South East London Integrated Care System

NHS South East London

Integrated Care Board – Meeting in Public

12.30 to 16.10 on 29 January 2025

Bexley Civic Offices
2 Watling St, Bexleyheath DA6 7AT

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
	Reducing Health Inequalities			
2	**Mental Health**	C (p22)	SC AE	12.40
	ICB Corporate Business			
3	**Sexual safety and domestic violence**	D (p60)	TF	13.05
4	**Specialised Services delegation**	E (p67)	SC	13.15
	Report for Assurance and discussion of current issues			
5	**Chief Executive Officer's report**	F (p77)	AB	13.25
6	**Board Assurance Framework**	G (p103)	TF	13.30
7	**Overall Report of the ICB Committees and Provider Collaboratives** • **Update on Quality and Safeguarding** • **Update on Performance** • **Update on Finance**	H (p124)	TF PL SC MF	13.45

Delivering our Integrated Care Strategy				
8	**Planning for 2025/26 and beyond**	I (p174)	SC MF	14.25
9	**Developing our Neighbourhood Health service**	J (p194)	CJ GV	14.55
10	**Showcase Bexley: Neighbourhood working to address Frailty**	K	DB	15.25
Closing Business				
11	**Any other business**	-	RD	15.55
12	**Public Questions and Answers**	-	RD	16.00
CLOSE 16.10				

Presenters

RD	**Sir Richard Douglas**	**ICB Chair**
AB	**Andrew Bland**	**ICB CEO**
DB	**Diana Braithwaite**	**Bexley Place Executive Lead**
SC	**Sarah Cottingham**	**ICB Director of Planning and Deputy CEO**
AE	**Andrew Eyres**	**Lambeth Place Executive Lead**
TF	**Tosca Fairchild**	**ICB Chief of Staff**
MF	**Mike Fox**	**ICB CFO**
CJ	**Ceri Jacob**	**Lewisham Place Executive Lead**
PL	**Paul Larrisey**	**ICB Chief Nurse**
GV	**Dr George Verghese**	**Primary Care Partner member**

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members and attendees
Date: 29/01/2025

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. NED 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. Non-executive board member for Recovery Focus mental health charity 2. Advisor to Care Quality Commission on their approach to adult social care assurance 3. Non-executive director for What Works Centre for Wellbeing 4. Local Government and Social Care Ombudsman 5. Non Executive Board member, The Health Foundation	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	April 2022 May 2022 April 2022 April 2023 March 2023	Current Current April 2024 January 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
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	Financial interest Indirect interest	May 2007 June 2014	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	Indirect Interest	09/06/2006	-
Sarah McClinton	Director of Place, Greenwich	1. Director, Health & Adult Services, employed by Royal Borough of Greenwich 2. Deputy Chief Executive, Royal Borough of Greenwich 3. President and Trustee of Association of Directors of Adult Social Services (ADASS) 4. Co-Chair, Research in Practice Partnership Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	November 2019 May 2021 April 2022 2016	Current Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Director, Sard JV Software Development 4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London 5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 6. Fellow of the Royal College of Psychiatrists 7. Fellow of the Royal Society of Medicine 8. International Fellow of the American Psychiatric Association 9. Member of the British Association of Psychopharmacology 10. Member of the Faculty of Medical Leadership and Management 11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest 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 2011 27/09/16 1992 1985	Current Current Current Current Current Current Current Current Current Current Current
Diana Braithwaite	Place Executive Lead, Bexley	none			
Meera Nair	Chief People Officer	1. Royal College of Psychiatrists Trustee (and Lead Trustee for safeguarding and EDI) 2. The Maya Centre, Chair since 28 November 2022, and Trustee before that. 3. Amnesty International Member Nominations Committee	Non-Financial Personal Non-Financial Personal Non-Financial Personal	2nd Aug 2021 26th Nov 2019 1st Jul 2023	Current Current Current
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	-
Paul Larrisey	Acting ICB Chief Nurse	None	-	-	-
Philippa Kirkpatrick	CDIO	Director – inactive company Philippa Kirkpatrick Ltd in use prior to start of ICB role	Financial Interest	April 2022	-
Georgina Fekete	Non executive member	Nothing to declare	-	-	-

Integrated Care Board meeting in public

Minutes of the meeting on 16 October 2024

Charlton Athletic FC the Valley

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
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
Sarah McClinton	Greenwich Place Executive Lead
Paul Najsarek	Non-Executive Member
Dr Ify Okocha	Partner Member Community Services
Anu Singh	Non Executive Member
Darren Summers	Southwark Place Executive Lead
Dr George Verghese	Partner Member Primary Care

In attendance:

Dr Abi Fadipe	Chief Medical Officer Oxleas NHS FT
Ben Travis	Chief Executive Lewisham and Greenwich Trust
Sam Hepplewhite	Director of Prevention and Partnerships
Dr Mary Doherty	Chief Medical Officer South London & Maudsley NHSFT
Michael Boyce	ICB Director of Corporate Operations
Ranjeet Kaile	ICB Director of Communications and Engagement
Fiona Howgego	System Sustainability Team
Neil Kennett-Brown	System Sustainability Team
Philippa Kirkpatrick	ICB Chief Digital Information Officer
Dave Borland	Royal Borough of Greenwich
Meera Nair	Chief People Officer Lewisham and Greenwich NHS Trust
Rupi Dev	ICB Director – Mental Health, Children and Young People & Health Inequalities

1.	**Welcome and Apologies**
1.01	Apologies were noted from Debbie Warren, Peter Matthews, Sarah Cottingham and Tosca Fairchild
1.02	Sir Richard Douglas welcomed Ben Travis to the meeting and explained that board meetings would now be attended by the CEO of Lewisham and Greenwich Trust and the CEO of Guys and St Thomas NHS FT in addition to chief executives who were part of the board membership. He thanked Sarah McClinton for her work for the board at her last meeting band noted that Meera Nair would soon move to another role.
1.03	The Board were also asked to note additional roles taken on by members and

	recorded in the declarations of interest: Anu Singh had taken up a role as Chair of Black Country ICB Paul Najsarek had taken up a role as Chair of North Central London ICB.
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.	**Borough Showcase Greenwich**
2.01	The Board received an update introduced by Sarah McClinton on the work on children and young people's mental health in Greenwich, noting the increasing need, and the ambition for a system approach to address this need. The update included an update on the EPEC (empowering parents empowering communities) programme. The programme provided space for parents to talk about parenting with no judgement and receive support, including a toolbox of potentially life changing techniques to try, as well as the support of other parents. Those who had been involved in the scheme shared the benefit they had received.
2.02	Anu Singh welcomed the insightful presentation which she hoped could be part of the Boards leadership in investing in the community and ceding power and control to voluntary community and social enterprises and local communities themselves.
2.03	Darren Summers asked about the gap between voluntary service sector provision and community support, especially for children who may be challenging and have additional needs.
2.04	Angela Bhan noted asked how the course would be tailored to participants, noting for example that 32% of the population did not speak English as a first language and the role of fostering.
2.05	Dr Ify Okocha noted that there may be a large number of families who could benefit from the support described and asked how the work would be scaled up and linked to other schemes with similar aims.
2.06	Meera Nair asked if the work was targeting the families who could benefit from it the most recognising the deprivation in some areas of Greenwich, and which of the many possible indicators would be monitored to show the impact over time.
3.	**ICB Governance Changes** **Changes to the ICB Constitution for approval** **Changes to the ICB's Governance for approval**
3.01	Michael Boyce referred the Board to the governance changes set out in the paper which were due to nationally mandated changes, new appointments, and the outcome of a recent review of the committee structure by the Board.
3.02	Dr Ify Okocha pointed out that it was difficult to see where some responsibilities were addressed in the diagram of committees for example community provider network and acute provider collaborative. Richard Douglas noted that the diagram was a summary and that the terms of reference and practice of the committees allowed the discussion of all areas.

3.03	The Board **approved** the revised ICB constitution for onward recommendation to NHS England.
3.04	The Board approved the proposed changes to the governance structure.
4.	**Chief Executive Officers report**
4.01	Andrew Bland referred board members to the detailed report highlighting an update on further actions taking place on the ICS's Green Plan, the update provided on the equality diversity and inclusion work, and an update on the Primary Care Access Recovery plan.
4.02	Prof Clive Kay alluded to the reference to the GP collective action in the report and asked about the impact on the system so far and what was expected in the future. Andrew Bland noted that there was a fortnightly opportunity at the Executive Committee on any impact that had been identified as well as in each borough. Sam Hepplewhite noted that a risk had been identified in relation to potential to pull out of data sharing agreements but no specific impacts identified so far but a view that there was a potential for impact to increase. Dr George Verghese added the medicines optimisation was another area of potential impact. Generally however there had been no indication of impact for example through data such 999 and 111 use that could be separated out from the impact of other events such as the cyberattack. There was a need for continuous awareness of the potential for this to have an impact across many different areas and over time.
4.03	Paul Najsarek welcomed the new EDI strategy, noting previous commitments that the next phase of the anti-racism work would be to expand the plan from ICB staff to the system, as well as some issues which had been highlighted in the staff survey, and emphasised the importance of an approach going forward which addressed these areas. Meera Nair highlighted work which had been done in programmes to scale up work across the ICS aimed at supporting staff and sharing best practice between organisations such as buddying schemes and funding secured for an inclusive recruitment support.
4.04	Sarah McClinton reflected that the three shifts identified as priorities following Lord Darzi's report were an opportunity for the Board to challenge itself whether it had the right metrics to measure progress in the shifts from analogue to digital; from hospital to community; and from cure to prevention.
4.05	Sir Richard Douglas agreed that most of the commitments in the ICS's own strategy were also aimed at these shifts, and that the board might usefully spend some time at a future meeting understanding the measures of progress and what was being delivered, which would link to work on south east London's medium term financial strategy. Andrew Bland added that some existing national requirements measured implementation of schemes designed to make the shift, for example cloud-based telephony in GP practices, but not necessarily whether these were making improvements to the experience of patients.
4.06	Anu Singh referred to discussions at the ICBs Finance and Performance committee where members had raised concerns about whether in maintaining the grip of day-to-day performance there was insufficient time given to transformation for the future. Whilst sessions with the Board were very helpful such as the recent deep dive on integrated neighbourhood teams, it should be for the Integrated Performance Committee to investigate in depth what the proxy measures might be

	to demonstrate these shifts that the Board could discuss and consider how to improve.
4.07	Sam Hepplewhite added that the inaugural meeting of a system-wide prevention, wellbeing and equity meeting had been held in the previous work with the aim of starting to move towards prevention.
4.08	David Bradley noted the significant new delegation of specialised services which were being delegated to the ICB, and asked if there were any services where there were risks or fragility, or services which were not fully funded. Andrew Bland noted that the executive committee had considered a risk register detailing the risks identified across London for these services as part of transitional work to prepare for delegation. An example might be an imbalance of demand and capacity for renal services in the north compared to the south of London which was currently being discussed at the London level.
4.09	The Board **noted** the CEO Report
5	**Board Assurance Framework**
5.01	Michael Boyce presented the Board assurance framework which showed 13 risks across South East London which were above the risk appetite set by the board as well as four local care partnership risks. There was one new risk in relation to intermediate care paid provision, and three risks had been closed
5.02	Paul Najsarek asked if the risk related to the system oversight of quality and safety could be explained further and the steps which were being taken in response.
5.03	David Bradley noted that 11 risks were above the maximum score, but asked how the board could be assured that risks just below the tolerance level were not missed.
5.04	Sir Richard Douglas welcomed the Boards interest in the individual risks and mitigations and proposed that the areas they highlighted ought to be addressed as part of the updates provided by the boards committees.
5.05	The Board **approved** the Board Assurance Framework
6	**Overall report of committee and provider collaborative**
6.01	Michael Boyce introduced the report and asked the Board to consider recommendations which had been made to the Board for final approval: two in relation to terms of reference for local care partnerships, the Executive Committee terms of reference, and for the Board to note 2023/24 audited accounts for the Greenwich Charitable Fund had been signed off and submitted to the charity commission.
6.02	The Board **noted** the update and that the audited accounts 2023/24 audited accounts for the Greenwich Charitable Fund have been signed off by the Audit Committee Chair and Chief Finance Officer.
6.03	The Board **approved** • Revised Terms of Reference for the Healthier Greenwich partnership Board • Revised Terms of Reference for the Partnership Southwark Strategic Board

- Revised Terms of Reference for the audit Committee.

Performance update

6.04 Sam Hepplewhite updated on acute performance. In August the system had performed relatively well in relation to the planned trajectory for the number of patients waiting less than four hours in emergency departments. Efforts continued to encourage the use of alternative services, to improve flow through the hospital and discharge, and address ambulance handover delays. Waiting times for elective care continued to be challenged with respect to 78 week and 65 week waits, although there was an improvement in the total number of children on the elective care waiting list. Despite the impact of the Synnovis cyber-attack incident it was expected that cancer performance remained on track to improve for the remainder of the year and performance against the Cancer faster diagnosis standard had improved and performance on the 62-day standard exceeded the planned trajectory.

6.05 Prof Clive Kay updated on elective care, noting that the Synnovis Cyber attack incident had led to a deterioration in the forecast position in relation to patients waiting longer than 78 weeks and 65 weeks. The Board could be assured, however, that the system was undertaking urgent work including a number of actions arising from a recent workshop on referral to treatment to reduce and ultimately eliminate waits of 65 weeks and over. This ranged from both clinical and administrative validation, appropriate and standardised access policies, and focused work on waits in areas such as ENT, general surgery and orthopaedic.

6.06 Sir Richard Douglas asked what the system might do to assist with the improvement. Prof Clive Kay noted that although everything possible was being done to improve and secure mutual aid, although it was possible that with some focused additional resource – if this could be provided without deteriorating the financial position- that patients who were waiting could be better balance across providers and contribute more to reducing waits. Sir Richard Douglas responded that in the current situation a source of funding would need to be found to make this possible which may lead to an effect on another priority but it was right that this continued to be looked at.

6.07 Ben Travis added that regular conversations between the chief executive officers of trusts and very regular meetings between chief operating officers took place to standardise what the trusts do and set best practice across South east London in facing challenges such as managing the patient treatment list, efficiently running theatres, and best clinical practice to reduce waits. Sir Richard Douglas welcomed this assurance and commented that the board assurance framework showed red rated risks in relation to elective care and operational performance and so it was important not just to deliver short term improvement but address the changes which would improve over the future.

6.08 David Bradley noted that several highly scored risks mentioned risk of harm to patients, including risks relating to system pressures industrial action; he asked if this risk had materialised and whether it was being controlled appropriately. Sir Richard Douglas noted that the board should address as part of its consideration of the BAF and committees report.

6.09 Anu Singh recalled a good session at a previous board considering people on the waiting list from a point of view of health inequalities. The waiting list information as presented did not appear to include data in relation to health inequalities. She

	asked for assurance that this continued to be addressed and whether it could become part of standards reporting.
6.10	Prof Clive Kay acknowledged that more needed to be done on the topic and to provide more detail. Ben Travis agreed pointing out that progress had been made for example in a relatively advanced population health database in Lewisham which had been expanded to Greenwich as well as targeted work to help people at risk of deterioration or who may not be fit for their operation.
6.11	Sir Richard Douglas suggested that consideration of the inequalities issues and the reporting of them in future session of the board might be useful. Andrew Bland noted suggested that the data was being gathered but the use of it could be discussed.
6.12	Anu Singh asked if in the board were prepared to accept pursuing its aim to addressing inequalities even if this meant that the scores of some existing risks increased. Andrew Bland suggested that that the presentation had suggested that improving in this area in general would not worsen risks in other areas.
6.13	Ben Travis noted strong performance in urgent and emergency care during the summer exceed the trajectory for the four hour target, but called out the pressure being felt across all of South East London, sometimes leading to the need for use measures such as boarding, or creating extra bays in wards. These measures would usually only be necessary in middle of winter and there was a therefore concern that a system already pressure in autumn would face still greater challenge in the winter. There was however a huge amount of activity across the whole system reflecting a desire and commitment to try to do the best possible for patients in the coming winter. For example around 100 leaders across the health and care system would meet the day after the board share plans and best practice. Place-based boards were overseeing work on out-of-hospital measures focussing on attendance avoidances such as winter illness hubs and enhanced primary care support. Virtual wards and urgent community response aimed to improve flow through hospitals and timely discharge, and transfer of care hubs partnered hospitals with community services and local authorities to help transfer care from hospitals to appropriate settings outside. Within hospitals there was also significant focus on managing the 'front door' through opportunities such as same day emergency care, flow improvement measures, discharge lounges and schemes to aim for discharges before midday. More efficient care within the hospital joined up with diagnostics and pushing to ensure weekend staffing models avoided a cycle of preparation and recovery from weekends.
6.14	Sir Richard Douglas noted that the performance as in planned care was not at the level the Board would wish it to be, but asked if there was anything not yet being done which may ease the situation.
6.15	Prof Clive Kay suggested that with so much scrutiny of the situation including internationally there may not be many new ideas, but the system could not necessarily assure the Board that all initiatives were being enacted fully, consistently and in a standardised way. However, the system was moving in the correct direction and had halted the decline in emergency care, and colleagues who were delivering this improvement needed the Board's support.
6.16	Sir Richard Douglas emphasised the appreciation the Board would had of the

efforts made the improvements they had secured, but suggested it was the boards responsibility to represent local people in recognition that the performance was below what everyone in the system would wish.

6.17 Paul Najsarek pointed to previous years in which additional financial support had been provided for winter, asking if this was expected in the current year and whether plans were in place to spend any such resources in an efficient and productive way.

6.18 Ben Travis noted that the South east London UEC Board and place boards had encouraged colleagues to consider if some funding did appear how it would be mobilised to maximum benefit, and so the board could be confident that if additional support were provided it would be put to good use.

6.19 Ceri Jacob reflected that in assuming delivery of schemes it was important to remember that the workforce would need to be in place including in social care, if the money was to have effect.

6.20 David Bradley noted that a business case for an urgent mental health centre had been developed but was dependent on capital but there was a challenge as to how this could be quickly put to use. Richard Douglas suggested that any capital in the current year was more likely to benefit next years performance.

Quality and Safeguarding update

6.21 Paul Larrisey noted

- irisk 431 had been kept on the register in order that the impact of GP collective action could be measured before the risk was reviewed. To date there had been little impact on the system due to the GP collective action and the risk could be reviewed. Serious incident reporting and quality alerts related to industrial action had been monitored over the last 12-18 months and had been reported regionally.
- risk 491 had been raised in the context of the system moving to the implementation of the national patient safety framework and away from the previous serious incident reporting framework, and reflected that under PSIRF ICBs had much less sight of what was going on in the system than the previous system. This issue had been raised nationally and regionally. The oversight of the Synnovis cyber-attack incident had demonstrated that for example demographic data enabling an equalities lens could not be accessed by the ICB. Mitigations and workarounds were being explored with provider colleagues.
- An expected decrease in the reporting of serious incidents was being seen as the new system was in place, and the serious incident framework would be switched off from the end to Q3. Fifty-six patient safety events had been reported in Q2 and seven ‘never events’ had taken place. All were being invested by providers through the patient safety framework.
- There had been a slight decrease in quality alerts from primary care colleagues reported in the last quarter. Top themes were feeding into programmes of improvement work considering areas such as the interface between primary and secondary care.
- The ICB would work with primary care colleagues to help implement the national patient safety strategy for primary care, which was likely to look different given primary care lacked the large architects of trusts.
- In relation to the Synnovis cyber-attack incident, weekly harm review panels

had tracked a very significant decrease in concerns now that the incident had closed and had prompted a stocktake of the process and how any potential harm gowing forward could be tracked.

- For Safeguarding, completion of the new NHSE Mandated National Safeguarding Tracker was a requirement for all ICBs on a quarterly basis, and the ICB was reporting on ICB staff compliance with safeguarding training, safeguarding supervision of designated and named safeguarding professionals, and statutory reviews with more reporting to be added. The national tracker would enable baselining against ICBs nationally.
- The ICB was broadly in line with national targets at 80% of staff completing mandatory training and supervision across designated professionals was 75% - above the required level, and reported south east London wide for the first time due to the tracker.
- Thematic issues arising from statutory reviews were domestic abuse, mental health neglect, with SEND and neurodiversity becoming increasingly bigger feature of reviews
- In south east London as part of the new governance framework a system safeguarding group was being set up to bring ICB and partners across the system together to start sharing learning.

6.22 David Bradley suggested that the risk 431 may be scored too high if the majority of incidents tracked were low harm.

6.23 Dr George Verghese noted in relation to quality alerts in relation to communication between teams and inappropriate requests to GPs had increased, suggesting acute/primary care interface work had not yet been successful. Paul Larrisey advised that it was thought some of the increase could have been related to the Synnovis cyber-attack incident.

6.24 Dr Toby Garrood noted that work on the interface of primary and secondary care was accelerated. A review of system data had taken place and interface groups had been established at all acute sites supported by an overarching system interface group. Specific work was going on particularly on discharge letters and fit notes. Colleagues were encouraged to use quality alerts as a way of providing running feedback. Paul Larrisey stated the aim to align the quality alert process better with the national patient safety framework.

6.25 Anu Singh noted that the quality story of the ICB seemed to relate only to failures of safety, and asked if the refreshed committee might also consider wider data including patient feedback.

6.26 Ben Travis asked if there could be an evaluation of the way finance was influencing the decisions made and systematically understand the impact the financial constraints were having on the quality of care. Paul Larrisey noted that this specific evaluation was not recorded but the quality and safeguarding committee had a role to consider all impacts on quality of care.

6.27 Dr Ify Okocha asked if the quality alerts were solely from primary care to providers or the reverse and noted the importance of promoting these. Paul Larrisey noted that the quality alert process was advertised on the website noting that any person could raise a quality alert however the majority were raised by primary care.

6.28 Prof Clive Kay supported the primary secondary care interface work but queried the seven ‘never events’ and asked what about the Boards responsibilities in

relation to these. Paul Larrisey explained that the ICB's role on never events was to oversee reporting and receive investigation and outcomes on each event, sharing any appropriate learning for the system via the system quality group. Individual organisations were responsible for investigating the never events and implementing necessary changes.

Action: Update on primary secondary care interface to be brought to a future board informal session.

Finance update

6.29 Mike Fox noted that the ICS had reported a deficit of £140m (£44m adverse to plan) at month 5. The main drivers were the Synnovis cyberattack incident, industrial action, and slippage on the delivery of cost improvement schemes. CIP was forecast to be short of the overall plan by £27m and although a plan to significantly ramp up CIP was planned towards the end of the financial year. Workforce numbers were expected to reduce as part of the delivery of the financial plan, and whilst in early 2024-25 there had been a reduction the pace of improvement had now slowed.
In relation to the question raised on the likelihood extra funding for winter the context had to be considered which was an extremely challenging one for the NHS as a whole.

6.30 Sir Richard Douglas asked about the work by KPMG in support of the system position Mike Fox noted that the work had identified potential further savings in addition to those planned. The investigation and intervention process had been voluntarily entered by the ICS and the stage one report had been submitted. It was viewed as a good but relatively quick piece of work which therefore had some limitations, and the output had been considered by the group for CFOs for implementation using expert support if necessary.

6.31 Ceri Jacob asked how the impact on other areas of the system of savings opportunities was being considered. Mike Fox noted that a significant portion of the opportunities were more technical relating to accounting practice, taxation and contractual management. The pathway redesign and improved efficiency was expected to be additional to existing workstreams rather than new.

People committee update

6.32 Meera Nair noted that the South East London People Strategy had been shared at previous boards. The previous year there had been efforts to ensure the strategy matched ICS priorities, aligned with the long term workplace plan and the adult social care workforce strategy.
The focus had been on recruitment and retention, as well as wellbeing, involving health and social care jobs hub, wellbeing schemes and work around retention to share best practice and buddying with other organisations.
Ther next 1-2 years would focus on working with communities, neighbourhoods and a future workforce model, exploring discussions such as how to leverage apprenticeships, make it easier to migrate between organisations, and new ways of working. There was a significant cultural and OD need to enable the move from current silos and teams to actively working across organisational boundaries. The focus of the work needed to shift from the People Team to clinical and operational leaders.

The work was overseen by the People Board and range of informal networks

6.33	reporting into it, and the people board had a set of criteria to decide on programmes to take forward.
6.34	Ceri Jacob noted that accountability within integrated teams would be a useful topic to explore as well as integrating the VCSE sector into decision making.
6.35	Andrew Bland noted that the organisation was preparing to become a national pilot on NHS health checks with employers
7	**Digital Data and System Intelligence Strategy**
7.01	Philippa Kirkpatrick noted that the strategy had been expanded in scope to include data and system intelligence as key reasons for moving to digital approaches. During 2023-34 significant information had been gathered from stakeholders, which had allowed for development with key stakeholders take place at an advanced level. After discussion there had been a decision it was better to engage patients on specific projects rather than fairly similar strategies across different ICSs. An example was a survey (8000 responses) conducted on the Let's Talk platform to gather views on improving peoples engagement with GP practices which had been nominated for an HSJ award.
7.02	The vision of the strategy was to enable delivery of high-quality care to the people of South East London through digital innovation and data driven intelligence. This informed four high-level targets and six priority workstreams. Partnership working had been added as a commitment of all partners to work on the strategy. In addition, recognising that each partners strategy currently reflected their own needs as an organisation, there was an aim to achieve greater alignment systemwide over time.
7.03	Workstreams included empowering people through digital and data, related to digital inclusion as well as our important work on the NHS app and other apps for patient as well as enabling people to stay at home where possible. Digital solutions for connected care aimed at achieving a baseline level of digital maturity, and initiatives to reduce silos through digital connectedness.Focus on data-driven insights and towards a data-driven health featured important work with the London Health Data Strategy. System and resilience and cyber security included a draft cyber security strategy which will be completed in the next six months. Continuous improvement and innovation included the potential of AI and automation as well as sure that the right controls in place to avoid additional risk. The team had been working closely with the people board and other HR directors to look at that workforce, including both specialist digital data and technology workforce but the potential for the wider workforce to start enacting changes through digital and data opportunities.
7.04	Paul Najsarek welcomed the strategy and it's areas of focus, as well as the choice of an enabling rather than top-down approach but asked how the accountability for joint delivery could be create. He also asked how the digital work might have a role in creating financial savings in future years.
7.05	Ranjeet Kaile noted in relation to the potential for the wider workforce and the recognition that current digital literacy was quite poor whether the European Computur driving licence may be something could be quite quickly put in place.

7.05	Anu Singh asked if the vision might better reflect empowering the patient rather than delivering care to them. She asked that as well as digital literacy, the strategy be implemented with a clinical approach to tackling cultural change to change fit in with technological solutions and fix problems experienced by patients.
7.05	Ben Travis noted that the there was a real desire from colleagues to be involved in the work, with a digital apprenticeship scheme attracting 120 applicants at Lewisham and Greenwich NHST within weeks. The trust was also committed to try to join the same electronic patient record system as the other acute trusts which would make a massive different in delivery of care and consistency of pathways as well as efficiency. Population health was also an area of opportunity.
7.05	Meera Nair noted that interest was huge in Digital and Data Academy and the apprenticeship scheme which was a good use of the levy. This had a real impact, with examples of individual staff using advanced Excel to identify patterns, use the i-hub to assess demand and capacity.
7.05	Dr Ify Okocha reinforced the point about building the digital skills in the workforce, and ensuring that the same systems were used and connectivity was aimed for. He asked that the 'community trust requires some improvement' to be reworded for clarity.
7.06	The Board **approved** the Digital Data and System Intelligence strategy.
8	**Update on System Sustainability Approach**
8.01	Mike Fox noted without action the system would reach a deficit in excess of £400m and the system sustainability work was intended to address this with an approach that was complementary to significant cost improvement work being done in organisations.
8.02	Fiona Howgego referred the paper which described the layers four levels of savings: the first two were traditional work on cost improvement carried out annually within individual organisations, newer work involving collaborations across parts of the system such as collaboration across acute trusts, or across mental health. The system sustainability team, led by the system sustainability group including partner trust CEOs and CFOs and other representatives, aimed to address savings where the it was necessary for the whole system to change its approach, or collaborate in order to achieve the outcome. By their nature these would not be short term projects and likely to deliver over 3-5 years. The metrics and programme infrastructure needed to deliver system sustainability would need to be developed whilst continuing to deliver Cost Improvement Plans in-year. With no new sources of funding, this would have to be delivered in a lean way through releasing resources within the system and it was crucial to work with and through all system partners. The paper illustrated how proposed solutions spanned community and primary care, mental health, acute trusts, as well as the need to harness the voluntary sector and other partners. The group aimed to refine ideas being generated into a shortlist to refine during Q4 2024/25 and begin delivering in 2025/26.
8.03	Neil Kennett-Brown observed the connection to the three shifts outlined in Lord Ara Darzi's assessment of the NHS were reflected in the options being put forward for example the shift from analogue to digital was a key element, addressing demand and prevention, and investing in more primary and community care development in areas such as frailty, children and young people and people with multiple long term conditions. Engagement and ideas spanned palliative end-of-life care to back-office efficiency opportunities across organisations to realising the opportunity for savings

	in outpatient care, and would involve close working with those beyond the NHS in voluntary and community sector organisations and local authorities.
8.04	Sir Richard Douglas welcomed focus on work that could not be delivered either by organisations or the ICB but as a partnership, and therefore the core purpose of the ICS to facilitate. Beyond financial sustainability the work was necessary to create the financial headroom for the ICS to pursue its strategic aims for residents.
8.05	Sarah McClinton emphasised the need for ownership of sustainability by the whole system and the consequent importance of linking back to Place, asking how the top two or three priorities to pursue would be picked and what the process would be for determining existing priorities to stop rather than layering on new ones.
8.06	Darren Summers suggested that the implementation of any scheme be considered also from the point of view of the impact on frontline and administrative staff. Experience had shown that without sufficient attention to this a relatively straightforward scheme to share back-office functions could result in severe disruption and delays to business as usual.
8.07	Paul Najsarek asked for the confidence level of future demand projections, asking whether the accuracy of previous projections had been assessed. There could then be a question on how to address this demand. The performance and quality implications of the three shifts would need consideration along with the financial expression of the shifts in the sustainability work.
8.08	Mike Fox pointed that prioritising the demand further needed to be considered in terms of realism given the £300m and the high sums needed for each scheme if limited to three or four. In relation to the confidence for forecasts a choice had been made for a reasonable level of confidence balancing the demands of greater accuracy with the need to make progress on mitigations.
8.09	Fiona Howgego noted that the final (likely 10-20) smaller projects would be distributed across the system rather than managed centrally by a single team. A multidisciplinary group would shortly meet to consider the options for feasibility and sense checking. There was further consideration about the impact on a limited pool of staff who may be called to help implement more than one scheme.
8.10	Neil Kennett-Brown noted that many of the schemes were developed in close working with place for example prevention. In conversation with directors of adult social care they had suggested organising around neighbourhood health and care, aligning with some of the national ambitions in this area. It was a welcome challenge.
8.11	Andrew Eyres emphasised the importance of the inclusion of local government in the process and recognising similar budget challenges they faced, noting that some staff worked across both organisations, and that their support would be crucial in delivery, noting the assurances given but the current lack of mention in the paper.
8.12	Prof Clive Kay asked how to ensure that cost improvement plans did not impact negatively on the system, act in opposition to the three shifts outlined by Lord Darzi and
8.13	Diana Braithwaite echoed the importance of recognising the challenges faced by local government, and on communicating effectively what would need to stop or the

	impact on others of measures necessary to achieve balance.
8.14	Anu Singh welcomed the realistic time frame of several years set to achieve the schemes but expressed some concern that the ideas did not reflect some of the hard choices other systems were making and asked if there was a risk of optimism bias which would mean by the time the schemes provided dividends there would be no time to consider more radical schemes. This was particularly important given the high proportion of prevention and population health ideas, given most thinking suggested that double running costs were necessary.
8.15	Sir Richard Douglas agreed that the local government was important to engage. The work was important to drive CIP as well as this work, and that the optimism bias might be checked in relation to each workstream. The medium term financial strategy would need to make assumptions about how to allocate resource based on what this may deliver as well as the CIPs in individual trusts.
8.16	The Board **noted** the update.
9	**Mental Health**
9.01	Rupi Dev noted that following the case of Valdo Calocane all systems had been asked to review services provided for people under the intensive and assertive outreach programme. In south east London the review had found some good practice, but also some variation in provision across trusts, as well as challenges generally.
9.02	Mary Doherty noted that the individuals needing these services were in scope of the work were of concern as some of the most complicated, underserved and vulnerable and often excluded individuals in society. The definition in the national guidance was relatively broad. In practice many patients living with psychosis due to the nature of their illness did not believe they were ill and were resistant to engagement feeling and a difficult experience with authority. There was however the then a much smaller group with complicated needs, perhaps co-morbid substance abuse problems and a history of trauma, a mental illness perhaps not sensitive to medication who may pose a risk to others. It was important to emphasise that the majority of people with severe mental illness posed a risk to themselves rather than others.
9.03	Drivers of the variation in how services were provided for this group included systemic challenges such as staffing, capacity, funding and availability of the specific skills needed to engage effectively with this group. There were also specific challenges related to multi-agency working, and a danger agencies sometimes retrenched into their areas, where close working with police, housing, third sector and the trusts was needed. A very small proportion of people may display warning signs that they were potentially at risk to others but not enough to meet evidentiary proof for the CPS and might never access forensic services or the mental health services they needed.
9.04	Dr Abi Fadipe added that there were significant health inequalities associated with the cohort of people and better working needed with the individuals and families. The public perception was that mental health trusts were able to detain indefinitely which was not the case. The key concern was the caseload in community services, and balancing support for this particular group as well as the wider cohort of patients.
9.05	Prof Clive Kay asked about and role for acute trusts in their contacts with severely

	mentally ill patients to be part of this work. Mary Doherty noted that while the main focus would be primary care acute trusts were important - past studies with Kings College Hospital data suggested that in contrast to those presenting with self-harm, those who presenting who had been involved in recent fights or other outwardly-directed violence may not be directed in the same way to the mental health support they may need. Dr Abi Fadipe added that the issue was of multiple organisations involved with an individual not connecting the dots with no agency having the full information to asses the total risk.
9.06	David Bradley asked how many cases of within the scope of the work might be on the caseload, and reflected that investigations into previous cases had shown the importance of sharing information, and asked if there were lessons to learn for community services.
9.07	Dr Abi Fadipe suggested that a narrow interpretation of the guidelines found 350 potential cases or 30% of the caseload of people with psychosis by the Oxleas trust. The concern would be with a relatively diffuse assertive outreach function as well as the limited number of staff with the expertise to engage. In some cases voluntary or community sector organisations may be better at helping people engage, and so it was important not just to look at community mental health transformation through the lens of this particular case.
9.08	Mary Doherty added that those at risk should have multiagency plans in place, but often there were community services stretched and with high agency rates and low continuity of care.
9.03	Dr George Verghese raised as issues people discharged with a presentation and non-engagement attributed to substance misuse, often a limited communication with primary care let alone consultation about whether to accept the discharge. A mandated plan with support network should be standard for any referral that comes in with discharge where there was a risk.
9.04	Mary Doherty note that this was already the standard, but extra discussion with the clinician to explain what behaviour or patterns to be alert would be needed. Many practices there was a team who would all know the client and provided the continuity of care and strength to provide good primary care to someone with serious mental illness. There were however often pressures and high levels of sessional work in some areas which may affect this necessary continuity for patients.
9.05	Darren Summers reflected on the tension between a need to care for the whole population as well as this particularly high-risk group within it, noting individuals may move between both groups as their mental health improved or deteriorated.
9.06	Meera Nair commented that there seemed to be a lack of a shared risk profile across the two mental health trusts and other partners and asked how far the system was from achieving this. Dr Abi Fadipe replied that there was still some way to go towards this, and the with all agencies facing their own pressures a tendency to withdraw, for example even though right care right people was seen as effective by police there may have been a pull back from joint police and healthcare projects as a result.
9.07	Sir Richard Douglas noted that the remainder of the paper would be discussed at the next Board meeting **Action**

9.08	The Board noted the update.
10 10.01	**Any Other Business** There was no other business
11 11.01	**Public Questions and Answers** There were no questions asked by the public members present.
12	**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 007	17-Apr-24	The Board to receive updates on work on infant mortality raised at board	to be closed	MW/Rupi Dev	29-Jan-25	To be dealt by Integrated Performance Committee at their next meeting
ICB 011	16-Oct-24	Consideration of how regular reporting received by the board might allow them to monitor inequalities in relation to performance items	open	SC/AB	19-Mar-25	IPC will report to 16 April 2025 board
ICB 012	16-Oct-24	Work on Primary Secondary Care interface to be presented to a future board session	open	TG	19-Mar-25	Work to be reported to 16 April 2025 board
ICB 013	16-Oct-24	To bring the mental health item to a future public board to consider the remaining elements.	to be closed	Rdev/SC	29-Jan-25	on agenda 29 Jan 2025

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Adult Mental Health Services in South East London – Programme Update for the ICB Board**						
Meeting date	29 January 2025		Agenda item Number	**2**	Paper Enclosure Ref		**C**
Author	Rupi Dev, Director for Mental Health, CYP and Inequalities						
Executive lead	Sarah Cottingham, Executive Director of Planning						
Paper is for:	Update	**x**	Discussion	**x**	Decision		**x**
Purpose of paper	The purpose of the paper is to provide the ICB Board with an update on the adult mental health programme in south east London (SEL), specifically: • A highlight of some the prevention and early intervention offers in place across SEL (see Appendix 1 for further details). • To share the system mental health, learning disabilities and autism inpatient quality						
Summary of main points	• People with mental health conditions experience health inequalities in many ways including in their access to care, in their experience of wider health services and overall outcomes. Addressing overall population need and the inequalities in adult mental health access, experience and outcome is a key priority within our Integrated Care Strategy. • From a prevention and early intervention lens, in adult mental health this involves working with people to identify mental health risk and address this at a very early stage wherever possible. This work is led through our borough based Local Care Partnerships, offering the most opportunity to integrate services early in someone's care journey. Appendix 1 sets out some of the key prevention and early intervention schemes in place, which include mental health and wellbeing hubs and expanding the access to and the offer of non-clinical services. Although these offers are tailored and targeted to local populations within our boroughs, they all put partnership at the heart of their work, whether this be across different healthcare settings, with local authorities, with voluntary and community sector providers or with people with lived experience. • The paper also shares the actions underway to ensure delivery of high quality inpatient services as part of a wider inpatient quality transformation programme for mental health, learning disabilities and autism. The full programme plan can be found in Appendix 2.						
Potential conflicts of Interest	None						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham		**x**
	Greenwich	**x**	Lambeth	**x**	Southwark		**x**
Equalities Impact	There are known health inequalities experienced by people with mental health conditions, whether this be in how they access care or in how they receive wider						

	treatment across the health sector. These are set out within Section 1 of the main body of the paper.
Financial Impact	There is no financial impact associated with the content of this paper. The findings from the assertive and intensive outreach review will be considered as part of operational planning for 2025/26 to develop a medium to longer term action plan for the transformation of community mental health services. Mental health investment will be considered as part of the ICB's refresh of the Medium Term Financial Strategy, inclusive of the continued delivery of the Mental Health Investment Standard in SEL.
Public Patient Engagement	Identification of adult mental health as one of the key strategic priorities for the ICS was subject to public engagement and the overall adult mental health programme is continuously being developed in line with feedback from service users, people with lived experience and wider communities. It is anticipated that the assertive and intensive outreach mental health services review will now be subject to lived experience input as we move into the next phase of the review.
Committee engagement	The findings of the assertive and intensive community mental health services review are subject to future discussion at the Board meetings of the two mental health trusts.
Recommendation	The Board are asked to: • Note the updates provided in this paper, including our work on prevention and early intervention • Endorse our SEL adult mental health inpatient quality transformation programme (Appendix 2), ahead of publication later this month on the ICB's website.

South East London Integrated Care System

NHS South East London

Adult Mental Health Services in South East London

Programme Update for NHS South East London Integrated Care Board (ICB) 29 January 2025

1. Background & Purpose

1.1. People with mental health conditions experience health inequalities in many ways including in their access to care, in their experience of wider health services and overall outcomes. There are known inequalities in access to mental health care linked to socio-economic characteristics and rates of recovery following treatment and satisfaction with the care people receive also varies between population groups. Furthermore, people with mental health problems are at greater risk of wider inequalities, with recent studies showing that people with severe mental illness are five times more likely to die before age 75 than those who do not have severe mental illness (often referred to as the 'mortality gap').

1.2. In south east London (SEL), we have the highest need for mental health services when compared to other ICSs in London. In 2023, 11% of the SEL population reported having a long-term mental health condition (London average 10%). Furthermore, when compared to London, SEL has the highest prevalence of depression (albeit below the national average) and the second highest prevalence of severe mental illness (above the national average).

