Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Partnership Southwark Strategic Board Agenda

Thursday 27th March 2025 13:30 – 16:30

Venue: Walworth Town Hall

Chair: Nancy Kuchemann

Time	Ref	Item	Lead	Enc
13:30	1	• Welcome and Introductions • Apologies • Declarations of Interest • Minutes of the last meeting • Action Log	Chair	Enc 1 – Declarations Enc 1i – Minutes Enc 1ii – Action Log
13:40	2	Spotlight: Neighbourhood Care - Insights from the Walworth Triangle Frailty Pilot	Nancy Kuchemann	Enc 2
14:00	3	Integrated neighbourhood teams	Darren Summers/ Louise Dark	Enc 3
14:45	4	Public Questions	Chair	
15.00		Break		
Business items				
15:10	5	**Strategic Director for Health & Care and Place Executive Lead Report** Reports from sub-committee chairs: • Integrated Governance and Assurance Committee (KP) • Partnership Southwark Delivery Executive (RJ) • Primary Care Group (KP)	Darren Summers / Katy Porter/ Rebecca Jarvis	Enc 4
15:30	6	Planning update	Sabera Ebrahim/ Adrian Ward	Enc 5
16:00	7	Integrated Assurance Report	Darren Summers/ Adrian Ward	Enc 6
16:25	8	Any Other Business	All	
16:30		Close Meeting	Chair	

Next held in-public meeting: 22/05/2025

Partnership Southwark

Declaration of Interests

Meeting Name: Partnership Southwark Strategic Board

Meeting Date: 27 March 2025

Name	Position Held	Declaration of Interest
Alasdair Smith	Director of Children's Services, Southwark Council	No interests to declare
Ami Kanabar	GP, Co-chair LMC	No interests to declare
Anood Al- Samerai	Director, Community Southwark	No interests to declare
Cedric Whilby	CCPL, VCSE representative	1. Producer of 'Talking Saves Lives' public information film on black men and cancer 2. Trustee for Community Southwark 3. Trustee for Pen People CIC 4. On Black Asian Minority Ethnic (BAME) panel that challenges the causes of health inequalities for the BAME community in Southwark – **Pending email validation**
Claire Belgard	Interim Director of Integrated Commissioning	No interests to declare
Cllr Evelyn Akoto	Partnership Southwark Co-Chair & Cabinet Member for Health & Wellbeing	No interests to declare
Darren Summers	Strategic Director of Health & Care & Place Executive Lead	1. Wife is Deputy Director of Financial reporting at North East London ICB 2. Member of GSTT Council of Governors (ICB representative)
David Quirke-Thornton	Strategic Director of Children's and Adult's Services	No interests to declare
Emily Finch	Clinical Lead, South London & Maudsley	No interests to declare
Eniko Nolan	Assistant Director of Finance for Children and Adult Services	No interests to declare – **Pending email validation**
Graham Head	Healthwatch	No interests to declare
Jeff Levine	Regional Director for London, Agincare	**Pending declaration**
Josephine Namusisiriley	CCPL, VCSE Representative	No interests to declare
Julie Lowe	Site Chief Executive for Denmark Hill	No interests to declare

Katy Porter	Independent Lay Member	1. Trustee, & Vice Chair, Depaul UK which is a national charity, working in the homelessness sector, and it's head office is based in Southwark. The organisation holds a contract with Southwark. 2. CEO for The Loop Drug Checking Service. The Loop is a national charity developing services across the UK, including London. It operates in the substance use and health sector. – **Pending email validation**
Louise Dark	Chief Executive Integrated and Specialist Medicine Clinical Group	No interests to declare
Monica Sibal	IHL representative	No interests to declare **– Pending email validation**
Nancy Küchemann	Co-Chair Partnership Southwark and Chair of Clinical and Care Professional Leads, Deputy Medical Director, SEL ICB	1. GP Partner at Villa Street Medical Centre. Practice is a member of SELDOC, the North Southwark GP Federation Quay Health Solutions and the North Southwark Primary Care Network. 2. Villa Street Medical Centre works with staff from Care Grow Live (CGL) to provide shared care clinics for people with drugs misuse, which is funded through the local enhanced service scheme. 3. Mrs Tilly Wright, Practice Manager at the practice and one of the Partners is a director of QHS. Mrs Wright is also the practice manager representative on the Local Medical Committee. 4. Mr Shaun Heath, Nurse Practitioner and Partner at the practice is a Senior lecturer at University of Greenwich. 5. Dr Joanna Cooper, GP and Partner at the practice is employed by Kings College Hospital as a GP with specialist interest in dermatology. 6. Husband Richard Leeming is councillor for Village Ward in south Southwark. 7. Deputy Medical Director at SEL ICB
Nigel Smith	Director, Improving Health London	No interests to declare
Olufemi Osonuga	PCN Clinical Director, North Southwark	1. GP Partner Nexus Health Group, Director Quay Health Solutions, Director PCN, North Southwark
Rebecca Dallmeyer	Director, QHS	1. Quay Health Solutions holds contracts for delivery of services through the following contracts commissioned by SEL ICB: New Mill Street GP Surgery
Rebecca Jarvis	Director of Partnership Delivery and Sustainability	No interests to declare
Sabera Ebrahim	Associate Director of Finance, SEL ICB, Southwark	No interests to declare

Sangeeta Leahy	Director of Public Health	No interests to declare
Sarah Kwofie	Director of Homecare (London & South) City and County Healthcare Group	No interests to declare
Sumeeta Dhir	Chair of Clinical and Care Professional Leads	No interests to declare
Winnie Baffoe	CCPL, VCSE representative	1. Director of Engagement and Influence at the South London Mission, which works closely with Impact on Urban Health. The South London Mission leases part of its building to Decima Street medical practice. 2. Board Member Community Southwark. 3. Married to the Executive Director of South London Mission

Minutes

PARTNERSHIP SOUTHWARK STRATEGIC BOARD

Date: Thursday, 30 January 2025 | 13:30 – 16:30
Location: St Peter's Crypt, Liverpool Grove, Walworth, SE17 2HH
Chair: Dr Nancy Küchemann

ATTENDEES

MEMBERS	TITLE AND ORGANISATION
Cllr Evelyn Akoto	Co-Chair, Cabinet Member of Health & Wellbeing, Southwark Council
Dr Nancy Küchemann	GP, Co-Chair Partnership Southwark
Anood Al-Sameria	CEO, Community Southwark
Winnie Baffoe	Director of Engagement & Influence, South London Mission; Voluntary and Community Sector (VCS) Representative
Claire Belgard	Interim Director of Integrated Commissioning, Southwark Council, SELICS
Rebecca Dallmeyer	Quay Health Solutions
Dr Sumeeta Dhir	GP, Chair of Care & Clinical Professional Leads (CCPL)
Sabera Ebrahim	Associate Director of Finance, Southwark, SEL ICB
Dr Emily Finch	Clinical Lead, South London & Maudsley NHS Trust
Graham Head	Healthwatch Southwark
Rebecca Jarvis	Director of Partnership Delivery & Sustainability, Partnership Southwark
Dr Ami Kanabar	GP, Local Medical Committee (LMC) Representative
Sarah Kwofie	Director of Homecare (London & South) City & County Healthcare Group
Sangeeta Leahy	Director of Public Health, Southwark Council
Jeff Levine	Regional Director for London, Agincare
Josephine Namusisiriley	Care & Clinical Professional Lead (CCPL), VCSE Representative
Eniko Nolan	Assistant Director of Finance for Children and Adult Services
Dr Olufemi Osonuga	GP, Clinical Director of North Southwark Primary Care Network (PCN)
Katy Porter	Independent Lay Member
Monica Sibal	Improving Health Limited (IHL) Representative
Darren Summers	Strategic Director for Health & Care / Place Executive Lead, Southwark
Cedric Whilby	Voluntary and Community Sector (VCS) Representative
IN ATTENDANCE	
Peace Ajiboye	Service Director, SLaM
Sehrish (Rish) Baloch	Programme Lead, Partnership Southwark, SEL ICB
Catherine Flynn	Head of Communications and Engagement, Lambeth and Southwark
Philippa Galligan	Deputy Chief Operating Officer, SLaM
Nicola Hanson	GP and Clinical Professional Lead for Children and Young People
Alice Jarvis **(on behalf of Louise Dark)**	Director of Operations and Partnerships Integrated and Specialist Medicine, GSTT
Isabel Lynagh	Business Support Lead, Southwark, SEL ICB
Pauline O'Hare **(on behalf of David Quirke-Thornton)**	Director Adult Social Care, Southwark Council
Geetika Singh	Programme Lead, Partnership Southwark, SEL ICB
Rachel Tebay	Project Manager System Delivery, Partnership Southwark, SEL ICB
Lewis Jackson	Project Co-ordinator, Partnership Southwark, SEL ICB
Natasha Wright	Healthwatch Southwark Advisory Board Member
Louisa Lamothe	Business Support Officer, Southwark, SEL ICB (Minutes)

APOLOGIES	
Alasdair Smith	Director of Children's Services, Southwark Council
Louise Dark	Chief Executive Integrated and Specialist Medicine Clinical Group, GSTT
Julie Lowe	Deputy Chief Executive, Kings College Hospital NHS Trust
David Quirke-Thornton	Strategic Director of Children's & Adult's Services, Southwark Council
Nigel Smith	Director, Improving Health Limited (IHL)

1.	Welcome & Introductions
1.1	The Chair welcomed attendees to the Partnership Southwark Strategic Board, including new member Jeff Levine, Regional Director of Agincare, who will now be replacing Laura Coupe, Managing Director of Agincare.
1.2	The Chair provided an update to the board on changes to the agenda, including omission of the integrated governance and assurance report due to lack of the usual stages of review and governance due to staff absence.
1.3	Introductions were made and apologies noted.
1.4	**Declarations of Interest** There were no additional declarations of interest in relation to matters in the meeting.
1.5	**Minutes of last meeting** Minutes of the last meeting were agreed as an accurate record, with no points of correction noted.
1.6	**Action Log** The action log was reviewed, and updates were shared as follows: **Action 1:** **CLOSED**. The Chair agreed to closure as connections between relevant representatives have now been made. Work will continue as part of the ongoing frailty project work. **Action 2:** **CLOSED**. The family hub presentation was circulated to the board following the last meeting. **Action 3:** **CLOSED.** A decision was taken to defer the proposed update until later in the year to allow for a more substantial update to the board on progress. Reviews will take place in the interim with links to the Integrated Neighbourhood Teams (INT) Programme Board. **Action 4:** **OPEN.** Cllr Evelyn Akoto to clarify the position ahead of potential closure.
1.7	Further to discussions at the last board meeting on 7 November 2024, the following action is noted:
1.8	**ACTION:** Cllr Evelyn Akoto to email members with further detail on the Maternity Commission Working Group. Members who would like to be part of the working group to email Cllr Evelyn Akoto.

