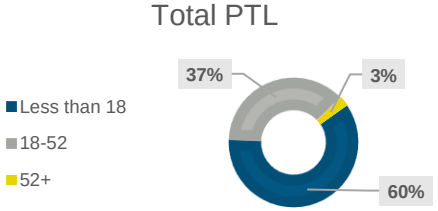








65+ Cohort
Total pathways which will breach 65+ weeks by 31/03/2025 if not seen.



RTT Patients still waiting		of which					
	Total	<18 ww	18 week perf	52+	65+	78+	104+
This month	**275,514**	**165,592**	**60.10%**	**6,886**	**691**	**74**	**-**
Plan	× 256,816		× 92%	✓ 8,156	× 55	× 0	✓ 0
Last month	▼ -2729 (-1.0%)	▲ 2375 (1.4%)	▲ 1.4% (2.4%)	▼ -285 (-4.1%)	▼ -77 (-11.1%)	▼ -7 (-9.5%)	▼ -2 ()
Latest week	**278,673**	**166,213**	**59.64%**	**7,746**	**658**	**65**	**1**

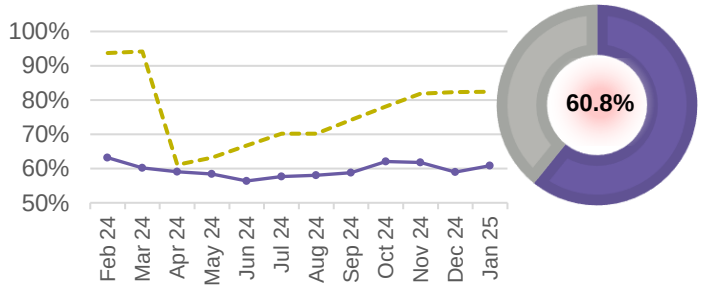
Diagnostics

Actual
Plan
SEL Trusts
SEL ICS

Notes and Issues

- Following Epic implementation, GSTT and KCH have now returned to reporting diagnostic activity which is reflected in the graph below. There are however ongoing data quality issues.
- Performance post EPIC implementation has shown a significant deterioration in performance. Recovery plans are being progressed to address diagnostic performance - NOUS and echos particularly challenged modalities.

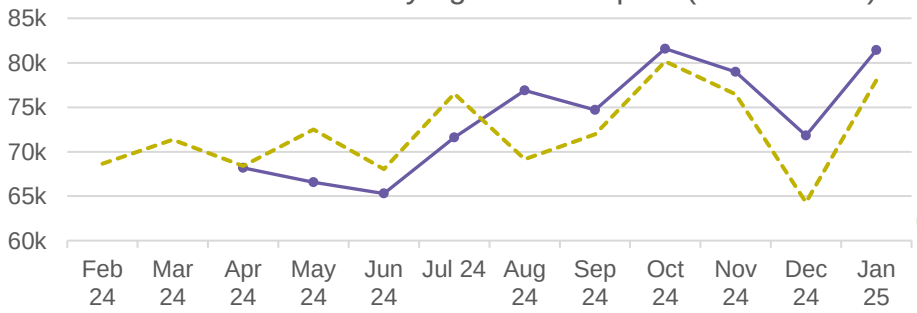
Proportion of SEL Trust patients receiving their diagnostic test within 6 weeks (9 modalities)



Recovery Actions

- National financial support for cancer diagnostics has been used to increase capacity both on site and at the CDC
- H2 trajectories to be delivered through additional activity by expanding capacity, use of Eltham CDC, ECHO mutual aid, demand management and validation.
- Acute Provider Collaborative led work to support improvement and sustainability specifically, demand management, capacity optimisation and utilisation initiatives.

SEL Trust activity against local plan (9 modalities)



Due to Epic implementation, only LGT reported diagnostic activity between Oct'23 & Mar'24.

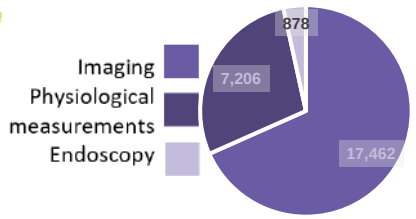
SEL ICS waiting list targets

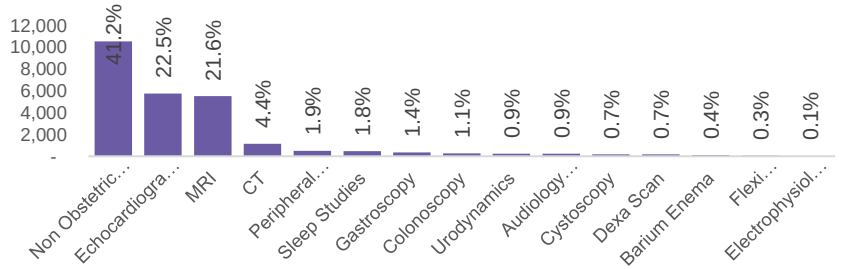
	6+ week waits			Total Waiting List		
Modality	**Actual**		Plan	**Actual**		Plan
MRI	4,270	×	1,483	12,569	×	10,289
CT	816	×	613	4,593	✓	6,033
Non Obstetric Ultrasound	8,990	×	4,333	26,049	×	22,936
Echocardiography	4,321	×	1,276	7,760	×	6,379
Colonoscopy	278	×	120	1,770	×	1,521
Flexi Sigmoidoscopy	73	×	62	401	✓	468
Gastroscopy	309	×	136	1,422	✓	1,445
Dexa Scan	182	×	56	1,910	×	1,389
Audiology Assessments	354	×	130	1,273	✓	1,504

This table covers waiting times and lists for SEL ICS.

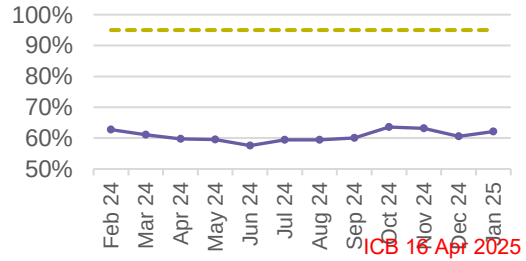
Current 6+ waiters (all modalities) **25,546**

All charts on this page report on the 9 key diagnostic modalities apart from these bottom 3, which cover the entire SEL Trust cohort.





Performance against 95% target
(all modalities)



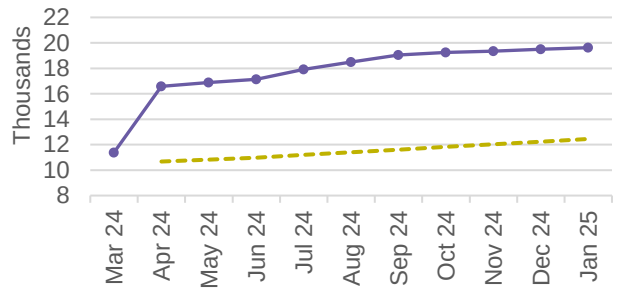
Mental Health

Actual
Target

Notes and Issues

- The waiting times targets for both routine and urgent CYP Eating Disorder were met in January.
- CYP Access performance is now performing just below target. This is likely to be because of an activity shift for ADHD/ASD which has moved from CYP Mental Health to CYP Community.
- SEL Talking Therapy services performance fell in January with none of the prescribed metrics being delivered in month. The number of patients completing a course of treatment remains significantly below trajectory.
- Perinatal access performance fell below target again in January.
- The number of Physical Health Checks for people with SMI is significantly below trajectory so far this year, local reporting indicates an improvement, but this has not been confirmed on publication of the Q3 data.

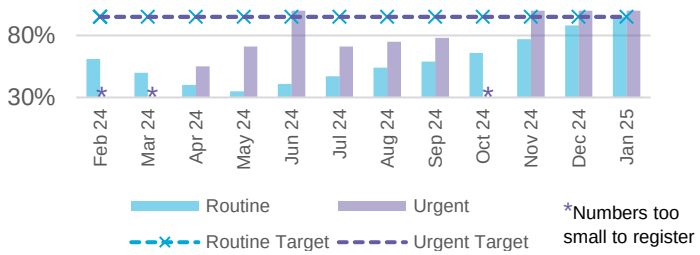
Access to Transformed Community Mental Health Services



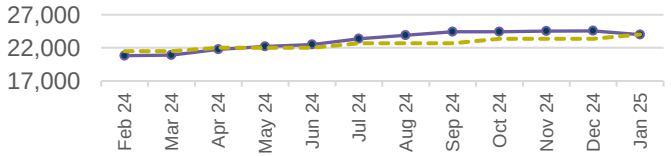
Recovery Actions

- Revised structure in place for the provider performance meetings to ensure focus on key deliverables.
- Continued support available to ensure all providers can submit data.
- Data Quality Improvement Plans embedded at both mental health providers. .
- Local improvement plans in place to increase the number of Physical Health Checks undertaken for people with SMI.
- Work underway to explore deterioration in TT performance.
- Work to understand the variance between locally and nationally reported SMI PHCs.

CYP Eating Disorders: percentage achieving standard

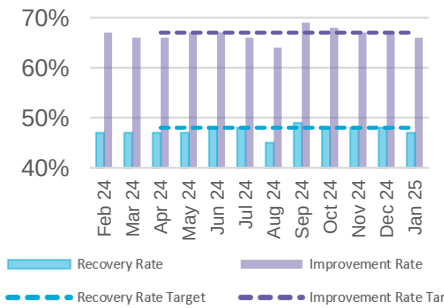


No. young people accessing NHS funded MH services



Talking Therapies (IAPT)

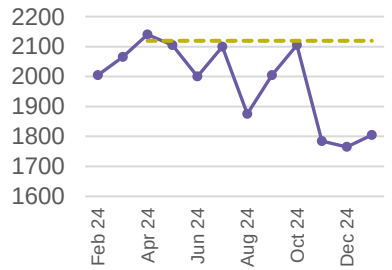
Improvement[1] & Recovery[2] Rates



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

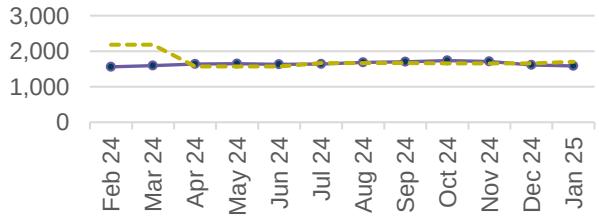
2. Reliable recovery rate for those completing a course of treatment and meeting caseness

Number Discharged

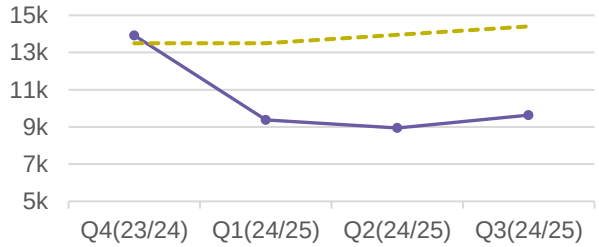


3. Number of patients discharged having received at least 2 treatment appointments in the reporting period

Number of people in contact with perinatal services



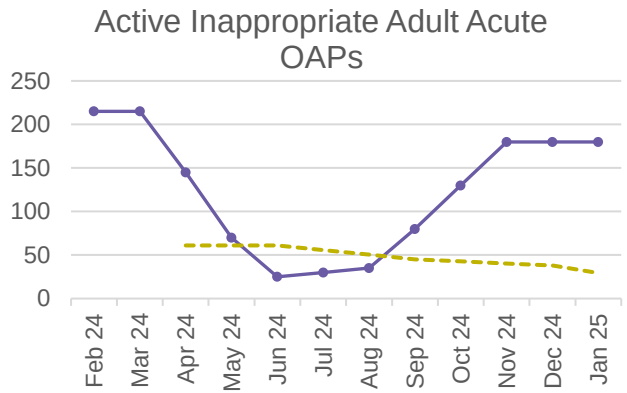
SMI-health check



Mental Health Crisis & Flow

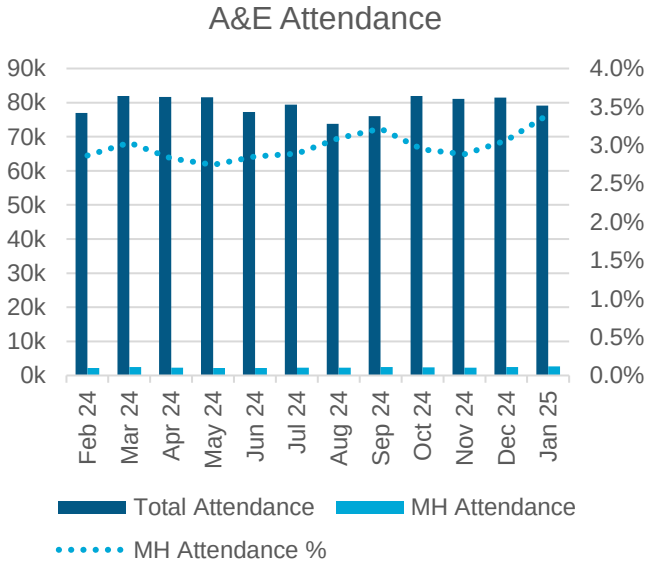
Notes and Issues

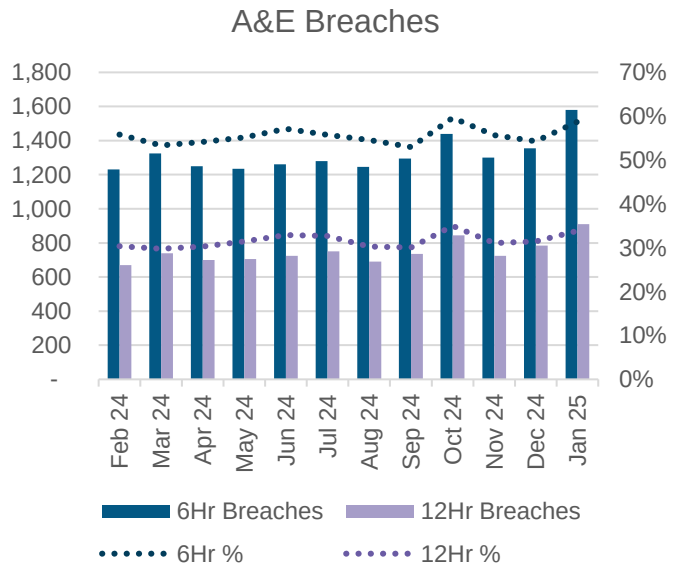
- Mental Health emergency pressures continue with surges in presentations to EDs and demand for admissions.
- The number of 72+ hour MH breaches remains problematic.
- In 2024/25 the focus measure for out of area placements (OAPs) changed to the number of active placements at the end of the reporting period. Data reporting of OAPs appears to be improving for SEL however, data for individual providers remains incorrect. The SEL position shows performance well above trajectory.
- A&E data shows that the proportion of MH presentations in A&E has increased slightly in January.
- 59% of MH patients waited more than 6 hours in ED and 34% more than 12 hours.

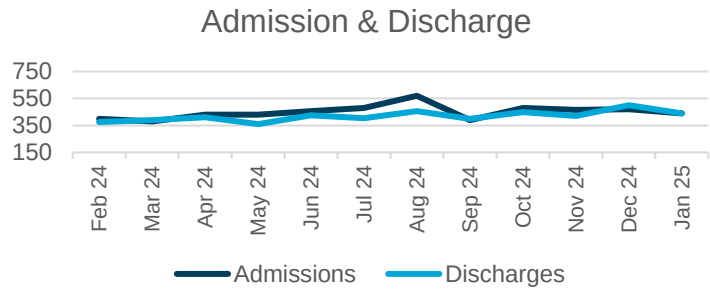


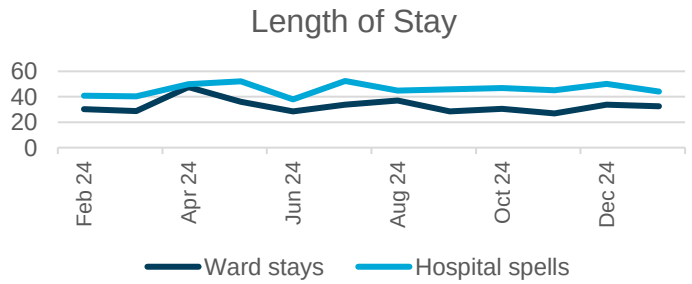
Recovery Actions

- 26 additional beds opened by SLAM.
- Continued focus from all system partners on expediting discharges for those patients that are clinically ready for discharge.
- 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.
- Increased focus on reducing the number of long delays in ED for MH patients.
- MH Trusts continue to work with private providers to ensure OAPs data is submitted via MHSDS correctly. Improvements are noted but the data is not yet flowing correctly for all providers.







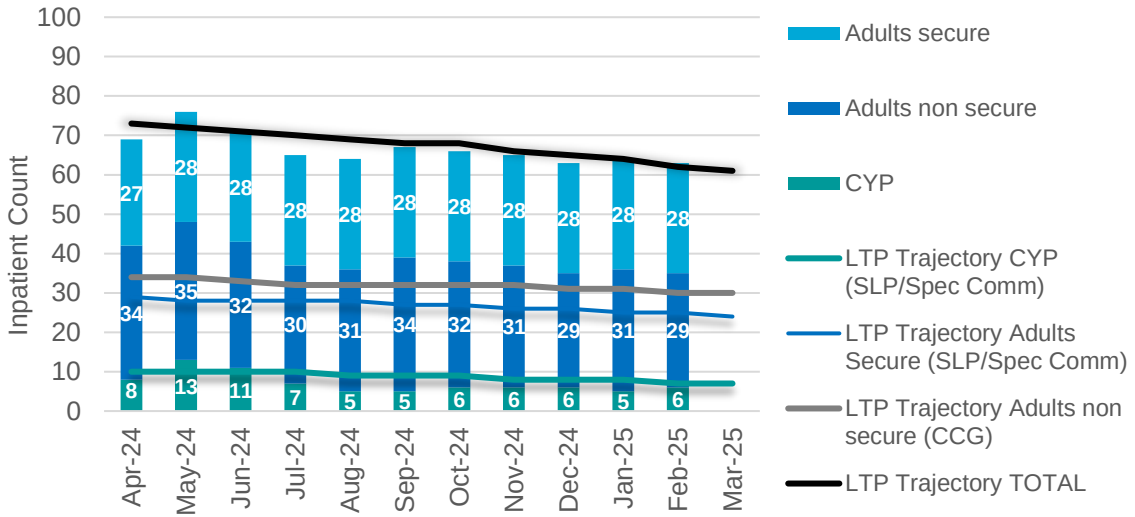


Learning disability and autism

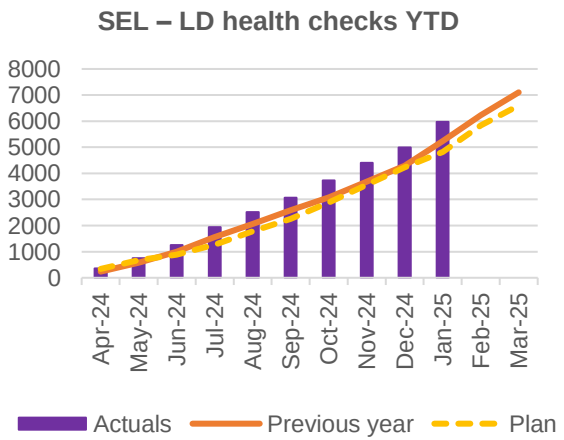
Notes and Issues

- At the end of February 2025 there were 63 inpatients, which is two above target position for the end of Q4. There were 57 adults in non-secure and secure units, three above the target for adults, and six children and young people, one below the target for CYP. There are 6 people due for discharge by end of March 2025. Three from secure care and one CYP and five adults in non-secure care.
- Continued increase in demand for autism assessments for both adults and children and young people across all boroughs. Work is on the way to explore the capacity and funding required to reduce adult waits in inner SEL, including work to understand referrals, capacity and productivity..
- All six boroughs achieved the 2023/24 operational target with majority surpassing the 75% annual health checks target. The focus in all boroughs is around assuring AHC are of a good quality and on improving peoples experience of AHCs. Operating Planning guidance confirmed no increase or change to the target, it remains 75% for 2025/26.
- Roll out of The Oliver McGowan Mandatory Training continues. Planning for a sustainable model from April 2025 has been undertaken however no additional funding has been identified. Working to understand how this may be managed within existing resources and seeking to secure existing programme management resource to implement as not possible without this.

LDA Inpatient Position



LD AHCs: SEL and Borough Level Position



	Jan 25 performance		Jan-25 Trajectory	2024/25 Plan
	%	Count		
Bexley	59%	736	675	889
Bromley	71%	885	695	915
Greenwich	67%	1128	906	1193
Lambeth	66%	1130	935	1230
Lewisham	61%	1202	1094	1440
Southwark	68%	893	710	934
SEL	65%	5974	4825	6,600

Recovery Actions

- Operational planning trajectories for 2024/25 have been set to consider the expected increase in admissions of autistic people.
- Community Autism Specialist services to support autistic only people are in development to prevent admission and support community placements.
- 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.
- All boroughs have implemented DSR guidance to support admission prevention. Workshops were held with boroughs with all agreeing DSR template, principles and processes. Digital DSRs to be rolled out across SEL.
- There are projects in primary care to support uptake and quality of AHCs. There is also an LDA Clinical and Care Professional Lead (CCPL) supporting AHCs.
- Ongoing plans to target people who are not on learning disability registers to increase registers and as a result the opportunity to do more AHCs. An AHC Strategic Group supports delivery of plans to achieve and exceed target.
- LDA Specialist Prescribing Advisor team, contributes to improving diagnostic validation and LDA prevalence

Primary care access

Notes and Issues

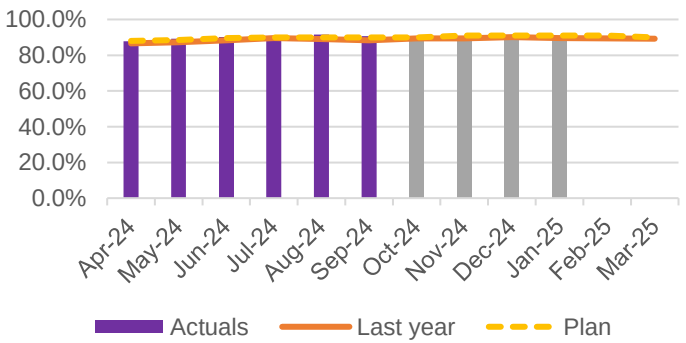
- Appointments have returned to pre-pandemic levels, as has the level of face to face care offered. However, capacity in general practice is increasingly constrained with surging patient demand which will be impacting on patients experience of access.
- Appointments totalled 832,234 in January against the operating plan of 727,247, noting variation by month.

Primary Care Recovery Plan

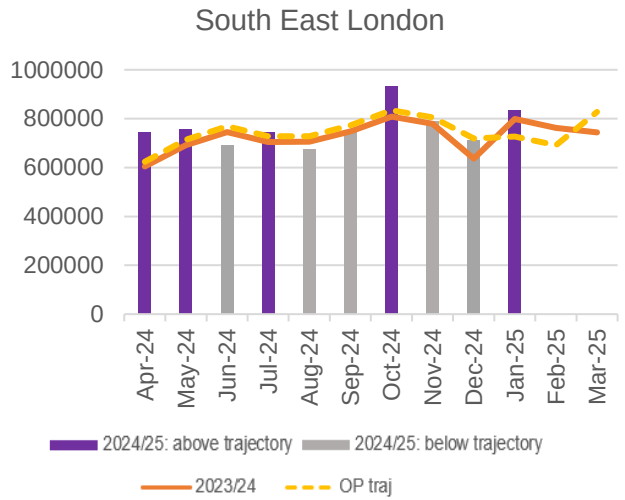
- SEL ICB and local systems are working closely together to deliver the key actions set out in the Primary Care Recovery Plan.
- All PCNs have produced Local Capacity and Access Improvement Plans and are monitored against these.
- All LCPs are working with their PCNs to implement the Capacity and Access Improvement Payment metrics for 24/25 which focus on better digital telephony, simpler online requests and faster care navigation, assessment, and response.