1.3. Addressing overall population need and the inequalities in adult mental health access, experience and outcome is a key priority within our Integrated Care Strategy. Furthermore, our ICB Medium Term Financial Strategy has a clear commitment to increasing investment into mental health services, supported by full delivery of the Mental Health Investment Standard and application of any national service development funds (SDF) for mental health specifically.

1.4. This paper provides an update to the ICB Board on the delivery of some of the key elements of our adult mental health programme. The areas covered in this paper are not a full reflection of our mental health programme, and supporting adults who present in mental health crisis, particularly through our emergency departments, in accessing timely care remains a key focus for our system and our overall mental health programme. Oversight of progress and delivery in this area has been discussed by the Board previously and is subject to discussion through other ICB committees and therefore is not included in this update.

1.5. The paper is split into two parts:

- Part A (Section Two of this paper) provides an overview of some of the key schemes and initiatives underway at a borough level and through Local Care Partnerships, to develop the ICB's prevention and early intervention offers for adult mental health. This section should be read in conjunction with Appendix One which provides details on these individual schemes at a borough level.

- Part B (Section Three of this paper) provides a summary of our review of intensive and assertive community mental health services, in line with the national programme of work following the inquiry into the Nottingham attacks and the Valdo Calocane case. This was presented and discussed at the ICB Board meeting in public in November 2024, in line with the national mandate for all ICB Boards to review the outcomes of the local reviews as part of phase one of the programme. This section of the paper also highlights the programme of work underway to aid recovery of these patients through our inpatient services, with further details provided in Appendix Two. Following testing at the ICB Board meeting in November

2024, the system Mental Health, Learning Disabilities and Autism Inpatient Quality Transformation Pplan has now been published on the ICB's website.

1.6. The ICB Board are asked to note the updates provided in this paper and in particular our work on prevention and early intervention in the adult mental health programme.

2. Prevention and Early Intervention for Adult Mental Health

2.1. Prevention and early intervention are a key focus within our mental health programme, aligned to our overall system strategic ambitions around increasing our focus on prevention. Specifically for adult mental health, this involves working with people to identify mental health risk and address this at a very early stage wherever possible.

2.2. Given the wider determinants of mental health and the opportunities to work with community groups and other voluntary and community sector groups, our work on preventing mental ill health is being primarily led through the ICB's borough based Local Care Partnerships (LCPs or 'Places'). Appendix One showcases some of the key initiatives underway across our boroughs.

2.3. The initiatives are tailored to local population need, reflecting the variation we have in SEL both in terms of mental health need and also population demographics. Specific initiatives include:

- Wellbeing hubs, integrating service offers and available support (Bromley, Greenwich, Lambeth and Southwark).
- Access to non-clinical support services including peer support and non-clinical therapeutic offers (Bexley, Lambeth and Lewisham).

2.4. Although work is being led with a borough lens, across all schemes there are some key themes which include: (i) the targeting of early intervention and prevention schemes to those population groups and communities who are at risk of experiencing health inequalities, including alignment to our Core20 and Plus populations; and (ii) building and growing partnerships across the sector across primary and secondary care, with people with lived experience, and with our voluntary and community sector in SEL as a trusted partner by our communities.

2.5. It should be noted that although this paper focuses on adult mental health, it is well recognised that almost 50% of mental health problems are established by the age of 14 and 75% by 24 years of age. Therefore, the system is also focusing on children and young people's mental health, which includes focusing on parental mental health offers and family approaches to care alongside providing early intervention and support for children and young people through schools.

3. Assertive and Intensive Community Mental Health Services

3.1. Over the last three years, there has been a significant focus on improving and transforming community mental health services to ensure people with a severe mental illness can receive evidence-based care and treatment that enables their recovery and supports them to live well in their local communities. In SEL, our community mental health transformation programme, supported by circa. £17 million of mental health service development funds in 2024/25, has resulted in the expansion of community mental health teams in our two mental health trusts, development of integrated single front doors

bringing together voluntary and community sector partners and some local authority services, and the piloting of lived experience/peer support worker roles.

3.2. However, it is well recognised that some people with severe mental health illness and in particular psychosis, require a more tailored approach, including more assertive and intensive outreach services.

3.3. As part of the 2024/25 NHS Priorities and Operational Planning Guidance, an expectation was set for ICBs to review their community mental health services to ensure they could meet the needs of these patients, and particularly those who require intensive and community treatment and follow-up but where engagement with services is a challenge. This was as a specific result of the inquiry into the Nottingham attacks and the Valdo Calocane case.

3.4. At the end of July 2024, national guidance was issued on how to undertake the first phase of this review, with a particular focus on individuals who have serious mental health illness and are most often marginalised, vulnerable, at high risk of accommodation instability or homelessness, and not accessing services for multiple reasons. Full details of the advised national approach to the first phase of the review can be found online here.

3.5. The ICB's review followed the national approach and was submitted to NHS England on 30 September 2024 in line with the national timetable. The findings of our review, along with the approach taken and our high-level actions were shared with the ICB Board in November 2024 as part of the mandate from NHS England on ensuring full system oversight of this programme of work.

3.6. In completing our review, the ICB has worked in partnership with Oxleas NHS Foundation Trust (Oxleas) and South London and Maudsley NHS Foundation Trust (SLaM). The work has included the following key outputs:

- A desk top review of relevant policies in line with the national guidance and relevant standard operating policies.
- A review of serious incidents (relating to the population cohort set out within the national guidance) for the last 24 months.
- Engagement sessions with a range of clinical and non-clinical staff within each provider organisation
- A SLaM review of all community mental health caseloads to determine the overall quantum of people in scope (those requiring assertive/intensive treatment), whether they had been contacted within 30 days and challenges to supporting this population group (as part of wider review of community mental health team caseloads).

3.7. Our review has found that although many of the services in SEL are able to identify, maintain contact and meet the needs of people who may require intensive and assertive community care and follow-up, there is variation in our approaches and capacity to provide assertive and intensive treatment consistently across our two Trusts and also within individual Trust footprints. The key areas of improvement identified are as follows:

a) Ensuring all Trust policies are up to date and are in a format that is easy for clinicians and teams to be able to understand and apply. The review has also noted variation in some of our operational policies and we will therefore be focusing on standardising these (where appropriate to do so).

b) Caseload volumes across community mental health teams, impacting on the ability of teams to effectively engage assertively with our service users and their families/carers. Caseloads are variable across the two Trusts and also within Trust footprints, however, overall flow through community mental health services, including appropriate step-down into primary care supported by effective stepped care arrangements, has been identified as a barrier to effective outreach services.

c) Identifying and managing high-risk individuals and communicating this consistently between teams, multi-agency partners (including the criminal justice system) and people's support networks. Across our services we need to ensure we have a consistent approach to support dynamic risk formulation across the Trust and wider system. This includes the need to capture violence more effectively, especially violence towards family members, friends, and neighbours, and to share this information and collectively manage risk across multi-agency partners. Furthermore, we need to ensure we are capturing alcohol and substance use effectively within this risk formulation and within information sharing.

d) Ensuring effective, consistent and accessible data capture in local patient record and information systems, a particular priority for SLaM.

3.8. In addressing all the areas identified above, the ICB will need to work collaboratively with the Trusts to develop a longer-term development and transformation plan aligned to system planning and resource allocation. Between now and the end of the financial year, across the system we will be focusing on the following shorter-term actions:

- Updating and streamlining Trust policies (including standard operational policies for individual teams) relating to access and discharge for this cohort of patients. This also includes ensuring policies are easily accessible and understood by clinical teams. This work will be led by our Trusts.
- Further audits of our community caseloads, led by the two Trusts. The nature of the audits will vary between the two Trusts but will include case note reviews, review of caseloads and discharges, and assessing compliance against National Institute for Health and Care Excellence (NICE) pathways for psychosis and for dual diagnosis.
- Developing clear and consistent engagement approaches across both Trusts for clinical teams. This includes engagement with service users and their families, as well as working with wider partners to provide safe and effective care planning across agencies and effective information sharing. This work will again be led by the two Trusts,
- Involving wider partners in the review, including the voice of people with Lived Experience to help develop the wider and medium to long term actions for community mental health services. Given the timescales of completing the first phase of the review we have been unable to meaningfully engage with voluntary and community sector partners, people with Lived Experience including patients and carers, and local authority partners. The ICB will work in collaboration with the Trusts and through our Places to ensure we involve wider system partners in the next stages of the review.

3.9. The review also identified good practice, which we will be seeking to build on across the system as we take forward this work, including:

- Extensive experience with well protocolised engagement and discharge approaches within our addiction services at SLaM.

- A care team approach at Oxleas which involves a nurse, social worker and two mental health advisors supporting teams with high caseloads and providing a safety net of multiple of professionals should a service relapse and require crisis care.
- An agile physical health intervention team at Oxleas to support those with a severe mental illness across primary and secondary care, supporting their physical health as well as their mental health.
- At SLaM national expertise (both in research and practice) in culturally appropriate responses to violence in care giving relationships, with an opportunity to share this work and expertise at a national level.
- Experience at SLaM of using a population health and management approach and multi-disciplinary team and peer interventions to engage and work with people involved in high rates of violence, restrictive practice and inpatient care.
- At SLaM, advancement of clinical informatics to support identification of cohorts who would benefit from enhanced engagement and intervention approaches.

3.10. As we plan for 2025/26, the ICB and the Trusts will need to consider our wider ambitions for community mental health services, taking into account the findings of this review. This will include work to ensure resource across the system is best aligned to mental health need, supporting step-down into primary care and other services to ensure caseload numbers enable targeted intervention for those who need it the most plus taking forward wider actions to ensure SEL is able to systematically and consistently provider a responsive service offer for people with serious mental illness.

3.11. In addition to ensuring our community services are providing the appropriate tailored support for these patients, it is equally as important that our inpatient services are able to provide an effective, purposeful and therapeutic environment which aids and promotes recovery to support our work in the community.

3.12. Appendix 2 sets our ambitions for high quality inpatient services, as part of the national inpatient quality transformation programme. Our programme covers inpatient services for mental health, learning disabilities and autism (in line with the national programme scope) and builds on the work already underway as part of our acute flow improvement programme. This includes a focus on reducing out of area placements, reducing length of stay and reducing the number of people who are clinically ready for discharge occupying mental health beds.

3.13. Although the programme is for all patients admitted into our mental inpatient services, we will paying particular attention to specific care pathways and population groups including those with psychosis. In year one of the programme, across SEL we are focusing on improving:

- Step-up and step-down care for intensive mental health care services. This will involve piloting outreach intensive care support on adult inpatient wards to provide early intervention and prevent admission into psychiatric intensive care units (PICUs).
- Care on our female wards. This is based on service user and carer feedback across both Trusts, and through this programme, we will be focusing on expanding the provision of activities and non-clinical therapeutic offers to support and aid overall recovery whilst in an inpatient setting. The learning from this work will be spread and shared across other wards.

- Access to physical health support for people in mental health inpatient settings with the aim of building physical health knowledge and capacity across the mental health sector, providing lifestyle advice to support people to stay well in inpatients and post discharge, and preventing unnecessary transfers to acute hospitals.

3.14. Following initial testing at the November ICB Board, the SEL Mental Health, Learning Disabilities and Autism Inpatient Quality Transformation Plan was published on our website (as currently set out in Appendix Two). It is anticipated that this will be an iterative document and we will update our plan on an annual basis.

3.15. It is worth recognising that all the work described above relates to service users who are known and referred into mental health services. We recognise that there is more to do to address unmet need in our communities and to enable equity of access to services and support. This further highlights the need to ensure we are developing our prevention and early intervention offers, engaging with our communities and residents to develop and tailor these offers to meet the needs of those at most risk of mental ill health in our population. We will need to ensure that we reflect this need as part of the upcoming refresh of our Joint Forward Plan and our Medium Term Financial Strategy.

4. Summary and Recommendations

4.1. The scope of adult mental health services is vast and spans from providing prevention and early intervention services in the community and in primary care, through to providing secure services for those most vulnerable and with the highest mental health needs.

4.2. This paper has articulated some of the work underway to improve adult mental health services across our sector. Across these areas and our full programme of work on adult mental health services we are focussed on reducing inequalities in the access, experience and outcomes of care in mental health.

4.3. The ICB Board are asked to note the updates provided in this paper and in particular our work on prevention and early intervention in the adult mental health programme.

South East London Integrated Care System

NHS South East London

Adult Mental Health Services – Appendix 1

Case Studies for Early Intervention and Prevention

ICB Board in Public

Wednesday 29th January 2025

Background and Purpose

- Adult mental health is one of the five Integrated Care Strategic Priorities with the key focus being on early intervention and prevention for those experiencing common mental health conditions.
- Early intervention and prevention involves working with people at the earliest opportunity to prevent existing health and care needs from deteriorating as well as supporting people to effectively manage any issues that they may be experiencing.
- Given the wider determinants of mental health and the opportunities to work with community groups and other voluntary and community sector groups, our work on preventing mental health ill is being primarily led by the ICB's boroughs in partnership with other members and through their local care partnerships (LCPs or 'Places').
- The purpose of this pack is to highlight and show-case some of the key interventions and initiatives underway across south east London as part of the wider ICB Board discussion on Adult Mental Health Services (Item 9 on the ICB Board agenda).
- Please note that the examples highlighted in this pack are **not exhaustive** and there many other schemes and initiatives underway to support people's mental health and wellbeing. Further details on these can be found in the system Joint Forward Plan and local borough-based Health and Wellbeing plans.

Bexley

Title/Scheme or Intervention:	Lived experience/volunteers and mentoring support

Brief Overview of the Scheme/Intervention Lived experience staff/volunteers who provide a mentoring role and enable increased social connection for residents to promote recovery

- Problem/issue addressed – Need to provide positive examples of mental health recovery, address stigma, build trust, overcome fear, empowering and training lived experienced staff and volunteers - address health inequalities.
- Intervention – Goal focused 1:1s and psychosocial and psychoeducational group facilitation led by lived experience staff/volunteers working with residents with common and severe mental illness. Lived experience includes personality disorder, psychosis, depression. Intervention is co-produced and developed further from resident and lived experience feedback.
- Partners – Mind in Bexley, Oxleas, Transformation Hub, Bexley Suicide Prevention (Barbers Project), Voluntary Sector partners, residents
- Key population groups/communities – focus on referrals from areas of high deprivation, minoritised communities, men, people with severe mental illness, digitally excluded people

Impact and Benefit to Date

- Impact includes increased: hope - seeing positive role models, normalisation, client satisfaction, wellbeing, knowledge and understanding, empathy across services, improved digital skills
- Quantitative measures: Friends and Family test 99%, Satisfaction survey 98% satisfied, 70% improved wellbeing
- Qualitative resident feedback: “Being with people that are going through the same things as you are is really helpful.” “I feel heard and listened to and it has helped me socialise more whereas before I was isolating myself” “These groups have helped me get back to a sense of normality which I am very thankful for. The (lived-experience) staff are all very friendly and well trained and knowledgeable”

Bromley

Title/Scheme or Intervention:	Bromley Mental Health Hub

Brief Overview of the Scheme/Intervention

The Joint Bromley Mental Health and Wellbeing Strategy (2020-25) set out an aim to establish a new community hub in the borough. The aim of the hub was to create an integrated service between Oxleas NHS Foundation Trust and a voluntary sector partner (SEL Mind), drawing in other partners and services in time. The hub was initially established on a three-year pilot basis, enabling more people to get help outside NHS services, with a common screening/triage approach to all referrals between Oxleas and Mind. The service is jointly funded by the ICB and Bromley Council.

The Bromley Mental Health and Wellbeing Hub provides information and advice (including benefits and housing advice), wellbeing support, employment support, support for new mums and a step-down offer for people in Oxleas. It is focused on people with Serious Mental Illness (SMI), but also has a role in terms of reaching hard-to-reach groups, and supporting people with more common mental health challenges.

A review of the Bromley Mental Health and Wellbeing Hub at the end of the pilot period has resulted in the Hub now being established on a permanent basis. The service is subject to an ongoing procurement exercise which is taking place at this time.

Impact and Benefit to Date

In 2023/24, the Bromley Mental Health and Wellbeing Hub supported 1,720 clients. Of these, 813 clients were provided with support into employment or training – which is a key obstacle for many people with mental health challenges. 53 new mums were supported by the Hub and are particularly enthusiastic about how this service provided them with the help they needed at a critical time – and spoke about this at a recent Mind event. The Hub has delivered some excellent outcomes, and has a positive reputation in the borough.

There remain challenges as we have seen an increase in demand for mental health services, notably with more people in mental health inpatient services. It is therefore critical that we further develop the Bromley Hub, linking this service to primary care, and helping to ensure that more people are able to receive early help.

Lewisham

Title/Scheme or Intervention:	Culturally Diverse Communities Programme

Brief Overview of the Scheme/Intervention

The Culturally Diverse Communities Programme was identified as a priority for the All-Age Mental Health Alliance. In Lewisham, according to the census, non-white minorities represent 48.5% of the population, we also have the highest percentage of black communities in London (27%). We have an over-representation of black people in the acute and crisis services. The programme was established to work with diverse communities and provide support at an early stage to prevent them from entering crisis. This programme was led by SEL Mind on behalf of the Alliance

SEL Mind recruited a Project Manager and sub-contracted with 4 organisations:

- Mabadiliko - Emotional Support Groups (ESGs) and Workshops to Black and Brown People online.
- Holistic Well Women - arts and crafts sessions, walking group, access to life coaching session
- Sydenham Garden - green therapy group for young people aged 18-25 years. The group is predominately LQBTQIA+ and are neuro diverse, although anyone can attend.
- Therapy 4 Healing - complimentary therapies, Counselling and Wellbeing groups.

Impact and Benefit to Date

A full evaluation of the programme is currently being undertaken, however to date:

- 60 Emotional Support Groups sessions, over 100 art therapy sessions and 68 Green Therapy sessions have taken place
- Over 70 wellbeing groups and 200 complimentary and counselling sessions have taken place
- This has provided the opportunities develop skills, abilities, confidence and reduce loneliness and social isolation for over 450 people of which:
- Women made up approximately 75% who accessed the programme across the 4 organisations.
- Approximately 280 (62%) Black Caribbean people and approximately 145 (32%) Black African people accessed the interventions.
- The age range of people accessing the interventions was from 18 – 85+, with majority falling between the age of 36-65 years.

Lambeth

Title/Scheme or Intervention:	Lambeth Primary Care Alliance Network (PCAN) and Staying Well Primary Care Mental Health Service

Brief Overview of the Scheme/Intervention

Lambeth Living Well Network Alliance have been seeking to ensure that patients registered with a GP in Lambeth have access to early advice, information and support regarding psychological and/or mental health related conditions closer to their homes and help reduce the need for referral into secondary community mental health services. In response to this the LWNA established:

1. **PCAN** – which are virtual multi-disciplinary neighbourhood meetings bringing together clinicians and practitioners from PCNs including GPs, Mental Health Practitioners, social prescribers and clinical and practitioner representatives from Lambeth's Living Well Centres (CMHTs) to share information, advice and agree how best to provide holistic support to individuals
2. **Staying Well** – a non-clinical team that can provide practical and psychosocial support to individuals such as medication, housing, benefits and employment and other issues that might lead to them being referred (back) to secondary mental health services.

Impact and Benefit to Date

- Enabled more people to be supported in their own homes and communities – by providing regular opportunities to discuss patients and share advice on areas such as: medication, care plans, referral pathways, community mental health services, etc.
- Built relationships, improved communication and shared knowledge between primary and secondary mental health services across Lambeth.
- Improving the quality/accuracy of referrals to the Lambeth Single Point of Access, reducing the number of rejected referrals.
- Increasing prevention and promoting independence – providing help earlier, in their own homes, means needs are less likely to escalate, reducing the demand for secondary health and care in the medium to long term.

Southwark

Title/Scheme or Intervention:	Southwark Wellbeing Hub

Brief Overview of the Scheme/Intervention

- The Wellbeing Hub offers free information, advice, and support to adults in Southwark to improve mental health and wellbeing.
- Jointly commissioned by the Council and the ICB, the Wellbeing Hub provides a single point of access into services, drop-in support at its Camberwell Road site, a helpline, and online support.
- Through the Hub, residents can access holistic support – including adult social care, housing, debt support, and advice services. Alongside professional help, the Hub also offers peer support activities, either on a 1:1 or group basis.
- Together for Mental Wellbeing lead on delivery of the Hub service. In addition they partner with other voluntary organisations such as The Bridge, Mental Fight Club, community centres, and Restorative Justice For All to provide pop-ups and workshops within the community

Impact and Benefit to Date

The Hub supports approximately 2,200 residents per year across the borough. Residents fed back the impact it had for them:

- *"Staff …supported me by just listening to me speak about my emotions,… not a lot of organisations have shown me kindness"*
- *"Staff…made a …referral …, I have now found a job and I'm going to save up. … [Staff] showed me how to use websites so I can look for properties and put me in touch with talking therapies so I can speak about my emotions"*
- *"I feel like I am finally on the right path, I was unhappy and confused before this but I'm a bit more positive recently. I can't find the right words, … The Hub has positively changed my life"*

South East London Integrated Care System

Adult Mental Health Services – Appendix 2

Mental Health, Learning Disabilities and Autism Inpatient Quality Transformation Plan

29 January 2025

Status: Draft for ICB Board

Version: 0.4

Introduction & Purpose

- Launched in February 2023, the mental health, learning disabilities and autism inpatient quality transformation programme is a national initiative focused on improving the quality and safety of care in mental health and learning disabilities and autism services. By partnering with patients, families, clinicians, systems, providers, and other stakeholders, the programme builds on existing good practices to enhance care.
- As part of the national programme, each integrated care system (ICS) has been tasked with developing a three-year mental health, learning disabilities and autism inpatient quality transformation plan to set out how they will deliver the ambitions and aims of the national programme for their local population.
- This is the first version of South East London's mental health, learning disabilities and autism inpatient quality transformation plan, published in October 2024.
- This plan specifically focuses on:
  - Acute mental health inpatient services including those services for people with a learning disability or who are autistic.
  - Psychiatric intensive care units (PICU).
  - Mental health rehabilitation inpatient services including services for autistic people and people with a learning disability – open and 'locked'.
- The plan should be read as an iterative working document. It is anticipated that the plan will be updated on regular basis.
- Although this plan is being published as a standalone document, it builds on the commitments set out within our annual ICS operating plan and the commitments within our existing system strategies including the ICS Strategic Priorities, South London and Maudsley NHS Foundation Trust Five Year Strategy 2021-2026 and Oxleas NHS Foundation Trust Strategy 2021 – 2024.

The National Programme

- Although many mental health services are delivering good care and outcomes, some part of the country still rely on certain types of poor quality and outdated bed-based provision, as demonstrated in the shocking and deeply distressing care scandal at Edenfield Centre in Greater Manchester, revealed in October 2022.
- The national programme aims to challenge local systems to support cultural changes and introduce a bold, radical, reimagined model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings.
- The national programme is built on the upon the principles of good mental healthcare; continuity of care, therapeutic relationships and a relentless commitment to mental health care meeting the needs of all citizens. The programme has five objectives:

Localise and realign inpatient services

Improve culture and support staff

Support systems and providers facing immediate challenges

Make oversight and support arrangements fit for the sector

Support the least coercive care

- Further information on the national programme is available on NHS England's website:- https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/

About South East London

- South east London has a population of approximately 2 million people and covers the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. NHS South East London Integrated Care Board (ICB) is directly responsible for a recurrent NHS budget of £3.9 billion and the combined annual resource allocation of the NHS partnership that makes up the ICB is £7.2 billion.
- We have a diverse and vibrant population, but a population who experiences significant health inequalities. We have a growing population who are living for longer with multiple long term conditions and demand for care, treatment and support is increasing.
- This pressure has shown itself in different ways and at different times on services, ranging from increases in waiting times and waiting list sizes, through to the need to use expensive non-NHS mental health beds when capacity is full to try to get people the care they need.
- There are five major NHS Trusts in south east London providing acute, mental health, community and specialist services to the population of south east London and wider for some services.

NHS provider landscape in South East London

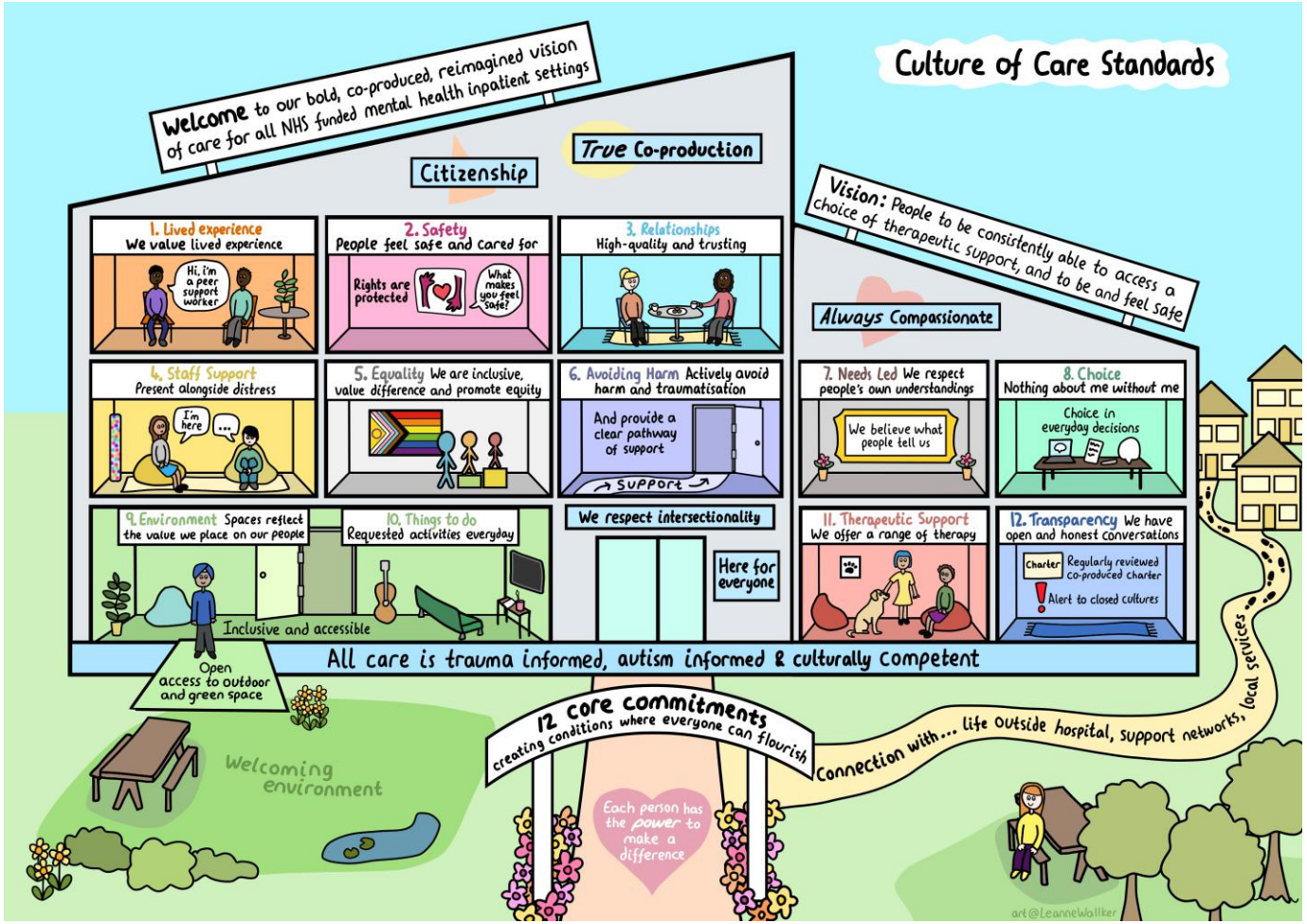
Our Mental Health System

- Adult inpatient mental health services and learning disability and autism services are provided by two NHS Trusts in South East London:
  - South London and Maudsley NHS Foundation Trust (SLaM). This Trust provides inpatient mental health services primarily for the boroughs of Lambeth, Lewisham and Southwark. The Trust also provides these services in Croydon which forms part of the South West London ICS.
  - Oxleas NHS Foundation Trust. This Trust provides inpatient mental health services primarily for the boroughs of Bexley, Bromley and Greenwich.
- Although need and demand for mental health services varies across our six boroughs, our mental health index is the highest of the five ICS' in London. There are circa. 20,000 known people with a diagnosis of a severe mental illness (SMI) in South East London and the mortality gap (the life expectancy gap of 10-15 years lower than the general population) is higher in five out of the six SEL boroughs, when compared to the London average.
- In 2021/22, we had the third highest rate of detentions under the Mental Health Act for any area of England, suggesting a high number of people reaching crisis point. This results in high demand for our inpatient services with bed occupancy being consistently over 100% for our system, high reliance on independent sector capacity, increasing lengths of stay across our inpatient units, and long waiting times in our emergency departments for admission to inpatient beds.
- As of August 2024, we have a total of 496 inpatient beds (including PICU) in our two mental health trusts serving the six boroughs of South East London (SLAM: 259 adult and older beds and 30 PICU) (Oxleas: 195 adult and older adult beds and 12 PICU beds). Furthermore, we have commissioned an additional 56 inpatient beds from the independent sector for 2024/25, however, we continue to purchase independent sector capacity above this for individual patients.
- There are 10 specialist beds in South East London for Autistic males. Under the mental health south London provider collaborative, there is access to low secure learning disability and autism beds in an NHS Trust in South West London.

Our Vision & Principles for Inpatient Services

South East London Integrated Care System

Our vision for inpatient services is based on national culture of care standards



Principles

In taking forward this vision we will ensure we build on the following principles with the person at the centre of their community:

Citizenship
Know your people

Localisation
Bring them home

Continuity
Keep them close

Belonging
Value everyone 'all means all'

Our Key Priorities for Inpatient Services 2024 - 2027

Aligned to our existing ambitions, the South East London mental health, learning disabilities and autism inpatient quality transformation plan has three key priorities over the next three years:

Priority 1: Improving access and flow through inpatient services.

Priority 2: Ensuring inpatient services offer effective, holistic and therapeutic care.

Priority 3: Developing community-based offers of support.

Delivery of these priorities will be underpinned by:

- The **voice** of people with lived experience.
- A culture of **continuous improvement**.
- Effective **partnership working** and pathways between services
- Developing a **skilled and competent workforce**.
- A clear, consistent and evidence based **therapeutic offer**.

Priority 1: Improving access and flow through inpatient services (1/3)

South East London Integrated Care System

Aim:

- To ensure patients receive appropriate, purposeful and timely access to inpatient care.
- Reduce out of area placements and reliance on independent sector provision, ensuring our residents receive care as close to home as possible

Our We Statements

- We will work collaboratively to ensure that admissions are appropriate, purposeful, therapeutic, and timely so that no-one is inappropriately admitted to hospital or experiences delays in their care.
- We will plan discharge with each person from the very start of their admission, mitigating the risk of delays and ensuring that transitions between services are carefully considered.

Key outcomes and measures over the next three years

Patient Outcomes

- Zero inappropriate out of area placements for South East London residents**.**
- Patients who require an inpatient admission (whether in emergency departments or in home treatment team/community team caseloads) are allocated a bed within 4 hours of identification of need.

Provider/ICB Outcomes

- Average length of stay for both providers consistently within national benchmarks.
- Patients clinically ready for discharge and occupying mental health beds less than 5% of the total South East London bed base.
- Bed occupancy rate at 85% and reduction in overall Occupied Bed Days (OBDs).
- Reduction in spend on independent sector provision.

Staff Outcomes

- Increased staff satisfaction.
- Improved staff retention rates.

Priority 1: Improving access and flow through inpatient services (2/3)

Key Actions for Year 1 of the Programme (2024/25)

- **Bed Capacity**
  - Expansion of NHS bed capacity for working age adults to reduce reliance on independent sector beds throughout the course of 2024/25 and reduce out of area placements.
  - Dedicated contracted independent sector capacity across the system to support timely access to inpatient care and admission. This will be supported by robust oversight and governance support with enhanced clinical leadership to oversee placements in the independent sector and strong partnership working to involve housing and social services in the management of care for any patients or residents placed in independent sector beds.
  - Completion of robust bed modelling to identify gaps in current inpatient bed provision across south east London including for working age adults, older adults, PICU and step down care.
- **Length of Stay**: Demonstrable reductions in length of stay by at least 1 day by the end of 2024/25 across working age adult inpatient services through a series of actions led by each individual mental health Trust. This includes:
  - Developing a continuous flow model to enable early discharges and admissions onto inpatient wards.
  - Embedding the principles of effective discharge resulting in early discharge planning and a reduction in the number of people clinically ready for discharge.
  - Focused work on pre- and post-admission Care Treatment Reviews (CETRs) and actioning CTR recommendations in a timely manner.
- **Step down care**: Working in partnership with the voluntary and community sector, to develop and pilot alternative models of step-down care (specifically for the boroughs of Lambeth, Lewisham and Southwark).
- **Repatriation:** The development of the low secure beds by the mental health south London provider collaborative to continue to support bringing people closer to home and supporting step-down from secure services.

Priority 1: Improving access and flow through inpatient services (3/3)

South East London Integrated Care System

Key Actions for Year 2 of the Programme (2025/26)

- Implementation of any agreed actions as result of the bed modelling work for completion in 2024/25. This may involve:
  - Ongoing contracting of private sector capacity with strong clinical and operational oversight from our mental health trusts.
  - Development of a consistent and sustainable model for the delivery of female PICU across the sector.
  - Further expansion of step down capacity to support flow across different inpatient units and services.
- Further improvements in length of stay across the two mental health trusts.

Key Actions for Year 3 of the Programme (2026/27)

- Ongoing implementation of any agreed actions as result of the bed modelling work for completion in 2024/25. This may involve:
  - Ongoing contracting of private sector capacity with strong clinical and operational oversight from our mental health trusts.
  - Development of a consistent and sustainable model for the delivery of female PICU across the sector.
  - Further expansion of step down capacity to support flow across different inpatient units and services.
- Further improvements in length of stay across the two mental health trusts.

Actions for years 2 and 3 of the programme are subject to change and will be further re-iterated in future versions of the plan.

Priority 2: Ensuring inpatient services offer effective, holistic and therapeutic care (1/4)

South East London Integrated Care System

Aim:

- Ensure inpatient services are purposeful, personalised, therapeutic and effective, avoiding unnecessary admission and ensuring patients are only in inpatient services for as long as they need enabling effective recovery for mind and body.

Our We Statements

- We will ensure that admissions are appropriate, purposeful, therapeutic, and timely.
- We will commission and deliver inpatient services that are least restrictive and where people are not confined in conditions of greater security than required.
- We will pay attention to our hospital environment and the impact it has on the wellbeing of people experiencing inpatient services and the staff working within them.
- We will work with people (and those who know and love them) to identify ‘what matters to them’ and make sure that the care they receive is personalised, needs led, respects their human rights and responds to people’s distress with compassion.
- We will invest in inpatient services that demonstrate a holistic, strengths based, integrated approach to care and make sure that mental and physical health conditions are considered, managed, and monitored.
- We are committed to delivering services that demonstrate therapeutic benefit. This includes continuous improvement of the inpatient pathway, co-producing service developments, making best use of data and using quality improvement methodology.

Priority 2: Ensuring inpatient services offer effective, holistic and therapeutic care (2/4)

South East London Integrated Care System

Key outcomes and measures over the next three years

Patient Outcomes

- Reduced time spent on inpatient wards.
- Improved occupational activity and relaxation with patient view captured on DIALOG.
- Choice and changes offered to every patient on antipsychotic medication
- Reduced transfers to emergency care.
- Increased engagement in relevant population screening programmes and prevention programmes.
- Reported patient confidence in self-management of long-term conditions.
- Reduction inequalities faced by people with severe mental illness in terms of physical health care, ultimately improving life expectancy.

Provider/ICB Outcomes

- Average length of stay for both providers consistently within national benchmarks.
- Bed occupancy rate at 85% and reduction in overall Occupied Bed Days (OBDs).
- Increase in the proportion of health screens carried out for inpatients.
- Wider system benefits in terms of long-term condition management for people with severe mental health illness (across primary care and acute physical health services).
- Reduction in spend on independent sector capacity.

Staff Outcomes

- Additional resource to provide pastoral, and alternative therapies for inpatient services.
- Increased staff satisfaction at work resulting in increased staff retention.
- Increased staff competency amongst inpatient staffing group with regards to physical health with increased staff numbers in mental health trusts trained in phlebotomy, electrocardiograms (ECGs) and glucose monitoring.
- Less staff time spent away from mental health clinical areas.

Priority 2: Ensuring inpatient services offer effective, holistic and therapeutic care (3/4)

South East London Integrated Care System

Key Actions for Year 1 of the Programme (2024/25)

- **Purposeful Admission Criteria**: Development and implementation of purposeful admission criteria for mental health services across south east London.
- **Intensive Care Pathway**: Development and pilot of a PICU outreach service across both mental health trusts. This will involve piloting the creating of a new multi-disciplinary team who would provide outreach to inpatient wards across the two mental health trusts. These teams will provide specialist assessment, support, and recommendations on management strategies for all patients referred to PICU, with the aim of managing the patient's care in the least restrictive environment, preferably in their original location/ward/unit.
- **Care Pathway for Females**: Development of an inpatient pathway that is more responsive to females with activities more tailored to the needs of women, including women with learning disabilities and autism. This will include commissioning of local, grassroot voluntary and community sector partners to provide alternative therapies as part of the care pathway.
- **Physical Health Service Offer**: Development and pilot of a new agile inpatient physical health team that supports parity of esteem between physical and mental health and to offer a comprehensive physical health care offer, including healthy lifestyle interventions such as physical health checks, physical activity, healthy food choices, and other interventions.
- **Rehabilitation Services**: Consolidation of the current 'locked' rehabilitation services in south east London onto one single site to support delivery in the consistency of care across units. This will result in a reduction in the number of beds that fall into this category. Development of an options appraisal on how to redeliver rehabilitation services, working in partnership with the voluntary and community sector.
- **Sensory Environments:** Implementing reasonable adjustments utilising consultation and advice to inpatient units.

Priority 2: Ensuring inpatient services offer effective, holistic and therapeutic care (4/4)

South East London Integrated Care System

Key Actions for Year 2 of the Programme (2025/26)

- Based on evaluation and feedback, to expand and scale the following offers from 2024/25:
  - Intensive care pathway outreach MDT.
  - Physical health service offer.
- To review care pathways for Under 25s with a view to develop alternative therapeutic models of care, building on the learning and partnership approaches for the female care pathway in 2024/25.
- To develop and test alternative models of rehabilitation services in partnership with the voluntary and community sector, with the aim and ambition to cease commissioning of 'locked' rehab services by the end of 2026/27.

Key Actions for Year 3 of the Programme (2026/27)

- Based on feedback and evaluation to expand and scale key initiatives from 2025/26.
- To decommission 'locked' rehab services by the end of the financial year. In order to do this, new models of rehab will be expanded from 2025/26 and there will be the relevant consultation with partners and the public.

Actions for years 2 and 3 of the programme are subject to change and will be further re-iterated in future versions of the plan.

Priority 3: Developing community-based offers of support (1/3)

South East London Integrated Care System

Aim:

- To ensure there are a range of services to support people within their local communities providing early intervention and prevention, avoiding unnecessary hospital admission and enabling people to stay and live well in their communities.

Our We Statements

- We will work in partnership across our system to ensure that locally, there is a range of services to support people within their local communities.
- We will employ interventions designed to avoid unnecessary admission to hospital
- We provide services that are needs led and accessible to all who need them, and we are proactive in facilitating choice.

Key outcomes and measures over the next three years

Patient Outcomes

- Reduction in inpatient admissions.
- Increase in choice in where patients to choose to have their care.
- Increase in patient satisfaction as reported via patient reported outcomes and DIALOG.
- Increase in patients in employment.

Provider/ICB Outcomes

- Reduction in the number of patients presenting to emergency departments in mental health crisis.
- Reduction in the number of patients requiring inpatient admission, resulting in bed occupancy rates of 85% and reduction in overall Occupied Bed Days (OBDs).
- Increase in voluntary and community sector service provision across the sector.

Staff Outcomes

- Increase opportunities for staff to work in different settings across the sector, developing new skills resulting in improved staff retention rates.