2.	**Community Spotlight: Adult Mental Health - How do we provide support for people with acute complex mental health needs?**
2.1	The Chair opened the presentation with an invitation for members to consider areas of collective action towards this priority to progress the current position.
2.2	Peace Ajiboye presented an overview of slides outlining acute mental health pathway activity and challenges over the last three months alongside Philippa Galligan. With focus on activity of the mental health liaison team at King's College Hospital (KCH) supporting information included data comparison and trends relating to Emergency Department (ED) activity; 72hr breaches; and length of stay in Lambeth and Southwark.
2.3	Key messages were explained, including less than 20% of 72hr ED breaches in SEL occurred in KCH over the last few months. Many breaches link to social factors, including, patients with no fixed abode, no recourse to public funds, or general accommodation issues impacting discharge. A gradual increase in ED presentations to the KCH liaison team since April 2022 is noted, with many patients known to services.
2.4	Over the last six months, work is progressing at South London and Maudsley Trust (SLaM) to stabilise breaches and support patients with stays longer than 72 hours following their initial ED presentation. With impact on inpatient bed capacity, Peace Ajiboye shared an overview on challenges with system flow.
2.5	Whilst a reduction in inpatient length of stay and patients who are clinically ready for discharge is noted, further work is required in reducing the number of patients with an extended length of stay over 30 days. Step Down accommodation is utilised to minimise and support extended ward stays, where a patient can wait while housing needs are progressed.
2.6	Additionally, Philippa Galligan explained that whilst the underlying length of stay on Southwark wards is low in comparison to other directorates, there is still a high number of patients with stays over 60 days and no change to associated figures. Work led by the Chief Medical Officer at SLaM is underway to investigate patients with long lengths of stay and barriers to discharge. Focused work is required to identify patients with comorbidities, including learning disabilities and autism resulting in delays in treatment optimisation.
2.7	The Chair opened discussions up to the board for comment with initial questions on ED presentations/conditions.
2.8	Cllr Evelyn Akoto commented on work to reduce impact on long stays, with questions on whether this is doable or potential obstructions in progressing plans have been identified.
2.9	Cedric Whilby shared thoughts on data collection regarding the demographic of long stay patients i.e. age, ethnicity, and socioeconomic status. Work with external agencies to support and mitigate some of the issues outlined was also raised.
2.10	Philippa Galligan confirmed demographic data is being collected and can be analysed for board information. Regarding the progression of plans, it is thought whilst some things are changeable, others relate to operational escalation e.g. inappropriate admission/escalation of

	patients within the learning disability and autism cohort. A review of various wards is taking place to identify and address key issues and drivers.
2.11	Furthermore, Peace Ajiboye gave insight on ED presentations being low mood, suicidal ideation/intent, and others accompanied by the Police due to risk of harm to self or others. Many presentations relate to people wanting to talk and often return home having done so.
2.12	Other questions and reflections from the board included understanding improvements in ED attendance following the implementation of resources via the community led transformation programme; the availability of dedicated wait spaces in ED; as well as the impact of/what can be done to help navigate difficulties associated with patients with complex comorbidities.
2.13	Echoing comments made, Anood Al-Sameria emphasised past failings and the need to support plans for a dedicated space at SLaM; and additionally, support those in the Voluntary and Community Sector (VCS). In considering flow, Monica Sibal reflected on the fact that 55% of presentations to ED are by patients known to services, questions on reasons for re-presentation and what can be done to better support this and create change via the community were raised.
2.14	Philippa Galligan updated on plans to recruit a nurse consultant in autism, with a key function of this role to support adaptations to inpatient wards to support recovery and mitigate barriers to discharge.
2.15	A case study of a patient who recently presented to ED via ambulance with suicidal intent was shared with the board for further insight on a journey from ED through to community pathways.
2.16	In summary, inadequate supported living arrangements across the borough was raised as a key takeaway, with emphasis placed on a high number of complex Southwark patients being placed out of borough.
2.17	**RECOMMENDATION**: With financial and quality implications, an **ASK** of the board to explore housing support/accommodation was raised by Peace Ajiboye.
2.18	The board thanked presenters for the comprehensive presentation and **NOTED** the findings and recommendations.
3.	**Health and Care Plan Priorities Refresh – Focus on Adult and CYP Mental Health**
3.1	Rebecca Jarvis introduced the item as an update on work to progress the Health and Care Plan Priorities approved by the board on 5 September 2024, with focus on Adult and Children and Young People (CYP) mental health.
3.2	Delivery plans are progressing, with intended focus on partnership working for evolution and greater impact. In recent weeks, work has also taken place to align plans with the Joint Health and Wellbeing Strategy (JHWS) action plan, which is also in the process of being refreshed.
3.3	Referring to Enclosure 2 of the meeting pack, Geetika Singh provided an overview of work to progress the CYP priority area, including an action plan for delivery over the next 12 to 18 months. Plans have been shaped by engagement meetings over recent months with partners

	and VCS representatives. A high-level mapping exercise of service offers was also completed to understand areas of strengths, improvement, and focus. With recognition of existing workstreams, intentions to build on these foundations were noted.
3.4	Triangulation of data findings include themes of improving access; reducing delays and duplication; addressing inequalities and language barriers to care; improving the wait experience for young people; strengthening partnership working across the system; and developing an integrated neurodevelopmental disorder (NDD) pathway.
3.5	An overview of the proposed CYP ambition was shared with the board, with two measures of success noted and themed areas of focus to drive work forward. Planned initiatives under each theme were highlighted with objectives and expected outcomes e.g. collaboration opportunities to enable a holistic approach to care and developing a health and wellbeing hub through co-design with the younger population in particularly deprived communities.
3.6	In continuation, Rish Baloch shared an overview of the adult mental health priority area noting similarities with CYP in terms of themes, areas of focus, and partner engagement. Nuances in the adult mental health space were highlighted, including themes of improving access and navigation of services for both partners and residents. An opportunity to connect services and address health inequalities was also shared.
3.7	Unlike CYP, three measures of success over the next 18 months and beyond were described, with areas of focus being: 1. Equity of access through an integrated community offer; 2. Enhancing the mental health offer within neighbourhoods to address health inequalities; and 3. Improving access and flow via partnership working for NDDs. Planned initiatives under each theme were also shared e.g. developing a no wrong door approach and supporting the transition period between CYP and adult mental health pathways.
3.8	Furthermore, an update on delivery plans was taken to the Partnership Southwark Delivery Executive (PSDE) on 12 December 2024, with additional feedback including a need to consider the incorporation of the Improving Access to Psychological Therapies (IAPT) service in multidisciplinary team (MDT) working and how support from home care teams could be utilised.
3.9	The Chair opened discussions up to the board for comment.
3.10	Darren Summers reflected considerations of workstreams through the lens of a parent or young person, with questions on how the proposed actions are going to deliver the described targets, particularly where data is limited. Katy Porter commented on wait times and what a good or better wait might look like.
3.11	Commenting on adult services, Dr Emily Finch observed similarities between proposed plans and a reorganisation in Lambeth some years ago that has recently been unpicked. In addition, it is understood Lewisham are participating in a national pilot to organise their adult mental services, with a SLaM programme in place to ensure learnings. A need to consider local and wider learning is noted; and more widely, a reminder to ensure equity does not negate the need for individualised responses was raised, with risks of a one size fits all approach to a complex problem.

3.12	Other questions and reflections from the board included emphasis on the initial interaction with a child or family and ensuring this works well. Aligned with earlier discussions, there is a requirement to use a holistic approach when first meeting and assessing an individual e.g. physical health and housing. The aim and benefits of a localised hub model for CYP with various youth services in one space were highlighted.
3.13	Additionally, board members raised questions on the availability of resources and capacity, as well as a need for training. Concerns regarding the hub model were also shared, with risks associated with the cutting and centralising of services. Recognising the importance of VCS collaboration and co-design and associated costs and time investment were highlighted as areas for consideration and clarity on funding sources.
3.14	Cllr Evelyn Akoto reflected positives on the CYP mapping exercise and echoed thoughts on the value of the parent voice. Concerns regarding the duplication of services such as The Nest were raised, with questions on opportunities to potentially expand their model and services. Further to Adult discussions, the consideration of wider determinants was noted, with questions on work with council departments to support a holistic approach. The absence of preventative measures within the presentation was observed and noted as a key area of work.
3.15	Josephine Namusisiriley commented on strategic collaboration with key organisations who share similar priorities e.g. the Maudsley charity and their Building Brighter Futures project. Additionally, Cedric Whilby raised the involvement of schools and education as a key area of work that seems to be missing, with rich data links on mental health support for children and parents, particularly for vulnerable groups and e.g. Pupil Referral Units (PRUs).
3.16	Sumeeta Dhir in her role as Primary Care Lead for Mental Health in Southwark gave further insight on target determinants and confirmed a lack of resources and capacity to meet demand. Additionally, wider prevention work is happening, with Public Health colleagues regularly meeting with the wider team to develop preventative resources within the community.
3.17	Geetika Singh commented on VCS co-production funding, noting this has been factored into health inequalities funding. With plans on maximising efforts between the Health and Care Plan and JHWS action plan, school, prevention, and promotion will be addressed via one of the two plans with clear deliverables.
3.18	In response to questions raised regarding The Nest, Nicola Hanson shared further insight, noting intentions to evolve, co-create, and expand upon their work in the mental health space to support the holistic service offer. Additionally, John Poyton, CEO of The Wells Centre Charity (and former CEO of Red Thread), has been leading on application for Building Brighter Futures funding. As part of this proposal, work will happen with Southwark to develop more adolescent wellbeing opportunities.
3.19	The Chair summarised comments on workforce development, noting there is further work to be done in this area.
3.20	The board thanked presenters and **NOTED** the updates.

4.	**Public Questions**
4.1	There were no public questions raised in advance of or during the meeting.
BREAK	
5.	**Strategic Director for Health & Care Report**
5.1	Darren Summers presented the Place Executive Lead's report to the board, with papers taken as read. Key highlights included work to develop the INT model as part of the five agreed Health and Care Plan priorities, and more recently, the national government priority to create a neighbourhood NHS.
5.2	Anticipated 2025/26 NHS planning guidance was released today. Whilst this has not yet been read, expectations on INT delivery are predicted to feature strongly and further update will be shared at the next board meeting.
5.3	Darren Summers noted broad expectations of INTs to 1. Offer more holistic care to e.g. patients with multiple long-term conditions in the community; and 2. Work well in neighbourhoods, building a connection and understanding of local communities to support proactive and preventative care. A programme board has been established, with two meetings having taken place so far. Programme delivery is currently in the design phase, with plans to move into the delivery phase imminently.
5.4	Additionally, Darren Summers commented on the Joint Forward Plan (JFP), general planning, and the finance section collectively; noting the JFP will be refreshed this year in line with national planning guidance and obligations. Planning guidance will include financial allocations to SEL, and a no growth position is projected. Whilst Southwark is expected to achieve financial balance, this is largely by way of a series of non-recurrent measures. Colleagues are exploring options for addressing the underlying deficit position mainly due to deficits in delegated primary care, prescribing, and mental health.
5.5	Lastly, Darren Summers highlighted the Lower Limb Wound Care Section of the report, noting key points regarding showcasing the work underway, and the Southwark Council Peer Review section of the report, with positive reflections on the operation of Southwark's adult social care services.
5.6	The Chair opened discussions up to the board for comment.
5.7	Cedric Whilby commented on the report cover sheet noting that the impact assessment section was incomplete. Darren Summers apologised to the board for this oversight due to staff absence.
5.8	Other questions and reflections from the Board included consequences of the deficit financial position. With planning guidance expected to note an approximate 4 to 5% efficiency savings target, Darren Summers explained the impact on opportunities to invest any growth money.
5.9	As chair of the Integrated Governance Assurance Committee (IGAC), Katy Porter commented on the financial position and subsequent programmes of work being the focus at meetings of the committee. Discussions are taking place regarding spend on mental health placements and

	the subsequent level of impact on investment.
5.10	The Chair invited Katy Porter and Rebecca Jarvis to speak to reports for sub-groups of the board.
5.11	As chair of IGAC and the Primary Care Group (PCG), Katy Porter commented on key areas of focus for IGAC. Whilst most areas are financially driven, a need for overview on quality provision was highlighted. Changes in quality reporting was also noted as a result of recent management changes. The committee is working closely with the quality team to understand and streamline the quality data reported to IGAC in future.
5.12	Moreover, Katy Porter updated on recent procurement decisions and noted procurement for the interpreting services contract has now concluded with a contract awarded to DA Languages Ltd. The committee also received an update on preparations for the SEND inspection, including plans for internal assessment.
5.13	In continuation, Katy Porter shared updates from the PCG, including the review of upcoming contracting arrangements for two local GP surgeries – Silverlock Medical Centre and Queens Road Surgery. A recommendation to proceed with full procurement of the two surgeries was submitted to the group and has been supported.
5.14	Rebecca Jarvis provided an update on the PSDE, noting two meetings have taken place since the last board meeting on 7 November 2024. Most areas of focus have been covered within items on today's board agenda e.g. work to progress the Health and Care delivery plans.
5.15	Terms of reference (ToR) for the PSDE have been reviewed with the main update being the PSDE will become the programme board for delivery of the Partnership Southwark Health and Care Plan and relevant sections of the JHWS, as well as the formal subcommittee of the PSSB. A new highlight reporting template has also been introduced to strengthen links between programmes of activity.
5.16	The board **NOTED** the report and updates.
6.	**Governance Review**
6.1	With papers taken as read, Darren Summers shared brief context with the board. After setting out plans to review governance arrangements some months ago, work has taken place to revise governance sub structure, including streamlining the number of meetings and clarifying the responsibilities and reporting structure into the board.
6.2	Revised ToR for sub-groups of the board (IGAC, PSDE, and Primary Care Committee, formerly PCG) were highlighted for board information and approval.
6.3	Graham Head commented on the quality aspect of IGAC and the possibility of including a patient voice. Katy Porter suggested given plans for quality reporting are evolving, the question will be held until plans are further developed.
6.4	With no further comments raised, the Chair noted board **APPROVAL** of the proposed governance arrangements.

7.	Any other Business
7.1	Darren Summers noted details of a Female Genital Mutilation (FGM) conference on 6 February 2025. Members are welcome to attend and Cllr Evelyn Akoto will share further details in due course. Discussions will focus on understanding the experience of health, care, and community support and any improvements that can be made.
7.2	The Chair noted details of the next in public board meeting on 27 March 2025 and development session on 27 February 2025.

The meeting closed at 16:10 and the Chair thanked members and guests for their time.