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

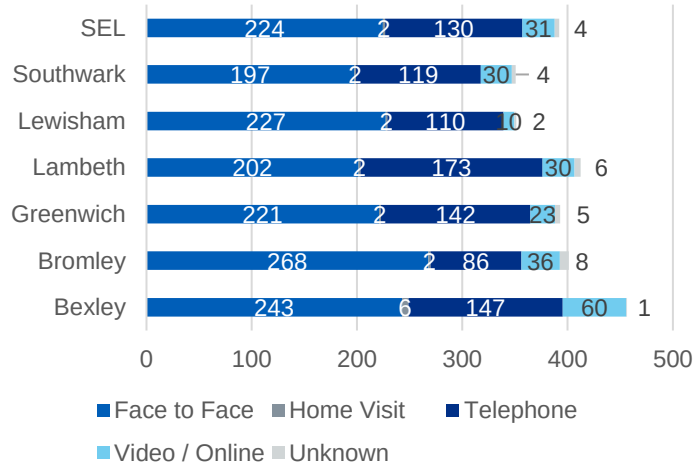
Percentage of appointments seen within two weeks (Jan 25)



Primary care access: appointments
National data vs Operational plan trajectory



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



Recovery Actions

- Work across LCPs 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 Edenbridge Apex 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.

LCP actions and progress (provided by leads)	
Bexley	• Significant improvement across Bexley practices with respect to the availability of online consultation and triage for clinical and admin requests during core hours (08:00 – 18:30). 90% of Bexley practices are now fully compliant in advance of the contractual deadline of October 2025. • NHS App utilisation is continuing to grow and now at 63.8% of the registered population, against an SEL average of 60.8%
Bromley	• Ensuring that the capture of GPAD information is complete and that mapping by practices is correct. Identifying issues affecting performance by monitoring known resilience issues which might impact delivery and ensuring that we have a better understanding of the reasons for a high number of patients waiting longer than 14 days and what actions practices are taking to resolve this • Ensuring that practices are developing plans and timeline to meet the requirements of the contract from October 2025. Wider use of different access routes to services will help to reduce time to access services and wait times. • Ensuring best use of ARRS and GP ARRS by PCNs. This will add appointment capacity to the system
Greenwich	• "Connecting Greenwich" a two-year initiative for primary care and public health to support neighbourhood development and reduce inequalities is progressing with 15 projects underway. • Digital leads continue to support access improvements through the Modern General Practice model and are working to increase the numbers of patients with access to the NHS App.
Lambeth	• The borough-level target for appointments (1.5%) has been exceeded. • A comprehensive roadmap has been developed in collaboration with our clinical cabinet, focusing on strengthening the general practice programme including the development of a GP provider alliance. • General Practice leads have been identified for each of the five Lambeth Neighbourhoods.
Lewisham	• •Deep dive review of General Practice Appointment Data to be undertaken to validate accuracy, particular in terms of inclusion of online consultation activity – *a trend has been identified with practices using a common online triage tool* • Following practice self declarations, 100% of the Transition and Transformation funding has been released to practices to support the implementation of the Modern General Practice Access model
Southwark	• Utilisation of the NHS app has increased by 5.4% between January 2024 and January 2025 with 60.1% of patients registered aged 13+. • Southwark GPs carried out additional 23,971 appointments in Q3 24/25 compared to Q3 23/24. This represents an 6.5% increase. • There has been an improvement in number of practices submitting Friends and Family Test data. 32 out of 32 practices submitted data in December 2024 compared to December 2023 when 24 out of 32 practices submitted data.

NHS continuing healthcare

Notes and Issues

- **28 day performance**
  February performance (local reporting) against the number of referrals completed within the 28-day timeframe is 86%. This is an increase from January's performance of 75% and above the national target of 80%.

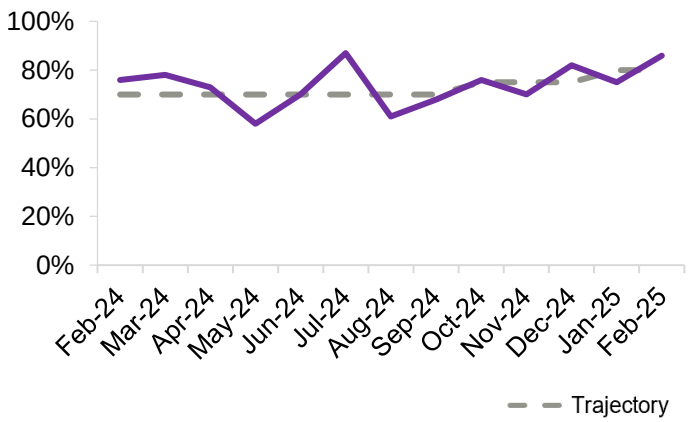
- **Incomplete referrals over 12 weeks**
  SEL reported zero 'long waits' over 12 weeks in February which meets the national target of zero.

- **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 221. This is a small decrease from the previous month (224) and overall numbers remain static.

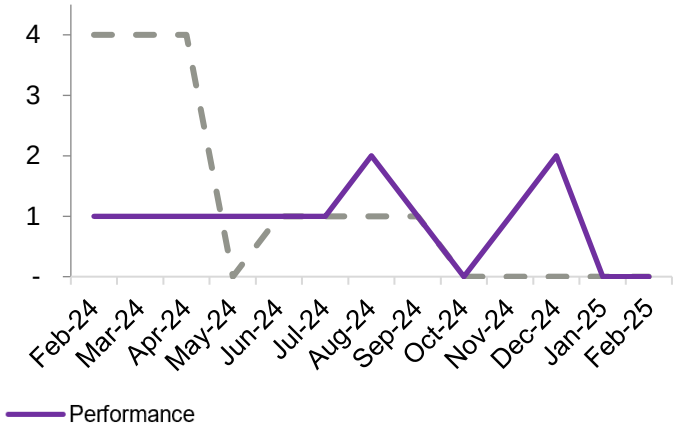
  The number of fast track reviews have increased since January's performance where 70 people were wating for a review. The number of people waiting for a review is now 87.

- **Funded Nursing Care Reviews**
  The number of Funded Nursing Care Reviews has increased since January (749) to 772.

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		
	Q3	Trajectory	Target	Q3	Trajectory	Target	Q3	Trajectory	Target
Bexley	0%	-	0	74%	75%	80%	0	0	0
Bromley	0%	-	0	93%	75%	80%	0	0	0
Greenwich	0%	-	0	81%	75%	80%	0	0	0
Lambeth	0%	-	0	41%	75%	80%	0	0	0
Lewisham	5%	-	0	80%	75%	80%	2	0	0
Southwark	0%	-	0	62%	75%	80%	0	0	0
SEL	1%	-	0	78%	75%	80%	2	0	0

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

Recovery Actions

The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, CHC teams have exceeded their savings targets.

An audit was completed as part of the internal audit plan for 2022/23, ensuring compliance with CHC assessments and reviews following the pandemic.

Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities.

The ICB has recovered performance against the assessment targets and is achieving performance trajectories agreed with NHS England. The ICB is on track to reach pre-pandemic levels in Q4.

UCR and community waits

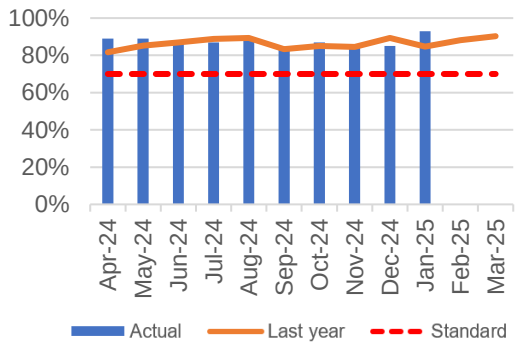
Notes and Issues

- Primary UCR data is available, however GSTT only submit to the final refresh – so there is no January data available for Lambeth and Southwark.
- Compliance against the 2-hour standards has been maintained at 92% (local data) and for the 2-day referral standard, which increased from 90% to 92%.
- The total number of patients reported on the Community Services waiting list for services in scope in SEL (excluding GSTT) was 21,565 - a decrease of 379 on the previous month. This was due to fewer patients waiting 0-1week. There have been small increases in numbers waiting at all other intervals.
- Of the total number of patients waiting, 12,947 (59%) have been waiting less than 12 weeks for a first appointment. This is a marginal improvement on December performance Key services contributing most to overall wait numbers continue to be MSK, Podiatry & Podiatric Surgery, Rehab and LTC Nursing (Continence) services in Adult Services and Community Paediatrics, Therapies (SLT) and Audiology in Children's Services.

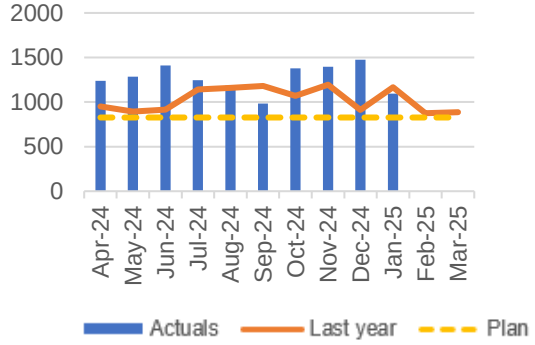
Long waiters:

- Of the 1,455 patients waiting 52-104 weeks 1,437 (98.7%) were in Community Paediatrics, 3 in Paed Audiology, 2 in Paed Physiotherapy and 1 in Paed SaLT. 12 patients were in adult services – these were all in Podiatry / Podiatric Surgery at Oxleas. Community Paediatrics waits are split evenly between Oxleas (674) and LGT (634). Long waits in Paediatrics at Bromley Healthcare have increased from 89 in December to 129.
- All of the 63 patients waiting over 104 weeks are in Community Paediatric Services at Oxleas. This is an increase of 16 on December performance.

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

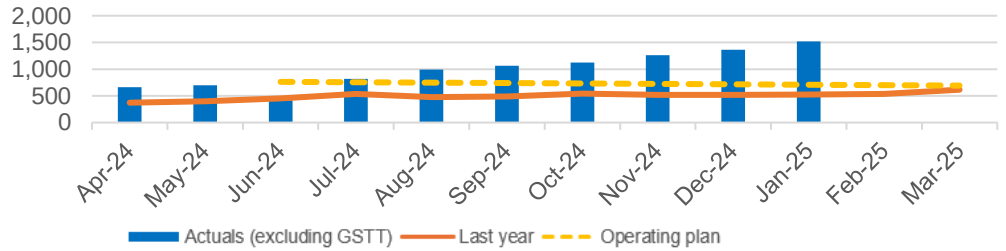


Referrals (all) to UCR services (Published data)**



**Provisional January data. GSTT not included in UCR referrals data. January performance data excludes GSTT and BHC.

Community waits >52 weeks (Excludes GSTT)



Recovery Actions

GSTT focussed recovery actions to support data provision:

Community waits – Work to provide return to full reporting by the end of Q2 with an interim consideration of the scope to provide a partial return from April covering the top 5/6 services with the largest number of waiters and the largest numbers of long waiters across adult and children's services. Waits are being monitored by the Trust.

UCR – work to enable the provisional data to be provided from end of Q1, plus providing Faster Data Flows daily upload.

Community wait list:

- Long waiters have started to appear in adult Podiatry / Podiatric Surgery services. However, numbers are small and are being driven by increased referrals. Workforce and theatre space limitations are slowing the pace of recovery but are subject to on going focus.

CYP Long wait performance:

- High referral demand and staff shortages continue to drive long waits in children's services. Trusts are using additional temporary capacity to keep up with demand and slow the growth of the list including data cleansing and demand and capacity work.

Borough level UCR performance – January 2025 (local data)

Borough	2hr referrals		2-day referrals	
	No.	%	No.	%
Bexley	106	87%	193	93%
Bromley	309	87%	14	93%
Greenwich	63	100%	31	61%
Lambeth	-	-	-	-
Lewisham	117	91%	56	82%
Southwark	-	-	-	-
SEL	595	92%	294	92 %

SEL Waiting List Breakdown (January 25)

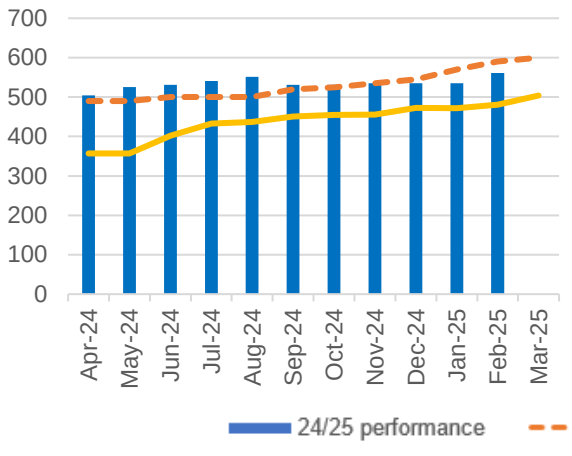
Weeks	Number of waiters
0-1 weeks	**2,211**
>1-2 weeks	**2,035**
>2-4 weeks	**2,534**
>4-12 weeks	**6,167**
>12-18 weeks	**2,764**
>18-52 weeks	**4,336**
>52-104 weeks	**1,455**
>104 weeks	**63**

Virtual wards

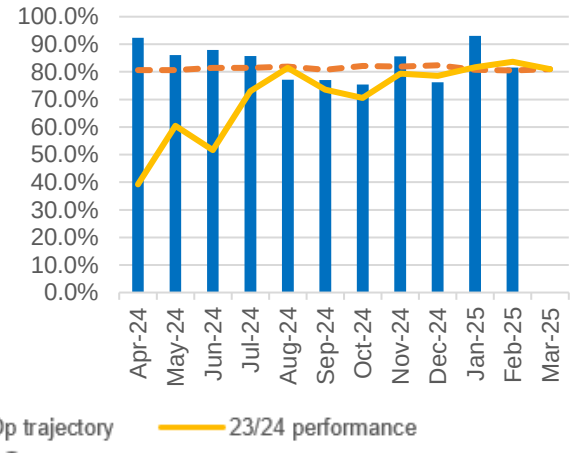
Notes and Issues

- 2024/25 planned capacity for SEL is 600 beds by March 2025 with a minimum occupancy rate of 81%.
- The ICB's virtual wards capacity is marginally below plan at 561 beds in February vs a target of 590.
- The average occupancy dropped to 83.7% when compared to the previous month but exceeds the planned occupancy of 80.5%.
- Data completeness has been maintained with all wards submitting a return.

Capacity (beds) vs plan



Occupancy vs plan



Tech Enabled Care

- The number of patients onboarded in Greenwich (adult services) continues to increase.
- Paediatric VWs: continue to show increase in the numbers of patients onboarded and positive feedback from parents on the service.
- Providers have extended existing contracts, most ending in March 2026 and there is interest in moving forward with a single procurement process.
- In order to complete the procurement and have a supplier in place for April 2026, a service specification will need to be agreed and finalised by June/July 2025. The process would be supported by the ICB's Digital Team and the London Procurement Hub.

Average of snapshots February 2025

Feb-25	Av. Capacity	Average Utilisation
SEL actuals	561	82%
SEL Plan	590	81%
BHC	56	66%
Greenwich and Bexley community hospice	14	71%
GSTT	227	63%
KCH OPAT	30	110%
LGT	20	85%
One Health Lewisham	50	122%
Oxleas	154	94%
Lambeth and Southwark - St Christophers Community Hospice	10	110%

2024/25 Plans and Actions

- February performance confirms that Virtual Ward beds are being fully utilised across the system.
- Work to progress the merging of virtual wards with UCR and UEC services is still ongoing, however has been impacted by lack of workforce capacity to drive this forward.
- Place teams have been asked to scope with their providers how Virtual Wards will fit within Integrated Neighbourhood Teams as an alternative care pathway.
- A review of virtual wards has been commissioned by NHSE Regional team to look at how Virtual Wards have been implemented and delivering across the 5 ICBs. The review aims to draw some conclusions about the efficacy of Virtual Wards in supporting admission avoidance and early supported discharge.
- Work to develop options for a single tech enabled monitoring system, building from work already completed and our the March workshop.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Quality and Nursing Report Quarter 3**					
Meeting date	16 April 2025	Agenda item Number	**10**	Paper Enclosure Ref	**J**	
Author	Elizabeth Aitken, Deputy Medical Director and CCPL Quality					
Executive lead	Paul Larrisey, Chief Nurse					
Paper is for:	Update	**X**	Discussion		Decision	
Purpose of paper	To provide an overview of quality and nursing within the ICS for Quarter 3					
Summary of main points	**Quality and Patient Safety:** Working collaboratively with Providers to embed the NHS Patient Safety Strategy remains a key focus. There were seventy-four Patient Safety Incident Investigations (PSIIs), and two Never Events reported. Quality Alerts highlighted ongoing challenges in appointment/referral, transfer of care, discharge, poor communication and medication. The PSIRF pilot in General Practice concluded, informing future rollout. This will remain a priority for the HiN for 2025/26. **Safeguarding**: The Safeguarding Leadership Programme launched in March 2025, supporting 16 practitioners in leadership development. Advancements have been made in the Serious Violence Duty, using Emergency Department (ED) data to support community safety initiatives and improving governance for Domestic Abuse Related Death Reviews. The ICB has continued to be an exemplar organisation for the completion of the Safeguarding Case Review Tracker (S-CRT). Workforce challenges persist, with ongoing recruitment for Named GPs and Designated Doctors. Delays in provider safeguarding reports and system issues with EPIC at GSTT and KCH remain key risks, with resolutions in progress. **All Age Continuing Care (AACC)**: CHC performance improved, exceeding savings targets and recovering assessment timelines post-pandemic. Governance enhancements, including a new handbook and risk dashboard, support clinical supervision and policy implementation. **Local Maternity and Neonatal System (LMNS)**: Data collection resumed for the LMNS dashboard. Key focus areas include perinatal mortality, improved bereavement care, and enhanced clinical escalation processes. Midwifery vacancies have improved, but late fetal losses at King's prompts a deep dive review. **Infection Prevention and Control (IPC)**: NHS England thresholds for key infections were met, but MRSA and E-coli cases exceeded targets. System-wide efforts on antimicrobial stewardship and system learning remain a priority. **Learning Disabilities and Autism (LDA)**: Demand for autism assessments continues to rise for both adults and children and young people but wait times have improved for adult autism assessments in boroughs served by Oxleas with trajectories looking positive. Annual health check targets were met, and discharge targets for inpatients are on track. Mandatory training rollout is progressing well. **Special Educational Needs and Disabilities (SEND)**: Governance has been strengthened, and a SEL SEND Network was established to support statutory duties and improve health services for children and young adults with SEND.						

Potential conflicts of Interest	Nil known					
Relevant to these boroughs	Bexley	X	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Considered as part of the report					
Financial Impact	Not the focus of this report					
Public Patient Engagement	The report is presented to the board meeting in public					
Committee engagement	The Quality and Safeguarding committee consider quality and safety and the Executive Committee receive updates by exception of issues arising.					
Recommendation	The Board are asked to note the content of the report					

Quality and Nursing Report

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

1. Introduction

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

2. Quality and Nursing Updates

2.1 Quality and Patient Safety

During Quarter 3, there were a total of 74 Patient Safety Incident Investigations (PSIIs) reported. 2 Never Events were also reported during this period; both Never Events were reported at Guy's and St. Thomas' Trust (GSTT) one was in relation to a retained 5 cm wire in the pulmonary artery following an emergency procedure three days previously and the other was in relation to incorrect surgery due to the incorrect patient's consultation being dictated onto another patient's records. GSTT have been focusing on surgical safety as part of their patient safety improvement plan and quality priorities for 2024/25. The top theme reported for other PSII's reported by Trusts continues to be delay in treatments and delayed diagnosis. These are key priorities within each Trust's Patient Safety Incident Response Plan (PSIRP).

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. The trending themes reported include appointment/referral, transfer of care, discharge, poor communication and medication. Delay in providing appointment / treatment remained a predominant theme with Acute providers - GSTT, Kings College Hospital (KCH) and Lewisham and Greenwich Trust (LGT). Common sub themes within this category included issues linked to appointment/referral issues and transfer of care issues between secondary and primary care. Transfer of care issues highlighted within reported QAs continue to be addressed through the Primary Secondary Care Interface Group led by the ICB Medical Director.

There has been targeted improvement work made in LGT from closed QAs:

- Delay in providing appointment / treatment: LGT implemented mandatory documentation on iCare for all ECG assessments where advice is needed, ensuring that it is properly recorded in the system.
- Transfer of care: Pre-assessment now have a dedicated Health Care Assistant who help manage patients with a urinary tract infection (UTI) or positive MRSA swabs and a Pre-assessment Co-ordinator who tracks the patient pathway.

The Patient Safety Incident Response Framework (PSIRF) pilot cycle in General Practice led by the Health Innovation Network (HiN) has now come to an end. The HiN are in the process of drawing up a report, gathering feedback via surveys and writing up example case studies. There were 4 practices across SEL that participated in the pilot. The rollout of PSIRF in Primary Care will also be a key focus and priority for the HiN in 2025/26. In February, the ICB held its second Stakeholder Event for Independent Service Providers (ISPs) following PSIRF implementation. The event was well attended by 5 ISPs and NHSE. ISPs presented their current updates and relayed associated challenges. Key highlights were the enthusiasm and engagement of teams with the new learning responses as well as all Providers having published their policy and PSIRP on their website. The focus of the event was to facilitate collaborative working, and the sharing of lessons learned amongst the different providers as well as establishing how the ICB can further support ISPs. A follow up event has been scheduled for September 2025.

The ICB quality team has led several patient safety investigations and learning responses in 2024/25. One Patient Safety Incident Investigation (PSII) focused on a delayed cancer diagnosis in a patient with learning disabilities. The resulting safety actions include reviewing and improving the vulnerable patient pathway and enhancing communication with patients regarding hospital appointments and follow-ups. Additionally, the quality team facilitated 6 After-Action Reviews in response to 72-hour breaches in SEL Emergency Departments (ED) involving mental health patients. Key actions from these reviews include developing an SEL mental health escalation process for patients waiting more than 12 hours in ED for a decision or confirmed outcome. Another priority is the creation of a Clinically Urgent Transfer Protocol, which will be developed and tested using the ‘Plan, Do, Study, Act’ (PDSA) quality improvement methodology.

Site visits with a subject matter expect (SME), NHSE London and the ICB have been scheduled in line with the Paediatric Audiology National Improvement Programme; however, there was a delay to the completion of the visits in Quarter 3 due to the availability of the SME however these are on track to being completed in Quarter 4.

2.2 Safeguarding

The safeguarding function has made progress in relation to a number of deliverables during Quarter 4. Following the 2024 safeguarding review and investment, borough teams have been strengthened in terms of resource to enable workforce compliance with the Inter Collegiate safeguarding Document (ICD).

In March 2025, the first module of the Safeguarding Leadership Programme, developed by the ICB in partnership with The King’s Fund, was launched. The Programme, devised by the ICB in conjunction with The Kings Fund, enables 16 safeguarding practitioners from across the SEL health and care system to develop their leadership skills. The programme continues through to July 2025.