Priority 3: Developing community-based offers of support (2/3)

South East London Integrated Care System

Key Actions for Year 1 of the Programme (2024/25)

- Embedding community mental health transformation, in line with the national roadmap. This will include ensuring there are clear plans in place for each Primary Care Network (PCN) that is not yet fully transformed in line with the national standards/expectations, supported by peer review and sharing of best practice across the sector.
- Improved data recording and capture through the Mental Health Services Dataset (MHSDS) to then develop a consistent local dashboard to track progress with delivery of community mental health transformation. This enable better oversight of caseloads and waiting times for community mental health services.
- Development of a new model of care in Lewisham as part of the national 24/7 community mental health services programme. This will include testing a new community model of care which brings together community mental health services with a stronger wrap-around offer from home treatment and crisis resolution teams.
- Targeted work in the boroughs of Bromley, Bexley and Greenwich reviewing attendances at emergency departments with a view to understand this from the perspective of different communities and population groups. Following analysis of the data, to work pro-actively with the local communities and voluntary and community sector providers to develop proposals for alternative models of care.
- Enhancing intensive support services for people with a learning disability and community autism only support services to support discharge and prevent admission alongside effective Dynamic Support Register (DSR) Management
- Fully implement the Learning Disabilities and Autism Pathway Strategy and Panel in partnership with the south London mental health provider collaborative who are responsible for secure inpatients and their discharge to the community as the least restrictive environment; including development of the Forensic Intellectual and Neurodevelopmental Disabilities (FIND) service to meet needs in the community.

Priority 3: Developing community-based offers of support (3/3)

South East London Integrated Care System

Key Actions for Year 2 of the Programme (2025/26)

- To continue to expand the community mental health transformation programme in line with local evaluation and national expectations.
- To continue to pilot the new 24/7 community mental health services offer in Lewisham borough with ongoing evaluation to consider what could be tested and implemented elsewhere in south east London.
- To pilot and test new models of community care using population health management approaches and targeted to local communities in partnership with voluntary and community sector providers.
- To continue to work collaboratively to implement community housing and accommodation options for secure and non-secure patients, including bespoke options.

Key Actions for Year 3 of the Programme (2026/27)

- transformation programme in line with local evaluation and national expectations.
- To continue to pilot the new 24/7 community mental health services offer in Lewisham borough with ongoing evaluation to consider what could be tested and implemented elsewhere in south east London.
- To pilot and test new models of community care using population health management approaches and targeted to local communities in partnership with voluntary and community sector providers.

Actions for years 2 and 3 of the programme are subject to change and will be further re-iterated in future versions of the plan.

Programme Governance & Oversight

- The mental health, learning disabilities and autism inpatient quality transformation programme will be core to our mental health transformation agenda across the ICS, building on the existing aims and ambitions for mental health services in south east London.
- The programme will involve strong oversight from the Executive Teams within the two mental health trusts and the ICB.
- Senior responsible officer (SRO) leadership for the programme will be provided by the Chief Medical Officers at the two mental health trusts and system oversight will be provided jointly by the ICB's Chief Nursing Officer and Executive Director of Planning/Deputy Chief Executive. These individuals will be responsible for ensuring their relevant Boards are kept informed of programme delivery.
- Key to our work in south east London is partnership working whether that be with the acute trusts providing physical health and community services or with our local authority and voluntary sector partners. The programme will embed into existing structures across the ICS that include these partners whether this be via Care Pathway Boards within the ICS (supported and co-ordinated by the ICB) or Local Care Partnership forums.

Involving our Services Users, Families, Carers and Communities

No decision about us, without us

- At the heart of this programme is the voice and views of people with Lived Experience including patients, service users, families and carers, as well as the wider views of our communities in south east London.
- All the key actions in this plan have been developed based on several years of feedback collated via:
  - **Insights collected by the ICB over the last 12 – 24 months and shared on our Insights Platform.** This includes feedback and insight from the South East London People's Panel, insighted gained as part of the development of the ICS strategy from April – December 2022, and insights from particular community groups included the Act for Change Report for gathering views from our Afro-Caribbean communities.
  - **Direct service user, carer and family feedback on services**. This includes our LDA User Patient Carer Forum, weekly ward community meetings where staff and patients come together to raise and address issues of concerns, and patient experience groups with learning from complaints and patient experience feedback. This feedback has shaped our priorities in developing plans to access alternative therapeutic activities.
  - **Engagement and co-design of individual, bespoke projects**. In developing our 24/7 community mental health services pilot, we have run bespoke workshops with people with lived experience and members of our communities, ensuring we have representation specifically from people from our Black communities.

How to get involved going forward?

As we further develop our programme into years 2 and 3, we will develop an engagement approach with an aim to co-produce solutions and service improvements. Engagement will include a mixture of outreach and face to face activity, as required. All information will be published on our ICB online engagement platform (Let's Talk Health and Care in South East London) and NHS Trust platforms.

Appendix 1: Glossary & Definitions

- **Access and flow** – this refers to the processes that move inpatients through a hospital from the moment they arrive to when they leave and their care transitions to the community.
- **Clinically ready for discharge –** sometimes referred to as medically ready for discharge, this term means that patients/service users have been assessed as no longer needing treatment in hospital and are ready to be discharged or have their care transferred to another team. Sometimes there are delays in the onwards transfer of care which may mean that some people stay in hospital for longer than required.
- **Integrated Care System ('ICS')** – legally established in July 2022, ICS' are responsible for joining up care across the NHS, councils, voluntary sector and others with an aim to improve health and care services across a defined geography. There are 42 ICS' across England. Further information can be found here:- https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
- **Integrated Care Board ('ICB')** – also formally established in July 2022, ICBs are NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices.
- **Inappropriate out of area placements –** an inappropriate out of area placement (OAP) is defined as when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services, usually due to a lack of availability for a mental health bed in their usual area. Inappropriate out of area placements are usually associated with poorer patient experience and outcomes.
- **Length of stay** – a metric that measures the time between a patient's admission and discharge.

Appendix 1: Glossary & Definitions (Cont.)

- **Local care partnerships (LCPs)** – sometimes referred to as ‘Place’, this term is used to describe a model of joined up team working to improve health and care for a local population. There are six LCPs in South East London, aligned to the six local authority boundaries. Each LCP is different but usually includes representation from the local NHS trusts, primary care, public health, social care, voluntary and community sector providers and Healthwatch.
- **Locked rehabilitation (‘rehab’) services** – this type of rehabilitation services prevent service users from leaving the unit at will. The new commissioning framework for adult inpatient mental health services states that mental health rehabilitation inpatient services should not be ‘locked’ and a new approach needs to be found to delivering this care.
- **NHS Trust –** an NHS organisation who provides NHS health and care services across either a geographical area or a specialised function.
- **Occupied bed days –** this refers to the number of days that inpatient beds are occupied by patients. It is used a measure to understand and define how much beds are used.
- **Older adults –** generally this refers to adults aged over 65 years of age.
- **Operating Plan** – an annual document that sets out the NHS’ priorities for the upcoming year across various domains including finance, performance, activity and workforce.
- **Psychiatric Intensive Care Units (‘PICU’)** – specialist wards that provide inpatient mental health care. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on an acute inpatient ward.

Appendix 1: Glossary & Definitions (Cont.)

- **Primary Care Networks ('PCNs') –** these are groups of GP practices that work together, and with other health and care providers, to deliver a wider range of services to the local population than might be possible within an individual practice.
- **Working age adults –** generally this refers to adults aged between 17 and 64, regardless of employment status.
- **VCSE** – VCSE stands for voluntary, community and social enterprise. It's an umbrella term which encompasses a diverse range of organisations from voluntary and community groups, social enterprises, charities, and nonprofit organisations.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**NHS Sexual Safety in Healthcare Organisational Charter**					
Meeting date	29 January 2025	Agenda item Number	3	Paper Enclosure Ref	D	
Author(s)	Tosca Fairchild - Chief of Staff & Senior Responsible Officer for Equalities. Florence Acquah - Designate Safeguarding Adults Nurse. David Rowley - Mental Capacity Act and Safeguarding Development Lead. Lucy McCaffery - Assistant Director of Organisational Development and Staff Engagement					
Executive lead	Tosca Fairchild - Chief of Staff & Senior Responsible Officer for Equalities.					
Paper is for:	Update	x	Discussion		Decision	
Purpose of paper	To inform the SEL ICB Board of the progress made to implement the "*NHS Sexual Safety in Healthcare - Organisational Charter"* and raise awareness of the Board and workforce's responsibility of Sexual Safety in the work place.					
Summary of main points	In September 2023 NHS England launched it's '*Sexual Safety in Healthcare Organisational Charter'* in collaboration with partners across the healthcare system. SEL ICB signed up to the NHS Sexual Safety in Healthcare – Organisational Charter in October 2023 and is committed to strengthening efforts to ensure a "*zero-tolerance"* approach to sexual misconduct and violence in the workplace. This paper provides an update on national policy and legal requirements relating to Sexual safety in healthcare and work being done to ensure SEL ICB meets the legal requirements, supports and protects it's workforce against sexual misconduct and violence in the workplace.					
Potential conflicts of Interest	None advised					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	The new policy will be subject to EIA					
Financial Impact	None					
Public Patient Engagement	Staff engagement via All Staff briefing sessions.					
Committee engagement	Progress on the implementation of national policy will be reported to the Executive Committee					
Recommendation(s)	The Board is asked to • note the national guidance					

	• welcome the position of all NHS providers and the ICB being fully signed up to the Sexual Safety in Healthcare Charter with executive leadership in place • note the legal requirements relating to sexual safety in the workplace • note 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.

NHS Sexual Safety in Healthcare

NHS South East London Integrated Care Board (ICB) 29 January 2025

In September 2023 NHS England launched it's '*Sexual Safety in Healthcare Organisational Charter'* in collaboration with partners across the healthcare system. South East London ICB signed up to the charter in October 2023 and is committed to strengthening efforts to ensure a zero-tolerance approach to sexual misconduct and violence in the workplace.

This paper provides an update on national policy and legal requirements relating to Sexual safety in healthcare and work being done to ensure SEL ICB meets the legal requirements, supports and protects it's workforce against sexual misconduct and violence in the workplace.

1. Introduction

1.1. The drive for the Sexual Safety initiative resulted from the launch of the Domestic Abuse and Sexual Violence (DASV) programme in July 2022. This was established by NHS England to build on robust safeguarding processes for protecting patients and staff, improving victim support and focus on early intervention and prevention.

1.2. Sexual harassment, sexual assault, and rape, referred to as sexual misconduct, is unacceptable in all spheres of life including the workplace.

1.3. SEL ICB has a duty of care to protect employees from, and prevent incidents of, sexual misconduct from individuals within the physical or digital workplace. SEL ICB expects all employees, contractors, secondees, agency staff, volunteers, students, interns, and casual and/or bank/agency/temporary workers to comply with this policy. Those who work, train, and learn within the healthcare system have the right to be safe and feel supported at work.

1.4. Organisations across the health and social care system need to work together and individually to tackle unwanted, inappropriate, and/or harmful sexual behaviour in the workplace. We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

1.5. In September 2023 NHS England launched its first ever "Sexual Safety in Healthcare Organisational Charter" following on from an independent report on sexual misconduct by colleagues in the surgical workforce "Breaking the silence - Addressing sexual misconduct in Healthcare" was published in September 2023 and highlighted

concerning levels of sexual assault and harassment experienced by female surgeons working in the NHS.

2. The ICBs commitments as a signatory to the Charter

2.1. SEL ICB signed up to the NHS England Sexual Safety Charter on the 3rd October 2023. As signatories to this charter, SEL ICB committed to a "zero-tolerance" approach to any inappropriate and/or harmful sexual behaviours towards patients and the workforce and will work towards delivery of the ten principles of the Charter:

NHS Sexual Safety in Healthcare 10 Principles

1. We (SEL ICB) will actively work to eradicate sexual harassment and abuse in the workplace.
2. We (SEL ICB) will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful, and/or inappropriate sexual behaviours.
3. We (SEL ICB) will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate. For example, women, black, ethnic minority, disabled and LGBTQ+ groups
4. We (SEL ICB) will provide appropriate support for those in our workforce who experience unwanted, inappropriate, and/or harmful sexual behaviours.
5. We (SEL ICB) will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted, and/or harmful sexual behaviour.
6. We (SEL ICB) will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We (SEL ICB) will ensure appropriate, specific, and clear training is in place.
8. We (SEL ICB) will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We (SEL ICB) will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We (SEL ICB) will capture and share data on prevalence and staff experience transparently.

These commitments will apply to *everyone* in our organisation equally.

3. NHS Providers serving south east London who have signed the Charter

3.1 In addition, NHS providers in south east London have also signed the Charter and as required, all the organisations have an executive director lead assigned to sexual safety:-

Hospital Trusts	Executive Lead
Guys and St Thomas NHS Foundation Trust	Chief Nursing Officer
King's College Hospital NHS Foundation Trust	Chief Nursing Officer and Chief Medical Officer
South London and the Maudsley NHS Foundation Trust	Chief People Officer
Lewisham and Greenwich NHS Trust	Chief People Officer
Oxleas NHS Foundation Trust	Chief Nursing Officer

3.2. The SEL ICB executive director lead is the Chief of Staff.

3.3.1 The *NHS England Sexual Safety Charter Assurance Framework* NHS England » Sexual safety charter assurance framework sets out the outcomes from each principle in the charter and lists actions that would assure their delivery. The actions are recommended as best practice.

4. Worker Protection Act 2023

4.1. On the 26 October 2024, the Worker Protection (Amendment of Equality Act 2010) Act 2023 came into force. This creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties.

4.2. The law requires employers to:

- Take a proactive and preventative approach to sexual harassment
- Be accountable for sexual harassment by third parties
- Promote reporting channels for complaints
- Respond promptly, fairly, and thoroughly to complaints
- Investigate and act on any evidence of discriminatory behaviour or harassment
- Send out a clear message that such behaviour will not be tolerated.

5. NHS England Sexual Safety Resources

5.1. The NHS England Domestic Abuse and Sexual Violence (DASV) team have issued several guidance documents and training to support NHS organisations to meet the legal requirements. These are:-

5.2. **Sexual Safety in the workplace toolkit: Resources and support** - This toolkit was launched in October 2023 and designed to support colleagues who have experienced sexual misconduct in the workplace.

5.3. **NHS England Sexual Misconduct Reporting Form –** This is a new form for reporting incidents of sexual misconduct and includes an option to report anonymously.

5.4. **NHS England Sexual Misconduct Policy –** The outlines the approach to tacking sexual misconduct and how to deal with perpetrators.

5.5. **NHS England Sexual Safety Policy Framework -** The policy framework has been developed with input from the national Workforce Issues Group of the NHS Social Partnership Forum. Nothing in the national people policy frameworks automatically overrides local terms unless agreed at local level.

5.6. **NHS England Sexual Misconduct Policy Overview** – This policy is for any working and volunteering, visiting, and learning at SEL ICB. It helps organisations and staff to understand their rights and responsibilities; recognise and report sexual misconduct at work and signpost to advice and support.

5.7. **NHS England E-Learning** – The training is for all staff on sexual misconduct can be used by NHS organisations to help raise awareness and develop understanding of sexual safety in the work place. In addition to this e-learning, specialist training for Human Resources (HR) and Freedom to Speak Up (FTSU) roles is in development.

6. Progress to date

6.1. The SEL ICB Charter was signed by the Chair and CEO.

6.2. A SEL ICB Sexual Misconduct policy informed by the guidance from NHS has been developed and subject to an equality impact assessment (EIA) will be undertaken to ensure that the policy supports Black, minoritised, disabled and LGBTQ+ staff who experience sexual abuse at a disproportionate rate.

6.3. SEL ICB staff have been made aware of the Sexual Safety in Healthcare Organisational Charter' and the legal requirements with engagement undertaken via the SEL ICB All staff briefing session.

6.4. An assessment of SEL ICB against the Sexual Safety Charter Assurance Framework has been undertaken.

7. Next Steps

7.1. The Chief of Staff will lead on seeking assurance from primary care and the voluntary sector on their implantation of the Sexual Safety in Healthcare Charter and that there is relevant leadership in place.

7.2. A Sexual Safety Charter Assurance Framework action plan to ensure delivery of actions for the Charter principles is being finalised. Progress of delivery will be reported to the Executive Committee.

8. Recommendations

8.1. The Board is asked to

- note the national guidance
- welcome the position of all NHS providers and the ICB being fully signed up to the Sexual Safety in Healthcare Charter with executive leadership in place
- note the legal requirements relating to sexual safety in the workplace

- note 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.

ICB Board Meeting in Public

Title	**Delegation of Specialised Services to South East London ICB**					
Meeting date	29 January 2025	Agenda item Number	**4**	Paper Enclosure Ref	**E**	
Author	**Martin Wilkinson – Director, South London Office of Specialised Services**					
Executive lead	**Sarah Cottingham - Director of Planning**					
Paper is for:	Update		Discussion		Decision	**X**
Purpose of paper	To update the board on progress towards delegation of specialised services, and to authorise the ICB CEO to sign the Delegation Agreement and Collaboration Agreement, to allow delegation to take place on 1st April 2025.					
Summary of main points	Specialised services have historically been commissioned by NHS England, with budgets held and managed centrally. From April 2025, designated specialised services will be delegated to London ICBs, in line with agreed national policy and South East London ICB will be responsible for commissioning the majority of specialised services for its population. South East London, alongside South West London ICB and the four acute tertiary providers in South London, have been working together on a South London Specialised Services Programme for three years, supported by the South London Office of Specialised Services (SLOSS), preparing for delegation and unlocking the benefits of joined-up end to end care pathway planning and delivery. The paper provides further information on: • The case for change and transformation pilots in South East London • The future operating model and governance arrangements under delegation • The risks, issues and mitigations that are associated with delegation. Two key documents that will support the delegation of specialised services are in final stages of development, and will require Chief Executive Officer signature prior to delegation: • Delegation Agreement: A mandated document outlining legal requirements that the ICB will commit to when receiving delegation. • Collaboration Agreement 2025/26: A framework detailing joint decision-making across the five London ICBs and NHS England, specifying service commissioning and financial structures					
Potential conflicts of Interest	None					
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**

Equalities Impact	The transformation pilots have shown that integrating specialised services into end-to-end pathways can have a positive impact on promoting equity and reducing unwarranted variation in care. Investment in the community offer for people with sickle cell disease and work in HIV to re-engage people back into treatment are good examples of the case for change.
Financial Impact	The ICB will receive a financial allocation from NHS England to commission the delegated services and pay providers for specialised activity. The exact figures to be received are not yet confirmed, however indicative allocations from 24/25 suggest that the ICB's allocation for the commissioning of specialised services will be in the region of £650m.
Public Patient Engagement	The ICB's duty to engage public and patients will extend to the delegated specialised services from April 2025.
Committee engagement	ICB executive committee and Board seminar, noting significant South London and London wide work and governance in place supporting delegation in addition.
Recommendation	1. Note 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. 2. Authorise the ICB Chief Executive to sign the Delegation Agreement with NHS England before April 2025. 3. Agree that internal ICB governance policies will be amended to support delegation - the Scheme of Reservation, Delegation and Standing Financial Instructions - to reflect new ICB's responsibilities through delegation.

Delegation of Specialised Services to South East London ICB

NHS South East London Integrated Care Board (ICB) 29 January 2025

1. Executive Summary

1.1. ICBs have collaborated with NHS England throughout 2023–2025 to commission acute specialised services, addressing associated risks and issues. On 5th December 2024, the NHS England Board confirmed that all regions not yet delegated, including London, would receive commissioning responsibility for the services to be delegated from 1st April 2025.

1.2. This paper provides Board members with an update on key aspects of the planned delegation and the preparatory work the SEL ICB has been undertaking with providers, other London ICBs and NHS England to prepare for delegation.

1.3. In this context the ICB Board is asked to:

- Note 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.
- Authorise the ICB Chief Executive to sign the Delegation Agreement with NHS England before April 2025.
- Agree to update internal ICB governance policies - the Scheme of Reservation, Delegation and Standing Financial Instructions - to reflect new responsibilities through delegation.

2. Background

2.1. Specialised services have historically been commissioned by NHS England (NHSE), with budgets held and managed centrally. This model is now changing, with NHSE and ICBs sharing joint responsibility for commissioning most specialised services since April 2023. In April 2024, ICBs within the East of England, North West, and Midlands regions received delegation and responsibility for commissioning most specialised services, with all other ICBs (including those in London) working to receive delegation in April 2025. The full list of services in scope for delegation to ICBs can be found here.

2.2. South East London, alongside South West London and the four tertiary providers in South London have been working together over the last three years to prepare for delegation and unlock benefits of joined-up commissioning. We have jointly funded the South London Office of Specialised Services (SLOSS), who have driven and supported this work. This included the 23/24 South London Pathfinder programme which successfully tested the case for change, testing and demonstrating how finance, business intelligence and contracting can be delegated to ICBs, with South East London directly paying providers for the delivery of specialised services. We have also developed and implemented a number of specialised transformation initiatives which have helped demonstrate the case for change alongside developing our governance and commissioning arrangements to support joint commissioning and delegation.

3. Case for Change

3.1. The delegation of specialised services will join-up services budgets to enable a whole-pathway approach to be taken when commissioning care. ICBs will be able to design services and pathways of care that better meet population need and local priorities. They will also have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for the local population. Financial incentives will be aligned, and any benefits of investing in non-specialised preventative care will be retained by ICBs if actions taken reduce spend on specialised services.

3.2. If successful, delegation should have a positive impact on care quality, equity and value:

- **Quality of patient care** - Patients will have better outcomes as we strengthen the continuum of care and multidisciplinary approaches, with a greater focus on population health and prevention.
- **Equity of access** - Shared planning and population-based budgets will encourage providers and commissioners to progress their shared vision for the needs of their populations.
- **Value** - Working across the array of settings and organisations will allow us to address demand on services, workforce, and investment, creating a better, more sustainable health system.

3.3. Our south London Specialised Services Programme has been testing the case for change through a number of transformation pilots, set out in the table below. Our objective is to apply learning from and build upon these pilots as we take on our new commissioning responsibilities.

Programme	Aims	Results
Renal Transformation Programme	• Early Chronic Kidney Disease detection and prevention in community, streamlining primary, secondary and community care across the renal cardiometabolic pathway. • Implementation of complex clinical case management clinics • Point of care testing and medicines optimisation	• Launched in 7 integrated neighbourhood teams, with over 1000 patients engaged to date. • Recruited two multi-specialty pharmacists at GSTT and KCH to work across all SEL integrated teams. • Working with palliative and end of life care colleagues to integrate renal services. • Developing a 'How to' guide to support integrated, holistic working across SEL.
Blood Borne Viruses (BBV) Emergency Department Testing	• Support elimination of HIV and Hepatitis B&C • Enhance patient outcomes for BBV patients. • Expand opt-out testing for BBVs. • Re-engaging patients no longer in care	• Approximately 450,000 HIV tests and 200 new diagnoses. • 250,000 Hep B tests with 1,500 positives. • 2,000 Hep C RNA tests with 200 new diagnoses. • Established South London HIV Network and clinical and service resources. • Approximately 200 individuals were successfully re-engaged, with many being from Black or Black British backgrounds (70%) leading to improvements in viral suppression
Sickle Cell disease (SCD) Improvement Programme	• Enhanced community support, focused on equity of care for patients of all ages. • Transfer of care plans on to the Universal Care Plan • Set up the Emergency Department (ED) bypass unit at Lewisham hospital	• Established expanded community team pilot with specialist nurses and MDTs. • High completion of Universal Care Plans • Lewisham Hospital ED bypass unit planned to start January 2025 • Over 60 young peer mentees on Sickle Cell Society programme • Welfare support advisors have received over 100 referrals

4. The Future Operating Model

4.1. A London group, comprising NHSE and ICB representatives, has overseen the development of a future operating model. The model respects NHSE's nationally defined parameters to ensure statutory compliance with regards commissioning for specialised services, seeks to ensure sustainable commissioning workforce and has developed agreed approaches around subsidiarity and decision making, including what makes sense to do together on either a 'once for London' or multi ICB level to maximise efficiency and effectiveness.

4.2. Whilst the vast majority of spend on specialised services is being delegated to ICBs, a number of smaller, highly specialised services will continue to be commissioned directly by NHS England. Therefore, the current regional commissioning team will be split, with staff working on services to be delegated being employed by an ICB in London, forming a Specialised Services Shared Commissioning Team (SSSCT) to support ICBs across London in their commissioning of the delegated services. This team will be functional by 1st April 2025, and with employment transferred to an ICB on 1st July 2025. Staff working on commissioning of retained services will continue to be employed by NHSE.

4.3. A co-designed single leadership model has been developed to mitigate potential fragmentation and to make the best use of available resource and expertise for both retained and delegated services. A single director will oversee the retained commissioning team working on behalf of NHSE and the SSSCT team supporting ICBs with delegated commissioning responsibilities, and report to both NHSE and the 5 London ICBs. Both teams will be co-located in NHSE offices to enhance cohesion and collaboration, ensuring streamlined support across functions and fostering an integrated approach to specialised commissioning. The SSSCT will have a workplan that is agreed by the ICBs with each ICB having developed its own specialised services infrastructure, expertise and resource to work alongside the SSSCT and with other ICBs.

4.4. We have engaged providers in developing the future proposed operating models through specialised services governance, including the South London Executive Management Board of SLOSS and the London Joint Committee.

5. Mental Health

5.1. A number of mental health services are included in the portfolio of specialised services being delegated to ICBs, such as Adult Secure, Children and Young People inpatient, Adult Eating Disorders, and Perinatal Mental Health Units. These services are currently delivered under the Provider Collaborative model, and ICBs will retain this existing model for mental health services to be delegated post-April 2025. London ICBs have endorsed hosting arrangements, reinforcing their commitment to cross-boundary, multi-ICB decision-making aligned with Provider Collaborative footprints. We are keen to build on the successes of the current model, but also secure the benefits associated with the national case for change going forward.

5.2. Provider Collaboratives are NHS-led, with a Lead Provider responsible for managing the commissioning budget and tasks within a defined geographic footprint. The Lead Provider holds a contract NHSE (which will transfer to ICBs as part of their new delegated responsibilities in April 25) and sub-contracts with

other providers, overseeing performance and quality. This setup is supported by dedicated resources across quality, clinical, and finance roles. NHSE maintains oversight through regular reporting and quality assurance frameworks. For SEL, the Mental Health Provider Collaborative is the South London Partnership, made up of South London and Maudsley, Oxleas and South West London and St Georges'.

6. Future Governance Arrangements

6.1. The delegation of specialised services impacts governance arrangements on multiple levels, which are set out below.

6.2. SEL ICB Governance

6.2.1. We have undertaken detailed work to prepare for delegation and to agree roles and responsibilities within the ICB to support effective multi-disciplinary commissioning of specialised services, collaborating with providers to do so. The SEL ICB Planning Directorate will hold the overall responsibility for specialised services delegation, working with other ICB Directorates such as Quality, Medical and Finance, as well as our providers, places, SLOSS and South West London ICB. These arrangements will feed into appropriate governance structures ensuring delegated specialised services are integrated to support end to end pathways and commissioning. The ICB will also be supported by both the SSSCT and the continued co-commissioning of specialised services Clinical Networks.

6.2.2. We are keen to ensure that the commissioning of delegated specialised services is embedded within our existing planning and commissioning approaches, recognising that the specialised services system architecture is complex, requiring ICB and multi ICB (in and out of London) working and joint working with NHSE. As above we are committed to a collaborative and coproduction approach with providers, with our existing specialised services programme having demonstrated the benefits of this approach through its collaborative partnership model.

6.3. Multi-ICB Governance

6.3.1. In order to exercise the delegated functions most efficiently and effectively, some delegated services are best commissioned on a multi-ICB footprint. The Integrated Collaborative Commissioning Agreement (ICA), a requirement of the delegation agreement, further details the pan-London arrangements regarding multi-ICB decision-making.

6.3.2. The governance arrangements are designed to balance collaborative decision-making with the sovereignty of each ICB. They set out the collaborative commitment to working together to maximise the benefits of delegation for patients and populations across complex pathways. The processes have been designed with other regions (South East and East of England) and ICBs with significant specialised activity flow into London.

6.3.3. The South London Executive Management Board, including non-London ICB partners, and the London Specialised Services Partnership Board, will support these arrangements. These boards are not formal committees of the board for any of the ICBs or NHSE. However, they have the authority to make decisions through individual Executives representing their organisations.

6.3.4. For mental health services, an integrated approach to commissioning has already been established.

ICBs will continue commissioning through this established channel. Agreed mechanisms ensure that the London Mental Health Board can provide relevant expertise to the specialised commissioning governance structures that span multiple ICBs.

6.3.5. These multi-ICB governance arrangements supplement NHSE's formal safeguards in relation to service changes and proliferation. NHSE will continue to set service specifications and provider eligibility lists, meaning providers would need national approval before they are able to start delivering an additional service. The Service Change Business Rules also set out how any change to a specialised service with an annual effect greater than £5m per provider will require a full business case and national sign-off.

6.4. Specialised Services Shared Commissioning Team (SSSCT) Governance

6.4.1. A Collaborative Oversight Group will oversee the operational running of the SSSCT. This includes agreeing the annual work plan, finances, staffing and recruitment. It will ensure the SSSCT operates within governance structures and multi-ICB decision-making frameworks, providing value for money. It will escalate any necessary items to the London Specialised Services Partnership Board.

6.4.2. The Collaborative Oversight Group's membership will be comprised of representatives from NHSE and each London ICB.

7. System Change

7.1. Alongside the future operating model and updated governance arrangements, changes to ways of working will be key to the success of delegated commissioning. NHSE and ICB teams will be required to work effectively together, with a clear focus on collaboration, transparency, and cultural alignment.

7.2. In preparation for delegation, pan-London functional groups have been set up over the past year, to ensure ICB staff members can begin to develop relationships with colleagues in NHSE. Additionally, an initial organisational development session was held in November 2024, with commissioning and provider colleagues from different functions in South East London and NHSE London joining together in-person to get to know each other better and discuss commissioning arrangements and ways of working for the future.

8. Finance

8.1. The ICB will receive a financial allocation from NHSE to commission the delegated services and pay providers for specialised activity. Transacting specialised services finance in this way was successfully evaluated during the South London Pathfinder programme in 2023/24. The exact figures to be received are not yet confirmed, however indicative allocations from 24/25 suggest that the ICB's allocation for the commissioning of specialised services will be in the region of £650m.

8.2. NHSE have initially constructed ICB allocations based on current levels of specialised service usage of each ICB's population. However, proposals to move towards 'needs-based' allocations have been announced, to calculate an allocation for specialised services in an equivalent way to how ICB allocations for core acute services are determined. South East London has been assessed as spending significantly more than the calculated 'needs-based' allocation, which could mean that allocation growth for specialised services in future years is severely constrained. However, NHSE have not announced any further detail on how long they anticipate it will take ICBs to converge towards the new targets and

discussions are on-going around allocative methodologies and approaches.

9. Risks & Issues

9.1. The delegation of specialised services introduces three main categories of risk, which are managed by the South London Specialised Services Programme and reviewed on a quarterly basis at the Programme's Executive Management Board (EMB):

Category	Risk(s)	Mitigation(s)
Finance	• Whilst initial 25/26 allocations have been set to cover the current cost of commissioning the delegated services, demand for specialised services is growing and future growth allocations are likely to be very constrained. • This could be further impacted by convergence towards new 'needs-based' allocations.	• Significant amount of financial analysis performed through the SLOSS System Analytics & Finance Group, to build an understanding of the regime changes and model potential scenarios. • A case is being presented to NHSE that outlines a number of issues associated with the 'needs-based' allocative methodology. • A holistic sustainability review is being initiated to understand where services could be delivered more efficiently and effectively.
Commissioning Support	• The capacity and structure of the Specialised Services Shared Commissioning Team (SSSCT) is still unknown. • This cannot be finalised until staff consultations within the current NHSE team are complete.	• The regional team will clarify staff positions and structures as soon as possible post consultation. • It has been agreed that there will be a single leader across the staff groups supporting both delegated and retained services. • Developmental work to support ways of working has been initiated.
Existing Service Risks & Issues	• ICBs will inherit existing risks and issues relating to specialised services that are currently managed by NHSE, from April 2025. • These include capacity constraints, provider finance pressures, and capital replacement issues.	• In order to capture and quantify the transfer of risk, a legacy risk log has been created. • The log will be used to track and monitor key risks and issues related to specialised services over the coming months and years. • These risks and issues will be reviewed on a quarterly basis by the South

10. Key Delegation Documents

10.1. The joint working groups have co-produced several key documents that support the delegation of the specialised services; these include:

- **Delegation Agreement:** A legal agreement between the ICB and NHSE detailing the responsibilities of each organisation post-delegation. A template delegation agreement can be found here.
- **Collaboration Agreement:** A framework detailing joint decision-making across the five London ICBs and NHSE, specifying service commissioning and financial structures. This is in final drafting and will be ready for the ICB Executive signature before 1 April 2025.
- **The Host ICB agreement and SSSCT operating model** describe the multidisciplinary team that supports ICBs with their delegated responsibilities. They will detail the team's composition, roles, operational structure, and financial agreements.

11. Recommendations

11.1. ICBs have collaborated with NHS England throughout 2023–2025 to commission acute specialised services, addressing associated risks and issues. On 5th December 2024, the NHS England board confirmed that all regions not yet delegated, including London, would receive commissioning responsibility for the services to be delegated from 1st April 2025. Therefore, the ICB board is asked to:

- Note 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.
- Authorise the ICB Chief Executive to sign the Delegation Agreement with NHSE before April 2025.
- Agree to update internal ICB governance policies - the Scheme of Reservation, Delegation and Standing Financial Instructions - to reflect new responsibilities through delegation.

Board meeting in Public

Title	**Chief Executive Officer's Report**						
Meeting date	29 January 2025		Agenda item Number	**5**	Paper Enclosure Ref	**F**	
Author	Andrew Bland, ICB Chief Executive Officer						
Executive lead	Andrew Bland, ICB Chief Executive Officer						
Paper is for:	Update	**x**	Discussion		Decision		
Purpose of paper	To receive the report from the Chief Executive Officer						
Summary of main points	This report updates the Board on matters of interest across NHS South East London since the last Board meeting on 16 October 2024						
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) 29 January 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 managed exceptional winter operational pressures, responded to further industrial action, whilst continuing to deliver against our operational plans for 2024/25. The agenda items prioritised at our Board today relate to these issues alongside key enablers of improvement and transformation.

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. The report sits alongside our wider Board meeting agenda that will deal with the performance of the system and the actions we are taking to improve it.

1. Industrial Action

1.1. In the last quarter of the 2024 year, there were three episodes of industrial action as follows:

Organisation	Date	Staff group
LGT	September 2024	HCA band 2 staff
LGT	September 2024	HCA band 2 staff
SLaM	November 2024	ISS staff (including Catering, Cleaning and Portering)

1.2. The industrial actions were localised to individual trusts, managed locally, and monitored via emergency planning (EPRR) routes, and on the daily Directors of Operations calls. No issues were escalated to SEL ICB.

GP Collective Action

1.3. GPs started taking collective action from 1 August 2024 which could have had a significant impact on general practice, as well as other NHS services such as 111, A&E and community pharmacy. However, the impact in south east London has been

minimal with GP practices providing over 5% more appointments this year than the same time last year.

1.4. Currently Urgent & Emergency Care (UEC) data shows no immediately obvious impact of GP collective action on UEC services, however A&E attendances (all types) have continued an upward trend in recent weeks, in line with trends observed last year. SEL ICB continues to work with NHS England London to monitor the impact of the collective action.

2. NHS Ten Year Plan

Change NHS listening exercise

2.1. The Department of Health and Social Care and NHS England launched Change NHS in October 2024 as a national initiative to gather insights from the public and healthcare workers. This feedback will shape the Ten-Year Health Plan, due in spring 2025, which focuses on three key areas: delivering more care in communities, leveraging technology to improve health and care, and prioritising illness prevention. Members of the public, staff, voluntary, community and social enterprise sector (VCSE) partners, local and national organisations, including NHS trusts and Local Authorities, have contributed responses to help guide the plan's development.

2.2. To support engagement, the South East London Integrated Care Board has promoted the engagement through online platforms, social media, newsletters, and workshops. This includes a dedicated webpage, webinars, and events in collaboration with community groups like the charity Citizens UK. Discussions are being integrated into existing forums and community events to ensure diverse perspectives are heard.

2.3. Workshops with the public, VCSE, and care professionals are planned in January and early February 2025 to delve deeper into the plan's priorities. This includes two workshops taking place on Monday 20 January 2025 12–2 pm and Wednesday 5 February 2025, 6–8 pm. More information including details of how to register are here.

3. Equalities Update

Statutory EDI duties

3.1. South East London ICB (SEL ICB) is awaiting findings of a re-monitoring exercise carried out by the Equality and Human Rights Commission in Autumn 2024. Feedback from its previous monitoring activity is being taken into consideration in the compilation of SEL ICB's Public Sector Equality Duty 2024/25 report which will be presented to the Board in due course. In alignment with EDS22 commitments, a new set of statutory Equality objectives are also in development. The Gender Pay Gap report is being collated to consider further steps SEL ICB can take to 'close the gap' with findings due to be reported to the Government Equalities Office in March 2025.

Equality Delivery System 2022 (EDS22)

3.2. A South East London ICS-wide programme has been established including a task and finish group leading system work, with all SEL NHS Trust partners represented. This programme also involves SEL ICB's Planning directorate and Place Executive Leads (PEL) to ensure full coverage. Two services have been selected and scored for the 2024/25 assessment: Integrated therapies for children and young people (Greenwich) and the Paediatric community dental service (SEL-wide). Planning for the upcoming 2025/26 assessment has begun, with Planning and PEL leads currently identifying a new set of services for review.

Workforce Equality Standards

3.3. 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 diversity 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. Initial discussions have taken place at SEL ICB's Senior Management Team and findings from the reports will be shared at a future Board meeting.

Anti-racism strategy review

3.4. The SEL ICB Staff Anti-racism strategy has been recently reviewed to understand it's overall impact since publication in summer 2023 and to determine actions to take forward in the forthcoming EDI strategy. Alongside this, SEL ICB was approached to participate in a pilot programme, the 'Race Equality Maturity Index' (REMI). The REMI framework is part of work being carried out by the London Anti-racism Collaboration for Health (LARCH). The SEL ICB strategy has also 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.

4. Health & Housing Coalition

4.1. In December, senior leaders from the NHS, local councils, communities and the voluntary sector across south London committed to addressing the link between housing and poor health at the first meeting of a newly formed South London Health and Housing Coalition.

4.2. The Coalition has been developed to directly deliver on commitments made by both south London ICBs at two South London Listens community listening assemblies to take action on the health impact of the housing crisis.

4.3. In July 2024, the South East London Integrated Care Partnership welcomed and endorsed plans to convene partners across south London to galvanise them to identify solutions and create a housing action plan.

4.4. The first Coalition meeting was a success, with NHS and Local Authority leaders committing to working together to progress recommendations that came out of a year-long participatory policy making process involving community leaders. Action will now be taken forward across south London in three key areas: leveraging NHS land to create affordable homes, embedding housing advocacy within health services and strengthening the role of the health system in identifying housing issues.

4.5. Detailed plans for delivering against the community priorities will be launched later this year, following wider engagement with communities and stakeholders.

5. Creative Health

5.1. On 19 December, South East London ICB formally launched an exciting new partnership with the Southbank Centre. Working together the two organisations will use the power of the creative arts to improve health and wellbeing for communities in south east London, especially for children and young people.

5.2. The partnership will focus on supporting the development of The Southbank Children and Young People's Creative Health Centre: A dedicated space for creative health programmes providing interventions that improve and support the mental health and wellbeing of local children and young people. It will also support collaboration between the Southbank Centre and NHS teams, including through creative health interventions for children on Child and Adolescent Mental Health Services (CAMHS) waiting lists.

5.3. Over the next 12 months through the partnership, the Southbank Centre and SEL ICB will work with NHS, local authority, and cultural, voluntary and charitable sector partners in setting a longer-term roadmap to help deliver key programmes for local communities.

6. Sustainability

Background/context

6.1. The SEL ICS Green Plan (2022-2025) is the three-year system-wide sustainability strategy that sets out aims, objectives, and delivery plans in support of the NHS net zero ambition. The plan contains a total of 122 objectives for delivery over the three-year cycle across eleven areas of focus. This being the third and final year of the plan all objectives are now live, however not all are in delivery (see Green Plan delivery position, below).

Green Plan delivery position

6.2. Green Plan delivery is assessed bi-annually in September and March. The delivery position from March 2024 was presented and discussed in detail at the July meeting of the ICB Board. Board members made observations and recommendations on the number of objectives, scale of ambition and support requirements. This Board feedback has been recorded and considered by the ICB Sustainability team and will

be used when updating objectives in the 2025-2028 Green *Plan* (see Green Plan update, below).

6.3. The delivery position from September 2024 (since included in the October 2024 Chief Executive Officer's report) remains the most recent reported position, where 90 of 122 objectives (74%) are in active delivery.