Enclosure: 1ii
Agenda item: 1

PARTNERSHIP SOUTHWARK STRATEGIC BOARD ACTION LOG					
No.	**MEETING DATE**	**ACTION**	**STATUS**	**OWNER**	**COMMENTS**
1	07/11/2024	Chair to follow up on support connections for the Healthwatch Interim Youth Programme and disseminate information via Cabinet colleagues	Open	Cllr Evelyn Akoto	30/01 - Cllr Evelyn Akoto to clarify the position ahead of potential closure
2	30/01/2025	Cllr Evelyn Akoto to email members with further detail on the Maternity Commission Working Group. Members who would like to be part of the working group to email Cllr Evelyn Akoto.	Ongoing	Cllr Evelyn Akoto	20/03 - First working group meeting held on 19/03 and membership of group in progress

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 2
Enclosure: 2

Title:	**Spotlight: Neighbourhood Care - Insights from the Walworth Triangle Frailty Project**
Meeting Date:	**27 March 2025**
Author:	Nancy Kuchemann, GP and Co-chair of Partnership Southwark, Deputy Medical Director SEL Integrated Care Board
Executive Lead:	Alice Jarvis, Director of Operations and Partnerships Integrated and Specialist Medicine, GSTT

Summary of main points
To help introduce and illustrate the item on integrated neighbourhood team development, Nancy is going to share her insights as a GP helping adopt the frailty pilot within her practice. The intention is not to provide a programme update but to share some reflections about the key elements that need to be in place and developed for transformation of this kind to have an impact.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
		X	

Action requested of PSSB
For colleagues to listen and digest and take into future conversations about neighbourhood team development

Anticipated follow up
Insights have already been shared with ageing well transformation programme leads.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	
Adult mental health	
Frailty	**X**
Integrated neighbourhood teams	**X**
Prevention and health inequalities	

Item Impact	
Equality Impact	*The intention is for this to be soft intelligence to guide colleagues thinking, no direct impacts expected.*
Quality Impact	
Financial Impact	
Medicines & Prescribing Impact	

Safeguarding Impact			
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	The intention is for this to be soft intelligence to guide colleagues thinking, no direct impacts expected.		

Describe the engagement has been carried out in relation to this item
Engagement has been undertaken with frailty project clinical and strategic leads.

Partnership Southwark

What does developing neighbourhood care look like?

Insights from the Walworth Triangle Frailty Project

Dr Nancy Küchemann, Villa Street Medical Centre

Frailty Pilot: What was offered?

Partnership Southwark

Project Objectives

- To take a population management approach to identify those with mild, moderate and severe frailty living in the community to case find and proactively perform community CGAs.
- Development of integrated neighbourhood teams with a blending primary and secondary care MDT to manage the frailty needs of the population in Lambeth and Southwark.
- Outreach into non-healthcare settings to identify and proactively manage frailty.

Defining the Frailty Offer

Partnership Southwark

- Patients suitable for the frailty pilot are identified in 3 ways: discussion at a Multidisciplinary Meeting, systematic EMIS searches, or via a screening questionnaire developed by the team.
- Once identified, the frailty team will contact the patient, and if/when suitable, arrange a home visit to conduct the frailty assessment. EMIS is a key enabler to allow information sharing, with the ability to record all patient interventions with a shared summary available across providers.
- To ensure appropriate follow up post-assessment, the team will ensure they conduct all necessary activities including documentation of notes, onward referrals and are able to arrange a Frailty INT discussion as necessary to discuss any complex patients.

Key Achievements

- **38 referrals** were made to the frailty team from both GP practices – East Street and Villa Street Medical Centre.
- The team conducted **19 home visits**, and a further **6 reviews** were booked
- **100%** of patients had a comprehensive geriatric review in their own home.
- **89%** of patients **(16 out of 18)** had an Advanced Care Plan completed.
- **27%** of patients **(5 out of 18)** were able to cancel their outpatient appointments
- **100%** of patients reviewed resulted in medication changes.
- **73%** of patients **(13 out of 18)** reviewed led to liaison with secondary care, reducing the need for outpatient referrals, improved co-ordination of care and reduced chasing up for GPs.
- Only two patients **(11%)** required a follow up with the Frailty INT team, otherwise all care was delivered in collaboration with GPs and existing community services.

Villa Street: what were the key elements?

Partnership

Professionals seconded or employed to offer time to a new setting (via QHS) - Physician fellow on secondment from GSTT - Social prescribers recruited	Data that is reliable and tools that can be used to stratify to identify patient cohorts followed by a validation process to select cases - Data sharing agreements - IT skilled staff - Front-line staff conversations and follow up	An understanding of and build onto existing work so that the interventions add value - Meeting with practice nurses - Understanding of current systems and how to evolve/adapt - Reflection and iteration important
Socialising of the model, introducing staff and new ways of working so that trust is built with in-house teams and patients - Meetings - Description of model and it's proposed outputs - Follow up emails - Visible outputs and visible modifications	Establishing of ways of working - Roles and responsibilities - Meetings - Patient lists - Notes and clinical summaries - Communication routes - Expectations of follow up, or not - Troubleshooting - Learning and modification	Awareness of risks, consideration of unintended consequences and a framework for evaluation - Patient outcomes - System outcomes - Project outcomes - Visible next steps which lead to improved integration

What did we need to pay attention to?

Partnership Southwark

Methods of communication – emailed lists, paper lists, teams, cross-org slots, meeting records, meeting scheduling, using tools such as accurx all needed thinking about	Importance of setting out aims and reviewing/refreshing – building reflection and iteration into projects – hard to do and often an after thought – how to bring in earlier?	Showing impact: importance of collecting right data at baseline and to show change – eg number of OPC cancelled, reducing waits for services
Doctor experience: letting someone else into the doc-pat relationship, new clinical decisions, sharing risk, picking up pieces	Patient experience: some loved the attention, others were confused by the duplication.	Equity – moving onto next practice – how to do? Tailoring next steps of the development work

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 3
Enclosure: 3

Title:	**Integrated Neighbourhood Teams**
Meeting Date:	**27 March 2025**
Author:	Rebecca Jarvis, Director of Partnership Delivery and Sustainability, and Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead
Executive Lead:	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

Summary of main points
The development of Integrated Neighbourhood Teams was one of the five priorities agreed by Partnership Southwark in September 2024, and this work follows on that agreement. We are developing neighbourhood working in response to national, system and borough level policy and needs. The overall aim of neighbourhood working and Integrated Neighbourhood Teams (INTs) in Southwark is to improve population health outcomes, reduce health inequalities, and develop a more preventative offer by working more closely with local communities.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
			x

Action requested of PSSB
○ The Board is asked to approve the SEL ICS Neighbourhood and INT Framework. ○ The Board is asked to support the neighbourhood footprint for INTs. ○ The Board is asked to review the roadmap

Anticipated follow up
The next steps are outlined in the roadmap contained in the main paper, with the aim to launch Integrated Neighbourhood Teams in Southwark in October 2025.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	**X**
Adult mental health	**X**
Frailty	**X**
Integrated neighbourhood teams	**X**
Prevention and health inequalities	**X**

Item Impact	
Equality Impact	The establishment of integrated neighbourhood teams will help address health inequalities, particularly through a more preventative offer by working more closely with local communities

Quality Impact	Integrated neighbourhood teams are expected to have a significant impact on the quality of services being offered to local residents, with improved outcomes through offering more holistic, joined up health and care.		
Financial Impact	Integrated neighbourhood teams will be constructed primarily through the deployment of existing services, staff and resources into the teams. As we move into implementation phase, start up and any additional costs can be determined.		
Medicines & Prescribing Impact	To be determined through more detailed modelling.		
Safeguarding Impact	To be determined		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
		Yes.	

Describe the engagement has been carried out in relation to this item
The proposals around integrated neighbourhood teams builds on wider engagement over a number of years, including with residents around Southwark 2030. Stakeholders and partners have been involved in the Southwark INT programme board, and have participated in a number of individual and group engagement sessions. Further engagement with residents, front line staff and, for example, voluntary and community groups, will be needed as we move into more detailed design and implementation phases.

Partnership Southwark

Southwark INT Development

Partnership Southwark update

27 March 2025

Executive summary

- The development of Integrated Neighbourhood Teams was one of the five priorities agreed by Partnership Southwark in September 2024, and this work follows on that agreement. We are developing neighbourhood working in response to National, system and borough level policy and needs. The overall aim of neighbourhood working and Integrated Neighbourhood Teams (INTs) in Southwark is to improve population health outcomes, reduce health inequalities, and develop a more preventative offer by working more closely with local communities.
- Southwark has history of integrated and neighbourhood working, which this programme is building upon, including the CHILDS framework, outlining multi-disciplinary early intervention for children with long term conditions, Intermediate Care/Reablement multi-disciplinary 'patch' teams, Integrated frailty pilot in the Walworth Triangle, The Southwark 2030 strategy and The Southwark Playbook for neighbourhood working.
- Services in Southwark operate across multiple geographical neighbourhoods and delivery models. There is currently no universally agreed model to support a fully integrated approach to service delivery around the resident.
- Southwark has undertaken desk-based research and stakeholder engagement to map boundaries, analyse population size and characteristics, and enabled a clearer understanding of the local landscape and resources. This provides a data-driven foundation for understanding characteristics and assets to support Partnership Southwark's decision on INT delivery footprints.
- The six Place/Borough Teams and their leads worked together and with their local partners to develop a SEL neighbourhood and Integrated Neighbourhood Team (INT) framework. This framework has been built up from local work across the six Places and provides a framework to guide ongoing development of neighbourhoods in southeast London. This document can be found at the end of this pack as an appendix.
    - **The Board is asked to approve the SEL ICS Neighbourhood and INT Framework.**
- Southwark is **proposing to establish 5 INTs,** for the delivery of neighbourhood health, based on the geographical footprints detailed on slide 23
    - **The Board is asked to support the neighbourhood footprint for INTs.**
- We have developed a 12-month roadmap to progress this work, in line with the SEL framework and milestones.
    - **The board is asked to review the roadmap**

High Level Roadmap

To deliver against the SEL-wide ask, Southwark has outlined the following roadmap, which outlines the work that will be done over the next 6-8 months to design, develop, launch and test INTs.

January- March

- Define population needs and services to include in Core INT
- Agreed neighbourhood footprints and started to develop the Southwark INT model
- Outline INT Integrator Functions within the Southwark lens
- Gap analysis from current working and shape high level 12 month Implementation Plan

April- September

- Refine Southwark INT model
- Identify the Southwark integrator
- Engagement and socialisation of INT model and implementation plan, with staff and residents to build momentum and further refine the detailed implementation plan, building on existing examples of neighbourhood working and lessons learnt
- Organisational Development to organise existing staff and services into Teams and build joint visions and ways of working
- Recruitment of team managers to support each INT

October

- INTs launch, under a programme of iterative testing and learning

Southwark INT Programme Board

Southwark established an Integrated Neighbourhood Programme Board to initially oversee the development of a shared vision and codesign a new model of care for INTs in Southwark. The group has been meeting monthly to:

- Design the operating model of Southwark INTs in line with population priorities and needs
- Ensure alignment with local and national healthcare priorities
- Agree a set of outcomes for INTs in Southwark that draw on best evidence about how to measure well-being without compromising our person-centred approach
- Agree the geographical footprints for INTs
- Develop an initial roadmap to get us from where we are now, to our 'end state'
- Drive the programme across the partnership
- Monitor progress and address risks or barriers to delivery

Context

National context

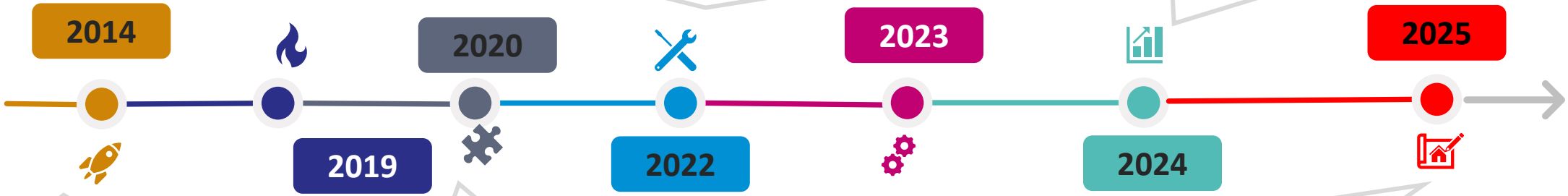
Successive governments have supported initiatives which bring Primary and Community Care closer together, including the development of integrated care and a more place-based approach to how services are organised.