The ICB has also advanced its understanding of its role within the Serious Violence Duty. In addition to supporting a number of Offensive Weapons Homicide Reviews, the ICB safeguarding and Business Intelligence (BI) teams have started to map how they can use relevant data from ED's (Information Sharing to Tackle Violence) to populate a SEL ICB dataset for use by Community Safety Partnerships. The ICB has continued to be an exemplar organisation for the completion of the Safeguarding Case Review Tracker (S-CRT), a portal which records safeguarding statutory reviews and helps to identify themes and actions. A compliance audit is completed quarterly. The latest audit showed improving compliance across the boroughs with the data fields

Additionally, a governance flowchart has been established to improve the ICB's sign-off process for Domestic Abuse Related Death Reviews, the flowchart aims to involve the central team including the Chief Nurse at an earlier juncture than currently occurs. Throughout the system, borough safeguarding teams continue to provide support at a borough level, for example through the delivery of training/advice and involvement in safeguarding Board and Partnership work. SEL wide team continue to offer support and advice to both SEL wide and place based borough teams.

Progress has been made in recruiting Named GPs and Designated Doctors, with newly appointed Named GPs currently undergoing induction and further recruitment efforts ongoing, alongside risk mitigation strategies for unfilled positions. A thematic review of health recommendations in relation to recent Domestic Homicide Reviews was undertaken by the ICB. The main themes emerging were in relation to recommendations about Training and Routine Enquiry. This review has prompted mitigating actions led by the new ICS System Safeguarding Group.

However, 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. There remains a delay in safeguarding papers being circulated from one of the providers vulnerabilities/ safeguarding committees. This does not enable a timely or a prepared understanding of safeguarding information. There remain challenges with EPIC for both GSTT and KCH and safeguarding information. Both GSTT and KCH advise they are in production stage and are near resolution. This risk has been escalated at ICB place and discussed through the providers safeguarding committee.

2.3 All Age Continuing Care (AACC)

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

The ICB has improved its service performance throughout the year, and, while localised financial challenges exist, Continuing Healthcare (CHC) teams have exceeded their savings targets. An audit was completed as part of the internal audit plan, ensuring compliance with CHC assessments and reviews following the pandemic. Borough teams and the Quality and Nursing directorate have worked collaboratively to address key priorities. The ICB has recovered performance against the assessment targets and is achieving performance trajectories agreed with NHS England. The ICB is on track to reach pre-pandemic levels in Q4.

Weekly monitoring of Independent Review Panels (IRPs) shows that SEL decisions were overturned 17% of the time, aligning with the national average (19%), indicating consistent decision-making. Key procedural recommendations were identified in six of seven IRPs. A training needs analysis has informed the SEL AACC Learning and Development Programme,

set to launch in May 2025, alongside Personal Health Budget (PHB) training and policy development. An AACC governance handbook linked to a model of clinical supervision to support the development of front-line staff has been co-designed. The Handbook has been published and includes a suite of policies, procedures, guidance and Quick Reference guides for AACC staff. The Handbook will continue to be developed with borough teams and a dynamic risk dashboard will be published prior to implementation of the new polices and escalation procedure.

The team has reviewed the current AACC related risks on the risk register and is proposing an increase to a current risk. The specific risk relates to SEL not meeting the AACC data set submission deadline of 1 April 2025 due to variations in digitalisation across the six boroughs. Since the last meeting, the risk score has increased from 8 to 12. This increase is driven by the fact that, while the Continuing Healthcare (CHC) element of the submission has been met, the Children and Young People Continuing Care (CYPCC) element has not. To ensure a more targeted approach to risk management, it is proposed that this risk be closed and replaced with a new risk specifically focused on the CYPCC element.

2.4 Local Maternity and Neonatal System (LMNS)

The BI team has recommenced the construction of the LMNS dashboard, with EPIC data now starting to come through. Action plans from the Three-Year Delivery Plan are being implemented at both the LMNS and provider levels. Options for strengthening perinatal mortality oversight and learning are under consideration to ensure timely learning and support, while a SEL-wide maternal mortality thematic review is being planned in Quarter 4. Key learning from PSIRF/MNSI themes includes the need for improved escalation of cases when the clinical picture changes, ensuring appropriate management. Work is ongoing to enhance bereavement care pathways, incorporating learning from early and late pregnancy losses, with a review of stillbirths at GSTT and a planned assessment of late fetal losses at King's. Bladder care management is also being addressed. There has been an improvement in midwifery vacancy rates at LGT, with several international midwives recruited.

Emerging complaint themes include issues such as waiting in inappropriate areas, access to pain relief alternatives, documentation of ethnicity, the 36-week scan process, and gaps in information and communication. In response, LGT has launched a maternity communication charter, while the Maternity and Neonatal Voices Partnership is focusing on neurodivergence, 15 Steps to Maternity feedback, and community engagement to improve services. Staff updates on venous thromboembolism (VTE) are also underway following a national rise in maternal mortality, with the sector awaiting an updated national VTE risk assessment.

Key exceptions include an increase in late fetal losses at King's, prompting a deep dive investigation. A review is required to assess how tongue-tie services are commissioned and delivered, as current waiting times and capacity constraints are affecting care for women and their babies.

2.5 Infection Prevention and Control (IPC)

Key activity during this quarter included ongoing general practice audits, visits prior to CQC inspections and teaching sessions. An IPC workshop with system IPC leads was held in January 2025 to identify key issues. The workshop captured objectives common to system providers that will be used to develop an SEL IPC strategy and priorities for SEL IPC Group.

SEL remains within NHS England set thresholds for cases of Clostridioides difficile, P. aeruginosa, and Klebsiella spp. however, it is currently above trajectory for E. coli and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases. There have been 34

MRSA bacteraemia cases reported year-to-date across all settings against a threshold of zero, with 15 classified as hospital-onset. Of these, 13 occurred within SEL; 3 at KCH, 6 at LGT, and 4 at GSTT. Efforts continue across the system to support the Antimicrobial Stewardship agenda with well-established systemwide networks and forums. Key priority workstreams include a focus on primary care, data and digital improvements, secondary care initiatives, and COVID-19 medications management.

2.6 Learning Disabilities and Autism (LDA)

There continues to be an increase in demand for autism assessments for both adults and children and young people (CYP) across all boroughs. Wait times for adult autism assessments in boroughs served by Oxleas have reduced with trajectories looking positive. This is due to wait list clearance funding provided over two years ago. Funding to support reducing CYP neurodiversity waits within existing NHS community providers has been identified.

All six boroughs achieved the 2023/24 operational target with the majority surpassing the 75% annual health checks (AHC) target. The focus in all boroughs is around assuring AHC are of a good quality and improving peoples experience of AHCs

During March six patients are expected to be discharged. Successfully discharging the five adults and one CYP, will lead to the achievement of the end of year target of 54 Adults and 7 CYP. At the end of February there were 57 adults in non-secure and secure units and 6 children and young people.

Roll out of the Oliver McGowan Mandatory Training continues. Train the Trainer provider has been secured to SEL support training for 2025/26. All funding received for 2024/25; 344 webinars were delivered up until 31st March 2025. 259 Workshops delivered up until Friday 21st March 2025. Additional 12 workshops scheduled between 24th-31st March 2025.

2.7 Special Education Needs and Disabilities (SEND)

SEL SEND assurance and governance was transferred into the role of the Associate Director for Learning Disability and Autism from May 2024 to support the Executive Lead for SEND in the ICB to meet health requirements and responsibilities for SEND and SEND Area Inspections. A SEL SEND Network has been established following a review of the membership of the DCO (Designated Clinical Officer) meeting to ensure SEND representation at borough level, from health and local authority. The network will support our key objectives to:

1. Deliver our statutory duties for SEND
2. Access to and quality of health provision for CYP and young adults with SEND
3. Strategic commissioning for SEND

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.

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Development of Neighbourhoods and Integrated Neighbourhood teams in SEL**						
Meeting date	16 April 2025		Agenda item Number	**11**	Paper Enclosure Ref	**K**	
Author	Ceri Jacob Place Executive Lead Lewisham						
Executive lead	Dr George Verghese Primary Care Partner Member; Ceri Jacob PEL Lewisham						
Paper is for:	Update		Discussion	**x**	Decision		
Purpose of paper	To provide an update to the ICB Board on progress with delivery of a neighbourhood based health service and associated Integrated Neighbourhood Teams (INTs).						
Summary of main points	The 6 Places, who are accountable for the development community-based care, formed the Neighbourhood Based Care Board (NBCB) to bring together the 6 Places and key partners from across the ICS to shape the SEL response to the Fuller Report of 2022 and to respond to the direction expected to be set out in the national 10 Year Plan to develop a neighbourhood health service. An overarching SEL INT framework has been developed to shape and guide how neighbourhood ways of working, and the INTs that are central to this, are implemented in SEL. The NBCB, the 6 SEL Places and enabler functions are now moving from the planning phase and into implementation. This paper provides an update on progress with implementation against the overarching SEL implementation plan. The NBCB will provide regular progress and impact updates to the ICB Board.						
Potential conflicts of Interest	None identified						
Relevant to these boroughs	Bexley	**X**	Bromley	**x**	Lewisham	**x**	
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**	
Equalities Impact	The development of neighbourhoods and INTs is expected to help to address health inequalities in SEL. EIAs are being carried out in each Place.						
Financial Impact	A focus on prevention, early intervention and pro-active care is expected to reduce the need for acute health care and social care. It is also expected to provide positive benefits to wider society through for example, reducing the number of people economically inactive due to chronic ill health. This work is reflected in the SEL System Financial Sustainability programme.						
Public Patient Engagement	This has been carried out at Place. A SEL wide communications and engagement plan has been developed						
Committee engagement	Neighbourhood Based Care Board Various Place fora South East London Integrated Care Partnership						
Recommendation	The Board is asked to note and comment on the update						

The development of

Neighbourhoods and Integrated Neighbourhood Teams in South East London

A progress update

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

1. Background

1.1. In May 2022, the Fuller Report, Next Steps for Integrating Primary Care, was published. The report included a focus on the need to increase levels of collaboration and integration of services at a neighbourhood level to improve prevention of ill health and more proactive care for people with long-term conditions and more complex health and care needs.

1.2. In 2024, the Secretary of State set a clear direction for the development of a neighbourhood-based health service. This is expected to be set out in the 10-year plan, which is due to be released later this year.

1.3. In the January 2025 ICB Board meeting, the Board supported the SEL framework for Neighbourhoods and Integrated Neighbourhood Teams (INT) and this has subsequently been ratified in each of the six Places. The framework sets out our ambition in SEL for

neighbourhood working and our ongoing commitment to system working to address health inequalities and improving the outcomes and experience of care for the population we serve. The SEL framework built on the work that had already been undertaken at Place and provides a clear framework for future development.

1.4. Alongside the work at SEL and the six Places, London ICBs are working together to agree the London wide approach to implementing a neighbourhood health service and to identify areas where a once for London approach is helpful. A Target Operating Model (TOM) and Case for Change were recently approved by the London Regional Executive Team meeting. The SEL work is fully aligned to and is helping to inform the London wide work.

2. Neighbourhood working

2.1. The overarching aim of a neighbourhood way of working is to bring together services, with communities through a population health management approach, at a scale which enables the delivery of genuinely preventative, holistic and locally tailored services.

2.2. Neighbourhood working will require a fundamentally different way of working and large cultural shift across the public sector, voluntary, community and social enterprise sector (VCSE), and our local populations. It will involve new means of collaboration, coordination, and, at times, integration. This reflects a significant transformation of how our system will operate together. In SEL, there has been a history of increasing collaboration and integrated ways of working and this provides a good platform to implement a neighbourhood-based health service.

2.3. Developing INTs will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health, social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area. INTs will not replace existing, effective multi-disciplinary teams.

2.4. The following two pictures, taken from the January Board paper, set out at a high level our approach to neighbourhoods and the INTs that sit at their core.

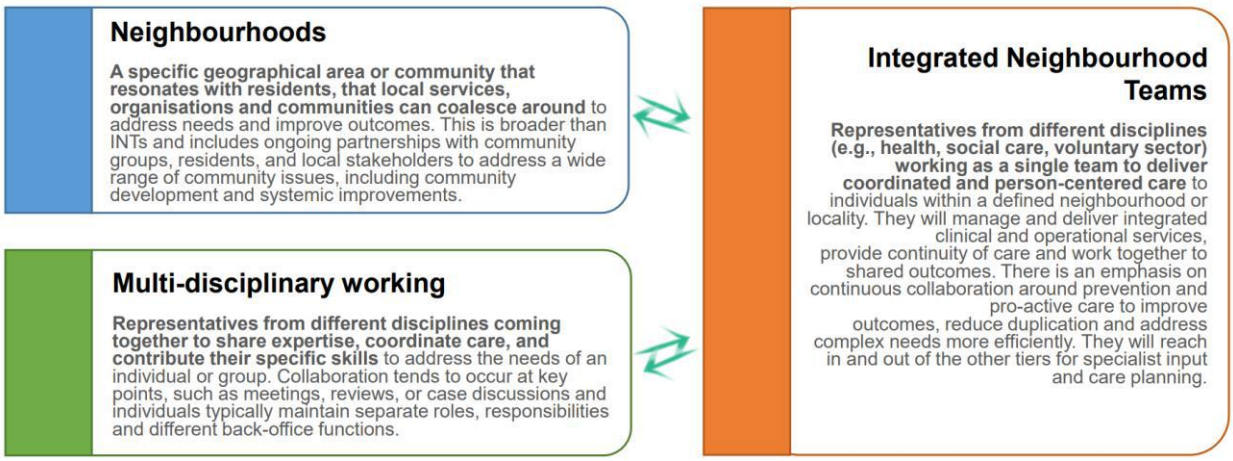


Figure 1

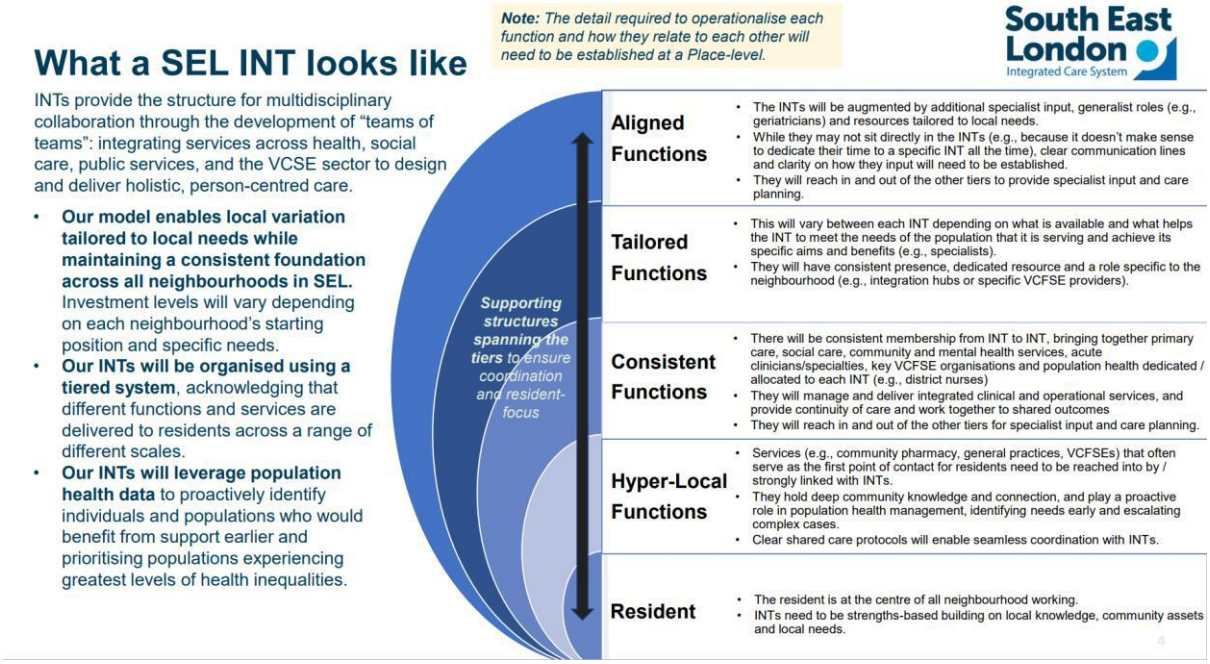


Figure 2

3. Governance

3.1. In response to the Fuller Report, the six Places established the Neighbourhood Based Care Board (NBCB) to share learning and best practice, ensure consistency of approach where it is required and to support enabler functions to understand the requirements of neighbourhood working. The enabler functions include Population Health Management (PHM), workforce, digital, estates and communications and engagement.

3.2. The NBCB is co-chaired by the ICB Board Primary Care representative and a Place Executive Lead (PEL). Membership includes all six PELs, or their representative and director leads for each of the enabler functions. There is also representation from the SEL Directors of Adult Social Care group, the Community Provider Network (CPN), the Mental Health Alliance and the Acute Provider Collaborative (APC).

3.3. The NBCB does not replace governance at Place and is not a decision-making group. Approval of detailed Place plans will continue to be via the Place Local Care Partnership Boards, which are sub-committees of the ICB Board. The NBCB reports into the ICB Executive Committee, which in turn reports to the ICB Board.

3.4. The SEL governance has been reviewed to reflect a move from planning to implementation and the proposed governance is set out in figure 3. Enabling functions and local LCP work all have established reporting lines. The intention is that the relevant working groups have a dotted line to the NBCB in relation to their work on neighbourhoods but retain their established reporting lines to SEL wide or Place groups.

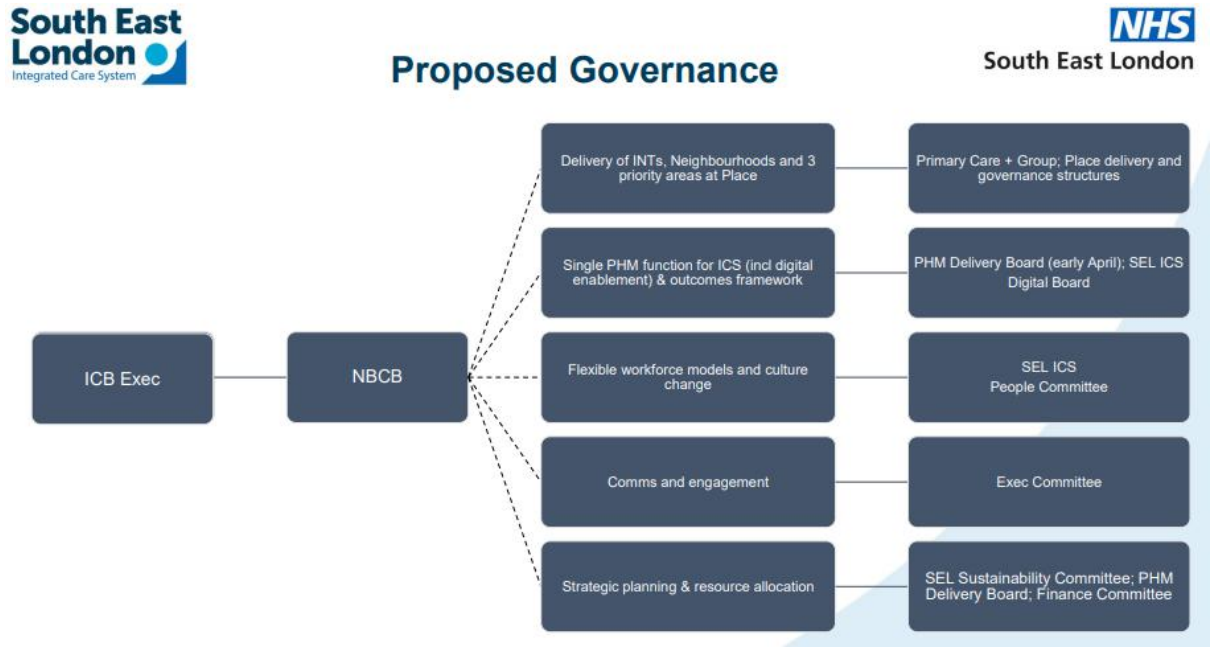


Figure 3

3.5. The NBCB TORs are under review to ensure they reflect the need to understand progress with implementation across the six Places and the enabler programmes, as they relate to the neighbourhood development programme. Work is also underway to establish an "engine room" to support the work of the NCBC, noting that this is being done in the context of a requirement to make significant reductions to ICB running costs and NHS provider corporate costs

4. Progress with Implementation

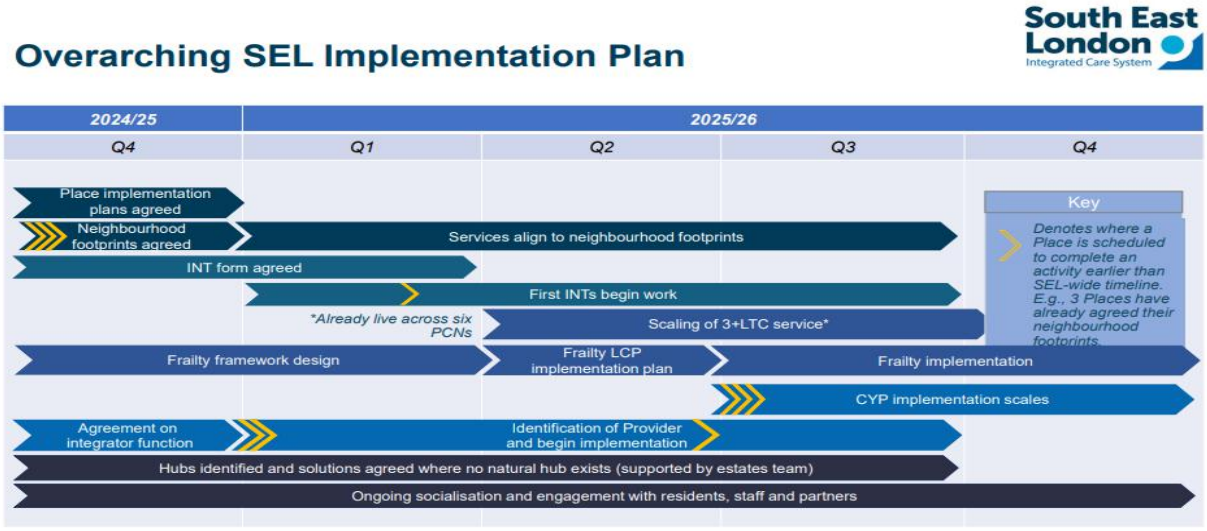


Figure 4

4.1. A high-level implementation plan was included in the January Board paper and is included as figure 4 above. With the exception of defining the integrator function, which has slipped by 2 weeks, SEL is delivering to the plan. The following section provides an update on progress with each element.

4.2. Places are in the process of developing more detailed plans that are aligned to the SEL timelines to guide implementation at a local level. The lead directors for this programme at Place meet regularly in the Primary Care Plus Group (PC+G) to support cross Place working, sharing best practice and to provide peer to peer challenge on variation, accepting that some variation is warranted.

4.a. Neighbourhood footprints

4.3. All 6 Local Care Partnerships (Place) have agreed their neighbourhood footprints and will now work with partners to align service delivery to these footprints. There are 25 neighbourhoods in total across SEL:

Place	No. of neighbourhoods	Populations served (range)
Bexley	3	40k to 103k
Bromley	4	77k to 100k
Greenwich	4	42k to 90k
Lambeth	5	62k to 111k
Lewisham	4	62k to 108k
Southwark	5	47k to 74k

4.4. A summary is attached as appendix 1a. Detailed profiles of the neighbourhoods will be developed using the example from Bromley included in appendix 1b as a template.

4.b. Integrated Neighbourhood Teams

4.5. Places are at different points in the development of their INTs, reflecting the different starting point however, good progress is being made across all six Places.

4.c. Target population groups

4.6. The SEL ICS agreed to target the initial work of neighbourhoods and INTs on three population groups where it was felt most impact could be achieved by working in a neighbourhood way. Impact will be measured in terms of patient outcomes, population level outcomes, activity trends and financial sustainability. The population groups are people with 3+ Long Term Conditions (LTCs), people who are frail or at the end of life and children with complex needs.

4.7. The 3+ LTCs SEL framework has been agreed and Place teams are finalising plans to refocus resources to support implementation. These will be reviewed after Easter and Places will then take forward implementation. A case will be made to secure sustainability funding to support more rapid implementation and impact.