6.4. The March delivery assessment will determine the final delivery position for the 2022-2025 Green Plan. The SEL ICB and SEL ICS will then create and work to an updated Green Plan (see Green Plan update, below).

Green Plan update (2025-2028)

6.5. Greener NHS (NHS England) has advised that an update of ICS Green Plans will be required, effective as of April 2025, to cover a minimum period of three years. This will allow for a review of objectives in the current iteration of the plan, and realignment to current priorities, resource levels and future ambitions.

6.6. Formal guidance advising of the update requirement was originally to be published in October 2024, but publication has been postponed and it is now expected during January 2025. Draft versions of the guidance have been shared but content has varied significantly between drafts; it is therefore not appropriate to commence work based on these versions. The drafts, however, provide some idea of key working concepts for the Green Plan update.

6.7. It is understood that Greener NHS will require updated plans to be completed within c.9 months of publication of guidance. Exact deadline dates are to be confirmed.

7. Armed Forces Covenant

Background/ context

7.1. Those who serve, or have served, in the UK Armed Forces will have experienced a number of disruptive impacts, both in the course of their service to the country and also in transition to civilian life when service careers come to an end. This may translate to disadvantages in accessing NHS services compared to other citizens but also, for SEL ICB as an employer organisation, disadvantages when service personnel apply for and work in ICB jobs.

7.2. The NHS constitution requires all NHS organisations to remove such disadvantage and ensure fair treatment. SEL ICB has historically done this informally and is now taking two important actions to highlight its commitment to the Armed Forces.

The Armed Forces Covenant

7.3. The Armed Forces Covenant is a promise by the Nation that those who serve (or have served) and their families are treated fairly. Whilst adherence to the covenant is implied in the NHS Constitution, SEL ICB has, as of 19 December 2024, formally signed the covenant and, in doing so, has made its own pledges to actively enhance and promote its status as an Armed Forces-friendly organisation.

The Defence Employer Recognition Scheme (ERS)

7.4. The Defence Employer Recognition Scheme (ERS) acknowledges employers that provide exceptional support to the Armed Forces community. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant.

7.5. Following signature of the Armed Forces Covenant (see section above), SEL ICB is applying for bronze ERS status. The ICB meets the criteria for the bronze award and should therefore achieve this.

8. Annual Assessment of SEL ICB's Adherence to NHS England EPRR Core Standards

8.1. On an annual basis, all NHS organisations are assessed for their compliance with the NHS Core Standards in Emergency Planning, Resilience and Response (EPRR). These standards determine the effectiveness of the governance, planning and delivery arrangements for each organisation's response to business continuity and emergency incidents.

8.2. The outcome of NHS South East London ICB's assessment in 2024 was that the ICB is fully compliant with the relevant standards. This is good news for the ICB and reflects the huge amount of work that has taken place to develop SEL ICB's EPRR processes and plans, alongside its response to a number of incidents including a cyber-attack affecting system partners, and industrial action.

8.3. As part of the formal annual process, **the Board is asked to note and confirm acceptance of this outcome.** A full report on EPRR activities, including incident response, training and exercising, will be considered by the SEL ICB Executive Committee in the coming weeks.

8.4. As part of system responsibilities, the SEL ICB EPRR team co-ordinated and chaired individual review meetings with the NHS Trusts and Bromley Healthcare in south east London to discuss their assessments against the EPRR core standards. It was pleasing to note the high standard of outcomes across the board, with all organisations being assessed as either fully or substantially compliant. This has resulted in a system-wide outcome of substantial compliance with relevant standards**.**

9. Our people

9.1. A warm welcome to Georgina Fekete who has joined SEL ICB as a Non-Executive Director from 1 December 2024. Georgina is a highly experienced leader, with over 25 years' experience in health-related roles in organisations with international reach and impact, including the Forward Institute, United Nations, Children's Investment Fund Foundation and the European Commission. Her work has focused on tackling health inequalities and addressing the social and economic determinants of health. She has developed and delivered strategies to enable transformation through large-scale public health projects, and related systems, in the UK, Africa and Asia. She

brings experience of working with politicians, policy makers, private sector leaders and civil society organisations, as well as extensive public engagement.

9.2. Meera Nair, Chief People Officer for LGT and SEL ICB will be leaving on 14 February to join Manchester University NHS Foundation Trust as Chief People Officer. Meera has worked in south east London for some time having previously been at Oxleas NHS Foundation Trust, where she was Director of Workforce and Quality Improvement. Crystal Akass, Chief People Officer at GSTT will be taking over from Meera working with the ICB.

9.3. Sarah McClinton, ICB Place Executive Lead for Greenwich left in December 2024 to take up the national role of Chief Social Worker for Adults at the Department of Health and Social Care in January 2025. Sarah joined the Royal Borough of Greenwich in 2019 and has had a long career in local government, holding several senior roles there and in the civil service. She has also served as President of ADASS (Association of Directors of Adult Social Services) and undertaken various ADASS roles in London and nationally. She was appointed to the Greenwich Place Executive Lead role at the ICB's inception in 2022 and has led the Healthier Greenwich Partnership locally.

9.4. The GSTT Trust Chairman Charles Alexander announced on 6 January that the Board of Directors has begun a rigorous, international recruitment process to find a successor to Professor Ian Abbs, who has led the Trust with both distinction and compassion since taking on the role in August 2019. Professor Abbs has confirmed his intention to stand down from the role of Chief Executive Officer (CEO) later in the year, once a new CEO has been appointed. He will remain as CEO until a successor is available to assume the role, with exact timings subject to the appointment process and the notice period of his successor.

Management Cost Reduction (MCR)

9.5. Following the Management Cost Reduction (MCR) programme last year, most staff placed at risk during the process left in December or are leaving imminently, with a handful of staff leaving later this year. The majority of redundancies fall into the financial year 2024/25; those that fall into 2025/26 are due primarily to reasons such as maternity leave (where additional protection in employment law is afforded) and/ or ongoing secondments where agreement has been reached to complete the term of the secondment. The search for suitable alternative employment continues for all displaced staff; where notice has been given and a suitable opportunity becomes available, notice can be retracted.

9.6. Displaced staff continue to be supported by the ICB’s HR and OD teams, and are encouraged to access to the Outplacement Support, which has received positive feedback, and the ICB’s employee assistance programme. Displaced staff are also given reasonable time to apply for new roles and attend interviews.

10. 2024 HSJ Awards

10.1. The 2024 Awards adhered to the 44-year-old values of sharing best practice, improving patient outcomes, and innovating drivers of better service, but also provided a well-deserved thanks to the sector. HSJ Awards shine a light on the outstanding efforts and achievements that the NHS has delivered.

10.2. A number of organisations and individuals within south east London were nominated for awards in 2024 with two winners, four highly commended and three further finalists as follows:

- **Winner** - Reducing Inequalities and Improving Outcomes for Children and Young People Award – Evelina London Patch Children's Community Nursing team
- **Winner** - NHS Communications Initiative of the year - South East London Cancer Alliance
- **Highly commended** - Innovation and Improvement in Reducing Healthcare Inequalities Award - Mind & Body Programme, Kings Health Partners, Stockwellbeing PCN and Thriving Stockwellbeing PCN
- **Highly commended** - Mental Health Innovation of the Year - South London Mental Health and Community Partnership - Oxleas, SLaM and SWLTStG NHS Mental Health Trusts in Partnership
- **Highly commended** - Patient Safety Award - Guy's and St Thomas' FT: Mechanical Life Support
- **Highly commended** - Clinical Leader of the Year –Waqas Akhtar, GSTT
- **Finalist** - Clinical Leader of the Year - Dr Stephanie Lamb, The Well Centre
- **Finalist -** Driving Efficiency through Technology Award - South East London Integrated Care Board: Improving Access to General Practice
- **Finalist** - Medicines, Pharmacy and Prescribing Initiative of the Year - South East London ICS: Tackling Overprescribing Using a Whole-Systems Approach

11. Bexley Borough Update

Dartford & Gravesham NHS Trust Hyper-Acute Stroke Unit

11.1. From 2 December 2024 Bexley residents who suffer a stroke or suspected stroke are taken to Darent Valley Hospital for treatment. This new Hyper-Acute Stroke Unit and service will ensure fast access to specialist stroke services. The faster someone receives specialised stroke care, the greater their chances of recovery and survival. This means:

- For 99% of the Bexley population travel time to Darent Valley Hospital is better or equal to previous transfer locations by the London Ambulance Service.
- Patients will be treated in a Hyper-Acute Stroke Unit at Darrent Valley Hospital, ensuring rapid assessment, immediate CT scans, and clot-busting treatment (if needed) within 30 minutes of arrival.
- After the Hyper-Acute Stroke Unit, patients will move to an Acute Stroke Unit at the same hospital, offering seven-day therapy services and specialised multidisciplinary care.

11.2. This change is the result of an extensive review of stroke services across Kent and Medway, emphasising the need for consolidated specialist units to save lives and reduce disability. The review ensured that the reconfiguration benefitted Bexley patients. Analysis showed that for 99% of the Bexley population travel time to

Darent Valley Hospital is better or equal to previous transfer locations (Princess Royal Hospital).

11.3. The Hyper-Acute Stroke Unit at Darent Valley Hospital will ensure that patients:

- receive dedicated expert care, including immediate assessment
- access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes of arrival at the hospital
- They will then be moved to the Acute Stroke Unit on the same site. Acute Stroke Units are for subsequent (after 72 hours) hospital care.
- These units offer ongoing specialist care with seven-day therapies services (physiotherapy, occupational therapy, speech and language therapy and dietetics input) and effective multi-disciplinary team working.

11.4. Since go live, twelve patients have been conveyed to the Hyper Acute Stroke Unit and 2 repatriations to the Acute Stroke Unit having presented elsewhere (from Queen Elizabeth and University Hospital Lewisham).

Supporting Diverse Communities – Black History Month

11.5. Bexley Wellbeing Partnership hosted two focused events during Black History Month 2024 to tackle health issues where Black communities are often under-represented in terms of accessing services.

11.6. The Black Women and Men's Health Matters event took place on Wednesday 23 October 2024 at Belvedere Community Centre and focused on Breast Cancer, Prostate Cancer, Menopause and Mental Health.

11.7. The second Black History Month event, which took place on 29 October 2024 focused on Sickle Cell Awareness. In the UK, approximately 17,000 black people are affected by this condition yet, it is often suggested by clinicians and community leaders that there is not enough awareness and resources on how to manage sickle cell, the importance of blood donations and the services available for those with lived experience.

Supporting Diverse Communities – Functional Fitness MOT Programme

11.8. The London Borough of Bexley Public Health team developed Local Health & Care Profiles for each of the three geographical Local Care Networks: Clocktower, Frognal and North Bexley. In response, Local Care Networks took a population health approach on deciding where to focus efforts to address health inequalities.

11.9. Frognal Local Care Network utilised funding from the Bexley Wellbeing Partnership Health Inequalities Fund to focus on frailty as a priority cohort. Age UK have been commissioned to deliver the Function Fitness MOT programme. Participants are targeted who are in danger of losing function and becoming frail, to motivate them into change to healthier behaviours which are intended to keep them well and living independently for longer.

11.10. For a Functional Fitness MOT, a trained assessor takes participants through 7 simple tasks to measure strength, flexibility and balance. There follows a motivational interview and the participant will leave with an action plan of achievable

goals for them to improve results and continue to carry out functional activities of daily living better. A date is then given for a second test for participants to see if their test scores have improved and if further assistance is needed.

11.11. The programme was launched as part of a borough Ageing Well event in October 2024 and to date 53 people received an MOT. Several events are being planned in Frognal (South Bexley), which will provide opportunities for people to engage with the MOTs. There are currently 28 people on the waiting list for an assessment.

Primary Access Recovery Plan: Progress

11.12. The Government's Delivery plan for recovering access to primary care (the Plan) was published on 9 May 2023. The NHS is focused on recovering core services from the significant and ongoing impact of the pandemic, and this plan sits alongside delivery plans for recovery of elective and urgent and emergency care services.

11.13. The second year of the delivery plan for recovering access to primary care focuses on realising the benefits to patients and staff from the foundations established in 2023/24.

11.14. Empowering patients**:** Continuing to break down the barriers patients face and make it easier for them to access care, whilst taking pressure off of general practice:

- Increasing sign-ups to the NHS App for viewing patient records and ordering repeat prescriptions
- Expanding and improving self-referral pathways
- Realising the potential of community pharmacies, growing the monthly patient volumes across pharmacy services

11.15. The local communications and engagement team launched the *Better Access Bexley,* which has been highlighting the range of NHS services available to the local community and online. The focus of the campaign has been:

- To relaunch existing services to Bexley residents that they may have been unaware of and to better communicate the support on offer to them.
- To build confidence amongst the residents of the services on offer to them, clearly explaining the support and how each service works. To increase patients' trust in their first point of contact (GP/other primary and healthcare professionals) which will help alleviate pressure on emergency and other urgent care services.

11.16. Building capacity: The South East London Integrated Care System launched its 'People Strategy', a key enabler to the NHS South East London Integrated Care Board (NHS SEL ICB) vision in 2023.

11.17. NHS SEL ICB is developing a short-term Primary Care Workforce Implementation Group, which will address specific challenges with primary care workforce, namely on recruitment, retention, and development strategies, prioritising retention of early career GPs, recruitment of nurses and development of practice management teams.

11.18. Cutting bureaucracy: Linking primary and secondary care clinicians and system leaders to tackle a range of issues has led to several 'quick win' improvements in

processes and an improved understanding of operational /clinical issues across teams.

11.19. Additionally, 17 (out of 20 eligible) Bexley practices have implemented automation of the patient GP registration process via the Healthtech 1 platform. This is a digital form on the practice's website which patients can fill in to join the practice. The system will then take that information and automatically complete the registration process without any human input and frees up a huge amount of admin time (20 minutes per registration) which can then be put towards other critical administrative work.

11.20. Based on the national GP Appointments Database (GPAD), in October 2024 Bexley GP practices provided 133,319 appointments in comparison to October 2023, where 114,572 appointments were provided.

12. Bromley Borough Update

Bromley Health and Wellbeing Centre – Project Update

12.1. A significant milestone has now been achieved for the Bromley Health & Wellbeing Centre (BHWBC) project. Commercial arrangements between the Landlord (Bromley Council), SEL ICB and the Dysart Surgery have all now been agreed. The lease and supplementary legal documentation were signed by all parties on 7 November. The Centre is an example of the successful partnership between the Council and NHS, working together as part of the One Bromley Local Care Partnership.

12.2. To be housed in Bromley's new Civic Centre, the Health and Wellbeing Centre will house a GP surgery and bring a range of healthcare services to the heart of Bromley town centre. The Centre will provide accessible, efficient and integrated healthcare, with spacious consulting and treatment rooms. With its complete refurbishment, the centre will offer a modern and welcoming environment, tailored to meet a range of health needs. The Dysart GP Surgery from Ravensbourne Road will move to the new centre, bringing GP services closer to more residents and providing care in a modern and accessible setting.

12.3. Project timelines have been revised to reflect the current position. Works will start on site in January 2025 and are estimated to be complete by the end of July 2025. A commissioning period of two months post works completion has been allowed for to provide sufficient time to procure equipment, furniture and to move the practice into the new building. Work will continue with partners to explore if there are any opportunities to bring forward the completion date.

Bromley Winter Vaccinations 2024

12.4. Winter vaccinations commenced in September 2024 with flu vaccines for children and pregnant patients, followed on 3 October by adult flu and Covid vaccinations. The Covid campaign runs until 31January 2025, whilst the Flu campaign runs until 31 March 2025. Bromley has performed well in both campaigns and currently has the highest uptake across south east London.

12.5. Flu vaccines are available for eligible patients from all Bromley GP practices and most Community Pharmacies across the borough. In addition, several outreach sessions were provided between October and December to provide greater access to both Flu and Covid vaccinations in under-served communities. Demand for the Flu vaccine remains strong and despite the later start this year, uptake is comparing favourably with 2023.

12.6. NHSE are predicting at least 1-2% less uptake overall year on year so the Bromley performance to date is especially encouraging for both the Under 18 at risk and 2–3 year-old cohorts who were targeted with active promotion from the start of the season.

12.7. Covid vaccines were available for eligible patients from some GP practices and 23 Community Pharmacies across the borough. There were also targeted outreach sessions held between October and December to provide greater access to both Flu and Covid vaccinations in underserved communities. Although the campaign was scheduled to end on 20 December 2024, five Community Pharmacies in Bromley will continue to provide Covid vaccinations until 31 January 2025 to further increase uptake. Additional outreach activities are also under consideration.

12.8. Due to the earlier (and staggered) start dates for the 2023 campaign; to enable a more accurate year on year comparison, the 2023 data below is from a similar point in the campaign.

12.9. The reduced demand for the Covid vaccine (as seen during the 2024 Spring campaign) continues and this is a trend seen across south east London and the UK. However, both housebound and care home uptake is much better than last year. This is due to the learning from previous campaigns that both Bromley Healthcare and Bromleag Care Practice have built on to improve performance.

12.10. In addition to the Winter vaccination programme, a new vaccine for Respiratory Syncytial Virus (RSV) was launched nationally on 1 September for pregnant patients and adults aged between 75 and 79 years. The aim of this new vaccine is to reduce the risk of serious illness amongst older adults and newborn babies.

12.11. Although this is a year-round programme, vaccinating these cohorts are a key part of the Winter resilience programme as it has significant potential to reduce presentations of RSV in general practice and acute settings. As of 1 December 2024, 43% of eligible older patients had been vaccinated in Bromley, the highest across SEL.

One Bromley Patient Network Event held in October

12.12. One Bromley hosted a meeting of the Patient Network on 3 October as part of the annual winter readiness programme, to outline the same day services available to patients this winter. Around 20 patient representatives joined, including Patient Participation Group chairs and community champions, to hear from a panel of One Bromley clinical and health leaders.

12.13. Bromley Partnership Recruitment Fair – Connecting people with local Opportunities

12.14. Nearly 600 residents came to the Bromley Partnership Recruitment Fair on Wednesday 23 October at Bromley United Reformed Church. It was possible to

attract such a large number due to extensive promotion of the fair supported by all system partners. Promotion included targeted organic and paid social media, electronic advertising boards in the Glades, graphics on GP screens, staff newsletters, online information, a press release and printed flyers distributed in local libraries, other community settings and by the Department for Work and Pensions (DWP).

12.15. The fair offered Bromley residents the chance to explore a diverse range of employment and volunteering opportunities and meet local public sector and voluntary sector employers such as the NHS, Social Care services, Mytime Active, London South East Colleges, London Metropolitan Police and the London Fire Brigade.

Mental Health Update

12.16. A comprehensive needs assessment of children, young people's and adult's mental health and emotional wellbeing services has now been completed. The needs assessment will underpin a new five-year All-Age Mental Health and Wellbeing Strategy in Bromley, which will commence in 2025.

12.17. Bromley children's and young people's mental health services have returned to the levels of activity that were last seen before the covid-19 pandemic. With this change, Bromley has seen lower waiting times for the key treatment pathways in CAMHS. There remain challenges, including in relation to children and young people who are neurodiverse. A new integrated single point of access (ISPA) between Bromley Y and Oxleas CAMHS is now in operation.

12.18. Bromley Council and SEL ICB are in the final stages of procuring the Bromley Mental Health and Wellbeing Hub, which will bring together core community mental health services into a single integrated model. The new service will open on 1 April 2025. The new Mental Health Support@Home service has also now opened, which provides support and housing services for people with long-term mental health conditions.

13. Greenwich Borough Update

Children and Young People - Child Health Teams Pilot

13.1. Greenwich has started a 6-month pilot in Greenwich West Primary Care Network of Local Child Health Teams. The pilot brings together a Consultant Paediatrician from Lewisham and Greenwich Trust, Lead GPs from the Primary Care Network and Community Nursing from Oxleas NHS Foundation Trust. Building off learning from Lambeth and Southwark but developed from the bottom up, the model consists of a weekly triage and monthly clinic bringing together Primary, Secondary and Community professionals to identify and provide better support to children at a neighbourhood level. An evaluation of the 6-month pilot is planned that will inform the next steps.

Integrated Commissioning – Adults - Staffing and team development

13.2. A full leadership team is now in place. After some time of working on a new organisational approach and structure after the MCR, this will enable effective delivery of local priorities and engagement with south east London colleagues. There are still some vacancies in key roles and work continues on the recruitment to these.

13.3. Collaboration across teams and with partners continues and some good progress has been seen 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 - Assistive Technology Enabled Care Service (ATEC),

13.4. Following the successful tender for a strategic partner, Greenwich Local Authority, as the lead commissioner, is now progressing the formal governance steps to award the contract. There was a slight delay in December which has impacted the overall timeline. Healthier Greenwich Partnership will be receiving a full update in February ahead of the new service going live in April. Work continues to progress towards implementation at pace alongside local partners; detailed work on the operational and system and data aspects has continued. This has allowed for greater collaboration and staff will soon access the learning and development opportunities which will be available to ensure they are equipped with the knowledge and skills to ensure ATEC is offered proactively to eligible residents with health and care needs.

13.5. Detailed work is also underway to design the benefits tracking model including NHS and Social Care so there is a robust way of tracking the impact on both residents, resources and the workforce from the outset.

13.6. As health specific monitoring devices have been commissioned as part of the new service, work is underway with Oxleas to ensure a smooth transition from the use of Doccla to the new model in the first few months. This will mean a short extension to the Doccla contract, but this will then cease to be the way health devices are supporting people in virtual wards going forward. It is being ensured that robust clinical oversight is designed in which will also support this transition.

13.7. Engagement is continuing engagement with a range of partners ahead of go-live including those in primary care in January. 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 - Urgent and Emergency Care and winter planning

13.8. Work alongside local partners continues to deliver actions outlined in Greenwich's Urgent & Emergency Care recovery plan. Recognising the pressures in community capacity, work was done to identify the local gaps in provision, particularly for

residential and nursing homes and support for people at home and intermediate care settings.

13.9. This was also linked to recent work with Lewisham & Greenwich NHS Trust (LGT) to use funds which could incentivise quicker and more effective discharges. The impact of the new capacity secured will be monitored in partnership with LGT and others between January and March.

13.10. The work continues to ensure Greenwich's Urgent Treatment Centre arrangements are as effective as possible. Recent feedback from NHSE highlighted areas which are working well and some areas requiring improvement for both LGT and the urgent treatment centre provider. Partnership meetings are regularly convened to work on key actions and monitor progress. Learning is being gained from elsewhere including from the lead clinical care professional lead (CCPL) to inform the work.

Integrated Commissioning – Adults – Continuing Healthcare (CHC)

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

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

13.13. The Direct Payment team was also re-organised including work with local residents in co-prediction which has informed the new ways of working which are emerging. This work has been recognised nationally and a visit from DHSC recently has meant the ability to influence policy and practice improvement plans at a national level.

Integrated Commissioning – Adults – 2025/26 planning

13.14. Local work has continued to review outcomes, actions and progress against Greenwich's Health and Wellbeing Strategy and the five-year forward view. This will support the planning process. There has also been work to ensure alignment across projects and programmes, support system intentions and priorities including key priorities such as Neighbourhood development, frailty model development and delivery, the sustainability programme and work to support people with long term conditions.

Greenwich Healthier Communities Fund

13.15. 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.

13.16. 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 organisation's capacity building to better tackle health inequalities, whilst the Delivery strand aims to fund projects that prevent and respond to key health inequalities. The programme will develop further in 2025, with plans to re-launch these strands in April 2025 with more targeted focus (set by local priorities), and further improvements based on stakeholder and grantee feedback.

13.17. The Enabling Strand has supported 31 organisations across three rounds, with a total of £245,726 awarded. 25 organisations have been supported through round 1 of the Delivery Strand totalling £542,189, with round 2 closing in early January 2025.

13.18. Overall, the fund is looking to build the collective capacity and capability of Greenwich's VSCE organisations and had a successful networking event in November 2024 which will be repeated.

Primary Care and Neighbourhoods - Neighbourhoods Development

13.19. Following successes over the past year of population and community based working models in several geographic 'test-beds' for integrated neighbourhoods in Greenwich, including Horn Park, Thamesmead, Plumstead and Glyndon and Blackheath and Charlton, momentum has gathered towards defining the key pathway/services that will be delivered by Integrated Neighbourhood Teams.

13.20. These include focusing on proactive care for frailty and complex long term conditions/'rising risk' patients, piloting local child health teams, improving local access to same day care and reducing health inequalities through the Connecting Greenwich and population health management programmes.

13.21. Focus is now moving toward defining Neighbourhood footprints based on optimal population sizes, natural communities within the borough and the existing infrastructure of health and care provision, such as the primary care networks (PCNs), community services and social care teams. Healthier Greenwich Partnership as the local care partnership is well engaged and there is good partner buy-in. The priority for early 2025 is ensuring general practice is robustly engaged in shaping the move towards integrated neighbourhood teams both as pathways and geographies.

Primary Care and Neighbourhoods - Connecting Greenwich

13.22. The Connecting Greenwich programme has been running since April 2024 and is actively working with two-thirds of Greenwich's general practices, including three 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.

13.23. 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.

Primary Care and Neighbourhoods - Primary, Community and Secondary Care Interface Programme

13.24. Through the joint Greenwich and Bexley Interface Forum, which is driven by local primary care Directors, GPs, CCPLs, Local Medical Committee (LMC) and Queen Elizabeth Hospital (QEH) leads, multiple successes have been secured since the programme commenced in May 2024. These include a reduction in delayed discharge summaries by over half, increasing fit notes being issued in hospital, direct referrals into the Memory Clinic by secondary care and into secondary care by private consultants, discussion of community interfaces with Oxleas and the Hospice, a visit to the QEH same day emergency care (SDEC) and active relationship building and networking between system wide clinical leaders.

13.25. The focus in 2025 will continue on reducing inappropriate requests for onward referrals, tests, recall or prescribing by secondary care, and will increase emphasis on how general practice is supported to improve the appropriateness and quality of referrals including through routine use of advice and guidance. Improving urgent care interfaces will also be part of the programme, recognising close interdependency with south east London urgent & emergency care priorities and 111 re-procurement.

Primary Care and Neighbourhoods - General Practice Estates Strategy

13.26. Development of a Greenwich general practice estates strategy began in December 2024. The strategy will be crucial for both proactively and reactively addressing estates related challenges and opportunities in the borough. It will aid Greenwich and South East London ICB teams to ensure decision-making and allocation of finite resources is robust and delivers maximal benefit for patient care. The Strategy will be developed ahead of the new financial year and launched in March/April, following extensive engagement with general practice and system-wide partners, including the Greenwich Local Estates Forum. It is likely to focus on three areas:

- Achieving a comprehensive understanding of existing general practice estates and the challenges or opportunities for improvement in the short, medium and long terms at each site and across neighbourhoods.
- Proactively planning ahead of the many large housing developments in the pipeline across Greenwich borough, to assess the likely impacts on healthcare provision and what our preferences would be for requesting and utilising section 106 resources in particular.
- Achieving a comprehensive understanding of existing general practice estates and the challenges or opportunities for improvement in the short, medium and long terms at each site and across neighbourhoods.

14. Lambeth Borough Update

Lambeth Together Care Partnership

14.1. Lambeth Together partners are approaching the end of the second year of '*Our Health, Our Lambeth 2023-2028*', Lambeth's Health and Care Plan and have started the process for the second annual review.

14.2. As part of the 5-year plan, Lambeth have committed to an annual refresh as an opportunity to take stock of delivery, celebrate progress and highlight key achievements from the year. The aim is to continue to refine priorities and update the action plan for 2025/26 and the refreshed plan will be finalised and published in May 2025 to coincide with local business planning processes, the updated South East London (SEL) Joint Forward Plan and wider national developments, including the launch of the new 10-Year NHS Plan expected in the Spring.

14.3. Since the last report, the Lambeth Together Care Partnership Board have said goodbye to Nathalie Zacharias who has left her role as Director of Therapies at South London and Maudsley NHS Foundation Trust (SLaM) and as the nominated SLaM representative on the Board. Her replacement will be announced in due course. In other leadership changes, Lambeth Council has announced the appointment of Ian Davis as the new Chief Executive, subject to the approval of full Council. Ian joins from Enfield Council, having served as Chief Executive since 2017 and has a background of almost 30 years of experience in local government.

14.4. At the beginning of November, Lambeth Council took part in a Local Government Association Corporate Peer Challenge, during which members of the Peer team attended the Lambeth Together Care Partnership Board public meeting on 7 November and held a focus group with a range of Board members on the work of Lambeth Together. The initial feedback has been hugely positive about Lambeth's work to support communities and the strength and quality of local partnership working. The level of understanding and buy-in amongst partners with shared ambitions was highlighted, including a clear commitment to equity and justice, as well as being incredibly impressed by the commitment and knowledge of the individuals met. The full report and action plan will be published by the Council in the Spring.

Managing System Pressures and Working with Lambeth Communities

14.5. Lambeth and Southwark partners have co-produced a shared Winter Plan through a collaborative approach which has built on the successes and lessons learned from the last two years in delivering urgent emergency care whilst addressing both local and national priorities for the winter season. Key areas of focus include:

- Same Day Emergency Care Units (SDECs): Improving the utilisation of SDECs to manage pressure on the system.
- Discharge Processes and Patient Flow: Optimising discharge procedures, including increasing the number of morning discharges, before 10:00am, weekend discharges, and making better use of discharge lounges to support patient flow and free up capacity more efficiently.
- New Medical Assessment and Frailty Units: Embedding and improving the use of the new medical assessment unit at King's College Hospital and the Frailty Unit

at Guy's and St Thomas' Trust (GSTT) to deliver care and improve outcomes for vulnerable patients.

- Mental Health Capacity and Flow: Enhancing capacity and ensuring efficient patient flow within mental health services, particularly during peak winter periods when demand typically increases.

Neighbourhood and Wellbeing Delivery Alliance (NWDA)

14.6. The Alliance continues to lead its longstanding work to develop a local approach to community–based working and multi-disciplinary teams. This builds on the 2022 Fuller Review and the recent report from Lord Darzi that advocates integrated health and social care and a collaborative approach to delivery.

14.7. Lambeth, along with other south east London boroughs, is developing its neighbourhood model for integrated neighbourhood working, using the lens of frailty and people living with multiple long-term conditions.

14.8. The NWDA ran a successful Musculoskeletal (MSK) community day, in the Fiveways Primary Care Network (PCN). The event was led by the MSK team who invited all 92 patients registered on their waiting list in the local area, with 69 attending on the day (75%). The event was delivered in partnership with a number of other organisations offering wider advice and support, including London Sport, the Department for Work and Pensions, and the Health and Wellbeing Bus, as well as Guy's and St Thomas' NHS Foundation Trust (GSTT) Geriatrician team who provided holistic frailty assessments to 14 patients.

Living Well Network Delivery Alliance (LWNA)

14.9. The LWNA has been formally in place since 2018, building from the Lambeth Living Well Collaborative and Integrated Personalised Support Alliance (IPSA), and making a real difference in the mental health care for working-age adults across Lambeth.

14.10. All five partner signatories to the Alliance agreed to utilise the three-year contract extension at the start of 2024, but in the context of taking the opportunity to stretch its ambitions and maximise partnership impact. To support this, the Alliance Leadership Team (ALT) has decided to commission a rapid review of the LWNA and has engaged Anu Singh, South East London ICB Non-Executive Director, to lead the review. Anu will meet with service users, carers, community partners, and a range of staff members, in addition to analysing data, to develop future recommendations.

14.11. An ongoing priority for the LWNA has been strengthening the Single Point of Access service to ensure it has the right resources in place to deliver a more resilient and sustainable service to manage the presenting demand for mental health support. The LWNA has launched the Lambeth Mental Health Inequalities Fund with the aim of supporting community projects that will improve access to mental health services and in turn improve mental wellbeing for Lambeth residents of Latin American and Black heritage.

Children and Young Persons Delivery Alliance (CYP)

14.12. The Alliance recently received an evaluation of the Well Centre, presented at the Emotional Wellbeing and Mental Health Committee, which highlighted the

transformative impact of its multidisciplinary, youth-focused model. By combining general practitioners, mental health practitioners, and health and wellbeing specialists, the Well Centre has significantly improved access to care, addressed inequalities, and built trust among young people. Its role in supporting those at risk of violence demonstrates the power of collaborative, holistic care in addressing complex challenges.

14.13. As well as this, Black Maternal Mental Health Week spotlighted the systemic barriers faced by Black mothers, fostering conversations around stigma, culturally competent care, and the urgent need for systemic reform. The Alliance is linking with colleagues in Southwark to engage with the findings of the Maternity Commission to explore opportunities to take forward shared goals on inclusivity, stronger service integration, and compassionate care.

Annual Public Health Report (2024) - Ageing Well in Lambeth

14.14. Lambeth's 2024 Annual Public Health Report (APHR) was published in December with a focus on the theme of Ageing Well. The APHR provides an overview of ageing in the borough, weaving together local data, health research, community views, and current initiatives that impact on ageing. It also explores the challenges and opportunities for Lambeth as the borough adapts its policies and services to be more age-friendly within the following areas:

- Environmental adaptations and the physical environment
- Preventing ill health in later life
- Service utilisation and services beyond health and care
- Economy, workplace, and cost of living
- Community and social environment

14.15. The APHR is intended to provide strategic direction and will support the implementation of the forthcoming Age-Friendly Lambeth Action Plan (2024 – 2027). Together, these pieces of work will help to achieve the ambitions outlined within Lambeth's Health and Wellbeing Strategy 2023-2028 and *Our Health Our Lambeth* Health and Care Plan 2023-2028.

Recognising Success and Valuing Achievement

14.16. Many examples of innovative and successful work by Lambeth partners have received both local and national recognition in recent months.

14.17. The Evelina London Patch Children's Community Nursing (CCN) team triumphed at the Health Service Journal Awards 2024, winning the Reducing Inequalities and Improving Outcomes for Children and Young People Award, whilst the Pain: Equality of Care and Support in the Community (PEACS) initiative which supports people with chronic pain was highly commended in the Innovation and Improvement in Reducing Healthcare Inequalities award category and was also recognised in the NHS Race Equality Award category. The South East London Cancer Alliance was awarded best NHS Communications Initiative of the Year by the HSJ for its campaign to improve the uptake of breast and prostate cancer screening in black communities, launched in Morley's department store Brixton last year.

14.18. The Lambeth Public Health team won the Association of Directors of Public Health Research Award for its efforts in embedding research into work to ensure that services and programmes remain responsive to the changing community needs in the borough.

14.19. The Public Health team hosts and supports Lambeth HEART, the National Institute for Health and Care Research funded Health Determinants Research Collaborative which aims to tackle health inequalities through effective research activities.

14.20. As part of the Staying Healthy programme to tackle food poverty and insecurity and promote healthy and sustainable food for Lambeth's Black African and Black Caribbean communities, Vida Cunningham won the Equity and Justice category at the Council's One Lambeth Staff Awards, whilst the Hospital Discharge Team were named Team of the Year.

14.21. Members of the Medicine's Optimisation team presented innovative work at the Royal Pharmaceutical Society conference in November. In collaboration with the GSTT pharmacy team and Kingston University, Sophie Bhandary led the development and implementation of a training programme for anticoagulation prescribing by pharmacists. The team's work has led to an increase in both skills and confidence of pharmacists to start and safely manage anticoagulant treatment in atrial fibrillation, a major risk factor for stroke. Work in developing leadership in south east London was also shared, showcasing the impact of an innovative leadership programme for new community pharmacy leads. This work, piloted in Lambeth, led to an increase in confidence amongst the pharmacy leads in engaging with general practice to increase referrals to the national Pharmacy First services.

15. Lewisham Borough Update

Neighbourhood development

15.1. An Integrated Neighbourhood Team (INT) Design Group is in place in Lewisham Health and Care Partnership and includes representatives from across the partnership including primary care, secondary care, and the Voluntary, Community and Social Enterprise (VCSE). In October an in-person INT Design workshop was held to review the population health data, consider models of care and map patient pathways. The initial INT model will focus on people with 3+ Long-Term (LTC) (out of 27 LTCs) and/or depression in the Core20PLUS group and have not seen their GP recently but have been seen in A&E recently.

15.2. Recruitment of people with lived experience to work with the Local Care Partnership on development of the INT is underway.

15.3. During 2024 the practice based multi-disciplinary meetings (MDMs) that take place in Primary Care have been reviewed. In the first four months of the year over 600 people were discussed in 88 separate MDM meetings. Work has taken place with stakeholders to explore how people can be systematically and proactively identified who should be considered for MDM review. This approach is planned to be introduced in 2025 with a focus on identifying those with a risk of non-elective hospital admission.

Integrating Data to Support Lewisham and Greenwich NHS Trust (LGT) Diabetes Service

15.4. LGT and the Population Health Management team developed a Data-Led Prioritisation project. This project used GP test results to identify and prioritise patients requiring immediate attention. The main goal was to improve individual patient care by bringing appointments forward for those who needed them urgently, and to reduce duplication of work carried out by Primary Care.

15.5. As a result of this work and the data provided the Trust was able to discharge 50% of the caseload identified per consultant which created space for patients who needed more urgent reviews. This has significantly improved efficiency in the system and enhanced individual patient care. Conversations are underway to repeat this work and expand it further.

Improving Hypertension Management

15.6. A Business Case for Improving Hypertension Management in the borough was approved by the Lewisham Local Health and Care Partnership (LHCP) Strategic Board in 2024 and will be fully live by the end of January. Key elements of the service include:

- VCSE specialist engagement advice and delivery service to raise awareness of hypertension and to support residents in BAME communities and the more deprived parts of the borough to engage in self-management.
- Training for primary care staff on hypertension control. This element is being led by Clinical Effectiveness South East London (CESEL). Aimed principally at non-clinical staff and the local community, a workshop was held in April in Neighbourhood 3 and more are planned throughout 2025. In addition, a cultural humility training session aimed at practice nurses was delivered by Mabadiliko in September and more sessions are planned in 2025.
- A 2-year primary care incentive scheme for practices to improve the overall rate of controlled hypertension for their diagnosed hypertensive patients. All six PCNs in the borough have signed up and submitted actions plans to achieve the target of 70% of registered hypertensive patients who are treated to the NICE guidance by August 2025.

15.7. An evaluation report of the Suvera hypertension pilot was also shared in September 2024. This pilot provided virtual clinical reviews for hypertension patients in two PCNs from February to August 2024. 7,443 successful consultations were held and over 15,000 Blood Pressure readings submitted by patients. Some very positive outcomes were achieved: Stage 3 Hypertensive patients fell from 55 to 28 (-50%), normotensive patients increased from 1617 to 1987 (+23%) and 74% of patients achieved control within 3 weeks of their first appointment. It is estimated this could in the long-term lead to a reduction of 40 Strokes and 25 Heart Attacks. The findings and lessons from this pilot are being widely disseminated locally to encourage good practice.

Lewisham Digital Plan

15.8. A workshop for the LHCP was held on 29 November 2024 in order to begin development of a local partnership digital programme through exploring where there

might be opportunities for joint work particularly at a neighbourhood level and for community based care.

15.9. The workshop reviewed the digital plans and strategies of the partners and areas for collective working and identified the following themes as the basis for a digital plan for the LHCP:

- Digital Inclusion & engagement – empowering people
- Data quality
- Digital solutions
- Linked Electronic Patient Records (EPR) & connected care
- Linked data – data insights

15.10. A draft action plan will be developed for review and agreement by the Lewisham LCP Board.

SEND Inspection

15.11. In September 2024 Lewisham was subject to a routine inspection of their SEND services by the Care Quality Commission (CQC) and OFSTED. The inspection spanned education, Children's and Young People's Services, social care and health. Three judgement outcomes are possible and Lewisham achieved the middle outcome: The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND).

15.12. It was confirmed by inspectors in feedback sessions as well as by the Department for Education and NHS England, in a recent review meeting, that this was a strong middle judgement. Three areas for action were identified:

- Leaders across the partnership need to strengthen the support for young people in preparing for adulthood.
- Leaders across education, health and social care should ensure that a multi-agency quality assurance framework is in place for existing and amended Education, Health & Care (EHC) plans.
- Health leaders should ensure that waiting times for specialist mental health pathways and neurodevelopmental assessments are reduced and that children and young people, and their families, consistently receive effective communication and support whilst waiting.

16. Southwark Borough Update

Partnership Southwark Strategic Board

16.1. The November meeting of Partnership Southwark Strategic Board (PSSB) covered a detailed focus and discussion on the delivery plan for frailty, which is one of five strategic priorities of the Partnership Southwark Health and Care Plan. The delivery plan described the work underway to develop an integrated frailty pathway, initially in the Walworth Triangle neighbourhood with a view to scaling this approach across

the borough. Work is quickly evolving with health and social care partners, but is also involving other partners such as housing, to identify frailty sooner and deliver a more coordinated and holistic care plan. Success measures are developing with recognition of both system and individual outcomes to promote wellbeing in local communities.