Fuller Stocktake

Stocktake undertaken by Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System and GP on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

NHS 'Shifts'

New government set out 3 'strategic shifts' for the NHS, including 'hospital to community', 'analogue to digital' and 'treatment to prevention'



Long Term Plan

NHS set out a widely supported vision for the future, describing the need for "triple integration" between hospitals and GPs, the NHS and social care, physical and mental health, and kicked off vanguard projects around the country.

COVID

The COVID-19 pandemic accelerated integrated working as health and care leaders joined forces to support people at risk, offer each other mutual aid, and deliver the vaccine programme.

2024 Darzi Report

Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.

Neighbourhood Health Guidelines 2025/26

Recognise the urgent need for radical change in England's health and care delivery, building on existing efforts. Systems must advance consistent, system-wide population health management, anticipating local needs by segmenting populations and using insights to design and deliver care in the most suitable settings.

The formation of Integrated Neighbourhood Teams has been a central movement within the NHS for a number of years and will continue into the foreseeable future.

Case for change

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 responsive to local needs.
- A consistent approach, clear understanding of self care and proactive support available and a strong message that service delivery in partnership with communities is required.
- Recognition that statutory services 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 activity.

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.

South East London Context

In response to the national context and case for change, South East London (SEL) has committed to working in a more integrated way at the neighbourhood level and developing Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of care with the variation required to improve population health and address long-standing inequalities.

Across all Places in SEL, there is a strategic requirement to establish neighbourhood working more formally. This begins with the development of INTs to ensure consistent access to local care while allowing flexibility to address local population health challenges and long-standing inequalities, starting with three initial focus areas, which build upon existing initiatives and address known challenges:

1. 3+ Long Term Conditions
2. Frailty and those approaching end of life
3. Children and complex needs

Across SEL, the initial key priorities for moving this work forward are:

- **Defining neighbourhood geographies:** Each Place must establish geographical boundaries for INTs to enable a "team of teams" approach, ensuring resources can be allocated based on local needs and priorities. This will ultimately support residents in receiving care closer to home.
- **Understanding local population needs:** There is a need to identify and prioritise the differing health and care requirements across various neighbourhoods within each Place.
- **Development of an operating model,** including agreeing a Population Health Management (PHM) approach
- Establishing an **integrator function** to coordinate services,
- **Moving into a test-and-learn phase** to refine and optimise the neighbourhood model in practice.

The SEL Neighbourhood and Integrated Neighbourhood Team (INT) Framework is included in this pack (see appendix) for approval by the Partnership Southwark board.

Local Context

Neighbourhood teams in Southwark are not a new concept. Over the years, various initiatives have aimed to bring together health and care partners to jointly address health inequalities across the borough. There are some excellent examples of integrated working across the Borough today. The development of INTs is an opportunity to build on these successes, identify additional opportunities for further integration, and ultimately to deliver better outcomes for local people.

Examples of existing integrated working in Southwark:

- **CHILDS framework**, outlining multi-disciplinary early intervention for children with long term conditions, hosted by the Evelina at GSTT.
- **Intermediate Care/Reablement multi-disciplinary 'patch' teams**, provided by LBS and GSTT.
- **Integrated frailty pilot** in the Walworth triangle.
- **The Southwark 2030 strategy**, which develops joint objectives between health and local authorities, as well as integrating local VCSEs and assets.
- The **Southwark Playbook** that detailed neighbourhood working at a localised level

Southwark currently has multiple versions of 'neighbourhood' / 'locality' footprints, including those used by Primary Care Networks (PCNs), the local authority, and the Intermediate Care/Reablement service. There is no universally agreed geographical framework to support an integrated service delivery approach.

Additionally, there is a need for a deeper understanding of population needs at a neighbourhood level. Without clearly defined boundaries and a clear view of local health and care priorities, delivering targeted, needs-based services will remain a challenge.

Our ambition for our residents and communities

Our hope is that neighbourhood working and Integrated Neighbourhood teams will reduce health inequalities and improve population health across Southwark.

1. **Easier access to support, when and where it is needed:** People will their story once and experience simplified access to different types of support that responds holistically to their physical and social care needs. People receive care close to or in their own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
2. **Help to stay well for longer:** INTs will provide earlier interventions and access to timely support so that residents stay well and independent for longer. Through accessible information and advice, and easily navigable services, residents will be empowered to manage their health and wellbeing, and to seek preventative support earlier.
3. **Greater input in shaping core services and support:** London is committing to designing neighbourhood services with people, recognising that without community support and leadership, no amount of investment in public services will provide the improvements that our neighbourhoods and services need.
4. **Stronger, more resilient communities:** At the heart of this model is a fundamental shift from hospital to community. Greater investment in local assets (e.g. family hubs, community diagnostic centres) will reduce demand and admissions to hospitals and long-term social care, freeing up capacity to support those with the most urgent or complex needs, those experiencing the greatest inequalities and those living in underserved communities.

The importance of community engagement

Community engagement will be a critical element of the INT model. This 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 and those facing the greatest health inequalities across the borough.

Our approach to defining Southwark's INTs

Establishment of a Programme Board

To steer the development of the Southwark INT model, an INT Programme Board has been established to meet monthly and whose purpose is to oversee the development and implementation of a shared vision and new model of care for Integrated Neighbourhood Teams (INTs) in Southwark.

Objectives

- Agree the geographical footprints of Southwark's INTs
- Design the operating model of INTs in line with population priorities and needs
- Ensure alignment with local and national healthcare priorities
- Develop a roadmap to get Southwark from where it is now, to an agreed 'end state'
- Drive the programme across the partnership to move to this end state
- Monitor progress and address risks or barriers to delivery.

Deliverables

- A detailed model of care for the neighbourhood health service.
- An implementation roadmap, including key milestones, timelines, and resource requirements.
- Stakeholder engagement reports and recommendations capturing progress and learnings.

Membership

Senior professional, clinical and managerial representatives from local health, care and VCSE services, including:

- SEL ICB
- Partnership Southwark
- South Southwark PCN & GP Federation
- North Southwark PCN & GP Federation
- Southwark Council
- GSTT
- King's College Hospital
- SLaM
- Voluntary and Community Sector
- Local Medical Committee

Other specialists will be invited to join the Project Board as and when necessary.

The project board will be chaired by Darren Summers and Louise Dark.

Remit and responsibilities

- Attend meetings and actively contribute to discussions.
- Ensure the programme remains aligned with organisational and community priorities.
- Review and approve key deliverables.

Governance and accountability

The Board is accountable to Partnership Southwark.

Methodology

The development of the Southwark INT model through the INT Programme Board meetings has followed a multi-layered approach, integrating data analysis, stakeholder engagement, and mapping exercises. This methodology ensured that proposed geographies aligned, as far as possible, with population health needs and existing service infrastructure, creating a data-driven foundation for defining neighbourhood delivery footprints and target populations.

Data Analysis & Mapping

Analysis of service footprints and population health needs to inform potential neighbourhood footprints. Key activities included:

- **Desktop review:** Examining reports and strategic frameworks to ensure alignment with national and local priorities.
- **Asset mapping**: Identifying primary care estates, community hubs, and voluntary sector organisations as potential service points.
- **Data-driven health profiling:** Classifying neighbourhoods based on indicators such as income deprivation, mortality rates, and prevalence of LTCs highlighting areas needing intervention.
- **Comparative needs assessment**: Using percentage-based analysis to measure neighbourhood deviations from borough averages, enabling identification of high-risk areas.

Stakeholder engagement

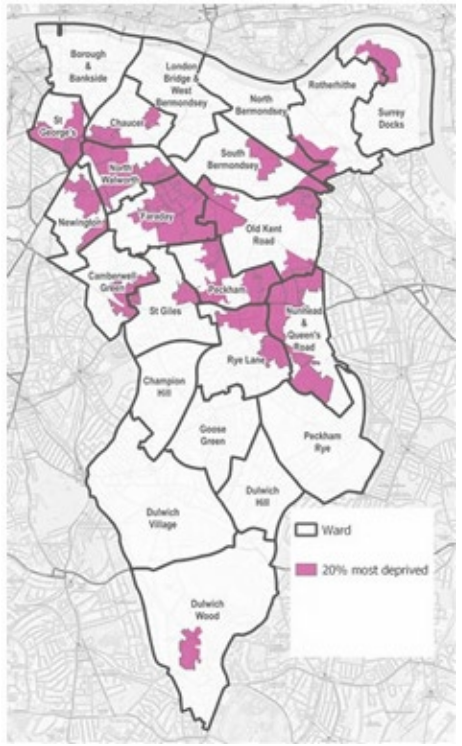
In addition to engaging stakeholder via the Southwark INT Programme Board, we are also conducting targeted engagement via interviews with key stakeholders. These engagements provided strategic and operational insights into effective neighbourhood working in Southwark.

Engagement has been carried out with PCN CDs and representatives from the GP federations, public health, acute and community trusts, and VCFSE organisations. Additional engagement is being planned with social care professionals and the mental health trust. Key lines of enquiry included:

- **Service access and interaction:** Understanding how residents navigate and utilise services across different neighbourhoods.
- **Barriers to delivery:** Identifying challenges in service coordination and cross-geographical collaboration.
- **Opportunities for integration:** Exploring improvements in service pathways, multidisciplinary working, and population-based care.
- **Alignment with infrastructure:** Ensuring neighbourhood models fit within existing estates and workforce structures.

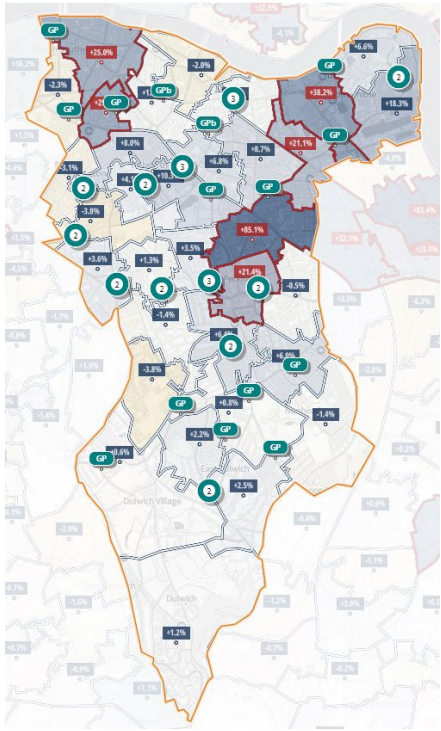
Need is not uniform across Southwark

2019 Index of Multiple Deprivation quintiles for Southwark LSOAs



This map highlights the areas of the borough that fall within the 20% most disadvantaged nationally. These are concentrated across the central and northern parts of Southwark. Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in these neighbourhoods. In particular, communities in Faraday and Peckham wards. However, it is important to acknowledge that pockets of disadvantage also exist within areas of affluence, such as the Kingswood estate in Dulwich Wood and Downtown estate in Surrey Docks.

GLA population projection to 2030.



Significant increases in population are expected to be limited to the North of the region by 2030.

In the main, this can be mapped to areas found to have the higher levels of deprivation.