4.8. Three system wide workshops have been held to design a frailty framework for SEL that will be implemented at Place. These workshops were well attended by partners from across the ICS and the outputs will come to the NBCB in April for endorsement and then ratification at Place LCP Boards.

4.9. Those Places that do not currently have an Integrated Complex Children service (Bexley, Greenwich and Lewisham) are developing their business cases and implementation plans.

4.d. Integrator Function

4.10. The PC+G have developed a draft set of function and form principles to support development of the Integrator Function in each Place where applicable. These will be reviewed at the NBCB in April and will be tested with Place partners and the ICB Executive. Work is also underway to set out and agree an appropriate assurance process.

5. Key Risks

5.1. There are a number of risks to implementation of the neighbourhood service. In particular, the programme is being implemented during a time of significant organisational change and reduction in staff across the ICB and health providers. There is a risk that there will be insufficient capacity to drive the programme after the reorganisation and a loss of focus during the reorganisation. Relationships that support this sort of programme are likely to be disrupted as well. Clear and agreed plans at Place and SEL will help to mitigate this risk. Restructuring plans will take account of the need to implement a neighbourhood model of service delivery.

5.2. Aligned to the risk above is capacity within non-NHS partners, all of whom also have significant challenges to manage.

5.3. Financial constraint is a feature across all partners which limits the ability to identify pump priming to support implementation of neighbourhoods. Implementation of the neighbourhoods is recognised within the SEL ICS system sustainability programme and in particular, work with the three target population groups, which potentially provides a source of funding to support the development of INTs.

5.4. Finally, there is a risk that SEL plans may not fully align with the 10-year plan when it is released. This is not felt to be a significant risk at this time.

6. Conclusion

6.1. SEL This complex programme represents a fundamental change in the way services are planned and delivered. Whilst the starting point for each Place is different, good progress is being made with implementation of the neighbourhood programme across all six Places and SEL wide enabler function plans are being developed to support this programme.

6.2. Future updates to the ICB Board will include a focus on enabler functions, an assessment of the impact of organisational change and any changes required in light of the 10-year plan.

ONE BROMLEY

WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Neighbourhood profile

Our Integrated Neighbourhood Teams

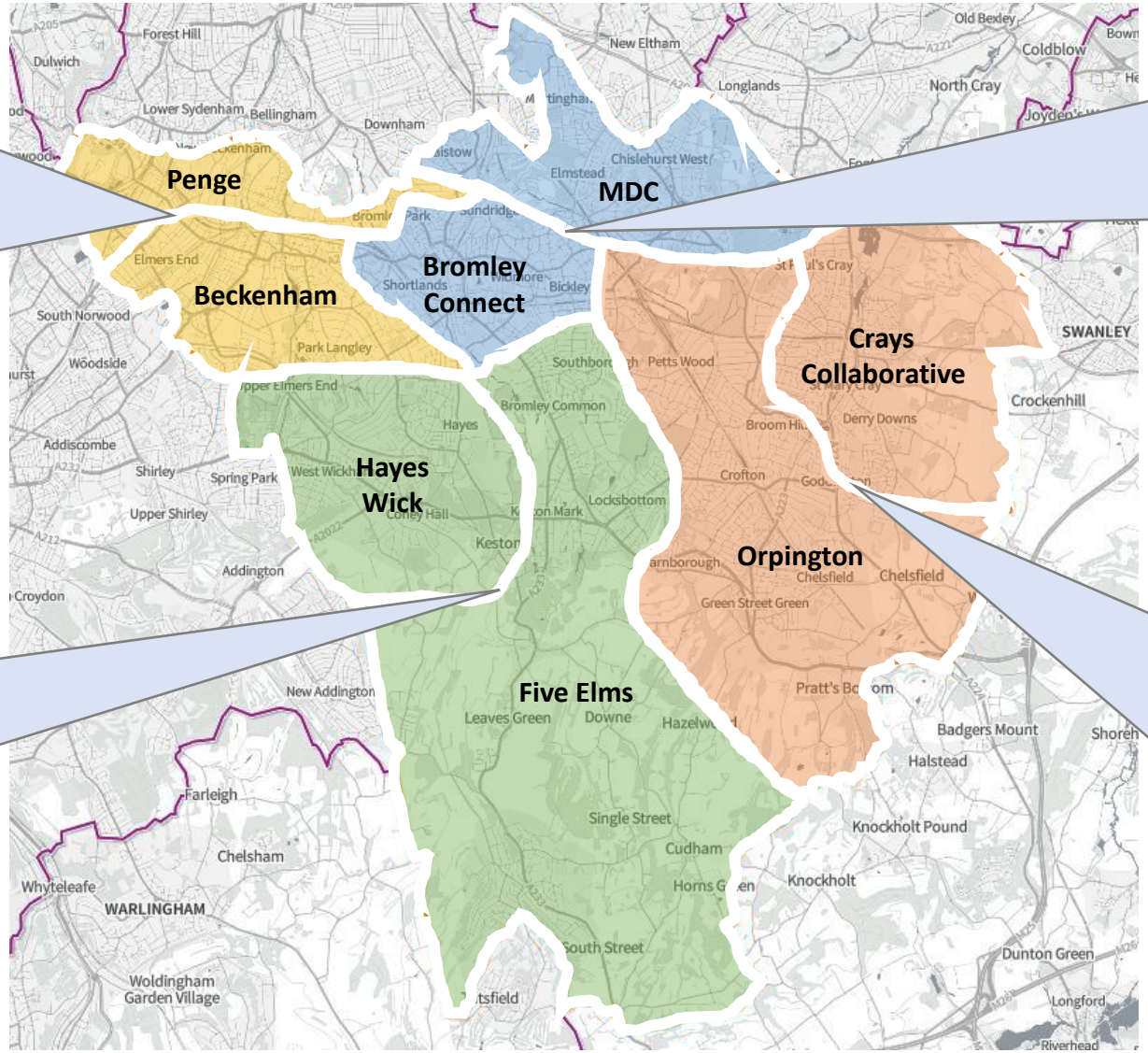
ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

North West

- Population size: 100k (91k weighted)
- Mixed demographics, pockets of deprivation (Penge 12.8% in Core20) and associated care and health challenges
- Key topics north: unemployment, ethnic minorities, learning disabilities, cardiovascular disease
- Key topics south: Depression, serious mental illness, high use of urgent care
- Majority of INT within 30 minutes by public transport

South West

- Population size: 84k (78k weighted)
- Broadly similar demographics with pockets of deprivation and greater commonality of health challenges
- Key topics: long term conditions, depression and dementia
- Majority of INT within 60 minutes by public transport



North East

- Population size: 77k (71k weighted)
- Mixed demographics and associated care and health challenges, with areas of deprivation (MDC 15% in Core20)
- Key topics west: Eastern European population
- Key topics east: unemployment, educational attainment, depression, serious mental illness, screening and immunisation
- Majority of INT within 45 minutes by public transport

South East

- Population size: 99k (98k weighted)
- Highly mixed demographics and associated care and health challenges with significant areas of deprivation
- Key topics west: loneliness, older population, multiple long term conditions
- Key topics east: 31% in Core20, unemployment, travelling community, depression, serious mental illness, screening, immunisation, use of urgent care
- Majority of INT within 45 minutes by public transport

North West INT

Example neighbourhood profile

Demographics

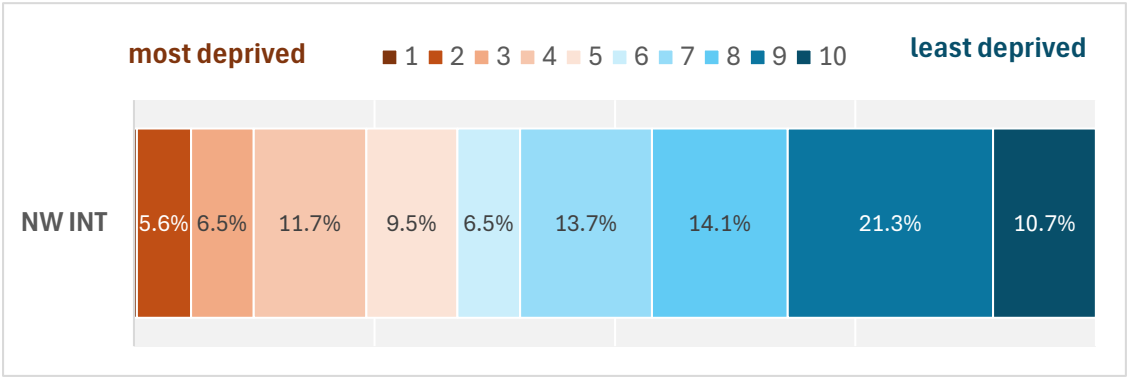
North West INT has a population of 100,000, with 1 in 5 people under 18.

1 in 7 are older adults, with just under 4,000 people aged 80 and over.

About a third of the population have a non-white ethnicity, and 6% live in the most deprived 20% (Core20 population)

Data source and notes: PCN profiles, and Shape Atlas for population projections

	Number	%
INT population size	100,060	
GP registered population under 18	21,190	21.2%
GP registered population aged over 65	14,347	14.3%
GP registered population aged over 80	3,713	3.7%
GP registered population with non-white ethnicity	37,272	37.2%
GP registered population in bottom 20% deprivation	5,920	5.9%



Age – older and younger

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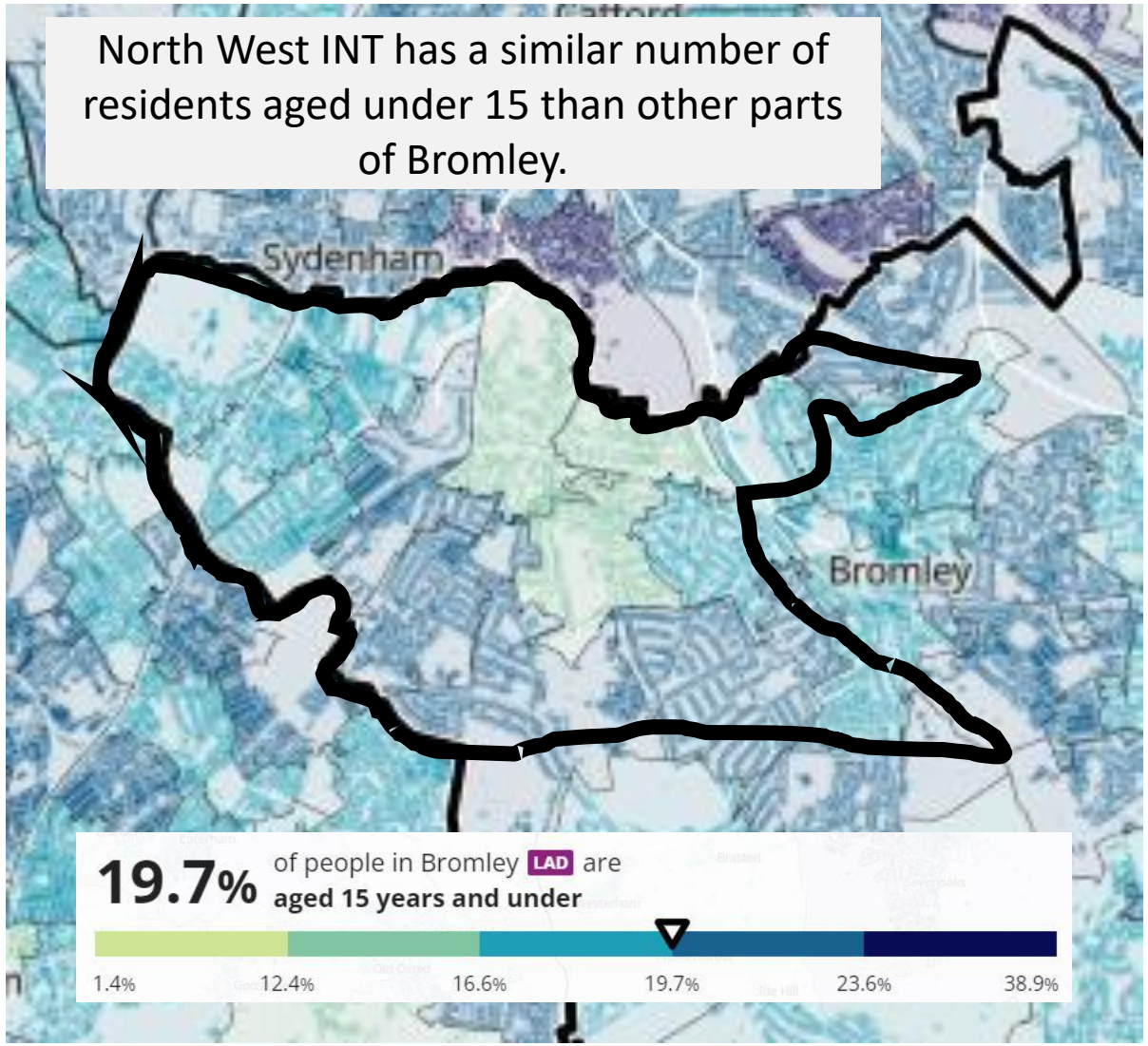
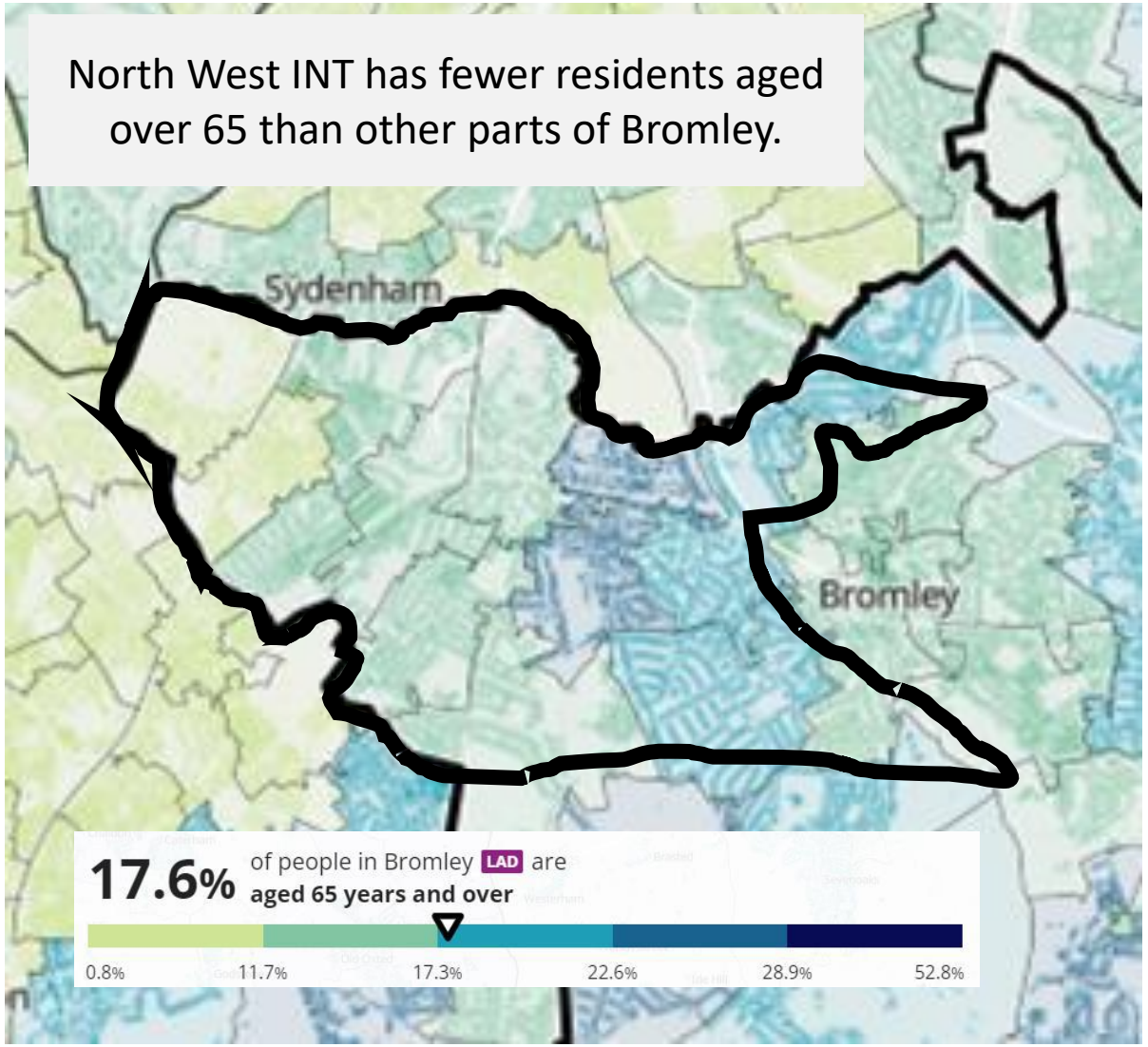
North West INT has a similar number of residents aged under 15 than other parts of Bromley.



North West INT has fewer residents aged over 65 than other parts of Bromley.



Age - Census Maps, ONS

Ethnic diversity map

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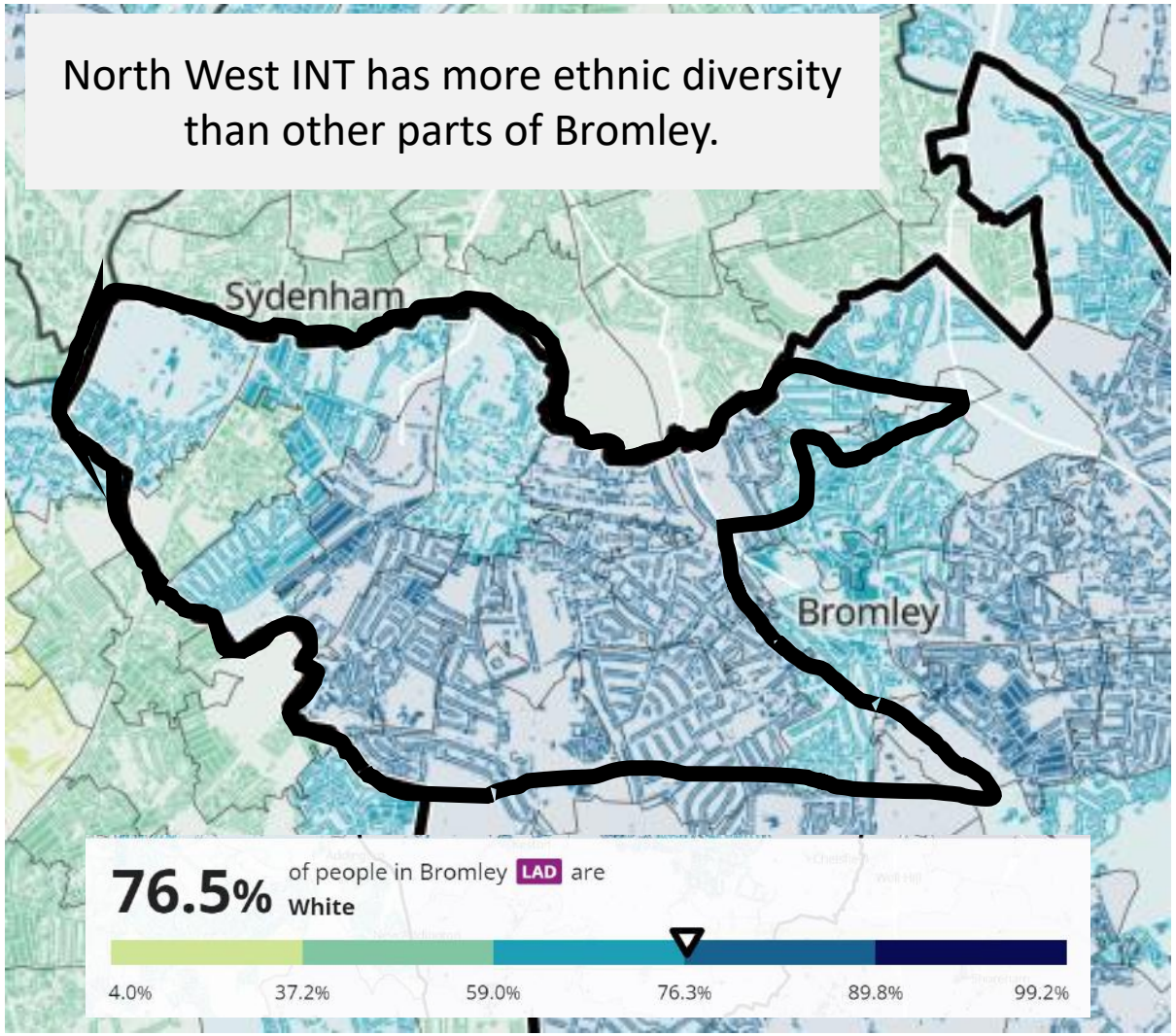
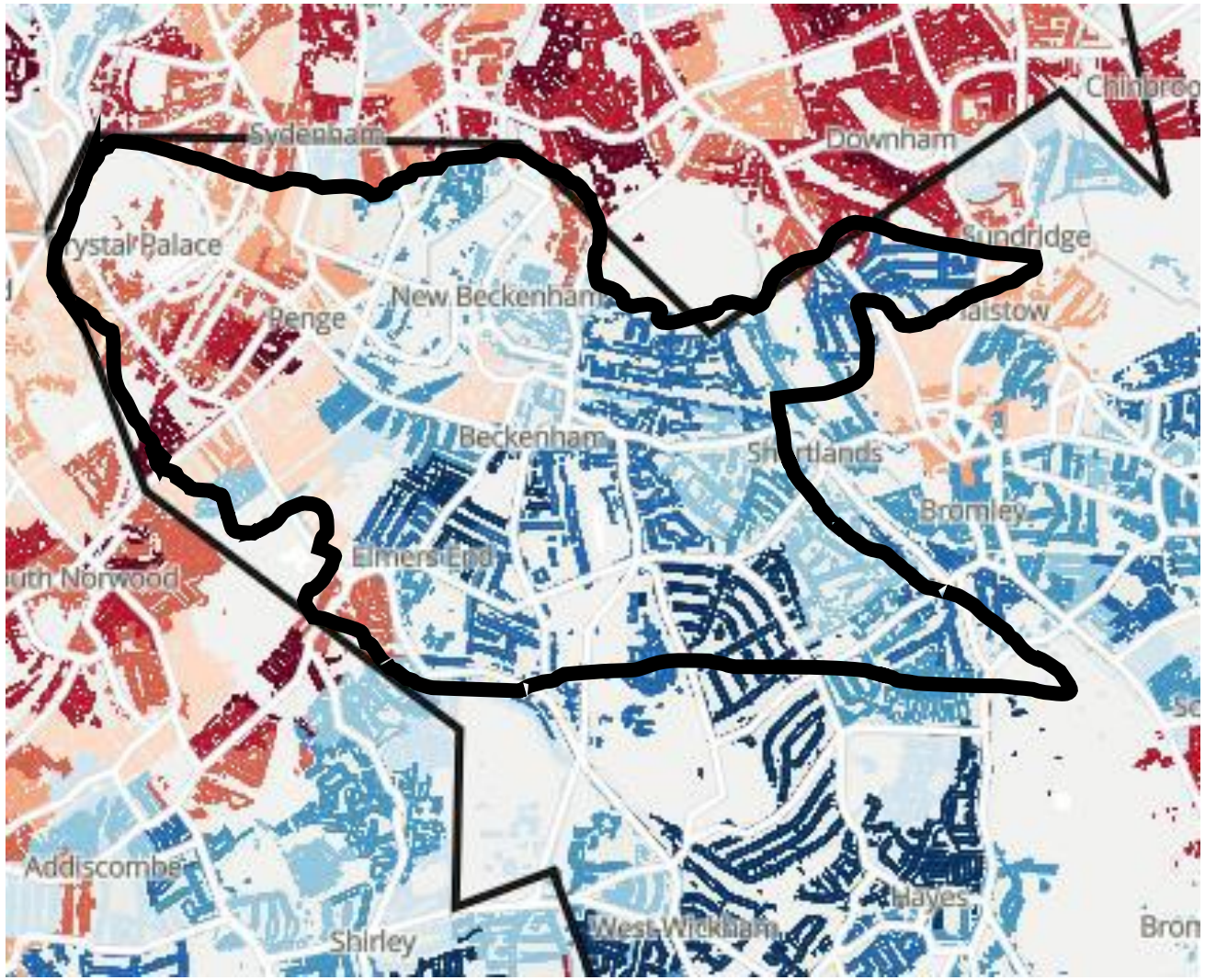
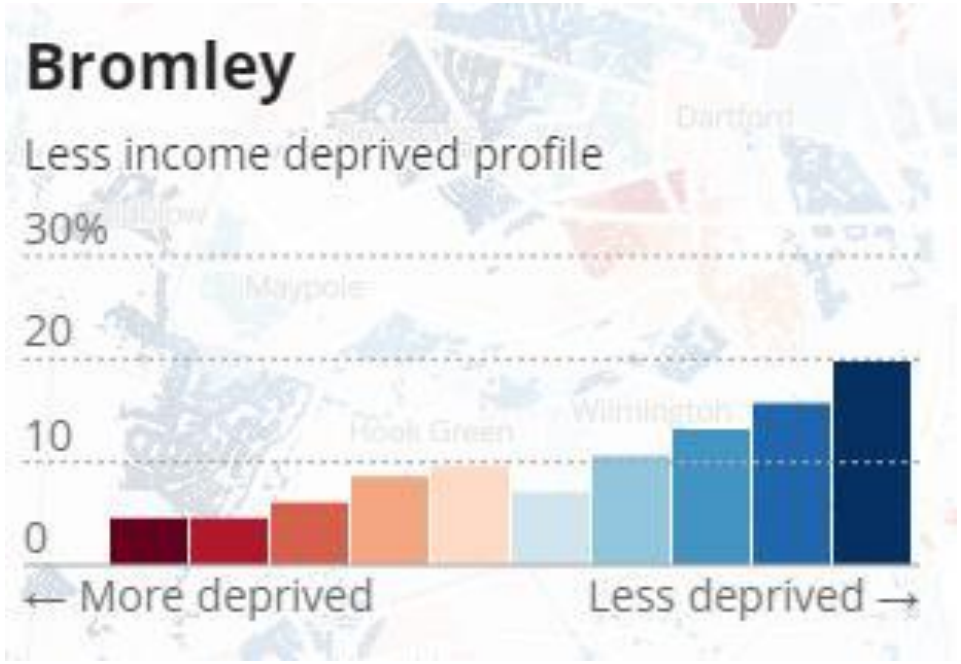