16.2. Other areas covered at the Board included the Southwark Maternity Commission (further details below), an update on the development of delivery plans for the strategic priorities and an update on Family Hubs, a government led programme of which 75 local authorities across the country (including Southwark) have been chosen to deliver an example of integrated working at neighbourhood level.

Southwark Health and Wellbeing Board

16.3. A significant proportion of the November meeting of the Southwark Health and Wellbeing Board (HWB) was devoted to the Southwark Maternity Commission report, published on 30 September. An action plan is being developed by the Public Health Division within the Council, based on the ten recommendations set out in the report, which will be finalised by April 2025. The action plan will then be implemented over the following two and a half years, with a view to all actions taking place by September 2029. The HWB agreed to take on the oversight of this work.

16.4. Public health colleagues presented a report on the Southwark Healthy Weight Strategy (a partnership between Southwark Council, SEL ICB and the Voluntary and Community Sector (VCS)) which outlined examples of good practice in promoting healthy weight in Southwark such as the Southwark School Meals Transformation Programme, School Superzones, the Good Food Retail Project and Hot Food takeaway exclusion zones. The people focused interventions include targeted adult weight management programmes such as Alive N Kicking, child weight management programme in schools, offering healthy weight training to healthcare and non-healthcare professionals and supporting individuals to be more physically active through a range of initiatives.

16.5. The report described the further work being undertaken to support people who are less likely to take up these opportunities, such as adults aged over 45 years, Black African and Caribbean residents, Council tenants and people at transition stages, i.e. children leaving home, retirement, becoming a carer, being diagnosed with a condition. The importance of working in partnership and at system level to achieve the ambitions of the strategy were strongly acknowledged and supported.

Developing Integrated Neighbourhood Teams

16.6. Progress has been made on the neighbourhood-based care programme, led by Partnership Southwark. The focus is on prevention, proactive care and managing complex health and social care needs. A programme board has been established to accelerate programme delivery. The first meeting of the programme board was held on 12 December and was co-chaired by the Southwark Strategic Director for Integrated Health and Care/ Southwark Place Executive Lead and the Chief Executive for the Integrated and Specialist Medicine Clinical Group at Guy's and St Thomas' NHS Foundation Trust. The current work underway includes designing the Integrated Neighbourhood Teams (INTs) model for Southwark, ensuring appropriate alignment with south east London approaches, and using population health data and

mapping local assets to determine what functions should be delivered by INTs in Southwark and their geographies.

Southwark Council Peer Review

16.7. Southwark Council took part in a Peer Review in November 2024 which was undertaken by Association of Directors of Adult Social Services (ADASS). Unlike the previous Local Government Association (LGA) peer review in 2023, ADASS do not make recommendations or publish their findings, but the review was a useful preparation for a future Care Quality Commission (CQC) inspection of Local Authority services.

16.8. Relevant findings were:

- Many good examples of embedding equality, diversity and inclusion (EDI) and cultural competence in service design and delivery; more could be done to tell the positive story of our Southwark Stands Together Journey.
- Positive feedback from carers on services available but better information about them required and some equality target groups are under-represented in carer services.
- Strong partnerships and good evidence of working across council departments, and with SEL ICB and NHS partners; more could be done to support smaller VCS partners.
- Staff are positive about working for Southwark, feel valued and that it is an inclusive and supportive environment; more could be done on system inefficiencies.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**ICB Board Assurance Framework**					
Meeting date	29 January 2025	Agenda item Number	6	Paper Enclosure Ref	G	
Author(s)	Kieran Swann (Associate Director of Assurance and Risk),					
Executive lead	Tara Patel (Head of Assurance - Risk)					
Paper is for:	Update		Discussion		Decision	x
Purpose of paper	This paper presents the updated 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 2024/25 (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 most recently met on 8 January 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.					

Summary of main points	**A. Key points to note:**
	
	• BAF risks reflect the assessed position of ICB risks as recorded on the ICB's Datix risks management system on 16 December 2024.
	
	• The current BAF includes risks above risk appetite thresholds for SEL and Lewisham LCP. There are no risks above threshold for Bexley, Bromley, Greenwich, Lambeth and Southwark LCPs.
	
	B. System versus ICB risks
	
	• 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 have also been shown on slide 11.

C. Summary of key changes

There are **10 SEL risks which are above risk appetite threshold, and 3 LCP risks**.

One new risk with a score greater than the risk appetite thresholds has been added to the BAF:

- **Lewisham risk 561**, relates to an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. This risk falls under the clinical, quality and safety category and has a current score of 12.

Four risks have **de-escalated** off the BAF:

- **Bromley risk 558** relates to primary care premises being lost due to landlord decisions. This risk has been reduced in score to 12, because engagement with PCNs and practices has been started to determine the current and future use and needs of the premises. A database of all primary care estates is to be reviewed regularly by the Bromley Primary Care Group.

- **Lambeth risk 513** relates to resource within the safeguarding structure, potentially impacting safeguarding processes. This risk was updated following discussion of the BAF risks at the Executive Committee on 8 January 2025. The risk score has been reduced to 8 because of recent recruitment and arrangements for cover of vacant posts.

- **SEL risk 484** relates to possible disruption to primary care activity through change initiatives being implemented by the NHS and healthcare and service providers. This risk has been reduced in score from 12 to 9 as a change advisory board process is in place to support review of any proposed system changes, proposed by partners or digital solutions providers.

- **SEL risk 491** relating to the ICB not having system oversight of quality and patient safety systems from the providers. This has been reduced in score from 12 to 9 because of new availability of data increasing the ability of the ICB to access necessary information in this domain.

Three risks have been **closed**:

	• **SEL risk 431**, relating to harm to patients due to system pressures contributed to by recent industrial action has been closed, as the strike action has ended. • **SEL risk 433** relates to potential reputational damage to SEL ICB due to the potential failure of a provider to meet statutory safeguarding requirements. This has been closed because the provider has managed the risk and has an implementation plan in place. • **SEL risk 512** relates to slow sign-off of MCR redundancies. This has been closed as the ICB Renumeration Committee gave approval for the redundancies on 9 September 2024.					
Potential conflicts of Interest	None advised					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	Not directly applicable to the production of this paper.					
Financial Impact	Not directly applicable to the production of this paper.					
Public Patient Engagement	Not directly applicable to the production of this paper.					
Committee engagement	ICB Executive Committee, 8 January 2025					
Recommendation(s)	The Board is asked to: • Review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee on 8 January 2025.					

SEL ICB Board Assurance Framework 2024/25 December 2024

Prepared for SEL ICB Board, 29 January 2025

Context and latest updates

- The ICB's risk appetite matrix is a way for 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 for 2024/25.

- 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 are continuing to collaborate with risk leaders from ICS NHS partner organisations on areas of common risk impacting the integrated care system in south east London.

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 8 - 9).
- **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 10).
- 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 begins to develop 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 11.

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 8 January 2025.

The current BAF

Key points to note:

- The risks included reflect the assessed position and risks were downloaded from Datix on 16 December 2024.
- The current version of the BAF includes 10 SEL risks above threshold and 3 LCP risks (Lewisham).
- There are no risks above threshold for Bexley, Bromley, Greenwich, Lambeth and Southwark LCPs.
- The place executive leads (PELs) completed a review of risks between the LCP risk registers in November 2024, which has resulted in the following changes being made to the LCP risk registers:
    - addition of risks against targets around proportion of the population vaccinated.
    - reduction in score for the risks relating to GP collective action (Bexley, Bromley, Lewisham). LCPs which had not yet recorded this risk have added a risk relating to GP collective action to their LCP risk register (Greenwich, Lambeth, Southwark).
    - addition of risks relating to other strategic objectives, e.g., CYP diagnostic waiting times for autism and ADHD targets
- Following discussion of the BAF at the Executive Committee on 8 January 2025, Lambeth risk 513 was updated to reflect recent additional mitigating actions in place. The risk score was consequently reduced and the risk de-escalated from the BAF (see next slide).

Summary of changes to ICB BAF since September 2024 (1 of 2)

- **One new risk** with a score greater than the risk appetite thresholds has been **added** to the BAF:
  - **Lewisham risk 561**, relates to an increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population. This risk falls under the clinical, quality and safety category and has a current score of 12.

- **Four risks** have **de-escalated** off the BAF:
  - **Bromley risk 558** relates to primary care premises potentially being lost in future due to landlord decisions. This risk has been reduced in score to 12, because follow-up meetings are being arranged with PCNs and practices to determine the current and future use and premises requirements. A database of all primary care estates is to be collated and presented regularly to the Bromley Primary Care Group.
  - **Lambeth risk 513** relates to resource within the safeguarding structure, potentially impacting safeguarding processes. This risk was updated following discussion of the BAF risks at the Executive Committee on 8 January 2025. The score has been reduced to 8 because recruitment in key roles has been progressed and sufficient cover arrangements have recently been put in place with on-call paediatricians fulfilling the roles.
  - **SEL risk 484** relates to potential disruption to primary care activity through the change initiatives being implemented by the NHS and healthcare and service providers. This risk has been reduced in score from 12 to 9. A change advisory board process is in place to support review of any proposed system changes, proposed by partners or digital solutions providers. These are then risk and impact reviewed with necessary mitigation actions identified and / or rollback process agreed as necessary prior to any approvals taking place.
  - **SEL risk 491** relating to the ICB not having system oversight of quality and patient safety systems from the providers. This has been reduced in score from 12 to 9 as the ICB now has greater access to data sources required for this purpose. The ICB can now directly access and review data from provider organisations, which allows identification of trends and themes.

Summary of changes to ICB BAF since September 2024 (2 of 2)

Summary of changes continued…

- **Three risks** have been **closed**:
  - **SEL risk 431**, relating to harm to patients due to system pressures contributed to by recent industrial action has been closed, as the strike action has ended.
  - **SEL risk 433** relates to potential reputational damage to SEL ICB due to the potential failure of a provider to meet statutory requirements, and the risk that an increase in numbers of patients may present with safeguarding concerns which are unable to be fully addressed. This has been closed because the provider has managed the risk and has an implementation plan in place.
  - **SEL risk 512** relates to slow sign-off of MCR redundancies. This has been closed as the ICB Renumeration Committee gave approval for the redundancies on 9 September 2024.
- All other risks have been reviewed by relevant risk owners and discussed at SMT meetings – there no other changes in score to report.

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

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	**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
	437	Disruption to IT/Digital systems across provider settings due to external factors		15
Clinical, Quality and Safety	**404**	New and emerging High Consequence Infections Diseases (HCID) & pandemics.	9	12
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews.		12

Key: Primarily system risk Primarily ICB risk

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

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**384**	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	12	16
	385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a 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

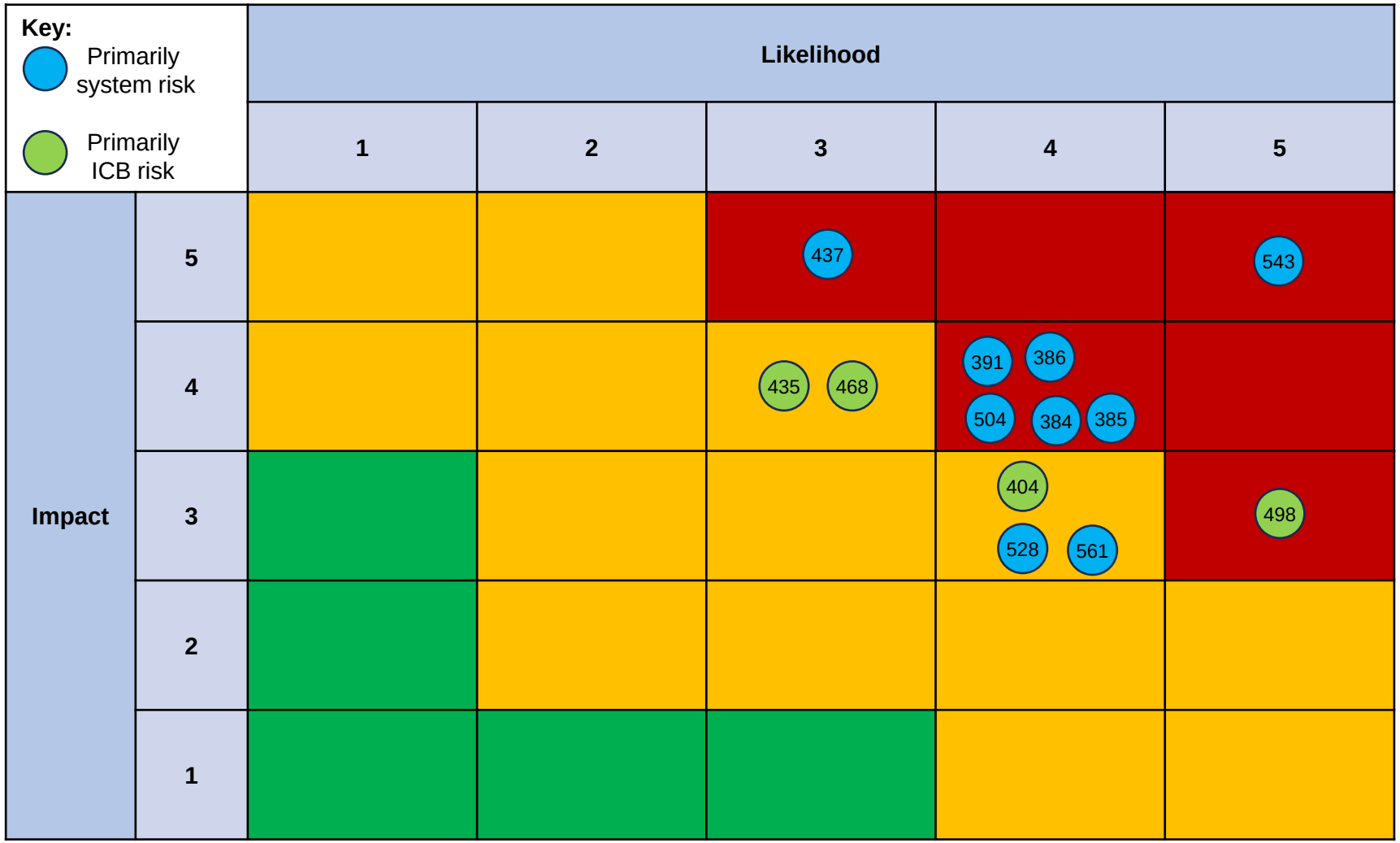
Summary of LCP risks exceeding tolerance levels

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.		12
	Lewisham 561	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations.		12
Finance	Lewisham 498	Achievement of LCP financial balance for 2024/25.	12	15

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
498	Achievement of LCP financial balance 2024/25
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 ICB risks above risk tolerance levels

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	Assurance in Place
384	Harriet Agyepong	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	There is a risk of non delivery in a range of elective care transformation programmes (theatres, admitted, non admitted) led by the Acute Provider Collaborative. This is caused by the limited bandwidth of clinical and operational teams due to: Multiple asks of the same clinical and operational teams (e.g. a single specialty is asked to introduce a range of initiatives simultaneously). This could result in confusion over priorities, teams being overwhelmed or lacking the resource and support required to secure impactful and sustainable delivery. Inadequate capacity for clinical and other leads to engage and co-design initiatives with partners across primary and secondary care, leading to lack of awareness, buy-in and adherence to new pathways/ways of working with consequent inconsistency and inefficiency of care pathways. Insufficient oversight and awareness of the range of asks on teams (e.g. elective, cancer, urgent care), and what support might be needed to enable delivery. This will impact on the ICB's ability to meet statutory obligations and will impact on the waiting times for services that residents receive, with resulting potential impacts on patient experience, quality of life and outcomes alongside broader socioeconomic impact. It will also impact delivery of optimal care for those with long-term conditions if patients requiring treatment cannot be seen in a timely way in the most appropriate setting.	3	4	12	4	4	16	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.	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.
385	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, potentially impacting quality of	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 participation 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.	Operational plan for 2024/25, in year plan refresh and winter plans (planning templates and recovery narratives) - inclusive of internal Board sign off and external/regulatory assurance and sign off., Regular review including through System Focus Meetings with the regional team. Minutes of APC Meetings – particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery, noting ICB participation and representation as part of ICB governance., Regional assurance and review elective meetings, including Tier 1 (LGT), 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
386	Kelly Hudson and Sara White	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Ongoing pressures across SEL UEC services	There is a risk of 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 estate/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.	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.
391	Carol-Ann Murray	Paul Larrisey	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	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.	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 heath Partnership meeting., Minutes from Monthly monitoring of ASD Support services and workforce with providers (Oxleas and SLaM).
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	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.
435	Jane Waite - Head of CHC/CYPCC	Paul Larrisey - 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 25/262	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. This could lead to an adverse reputational impact on SEL ICB.	5	4	20	3	4	12	The London CYP Continuing Care network meeting has oversight on the project and is supporting the development of the approach to be taken regionally.	CHC have started to identify potential gaps in data collections across the CYPCC teams, There are already local CYPCC meetings at place level
437	Philippa Kirkpatrick, Michael Knight	Andrew Bland	Data and information management	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 10) . These occurrences could result in patient harm or death, and may lead to significant financial loss. It could also lead to adverse public reaction and reputation damage.	2	5	10	3	5	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 undertaken 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., 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.	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.
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Paul Larrisey - 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, This risk is also monitored 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.	There are minimal vacancies across the place based teams., Individual borough plans in place and teams are working towards reducing the backlogs
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.	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.

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	Assurance in Place
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.	£100m non recurrent deficit funding received from NHSE, enabling a breakeven plan, Budgets agreed., SEL CFO group meeting fortnightly., SSG meeting monthly

Appendix 2. LCP risks above risk tolerance scores

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	Assurance in Place
Lewisham 498	Michael Cunningham - Associate Director of Finance	Ceri Jacob - Place Executive Lead	Finance	10 - 12	Achievement of Recurrent Financial Balance 2024/25	During 2023/24 Lewisham delivered efficiencies in excess of the targeted 4.5% (c.£4.2m) of the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and expected to continue into 2024/25. Whilst the borough is working to deliver business as usual efficiencies for 2024/25 targeted at a minimum of 4% (c.£3.6m), it is unlikely these will be sufficient and available non recurrent measures are limited. There is therefore a material risk the borough will not be able to achieve recurrent financial balance in 2024/25.	5	3	15	5	3	15	A careful and detailed budget setting process has been conducted to identify target savings., Sound budgetary control will continue to be applied to ensure expenditure trends are monitored and any deviations from budget are identified at an early stage., The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target., The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis. This includes for 2024/25 development of business cases to identify opportunities for system wide efficiencies and meetings with system partners have been arranged to discuss these proposals., Review at LCP meetings with members on a bi-monthly basis. 6. System approach is being followed with LCP partners to align savings opportunities., System approach is being followed with LCP partners to align savings opportunities.	Monthly budget meetings., Monthly financial closedown process., Monthly financial reports for ICS and external reporting., Review financial position at CHC Executive meeting., Lewisham Senior Management Team Review.
Lewisham 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	Working in conjunction with the Lewisham Peoples Partnership, develop and implement a Lewisham Primary Care Communications and Engagement Plan., As outlined in controls
Lewisham 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 underserved 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/flu/polio.	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

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Overall Committees Report**					
Meeting date	29 January 2025	Agenda item Number	**7**	Paper Enclosure Ref	**H**	
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 the activity of the committee meetings.					
Summary of main points	The Overall Committees paper provides an overview to the Board 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. 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 decisions referred to the Board for approval, detailed in section 4. • Note decisions made by committees, under their own delegated authority					

Overall Report of the ICB Committees

ICB Board 29 January 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 Healthier Communities Fund**	**Clinical and Care Professional Committee**	**People Committee**	**Digital Committee**	**Executive Committee**
Meeting date	9 October 2024	19 November 2024	10 October 2024	16 January 2025	11 December 2024	-	25 November 2024	12 November 2024	9 October 2024
	12 December 2024	15 January 2025	14 January 2025	-	-	-	-	14 January 2025	23 October 2024
	-	-	-	-	-	-	-	-	6 November 2024
	-	-	-	-	-	-	-	-	20 November 2024
	-	-	-	-	-	-	-	-	18 December 2024
	-	-	-	-	-	-	-	-	8 January 2025

	Local Care Partnerships					
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
Meeting date	26 September 2024	26 September 2024	25 September 2024	7 November 2024	21 November 2024	7 November 2024
	28 November 2024	28 November 2024	11 December 2024	9 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 As discussed in the Chief Executives Report, the Board is asked to formally **NOTE** and **CONFIRM 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. This formal acceptance will be confirmed back to NHS England as part of the annual process.

4.2 The Board is asked to formally **NOTE** 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.

4.3 The Board is asked to **APPROVE** the revised Quality and Safeguarding Committee Terms of Reference, which have been amended on the recommendation of the Committee. The amendments to the previous version are:

- Provision for Independent Safeguarding Board Member to be part of membership instead of only an Independent Safeguarding Board Chair
- Inclusion of 1 x Designated Professional for Safeguarding Adults/ Children/ Children Looked After as "in attendance"
- Deputy Chair changed from Independent Safeguarding Board/ Partnership Chair to "to be confirmed".
- Director of Children's Services or Director of Adult Services to be removed from quoracy requirement.
- Chief of Staff or Deputy to be added to quoracy requirement.
- Quoracy to include Place Executive Lead deputy (previously no specific reference to PEL deputy).

4.4 The Board is asked to **APPROVE** the revised Terms of Reference for the Lambeth Together Care Partnership Board, which have been amended on the recommendation of the LCP to:

- Include explicit reference to the commitment to tackle health inequalities, ensuring equitable access to care and support for all communities and responsibility for meaningful community engagement as core elements of its purpose and duties.
- Replace the clause 'the relevant delegation agreement', with 'the delegated responsibilities for the Local Care Partnership (LCP) as agreed by the Integrated Care Board'
- Explain acronyms including NHS South East London Integrated Care Partnership (SEL ICP), South East London Integrated Care Board (ICB) and Integrated Care System (ICS).
- Explain the term 'Place'.

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.	One Bromley Local Care Partnership	26 September 2024	• Approval of approach for predominately joint implementation of One Bromley Strategy and Bromley Health and Wellbeing Board Strategy Joint Implementation Plan, with reporting to both Health and Wellbeing Board and One Bromley LCP Board.
2.	One Bromley Local Care Partnership	26 September 2024	• Approval of One Bromley Executive Committee revised terms of reference.
3.	Executive Committee	9 October 2024	• Approval of the award of contracts for termination of pregnancy services.
4.	Executive Committee	6 November 2024	• Approval of the Equalities Sub-Committee revised terms of reference.
5.	Executive Committee	6 November 2024	• Approval for award of a contract for community ophthalmology services, under Direct Award C of the Provider Selection Regime.
6.	Executive Committee	8 January 2025	• Reached a decision not to approve an application for accreditation for an independent sector provider.
7.	Executive Committee	8 January 2025	• Approved a contract award for Hospice provision for three years (with an option to extend for a further three years) under Provider Selection Regime Direct Award A.
8.	Remuneration Committee	16 January 2025	• Approval of additional redundancy payments as a result of ICB's Management Cost Reduction programme.

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	9 October 2024	• This was the inaugural meeting of the Integrated Performance Committee. The members therefore discussed the purpose of the committee, reviewed the terms of reference – noting two requested amendments, considered the context for the committees work, and approved the draft workplan. • The members received a report on the month 5 financial position of the ICS. • A paper was presented on the operational plan commitments for 2024/25, with discussion on workforce reductions and system sustainability.
2.	Executive Committee	9 October 2024	• The Committee members noted the work ongoing to recruit a fourth NEM and received a general update from the Chief Executive on key items of note, including discussions between the Chair and Chief Executive with borough Leaders and Chief Executives. • Exco were updated on the latest position regarding incidents including the Synnovis cyber attack and GP collective action. • System performance was discussed, noting the release of new guidance on paediatric audiology, diagnostics performance, a focus on reduction of RTT backlogs and an extensive discussion on mental health needs in EDs. • Updates to the IMOC terms of reference were presented and noted. • The Committee were updated on the procurement and approved the award of termination of pregnancy services contracts. • The NHS Oversight Framework was discussed including plans to ensure the ICB was working towards improving its ratings. • The Executive Committee discussed changes to the structure of the Executive Committee meetings, reintroduction of a Senior Management Team meeting, and recommended its revised terms of reference to the Board for approval. This approval was discussed and granted at the Board meeting held in public on 16 October 2024.

			• A report on the financial position at month 5 was received. • An update was provided on the outcomes of a review of CHC operations.
3.	Audit & Risk Committee	10 October 2024	• The meeting focussed on a discussion to define the scope of the committees work in relation to risk and assurance. The members considered their responsibilities for oversight of system risk vs ICB risk and proposed regular reporting of system risks to the committee and a focus on BAF system risks. • Reports by exception were received on internal audit – noting three completed reviews and some concerns around outstanding management actions which would be escalated to Exco, external audit – noting 24/25 planning was underway, and TIAA – who advised on progress made against the annual work plan. • A paper was received on the outcome of a recent cyber maturity review undertaken by EY and the proposal to refine the scope of the internal audit on cyber security as a result.
4.	Executive Committee	23 October 2024	• The Committee received updates on the ICBs financial allocation in relation to the nationally agreed pay award from the CFO and system updates from the Chief Executive. • System performance and quality was discussed. • Members received an update on delivery against corporate objectives for 2024/25, agreeing to have further focussed discussions on specific objectives at future meetings. • Extensive discussion took place on winter planning with a dedicated item looking at the LAS winter plan with senior LAS representatives.
5.	Executive Committee	6 November 2024	• Executive Committee received a sub-committees update, approving revised terms of reference of the Equalities sub-committee. • Updates on CQC SEND inspections and the NHS 10 Year Plan engagement work were discussed. • The committee were briefed on the work underway in London to develop integrated neighbourhood teams and considered the first steps required in SEL. • The committee considered and approved the awarding of a contract for community ophthalmology services. • A discussion on diagnostics considered current performance, how to reduce waiting lists, and improvement actions including increases in capacity.

			• A corporate objectives deep dive looked at delivery of adult flu immunisation. • The ICB Chief Digital Information Officer delivered an update paper on roll out plans for the Federated Data Platform for SEL ICB. • A report was provided on the ICBs month 7 financial position.
6.	Greenwich Charitable Funds Committee	11 November 2024	• The group considered current membership and agreed that the Greenwich COO should attend as deputy for the vacant Greenwich PEL post and a representative from the Royal Borough of Greenwich public health should be “in attendance”. No changes to the Terms of Reference would be required to achieve this. • The committee received an update on the Groundwork London project underway and noted a general charity finance update. • The committee agreed to support a proposal that the charity continue to ensure there is strategic alignment with the Council and NHS SEL ICB objectives.
7.	Digital Committee	12 November 2024	• **Digital Inclusion:** Members received a presentation on digital inclusion, noting the existence of an ICB digital inclusion function, the progress to date in this area, and next steps to raise its profile. • **London Care Record for staff:** London Care Record training and awareness was discussed, with comments received from the group to contribute to development of a future plan. • **Federated Data Platform:** Members received an update on the rollout of the Federated Data Platform (FDP) in south east London, with the committee endorsing a implementation of an instance of the FDP for the South East London ICB. • **London Health Data Strategy:** A briefing on the London Health Data Strategy was delivered, with a technically capable London data service expected by April 2025 and work ongoing on to land the governance arrangements around the sharing of data. • **Digital success:** The need to communicate and promote the digital and data achievements delivered in south east London was highlighted.
8.	Quality & Safeguarding Committee	19 November 2024	• This was the inaugural meeting of the Quality & Safeguarding Committee. The members therefore discussed the purpose of the committee and reviewed the terms of reference.

			• The members received updates on the quality and safeguarding standing items, being
			  • quality and safety report and safety alerts, discussing the transfer to PSIRF and the need to alternate quality and safeguarding items on the agenda to evenly distribute energy,
			  • local maternity and neonatal system report, noting the focus on reducing morbidity and mortality and looking at inequalities within that,
			  • all age continuing healthcare report,
			  • infection prevention and control – especially highlighting the exemplar system approach,
			  • medicines safety reporting on 24/25 priorities,
			  • patient experience and a desire to understand the experiences in a holistic way rather than simply focus on complaints,
			  • learning disability, autism and SEND recognising good progress across a number of areas.
			• The members received updates on the safeguarding assurance standing items, being
			  • Safeguarding training and supervision and the implementation of an improvement strategy to improve ICB mandatory compliance.
			  • Updates on NHSE safeguarding assurance requirements.
			  • Safeguarding reports from Place.
			  • Updates on safeguarding statutory reviews that have taken place.
			  • Discussion on key changes to the quality, safety and safeguarding risk register.

9.	Executive Committee	20 November 2024	• The Committee were updated on the national recognition the ICBs equalities sub-committee had received, recruitment of the fourth NEM, and the developing Operating Model for the NHS. • The team discussed the SEL response to the NHS 10 year plan consultation. • Integrated Neighbourhood Teams were discussed at borough level. • The Committee received a presentation on a project underway to improve access to general practice through digital innovations.

10.	People Committee	25 November 2024	• **Bi-annual report**: Members received an update on the Workforce Bi-annual report. The discussion focussed on the link between workforce expansion and estates capacity as well as consideration of the three government shifts (hospital to community, analogue to digital and treatment to prevention).
			• An update on the **Educator Workforce Strategy** was provided. The People Committee discussed the need for EDI objectives in educator frameworks and the importance of integrating innovation, community needs and curriculum changes to address health inequalities and improve workforce strategies.
			• A **spotlight on the state of the Adult Social Care Sector and workforce** was presented. The critical need to integrate social care into NHS workforce planning was noted, with a focus on shared recruitment drives, hybrid roles and innovative employment models to address growing workforce demands.
			• **Darzi Report**: Committee members discussed the key recommendations and implications of the Lord Darzi's review of the state of the NHS, with further discussions to take place at future Committee meetings.
			• **Workforce risk:** Members commented on and approved the description, controls and rating of the workforce risk. The latter remained unchanged from previous months.
			• The **next People Board** in January will notably focus on:
			  ◦ Integrated Neighbourhood Teams Spotlight
			  ◦ SEL AHP Council and SEL AHP Faculty update
			  ◦ Assisted dying discussion

11.	Integrated Performance Committee	12 December 2024	• The committee discussed their workplan for the year, emphasising the importance of focussing on the four aims of the ICS. • Papers were presented on how Lambeth, Lewisham and Southwark boroughs are contributing towards the overall aims of the ICB, particularly in respect of progress in delivering the Joint Forward View and Health and Wellbeing commitments. • The committee received an update on the month 7 financial position of the ICS.
12.	Executive Committee	18 December 2024	The Executive Committee: • Received an update on a Primary Care Digital delivery plan aligned with the primary care IT strategy and ICS Digital data and systems intelligence strategy

			aimed to address questions and concerns from primary care colleagues and endorsed the plan. • Received an update on work with the Southbank Centre on youth creative health facilities and endorsed a memorandum of understanding to better align partners in the work. • Asked for more consideration on updates to the Schedule of Matters delegated to officers. • Agreed to a change to the budget for clinical waste services, and to the commencement of a stand-alone procurement process. • Considered options in relation to the 111 procurement and made known it's views to the Board in relation to options on the upcoming procurement. • Received an update on work to develop integrated neighbourhood teams in partnership with local stakeholders. • Received an update on Performance including work on financial recovery and pressure affecting London Ambulance Service.
13.	Executive Committee	8 January 2025	The Executive Committee: • Received an update on current performance noting pressures in hospitals and focus on 65 week waits and on effective community alternatives to ambulance conveyances and hospital admission. • Received an update on work being done to update the Medium Term Financial Strategy and to prepare for planning 2025/26. • Received an update on Specialised Commissioning and recommended the update to the Board. • Received the Finance report for month 8 noting work to manage run rates across the system in order to meet the planned position and the impact on providers and Place. • Reviewed the Board Assurance Framework and recommended it to the Board.
14.	Audit & Risk Committee	14 January 2025	• The Committee received an update on the high-level external audit planning being progressed, with a final audit plan to be reported at the April meeting. • Internal audit presented their progress report, advising three reports had been finalised with all remaining audits for the year on plan. The committee discussed significant concerns in relation to the pushing back of management action

			deadlines, on multiple occasions in some cases, with a request this was highlighted to the executive team. • TIAA reported on their anti-crime work with good practice noted and ongoing work on the Government Functional Standards. • The committee were updated on development of the systems approach to risk, discussing the ICBs role, how to align risk scoring across the system, and the benefits of working collaboratively to share good practice. • The committee received confirmation that no tender waivers, special payments or losses had been booked in the quarter and reviewed the gifts and hospitality declarations of staff for the year. • The committee discussed and agreed a draft workplan for the year, noting the need for flexibility to respond to emerging issues.
15.	Digital Committee	14 January 2025	• **Cyber Security and System Resilience:** The committee received an update on the development of the Cyber Security and System Resilience Strategy for the ICS, including reporting processes, and endorsed its escalation to the ICS Board for approval. • **AI Framework SELICS:** The ICB Chief Digital Information Officer updated the members on work to develop a consistent approach to Artificial Intelligence (AI) application across south east London, with the group endorsing the draft framework and investment in this area. • An update was presented on the roll out of Assistive Technology in Greenwich. • **Digital Delivery in Primary Care:** The committee approved the Primary Care Digital Delivery Plan which outlines the development of digital solutions to better support primary care. • **Integrated Neighbourhood Teams:** The committee received an update on the digital enablement of Integrated Neighbourhood Teams.
16.	Quality and Safeguarding Committee	15 January 2025	The Committee: • Agreed Quality & Safeguarding Committee Terms of Reference for recommendation to the Board. • Noted progress with ICB Business Intelligence team to improve data streams.

			• Received a safeguarding update by exception on fatal self harm, sexual safety in healthcare, safeguarding competency strategy, domestic homicide reviews, Place and improvement programmes. • Received a quality and safety update by exception on PSII, quality alerts, NRS, Sodium Valporate, Synnovis harm review, paediatric audiology, SQG escalation, learning from deaths, themes and concerns and improvement programmes. • Received a LMNS update by exception on MIS compliance, positive progress with step down from support programme, unit closure updates with progress in recruitment and rolling action plans from CQC maternity survey. • Received a Medicines Safety update providing scope of the new network and plan to work cross sector on medicine safety issues, updated on Pancreatic Enzyme Replacement Therapy, Sodium Valproate, Methotrexate prescribing and gave overview of ICB and Place prescribing data. • Received the patient experience update by exception. Noted a slight decrease in Q2 contacts but with 60% increase in MP enquiries. Themes of concern remain similar. • Received the Learning Disability Autism and Send update by exception. Noted co-production to improve community services to avoid admissions, dynamic support registers are on schedule and network task and finish group progress. • Discussed the future strategy of the committee to identify key themes to verbally inform Board of priorities.
17.	Remuneration Committee	16 January 2025	• The committee discussed and approved two additional redundancy papers resulting from the ICB's Management Cost Reduction programme.

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.	26 September 2024	Bexley Autism Strategy	The Bexley Wellbeing Partnership Committee received an update from the London Borough of Bexley on the Autism Strategy. Bexley Borough has had an autism strategy since 2015, which has now been expanded to include Child and Adults. The Bexley Wellbeing Partnership Committee: • Noted the engagement completed to inform the draft strategy. • Reviewed and endorsed the draft Autism Strategy.
2.	26 September 2024	Bexley Safer, Haven, Inspiring, Empowering, Leading & Defending (SHIELD) Partnership: Annual Report 2023/24	The Bexley Wellbeing Partnership Committee received a presentation on the Bexley SHIELD Partnership Annual Report 2023/24. The report summarised the work done by the SHIELD partners (local authority, NHS, and police) over the year, focusing on safeguarding and supporting young people. The Bexley Wellbeing Partnership Committee: • Noted the report, plans and priorities for 2024/25 and provided feedback on the format and accessibility of the report.
3.	26 September 2024	Better Care Fund 2024/25	The Better Care Fund (BCF) 2024/25 report sought the committee's endorsement to update the schedules and appendices of the Section 75 agreement between the London

			Borough of Bexley and NHS South East London Integrated Care Board. The BCF plan for 2024/25 was approved by NHS England. The Bexley Wellbeing Partnership Committee: • Considered and endorsed the proposal to update the schedules and appendices to the Section 75 Agreement between the London Borough of Bexley and NHS South East London Integrated Care Board.
4.	28 November 2024	Children's & Adults Safeguarding Annual Report	The Bexley Wellbeing Partnership Committee received the Children's & Adults Safeguarding Annual Report, which set out the governance structure of safeguarding within NHS South East London Integrated Care Board and at place. The report outlined all the statutory reviews, which have taken place in 2024/25 across children and adults and progress against the local health and care system priorities. The Bexley Wellbeing Partnership Committee: • Approved the Children & Adults Safeguarding Annual Report 2023/24 and review the priorities for 2024/25.

3. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	26 September 2024	Primary Care Delivery Group Business Update Report – Q1 & Q2 2024/25	The Bexley Wellbeing Partnership Committee received a Primary Care Delivery Group (PCDG) Business Update Report for Q1 and Q2 2024/25. The PCDG, a sub-committee of the Bexley Partnership, manages primary care matters, including GP contracts, enhanced service contracts, estates, budgets, and developmental work related to integrated neighbourhood teams. The Bexley Wellbeing Partnership Committee:

			• Reviewed and discussed the summary of decisions taken by the Primary Care Delivery Sub-committee during Q1 and Q2 2024/25.
2.	26 September 2024	Community & Mental Health Services – Operational Report (Oxleas NHS Foundation Trust)	The Bexley Wellbeing Partnership Committee received a report Operational Report from Oxleas NHS Foundation Trust on commissioned community and mental health services for Bexley. The Bexley Wellbeing Partnership Committee: • Noted the contents of the report.
3.	28 November 2024	Joint Forward Integrated Plan – 2024/25 Progress Report	Bexley Wellbeing Partnership Committee received a progress report on delivering the Joint Forward Integrated Plan. The report captured key successes from April to September 2024, highlighted any challenges and key learning. The Bexley Wellbeing Partnership Committee: • Reviewed the progress made on delivering the Bexley Wellbeing Partnership Integrated Forward Plan.
4.	28 November 2024	*Let's talk about* – Tackling Health Inequalities	The *Let's Talk* discussion highlighted some of the work being done to address tackling health inequalities in the three Local Care Networks. Representatives from Age UK and Counselling Matters spoke about the Functional Fitness MOT project commissioned in Frognal Local Care Network and funded by the partnership, to tackle issues around frailty.

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 Approval of approach for predominately joint implementation of One Bromley Strategy and Bromley Health and Wellbeing Board Strategy Joint Implementation Plan, with reporting to both Health and Wellbeing Board and One Bromley LCP Board.

2.2 Approval of One Bromley Executive Committee revised terms of reference.

3. Agenda Items of Note

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

No.	Meeting date	Agenda item	Items discussed
1.	26 September 2024	Item 6 - One Bromley Strategy and Bromley Health and Wellbeing Board Strategy Joint Implementation Plan	• Members discussed and approved a joint approach to implementation of the strategic plans.
2.	26 September 2024	Item 7 - Partnership Report	• The members received the Joint Partnership Report, noting the work underway to prepare for winter including the rollout of vaccination programmes. A number of award nominations were highlighted, including Bromley Healthcare's two HSJ Award nominations and the nomination of the B-CHIP programme for a parliamentary award.

3.	26 September 2024	Item 8 - Pharmacy First Update	• An update on Pharmacy First was given, this included progress within the service. • Members discussed the item, the importance of the close working relationship between primary care and community pharmacy was noted. Work on this area continued, with further updates to come to a future meeting.
4.	26 September 2024	Item 9 - Finance Month 4 Update	• The members received an update on the month 4 Bromley ICB/LCP place financial position, noting a forecasted £4k underspend at year end, and the three principal areas posing potential financial challenges being Mental Health CPC placements, Continuing Healthcare and Prescribing. • It was agreed that information on system savings plans would be included in future reports.
5.	26 September 2024	Item 10 - Updates to the Bromley NHS Act 2006 Section 75 Agreement for 2024-2025	• Members received the annual report on the boroughs Section 75 agreement, which has been in place since 2014, noting no major changes to the agreement this year, with most projects in the Section 75 are covered by the Better Care Fund (BCF).
6.	26 September 2024	Item 11 - Primary Care Group Report	• Members received the report, with no comments or questions raised.
7.	26 September 2024	Item 12 - Contracts and Procurement Group Report	• Members were advised a contract had been awarded for transvaginal scanning. • It was agreed that the forward plan of all procurements being considered by the ICB would be shared with the committee.
8.	26 September 2024	Item 13 - Performance, Quality and Safeguarding Group Report	• Members received the report with no questions or comments received.
9.	28 November 2024	Item 6 - One Bromley Executive Committee Terms of Reference	• The Board discussed and approved the updated terms of reference, noting no major changes had been made and that the Chair role had now been taken over by Angela Helleur. A more detailed forward workplan along with a programme of development would be produced, with the first session planned for early February.
10.	28 November 2024	Item 7 - One Bromley Local Care Partnership Board Terms of Reference	• Revised terms of reference, updated to define and clearly outline voting and non-voting members in attendance for Part 1 and Part 2 of the meeting, were presented and approved.