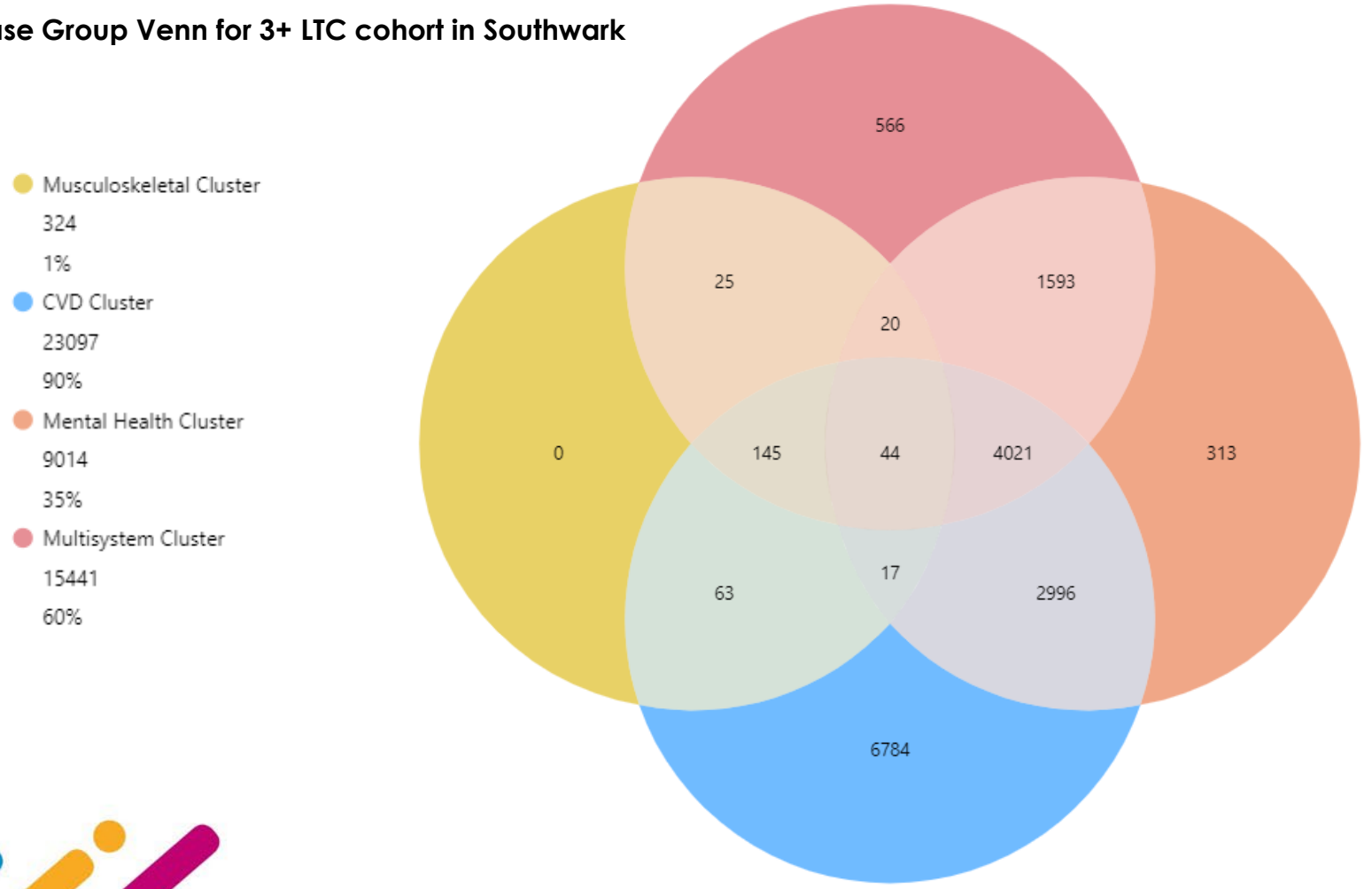
Comparatively the areas to the South of the borough show significantly less growth in the period up to 2030.

As of June 2024….

- 88,979 Southwark residents (25%) reside in the lowest 2 deprivation deciles. Relative to Southwark's population, Black ethnic residents disproportionately live in our most disadvantaged neighbourhoods.
- 12% of Southwark's Core20 population have hypertension, compared with 11% of the total population. The diagnosed hypertension prevalence in Southwark's Core20 population is disproportionately higher for non-White residents and those aged over 39 yr
- 5.5% (approx. 20,000) people in Southwark have been diagnosed with diabetes. The diagnosed prevalence of diabetes is disproportionately higher for Black residents and residents residing in areas of highest socio-economic disadvantage (IMD 1-3).

Often those with needs will require coordinated care across multiple teams

Disease Group Venn for 3+ LTC cohort in Southwark



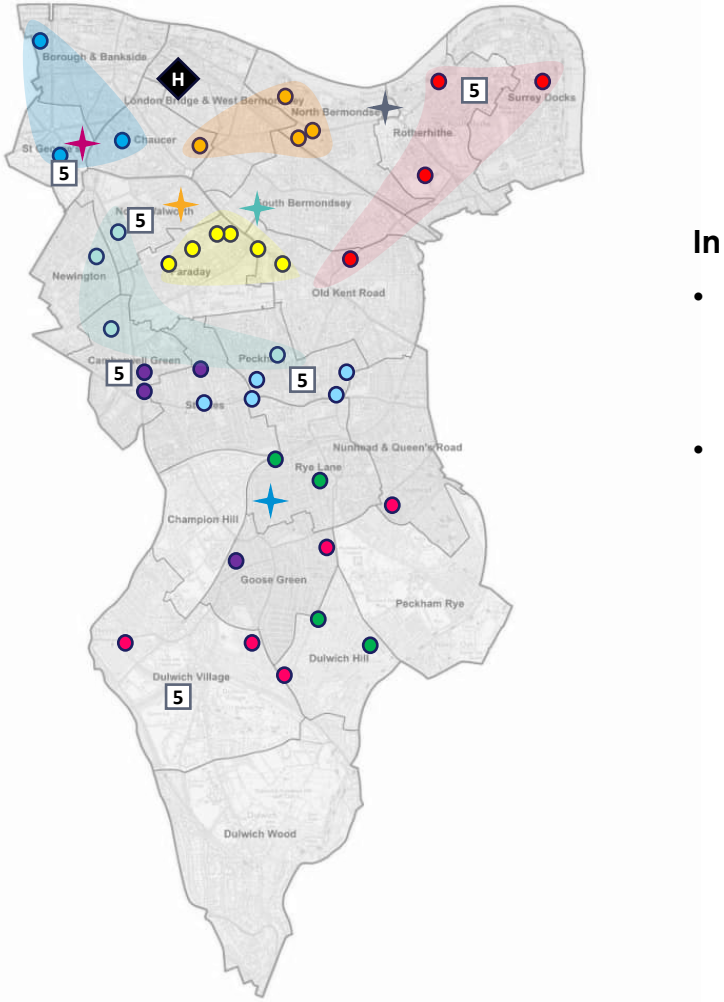
As illustrated by this diagram, it is uncommon for individuals to be affected by only one condition. Rather, there is a significant overlap between clusters, indicating that many individuals suffer from two, three, or even four conditions concurrently. For example:

- Only 313 individuals, around 4%, have isolated mental health conditions. Most have comorbidities, with 45% (4,091) affected by both CVD and Multisystem cluster,18% (1,593) overlapping with Multisystem conditions
- The CVD Cluster, comprising 22,097 individuals, shows a substantial overlap with other clusters. This includes 2,996 individuals in the Mental Health Cluster
- Musculoskeletal Cluster includes 324 individuals, all with comorbidities involving other conditions. Indicating MSK issues are consistently part of broader, complex health profiles

Source: South East London Integrated Care System: Long Term Conditions Dashboard
Note: All data presented is taken from GP systems, and could be enriched by triangulating social care, broader local authority and secondary care data

There are several assets we can built upon to support these populations across Southwark

- North PCN – Rotherhithe
- North PCN – Bermondsey
- North PCN – Walworth triangle
- North PCN – Borough
- North PCN – South Walworth
- South PCN – Camberwell
- South PCN – Peckham
- South PCN – Dulwich & Nunhead Villages
- South PCN – Dulwich
- Hospital
- Elephant Park Health Hub*
- Harold Moody Health Centre
- Tessa Jowell Health Centre
- Old Kent Road Development*
- Canada Water Health Hub*
- Vital 5 Health Kiosk



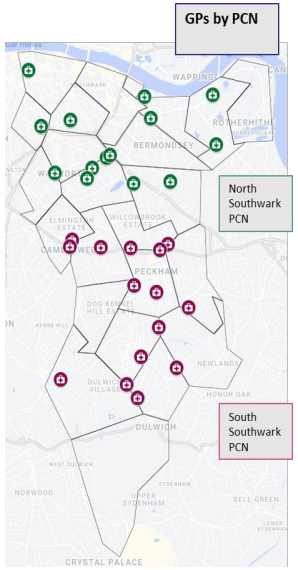
In addition to these assets

- There are a wealth of VCFSE organisations across the borough, some providing hyperlocal services, others part borough and others whole borough
- Further work needs to be done within the INT programme board to identify potential estates options that might serve as neighbourhood hubs (for co-location and access to services)

*Planned developments.

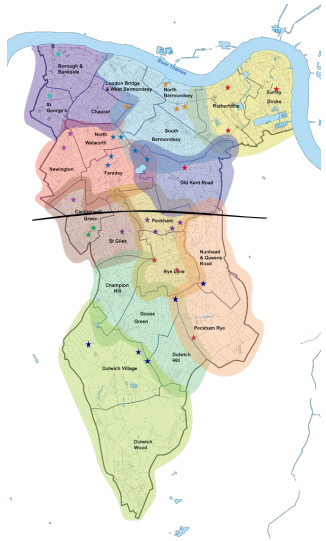
There are a variety of existing ‘neighbourhood' / 'locality’ groupings being used across Southwark

10 Local Authority Neighbourhoods

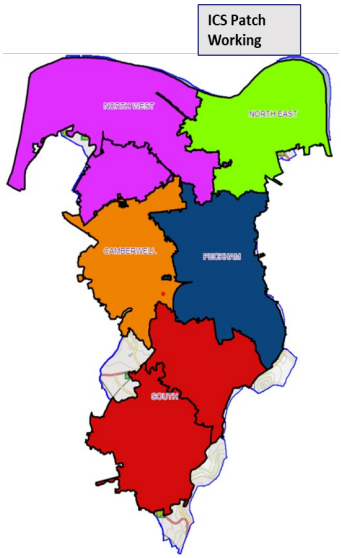


2 PCNs - North and South

9 PCN neighbourhoods (5 in North, 4 in South)



SLaM North/South (above and below line)



GSTT / LBS intermediate care MDT patches

In addition to these footprints

- Community providers operate locality models with e.g. 5 intermediate care/reablement ‘patches’ provided by GSTT and LBS, and 2 locality services provided by SLAM.

In addition to data analysis, we have been engaging stakeholders across the system

- The INT programme board has been meeting on a monthly basis since December, to oversee the development of a shared vision and new model of care for INTs in Southwark. Following on from the initial design and engagement phase, the Terms of Reference for the board will be reviewed to enable a shift in focus towards implementation and reporting directly into the Partnership Southwark board.
- The INT programme board includes representatives from:
    - Southwark Council, including children and adult's social care and public health
    - Guy's and St Thomas' NHS Foundation Trust
    - South Southwark GP Federation
    - King's College Hospital NHS Foundation Trust
    - VCFSE organisations, including Community Southwark and South London Mission
    - Partnership Southwark, including GP leads
    - North Southwark GP Federation
    - South London and Maudsley NHS Foundation Trust
- In addition to engagement through the Programme Board, one to one and group interviews have been conducted with members of the board and additional stakeholders from the above organisations
- **In the next phase, we recognise the need to engage with residents and community groups to understand their needs in more detail as part of further developing the INT model and implementation plan**

What we have learnt through our engagement

Learning from previous work:

- **Data and evidence led planning** has been a critical enabler in identifying local service needs and informing care strategies in South Southwark. Learning from work such as the Walworth Frailty Pilot and other Population Health Management approaches will ensure INTs target the right populations with proactive, joined-up interventions
- **Governance:** Challenges have hindered past integration efforts—variability in leadership structures has created inconsistencies, making it difficult to establish clear lines of accountability. Ensuring INTs are embedded in a streamlined governance model will help sustain impact.
- **Place-based knowledge:** Experienced GPs highlight that past efforts have sometimes been too top-down. Future success will rely on empowering local teams and ensuring they have autonomy to shape services based on the needs of their communities.
- **Locally driven initiatives:** Neighbourhood-based working has shown promise, particularly within local councils. However, past efforts have sometimes been undermined by changes in governance structures and short-term funding cycles. INTs can learn from these lessons by ensuring clear accountability and sustained commitment across all partners.

Opportunities to improve how we deliver services:

- **Data sharing and PHM** can be major enablers, and a more joined-up approach to data will support early intervention and better identification of at-risk populations. INTs will be able to use PHM insights to target joint interventions more effectively and target specific populations where need is the greatest.
- **Workforce integration is improving,** with examples like the Walworth frailty pilot providing a model for better workforce alignment. Expanding this co-location and shared service delivery will help embed INTs more effectively.
- **VCSE partnerships** offer untapped potential, but INTs will need to embed structured collaboration with the voluntary sector to effectively enhance service accessibility and impact, particularly in preventative care and early intervention. This collaboration will need to be appropriately resourced and supported.

What will need to be developed

Accountability and Decision Making: Decision-making structures remain fragmented, with a lack of clarity on where INTs fit within existing governance. Variability in leadership roles across different care teams and sectors creates inconsistency, making it difficult to embed a standardised approach. Greater alignment is required across NHS, local authority, and community-led structures to ensure effective governance.

Funding: Existing financial structures create inconsistencies in resource allocation, particularly across different care teams with varied geographical scopes. More strategic coordination is needed to ensure funding models support integrated neighbourhood teams effectively. Additionally, there will need to be an agreed approach to collating resource for the integrator to allow it to successfully operate across partner organisations.

VCSE Collaboration: The role of VCSE organisations in delivering community-based care is recognised but not fully leveraged. There is an opportunity to use local knowledge and data to shape service design and delivery. More structured partnerships with VCSEs could enhance service accessibility and impact and the development of these partnerships will be a key element in the next stage of INT development.

Estates and Co-location: Estate planning needs to be more closely linked to service integration efforts, ensuring physical spaces support multidisciplinary working, especially for the Core INTs in each neighbourhood.