Age - Census Maps, ONS

Deprivation map



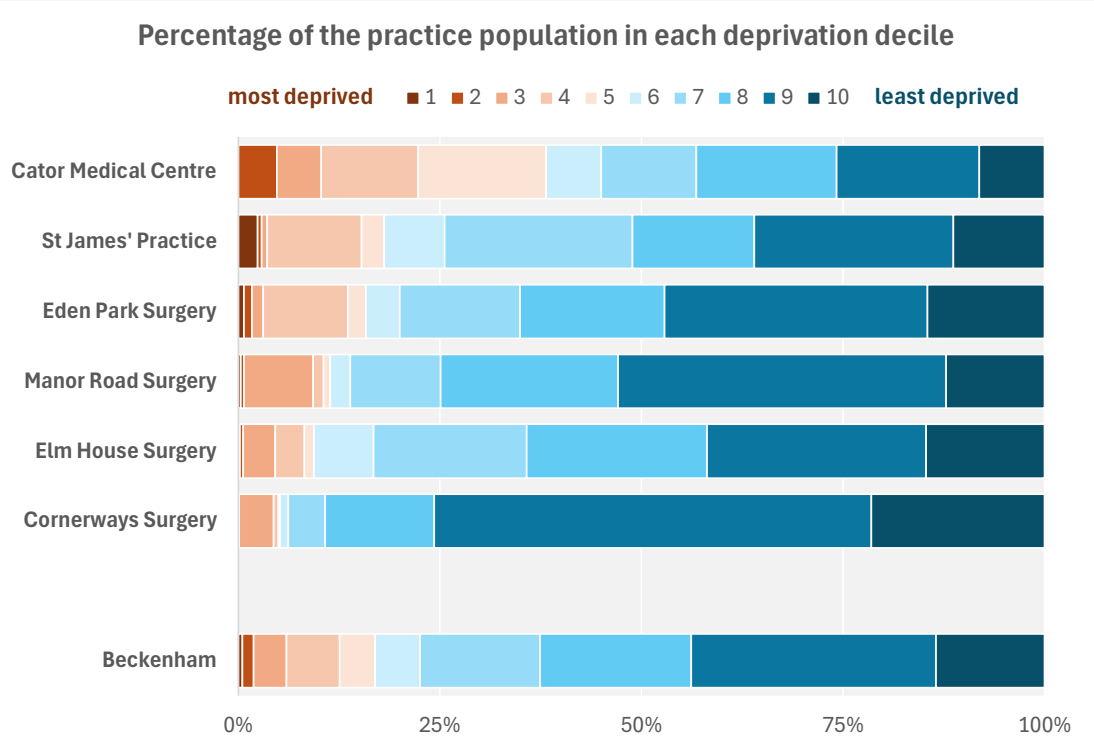
There are higher levels of deprivation in the west of North West INT than the east.

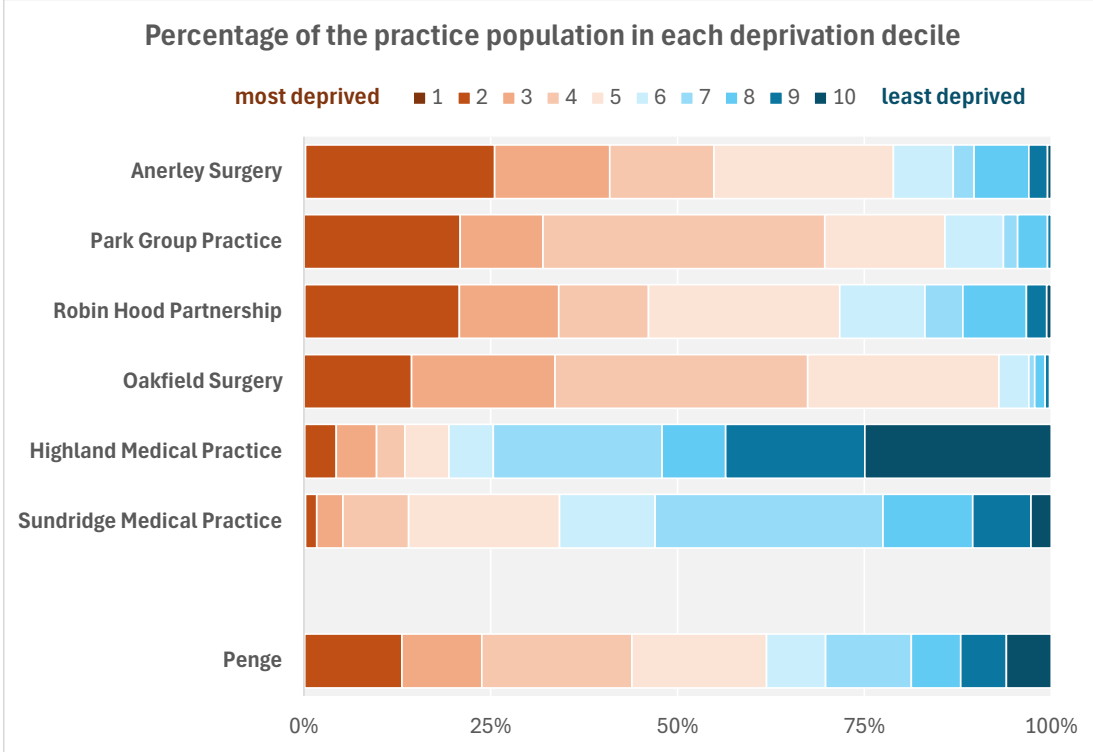


[Exploring local income deprivation (ons.gov.uk)]

Deprivation

The north of the INT (Penge PCN) generally has higher levels of deprivation than the south. There is wide variation at practice level: St James' Practice has 2.4% of its patients living in the bottom 10%, whilst 25% of patients at Highland Medical Practice are in the top 10%.





Data source and notes: PCN profiles

GPs

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There are 12 GP practices in North West INT – 6 in Beckenham PCN and 6 in Penge PCN. The practices range from having just over 2,500 registered patients to almost 20,000 registered patients. All are CQC rated good.

Manor Road Surgery:
- 6,203 registered patients

Eden Park Surgery:
- 8,571 registered patients

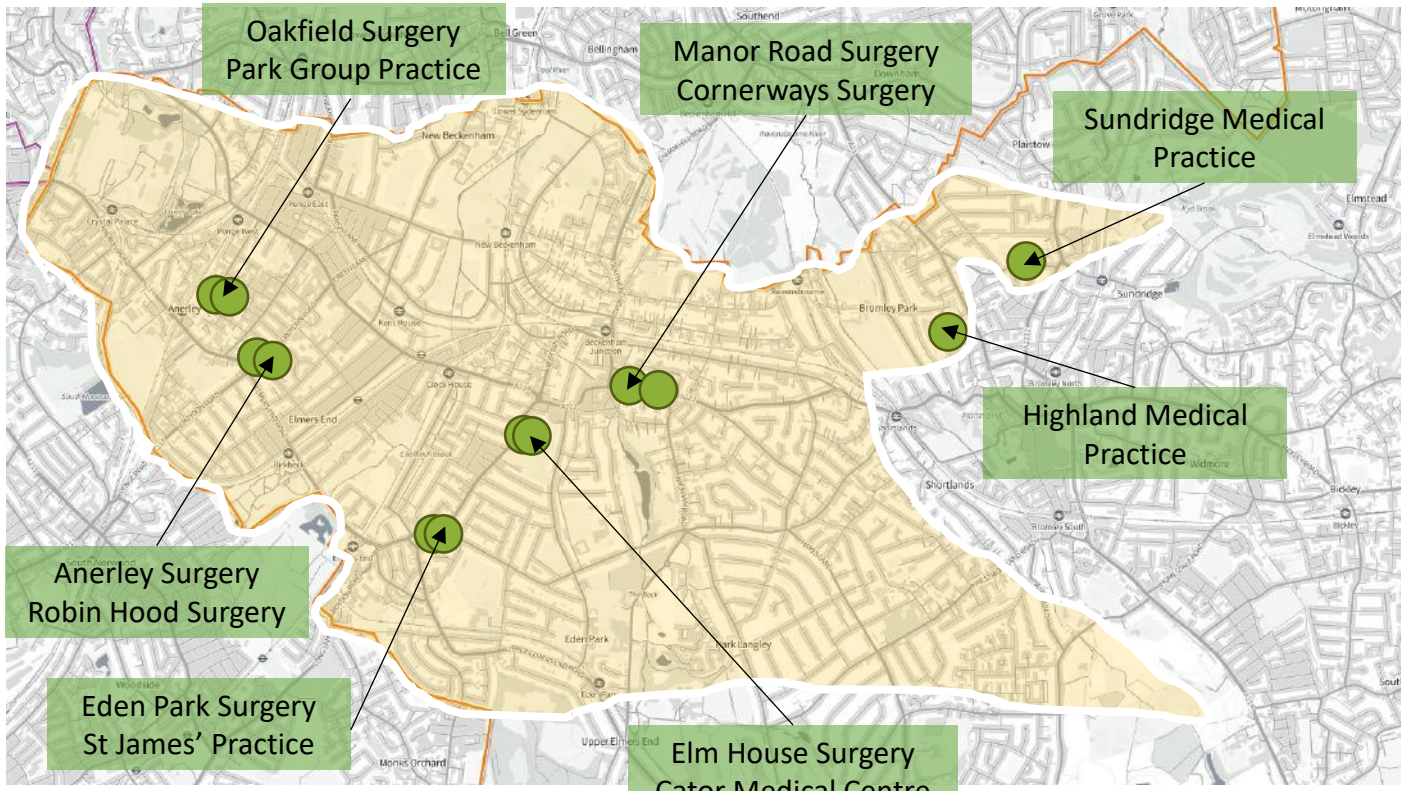
St James' Practice:
- 6,970 registered patients

Cornerways Surgery:
- 7,814 registered patients

Elm House Surgery:
- 19,855 registered patients

Cator Medical Centre:
- 12,823 registered patients

Beckenham PCN



Data source and notes: Shape Atlas

Oakfield Surgery:
- 7,280 registered patients

Park Group Practice:
- 8,798 registered patients

Anerley Surgery:
- 2,642 registered patients

Robin Hood Surgery:
- 3,962 registered patients

Sundridge Medical Practice:
- 6,327 registered patients

Highland Medical Practice:
- 8,008 registered patients

Penge PCN

Workforce – additional roles

ARRS (as at June 2024)	**Beckenham**	**Penge**
Advanced Clinical Practitioner Nurse	2	0
Advanced Pharmacist Practitioner	1	0
Advanced Physiotherapist Practitioner	1	0
Care coordinator	5	3
Clinical pharmacist	8	4
Dietician	1	1
Digital & transformation lead	2	1
First contact physiotherapist	4	2
General Practice Assistant	0	1
Mental Health Practitioner (band 7)	1	2
Nursing Associate	0	1
Pharmacy technician	2	0
Physician associate	1	0
Podiatrist	1	2
Social prescribing link worker	2	2
Total headcount	31	19
Total FTE	21.65	14.13

Data source and notes: SEL PCN workforce & Financial Dashboard

MHPs (via Oxleas)

Beckenham PCN: 1 x MHP

- Jenny Ly

Penge PCN: 2 x MHP

- Better Immanuel
- Angela Ogbodiegwu

Data source and notes: via Agnes Marossy

Social Prescribers

Beckenham PCN: 1 x social prescriber

- Dionne Hayter (full-time)

Penge PCN: 1 x social prescriber

- Shirley Ballin (part-time)

Data source and notes: via Sarah McCombie-Brown

Care homes

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There are a wide range of care homes across North West INT. There are 417 nursing home beds, primarily in the east of the INT. There are 47 beds for residents with mental health or learning disabilities, including High View Care Services which cares for residents with brain injuries.

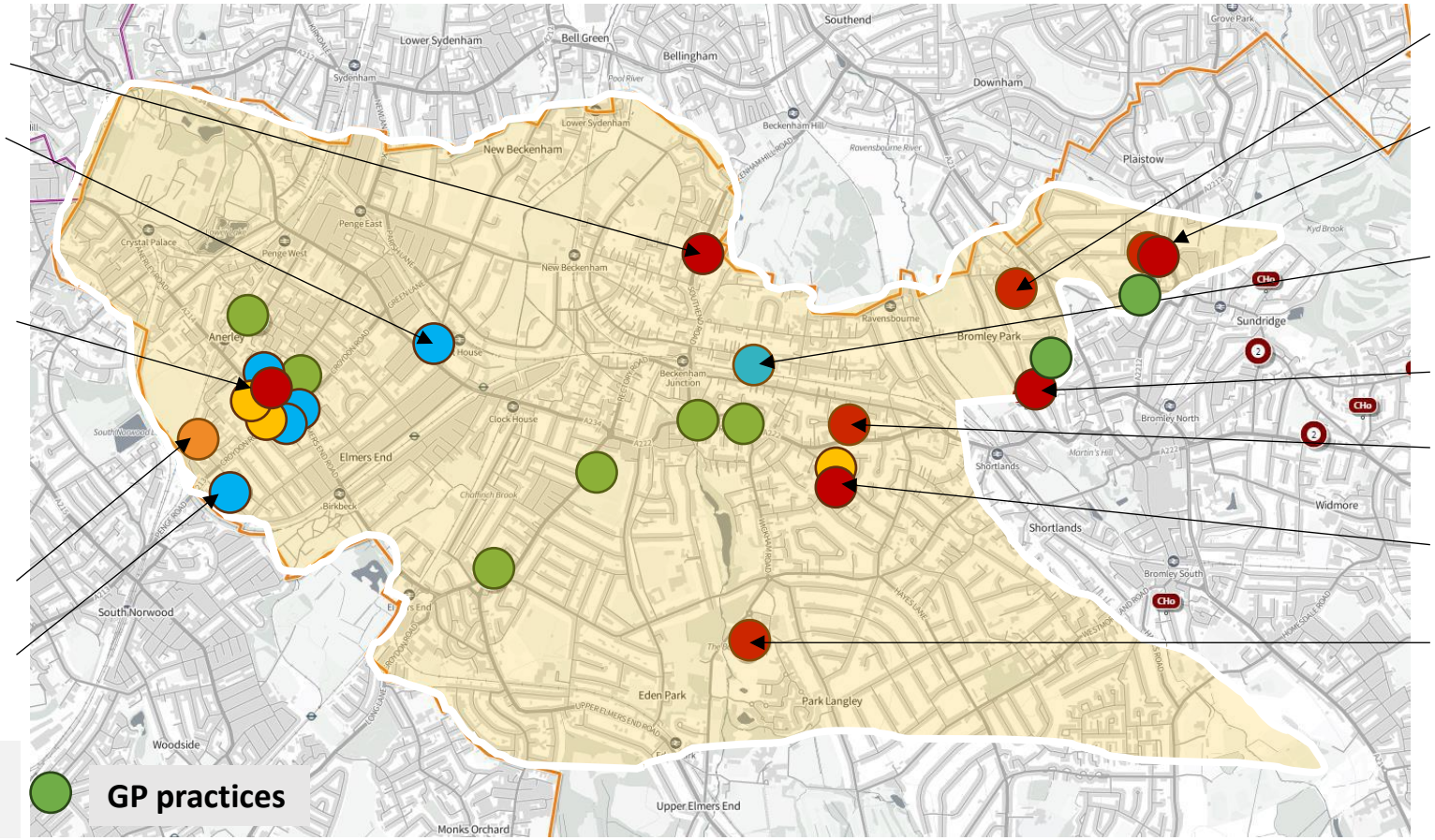
The Sloane Nursing Home: (36 beds)

Angelina Care: (12 beds)

78 Croydon Road: (7 beds)
Oatleigh Care Ltd: (42 beds)
Homelands: (14 beds)
Oatlands Care Ltd: (43 beds)
Maple House: (5 beds)
High View Care Services Ltd: (11 beds)

Burrows House: (54 beds)

19 Wheathill Road: (5 beds)



Greenhill: (64 beds)

Park Avenue Care Home: (51 beds)
Florence Nursing Home: (30 beds)

33 Albemarle Road: (7 beds)

Blyth House: (16 beds)

Bromley Park Dementia: (50 beds)

Oak Lodge Care Home: (22 beds)
Jansondean Care Home: (28 beds)

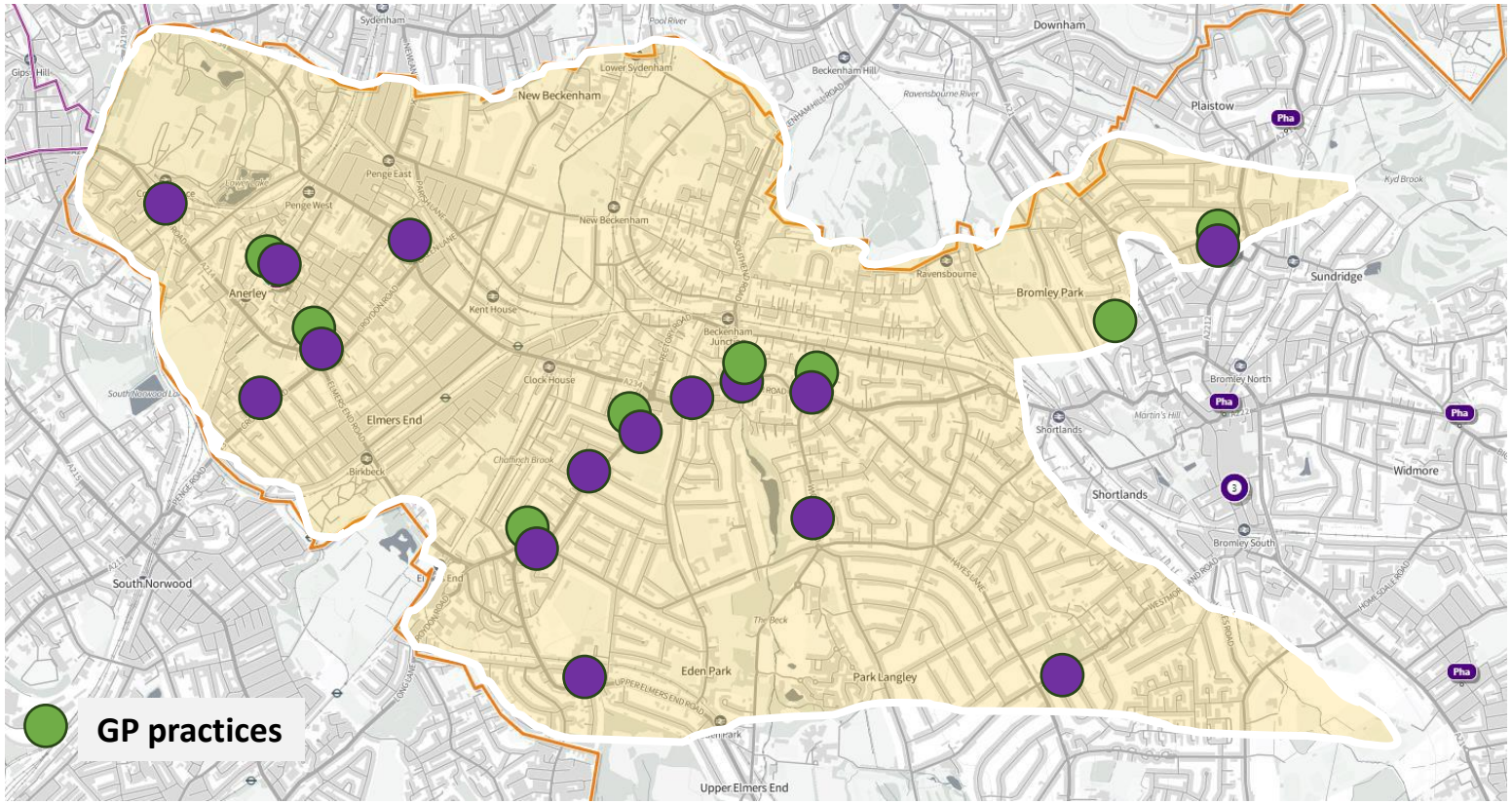
Beckenham Park Care Home: (100 beds)

Nursing **Mixed**
Residential **MH/LD**

Data source and notes: Shape Atlas plus care homes data from Sara Quirke

Pharmacies

There are 18 pharmacies in North West INT, all of which offer Pharmacy First services and the majority of which also offer blood pressure check services.