11.	28 November 2024	Item 8 - Winter Plan 2024-25	• Members received an update on progress with the Winter Plan noting capacity was being increased across the system, joining up the arrangements between hospital and community and expanding communication and escalation arrangements. • Members discussed the winter plan, with a focus on staff vaccination rates across the system. • It was noted that winter pressures had already commenced, organisational leads gave updates on progress and any challenges faced.
12.	28 November 2024	Item 9 - Partnership Report	• The report was received with a few items highlighted for further discussion including the Bromley Health and Wellbeing Centre, which would be located within the new Civic Centre site. • Organisations had won a number of awards in recent months, including the Hospital at Home Service receiving a LaingBusson award for pre-hospital care for reducing admissions.
13.	28 November 2024	Item 10 - Month 6 SEL ICB Finance Report	• The Committee received an update on the month 6 financial position for Bromley Place.
14.	28 November 2024	Item 11 - Primary Care Group Report	• Members received the report with no questions or comments received.
15.	28 November 2024	Item 12 - Contracts and Procurement Group Report	• The report was noted, with the inclusion of an appendix detailing a list of contracts due to go out to procurement in the next year being highlighted.
16.	28 November 2024	Item 13 - Performance, Quality and Safeguarding Group Report	• The report was received noting discussions at the last meeting had focused on the implementation of PSIRF in primary care, and the next meeting would focus on IT security, with the Chief Digital Security Officer to attend to present and answer any questions. • The heightened risk of cyber-attacks in light of world events was highlighted.
17.	28 November 2024	Item 14 - Any Other Business	• An update was given on the Pharmaceutical Needs Assessment (PNA). This was produced every three years by the Public Health team, per statutory requirements for the Health and Wellbeing Board with a public survey live until the end of February. The item was discussed, to include how this can best be promoted to staff within the system. The report would go to the Health and Wellbeing Board in September, with regular updates in the interim.

			• The Healthwatch research project on young carers in Bromley was highlighted and discussed.

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

No.	Meeting date	Agenda item	Items for Board to note
2.	11 December 2024	3. Thamesmead Procurement for Approval	• The LCP members agreed to the recommendation to award the APMS contract for Thamesmead Health Centre

3. Agenda Items of Note

3.1 No other items have been discussed of note for the period.

Appendix 4

Lambeth Local Care Partnership – Lambeth Together

1. Recommendations to the Board for Decision / Approval

1.1 The following decision is recommended to the Board for approval:

No.	Meeting date	Agenda item	Items for Board to note
1.	9 January 2025	Lambeth Together Care Partnership Board Terms of Reference	Board members noted the recommended updates to the Lambeth Together Care Partnership Terms of Reference; and approved the proposed 9 January 2025 Lambeth Together Care Partnership Board Terms of Reference for submission to the SEL ICB Board.

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.	7 November 2024	Lambeth Together Assurance	Members of the Partnership Board noted the update on discussions held at the Primary Care Commissioning Committee on 11th September 2024 and ratified decisions made: • Service Development Fund (SDF): The Committee noted and reviewed the financial envelope and associated budget lines. The Committee approved the budget lines for the proposed SDF allocation for 2024/2025. • Enhanced Access Primary Care Network (PCN) Directed Enhanced Service (DES): The Committee noted and approved the proposed service model changes requested by the North Lambeth PCN, Fiveways, and Clapham PCN.

			• Primary Care Network formation and Clinical Director (CD) Leadership update in Lambeth: The Committee approved the changes in the CD leadership and noted the update to the PCN Map. • NHS South East London (SEL) Integrated Care Board (ICB) service specification for the Primary Care Interpreting and Translation service: Approval of the SEL ICB service specification for the Primary Care Interpreting and Translation Service (ITS) across Lambeth, Lewisham, and Southwark was given by Chairs' Action.
2.	9 January 2025	Lambeth Together Primary Care Commissioning Committee	Members of the Partnership Board noted the update on discussions held at the Primary Care Commissioning Committee on 20th November 2024 and ratified decisions made: • Primary Care Interpreting Service across Lambeth, Lewisham, and Southwark– Contract Award Recommendation Report (CARR): The Committee noted that the recommended bidder for the re-procured Interpreting service is Bidder 4, and approved the decision in line with the Contract Award Recommendation Report (CARR). • 2024 / 2025 Building Practice Resilience: The Committee noted and approved the release of £30,790.00 in building practice resilience funding as recommended by the Panel review. • Lambeth Offer Project Initiation Document (PID), Evaluation of Lambeth's existing schemes and Lambeth Together Primary Care Commissioning Intentions for 2025/26: The Committee noted and approved the evaluation of Lambeth's existing schemes, the Project Initiation Document (PID), and the Primary Care Commissioning Intentions letter (which is to be updated to capture LTPCC approval) for 2025/2026. • Population Health Management (PHM) Tool procurement update: The Committee noted the update.

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.	7 November 2024	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 5th September 2024, reporting on key issues, achievements, and developments from across the Lambeth Together Partnership.
2.	7 November 2024	Hospital @Home (Virtual Wards)	Members of the Partnership Board received an update on developments within this programme of work and considered the following recommendations: • That wider partners, putting the patient voice at the centre, support Hospital @home becoming synonymous with hospital quality care, associated with A&E, delivered closer to home in the minds of our population. • Assist by helping establish and promote the model of 'Virtual Wards' as 'Hospital @ home'. • Enable expansion of Hospital @home services to ensure more care is delivered in peoples' homes when that is the right thing to do.
3.	7 November 2024	Lambeth Together Assurance Group (LTAG) Update	• Members of the Partnership Board noted the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 10th September 2024.
4.	7 November 2024	Children & Young Person Alliance Deep Dive: Good to Outstanding, Evelina London Maternity Strategy	Members of the Partnership Board: • Received the update from Evelina London on their agreed priorities prior to publication of their maternity strategy. • Acknowledged the collaborative working in maternity services to date and discussed how agreed maternity priorities support the agreed activities for maternity as outlined in the Our Health, Our Lambeth - Health and Care Plan. • Discussed how elements of the agreed maternity priorities can be best supported through the alliances and Lambeth Together.

5.	7 November 2024	Living Well Network Alliance (LWNA) – Progress Report 2023/24	• Members of the Partnership Board received and welcomed the report of the Lambeth Living Well Network Delivery Alliance, as set out in its 2023/24 Progress Report.
6.	9 January 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 7th November 2024, reporting on key issues, achievements, and developments from across the Lambeth Together Partnership.
7.	9 January 2025	Staying Healthy Deep Dive: Lambeth Suicide Prevention Strategy 2025-2030	Members of the Partnership Board: • Received an on overview of the achievements of the current Lambeth Suicide Prevention Strategy, and an outline of the proposed refresh and development of the Strategy for 2025-2030. • Resolved to support further opportunities for sharing of relevant data, such as self-harm and suicide attempts data from Emergency Departments
8.	9 January 2025	Ageing Well in Lambeth	Members of the Partnership Board: • Received an update on progress made by Age-Friendly Lambeth and Age UK Lambeth over the last year • Resolved to support upcoming areas of work including the Ageing Well programme and discussed how partners can continue to provide input to the work to support residents to age well in Lambeth
9.	9 January 2025	Lambeth Together Assurance Group (LTAG) Update	Members of the Partnership Board noted the report from the Lambeth Together Assurance Sub-Group and the associated Integrated Assurance Report presented on 05 November 2024.
10.	9 January 2025	Business and Financial Planning 2025/26 – Health and Care Plan Review	Members of the Partnership Board: • Received and noted the requirements of the 2025/26 Lambeth Together business planning and associated timeframes; • Provided feedback on the approach and considered their role within the planning process; including the development of Integrated Neighbourhood Teams (INTs) • Committed to collaborate on producing and delivering an impactful plan.

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.	21 November 2024	(7). Part I **Intermediate Care Beds procurement**	• The Partnership noted that the Intermediate Care Beds contract had been extended to 12 months; however the Director for Adults Integrated Commissioning requested a further 6-month extension to allow time for procurement to be completed. The Board approved the Intermediate Care Beds procurement for a further 6 months.
2.	21 November 2024	(8) Part I **Lewisham Winter Resilience Plan**	• Members received an update on actions and recommendations around winter planning. The LCP Board noted the update and approved the Lewisham Winter Resilience Plan.
3.	21 November 2024	(1). Part II **Lewisham Community Dermatology Service – Contract Award**	• A Part II was held for key Board members due to a conflict of interest. • The Lewisham Community Dermatology Service requested approval on the recommended preferred bidder as outlined in the Contract Award Recommendation Report (CARR). The Board approved Lewisham Community Dermatology service contract and the preferred bidder.
4.	21 November 2024	(2). Part II **Interpreting Contract Award Recommendation Report**	• A Part II was held for key Board members due to a conflict of interest. • The Board approved on the outcome of the procurement exercise for the LSL Primary Care Interpreting Service and requested approval on the recommended preferred bidder as outlined in the Contract Award Recommendation Report (CARR). The Board approved Interpreting Contract award and the preferred bidder.

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.	21 November 2024	(3). PEL Report	• The Board noted the update from Ceri Jacob, Place Executive Lead. This included an update on the Rotation of Co-Chair for the Lewisham Health and Care Partnership Strategic Board, NHS 10 Year Plan and SEND inspection report.
2.	21 November 2024	(4, 5, 6). CYP	• The LCP Board noted CYP areas of work such as the Children's Services DfE Family Help Pathfinder Update, GP-Led Youth Clinic Update and Plans for Potentially Scaling Provision Across the Borough and Start for Life Programme Update and Continuation Beyond March 2025.
3.	21 November 2024	(9) Lewisham Assurance Report	• The members received an update on childhood Immunisations and vaccinations.
4.	21 November 2024	(10) PSR Cover sheet and Terms of reference	• A Provider Selection Regime paper was presented, which provided insight into how the NHS procures services and how this is changing. For example, procurements will be undertaken at Place on behalf of the ICB.
5.	21 November 2024	(11). Risk Register	• The Board noted the Risk Register update. Risks are regularly reviewed at key borough meetings as well as individual risk owner meetings.
6.	21 November 2024	(12). Finance update	• The Board noted the Finance update and the challenging financial situation. Material cost pressures on prescribing and CHC (continuing health care) were noted.

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.	7 November 2024	Item 1: Welcome and introductions	• The Board welcomed two new members in the new category of social care provider, one representing a local care home provider and the other a home care provider.
2.	7 November 2024	Item 2: Family Hubs	• The Director of Children's Services of the council gave a presentation on the multi-disciplinary Family Hub programme focussing on early intervention and early help. It is a government led programme of which 75 local authorities across the country have been chosen to deliver (including Southwark) and an example of integrated working at neighbourhood level. Whilst programme governance sits with the council it has a strong link to the Partnership Southwark Start Well priority and it has been agreed that the board will receive regular updates on progress and issues.

3.	7 November 2024	Item 3: Maternity Commission	A presentation was given by Public Health officers on the Southwark Maternity Commission report commissioned by Southwark Council which was published in September. The report focusses on 5 key themes: 1. Tackling discrimination and better supporting women with specific needs. 2. Making sure women are listened to and supported to speak up, whatever their language or background. 3. Providing women with the right information at the right time in the right way. 4. Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders. 5. Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers. ○ An action plan is being developed by the Public Health Division within the Council, based on the recommendations set out in the report, which will be finalised by April 2025. The action plan will then be implemented over the following two and a half years, with a view to all actions taking place by September 2029. The governance of the Maternity Commission falls under Health and Wellbeing Board. The Partnership Southwark Board agreed to receive further updates as the action plan develops.
4.	7 November 2024	Item 5: Health and Care Plan Priorities Refresh – Focus on Frailty	• The Partnership Southwark Age Well programme team provided a detailed focus and facilitated discussion on the delivery plan for frailty, which is one of five refreshed strategic priorities of the Partnership Southwark Health and Care Plan. The delivery plan described the work underway to develop an integrated frailty pathway, initially in the Walworth Triangle neighbourhood with a view to scaling this approach across the borough. Work is quickly evolving with health and social care partners, but is also involving other partners such as housing, to identify frailty sooner and deliver a more coordinated and holistic care plan. Success measures are developing with recognition of both system and individual outcomes to promote wellbeing in local communities.
5.	7 November 2024	Item 6: Strategic Director for Health and	The Strategic Director for Health and Care and Place Executive Lead presented the report to the board including:

		Care and Place Executive Lead Report	• A summary of the SEL ICB Board visit to Southwark in August 2024 which visited the Southwark Resource Centre for disabled people, met with community health ambassadors and the Vital 5 Health Check team, staff and volunteers from the Wellbeing Hub rounded off by a visit to the new Camberwell Lodge care home. • Report back from the annual State of the Sector VCSE event hosted by Community Southwark • Update on Southwark Maternity commission (also substantive item on agenda) • Southwark's Borough of Sanctuary status • New board members update and senior leadership changes • Update on governance review formalising the role of sub-groups of the board and the development of an integrated assurance report • An update on the latest ICB financial position at month 6 highlighting a range of challenges including in-year deficits in mental health service, prescribing and primary care, and an underlying deficit of £4.5m • Update on the transfer of Continuing Heath Care staff and associated functions from GSTT to the ICB as agreed by the ICB Board • Promotion of the national Change NHS consultation • Sub-group reports from the Integrated Governance and Assurance Committee and Primary Care Group were presented by the chair of these groups
6.	7 November 2024	Item 7: Healthwatch report	• Healthwatch Southwark presented on the findings from their extensive consultation undertaken with residents during its recent listening tour as set out in the "What matters to you?" report. The biggest concern reported was GP access, followed by mental health and hospital care waiting times and quality. The board noted the finding which will be taken into account in the development of plans for the partnership priorities and core business delivery.

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 2 October 2024 and 9 January 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 2 October 2024 and 9 January 2025.

No.	Meeting	Agenda item	Items for Board to note
1.	Committee in Common, 13 December	APC Outline Strategic Direction	The group approved the draft Outline Strategic Direction proposed for the SEL Acute Provider Collaborative, a high-level document emphasising close alignment with emerging national policy on elective and diagnostic recovery They requested further work be undertaken via engagement with stakeholders to refine the draft and develop an implementation plan.
2.	APC Executive, September to December	Network SRO appointments	The group agreed transitional SRO arrangements for some APC elective networks. The group has agreed the following substantive arrangements following this transitional period: • Mamta Shetty Vaidya (KCH CMO) - Gynaecology Network • Rantimi Ayodele (KCH-PRUH CMO) – Orthopaedic Network • Anne Rigg (CD, Cancer & Surgery Care Group, GSTT) – Urology Network
3.	APC Executive, 13 December	Clinical Director role	The group approved a one-year fixed term appointment of a Clinical Director for Elective & Diagnostic Recovery to provide clinical leadership across the APC programmes and networks. Further work is under way to develop the role description and person specification before seeking expressions of interest

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 2 October 2024 to 9 January 2025, for Board information.

No.	Meeting	Agenda item	Items discussed
1.	APC Executive and other APC Groups	System Sustainability Group work	The work of the System Sustainability Group has been discussed in multiple APC meetings. This has included discussions on potential duplication of work and how this can be avoided or addressed. In addition, APC meetings have provided the opportunity for engagement with additional colleagues on the acute clinical strategic plan work.
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 a number of APC groups. There has been a strong focus on the trajectory to eliminate 65 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.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 There has not been a formal South London Partnership Committees in Common meeting in the interim. Below is an update on decisions previously reported for Board information.

2. Agenda Items of Note

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

No.	Agenda item	Items discussed
1.	Complex care	A new community-based mental health rehabilitation unit opened in Lewisham last year and a potential location for a similar unit within Bexley, Bromley and Greenwich has been identified. 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.
2.	Specialist Commissioning	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. A workshop is being held in early February to agree oversight approaches and transformation aims.
3.	Efficiency	SLP is engaging with the SEL ICS System Sustainability programme.
4.	NHS 111 for mental health	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 SLaM.

South East London Integrated Care System

NHS South East London

Integrated Care Board
Quality and Safeguarding Committee

Terms of Reference

[Draft Proposed by QSC] 15 January 2025

1. Introduction

1.1 The NHS South East London Integrated Care Board (ICB) Safeguarding and Quality Committee [the "committee"] is established as a committee of the ICB.

1.2 The committee has no executive powers other than those specifically delegated in these Terms of Reference. These terms of reference can only be amended by the ICB Board.

1.3 These terms of reference set out the purpose, duties, responsibilities and accountabilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.4 ICB Board Members and employees are directed to co-operate with any requests made by the committee.

2. Purpose

2.1. The committee will act as a focal point for the collective oversight and strategic direction of safeguarding and quality matters across SEL Integrated Care System. The committee is 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.

2.2. It's work will ultimately support improved health outcomes, reduced inequalities and enhanced patient experience.

2.3. The committee will provide the ICB Board with assurance that the ICB is delivering it's safeguarding and quality functions and obligations in a way that is compliant with the NHS Safeguarding Assurance and Accountability Framework (2024) and the advice and recommendations of the National Quality Board.

2.4. The scope of the committee's activities will be in relation to services commissioned by the ICB on behalf of the resident population of South East London.

3. Duties

3.1. The committee is responsible for ensuring the robustness of the systems in place across the ICB to secure effective quality and safeguarding governance, assurance and internal control across the ICB.

3.2. The committee will oversee that these systems and processes allow the ICB to comply with all relevant legislation, effectively delivering its strategic objectives to provide sustainable and high-quality care, and ensuring appropriate safeguards are in place to protect children and adults at risk.

3.3. The committee will pro-actively identify and obtain assurance that declining quality and safeguarding indicators are being addressed, ensuring risks are managed rapidly by a designated responsible officer or responsible group. In this the committee will ensure the development and delivery of system action plans has been actioned by the ICB Executive Committee and system partners as appropriate, where these are required due to variance against agreed standards.

3.4. The committee is expected to work across the system to review and endorse mitigating actions at South East London, Local Care Partnership / Borough and Provider Collaborative level, as put forward by these partnerships and collaboratives for their agreed areas of responsibility.

3.5. The System Quality Group (SQG) and System Safeguarding Group (SSG) are sub-groups of the Safeguarding and Quality Committee. The committee will act both directly, and through its oversight of the SQG and SSG to:

- input into the development of shared ambitions and priorities.
- act to ensure inequalities and variation in the quality of care and outcomes are addressed.
- ensure serious safeguarding and quality risks and concerns are managed effectively; and that learning, intelligence and improvement are shared across the system and beyond to inform ongoing improvement.
- obtain assurance that actions are delivered in keeping with agreed timescales
- ensuring training provision for the workforce is robust – succession planning, professional development, clinical governance are central to ICB delivery

3.6. The committee will undertake the following specific activities:

3.6.1 Receive and review a risk report to agree the main risks (internal and external) related to safeguarding and quality. The committee will oversee the ICB's objective to minimise risk related to its responsibilities towards securing continuous improvement in safeguarding and quality and improving outcomes for the resident population. Whilst responsibility for detailed review

and remedial action on risks rests with the ICB Executive Committee, the committee is expected to maintain an awareness of related risks and assure itself that the proposed actions are adequate, acting as the point of escalation for concerns relating to safeguarding and quality which are raised by the ICB Executive Committee.

3.6.2 Receive reports from the SQG and SSG to review identified themes and shared learning from statutory and non-statutory learning reviews, drawing on intelligence from borough-based forums such as Local Care Partnerships, Safeguarding Children Partnerships, Safeguarding Adult Boards and Safer Community Partnerships, and working collaboratively with partner organisations to do so.

3.6.3 Oversee and scrutinise the ICB's response to all relevant directives, regulations, statutes, national standards, policies, reports, reviews and best practice as issued by the DHSC, NHSE, and other regulatory bodies / external agencies (e.g. CQC, NICE), including giving guidance to the system as required and gaining assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

3.6.4 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

3.6.5 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Deaths reports).

3.6.6 Provide the ICB Board with assurance that it is delivering its statutory duties for Safeguarding Adults, Safeguarding Children and Children Looked After as laid out in Section 11 of the Children Act (2004), Working Together to Safeguard Children (2023), the Care Act (2014), and Promoting the Health and Wellbeing of Looked After Children (2015).

3.6.7 Provide the ICB Board with assurance that it is delivering its statutory duties in relation to people with Special Educational Needs and Disabilities (SEND) outlined in the SEND Code of Practice (2015) and Children and Families Act (2014)

3.6.8 Comprehensively scrutinise the robustness of the arrangements for, and assure compliance with, the ICB's statutory responsibilities for:

- Infection Prevention and Control
- Local Maternity and Neonatal System
- Patient Experience
- Learning Disabilities and Autism

- Medicines safety and antimicrobial stewardship.
- Equality, Diversity and Inclusion (where these relate to specific performance standards or matters of care quality)
- Continuing Healthcare
- Safeguarding

3.6.9 Arrange a rolling programme of deep-dive reviews across both the committee and SQG and SSG with the aim of understanding in detail key areas of ICB risks and performance and contributing through this process to improvement activities and the promotion of shared learning.

3.6.10 Ensure that the SQG and SSG maintains effective processes for system-wide learning in accordance with the principles of the National Patient Safety Framework, learning from significant events including themes and trends from incidents and safeguarding reviews. This assurance will be provided via SSG and SQG reports and supplementary papers, the committee's role being to ensure that lessons learned are implemented and are making a positive difference.

3.6.11 Contribute to the development and utilisation of a common ICS Safeguarding and Quality Framework to measure the impact of the actions taken by the ICB Board or the ICS more broadly (including ICS transformation programmes). This framework will include quantitative and qualitative intelligence relating to service performance and the quality and safety of care, including patient experience and outcomes.

3.6.12 Receive and review a quarterly exception report on Safeguarding and Children Looked After. This will include matters related to borough based safeguarding arrangements, risks and performance.

3.6.13 Receive updates in relation to local, regional or national safeguarding and quality priorities, agreeing a strategic and/or operational response as appropriate, and monitoring ICB delivery on any priorities.

3.6.14 Identify and share best practice across the ICS in relation to safeguarding and quality.

3.6.15 Receive updates from the SEL Forum for Antimicrobial Stewardship (via the Infection Prevention & Control Group), the SEL Medicines Safety Network and the SEL Integrated Medicines Optimisation Committee on quality improvement work relating to medicines.

4. Accountabilities, authority, and delegation

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

4.2. The committee will act to agree and report against all duties within its scope. It will report on risks and planned improvements related to its performance and quality assurance activities and update on improvement work to the ICB Board.

4.3. The committee will be provided with a regular opportunity to hear from representatives of its supporting groups. It will be able to act on recommendations or proposals that arise at those supporting groups (SQG, SSG, CHC Quality Assurance Group, IPC group) in line with the ICB Scheme of Reservation and Delegation

4.4. The committee will link with other partnership assurance processes, such as Local Authority Overview and Scrutiny and Safeguarding Boards/ Partnerships.

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

5. Membership and attendance

5.1. Committee members shall be appointed by the ICB Board in accordance with the ICB Constitution.

5.2. As far as is possible, the membership of the committee should be representative of the population it covers, in line with relevant ICB Equality, Diversity and Inclusion processes, guidance and objectives.

5.3. At any point, the Chair may ask any non-committee members in attendance to withdraw in order to facilitate open and frank discussion by committee members of a particular matter or issue.

5.4. The membership of the committee will be

- ICB Non-Executive Director (Chair)
- Independent Safeguarding Board/ Partnership Chair or Independent Safeguarding Board member
- ICB Chief Nurse
- ICB Medical Director
- ICB Place Executive Lead (x1)
- ICB Chief of Staff
- ICB Chief Pharmacist or Associate Chief Pharmacist
- SEL Director of Children's or Adult Services (x1)
- ICB Director for Mental Health, Children & Young People and Inequalities

5.5. The committee will meet with the following in attendance:

- ICB Deputy Chief Nursing Officer
- ICB Head of Nursing – Safeguarding
- ICB Head of Primary Care
- ICB Head of Quality – Clinical and Care Professional Lead (CCPL)
- Director of Public Health (x1)
- Designated Professional for Safeguarding Adults/ Children/ Children looked After (x1)
- SEL Provider Chief Nursing Officer
- Director, SEL Healthwatch

5.6. Any member of the ICB Board additional to those listed as committee members may join the committee in attendance.

5.7. Other individuals from across the ICS (health or social care organisations) may be invited to attend as required for specific items.

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

5.9. Committee members will be expected to conduct business in line with the ICB values. Members of, and those attending, the committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy

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

5.11. All committee decisions must be taken in line with ICB Equality, Diversity and Inclusion processes and procedures, for example the consideration of an Equalities Impact Assessment where relevant. All decisions must also seek to include an appropriate level and mechanism of public/ service user engagement.

6. Chair arrangements

6.1. The committee will be chaired by an ICB Non-Executive Director.

6.2. The Deputy Chair will be TBC.

6.3. At any meeting of the committee, the Chair 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.

7. Quoracy and Conflict of Interest

7.1. To be quorate, the following four members must be present:

- ICB Chief Nurse or ICB Chief Medical Officer
- Chief of Staff or Deputy
- Place Executive Lead or Deputy
- Chief Pharmacist or Associate Chief Pharmacist

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

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

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

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. 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 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 Chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in Para. 7.1, expresses by email or signed written communication by the stated response date, that they are in favour.

9.2. The ICB's Corporate 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 the next committee meeting.

10. Frequency

10.1. The committee will meet on a quarterly basis.

10.2. Given the importance of the committee, members will be expected to prioritise attendance. They should provide apologies in advance should they be unable to attend.

10.3. Members are responsible for identifying a suitable representative should they be unable to attend a committee meeting. The representative must be agreed in advance with the Chair, and notified to the meeting administrator.

10.4. Nominated representatives will count towards the meeting quoracy if attendance has been agreed by the committee Chair.

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

11. Reporting

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

11.2. The committee will report on its activities to the ICB Board primarily through the committee minutes and an accompanying report which will summarise key points of discussions, items recommended for decisions, the key assurance and improvement activities undertaken or coordinated by the committee, and any actions agreed to be implemented. The committee will also provide any ad hoc report or communications as the ICB Board so request.

11.3. Committee papers will be publicly available as part of the ICB Board Meeting in Public board pack.

12. Administrative Support

12.1. The committee will be supported administratively by the ICB's Corporate Governance team.

12.2. Draft minutes will be shared with the Chair for approval within five working days of the committee meeting.

12.3. Approved minutes will be circulated to members together with a summary of activities and actions within ten working days of the meeting.

13. Monitoring adherence to the Terms of Reference

13.1. The Chair will be responsible for ensuring the committee abides by the Terms of Reference.

14. Review of Arrangements

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

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

NHS South East London Integrated Care Board

Lambeth Local Care Partnership Committee (Lambeth Together)

Terms of Reference

09 January 2025

1. Introduction

1.1. The NHS South East London Integrated Care Partnership (ICP) Board provides a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from across the system and community. The Partnership sets strategic direction, provides leadership and support of key South East London-wide programmes, and holds system partners to account for delivery.

1.2. The NHS South East London Integrated Care Board (ICB) is an NHS statutory organisation that brings together partners involved in planning and providing NHS services, working together to meet the health needs of the population within South East London and deliver the Integrated Care Partnership's strategy

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

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

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

2. Purpose

2.1. **'**Lambeth Together**'** seeks to ensure that partners can design, plan, deliver and evaluate their work together to improve services and outcomes for residents, with a particular focus on tackling health inequalities and ensuring equitable access to care and support for all communities. The partner organisations represented through the core members of the Lambeth Together Care Partnership Board may opt to bring their formal delegations to the decisions of the Board. Lambeth Council will act through the delegated authority of Cabinet and Executive Leads.

2.2. The committee is responsible for the effective discharge and delivery of the Place-based functions as agreed by the ICB. The committee is responsible for ensuring:

a. **The Place[1] contribution to the ICB's agreed overall planning processes including** the effective planning and delivery of place based services to meet the needs of the local population, with a specific focus on community based care and integration across primary care, community services and social care, managing the place delegated budget, taking action to meet agreed performance, quality and health outcomes, ensuring proactive and effective communication and engagement with local communities and developing the Local Care Partnership to ensure it is able to collaborate and deliver effectively, within the partnership and in its interactions with the wider Integrated Care System (ICS).

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

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

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

3. Duties

3.1. **Place-based leadership and development:** Responsibility for the overall leadership and development of the Local Care Partnership to ensure it can operate effectively and with maturity, work as a collective and collaborative partnership and secure its delegated responsibilities with appropriate governance and processes.

3.2 **Community engagement:** Responsibility for development, relationship-building activities and meaningful local community and resident engagement to ensure that services are responsive to the needs of all residents. The Local Care Partnership also needs to support the Place Executive Lead to effectively represent the Partnership's views, while also considering the needs of the wider ICS, and fostering strong, ongoing partnerships with local communities to ensure their voices are heard in decision-making.

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

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

[1] Within Integrated Care Systems (ICSs), 'Place' refers to a smaller geographic footprint, which in most cases is based on local authority boundaries. South East London ICS is made up of six places, co-terminous with the six borough councils.

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

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

4. Accountabilities, authority and delegation

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

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

5. Membership and attendance

5.1. Core members of the committee will include representatives of the following organisations including specific postholders, where named.

Clinical and Professional Membership

a. Lambeth Together Care Partnership Board Co-Chair - Clinical lead
b. Director of Public Health, Lambeth Council
c. Corporate Director Housing and Adult Social Care (DASS), Lambeth Council
d. Corporate Director Children, Families and Education (DCS), Lambeth Council
e. Chair of Lambeth GP Clinical Cabinet
f. Delivery Alliance Clinical and Care Professional Lead(s) x 3

Community Membership

a. Cabinet Member(s) for Healthier Communities and Lambeth Together Care Partnership Board Co-Chair
b. Young People's Champion, Lambeth Council
c. Programme Director, Black Thrive
d. Lambeth Together Lay member
e. Patient & Public Voice representatives x 2

Executive Membership

a. Place Executive Lead - Corporate Director, Integrated Health and Care
b. Executive, Guys and St Thomas' NHS Foundation Trust
c. Executive, Kings College Hospital NHS Foundation Trust
d. Executive, South London and the Maudsley NHS Foundation Trust
e. Managing Director, GP Federation
f. CEO, Age UK

5.2. Non-voting members. Additional members are included in all committee meetings and activity, as key partners of the Lambeth Together Care Partnership, but do not hold a vote and are not part of the quoracy.

a. Lambeth Healthwatch
b. Lambeth Local Medical Committee.

6. Chair of meeting

6.1. The meeting will be co-chaired by the Cabinet Member for Healthier Communities and an LCP clinical lead as appointed by Board members, and subject to regular review.

6.2. At any meeting of the committee the co-chairs shall preside.

6.3. If one co-chair is temporarily absent on the grounds of conflict of interest, the other co-chair shall preside, or, in the case that they also may not, then a person chosen by the committee members shall preside.

7. Quorum and conflict of interest

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

7.2. Each core member has one vote, unless otherwise specified in section 5.1 by virtue of multiples of the same role.

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

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

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

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

8. Decision-making

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

8.2. The partner organisations represented through the members of the Lambeth Together Care Partnership Board may opt to bring their formal delegations to the decisions of the Board. Lambeth Council will act through the delegated authority of Cabinet and Executive Leads.

9. Frequency

9.1. The committee will meet once every two months (in public) with ability to have a private session as Part B in addition to this.

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

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

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

10. Reporting

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

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

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

11. Committee support

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

12. Review of Arrangements

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

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Planning for 2025/26 and beyond**					
Meeting date	29 January 2025	Agenda item Number	**8**	Paper Enclosure Ref	**i**	
Author(s)	Sarah Cottingham, Deputy CEO and Director of Planning					
Executive lead	Sarah Cottingham, Deputy CEO and Director of Planning Mike Fox, Chief Financial Officer					
Paper is for:	Update		Discussion		Decision	**X**
Purpose of paper	• To receive an update on the work being undertaken across the SEL system to refresh our medium term plans - the Joint Forward Plan, Medium Term Financial Strategy and Medium Term Financial Plan, alongside the work being undertaken on 2025/26 operational planning. • To seek the Board's endorsement of the approaches set out in the paper.					
Summary of main points	• Overview of the key planning outputs for our system over Quarter 4, to refresh our medium term strategic plans and objectives and secure an agreed operational plan for next year. • Paper provides the national and local strategic context with a specific focus on our work around system sustainability. • As part of this the ICB has been working to update its Medium Term Financial Strategy, which set out proposed allocative approach. This sets the parameters for our wider planning whilst also enabling the delivery of our strategic objectives through aligning our allocative approach to our strategic priorities. • The ICB has been working with system partners to further understand the overall financial position taking account of all income, our existing underlying financial position and future forecast spend. This work has enabled us to assess the financial challenge we will need to address if we are to meet our strategic objective of addressing our deficit and securing financial sustainability for our system. The work includes the identification of the level of cost improvement we will need to secure to do so, including our approach to organisational cost improvement plans, productivity and efficiency and collaborative system savings.					
Potential conflicts of Interest	The MTFS allocative approach will flow through to the financial plans of SEL's five NHS providers, noting that the associated income has been reflected in our forward financial modelling.					
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**
Equalities Impact	EIA will be completed in response to specific planning decisions and cost improvement plan proposals. Our allocative strategy seeks to address identified inequalities in investment across our system and aligns to our agreed population priorities.					
Financial Impact	The paper sets out our planning assumptions with regards income, expenditure and cost improvement.					
Public Patient Engagement	Our integrated care strategy and Joint Forward Plan were subject to extensive engagement.					

Committee engagement	Informal Board meeting November 2024 SEL System Sustainability Group
Recommendation(s)	**The Board is asked to:** (1) Note the key planning outputs that the ICB will complete during Quarter 4 around medium term and operational planning and the progress made in developing these plans. (2) Endorse the overall strategic direction, ambition, commitment and intent set out in this paper and in our planning to date. (3) Provide any further feedback to be considered as we develop our work further, noting that regular updates and discussion will be provided for the Board over Quarter 4.

Planning for 2025/26 and beyond

NHS South East London Integrated Care Board (ICB) 29 January 2025

1. Purpose and Context

Planning requirements

1.1. Quarter 4 of 2025/26 will have a significant planning focus for the ICB and its partner organisations, with a number of associated planning outputs. These include:

1.2. A refresh of the ICB's **Joint Forward Plan (JFP)** - this is a medium term three to five year strategic plan, which sets out our ambition, objectives and priorities, with a focus on both SEL wide and borough based priorities from a population, care pathway and enabler perspective. We published our first JFP in 2023/24 and our 2025/26 refresh will build from and update that original plan and last year's refresh.

1.3. Our **Medium Term Financial Strategy (MTFS)** – aligned to the above, this is medium term three to five year strategic approach. It focusses on how we propose to allocate the funding made available to us to meet the health needs of our population and enable the delivery of the objectives set out in our JFP. The Board agreed our first MTFS in 2023 (for 23/24 -27/28) and our 2025/26 refresh is driven by our agreed strategic priorities, whilst also taking account of the financial challenges of the last couple of years, extending our forward look to 2029/30.

1.4. Our **Medium Term Financial Plan (MTFP)** - a system wide plan that builds in both the ICB's allocative approach as set out in its MTFS, plus an assessment of our overall provider positions, from both an income and expenditure perspective. It identifies the financial challenge that we will need to address if we are to meet our commitment to securing a financially sustainable system.

1.5. Our **2025/26 Operational Plan** – a system wide plan that sets out the key planned actions and deliverables for the forthcoming year, encompassing both our local plans and national planning guidance, inclusive of detailed plans for finance, activity, workforce and performance. Operational Plans will be developed for the ICB and its five constituent NHS provider organisations with an aggregated system plan bringing everything together.

1.6. This paper provides an overview of the progress we are making in taking forward this planning work, with a key focus on our MTFS and MTFP, recognising the significant financial challenge we are facing as a system and that the successful delivery of our wider strategic and operational priorities will be dependent upon us improving our financial position and addressing our underlying financial deficit.

Planning context

1.7. Our strategic planning is taking place whilst work is underway to develop a national 10 year NHS plan. This work will not be completed in time for 2025/26, but the Darzi report has given us a good indication of the likely areas of focus in response to the challenges and opportunities identified. The government has already highlighted the three shifts it is seeking to secure across the NHS: Sickness to prevention; Hospital to community care and the development of a neighbourhood health service; Analogue to digital. It will be important to assess our JFP refresh in terms of ambition across these three areas, noting that we would further expect to reflect the detail of the 10 year plan in our JFP refresh for 2026/27 onwards.

1.8. On operational planning we expect to receive national planning guidance in January 2025, and this will confirm the expectations with regards performance and delivery for 2025/26. Again, whilst at the time of writing we do not yet have the detail, we have a good indication of expected areas of focus for the forthcoming year.

1.9. Finally our commissioning responsibilities will increase over this same period with the ICB taking on delegated responsibility for a number of specialised services from April 2025, a shift which brings clear benefits and opportunities but also challenges, including increased complexity across both services and finance.

Our strategic challenge

1.10. We face many challenges as a system, including population health and inequalities, access, performance and quality and a recurrent underlying deficit. These challenges exist now but will worsen if we do not take clear action to address them over the next 3-5 years.

1.11. Equally NHS in SEL does not operate in isolation and we are aware of the pressures in local government and particularly social care. Over the last few years the wider determinants of health have also worsened for many south east London residents adding to the population health challenge. The financial challenge we are facing is heightened by the application of a convergence factors to our national allocation to bring SEL's allocation in to line with expected levels of funding.

1.12. Securing systematic improvement has been a challenge for us as a system and our plans will need to give confidence in our ability to shift the dial in terms of both delivery and outcomes. We will need to:

- Demonstrate clear, coherent, joined up plans to tackle these issues.
- Challenge ourselves around ambition, rigour and accountability in delivery.
- Optimise the benefits associated with our integrated care systems through harnessing the opportunities associated with collaboration and integration at all levels, across our services and care pathways.
- Identify enabling support and infrastructure requirements and ensure this is in place, alongside supporting and incentivising change.
- Pay due regard to cultural and behavioural barriers and work together to address these.

1.13. Whilst this paper focusses primarily on our financial position we must not lose sight of the wider challenges we are facing, recognising that failure to address population health, inequalities and operational delivery will drive higher cost now and in the future. Our strategic and operational plans must demonstrate an ability to address population health, operational delivery, performance and quality as well as our financial deficit.

2. ICB Strategic Objectives

2.1. On overall terms our system has two overarching strategic priorities:

- Improving population health and reducing inequalities.
- Securing a sustainable system across finance, performance and quality.

2.2. Improving population health is one of the core purposes of integrated care systems with a need to ensure that we are equally focussed on reducing inequalities in population access, experience and outcomes. Our challenge is one of significant health need and clear population inequalities and we need to embed a shift in approach which sees population health and inequalities as fundamental to everything we are doing, inclusive of a step change in focus from the treatment of ill health to prevention, early detection and intervention with approaches that are population specific, targeting inequalities and ensuring a responsive service offer for our residents. To support this we are working to move beyond generic commitments to be more intentional around the specific outcome improvements we will seek to secure, a challenge we will start to address in our current JFP refresh.

2.3. Our integrated care strategy identifies five key population priorities, which are characterised by significant opportunities to improve health outcomes and to reduce inequalities: prevention, children and young people, with a specific focus on early years and child and adolescent mental health, adult mental health and long term conditions.

2.4. There is a strong alignment across our SEL strategic priority and the Darzi report's identification of a shift from sickness to prevention as one of the three government priorities for the future.

2.5. Securing a sustainable system across finance, performance and quality is also vital, as a key enabler to helping us address our population health and inequalities challenges. Our financial deficit, performance and quality issues mean a disproportionate focus on short term actions that represent an overall opportunity cost to our system in terms of resourcing and bandwidth whilst also detracting from medium term strategic action and delivery. Our existing plans make some clear strategic commitments in terms of system sustainability, with the stated objective of eliminating our deficit and meeting national quality and performance standards including clear incremental improvement across these areas. However we have more work to do to establish credible medium term plans for doing so.