Resident and Staff Engagement: We have not had an opportunity to engage with residents and staff directly around the set up or running of the INTs. However, we have been closely utilising outputs from the wider engagement that has been conducted as part of the Southward 2030 work and have agreed to engage residents as part of the planned wider council engagement activity in the summer.

These elements will be taken forward by the current INT Programme Board, as it transitions into an INT Implementation Board after a review and an update of its Terms of Reference. This Implementation Board will continue to report directly into the Partnership Board.

Our principles for future engagement with staff and communities

Aligning engagement efforts: We need to ensure we are maximising opportunities to align engagement so that we are not asking residents and staff the same thing twice across neighbourhoods, organisations and teams. There is an opportunity to join engagement around INTs with broader engagement around the development of council neighbourhoods.

Staff engagement: We need to clearly community what this means for staff and teams and ensure that we are listening to this perspective. A vital part of the INT Implementation Plan will be ensuring that staff deployed into the INT teams are actively engaged and have the support they need to adopt the change.

Clarity around what we are and are not bringing to resident engagement session: When engaging residents, we need to be clear what we are and are not asking them, and what decisions have and have not been made. For example, residents will not have any influence over the neighbourhood footprint options (although analysis has been done to ensure these align with natural communities as far as possible), however we can engage residents on their local needs and priorities. Setting these boundaries will help to build trust with residents during engagement.

Ensuring broad engagement: We will need to ensure that we are reaching out to communities that we don't always hear from, and that we are not just listening to residents who are already engaged. This can be through working closely with our VCSF partners to ensure our feedback is as broad as the residents we are looking to support.

Resident Insight Survey: We should consider how we can use the Resident Insight Survey as a tool for engagement, as well as other existing tools and forums to make use of already established routes for gaining feedback.

Southwark Neighbourhoods

Our recommendation for our INT Neighbourhoods: For agreement

The INT programme board spent time discussing what the best footprints for the Neighbourhood Health and INTs would be. It considered data that showed assets and resources across the borough, existing neighbourhood footprints from different services, demographic information, including health inequalities, current population size and projected growth and prevalence of different health conditions. Additional stakeholder engagement gave stakeholders a chance to share their views in more detail, reflecting the strengths and learning from existing integrated working and exploring potential challenges and opportunities.

Following on from these activities, we are recommending the development of a five neighbourhood INT model.

- This model aligns closest to development of the democratically agreed neighbourhoods that are being implemented by Southwark Council. The five neighbourhood INT footprint is better positioned to maximise opportunities for broader public sector integration in the future
- Alignment with natural communities, this option splits Camberwell and Peckham across two neighbourhoods, better aligning to people's ties to these distinct areas.
- The five proposed neighbourhoods are well positioned to respond to expected population growth (specifically around the Old Kent Road, Canada Water and Borough & Bankside developments).
- Ahead of the set-up of the INTs, significant work will be required to align current practices across partner organisations to the new models.
- The INTs will likely require iterative development over the course of the year, as new teams, relationships and services are formed.

Five neighbourhoods

	Population*
Borough	47,300
Bermondsey & Rotherhithe	59,800
Camberwell & Walworth	73,100
Peckham & Nunhead	74,100
Dulwich	53,300
	307,600

**Population estimates sourced from ONS Census 2021*

The Challenges for Primary Care

General practice and associated primary care service have long-standing structures that has enabled relationships and collaborative working to be built between practices. The current structure of two Primary Care Networks (PCN) – one in the north and one in the south of the borough – aligned with two GP Federations, has been in place for the past decade. Over this period nine PCN neighbourhoods have been established, and integrated working between practices and with community services has advanced with and for a number of clinical and care pathways and population groups.

Feedback from General Practice, the Primary Care Networks and GP Federations, and from the Local Medical Committee, has detailed concern that establishing five integrated neighbourhood teams would cut across existing organisational boundaries, could undermine established working relationships, and would require significant organisational change. Neighbourhood boundaries would mean PCNs and Federations 'sharing' responsibilities and working in partnership in two of the five neighbourhoods. A number of specific challenges and risks have been raised:

1. There is a risk that the organisational change required to align to five neighbourhoods will hinder INT development and the achievement of its aims and objectives. We need to ensure that the GP Federations, PCNs and GP practices have the support they need to
    a. establish new structures as appropriate,
    b. develop workforce plans,
    c. build working relationships and member engagement,
    d. develop network agreements and data sharing agreements,
    e. address other operational concerns.
2. The proposed boundaries split multiple practice providers across more than one neighbourhood. Some neighbourhoods have a significantly higher number of GP practices in their catchment than others. We will need to work through and confirm which practices best fit into which neighbourhoods based on, for example, where their registered list is resident rather than exact geographical location.
3. Contractual implications of the PCN Directed Enhanced Services (DES) and any forthcoming contractual requirements in relation to INTs need to be considered.

The ICB and partners will continue to work with and resource the PCNs and Federations and their member practices, and the LMC, to determine the support required to address these and other emerging challenges.

Defining our INT Neighbourhood boundaries: our principles

We have identified a set of Southwark Geography Principles to inform the identification of neighbourhood footprints in Southwark. These build on SEL's proposed Geography Principles which are shown in the left-hand column below.

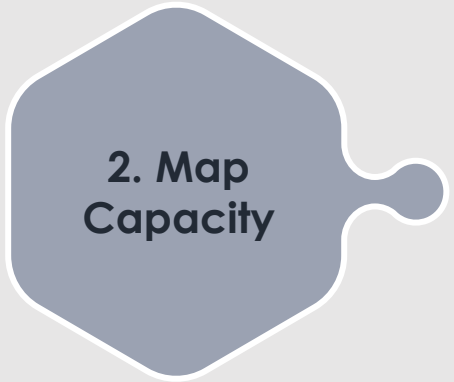
SEL principle	What does this look like in Southwark?
Build on existing structures, networks and local assets	It will be important to work around what already exists in the Borough. Southwark neighbourhoods will likely adopt natural boundaries, with existing networks adapting to support integrated working. Further asset mapping, including of the VCFSE footprint and other existing structures, will ensure that existing opportunities (including physical hubs) are maximised.
Align footprints to appropriate population sizes	Southwark, with a population of just over 350,000, has variations in population density across the borough. Further analysis of need, capacity and population density is needed at a neighbourhood level to ensure INTs have appropriate footprints, however these are likely to align with current definitions of neighbourhoods in use.
Centre around populations and natural communities	In Southwark, people's day-to-day experiences of 'community' are generally smaller than current delineations of neighbourhoods, PCNs and Wards. Southwark's INT model will need to explore ways to reach people that align with their 'natural communities'. Community engagement will be important for ensuring that initiatives reflect people's experience of community, are inclusive and culturally aware.
Enable not hinder joint working	There are already a variety of well-established neighbourhood footprints across Southwark that will need to align with and support INT footprints. In most cases the various footprints map onto each other well. Further alignment should not be dependent on complex restructurings (particularly given that this has recently taken place in acute settings) but will require practical considerations that could impact ways of working for staff delivering services. Southwark also has a high number of residents who are registered with GPs in Lambeth, meaning that joint working may need to extend beyond borough boundaries to ensure vulnerable out-of-boundary patients get the support they need.
Adapt footprints based on specific challenges	Southwark has greater deprivation in the North West, with additional pockets of deprivation in the North East and East of the Borough. Tighter INT boundaries and additional resource will need to be allocated accordingly to prevent any exacerbation in inequalities. Further analysis of population density heatmaps, population complexity heatmaps and social/temporary housing data should inform the geographical boundaries of INTs in the Borough.

These principles are underpinned by a red line that INT footprints in Southwark will not dissect Council Wards or neighbourhoods. This is to ensure alignment between health and care models.

Defining our INT Neighbourhood boundaries: our approach

Working from these Geography Principles, the development of Southwark INT footprint options then used the following three-step process, integrating data analysis, stakeholder engagement, and mapping exercises, to identify possible solutions.

Identifying viable INT geographies in Southwark



1. Population Health

Identify who is in each area across the life cycle – where are the areas that have higher levels of need where more targeted support might be required?

2. Asset mapping

Understand what is available to each INT and what might need to be upscaled - how are people interacting with health and care services in our neighbourhoods today? What resources do we already have that we can build on?

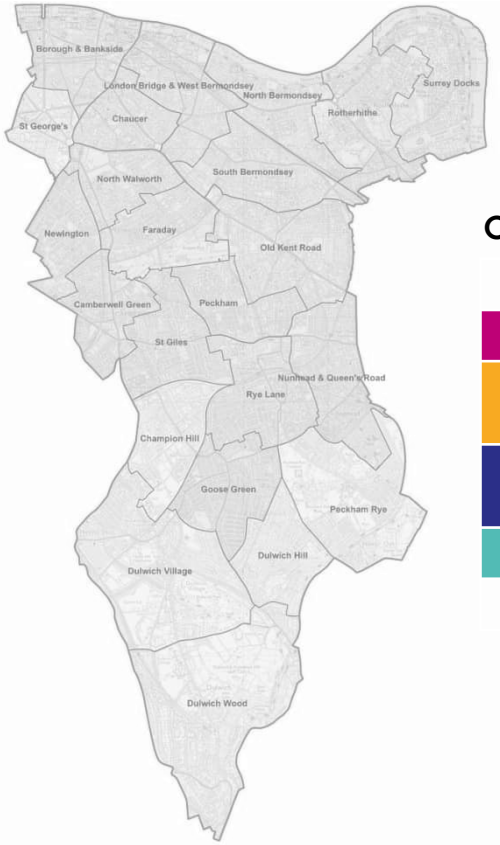
3. Geography

Define INT boundaries that will be able to serve the needs of the local populations – where does it make sense for multi-disciplinary working? Will local people resonate with the defined neighbourhood?

INT Neighbourhood options in Southwark

Following this process, the INT Programme Board considered two potential options for INT footprints.

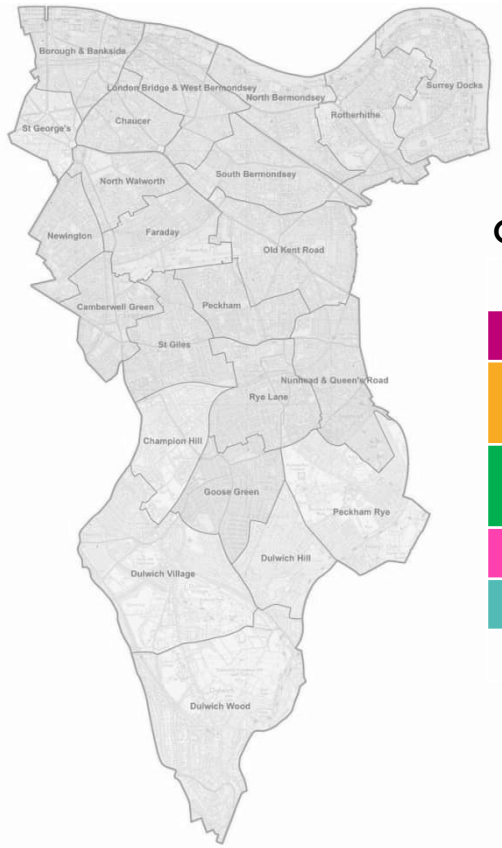
Opt. 1



Option 1 – Four neighbourhoods

	Population
Borough & Walworth	89,000
Bermondsey & Rotherhithe	78,800
Camberwell, Peckham & Nunhead	86,500
Dulwich	53,300
	307,600

Opt. 2



Option 2 – Five neighbourhoods

	Population
Borough	47,300
Bermondsey & Rotherhithe	59,800
Camberwell & Walworth	73,100
Peckham & Nunhead	74,100
Dulwich	53,300
	307,600