Data source and notes: Shape Atlas, NHS Service Finder, NHS pharmacy information

Green space

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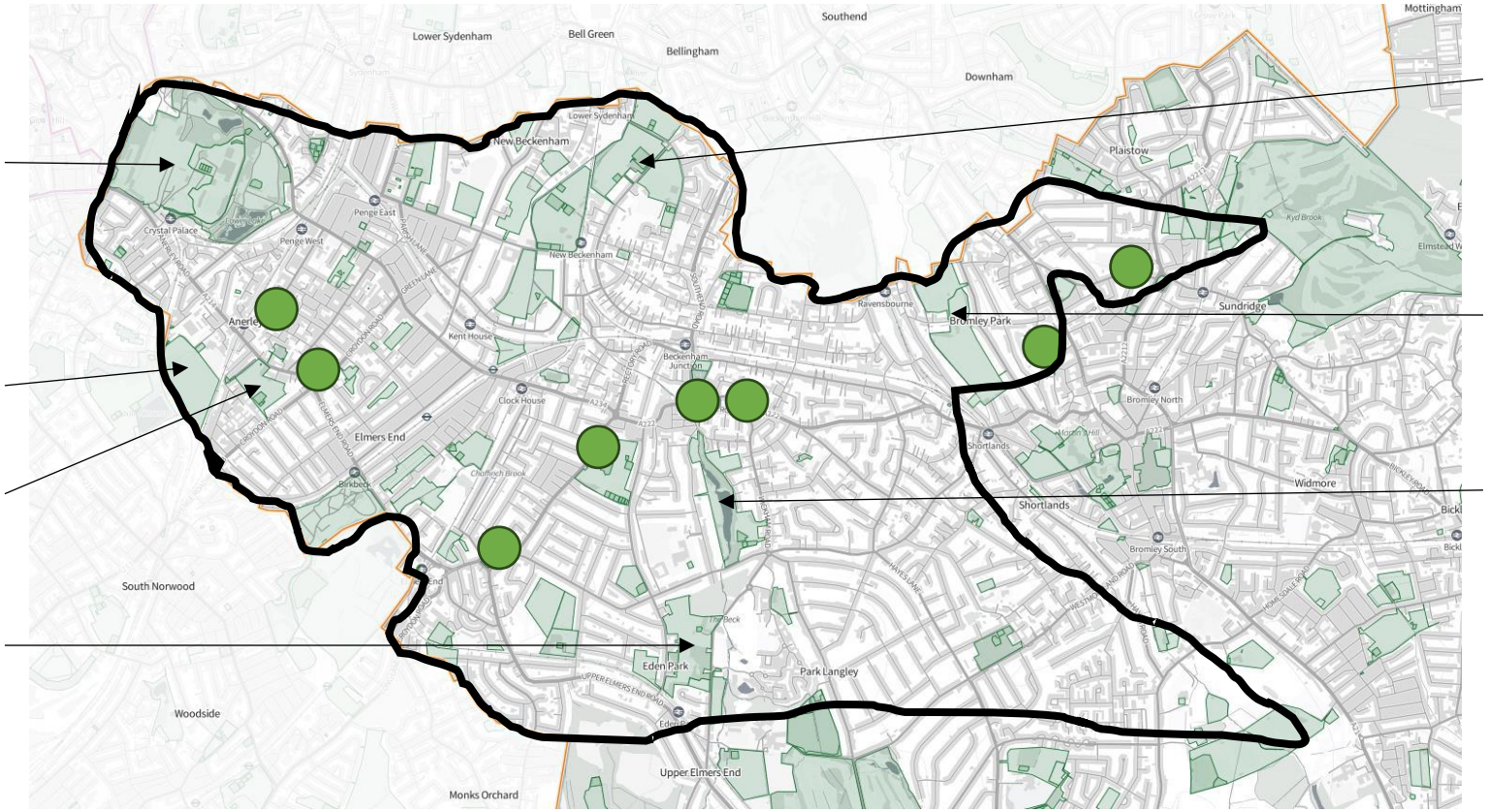
North West INT includes some large areas of green space and a number of sports grounds, including Crystal Palace Park and the National Sports Centre.

Crystal Palace Park & National Sports Centre

Orchard School Sports Centre

Betts Park Outdoor Gym

Harvington Sports Ground



HSBC sports ground
RBS sports ground
Kent CCC

Golf Course

Kelsey Park

Data source and notes: Shape Atlas

Supermarkets

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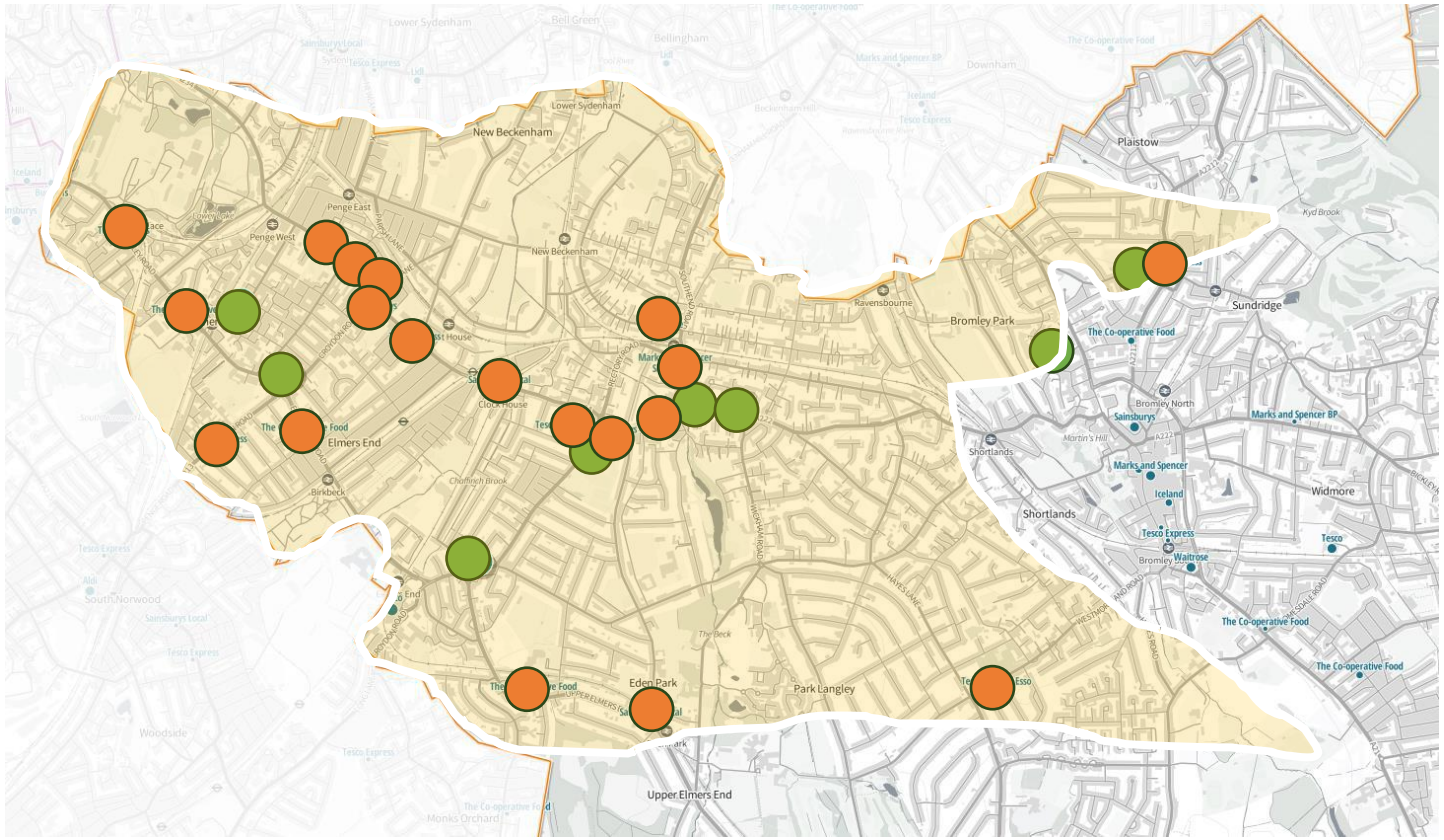
The supermarkets in North West INT are concentrated around Penge and Beckenham high streets.



Data source and notes: Shape Atlas

Libraries & Sports Clubs

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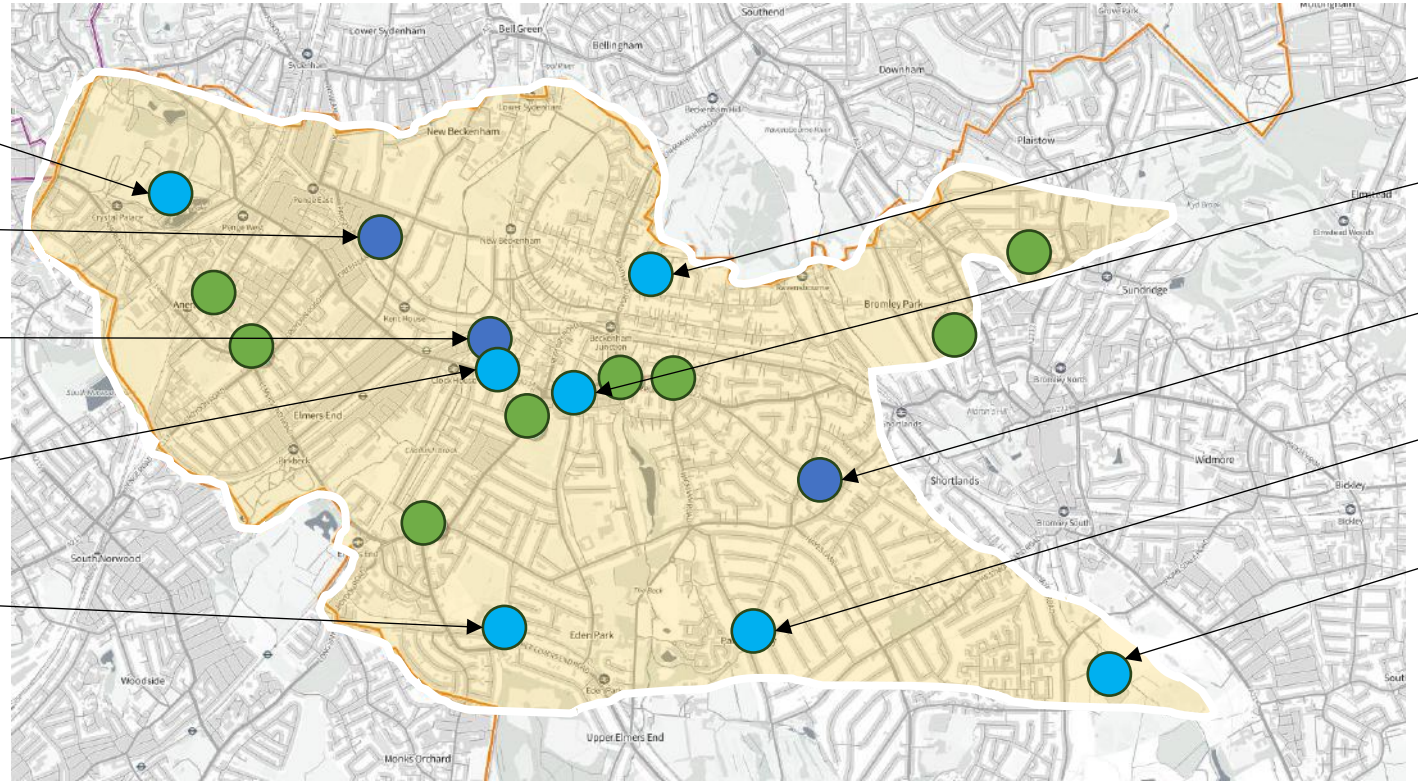
There are 3 libraries in North West INT as well as 7 large gyms or sports centres.



Data source and notes: Shape Atlas

Food banks & Children's Centres

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There are 2 children's centres and 4 food banks in North West INT, primarily in the north-west of the INT in the Penge area.

Living Well food bank

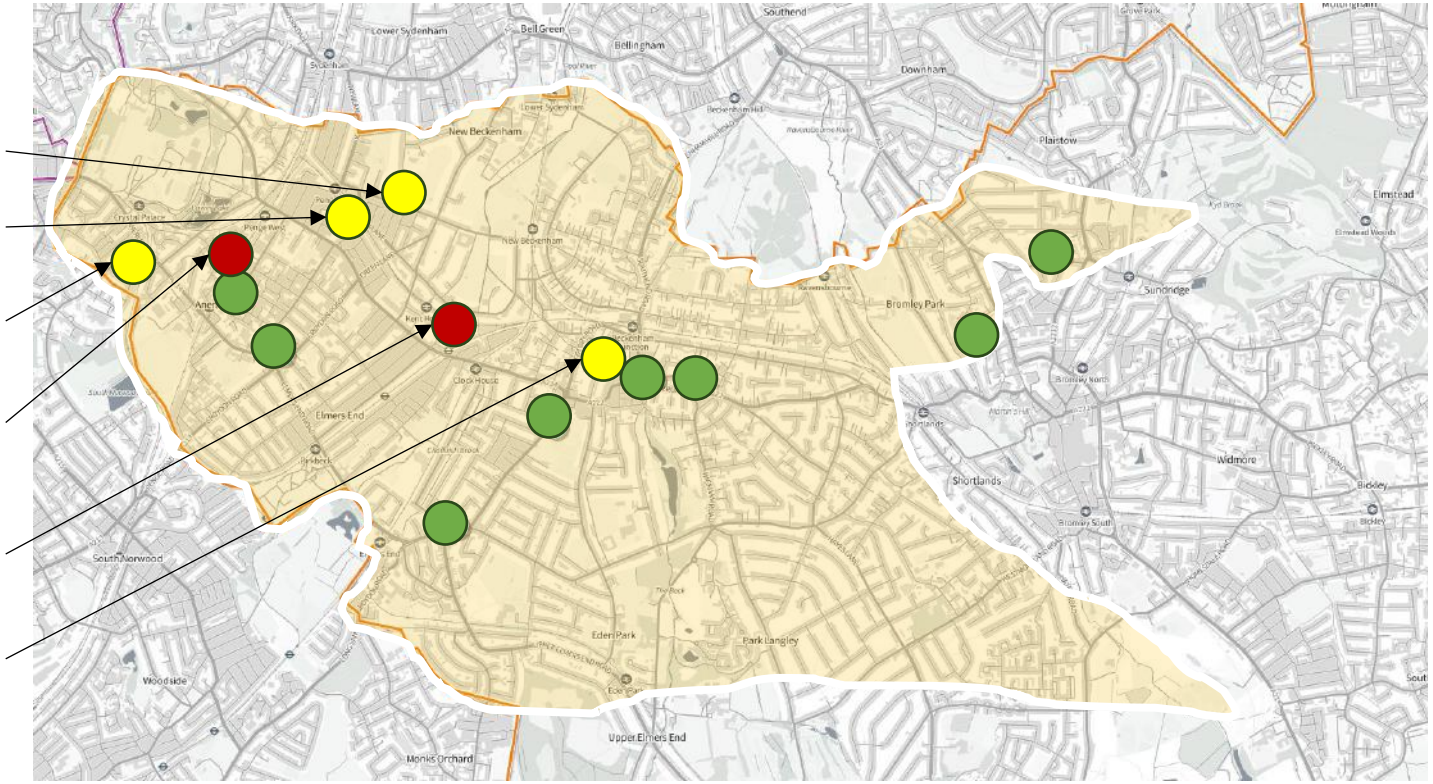
Bromley Borough food bank

Crystal Palace Community Trust

Community Vision Children & Family Centre

Royston Children & Family Centre

Food+ food bank



Data source and notes: Shape Atlas

NHS health checks

The latest NHS health check data at practice level is for 2022/23.

In 2022/23 5 practices were above the Bromley average and 7 were below.

2 practices delivered health checks to over half their eligible population, and in 2 practices it was less than 1 in 50 patients.

Data source and notes: PCN profiles

	% eligible population who received an NHS health check 2022/23
Sundridge Medical Practice	56.9%
Manor Road Surgery	50.4%
Eden Park Surgery	37.5%
Robin Hood Partnership	35.0%
Anerley Surgery	31.0%
Penge PCN	**26.2%** ↑
Bromley	**22.1%**
Oakfield Surgery	21.1% ↓
Beckenham PCN	**18.0%**
Park Group Practice	15.3%
Cator Medical Centre	12.2%
Elm House Surgery	12.2%
Highland Medical Practice	10.3%
Cornerways Surgery	2.0%
St James' Practice	1.5%

Simply Connect Bromley

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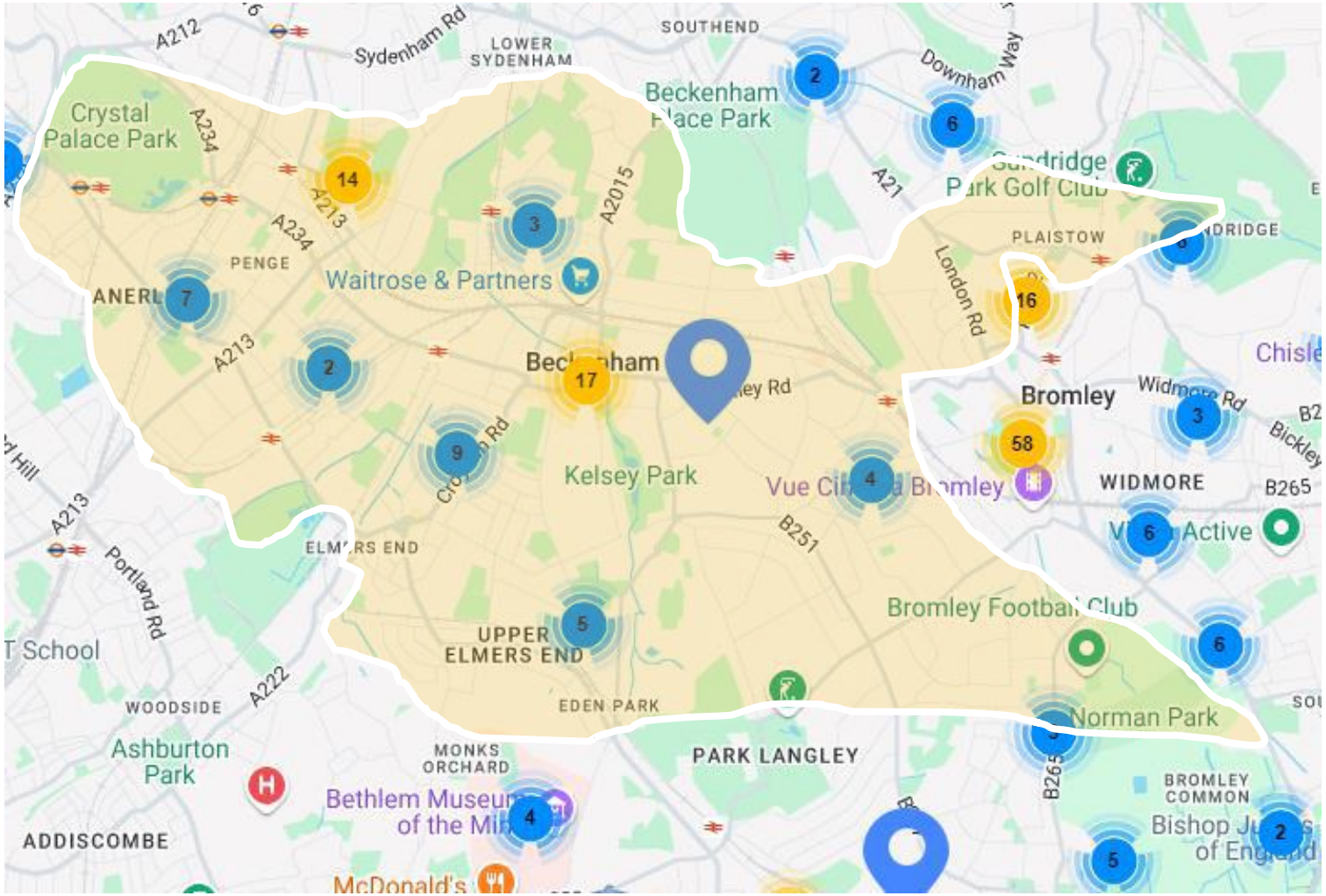
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Simply Connect Bromley lists a wide range of face-to-face community activities in the North West INT area.



Data source and notes: Simply Connect Bromley - connecting you to your local community

LTCs

In the latest QOF only 1 practice in North West INT had a higher proportion of patients with 5+ LTCs than the Bromley average.

3 of the 5 most common LTCs were the same for all practices: hypertension, diabetes and obesity.

	Patients with 5+ LTCs, per 1,000 population
Robin Hood Partnership	30.72 ↑
Bromley	**30.05**
Cornerways Surgery	29.69 ↓
St James' Practice	26.57
Park Group Practice	24.70
Anerley Surgery	24.03
Cator Medical Centre	23.30
Beckenham PCN	**22.89**
Eden Park Surgery	22.51
Elm House Surgery	22.24
Penge PCN	**19.76**
Sundridge Medical Practice	19.34
Highland Medical Practice	15.14
Oakfield Surgery	11.91
Manor Road Surgery	11.87

Data source and notes: SEL Comorbidities QOF dashboard

LTCs

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

	Beckenham PCN						Penge PCN					
	Cator Medical Centre	Cornerways Surgery	Eden Park Surgery	Elm House Surgery	Manor Road Surgery	St James' Practice	Anerley Surgery	Highland Medical Practice	Oakfield Surgery	Park Group Practice	Robin Hood Partnership	Sundridge Medical Practice
1	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension	Hyper-tension
2	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes
3	Obesity	Chronic Kidney Disease	Obesity	Obesity	Obesity	Chronic Kidney Disease	Obesity	Obesity	Obesity	Obesity	Obesity	Obesity
4	Depress-ion	Obesity	Coronary Heart Disease	Depress-ion	Chronic Kidney Disease	Obesity	Chronic Kidney Disease	Chronic Kidney Disease	Depress-ion	Depress-ion	Chronic Kidney Disease	Chronic Kidney Disease
5	Coronary Heart Disease	Non-Diabetic Hyperglycaemia	Depress-ion	Coronary Heart Disease	Coronary Heart Disease	Atrial Fibrillation	Asthma	Coronary Heart Disease	Cancer	Asthma	Coronary Heart Disease	Coronary Heart Disease

Data source and notes: SEL Comorbidities QOF dashboard

Universal Care Plans

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The majority of GP practices in North West INT have a lower proportion of their patients with an active UCP than the Bromley average.

In 2023/24 3 practices didn't create any UCPs, and a further 5 created 5 or less.

	% GP registered population with an active UCP (as at 2 Dec 24)		No. GP registered population with an active UCP (as at 2 Dec 24)	No. UCPs created 2023/24	No. deaths with a UCP 2023/24
St James's Practice	0.9%		66	29	33
Eden Park Surgery	0.8%	↑	67	26	18
Bromley GPs	**0.8%**		**2,832**	**403**	**1,018**
Cator Medical Centre	0.6%	↓	69	23	7
Anerley Surgery	0.6%		15	3	7
Beckenham PCN	**0.6%**		**367**	**119**	**121**
Robin Hood Partnership	0.5%		19	0	3
Sundridge Medical Practice	0.5%		34	0	24
Cornerways Surgery	0.5%		41	5	23
Elm House Surgery	0.5%		109	34	32
Highland Medical Practice	0.4%		33	0	12
Penge PCN	**0.4%**		**151**	**5**	**62**
Oakfield Surgery	0.3%		24	1	3
Park Group Practice	0.3%		26	1	13
Manor Road Surgery	0.2%		15	2	8

Data source and notes: UCP dashboard

South East London Integrated Care System

NHS South East London

ICB Board Meeting in Public

Title	**Winter Vaccinations Performance and Approach**					
Meeting date	16 April 2025	Agenda item Number	**12**	Paper Enclosure Ref	**L**	
Author	Sam Hepplewhite, Director of Prevention and Partnerships					
Executive lead	Angela Bhan, Place Executive Lead Bromley					
Paper is for:	Update	**x**	Discussion	**x**	Decision	
Purpose of paper	The purpose of this paper is to provide the board with an overview of the approach taken by South East London ICS to engage and deliver the winter vaccination programme.					