2.6. The Darzi report sets out two further strategic shifts as fundamental to supporting the NHS in addressing its challenges and opportunities, hospital to community care and the development of a neighbourhood health service and analogue to digital. Again there is strong alignment across these identified national priorities and our own identification of community based care and digital as two key enabling opportunities that will help us drive forward our ambitions around system sustainability but also population health and inequalities.

2.7. As part of our JFP we will need to review our plans with regards scope, pace, scale, enabling investment and infrastructure, including a consideration of:

- Whether we need more focus and investment than currently planned on prevention, secured through both reorienting our current services/investment and developing additional prevention and investment support for residents.
- Whether our plans give sufficient focus and resource to secure a demonstrable

shift from hospital to community and neighbourhood care, recognising the need to consider existing resources and the reorientation of these to support this shift as well as new resourcing and investment.

- How we might optimally use our overall capital, revenue and ring-fenced budgets such as digital to secure a step change in our analogue to digital transformation.

2.8. Our borough Local Care Partnerships (LCPs) will be key in developing integrated neighbourhood care, a key enabler to addressing prevention and inequalities plus an impactful shift to community neighbourhood based care. Securing these objectives will therefore be the overarching objective of our LCPs ensuring that in doing so we are able to secure a core offer for our SEL population, that we are driving all possible opportunities to transform and integrate services, including the use of digital, and that we are able to demonstrate value for money, productivity and a clear return on investment (ROI). That ROI being assessed through improvements in population health outcomes and reduce inequalities and a clear increase in our support to residents and patients in community settings.

2.9. Our providers will form part of our integrated neighbourhood teams but will also need do double down on managing expenditure and improving productivity and efficiency. Again how this is done will be important with the need to focus on pathway and service transformation including the use of digital, plus the harnessing of available resource on a system basis to support increased consistency and reduce variation in our service offer, measured through assessing equity of access, experience and outcome and through the delivery of agreed performance and quality standards across SEL, whilst also eliminating our financial deficits. The challenge of doing so is significant, recognising SEL continues to face significant access, waiting times and flow challenges across urgent and emergency, cancer and elective care.

3. An Enabling Medium Term Financial Strategy

3.1. The **ICB's Medium Term Financial Strategy (MTFS)** focuses on how we propose to allocate the funding made available to us to meet the health needs of our SEL population as a key enabler to our wider strategic plans.

3.2. We have refreshed and built upon our 2023 MTFS, with our allocative approach aligned to and driven by our population priorities, alongside a recognised need to address identified inequalities in investment. We have also sought to recognise the financial reality, including the deterioration in our financial position and the need to ensure we are able to support key underpinning strategic and infrastructure shifts and pump prime system savings over the next few years. All this is within the context of our commitment to eliminate our financial deficit, with the retained objective of securing financial balance at a system level by 2027/28, as per our 23/24 MTFS.

3.3. This results in a reaffirmation of our allocative approach with the relative prioritisation of prevention and inequalities, children and young people, mental health and community-based care, aligned to our integrated care strategy and JFP priorities. Specifically we have:

- Assumed average or higher than average levels of funding for community based care and mental health services.
- Committed to ensuring ring fenced funding that is disproportionate to population share for our children and young people.

- Identified a separate funding stream to support targeted investment in support of our two overarching system priorities – population health and inequalities and system sustainability. Our MTFS sets aside a proposed budget of £30m per annum in each of the five years, building to a cumulative investment of £150m by year 5. We anticipate the level of population health and inequalities funding within this amount will increase proportionately and the pump priming investment required to support system sustainability either dropping out or reducing over the period, recognising more work is required to determine annual splits focusing on the short term initially as well as confirming the overall quantum of investment required or feasible.
- As a result growth for acute services will be below our average uplift, although the acute sector will still receive growth

3.4. Applying these allocative approaches results in important funding uplifts for community based care and mental health, the former recognising the strategic imperative around developing community and neighbourhood based care and the latter recognising the need to address the historic under investment in mental health services that exists.

3.5. The allocation of funding to support population health and inequalities is equally important, as it will secure a degree of pump priming targeted investment, alongside approaches that focus on the reorientation of existing spend to target population health and inequalities to maximise available opportunities. For all areas of investment there is a recognised need and commitment to focus on securing an associated return on investment and outcome improvement.

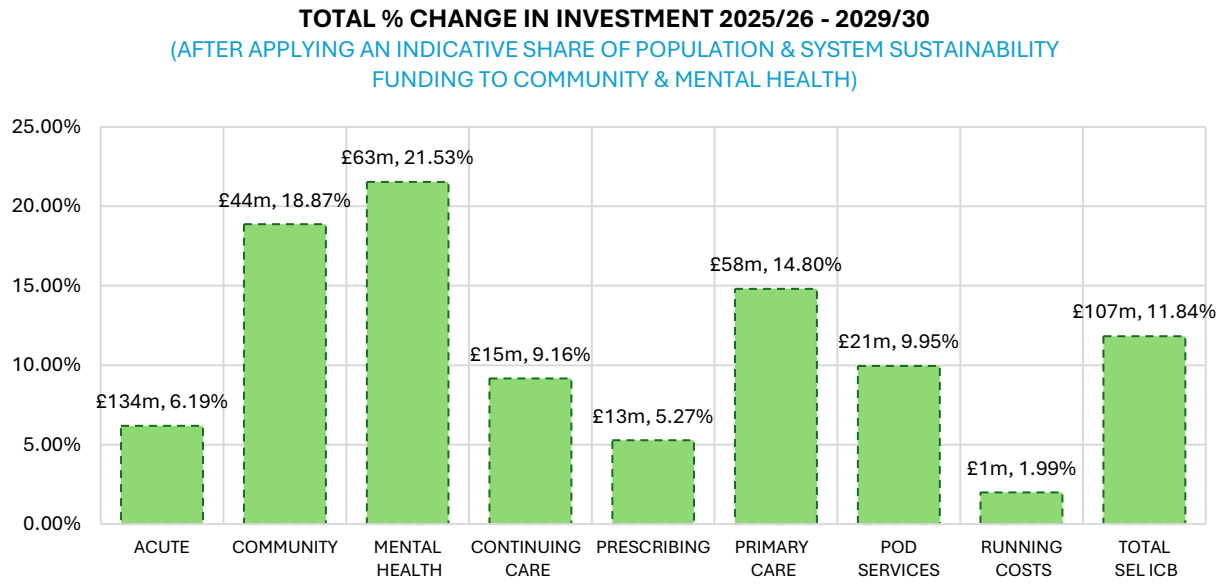
3.6. In overall terms:

- Funding for community services will increase by 9.2%, from £483m to £528m over this period.
- Funding for mental health will increase by 11.3%, from £536m to £600m over this period.

3.7. However, if we assume that a minimum of 66% of the population health and inequalities and system sustainability funding is allocated to community based care and mental health, a split that would align the use of this funding with our strategic ambition, the figures change as follows:

- Funding for community services will increase by 18.9%, from £483m to £575m over this period.
- Funding for mental health will increase by 21.5%, from £536m to £652m over this period.
- The relative share of the ICB's investment across these services will increase from 23.6% to 25.4%, and the acute share will reduce from 50.3% 47.7%. Whilst this is a modest overall % shift, the uplift in funding for community based care and mental health services will support significant strategic investment, noting this is achieved with a relatively small % reduction in the overall acute share of ICB spend.

3.8. Changes in funding over the period are also shown in the chart below:



3.9. The MTFS also recognises the importance of continuing our work to understand national allocations and wider allocative policy and to make the case for review and change where we can demonstrate unintended consequences, adverse impacts or inaccuracies. This will be important in areas such as specialised services where it is planned to shift national allocation approaches from historic levels to population based allocations.

4. Securing financial sustainability – the Medium Term Financial Plan

4.1. A key commitment the ICB has made in its Joint Forward Plan and its Medium Term Financial Strategy (MTFS) is to secure a financially sustainable position, with our 2023 MTFS having assumed a return to a break even financial position at a system level from 2027/28 onwards.

4.2. The modelling assumptions we have used in our Medium Term Financial Plan (MTFP) assumes the retention of that break even commitment for 2027/28 and demonstrates what will be required to secure this.

4.3. The MTFP brings together the ICB allocation and investment assumptions set out in section 3, plus makes further assumptions around expected income into SEL's providers from other commissioners. It further builds in a set of provider expenditure assumptions and assesses the difference between income and do nothing expenditure (spend prior to the application of any cost improvement/efficiency measures).

4.4. The 'do nothing' forecast shows a very significant potential financial gap over the next five years, with a 2024/25 underlying system deficit of £359m (4.4%), rising to £552m (6.7%) in 2025/26 and with further rises incrementally each year, to £1,306m (15.9%) by 2029/30, noting provider expenditure assumptions need further testing and validation.

4.5. Whilst actual income might differ to the assumptions, we have made in our MTFS and MTFP, the impact of any changes is likely to be marginal. Our key focus as a system therefore needs to be on driving forward plans, though a combination of business as

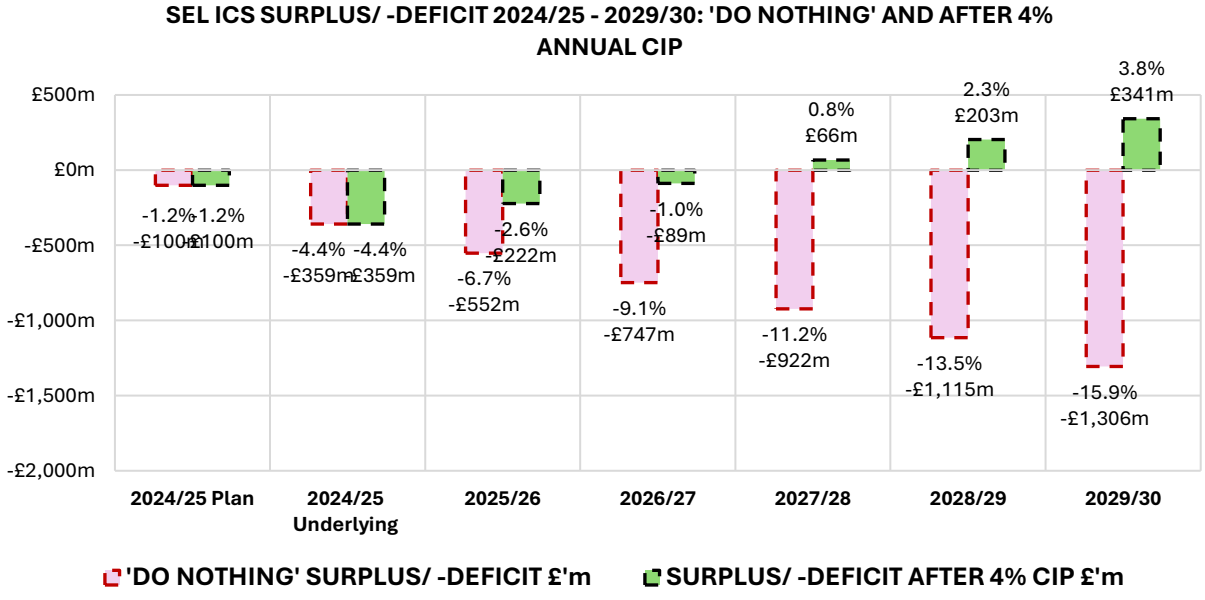
usual organisational cost improvements, productivity and efficiency/care pathway redesign programmes and cross cutting collaborative system savings, to reduce our cost base and contain expenditure growth. Without this we will be unable to address our underlying financial deficit and ensure a financially sustainable system.

4.6. To add to the challenge, we need to do this at the same time as improving population health, reducing inequalities, improving access, experience and outcomes for our population and securing high performing quality services.

4.7. The MTFP models an annual 4% annual cash releasing cost improvement assumption, noting if we were able to secure this as a system we would:

- Return to a break even financial position for 2027/28, aligned to our original MTFS break even commitment, with a three year timeline to recover our current underlying deficit. Whilst challenging, a 4% cash releasing efficiency is aligned to our understanding of national expectations, which are anticipated to be in the region of a 4-5% productivity improvement per annum. The 4% assumption in our MTFP is therefore likely to reflect the minimum national expectation, particularly for a deficit system.
- The generation of a small surplus in years 4 and 5 of the MTFP subject to retaining the delivery of a 4% cost efficiency in these years. We would need slightly less than that, at 3.1%, to secure a break-even position over this same period. It is however considered important that we plan for the generation of a surplus rather than the do minimum position, thereby providing vital headroom for the system, the only certainty being new issues that we will need to manage will emerge over the next five years.

4.8. The ‘do nothing’ deficit position is set out below, alongside the modelled position after assuming delivery of 4% recurrent cost improvement plans each year:



4.9. As above the MTFP modelling brings us to a break-even position in 2027/28 but leaves us with a financial gap in 2025/26 and 2026/27. The extent to which our planning assumptions represent a realistic but ambitious glide path and one that demonstrates we are doing everything possible to optimise our underlying position will be tested as we undertake our planning for 2025/26. We will need to give confidence around the

robustness of our plans and will need to include a consideration of the scope and impact of securing a higher than 4% cost improvement saving over the next two years to demonstrate what it would take to break even in each year. Securing a break even position would require an increase to 6.7% cost improvement in 2025/26, and if this were delivered recurrently in 2025/26 a further cost improvement of 2.4% in 2026/27.

4.10. Our financial planning will therefore need to secure:

- Absolute rigour around ambitious out cost improvement plans (CIPs), focussed on recurrent savings plus a clear pipeline process and timetable for the identification and delivery.
- A set of ambitious and challenging targets and commitments to demonstrate a significant step change in productivity and efficiency, underpinned by the optimisation of care pathway transformation opportunities.
- The identification and fast track implementation of the cross cutting collaborative system sustainability initiatives that are being developed in response to identified opportunities.
- A clear and agreed return on investment that is tracked through, including ensuring we are rigorous in tracking through the return on investment for existing transformation programmes.
- A consideration of other options, including non-recurrent solutions and an assessment of what we would deprioritise, stop doing or investing in as a system if required, with any such consideration a last resort to be employed only after we have satisfied ourselves and our regulators that we have done everything possible to maximise available cost and productivity improvement opportunities.

4.11. Whilst challenging the opportunity costs of not meeting the above efficiency requirements, considered to represent the minimum required, is significant and will result in an inability to secure targeted investment in population health, inequalities, performance and quality improvement, with poorer associated outcomes recognising that these factors are crucial to medium term financial sustainability as well as being end in themselves.

5. Our System Sustainability Plan

5.1. Our MTFP sets out the scale of cash releasing cost improvement required to meet our financial commitments and the expectations of us. Given this imperative we have already started work on the detail of our financial plans, focusing initially on the short term, to meet these commitments.

5.2. In delivering the required cost improvement, organisations will be working to contain and reduce cost, across the corporate, operational and service cost base, with further savings secured through our system sustainability initiatives. These system sustainability initiatives will contribute to organisational cost improvement targets. Cross cutting all initiatives will be a requirement that productivity, efficiency and service transformation opportunities are optimised.

5.3. Given the scale of the challenge we will need to drive the maximum possible benefits from each of these strands of cost improvement work, noting our cost improvement plans (CIPs) need to be cash releasing to support our deficit reduction. Delivery of the required cost improvement will therefore require the following:

- Organisational cost improvement plans

5.4. Each organisation is currently working to identify its cost improvement plan initiatives for 2025/26, to include full year effect and carry forward benefits from 2024/25 CIPs and the identification of new CIPs for implementation next year. These organisational CIP initiatives will form the backbone of our cost reduction programme.

- Productivity and efficiency improvement

5.5. We recognise the productivity and efficiency gap that has opened up post the Covid pandemic and the need to both close the gap and further improve our productivity and efficiency to secure best value for money and the optimal utilisation of our resources. Whilst individual organisational CIPs will include productivity and efficiency improvements, we will seek to agree a set of consistent targets and commitments in this area. This will ensure the system is able to harness enabling support to maximise available opportunities consistently delivered, noting we are keen to ensure this approach covers acute, mental health and community based care services.

5.6. We know that productivity and efficiency will be a significant focus nationally, with a minimum 4-5% improvement expectation, with the planned release of supporting data to enable ICBs to plan effectively for improvement in 2025/26 and beyond.

- System sustainability initiatives

5.7. Recognising the need to enhance our approach through moving beyond organisational opportunities to unlock the scope for collaborative, system savings, the ICB established a system sustainability group which includes our system CEOs, CFO and other leads, to oversee the development of concrete proposals to support this requirement. We have also established a system sustainability team to provide underpinning leadership, capacity and expertise to drive the work forward.

5.8. Detailed work has been undertaken over the last few months on opportunities identification, modelling and engagement to develop a set of potential schemes for testing and consideration. The aim is that 2025/26 will represent the start of a rolling programme of system sustainability schemes over the next 3-5 years. Delivery will support our overall financial position and provide a key contribution to our overall savings target, additional but complimentary to organisational CIPs.

5.9. As of January 2025 we have moved from the identification of a wide range of potential opportunities to a short list of proposed schemes for 2025/26 implementation, along with a clear pipeline line for on-going scheme identification and implementation. The prioritisation work has taken a systematic approach, differentiating between high, medium and low impact actions in terms of savings, plus an assessment of the relative and overall feasibility and complexity of identified opportunities. We have further sought to differentiate those schemes that need enabling and infrastructure support and those which could be taken forward through existing processes and governance.

5.10. The proposed priorities are set out in Annex B to this paper. They are now being developed into more detailed implementation plans, focussed on 2025/26 in the first instance.

6. Planning for 2025/26 in this context

6.1. Our medium term plans, both the Joint Forward Plan and our Financial Plans, set out our medium term objectives and provide the overarching framework for our shorter term 2025/26 operational planning. This will include being clear about the actions and

outcomes we will take forward next year as a contribution to these medium term objectives. The operational planning process will also include a significant focus on our plans to meet national planning guidance for 2025/26 and the priorities and outcomes set within that guidance.

6.2. At the time of writing we have yet to receive national planning guidance but do have a broad indication of likely expectations, which are summarised below.

6.3. **Finance** - The need for the NHS to secure a break even financial position, including at a system level e.g. for us at a SEL ICB aggregate level. The emphasis will be on managing operational delivery and expenditure within the money that is available to the NHS with the level of available growth funding expected to be low, after taking account of inflation and pay awards.

- We anticipate there being a degree of greater flexibility around the ring fencing of budgets to enable systems to ensure best value and to reallocate resources as required to optimise impact and the overall financial position.
- We further expect a clear ambition and requirement around cost and productivity improvement of 4-5% across all services, inclusive of work to close activity and workforce productivity gaps. On workforce we will need to demonstrate rigour in addressing the increased and unaffordable headcount increases that have occurred since the pandemic.
- Where additional funding is made available, we expect it to be targeted at specific priority areas with associated deliverables, for example on mental health and elective wating times.

6.4. **Operational performance** - In terms of operational delivery we expect national planning guidance to set out a number of clear deliverables, with a core focus on improving access and waiting times for elective care (Referral to Treatment Times), plus incremental improvement with regards other waits such as cancer alongside a focus on urgent and emergency care quality, safety and performance. The current pressures we are experiencing in terms of urgent and emergency care waits and flow, elective, cancer and diagnostic waits and access across other services represent a challenging start point for the planning round.

- Our delivery solutions will be a combination of pathway, demand and capacity management, productivity and efficiency improvement but also service transformation including optimising opportunities associated with prevention, integrated neighbourhood/community based care and digital.
- We are likely to be asked to demonstrate that we are reducing variation and spreading best practice to optimise outcomes.

6.5. The intention nationally is to have a shorter, very focussed planning process to enable system plans to be finalised for March 2025, which will require a significant amount of work over the next two months.

6.6. We know that 2025/26 will be an incredibly challenging year as it is the year where we have to manage a significant underlying carry forward deficit alongside further forecast expenditure growth over 2025/26. We are also facing a number of operational delivery, access and performance challenges. It is recognised nationally and locally that there will be trade-offs as we work through the funding available against the operational delivery, quality and performance targets we are being asked to meet and the imperatives around population health and inequalities.

- We will need to be able to both demonstrate a robust improvement plan that

shows we are doing everything possible to maximise outcomes within the resources available, whilst also being prepared to make difficult decisions around relative priorities and investment if we cannot get to an acceptable position with regards our financial plan.

- This is in the context of a start national expectation around break even plans and an ICB MTFS that commits to financial recovery over a longer, three year period.

6.7. The key risk is that we are unable to secure an agreement locally and nationally around our financial recovery glidepath through giving sufficient confidence around our medium term ambition, commitment and planning, requiring action to reduce spend beyond our current modelling for the short term, with associated impacts on local services and opportunity costs for the SEL population. The requirement for the timely development of robust deliverable plans to support recurrent cost reductions that are demonstrably secured is therefore stark, with a need to do things differently and at a rapid pace and scale.

7. Next Steps

7.1. In summary the key next steps are as follows:

- To continue to iterate and develop our Joint Forward Plan refresh, with an emphasis on our commitments and objectives around population health and inequalities and system sustainability in each area. We will undertake a more fundamental refresh for 2026/27 in the context of the 10 year national plan and out ambition locally to be more intentional around outcomes and their delivery.
- To continue to iterate and develop our Medium Term Financial Strategy and Plan, including a review of our planning assumptions in the context of national planning guidance for 2025/26, the validation of our forecast outturn and expenditure and the rapid development of robust CIP, productivity and efficiency and system sustainability plans for 2025/26.
- To work through the national operational planning guidance for 2025/26 to enable a rapid assessment to be made of the system position and specifically the balance across financial and productivity delivery, performance and quality improvement, investment and return on investment around our strategic priorities and options for deprioritising or reducing spend if needed to optimise our financial position. This will need to consider both how we will secure our MTFS commitments but also demonstrate what it will take to get to a balanced financial position in each year.

8. Recommendation

8.1. The Board is asked to

- Note the key planning outputs that the ICB will complete during Quarter 4 around medium term and operational planning and the progress made in developing these plans.
- Endorse the overall strategic direction, ambition, commitment and intent set out in this paper and in our planning to date.

- Provide any further feedback to be considered as we develop our work further, noting that regular updates and discussion will be provided for the Board over Quarter 4.

South East London Integrated Care System

Appendix

29th January 2025

System Review Workshop to progress System Sustainability Proposals

A full day workshop was held on 4 December 2024. This was a multidisciplinary meeting with attendees from across the system, coming together to review the proposals put forward by the System Sustainability Programme and agree some next steps and priorities from each area. The aim was to test the feasibility of ideas, integrate perspectives and explore potential priorities. There was representation from all trusts, alongside ICB, place and primary care members of the System Sustainability team. Nearly half of the invitees were clinicians, and there were additional subject matter experts presenting on key opportunities.

Consider opportunities

Provide a multi-disciplinary, pan-system view on the opportunities of the projects. Consider how they can be delivered to ensure the benefits (financial and others) are maximised

Challenge ambition and timescale

Test whether current plans are sufficiently ambitious or whether they could be enhanced or pushed further. Test whether the suggested timeframes are realistic

Propose highest priority to focus on

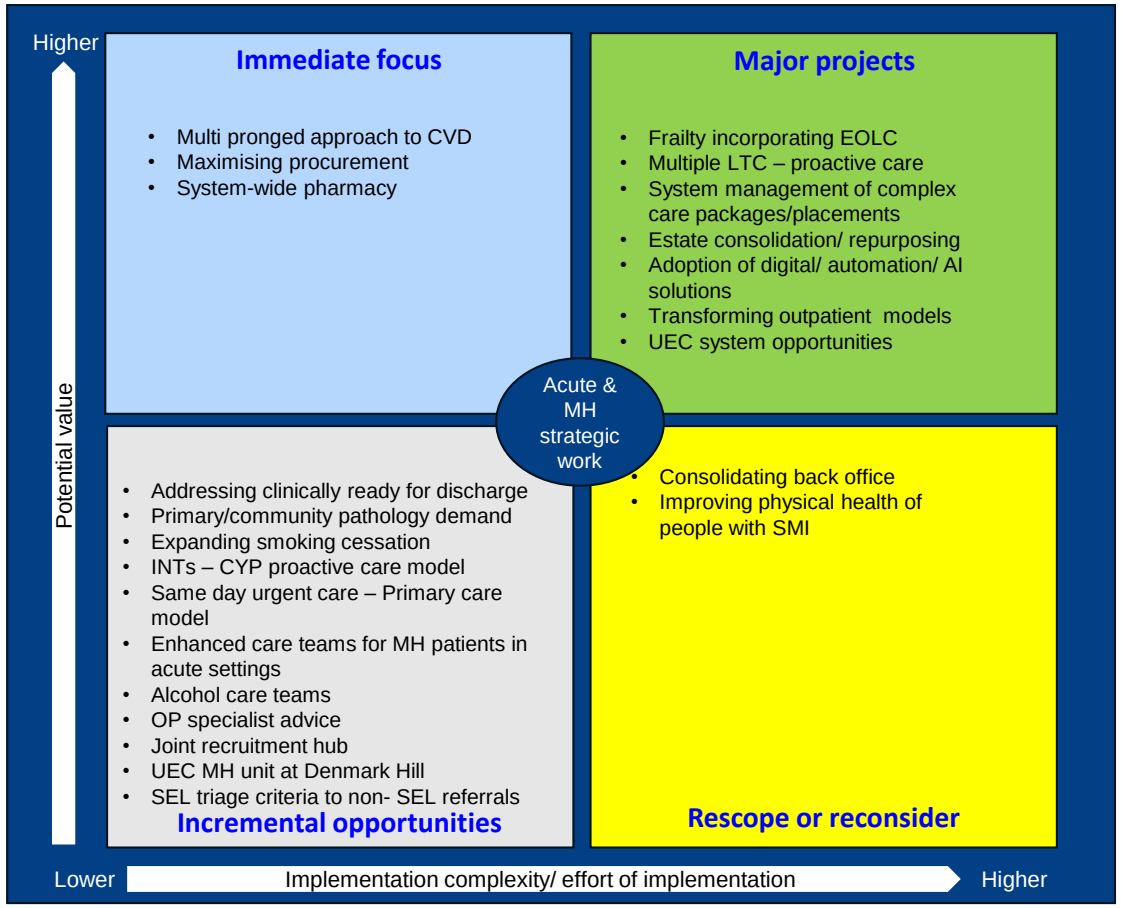
There is a view that the system is only able to focus on a small number of high priority areas – explore whether it is possible to propose a priority list for SSG to consider

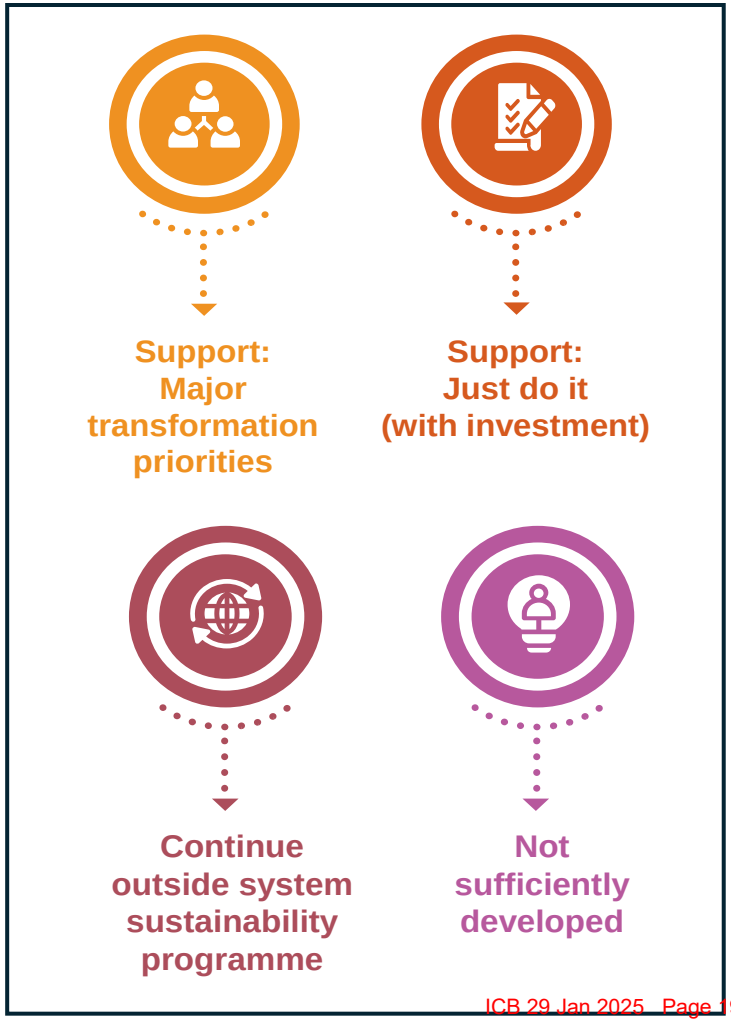
Attendees were encouraged to consider the following **four questions** in relation to each opportunity:

1. Do you agree that the opportunity would make a significant contribution to the system sustainability challenge?
2. Where would you prioritise the idea?
3. What are the key lessons from existing work in this area?
4. Could we be more ambitious?

Refocussing programme on a smaller group of priorities

The initial system sustainability ideas had been divided into the left-hand model below, based on extent of financial value and complexity of implementation. At the workshop, after discussion, all areas were plotted into one of the four areas on the right-hand side. This brings together the opportunities into prioritised groups and clear actions for each can be established.





Summarised workshop outputs

South East London Integrated Care System

Category of scheme	Major transformation	Just do it/ Proceed at pace	Not sufficiently developed	Continue outside the system programme
	Supported to continue due to potential size but complexity recognised. Likely to involve many stakeholders/organisations and deliver major system transformation. Requires more complex up-front planning than 'just do it' schemes	Supported to continue at pace. Recognition of the financial opportunity and wider benefit to system. Less complex to implement than 'major transformation' projects. Will require focus and effort, resourcing and potential pump-priming investment to proceed with scheme asap, with governance/oversight.	Likely to be a key component of the sustainability programme but currently insufficient detail to make a decision or agree next steps. Further work required to develop proposal for further discussion, with clear timeframes, and clarity on focus/effort, resourcing to get impact delivered.	Agreement that this is an important programme of work which needs to be done but does not need to sit within the System Sustainability programme. The work can sit within an alternative governance and oversight arrangement and does not need SSG support to implement
Schemes	• UEC system opportunities, incorporating discharge • INTs - Frailty, EOLC and Multiple LTCs • Same day urgent care – Primary care model • Adoption of digital/ automation/ AI solutions • Outpatient Transformation (initial focus on OP specialist advice) • Estate consolidation/ repurposing	• Multi-pronged approach to CVD • Maximising procurement • System-wide pharmacy • MH collaboration • Primary/community pathology demand • Expanding smoking cessation • INTs – CYP proactive care model • Enhanced care teams for MH patients in acute settings • Alcohol care teams	• Acute strategic plan • System management of complex care packages • Consolidating back office • Joint recruitment hub	• UEC MH unit at Maudsley Denmark Hill site • SEL triage criteria to non-SEL referrals • Improving physical health of people with SMI
Next step	✓ Refine proposals with system partners – develop granular view of timescales, savings, investment and ROI. Develop full proposal documentation and determine governance and delivery oversight to get us from A to B. ✓ ''Major Transformation' schemes will require collaborative process to work up in more detail		✓ Further work-up to be undertaken on each scheme and brought back to SSG/sub-group from SSG for discussion and decision	✓ Agree with system partners that work continues but will not be reported or monitored through the System Sustainability programme

Acute and Mental Health strategic plans – identified priority areas

South East London Integrated Care System

- The Acute Trusts and Mental Health Trusts have undertaken aligned but separate processes to identify areas where enhancing collaboration in specific service areas has the potential to contribute to the system sustainability agenda
- The table below lists the areas initially prioritised; the Trusts are considering feedback received at the System Review Workshop as they continue this strategic work and develop tangible proposals for change.

Acute areas for strategic focus	Mental health areas for strategic focus
Gynaecology	Adults and Older Adults crisis services
Orthopaedics	Psychosis pathway and shared care arrangements
Imaging / diagnostics	CYP pathways (digital assessment and therapeutics and crisis pathways)
Breast	
Stroke and neuro-rehab	

Link to the Planning Round

- The outputs from the 4th Dec workshop mean that there is a clear understanding of the proposals to be delivered and further priorities to be actively progressed within the System Sustainability programme during 25/26
- There is an opportunity to progress some proposals rapidly, and for financial benefits of these proposals to support delivery of Trust savings targets for 25/26
- The programme's aim is to ensure fully worked up plans are in place for the "Just Do It" proposals by end of March 2025. Where required to support implementation, these schemes will be taken forwards through the planning round to ensure clear commitment to delivery, resource required is in place, and there is a clear plan and agreement for how savings will be delivered as well as mechanisms for tracking other non-financial benefits
- There may also be opportunities to drive forward some key principles and early stage work related to the "major transformation" programmes within the 25/26 planning round. This will ensure we are maximising the benefits we can deliver next financial year alongside delivering the ground work that will be needed to secure financial benefits from these large scale programmes over the coming years.

South East London Integrated Care System

NHS South East London

Board meeting in Public

Title	**Developing our Neighbourhood Health Service**					
Meeting date	29 January 2025	Agenda item Number	**9**	Paper Enclosure Ref	**J**	
Author(s)	Kate Fisher Jenny Sanderson					
Executive lead	Dr George Verghese Primary Care Partner Member Ceri Jacob Place Executive Lead Lewisham					
Paper is for:	Update	**x**	Discussion	**x**	Decision	
Purpose of paper	To update the Board on progress that has been made in the development of a SEL framework for neighbourhood working and INTs. To provide an opportunity to discuss and explore the implications and opportunities for SEL and the population it serves.					
Summary of main points	All Places in SEL have been working for a number of years to increase levels of collaboration and integrated working between health, social care and the VCSE through community-based care. In May 2022, the Fuller Report was published and outlined the need to develop pro-active care at a neighbourhood level. More recently, the Secretary of State has identified the need to develop integrated and collaborative neighbourhood-based services. 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 and to respond to the direction expected to be set out in the national 10 Year Plan. The NBCB reports to the 6 Local Care Partnership Boards and is co-chaired by a PEL and the ICB Board Primary Care Partner Member. 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. This has been developed from the bottom up, based on significant work and engagement already undertaken in each Place. The Framework provides a consistent narrative on the approach being taken across SEL and a clear articulation of the common end point all Places are working towards, noting that starting points are different for each Place. The SEL Framework takes an asset-based approach, building on our existing strengths. A “test and learn” approach to support the need to experiment and adapt as we implement a fundamentally different way of working will allow local systems to address any gaps and evaluate the impact. It will also provide the flexibility that will be essential to address local inequalities and deliver services that are genuinely holistic and preventative. The framework begins to set out what is needed from key enabler functions, including workforce and population health management (PHM) to support implementation. Work is underway with enabler function leads and partners to ensure there is a pivot towards neighbourhood ways of working across the whole ICS to ensure the significant cultural and organisational shift is achieved. The NBCB will provide regular progress and impact updates to the ICB Board.						

Potential conflicts of Interest	None advised					
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. A full EIA will be carried out during Q4 of 2024/25.					
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 is in development.					
Committee engagement	• Neighbourhood Based Care Board • Various Place for fora Integrated Performance Committee					
Recommendation(s)	The Board is asked to note and comment on the paper and support the direction of travel on the SEL neighbourhood and INT framework development.					

South East London Integrated Care System

Developing our shared approach to Neighbourhood development

Board Papers

January 2025

This document

This document outlines how neighbourhood working, and integrated neighbourhood teams within that, will be realised in South East London. This documents responds to and will sit alongside emergent national and regional guidance and related London-wide work on Healthier Communities, ensuring neighbourhood working in SEL both reflects and models wider policy aspirations to:

- **Establish a clear and shared vision for the Neighbourhood Health Service,** so we can communicate what it means for professionals, patients and service users, and communities across SEL.
- **Balance a need for consistency**, building from where we are, and being flexible to local needs
- **Be clear on what good looks like** and the role of national bodies, systems, providers, places and neighbourhoods in delivering this
- **Set out the roadmap** in the short, medium and longer term

This document sets out key definitions, and a delivery framework and roadmap aligned to and building on implementation work already underway across our six Places and their local partnerships; scaling and spreading key existing initiatives such as the 3+ Long Term Conditions (LTCs) focussed work ongoing in at least one Primary Care Network (PCN) per borough.

Places will be responsible for realising this framework at a local level and working through local challenges and delivery nuances – SEL must support and facilitate Places in this endeavour, and in ensuring we are all moving toward the same end point.

Contents	Pages

This work has been produced in partnership with PPL, a social enterprise based in Southwark, which is working to improve health and care outcomes across the UK.

Context

- **In response to the national drive to deliver a Neighbourhood Health Service, South East London (SEL) previously committed to working in a more integrated way at the neighbourhood level,** and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities.
- **Without this shift in focus, any improvements in delivery of individual services across health, local government and wider partners will continue to be overwhelmed** by growth in activity and demand and will become unaffordable too.
- **Neighbourhood working is a continuation of local, regional and national initiatives** across successive governments that have aimed to bring Primary and Community Care closer together, including the development of integrated care and a more place-based approach to how services are organised, to address the drivers for change:

Social

- Many services are working in isolation, and there is a need for more joined-up, proactive care, which is flexible and able to respond to local needs.
- A consistent approach, clear understanding of what self care and proactive support is available and a strong message that service delivery in partnership with communities is required.
- Recognition that statutory services alone cannot provide all the support people need, particularly with regards to addressing inequalities and reaching underserved communities.

Political

- Government priority to transform the NHS into a 'Neighbourhood Health Service' and shift from hospital to community and sickness to prevention.
- Access issues in primary, community and mental health care, and delays in Emergency Departments and diagnostics.
- Increasing wider social determinants and underinvestment in public health has led to the deterioration of the overall health of the nation.

Economic

- There are significant costs associated with the failure to prevent ill health, to detect and intervene and to mitigate complications.
- Strong and shared economic case especially for the working age adult population – to prevent people becoming economically inactive and to support people back to work.
- Long term sickness is contributory factor to economic inactivity.

Technological

- One of the shifts planned for health and care services nationally – analogue to digital.
- Investment is required to build and maintain effective infrastructure outside of hospitals.
- Finding effective and practical solutions to co-ordinate and share data for planning, delivery and evaluation purposes.
- Utilising technology at scale to improve efficiency and effectiveness.

Neighbourhood working and INTs in SEL

The overarching aim of this work is to develop a shared approach to INT development across SEL, which will bring together services with communities through a population health management approach, at a scale which enables the delivery of genuinely preventative, holistic, locally tailored services.

Neighbourhood working will require a fundamentally different way of working and large cultural shift across the public sector, voluntary and community sector (VCSE), and our local populations; involving new means of collaboration, coordination, and, at times, integration. This reflects a significant transformation of how our system will operate together.

A key (but not the only) element of delivering neighbourhood working will be the establishment of INTs. This document is focussed on this element and presents an overarching framework for INT delivery which Places will be required to develop locally, tailoring to their local population needs and services. This framework will be subject to further socialisation and input before a final document is delivered early this year.

Moving forward, key enablers within the SEL system such as resourcing, workforce, and data analytics, will need to be configured to support the delivery of INTs and neighbourhood working.

What we mean by neighbourhood working

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.

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than INTs and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual or group. Collaboration tends to occur at key points, such as meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Representatives from different disciplines (e.g., health, social care, voluntary sector) working as a single team to deliver coordinated and person-centered care to individuals within a defined neighbourhood or locality. They will manage and deliver integrated clinical and operational services, provide continuity of care and work together to shared outcomes. There is an emphasis on continuous collaboration around prevention and pro-active care to improve outcomes, reduce duplication and address complex needs more efficiently. They will reach in and out of the other tiers for specialist input and care planning.

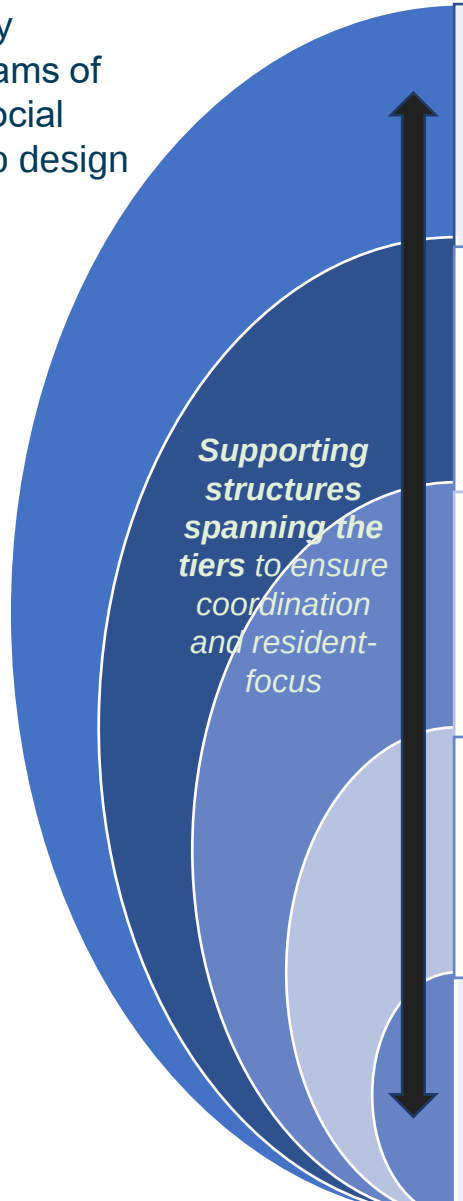
(see p.5 for further detail)

What a SEL INT looks like

Note: The detail required to operationalise each function and how they relate to each other will need to be established at a Place-level.