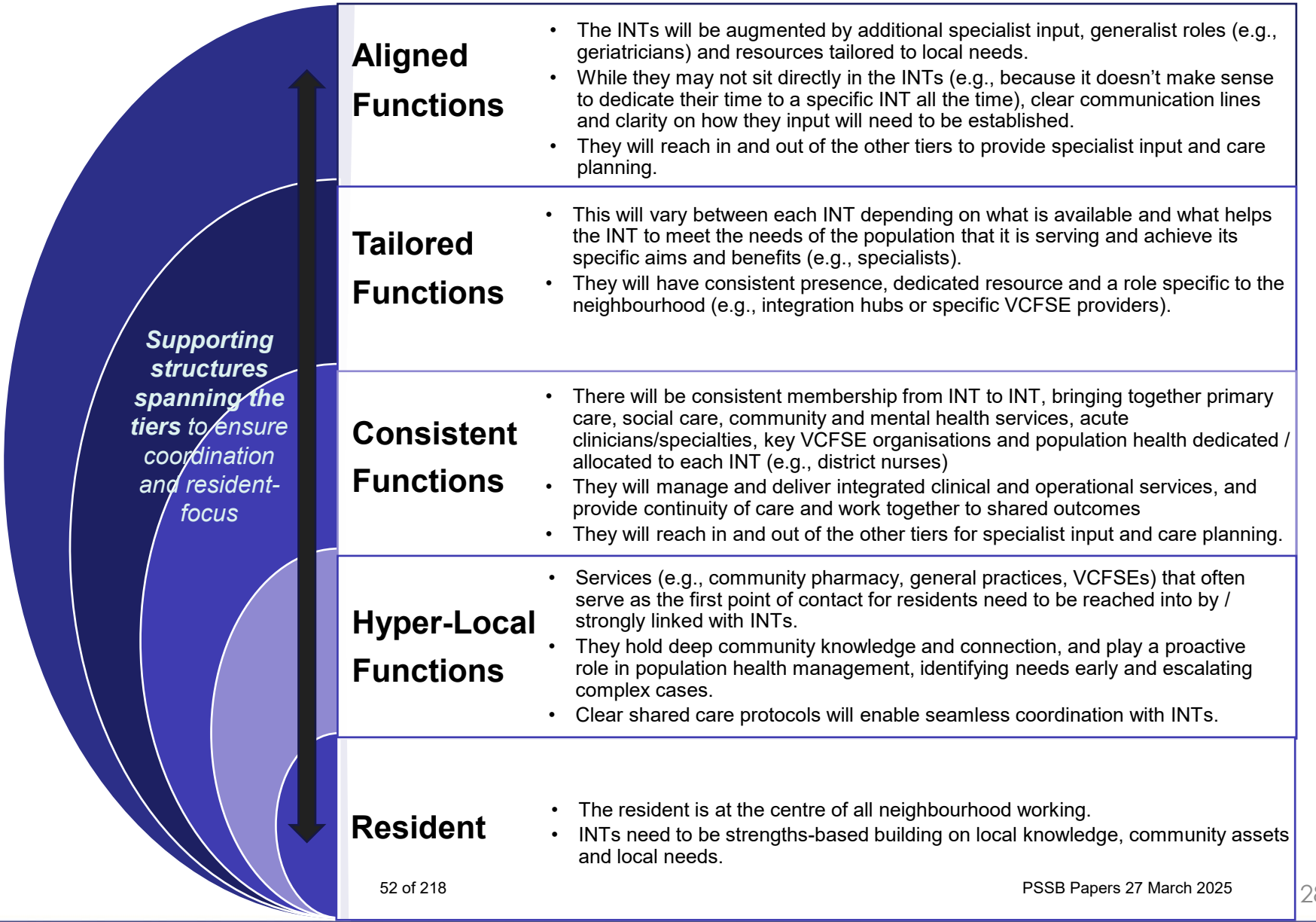
**Population estimates sourced from ONS Census 2021*

Southwark's INT model

Aligning with the SEL model

The emerging Southwark model aligns with the wider SEL INT model, which aims to:

- **Enable local variation while maintaining a consistent foundation across all neighbourhoods in SEL.** Investment levels will vary depending on each neighbourhood's starting position and specific needs.
- **Organise INTs using a tiered system**, acknowledging that different functions and services are delivered to residents a range of different scales.
- **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



What a Southwark INT looks like

Southwark is currently in the design phase in developing its INT operating model. The emerging model (Figure 1) works on the same assumptions presented in the SEL model, including the use of a tiered system, which acknowledges that different functions and services are delivered to residents at a range of different scales. This model will continue to be developed up until the end of March as it is tested against the local context of population health, demand and capacity.

What a Southwark INT does

In Southwark, all INTs will identify unmet need in their neighbourhood and deliver innovative, integrated solutions to meet these needs, including:

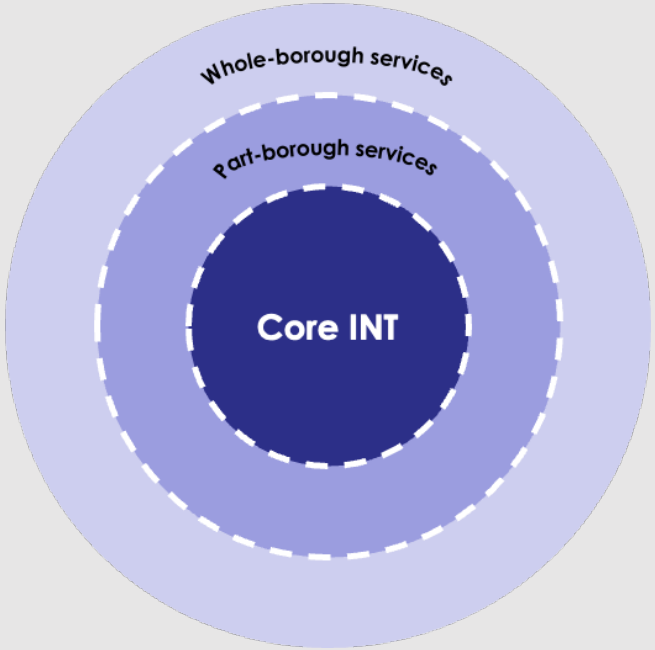
1. Bringing together multi-disciplinary teams to provide holistic, joined-up care closer to home for people with complex needs and multiple Long Term Conditions (LTCs)
2. Conducting outreach initiatives that focus on prevention and early intervention, prioritising populations experiencing the greatest levels of health inequalities and underserved communities.

Who a Core INT in Southwark includes

Each INT will have a standard set of professionals, services and organisations who will deliver the core offer. This will likely include GPs and practice nurses; social prescribers; community pharmacists; care coordinators/navigators; mental health workers; neighbourhood nurses; Intermediate Care Teams; social workers; occupational therapists; representatives from housing/benefits teams; VCFSE representatives; community champions or representatives from patient reference groups; and specialists or access to specialists identified from population health needs (e.g. Frailty Consultants, Dieticians, Cardiologists, Respiratory Consultants).

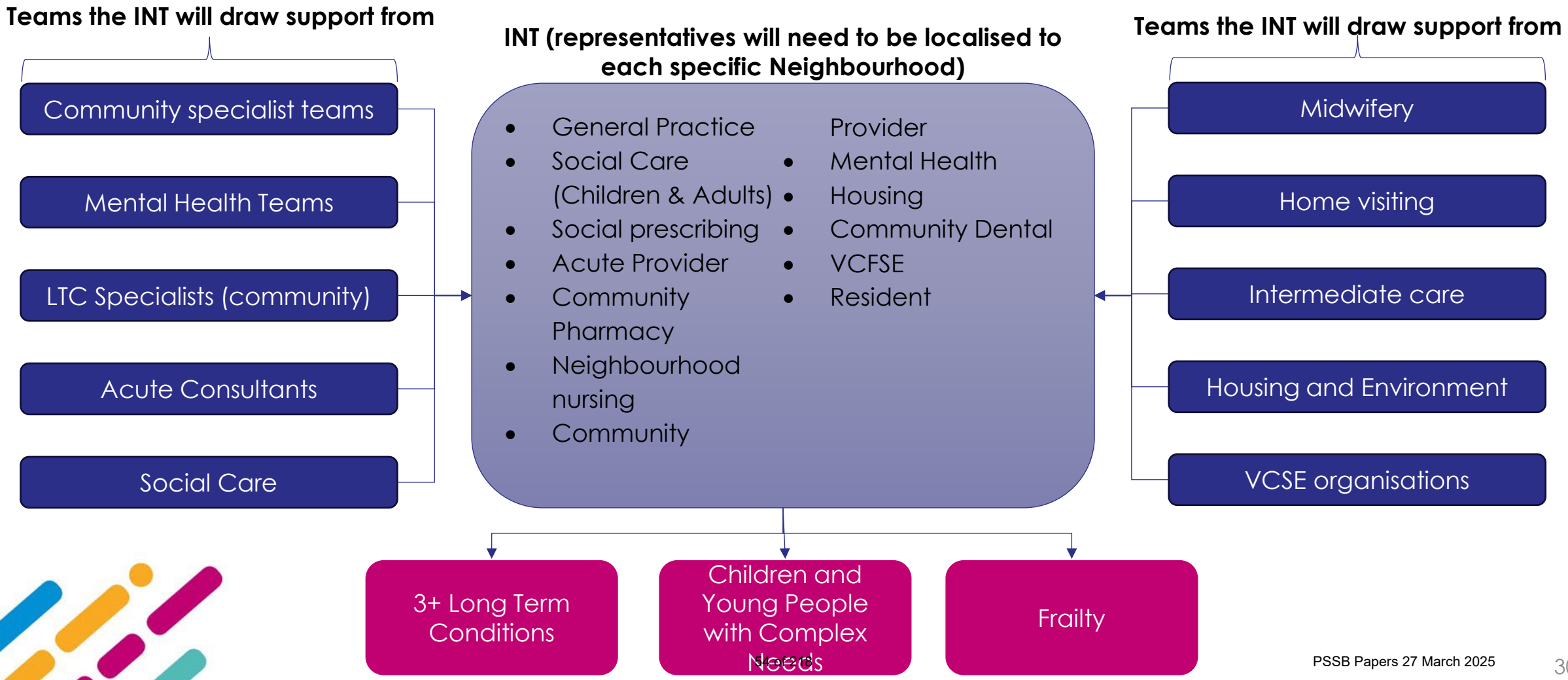
Everyone in the Core INT team will have a good understanding of the services that exist in the system so that they can signpost proactively, with care coordinators responsible for delivering consistency and relationship-based care.

Figure 1: Southwark's emerging Neighbourhood Model



What this might look like in practice: example model

The exact make-up of each INT will be tailored to specific need in that neighbourhood. All members of the Core INT should also have generalist skills and a clear accountability and risk management framework that provides the right level of autonomy and clinical supervision. The Core INT will draw on wider support from part-borough, whole-borough or hyper-specialised teams as needed.



Using Dulwich as an example, an initial working group with Programme board members talked through how INTs could work in practice

Population

Dulwich has a population of approximately 53,000 with a predominantly White demographic (61%), followed by 15% Black. The population is evenly split by gender and has a balanced age distribution, with 21% under 18 and 43% aged 40+. While **1,357** residents live in highly deprived areas, most fall within middle deprivation bands. These demographics highlight the need for inclusive services across all age groups.

LTC Health and Care Needs

Using data from sources pulled in from ward, practice and PCN levels, we can start to build a picture of need across Dulwich

Dulwich has a higher proportion of population vs Southwark in both the Under 14 and over 60 brackets and there are 12,600 under 20s and 5,700 over 65s in the area.

Overall, Dulwich has a significantly lower rate of Diabetes vs Southwark, but Dulwich Wood and Champion Hill show a higher-than-expected prevalence, with c.1000 people affected in these areas. This also correlates to these two areas having the largest non-White populations in Southwark.

We can predict that most social care in Dulwich is self funded, given that much of the population is amongst the least deprived quintiles. This means that overall, much of the social care support needed will be advice and signposting.

Dulwich Wood shows a significantly higher rate of hypertension vs the rest of Southwark, affecting c.1,240 people, of the c 5490 across Dulwich as a whole.

Nearly half of MSK cases presented in South Southwark involve both cardiovascular disease and multisystem conditions. There are c. 6,360 individuals in Dulwich with MSK, meaning there are potentially 2,989 individuals who also have CVD and multisystem conditions.

While Dulwich overall has lower rates of severe mental illness than Southwark, depression rates are highest in Goose Green (c. 1,660) and Dulwich Hill (c. 1,160). In South Southwark overall, 34% of individuals with mental health conditions also have cardiovascular disease. This would mean that in Dulwich, we can predict that around 3,748 people would have similar co-morbidities

Who might be involved in tackling a specific problem in Dulwich?