Summary of main points	• This report covers the winter vaccination programme which includes influenza, RSV and covid vaccination delivery and outcomes during 24/25.
	• This paper provides the board with further information on:
	  ○ Overall performance broken down into different population groups
	  ○ A summary of the work that has been done at both borough and system level to reach the population of SEL
	  ○ Examples of specific initiatives that have been undertaken by services
	  ○ Key insights from various engagement events that continue to shape the approach taken to planning and delivery
	  ○ A summary of the communication plan approach and evaluation outcomes.
	• Despite all local and system efforts the uptake of the influenza vaccination is not increasing overall, though the number of pregnant people and over 65 year olds has increased this year compared with 23/24.
	• The uptake across SEL for the covid 19 vaccination has reduced this year across all eligible groups.					

Potential conflicts of Interest	None identified.					
Relevant to these boroughs	Bexley	**X**	Bromley	**X**	Lewisham	**X**
	Greenwich	**X**	Lambeth	**X**	Southwark	**X**
Equalities Impact	The winter vaccination programme was undertaken with a population health approach to ensure that inequalities in access, outcomes and experience was considered. The pack provides information on the uptake across different population groups.					
Financial Impact	This report is for information and does not require any additional financial resources.					
Public Patient Engagement	The report does provide a summary of the insights that have been captured and the engagement that has been completed during the winter period.					

Committee engagement	The South East London Vaccination and Immunisation Board is planning a learning session in April 2025 to inform the planning of the 25/26 winter campaign.
Recommendation	The Board is asked to note the contents of the report and the outcomes of the winter vaccination programme.

South East London Integrated Care System

NHS South East London

Winter vaccination programme 24/25

Sam Hepplewhite and Angela Bhan

WINTER VACCINATION PROGRAMMES

1. Background, strategy and organisation of the programmes

2. Range of vaccinations covered and uptake in Autumn/Winter 24/25

3. Winter vaccination approaches

4. Appendix showing data

Background (1 of 2)

- Vaccination is a high priority for SEL ICS, the NHS and Public Health partners to protect the population from serious vaccine preventable diseases and to support the NHS and adult social care capacity and resilience.
- All national vaccination programmes are currently commissioned by NHS England. Integrated Care Boards (ICBs) support the delivery of these programmes and have a key role in addressing inequalities in immunisation coverage and improve overall uptake to protect the local population from vaccine preventable diseases.
- The SEL Immunisation and Vaccination Service (IVS) is delivered through GSTT. It provides leadership, coordinating capacity and support for local delivery
- The ICB and the SEL IVS works in partnership with NHS organisations and Public Health teams within our 6 Local Authorities, voluntary sector organisations including grass roots organisations and NHS England to improve uptake in all vaccination programmes and to monitor uptake and address areas of low engagement to improve overall vaccinations levels. The ICB focuses on improving effective communication for the vaccination programme, community engagement and working with providers of vaccination services to deliver evidence-based interventions and innovation to improve coverage and reduce inequalities in uptake.

Background (2 of 2)

- From April 2026, the commissioning of routine NHS vaccination programmes will be delegated from NHS England to the ICBs. The ICB is working with NHS England to prepare for this additional commissioning responsibility It is proposed that NHS England will provide oversight and assurance of the delegated vaccination commissioning, but these changes will enable ICBs to review services and pathways to better meet the local priorities, integrate services more effectively and improve health outcomes for our local populations.
- The ICB currently supports delivery of all routine NHS vaccination programmes however there is a particular focus during the winter period on seasonal influenza, COVID-19 vaccinations and Respiratory Syncytial Virus (RSV)
- A key function in the successful delivery of vaccination programmes is to ensure that people receive high quality information on vaccinations from trusted individuals/organisations and to provide accessible and convenient availability of vaccinations.
- A new Respiratory Syncytial Virus (RSV) programme for protection of older adults and pregnant women was introduced in September 2024. Whilst not a specific winter vaccination programme, it is included in the winter programmes and is designed to protect against viruses that are more common in autumn, winter and early spring
- The majority of covid vaccinations are now given within a community pharmacy setting.
- GPs continue to provide the majority of flu vaccinations (54%).

Overview of programmes

- This report covers the winter vaccination programme which includes influenza, RSV and covid vaccination delivery and outcomes during 24/25.
- A little reminder of cohorts for the various programmes

Influenza vaccination cohort:
- **2 to 3 years of age on the 31 August 2024**
- **4 to 16 years of age on the 31 August 2024**
- **65 years of age and over on the 31 March 2025**
- **Clinical risk groups including pregnant women**

Campaign 3/10/24 – 31/3/25

Covid vaccination cohort:
- **Residents in older adults care homes**
- **All adults aged 65 years and over**
- **Clinical risk groups**
- **Front-line health and care staff**

Campaign 3/10/24 – 20/12/25

Respiratory Syncytial Virus cohort:
- **All adults aged 75 to 79 years of age**
- **People who are more than 28 weeks pregnant**

Commenced September 2024

Strategic approaches to vaccine programme implementation in SEL

Coordinated programmes with the right communications

Ensure Access and communicate how to get vaccinated

Work with communities – engagement and use of information

Population Health

Overview of performance

Current Performance	vs 2023/24	Further detail
Influenza **43.7%** **65+ 63%** **At risk 29%** **Pregnant 26%** **2-3 year olds 38%**	**44.5%** **65+ 62.6%** **At Risk 37%** **Pregnant 15.5%** **2-3 year olds 36%**	• Uptake of the flu vaccination was slightly below the previous year however the programme does not end until the 31st March 2025 • GP practices provided 53.8% and Community Pharmacy 31.4% of the vaccinations • 53% of the eligible white population in SEL had their flu vaccination but only 20% of black Caribbean residents and 26% of black African residents took up the vaccination • There was an equal take up of the vaccination across male and females • The highest uptake was in the care home population with 73% of residents taking up the offer • 29% of the clinically at risk group were vaccinated and 26% of pregnant people • There was variation across the boroughs both at an overall uptake level and across various cohorts and ethnic groups
Covid 19 **30%** **80+ 53%** **Care Home residents 64%** **At risk 17%** **5-11 at risk 2.2%**	**41%** **80+ 69%** **Care Home Residents 75%** **At Risk 24%** **5-11 at risk 22%**	• Uptake of the covid vaccination was considerably lower than in the Autumn 2023/24 campaign • Community Pharmacy provided over 70% of the covid vaccinations during the Autumn/winter campaign with PCNs providing 22.4% • 44% of the eligible white population in SEL had their covid vaccination but only 9% of black Caribbean residents and 10% of black African residents took up the vaccination offer • The highest uptake was in the care home population with 64% of residents taking up the offer and 53% of the over 80 year olds • Less than 4% of children who were clinically at risk were vaccinated • There was variation across the boroughs both at an overall uptake level and across various cohorts and ethnic groups

RSV
50.2%
10th March 2025
	N/A	• In September 2024 two new respiratory syncytial virus (RVS) vaccination programmes were introduced
		  • A programme for older adults aged 75 to 79 years old – provided by general practice
		  • A programme for pregnant women to protect infants – available to women who are at least 28 weeks pregnant – provided by maternity services
		• Significant local and national communication campaigns were undertaken
		• Uptake at borough level – Bromley 57%, Greenwich 56%, Bexley 56%, Lewisham 49% and Lambeth and Southwark 48%

Key Headlines – what the data and population tell us (1 of 2)

- Covid vaccinations are offered twice a year and in successive years we have nationally seen a reduction during each campaign of uptake across all cohorts. A well recognized phenomenon of ‘vaccine fatigue’ has been observed nationally.
- People from certain ethnic groups are much less likely to take up vaccination. This is seen repeatedly and has been well documented in detailed analysis of vaccination rates during the early years of covid vaccination.
- The lowest rates of uptake of flu and covid vaccination are in Black or Black British (African and Caribbean) groups and in mixed White and Black African and Caribbean populations.
- Our core 20 plus population has an average uptake of covid vaccinations of 15.6% compared to our least deprived wards where the average uptake is 49.1%
- Certain populations are much less likely to be vaccinated, hence the focus on gaining insights from these groups.
- Despite all local and system efforts the uptake of the influenza vaccination is not increasing overall, though the number of pregnant people and over 65 year olds has increased this year.
- SEL achieved an overall coverage of 43.7% for flu vaccinations in 2024/25. The London average was 37.9%

Key Headlines – what the data and population tell us (2 of 2)

- Despite all local and system efforts the uptake of the influenza vaccination is not increasing overall, though the number of pregnant people and over 65 year olds has increased this year.
- In 24/25 more children aged 2-3 years had their flu vaccination than in the previous two years (22/23 and 23/24)
- SEL achieved an overall coverage of 43.7% for flu vaccinations in 2024/25. The London average was 37.9%
- In 24/25 more children aged 2-3 years had their flu vaccination than in the previous two years (22/23 and 23/24)
- Nationally, in London and in SEL, uptake of vaccination in the under 65s who are at increased risk (because they have an underlying condition) is not as high as we would like. All of these groups have a higher chance of having serious illness, being hospitalized and dying if they contract flu or covid.

Winter Vaccination Approaches 24/25

The South East London Vaccination and Immunisation Board in partnership with the delivery group undertook a robust process to review outcomes and learning from 2023/24 in the development of the Winter Vaccination Plan.

The approach was built on partnership working with local authorities, the voluntary sector and community stakeholders who local groups to helped provide targeted support to the delivery of vaccination programmes.

Examples of activities detailed in this section include:

- Key insights from our residents and community groups which shaped the approach to planning (slide 11)
- A summary of some of the key actions that were taken at a system level including the work on building trust and confidence to partner with five voluntary, community and social enterprise (VCSE) organisations to co-develop ways to enable community-led health creation and reduce health inequalities by supporting the ICS to re-imagine prevention and health creation in a way that is community-led and built on trust. (slide 12)
- Our approach to local communications and engagement where we took a proactive and collaborative approach working with key partners and stakeholders across both statutory of voluntary sector organisations and community groups. (slide 13)
- Examples of where we have worked specifically with groups of the population who are most at risk including the maternity project (slide 14) and outreach activity (slide 15)
- Some of the work that has been carried within the boroughs focusing on specific groups and communities (slides 16 and 17)

Key Insights from our Residents

Through various forums, at neighbourhood, community, borough and across South East London level, valuable insights have been provided by our residents that continue to shape the planning and delivery of our vaccination services. These include:

- Not making the assumption that because it is a priority for the NHS, vaccination is a priority for individuals and families. There are lots of different reasons why people are making decisions regarding their preventive health programmes and some of these decisions are influenced by a much wider context and personal circumstances.
- Services need to be easily accessible, non-judgmental, culturally sensitive, confidential and respectful
- Whenever possible a number of services should be offered from the same place for multi-generations to avoid multiple trips to different locations.
- Time should be given for people to consider their options, with access to evidence based information to inform their decision.
- Services should be provided, whenever possible, by trusted, known and local teams who have a relationship in the local community.
- Services should be co-produced and co-designed with local communities and around local people not the organisations that are providing the services
- Services should be designed, planned and delivered with the most vulnerable and underserved at the core.

Examples of Key System Actions

- We have launched a unique opportunity to partner with five by and for voluntary, community and social enterprise (VCSE) organisations to co-develop ways to enable community-led health creation and reduce health inequalities by supporting the ICS to re-imagine prevention and health creation in a way that is community-led and built on trust. This is a 3-year funded partnership opportunity with organisations that are embedded in and hold a trusted relationship with their community. This ambition is to incorporate health into their existing holistic community-based services and work together to transform health-led prevention. This innovative approach has been led in conjunction with the SEL VCSE Alliance and has been designed and co-led by leads representing the communities that face the biggest health inequalities. The process for partnering has included a webinar hosted in January 2025, which drew over 175 people and created a platform to provide more information about this opportunity and answered queries from interested organisations. As a result, we received 140 applications for the chance to partner and deliver new approaches that specifically serves the following communities/groups: Black, African, and Caribbean adults, LGBTQ+ communities, people with learning disabilities and children and young people (age 0-18). Through a combination of analysis of health-held data and of community/VCSE led insight we have identified 4 successful communities/groups of focus.
- Our Children and young people community immunisation service put on additional clinics, at different times and locations to enable families to easily access the service.
- Dr Richard Parker, Consultant in Emergency Medicine recorded a video to encourage people to have their flu vaccination
- Using our shared data sets across SEL and within boroughs and the valuable insights we have been able to take a targeted approach to allocating resources to those populations with the greatest need.

Outreach Summary and Evaluation

- SEL ICB outreach encompassed a multifaceted approach, deploying roving teams and pop-up clinics and collaborating with stakeholders in underserved communities and healthcare services for opportunistic vaccinations. The communications campaign, aimed at building trust, involved collaborating with healthcare providers for targeted messaging, utilising QR codes for booking access, and engaging community leaders to address concerns.
- SEL targeted specific groups including Core20Plus5 populations, asylum seekers and rough sleepers.
- Outreach activities were generally considered effective in engaging communities and building trust, but there was a strong call for a more holistic approach, focusing on broader health needs rather than solely on vaccination.
- One example of this approach was bringing vaccination services directly to dialysis patients during their routine dialysis appointments. This strategy effectively addressed access challenges for this group and highlights the potential of integrating vaccination services with existing healthcare provision.
- The outreach programme was evaluated and was found to have demonstrated a strong commitment to data-driven planning, community engagement, and collaboration with local partners. The evaluation found that the use of the RAVS system and the targeted communications campaign, which included working with healthcare providers and community leaders, was a notable success. It was felt that the programme had effectively utilised roving teams, pop-up clinics, and existing healthcare channels to deliver vaccines and engage with underserved communities.

Maternity Project Summary

- The SEL Vaccination and Intervention Service worked with maternity units during the winter period to actively reach out to women who were over 20 weeks pregnant to ensure that they were aware of the different vaccinations that were available to them, how and when to get them and if needed any further information to make an informed decision to get vaccinated.
- Weekly meetings were held with the maternity department and the SEL community leads to review outcomes and discuss further opportunities. One of the results of this was the team revising the process & offering a RSV/Pertussis/Covid/Flu clinic at Francis House in conjunction to supporting in the Maternity clinics.
- On average over 100 patients were proactively contacted each week with a 62% successfully contacted of these 42% took up the offer of a follow up appointment. Following 634 contacts, 195 (31%) pregnant patients received at least one of the vaccines on offer.
- 1205 GSTT patients have been vaccinated at Francis House and within the Maternity department which is a 15% increase in total number compared to the same period during AW23. This resulted in pregnant people receiving:
  - 200% more covid vaccinations (46% were administered to patients with a non-white ethnicity)
  - 72% more flu vaccinations (50% were administered to patients with a non-white ethnicity)
  - 29% more pertussis (46% were administered to patients with a non-white ethnicity)

Communication Summary

- South East London took a proactive and collaborative approach to the winter vaccination programme during 2024/25 working with both NHS England London and other London ICBs and at a place level with Local Authorities, communities groups and voluntary sector organisations.
- The national campaign started on the 7 October with ads on TV, billboards, national radio and podcasts, multicultural media, social media, as well as the promotion of key messages on partner and influencer channels. Working with NHS London and London ICBs we developed our local campaigns that complemented each other and avoided duplication. This included advertisements in London and local newspapers, culturally specific ads in **community ethnic media** to reach South Asian, Black African, Black Caribbean and Easten European communities, working with **London partners** e.g London Age UK, Motherhood Group (targeting Black pregnant women), Lupus Trust and Psoriasis Association, **Webinars** with London Bangladeshi Health Partnership, Pakistani Vaccine Steering Group and Voice4Change.
- In south east London, our communications objectives were to **increase awareness** of the flu and COVID-19 vaccine offer and **encourage visits** to the NHS vaccination booking page.
- To raise awareness, we ran digital ads across Facebook, Instagram, YouTube and Google's Display Network. These ads targeted specific cohorts, and on social media had a focus on underserved communities and recent immigrants to the UK. They were shown **14,665,943 times on people's screens.** We also created cohort specific content, focusing on the barriers to vaccination and shared these across our channels and with partners.
- Our trackable activity led to **25,733 direct visits** to the NHS vaccination booking page.

Addressing Inequality – Borough Examples

Bromley – focusing on the regions with lowest vaccine uptake across all immunisations (The Crays, Mottingham and Penge) through outreach, engagement/understanding, trusted relationships and new pop-up locations. Also, working with Mencap and LD leads to provide additional support for both education and vaccine access to LD patients.

Lambeth – Lambeth Public Health led a series of flu engagement and vaccination sessions in some of the borough's most deprived areas, including Brixton and Stockwell. These took place at large supermarkets – high-footfall, accessible locations that enabled direct engagement with residents who may not typically seek vaccinations through traditional healthcare settings. To maximise reach, the Health and Wellbeing Bus was stationed in supermarket car parks, providing flu-related information and offering opportunistic on-site vaccinations in collaboration with the GP Federation. The team also partnered with a local community pharmacy to deliver community-based engagement sessions in collaboration with voluntary and community sector groups and Health and Wellbeing Hubs such as Black Prince Trust and Age UK. These partnerships were key to engaging priority populations, including older adults and those with long-term health conditions

Southwark – Continue to focus on communities that have a low take up of vaccinations, Black Afro Caribbean communities and other communities, and work with local organisations and utilize their expertise to reach and engage with people, build trust, provide information and to improve the uptake of vaccinations. An example of this was working with a local community organisation (Southwark Refugee Community Forum) to plan and deliver a meal and wellbeing event for refugees and asylum seekers, which included providing information about vaccinations and offering the COVID-19 and flu vaccinations. Southwark has 3 asylum seeker hotels in the borough. The team also worked with Southwark Health Intervention Team and local pharmacist to provide information sessions at hostels for homeless people. Residents were also offered COVID-19 and Flu vaccinations.

Greenwich – Work included vaccination pop-ups held at the homeless shelter in Greenwich, Woolwich community centre and the Source in Horn Park, The Source with proactive leafletting in the area before hand to advertise with the help of CACT and at the Christmas Fair at Hornpark Primary School the team manned an immunisation stall to provide information and answer questions. In addition a programmatic advertising campaign to reach the At-risk cohort in Greenwich was undertaken .

Focus on Bexley Vaccination Programme – children and young people

Bexley achieved a high level of uptake of the flu vaccination in children in 2024/25.

What we did:

- Communication materials were shared with the London Borough of Bexley with insight provided by the Children & Young People Community Immunisation Service (CYPCIS) for schools with low uptake of flu vaccine to support tailoring outputs/products.
- Shared the school's toolkit provided by CYPCIS, which included social media collateral and printable posters with QR codes for schools to share with parents.
- Communicated details of catch-up vaccination clinics provided by CYCPIS to all GP Practices to support signposting of patients
- Details of catch-up clinics posted on the London Borough Bexley website – which has a higher footfall.
- Shared printed information in the relevant languages. Printed material was also shared across community groups and at community health and wellbeing events.

Rationale:

- ✓ Provide opportunities for focused support to schools with previous poor engagement to the CYPCIS.
- ✓ Support homeschool children to have an equitable opportunity for the flu vaccination
- ✓ Ensure catch-up clinics were widely promoted.
- ✓ Provide robust signposting for parents with children of different ages.
- ✓ Provide consistent messaging across the system.

Learning from 24/25 to shape 25/26 planning

- During the 2024/25 campaign there has been progress made by teams to address some of the challenges that had been identified as part of the planning process and which needed focused attention for example the number of pregnant people who have had their influenza vaccination this year has increased by 10%. This was partly due to a consistent and sustained programme of work that was carried out across SEL to ensure that the range of vaccinations that were available to this group, and the information they needed to make a decision was provided in a timely way, in an appropriate format and by the right teams. This population health approach has demonstrated that uptake can increase if services are able to flex their delivery to the group of the residents they are looking to engage with.
- Our evaluation of the communication strategy identified what worked and what did not for different cohorts of the population of SEL. This valuable insight will shape future communication plans and approaches.
- The outreach evaluation identified that we needed to maintain a strong commitment to data-driven planning, community engagement, and collaboration with local partners. The evaluation found that the use of data and insights and the targeted communications campaign, which included working with healthcare providers and community leaders, was a notable success. The programme needs to continue to effectively utilise roving teams, pop-up clinics, and existing healthcare channels to deliver vaccines and engage with underserved communities.
- The issue of trust in NHS services continues to be a key theme and in SEL we recognise that this is a challenge which we need to continue to acknowledge and address. Through our place based partnerships and collaborations throughout South East London we need to incorporate health into existing holistic community-based services and work together to transform health-led prevention.

South East London Integrated Care System

NHS South East London

Appendix showing data

Detailed analysis on uptake

Seasonal Influenza

Within the Appendix there is more detailed summary of the uptake of seasonal Influenza including:

- Uptake by cohort, gender and ethnicity at a SEL level (slide 19) and at a borough level (slide 20)

Key Points to note:

- Whilst overall uptake is down in 24/25 compared with 23/24 there has been a slight increase in the numbers of 65+ who have taken up the vaccination and a 10% increase in the numbers of pregnant people who have been vaccinated.
- The London average for flu uptake is 37.9% compared with a national average of 51.9%
- We see the highest flu uptake in the White British and White Irish groups, with high uptake also seen in Chinese and Indian groups.
- Uptake is lowest in unknown ethnic groups as well as across all black/mixed black ethnic groups.
- Across ethnicity groups in London, we see a clear gradient of lower uptake in more deprived Indices of Multiple Deprivation (IMD) deciles to higher uptake in less deprived deciles.
- 29% of those in the clinical risk group have been vaccinated this year which is a reduction of 8%. Highest uptake is by individuals with diabetes, and all other chronic conditions except liver disease also have relatively high uptake. Lowest uptake is by individuals who are morbidly obese.
- Uptake is higher in primary school age children (44%) than secondary school age children (33%).
- Uptake is higher in primary school age children (1.4%) and higher in secondary school age children (3.9%) compared to 2023/24 uptake.