INTs provide the structure for multidisciplinary collaboration through the development of “teams of teams”: integrating services across health, social care, public services, and the VCSE sector to design and deliver holistic, person-centred care.

- **Our model enables local variation tailored to local needs while maintaining a consistent foundation across all neighbourhoods in SEL.** Investment levels will vary depending on each neighbourhood’s starting position and specific needs.
- **Our INTs will be organised using a tiered system**, acknowledging that different functions and services are delivered to residents across a range of different scales.
- **Our INTs will leverage population health data** to proactively identify individuals and populations who would benefit from support earlier and prioritising populations experiencing greatest levels of health inequalities.



Aligned Functions	• The INTs will be augmented by additional specialist input, generalist roles (e.g., geriatricians) and resources tailored to local needs. • While they may not sit directly in the INTs (e.g., because it doesn’t make sense to dedicate their time to a specific INT all the time), clear communication lines and clarity on how they input will need to be established. • They will reach in and out of the other tiers to provide specialist input and care planning.
Tailored Functions	• This will vary between each INT depending on what is available and what helps the INT to meet the needs of the population that it is serving and achieve its specific aims and benefits (e.g., specialists). • They will have consistent presence, dedicated resource and a role specific to the neighbourhood (e.g., integration hubs or specific VCFSE providers).
Consistent Functions	• There will be consistent membership from INT to INT, bringing together primary care, social care, community and mental health services, acute clinicians/specialties, key VCFSE organisations and population health dedicated / allocated to each INT (e.g., district nurses) • They will manage and deliver integrated clinical and operational services, and provide continuity of care and work together to shared outcomes • They will reach in and out of the other tiers for specialist input and care planning.
Hyper-Local Functions	• Services (e.g., community pharmacy, general practices, VCFSEs) that often serve as the first point of contact for residents need to be reached into by / strongly linked with INTs. • They hold deep community knowledge and connection, and play a proactive role in population health management, identifying needs early and escalating complex cases. • Clear shared care protocols will enable seamless coordination with INTs.
Resident	• The resident is at the centre of all neighbourhood working. • INTs need to be strengths-based building on local knowledge, community assets and local needs.

How to enable integration

Why is this important? We recognise that Place will be the key enabling layer for developing neighbourhood working and INTs which will sit at their core. Each Place will be responsible for identifying an "integrator" to host integration "functions" required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level. Acting as a bridge, these integrators will help INTs function cohesively while maintaining flexibility to respond to local needs and adapt as neighbourhoods transition from development to delivery.

This role cannot operate in isolation or replace individual responsibility and accountability from partnering local organisations.

Thoughts on Key Integrator Functions Consistent Across Places

- **Support operational coordination** between sectors and partners across the borough and between INTs, bridging the gap across the current reality of fragmented pathways and services by addressing the practicalities of collaboration (e.g., building interfaces and relationships, supporting workforce planning, and business intelligence).
- **Facilitate population health management** (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes.
- **Address interface issues and share learning** through coordinating discussions at Place level (e.g., sharing resources and managing care transitions) and escalating issues affecting multiple neighbourhoods to ensure system-wide alignment.
- **Drive equity in access and outcomes** using PHM data and working closely with partners (including VCSFEs) to identify and address disparities in access and care delivery, supporting INTs to meet local needs and reduce inequalities.
- **Provide essential infrastructure** supporting people, finance, governance and risk management for INTs in a way which is consistent and cost-effective so that neighbourhood delivery becomes business-as-usual, harnessing existing local assets and resources.

What we want our INTs to do

Our initial focus for INTs is to provide proactive care for higher and rising risk populations, and to work with communities on preventing ill health. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSE and social care, to meet the holistic needs of their local populations. These INTs will be able to easily draw upon specialist input as needed across all levels (from hyper-local to regional).

This is not about minor tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level in INTs will require a fundamental shift in how we work together as a system, with residents and within communities.

In SEL, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g. addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs,** through a combination of integrated working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities,** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders,** holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all SEL residents receive the same standards of care**, wherever they live and whatever their individual needs.

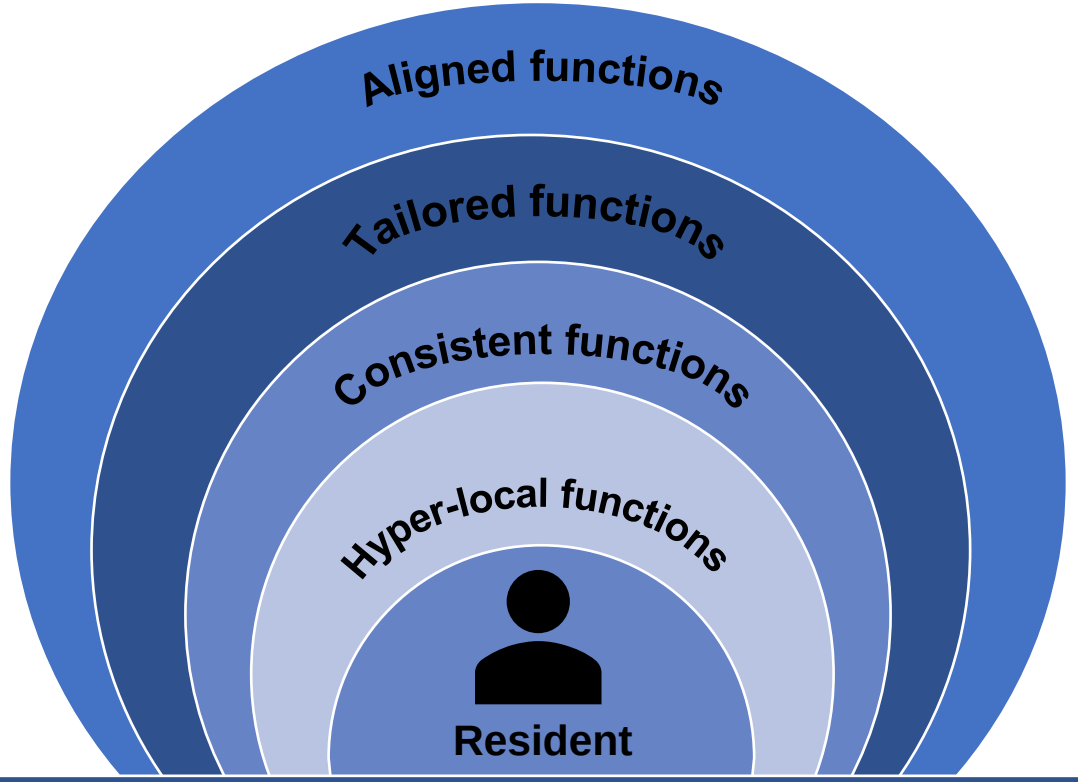
South East London Integrated Care System

NHS South East London

INT delivery framework

Components of our SEL INT Framework

Our SEL INT Framework outlines a shared approach to INT development across Places, and a way in which SEL can increase the proportion of resources used to support people to stay well for longer, and release capacity which is reinvested to scale the model sustainably.



SEL INTs will be underpinned by a number of key ingredients, including a population health management approach and the recognition that we will have to 'test and learn' our approach as INTs develop to ensure they meet population health needs effectively.

Underpinned by key ingredients:

- Organisational development to enable culture shift for system-wide way of working
- Population health management approach
- Shared, clear metrics
- Test and learn approach
- Robust leadership and shared governance
- Interprofessional training infrastructure
- Overarching quality management system
- Alignment with partner and system priorities
- Interoperable digital tools and knowledge
- Contractual mechanisms and human resources (HR) infrastructure to allow joint working
- Geography principles to ensure organised around population needs

What this framework is (and what it is not)

The framework set out is…

- **An overarching structure for INTs across SEL**, providing 'enough' structure to ensure we deliver consistently and in alignment, without being prescriptive, and recognising that local nuances will mean INTs look different in each Place.
- **A commitment from each of our Places** to work ambitiously and intentionally, through a 'test and learn' approach, toward a shared vision for neighbourhood working.
- **Providing a way to build upon, not undo, existing integration successes** recognising that there has been significant progress in recent years and any re-structure takes capacity, time and energy. We do not want to overhaul what is working well, rather we want to develop an adaptable strengths-based way of working.

It is **not**…

- **Static**: this framework will evolve over the coming years as neighbourhood working builds across the SEL system and will be updated to integrate new and effective approaches that have been developed and tested, bringing in learning from previous integration efforts.
- **Exhaustive**: each Place and INT will need to work through local challenges and delivery questions to ensure their INTs work effectively within their local system and are tailored to the needs of their local populations.
- **About just the 'top of the pyramid':** this framework describes a whole system, whole-population approach which strives to improve the lives of all people of all ages across SEL.

Key ingredients

Drawing on learning from other INTs, as well as the conversations we have had to date with stakeholders, key commonalities across models and suggestions for effective neighbourhood working include:

- **Be organised around population health needs** and avoid unwarranted variation. This will involve using population health data to obtain a deep understanding of local communities and use this to proactively identify people who would benefit from support earlier.
- **Be a system-wide way of working and a model of care, and not a programme of discrete projects.** This will include joint workforce and estates planning to enable sharing of assets to best use system resources and promote integration.
- **Eliminate siloed working practices** through equal access to information and flexible models of working. Supporting frontline staff to work in an integrated way—where every connection counts—ensures that teams are equipped to collaborate seamlessly across boundaries. This approach minimises gaps in care and encourage cohesive service delivery, so residents are unaware of how they are being moved through the system to meet their needs.
- **Embed a robust interprofessional training infrastructure.** System leadership training should be a core component of the INT model, with health professionals trained together to strengthen collaboration, build cohesive teams, and foster interprofessional relationships. Training must include data analysis and interpretation to enable INTs to effectively use Population Health Management (PHM) tools for proactive decision-making. This will support succession planning and sustainable leadership within and beyond INTs
- **Have an overarching quality management system** – ideally linked with the quality improvement method – so teams can work in psychological safety, confident in what they are delivering and how they do works and be assured of the impact of the INT way of working.
- **Align to partner and system priorities** to ensure one direction of travel.
- **Shared, clear metrics** expected for INTs will help ensure local decisions are data-driven and ultimately achieve the expected outcomes, even if *what* they do is different to achieve these dependent on local populations and assets. Consistent processes for reviewing outcomes will ensure those which do not see progress over time are understood, addressed, and relevant learning is shared.
- **Release capacity which is reinvested to scale the model sustainably.** This will require routinely measuring impact to understand and embed what works and build a body of evidence.
- **Increase the proportion of resources used to support people to stay well for longer.** This will include offering joined up accessible preventative care, making full use of the knowledge and skills of the team, as well as ensuring the contractual mechanism and human resources (HR) infrastructure is in place to enable this. Commissioners /partners should be able to readily draw on this in relation to job planning/recruitment.
- **Be underpinned by interoperable digital tools and knowledge** that support population data analysis and enable person-based care.
- **Have robust leadership and shared governance arrangements** enabling services to be arranged at neighbourhood level to maximise their ability to engage with local communities and shift investment towards prevention. This includes effective clinical governance that allows genuinely shared care between organisations and professions that make up an INT.

We recognise there will be a level of local variation to ensure each neighbourhood can serve the local population needs. However, the broad approach to integrated neighbourhood working should remain consistent across all population groups and all areas within SEL.

Taking a population health approach

The success of INTs will rest on our ability to develop a deep understanding of our local populations. INTs will be organised around data insights drawn from **Population Health Management (PHM) analyses** - providing the evidence base to tailor services to local need and shift the dial to prevention.

To understand local needs, we will need to define a way to effectively **segmenting our population** (including those who are not registered in SEL general practices) and capturing key priority cohorts. Our segmentation model must:

- **Cohort across all life stages (children to older people) and need status (low- to high-)**, ensuring no one slips through the net
- **Reflect the different factors** that influence a person's needs (e.g., health conditions, psychosocial attributes, wider determinants)

PHM will be used to build up a richer picture of local populations over time, recognising that **data availability may be limited during the mobilisation of INTs** and **processes for continuous learning and adaptation to PHM insights** will ensure INTs remain responsive to changing population health needs.

The voice of residents will be a key input into PHM, essential for completing the picture implied by the data.

How do we get there?

- Agree a common language to describe our population segments to facilitate integrated planning and support collaborative working.
- Agree key metrics to enable a degree of comparability between Places.
- Invest in organisational development to implement new tools, and ensure staff have the ability to effectively use them and integrate insights into delivery and improvement.

A number of our Places in SEL and INTs elsewhere in London are adopting the **Bridges to Health** approach to segmentation. The approach can be tailored to different INT priorities (e.g., around CORE 20 plus 5 and to include social determinants of health). Examples of key areas identified using the Bridges to Health approach in SEL:

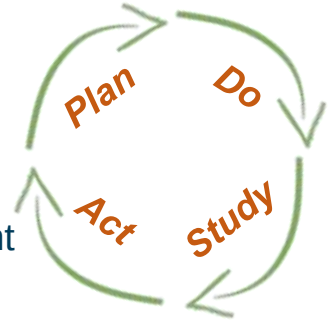
Healthy	Healthy at Risk	Single Illness	Lower Complexity	Higher Complexity	End of Life
	e.g. hypertension low frailty obesity	e.g. single LTC high utilisation mild mental illness	e.g. 2-3 LTCs severe mental illness disability	e.g. 4+ LTCs organ failure dementia high frailty	

Adopting a test and learn approach

We recognise that INTs are a radical change to existing ways of working and will therefore require experimentation through the early implementation phases to understand what is and is not working and explore ways of overcoming challenges.

Over time, our INTs across SEL will also evolve to respond to local population needs. This flexibility will be essential to address local inequalities and deliver services which are genuinely holistic and preventative.

To ensure INTs are delivering impact in the right places, we will adopt a "test and learn" approach to quality improvement which creates space for failure and ensures we understand our impact with each new iteration of the INT model, enabled by:



- **Quality Improvement (QI) metrics aligned to and embedded within the local and SEL-wide vision for INTs.** Metrics must develop our understanding of our impact in key INT priority areas including inequalities and prevention, recognising that preventative interventions demonstrate impact over the long-term, often in diffuse ways.
- **Being expansive and innovative when sourcing data and evidence,** drawing in and learning from ongoing QI insights, while making best use of existing evidence and information collected in the community, regionally, and nationally.
- **A culture of evidence gathering and rigorous and rapid evaluation** to inform future planning, design, and delivery. By building a robust evidence base, our INTs will be able to learn from each other, develop sustainably and target improvement efforts toward what we know works, and demonstrate impact which can secure funding into the future. Evidence gathering should be coordinated at system-level to coordinate efforts and ensure all Places benefit from key learning.
- **Ensuring a degree of comparability between QI metrics for our INTs and Places** so we can understand the drivers of impact across SEL, action system inequalities, and ensure every resident in SEL experiences good quality neighbourhood services.
- **Concise reporting requirements** which are focussed on impact and proportionate to the monitoring capacity of each INT partner.
- **A standard approach to applying PDSA-style (Plan, Do, Study, Act) improvement cycles between INTs**, and embedding learning, evaluation, and improvement.

Geography principles

Designing the geographical footprint for INTs needs to balance local population needs, existing healthcare boundaries, local assets, and operational efficiency. Key components for SEL to ensure boundaries enable effective INT functionality include:

Centre around populations and natural communities. While INTs are expected to naturally coalesce around registered populations linked to GP lists, it is crucial to address challenges such as PCNs engaging in multiple neighbourhoods where INT boundaries do not align and recognise that SEL maintains responsibility for those not registered but living in SEL too. This requires clear differentiation between integrated neighbourhood working and INTs, ensuring alignment without disrupting care continuity.

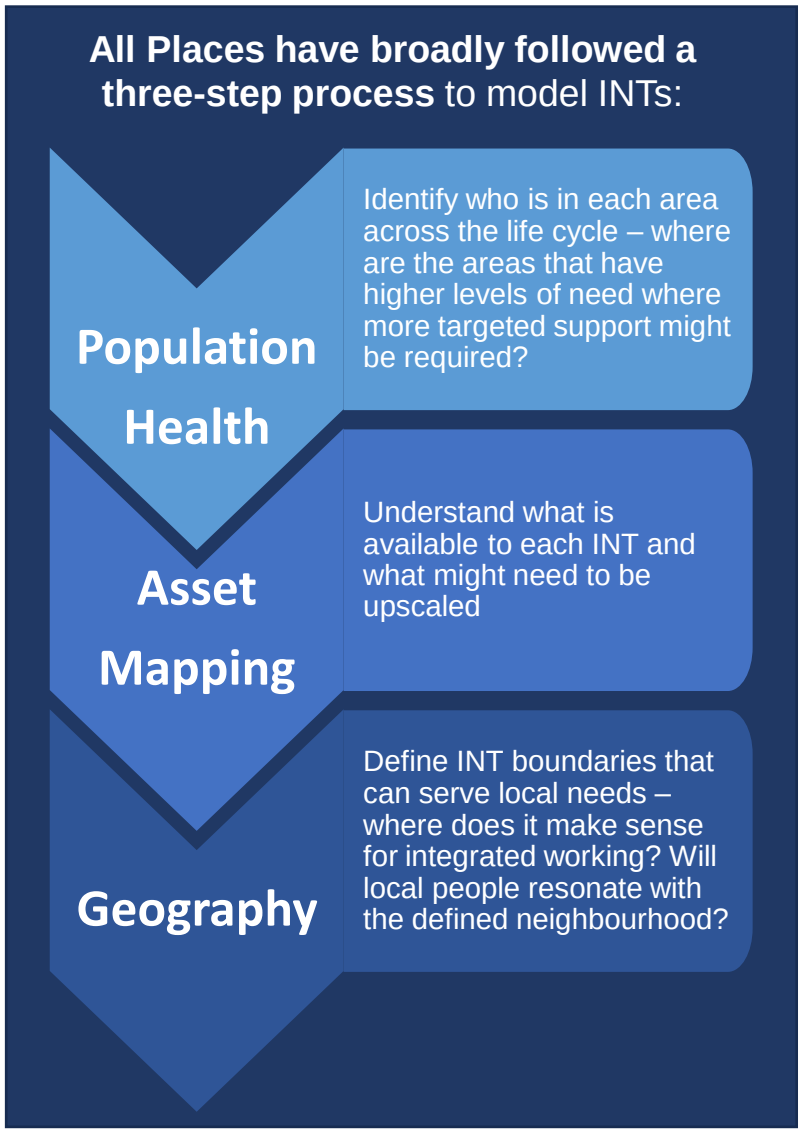
Build on existing networks and local assets. Enhancing integration without requiring new infrastructure where possible is essential to ensure equitable service delivery while maximising existing resources. This will require better use of primary care estates (e.g., community pharmacy consultation rooms) and addressing challenges in engaging community pharmacies with PCNs (particularly those arising from PCN contractual frameworks).

Include population sizes roughly between 50k-100k. Where the population size exceeds 100k, there needs to be consideration of the additional resource required for this area to ensure the size is 'manageable'.

Enable not hinder joint working. The number of INTs must be of a minimum viable scale for team co-ordination; able to be effectively in-reached to by borough-wide services and have appropriate travel times for staff to patients' homes and residents to services.

Adapt footprints based on specific challenges. Areas where there are higher levels of deprivation or inequality require additional, smaller INTs – or at least 'mini-hubs'– for targeted support while larger geographical area could allow for fewer but geographically broader INTs focused on e.g., long-term conditions and frailty. INTs should still pro-actively maintain a degree of demographic and needs variation within INT footprints.

All Places have broadly followed a three-step process to model INTs:



Where there needs to be consistency

Taking a strengths-based approach means there will be local differences. But, beyond working to the same objectives regarding improving health outcomes and addressing inequalities, SEL would expect all to have:

Access to core services: INTs should enable increased service access, and ensure residents have equitable access to essential health and care services within the 'consistent functions' of the INT model (see slide 5) regardless of where they live, proactively identifying and acting on access inequalities.

Proactive care for those with both rising risk and high risk of acute intervention and prevention, beginning with 3+ LTCs, moving along the frailty continuum. This supports overall better outcomes, improved sustainability, and a population well enough to improve access/ address inequalities (e.g., by spotting if there are patterns in service access issues at a level where it can be addressed).

Access to and use of population data: an enabler to the above, population health management (PMH) analysis will drive the composition and priorities of INTs. Each INT will need to identify their baseline position to measure change in outcomes and ability to re-identify patients, as well as a consistent approach and sufficient capabilities to interpret and draw insight from population data.

Data sharing and digital platforms: there needs to be a concentrated effort to ensure INTs are underpinned by interoperable systems and common digital infrastructure to enable co-ordinated care.

Governance and accountability: consistent governance structures across INTs will support clarity in roles, decision-making and accountability. There will need to be clear reporting mechanisms, such as the existing ICB Executive Groups and Local Care Partnerships, and standardised metrics* to report against to share learning, establish effective two-way communication channels, and iterate priorities.

A test and learn approach: recognising that neighbourhood working will take time and will require iteration. INTs should adopt a consistent approach to applying PDSA improvement cycles and embedding learning, evaluation, and improvement.

Coproduction and engagement with communities: communities should experience, understand, and have the opportunity to input into INTs in the same way no matter which INT their locality is served by. Messaging to the public should be consistent to prevent confusion and support proactive engagement and uptake of services.

Common interface with larger / cross-Place providers: e.g., with acute trusts. This will help avoid providers managing an impractical number of different systems.

**Note different Places will want to maintain or develop some specific outcomes measures which speak to major issues on their own patch too.*

Where there will be local variation

Fundamental to our INT model is the need to balance consistency with local variation and taking a strengths-based approach. This means that INTs can effectively meet the differences in local population needs. Emerging thoughts on where there will need to be local variation in INT models include:

Partnering with the voluntary sector: each neighbourhood will have its unique network of voluntary and community sector organisations; leveraging local strengths can amplify the impact of INTs. Consistency in the manner of partnering and engagement, however, should be upheld through common partnering principles.

Interfaces with local authorities: local authorities will have different structures feeding into INT delivery - INTs will need to variously respond and integrate with these to ensure local authority voices are centred in delivery.

Composition of specialist input and resources feeding into each INT: while the core INT will remain consistent from INT to INT, based on local population needs, specialist services should be positioned to flexibly respond to changes in local demand and ensure staff operate on the right spatial level with respect to capacity and demand. Where there is more limited workforce capacity or services, these resources may need to be shared across INTs.

Community engagement: a critical element of the INT model will involve co-designing services with communities and residents to ensure solutions are shaped by lived experiences and local priorities. Tailored public engagement strategies in particularly diverse areas will ensure that INTs meet the needs of all their residents, especially those historically underserved.

Local health system economics: INT priorities will be informed by and respond to local variance in demand for services and supply– for instance, where there may be high, avoidable utilisation of high-cost placements such as residential care.

Physical infrastructure: like workforce, effective INTs should be built on what is already working well within communities which will necessarily look different in each neighbourhood depending on how residents want to and can engage with health and care and wider public services. This might mean developing integration hubs that e.g., leverage hospitals as in Bexley, build on existing community hubs or form ‘mini-hubs’ as in Lewisham.

Key areas of work to deliver Neighbourhoods

SEL recognises INTs require a big shift in ways of working, and some requirements will take time to fully implement. However, this should not prevent Places from progressing INT implementation. The following describes key areas of work that will be included in the INT implementation plans at Place and SEL levels, that will need to be driven from a local level upwards with support from SEL to ensure that INTs meet local population needs.

Delivery of INTs	Enabling functions delivered once across SEL, building from Place upwards	Enabling functions delivered at Place and across SEL concurrently
• Confirm neighbourhood footprints and align service delivery • Establish Integrated Neighbourhood Teams (INT) • Implement 3+ LTC scheme* • Implement Frailty scheme* • Implement CYP scheme* • Agree and implement integrator function • Utilisation of population health management (PHM) to address health inequalities through neighbourhood working	• Single PHM function for the ICS • Ongoing evaluation of impact • Outcomes framework, using shared metrics • Digital enablement of neighbourhood working including single health and care record	• Flexible workforce models and associated culture change • Comms and engagement • Delivery and implementation of a common QI process to support test and learn approach • Agree governance to understand implications and secure good governance of neighbourhoods • Identify and implement neighbourhood hubs, linking to broader estates planning and community diagnostic centres (CDC) development • Create business cases, linked to SEL sustainability

*To common spec collaboratively developed by the 6 Places and with support from SEL.

South East London Integrated Care System

Where we are now

Overview of where Places are

All six Places have made significant efforts and are focusing on developing their neighbourhoods, and all have best practice examples of integrated working at a neighbourhood level. The challenge will be to move from a set of projects to an embedded, systemic shift in the way of working to provide a tangible impact on patient outcomes, moving towards a preventative more integrated approach.

How do INT models align with the SEL Framework?

The development of INT models across all Places broadly align with the tiered system outlined in the SEL Framework (page 5). All INTs will be centred on neighbourhood-based care, with consistent principles such as population health management, proactive prevention, and integration across health, social care, and voluntary sectors. Collaboration with local authorities, PCNs, and the VCSE sector has been recognised as critical across all Places, ensuring models are tailored to local needs while maintaining alignment with system-wide priorities. There is an emphasis on resident-centred approaches, using population health data to identify and address inequalities.

What will neighbourhood governance look like?

- The strategic direction and associated outcomes for INTs are to be determined by the ICB and Local Care Partnerships, while the INTs will be responsible for their delivery.
- Our INT governance structure at a SEL-level for INTs is in development, but will encourage collaboration and shared accountability across organisations and sectors whilst reducing silos. It will leverage the existing Neighbourhood Based Care Board, Primary Care+ Group and Local Care Partnership Boards to help support working across organisational boundaries, resolving interface issues and balancing autonomy with consistency.
- Many Places have started to or already agreed governance and oversight arrangements for INT design and implementation; with many structured through a neighbourhood strategic leadership function with cross-system membership, reporting to Place-level governance, and with reports including INT and programme-specific working groups.
- Places have sought to align governance arrangements with existing neighbourhood-based programmes (e.g. CHILDs).

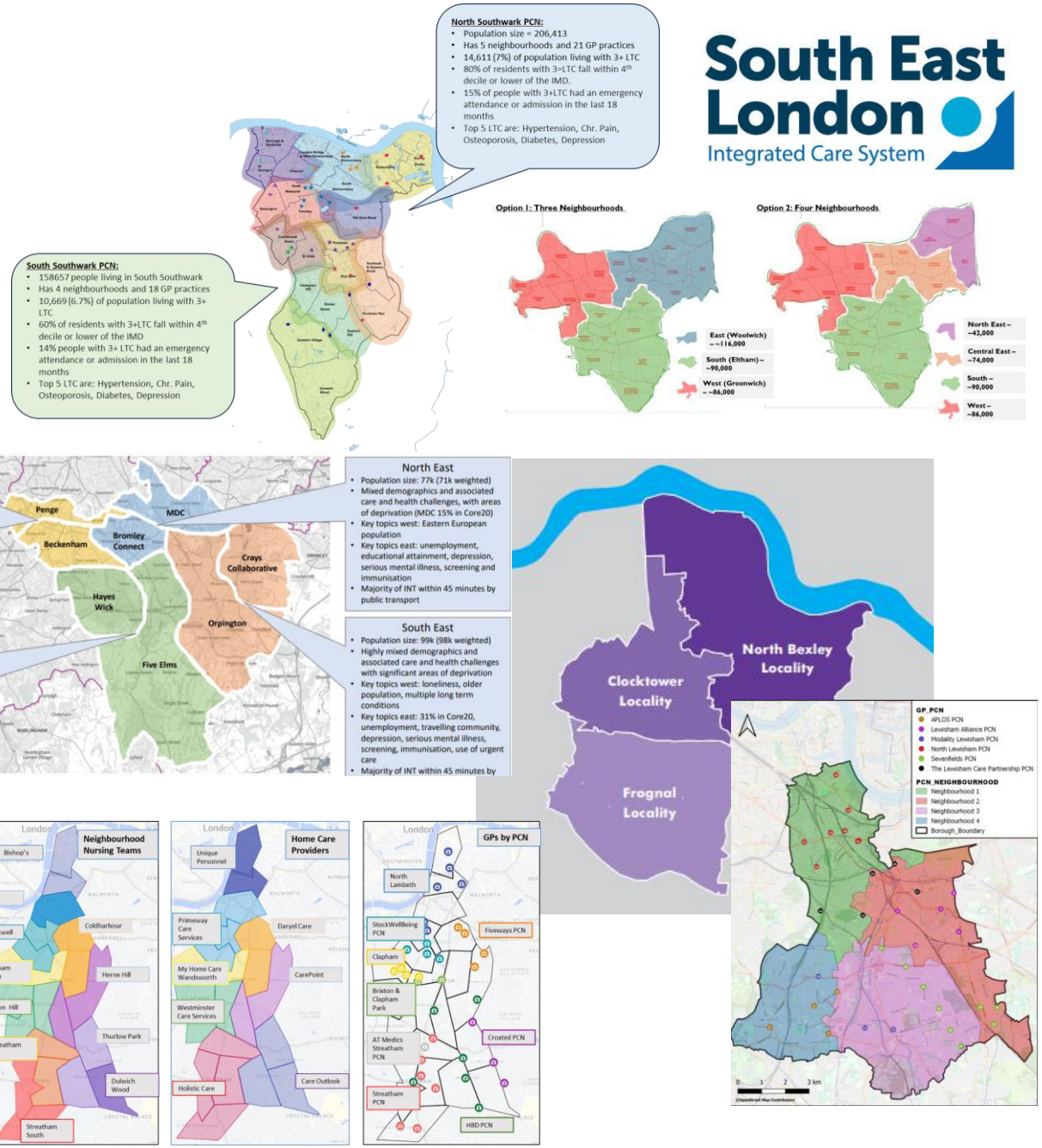
Overview of where Places are

All Places are at the point of reaching consensus on neighbourhood footprints (4 Places have confirmed; 2 are at final stages). It is likely we will have c.27 neighbourhoods across SEL:

- Bexley: 3 Neighbourhoods
- Bromley: 4 Neighbourhoods
- Lewisham: 4 Neighbourhoods
- Lambeth: 8 Neighbourhoods
- Greenwich: TBC – likely 3 or 4 Neighbourhoods
- Southwark: TBC – likely 4 or 5 Neighbourhoods

Neighbourhoods in each Place will adhere to SEL's geography principles (p.13). It is anticipated that some PCNs will have to work across neighbourhood boundaries to provide wrap-around support to all residents.

SEL Places have started to identify potential sites for integration to support INTs as their physical place for collaboration. As part of taking an asset-based approach, these sites already have some level of multi-disciplinary working and integrated services being delivered and will be different in each Place.



INT initial areas of focus

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.
- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

1. **3+ Long-Term Conditions**
   There are currently pilots in each place, and there is a current cost of £18m, £16 Non-Elective (NEL) admissions per year, £3-6m outpatient opportunities for diabetes alone.

2. **Frailty and those approaching end of life**
   There are examples of best practice already and a current cost of £244m* per year on NEL admissions. This also aligns with how many Places are prioritising Ageing well as a strategic goal over the next six years. This might mean pivoting virtual wards and other admission avoidance initiatives into maximising independence outside of the hospital.

3. **Children and Complex Needs**
   There is an existing model which has demonstrated reductions in GP and outpatient appointments, Accident and Emergency (A&E) attendances and NEL admissions.

- Initial INT rollouts and pilots within each Place will focus on these areas. However, there is an expectation that as INTs develop, they may identify additional specific priorities based on their local population needs.

Key assets and challenges within Places

The following details examples of existing assets that Places are building upon, as well as key challenges that have been identified that Places will look to address as they implement their INTs.

EXAMPLES OF EXISTING ASSETS

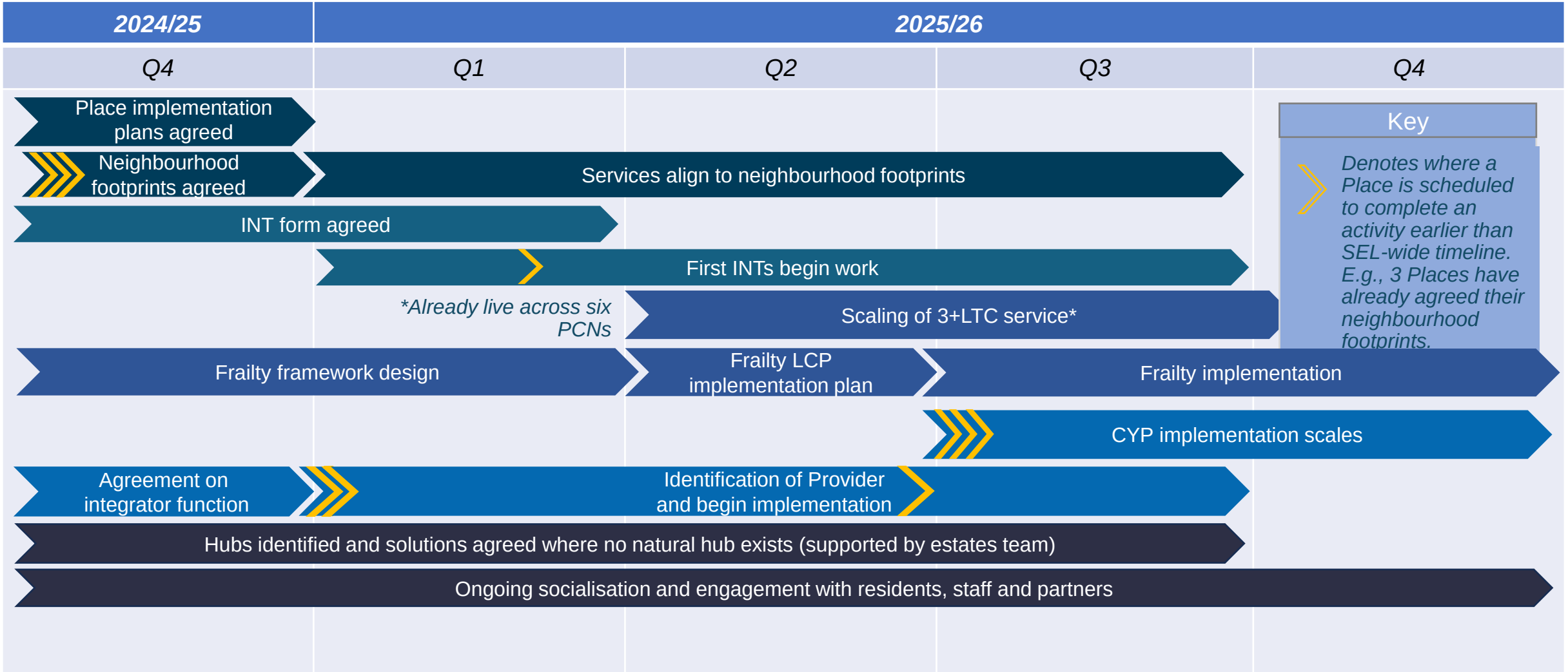
1. **Established PCNs:** In many places, PCNs form the foundation of neighbourhood-based care, providing a structure for GP practices and associated services to work collaboratively within INTs.
2. **Local authority partnerships:** Strong partnerships with local councils are facilitating better integration of health and social care, particularly through joint governance structures and co-designed programmes like housing and benefits support. Local authorities are also providing critical infrastructure for neighbourhood hubs.
3. **Existing community hubs and networks:** Community hubs and voluntary sector organisations have well-established relationships with residents and are being leveraged to provide hyper-local, resident-focused care. Many Places have already trialled co-location of services, which has improved access and coordination in some areas.
4. **Population Health Management (PHM) Tools:** All Places are beginning to use PHM data to proactively identify health needs and target interventions, particularly for underserved populations and those at higher risk (e.g., long-term conditions and frailty).
5. **Proactive approaches to preventative care:** Initiatives such as social connection programmes, support for carers, and community-based activities are being trialled across SEL, building on existing voluntary sector strengths.
6. **Workforce and leadership development:** There is a focus on multidisciplinary training, fostering stronger collaboration across sectors, and building the leadership capacity needed to drive system-wide change.
7. **Digital integration and interoperability:** Progress is being made on shared care records and data-sharing agreements, which are helping to reduce silos and improve coordination.

EXAMPLES OF KEY CHALLENGES

1. **Geographic and boundary misalignment:** Misaligned PCN and neighbourhood footprints create complexity in planning, cross-boundary coordination, and service delivery for INTs.
2. **Data sharing and interoperability:** Barriers to data sharing between health, social care, and voluntary sectors hinder real-time decision-making and seamless, person-centred care.
3. **Governance and accountability:** Current governance arrangements vary at Place level around INT implementation and alignment with broader system priorities.
4. **Workforce and voluntary sector capacity:** Workforce shortages, cultural change requirements, and reliance on under-resourced voluntary organisations challenge the ability to scale and sustain INTs.
5. **Infrastructure and resource allocation:** Disparities in access to suitable community spaces and inequitable resource distribution hinder efforts to meet the needs of underserved areas.
6. **Cultural and operational alignment:** Aligning organisational cultures and shifting from reactive to proactive, preventative care requires time, effort, and significant mindset change.
7. **Sustainability and resident engagement:** Embedding pilot successes into sustainable models and involving residents in co-design remains inconsistent across SEL, limiting long-term impact.

Next steps: testing, learning and scaling

Each Place is making significant progress towards establishing and embedding their respective INT models. The following timeline sets out when all Places will have delivered an area of work, reflecting the different starting points and assets in each Place.



South East London Integrated Care System

NHS South East London

Roadmap

Initial neighbourhood implementation approach

Each SEL Place is in a different stage of developing their approach to integrated neighbourhood working. The following represents a starter for ten based on initial conversations for the decisions and activities that need to be co-developed with partners and residents locally to ensure neighbourhoods and services delivered are built around and address population needs.

Where we are now

Phase 1
Scope & design

- ✓ **Have a clear shared vision, purpose and high-level outcomes** aligned to SEL vision
- ✓ **Expand scope of what we mean by primary care** to inform development, thinking beyond health to include e.g., social determinants, urban planning, non-health-specific community services
- ✓ **Pull together data** from across health, public health and social care to achieve a clear view on: existing neighbourhood footprints, community assets and population needs, including inequalities
- ✓ **Agree common language** describing our population segments to facilitate integrated planning and working
- ✓ **Define geographies** for neighbourhood footprints, including how PCNs align with neighbourhood teams
- ✓ **Identify initial priority cohorts** for INTs
- ✓ **Align plans with existing** integrated neighbourhood working iniatives (e.g., existing work across PCNs)

Phase 2
Refine design and set up

- ✓ **Identify and agree workforce, skills and resource requirements** of INTs to meet population needs
- ✓ **Assess whether the right resources are in the right place** for integrated delivery. If things need to change, work out how – with population input
- ✓ **Collectively allocate resources** based on identified need, exploring novel arrangements (e.g., contracts, incentives) removing historical integration barriers
- ✓ **Develop population health management** approach to enable proactive identification and management of residents
- ✓ **Establish governance** to ensure clear leadership and accountability, including risk management and clinical governance
- ✓ **Design and agree how INTs will perform integrator functions**
- ✓ **Agree measures of success** and monitoring approach for initial implementation

Phase 3
Test and learn

- ✓ **Develop integrated multi-organisational neighbourhood teams** for a chosen population cohort in an agreed geographic footprint
- ✓ **Embed digital tools and knowledge** that enable a shared, population-health driven approach
- ✓ **Facilitate cross-sector relationships and deploy collective resources** to support workforce, digital solutions, estate utilisation and wider infrastructure
- ✓ **Share learning, capacity and resource across neighbourhoods**, converging around best practice
- ✓ **Use established governance** to continously assess learning, progress and impact and integrate into the development of the full INT implementation
- ✓ **Based on learning, start shifting resources** to enable expanded population coverage and increase resource proportion supporting prevention

Underpinned by…

Ongoing engagement and meaningful participation

with partners and residents to enable cultural change and INTs being built and flexed around residents needs, making full use of the knowledge and skills of the team across organisations and ensuring learning and experience is maximised and shared to continuously improve.