Flu uptake by cohort, gender and ethnicity (SEL)

AW24 Cohorts (Flu)	Total Eligible	Total Vaccinated	Total Uptake	Total Remaining
01: CH Res	4618	3350	73%	1268
02: 65+	244319	153684	63%	90635
03: HCW (ESR)	27379	8491	31%	18888
03: HCW (Self-Declared)	7130	4480	63%	2650
04: SCW	31014	4393	14%	26621
05: At-Risk	280337	82643	29%	197694
06: Pregnant	26473	6803	26%	19670
07: Secondary	109267	31656	29%	77611
08: Primary	146910	56288	38%	90622
09: 2-3	38897	14916	38%	23981
Total	**916344**	**366704**	**40.0%**	**549640**

AW24 Cohorts (Flu)	Total Eligible	Total Vaccinated	Total Uptake	Total Remaining
Female	492881	197188	40%	295693
Male	423401	169503	40%	253898
Not specified	37	8	22%	29
Not known	25	5	20%	20

Ethnic group	Total Eligible	Total Vaccinated	Total Uptake	Total Remaining
A: White - British	382435	202846	53%	179589
B: White - Irish	10760	5509	51%	5251
C: White - Any other white background	116531	39707	34%	76824
D: Mixed - White and Black Caribbean	13303	2823	21%	10480
E: Mixed - White and Black African	10529	2817	27%	7712
F: Mixed - White and Asian	7206	3341	46%	3865
G: Mixed - Any other mixed background	23475	7350	31%	16125
H: Asian or Asian British - Indian	26969	12996	48%	13973
J: Asian or Asian British - Pakistani	7547	2296	30%	5251
K: Asian or Asian British - Bangladeshi	7236	2482	34%	4754
L: Asian or Asian British - Any other Asian background	33420	14576	44%	18844
M: Black or Black British - Caribbean	47566	9575	20%	37991
N: Black or Black British - African	110440	28813	26%	81627
P: Black or Black British - Any other Black background	40600	8718	21%	31882
R: Other ethnic groups - Chinese	13421	6455	48%	6966
S: Other ethnic groups - Any other ethnic group	42582	12366	29%	30216
X:Unknown	22324	4034	18%	18290
Total	**916344**	**366704**	**40.0%**	**549640**

Source: FDP (10/03/2025)

Flu uptake by cohort, gender and ethnicity (Boroughs)

AW24 Cohorts (Flu)	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
01: CH Res	75%	78%	72%	63%	57%	78%
02: 65+	70%	74%	62%	53%	54%	55%
03: HCW (ESR)	27%	39%	24%	35%	29%	30%
03: HCW (Self-Declared)	66%	64%	62%	63%	61%	61%
04: SCW	16%	17%	14%	11%	13%	14%
05: At-Risk	34%	38%	33%	24%	26%	26%
06: Pregnant	25%	24%	24%	25%	30%	25%
07: Secondary	36%	45%	25%	21%	24%	20%
08: Primary	53%	55%	36%	26%	31%	27%
09: 2-3	33%	48%	36%	37%	37%	37%

AW24 Cohorts (Flu)	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Male	49%	54%	39%	31%	34%	32%
Female	48%	54%	38%	32%	34%	32%
Not known	21%	30%	0%	0%	0%	0%
Not specified	0%	50%	20%	14%	30%	40%

Ethnic group	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
A: White - British	55%	60%	49%	47%	49%	46%
B: White - Irish	54%	60%	55%	45%	50%	48%
C: White - Any other white background	38%	44%	32%	31%	31%	32%
D: Mixed - White and Black Caribbean	31%	29%	21%	18%	20%	17%
E: Mixed - White and Black African	32%	36%	28%	22%	24%	22%
F: Mixed - White and Asian	51%	59%	42%	40%	45%	38%
G: Mixed - Any other mixed background	43%	43%	30%	25%	29%	26%
H: Asian or Asian British - Indian	52%	56%	46%	42%	42%	36%
J: Asian or Asian British - Pakistani	36%	40%	31%	27%	26%	27%
K: Asian or Asian British - Bangladeshi	41%	43%	38%	31%	31%	30%
L: Asian or Asian British - Any other Asian background	50%	52%	48%	37%	40%	35%
M: Black or Black British - Caribbean	27%	24%	21%	18%	19%	22%
N: Black or Black British - African	33%	31%	29%	23%	23%	25%
P: Black or Black British - Any other Black background	33%	26%	28%	16%	17%	21%
R: Other ethnic groups - Chinese	57%	62%	48%	41%	45%	37%
S: Other ethnic groups - Any other ethnic group	38%	41%	30%	25%	28%	25%
X:Unknown	26%	30%	19%	13%	15%	13%

Source: FDP (10/03/2025)

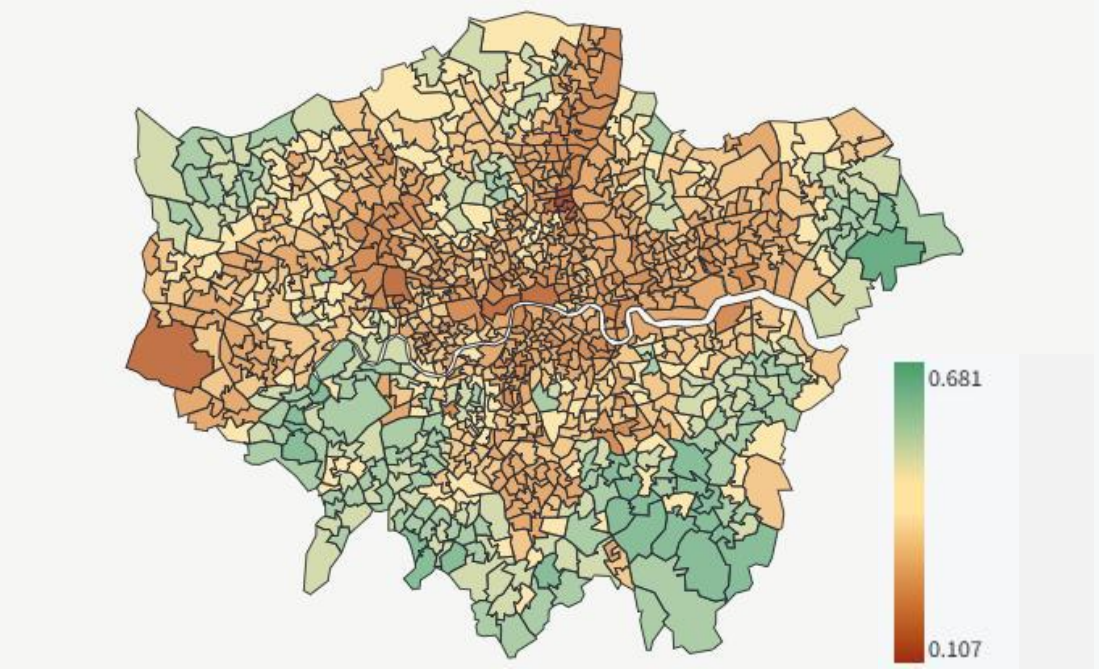
A/W 2024 Flu Vaccination – Overall Uptake

- Up to 2nd March, overall uptake in London is 37.9% with over 2.9m eligible remaining. Uptake Across SEL 40%. The overall uptake in England is higher at 51.9%.
- The MSOA map highlights that uptake tends to be much higher in outer London, especially across SW and SE.

Flu Uptake:

	Population	Vaccinated	Uptake	Remaining
England	33,026,372	17,132,658	51.9%	15,893,714
London	4,780,401	1,810,215	37.9%	2,970,186
NCL	773,263	271,931	35.2%	501,332
NEL	1,066,804	367,830	34.5%	698,974
NWL	1,200,047	431,672	36.0%	768,375
SEL	944,319	375,562	39.8%	568,757
SWL	795,968	363,220	45.6%	432,748

Flu Uptake by MSOA of Residence:



Source: NHS Federated Data Platform (FDP)
Notes: Figures in the table are GP registered in London, Map uses MSOA of residence.

A/W 2024 Flu Uptake by IMD and Ethnicity

- We see the highest flu uptake in the White British and White Irish groups, with high uptake also seen in Chinese and Indian groups. Uptake is lowest in unknown ethnic groups as well as across all black/mixed black ethnic groups.
- Across ethnicity groups in London, we see a clear gradient of lower uptake in more deprived Indices of Multiple Deprivation (IMD) deciles to higher uptake in less deprived deciles.

Ethnicity Category	Eligible	Total Uptake	1	2	3	4	5	6	7	8	9	10
A: White - British	1,505,959	52.8%	40.2%	41.9%	44.8%	48.0%	51.1%	53.5%	56.7%	58.3%	61.3%	65.1%
B: White - Irish	59,838	50.9%	43.0%	45.7%	47.8%	49.5%	50.0%	52.2%	54.8%	54.4%	57.2%	59.2%
C: White - Any other White background	749,550	29.7%	23.6%	23.9%	25.0%	26.4%	28.1%	29.9%	33.6%	36.2%	41.6%	46.2%
D: Mixed - White and Black Caribbean	47,589	22.6%	17.7%	18.5%	19.8%	21.8%	23.0%	25.7%	27.4%	30.6%	33.3%	38.8%
E: Mixed - White and Black African	38,573	25.7%	22.1%	22.8%	23.4%	23.2%	26.0%	28.1%	32.4%	32.2%	35.9%	40.5%
F: Mixed - White and Asian	39,915	43.1%	33.5%	33.0%	36.7%	37.5%	41.2%	43.5%	47.1%	47.5%	53.9%	57.8%
G: Mixed - Any other Mixed background	105,872	30.9%	19.8%	22.8%	24.7%	28.1%	30.7%	32.9%	37.2%	39.8%	45.3%	49.9%
H: Asian or Asian British - Indian	378,862	44.4%	38.9%	40.5%	40.1%	41.2%	43.3%	45.2%	48.0%	49.0%	51.4%	53.6%
J: Asian or Asian British - Pakistani	157,909	28.5%	26.9%	27.5%	28.0%	27.2%	26.9%	28.3%	30.6%	32.3%	35.0%	37.3%
K: Asian or Asian British - Bangladeshi	175,581	32.9%	30.6%	31.3%	33.2%	33.9%	32.5%	32.5%	35.4%	37.2%	39.0%	43.6%
L: Asian or Asian British - Any other Asian background	292,939	39.3%	33.9%	35.4%	37.0%	37.7%	38.4%	40.0%	41.5%	42.3%	46.7%	49.4%
M: Black or Black British - Caribbean	164,913	22.6%	19.8%	20.5%	21.8%	22.7%	23.3%	25.3%	26.3%	27.9%	30.9%	34.7%
N: Black or Black British - African	361,850	24.7%	23.7%	24.0%	24.6%	24.2%	25.6%	25.4%	26.5%	26.9%	29.0%	29.8%
P: Black or Black British - Any other Black background	149,379	20.4%	17.9%	19.1%	19.4%	20.2%	21.0%	22.4%	23.5%	24.4%	28.2%	31.3%
R: Other ethnic groups - Chinese	61,517	45.6%	45.1%	42.3%	41.1%	41.0%	44.8%	41.9%	48.8%	49.1%	54.1%	54.4%
S: Other ethnic groups - Any other ethnic group	329,647	28.3%	22.2%	23.3%	24.3%	25.9%	29.1%	30.0%	33.5%	34.8%	40.3%	45.1%
X:Unknown	153,276	17.0%	11.9%	13.5%	14.3%	14.6%	15.7%	16.2%	20.6%	20.4%	25.4%	27.6%
Total Uptake		**37.9%**	**27.0%**	**29.4%**	**31.6%**	**33.9%**	**37.0%**	**39.5%**	**44.1%**	**46.9%**	**52.2%**	**56.8%**
Eligible	**4,773,169**		**110,185**	**710,924**	**854,769**	**674,076**	**553,208**	**509,551**	**409,793**	**376,529**	**365,920**	**208,214**

Source: NHS Federated Data Platform (FDP).
Notes: National IMD deciles are used. Patients with no IMD decile (i.e. no patient address information) recorded are excluded from this overview and therefore the eligible population and total uptake figures may not match those shown on previous slides.

A/W 2024 Flu Uptake by Clinical Risk Group

- The table below presents AW24 flu uptake by clinical risk group, please note that these are not mutually exclusive.
- Highest uptake is by individuals with diabetes, and all other chronic conditions except liver disease also have relatively high uptake.
- Lowest uptake is by individuals who are morbidly obese.

Clinical Risk Group	England	London	NCL	NEL	NWL	SEL	SWL
Chronic Heart Disease	43.6%	37.1%	34.3%	36.1%	37.2%	37.5%	40.7%
Chronic Kidney Disease	47.1%	36.6%	34.6%	36.2%	38.0%	35.8%	38.9%
Chronic Liver Disease	36.9%	30.2%	26.6%	29.5%	30.2%	32.0%	33.7%
Chronic Neurological Disease	44.9%	36.9%	35.2%	36.1%	36.2%	36.5%	41.3%
Chronic Respiratory Disease (Long-term)	45.7%	37.8%	35.6%	36.7%	37.0%	38.3%	42.3%
Diabetes	47.7%	42.6%	38.1%	42.6%	44.7%	41.3%	44.5%
Immunosuppressed	39.8%	31.5%	30.1%	28.3%	30.3%	33.5%	36.1%
Morbidly Obese	29.2%	20.8%	17.8%	19.9%	20.7%	21.9%	23.9%
Other Clinical	49.1%	46.5%	40.2%	36.1%	52.9%	50.2%	49.8%

Source: NHS Federated Data Platform (FDP)
Notes: Patients are only included in these uptake figures where the stated condition means that being “at-risk” is their “highest priority cohort”.

A/W 2024 Flu uptake in school age children

- AW24 Uptake is higher in primary school age children (44%) than secondary school age children (33%).
- Uptake is higher in primary school age children (1.4%) and higher in secondary school age children (3.9%) compared to 2023/24 uptake.
- Overall uptake in school age children varies across ICBs; it is lowest in NWL and highest in SWL. However positively NWL has seen the largest increase in uptake for both primary school and secondary school age children compared to last year.

School Group	ICB	Vaccinated	Uptake in Denominator (%)	Final Uptake Last Year	YTD difference from 2023/24 final uptake
Primary	NCL	45,414	42%	41%	+0.5%
	NEL	74,267	42%	39%	+3.8%
	NWL	62,557	39%	34%	+4.8%
	SEL	62,230	44%	46%	-2.0%
	SWL	66,301	53%	55%	-1.8%
Secondary	NCL	26,079	33%	29%	+4.0%
	NEL	36,756	30%	25%	+5.1%
	NWL	33,195	28%	23%	+5.6%
	SEL	32,237	33%	31%	+1.7%
	SWL	40,517	45%	42%	+2.7%

ICB	Borough	Primary School		Secondary School	
		Vaccinated	Uptake in Denominator (%)	Vaccinated	Uptake in Denominator (%)
NCL	Enfield	9,306	32%	4,933	25%
NCL	Camden	6,276	43%	3,082	31%
NCL	Barnet	14,947	45%	10,185	38%
NCL	Islington	5,033	41%	2,302	31%
NCL	Haringey	9,852	49%	5,577	38%
NEL	Tower Hamlets	7,538	32%	3,363	22%
NEL	Barking & Dagenham	8,261	34%	4,434	27%
NEL	City & Hackney	6,788	41%	4,508	34%
NEL	Newham	14,029	43%	5,666	24%
NEL	Redbridge	13,157	43%	6,294	31%
NEL	Havering	13,784	56%	8,266	51%
NEL	Waltham Forest	10,710	45%	4,225	28%
NWL	Westminster	3,438	32%	3,253	26%
NWL	Kensington & Chelsea	5,035	43%	1,838	24%
NWL	Hammersmith & Fulham	4,866	43%	3,220	34%
NWL	Harrow	10,167	44%	5,062	33%
NWL	Hillingdon	11,198	39%	5,415	28%
NWL	Ealing	10,698	37%	5,110	28%
NWL	Hounslow	9,996	45%	5,740	33%
NWL	Brent	7,159	29%	3,557	20%
SEL	Greenwich	10,103	40%	5,021	30%
SEL	Bromley	16,785	57%	9,849	46%
SEL	Bexley	12,643	58%	5,949	38%
SEL	Lewisham	8,137	35%	3,575	28%
SEL	Southwark	8,031	36%	5,521	29%
SEL	Lambeth	6,531	32%	2,322	19%
SWL	Croydon	12,401	38%	6,292	28%
SWL	Wandsworth	12,014	53%	5,043	39%
SWL	Merton	9,599	57%	5,046	47%
SWL	Kingston	8,658	61%	6,472	53%
SWL	Richmond	12,515	64%	8,015	54%
SWL	Sutton	11,114	60%	9,649	55%

Source: CYPCIS weekly flu submissions
Notes: Figures do not include SEND school children (11-18 years)

Covid 19

Within the Appendix there is more detailed summary of the uptake of covid 19 including:

- Uptake by cohort, gender and ethnicity at a SEL level (slide 26) and at a borough level (slide 27)

Key Points to note:

- Overall uptake has reduced to 30% from 41% in 2023/24
- Overall uptake in London was 27%.
- Overall uptake in England was 44.5%.
- The highest uptake was in the care home population with 64% of residents taking up the offer and 53% of the over 80 year olds
- Less than 4% of children who were clinically at risk were vaccinated
- 44% of the eligible white population in SEL had their covid vaccination but only 9% of black Caribbean residents and 10% of black African residents took up the vaccination offer
- Overall uptake for Health and Care workers in London is 17.3% compared with 21% in England overall.

Appendix 3 - A/W COVID-19 Uptake in Frontline HCWs 24/25

Trust	Frontline Staff	AW24 Doses	Uptake	Remaining
GOSH	3,934	1,441	36.6%	2,493
K&R FT	3,761	1,150	30.6%	2,611
UCLH	7,565	2,232	29.5%	5,333
Whittington	2,896	773	26.7%	2,123
ChelWest	5,369	1,365	25.4%	4,004
SLAM	4,294	1,001	23.3%	3,293
Homerton	3,833	813	21.2%	3,020
RNOH	1,047	216	20.6%	831
Epsom	5,698	1,142	20.0%	4,556
Moorfields	1,639	324	19.8%	1,315
T&P	448	88	19.6%	360
Croydon	3,378	660	19.5%	2,718
Imperial	12,092	2,308	19.1%	9,784
Royal Free	15,491	2,893	18.7%	12,598
GSTT	17,424	3,125	17.9%	14,299
L&G	7,417	1,292	17.4%	6,125
CLCH	2,725	459	16.8%	2,266
St George's	7,213	1,130	15.7%	6,083
LNW	5,417	792	14.6%	4,625
Barts	20,173	2,933	14.5%	17,240
Hillingdon	3,068	437	14.2%	2,631
BHR	6,692	914	13.7%	5,778
Oxleas	3,165	401	12.7%	2,764
CNWL	5,683	711	12.5%	4,972
LAS	3,983	497	12.5%	3,486
West London	3,560	414	11.6%	3,146
North London	4,450	513	11.5%	3,937
SWL&StG	2,536	290	11.4%	2,246
ELFT	7,354	834	11.3%	6,520
King's	9,395	965	10.3%	8,430
NELFT	5,930	575	9.7%	5,355
Marsden	3,125	262	8.4%	2,863

Region	Frontline Staff	AW24 Doses	Uptake	Remaining
East of England	107,340	20,344	19.0%	86,996
London	190,755	32,950	17.3%	157,805
Midlands	225,568	41,428	18.4%	184,140
North East and Yorkshire	188,686	39,324	20.8%	149,362
North West	168,709	28,320	16.8%	140,389
South East	141,314	37,295	26.4%	104,019
South West	114,983	39,274	34.2%	75,709
Unknown	*2,431*	*767*	31.6%	*1,664*
England	**1,139,786**	**239,702**	**21.0%**	**900,084**

ICB	Frontline Staff	AW24 Doses	Uptake	Remaining
NCL	43,153	9,191	21.3%	33,962
NEL	43,982	6,069	13.8%	37,913
NWL	36,214	6,272	17.3%	29,942
SEL	41,695	6,784	16.3%	34,911
SWL	25,711	4,634	18.0%	21,077
London	**190,755**	**32,950**	**17.3%**	**157,805**

- Overall uptake for HCW in London is 17.3% compared with 21% in England overall. North West Region has the lowest uptake with 16.8%, whilst South West has the highest uptake at 34.2%.
- Uptake across London ICBs ranges from 13.8% in NEL to 21.3% in NCL.
- GOSH is the trust with the highest uptake of 36.6%; the lowest uptake is at Marsden at 8.4%.

Source: ESR, NHS Foundry, FDP

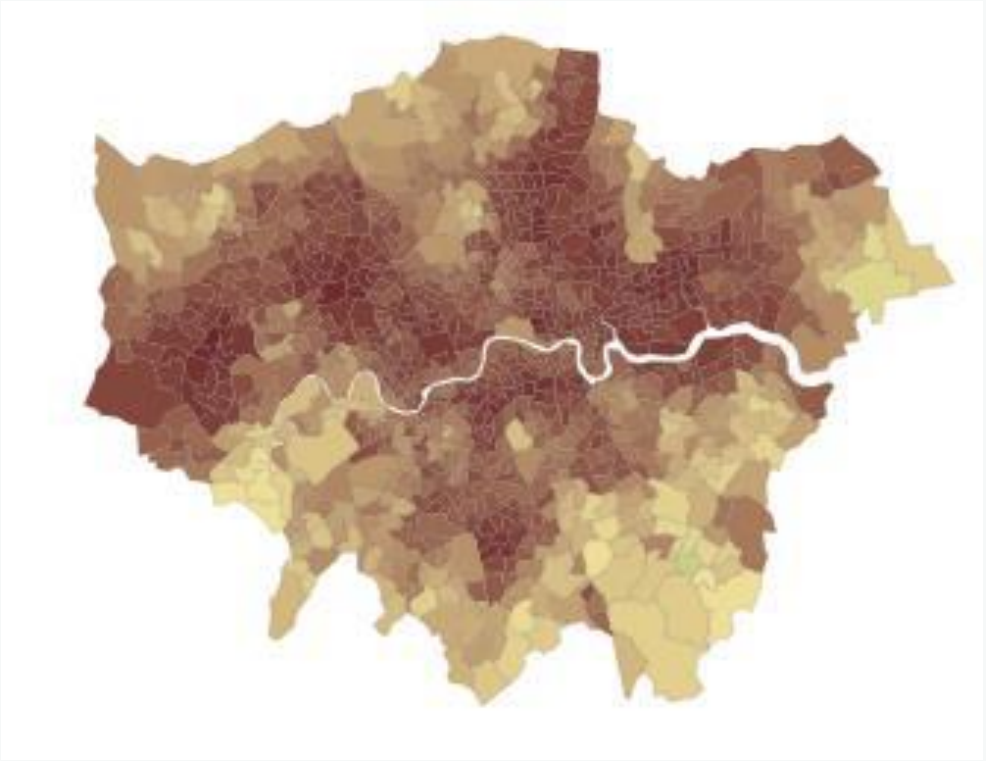
A/W 2024 COVID-19 Vaccination – Overall Uptake

- Overall uptake in London was 27%; uptake across SEL 30% Overall uptake in England was 44.5%.
- The MSOA map highlights that uptake trends are much higher in outer London, especially across SW and SE.
- Newham (14.8%), Brent (16.2%), Barking and Dagenham (17.8%), Tower Hamlets (18.4%) and Waltham Forest (20.3%) had the lowest AW 24 COVID-19 vaccination uptake. Newham (69.2%), Brent (65.4%) and Tower Hamlets (60.6%) are three of London's most diverse boroughs, where over 60% of the population is non-white. The IMD (rank of) average rank, which summarises the average level of deprivation across an area, for all 5 boroughs fall within the lowest fifth of all England boroughs.

AW24 Uptake:

	Population	Vaccinated	Uptake	Remaining
England	20,616,982	9,183,659	44.5%	11,433,323
London	2,685,597	725,377	27.0%	1,960,220
NCL	435,907	125,367	28.8%	310,540
NEL	575,113	122,964	21.4%	452,149
NWL	671,335	157,689	23.5%	513,646
SEL	552,379	163,957	29.7%	388,422
SWL	450,863	155,400	34.5%	295,463

AW24 Uptake by MSOA of Residence:



Source: FDP – data as of 4th February 2025
Notes: Figures in the table are GP registered in London, Map uses MSOA of residence.

A/W 2024 COVID-19 Uptake by Cohort

- Uptake is highest in care home residents and those aged 75+. Uptake is lowest in the at-risk cohorts, particularly the younger at-risk groups.
- London's uptake across cohorts is consistently lower than the national position.
- Uptake in Health Care Workers Cross SEL is 32.2%.
- Uptake is lower in NEL and NWL across older age priority groupings and adult "At risk".

Cohort	England	London	NCL	NEL	NWL	SEL	SWL
1: Care homes	**72.1%**	64.3%	68.2%	62.3%	64.8%	63.8%	62.9%
2: HCW	**33.2%**	26.8%	31.7%	20.6%	26.8%	25.9%	31.0%
4: 80+	**68.7%**	48.6%	49.3%	42.9%	43.2%	53.2%	56.0%
5: 75-79	**66.1%**	46.0%	46.4%	40.5%	39.2%	51.1%	54.4%
6: 70-74	**59.2%**	37.9%	39.6%	32.2%	31.3%	42.6%	46.8%
7: 65-69	**48.5%**	29.2%	30.8%	24.3%	24.2%	32.6%	36.7%
8: At risk	**24.8%**	15.1%	16.0%	12.3%	12.6%	17.4%	19.6%
9: 12-15 At risk	**3.9%**	2.6%	2.1%	2.1%	2.2%	3.2%	3.7%
11: 5-11 At risk	**2.0%**	1.7%	1.5%	1.6%	1.4%	2.2%	1.9%

Source: NHS Federated Data Platform (FDP).
Notes: For AW24 campaign, jcvi cohort 10 (household contacts of immunosuppressed) are no longer eligible for covid vaccination.