Using the data as a guide, we know that a core issue that faces the residents of Dulwich is higher level of hypertension rates, especially in Dulwich wood. However, as we know that CVD issues often co-present with other conditions, the reduction of hypertension rates in the 3+ LTC cohort in Dulwich might become a mission that the Dulwich Core INT will look to solve, and they might draw in resource in the following way:

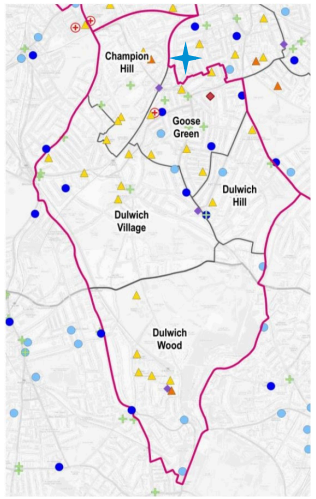
Dulwich Core INT

The Core INT will act to draw in and coordinate wider teams

King's Acute Hypertension Specialist/Cardiologist	Providing a specialist view on hypertension prevention and treatment
King's Acute Renal and Diabetes Specialists	In the 3+ LTC population, there is often an overlap between hypertension, and these conditions
Minority Ethnicity focused VCSE Groups	Core 20 Reviews shows that there is a disproportionate prevalence of hypertension in ME populations
British Heart Foundation (or similar VCSE)	Specialist VCSE groups provide advice and guidance on the risks, causes and management of hypertension
SLAM	Data tells us that there is a non-insignificant overlap between MH issues and hypertension, especially in certain populations
Adult Social Workers and Case Managers	Middling deprivation levels mean that more people are likely to pay for social care, but will need advice and guidance services

Examples of local assets in Dulwich we can utilise:

- The **Health Kiosk at Dulwich Library** provides free five-minute health checks
- **Dulwich Leisure Centre** provides health and wellness activities for residents.
- The **Tessa Jowell Health Centre** is located just outside of the Dulwich neighbourhood, but could provide services to those in the north of the neighbourhood, or act as a co-location space for the core INT.
- There are strong **University of the Third Age (U3A) groups** in Dulwich, which provide a range of activities for people who are retired or no longer in full-time work.
- **The Dulwich Park Runners** help people stay active.



- GP Practices
- Care homes
- NHS Hospitals
- Pharmacies
- Schools
- Children and family centres
- Leisure centres
- Libraries
- Tessa Jowell Health Centre

SEL: initial integrator functions

Why is this important? We recognise that Place will be the key enabling layer for developing neighbourhood working and INTs. 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.

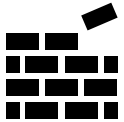
The Integrator for Southwark will be determined by a process that is currently being designed at a London-wide and SEL level. This process will be dependent on the finalisation of the integrator functions. This phase is about feeding into the Integrator Functions.

What elements should feed into the Integrator

Working with the INT Programme Board, some core elements were raised that will needed to be considered during the specification development and delivery of the integrator to ensure that it effectively supports the running of the INTs.

Data sharing: We will need to ensure that the solution offers all relevant partners the right level of access to data, and consistency in the way data and information is recorded. To do this, we can learn from the CYP data sharing agreements for the CHILDS programme. The core actions and steps needed to conduct this is known, however the effort and time needed should not be underestimated.

Asset and resource mapping: The INTs will need a live view of assets and resources available across the system, and the integrator will need to develop a methodology to ensure that this view is kept up to date and is as comprehensive as possible.



One public estates: The integrator will need to ensure that the system is maximising the use of local assets, including buildings, and not reserving the use of these for a small number of services. As a partnership, we will need to develop principles to ensure we are making best use of the spaces we have available as a collective.

Shared responsibility and a partnership approach: the integrator role cannot be about 'outsourcing' responsibility, all the integrator functions depend on positive, committed partnership working towards a singular mission.

To take these elements forward, we will be defining the 'how' for each integrator function and the governance structures needed to ensure the integrator can fulfil these functions effectively.

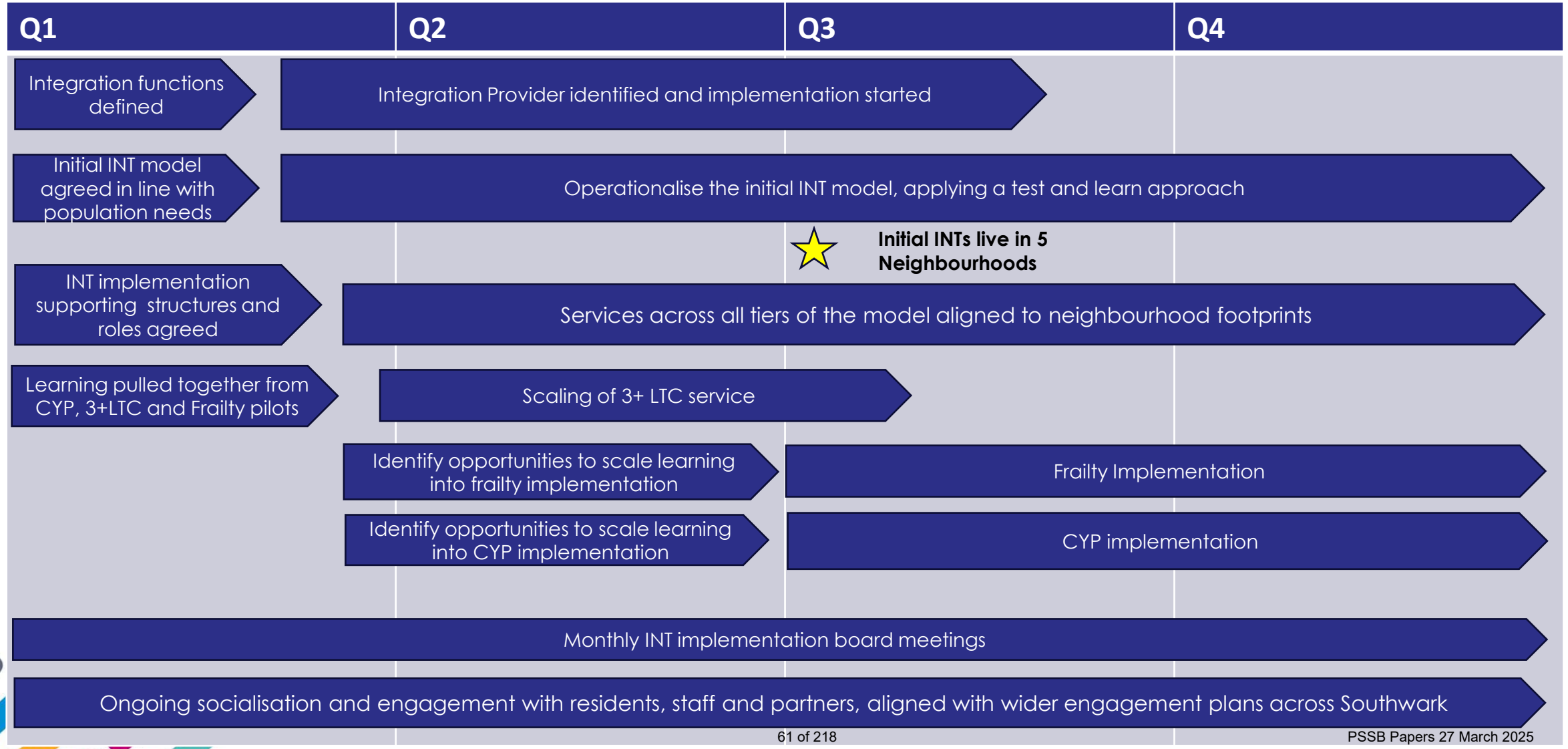
Initial Implementation Plan: Making INTs and Neighbourhood working a reality

Next Steps

There are some immediate steps and opportunities that we will want to take forward over the next three months that will build a foundation for the longer-term work with the INTs.

- ☑ Finalise the integration functions needed to support the implementation of INTs and neighbourhood working
- ☑ Identify and develop solutions to 'interface issues' that have been affecting working relationships and processes between partner organisations that will encourage trusts and a set of commitments to the INT model. This includes quick wins such as providing primary care with discharge letters from intermediate care teams.
- ☑ Finalise the INT model for Southwark to meet local population needs, in line with the South East London Framework and emerging regional and national guidance.
- ☑ Establish the supporting structures needed to drive this work forward across Southwark.
- ☑ Agree the approach to appointing an integrator, linking into the SEL process and mirroring this plan in Southwark. Once the integrator is established, Southwark will appoint INT managers.
- ☑ Pull together the learning from existing initiatives and pilots, including the Walworth Triangle Frailty Pilot, 3+LTC service and CHILDS model and identify opportunities for the neighbourhoods to adapt these models as part of INT and neighbourhood health delivery.
- ☑ Develop a detailed implementation plan for the SEL 3+ LTC framework via neighbourhood working, identifying an initial set of LTC clusters to target and selecting the most appropriate neighbourhood to begin work based on established relationships and analytics.

Southwark's 12-month roadmap for implementing INTs: for review



Appendix

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

South East London Integrated Care System

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.

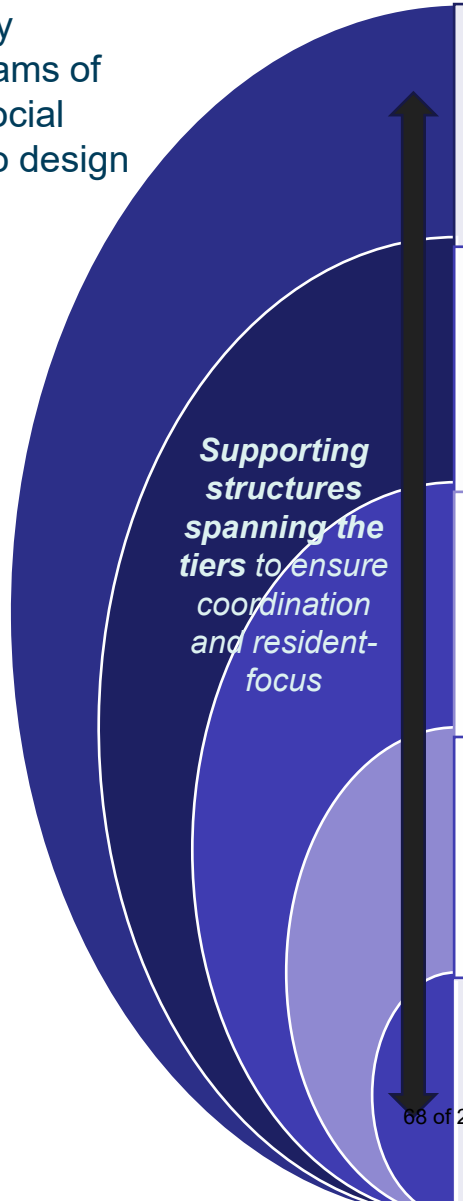
(see p.5 for further detail)

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

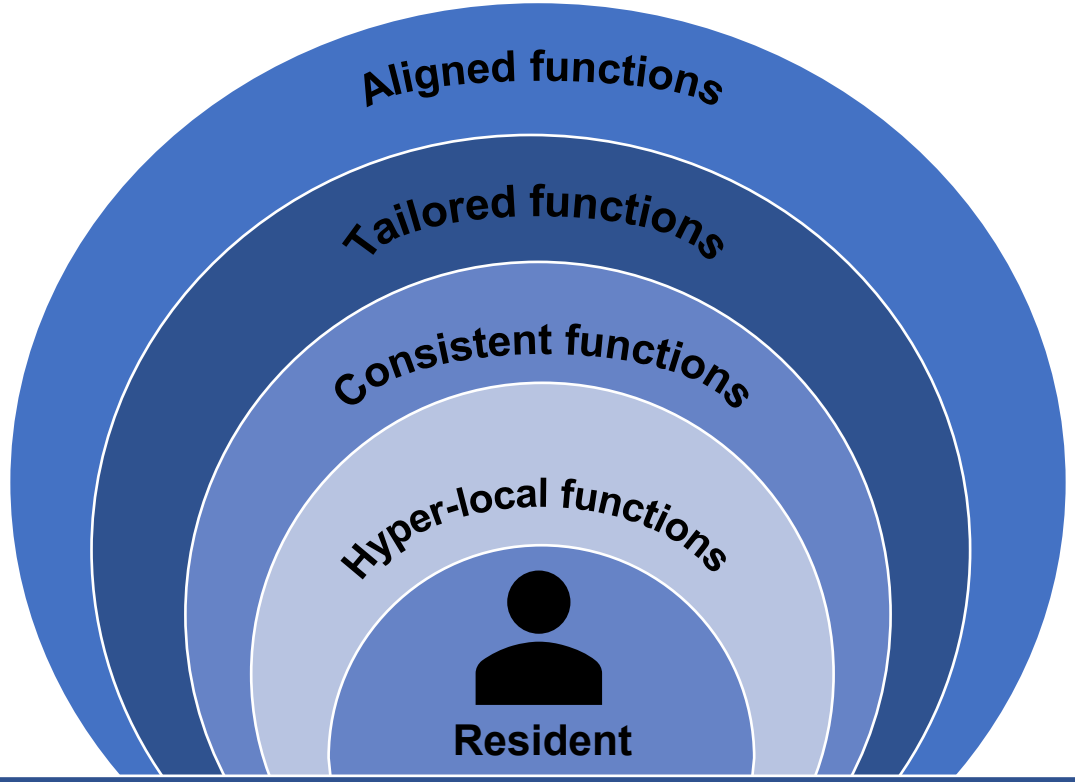
NHS South East London

INT delivery framework

Components of our SEL INT Framework

South East London Integrated Care System

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)

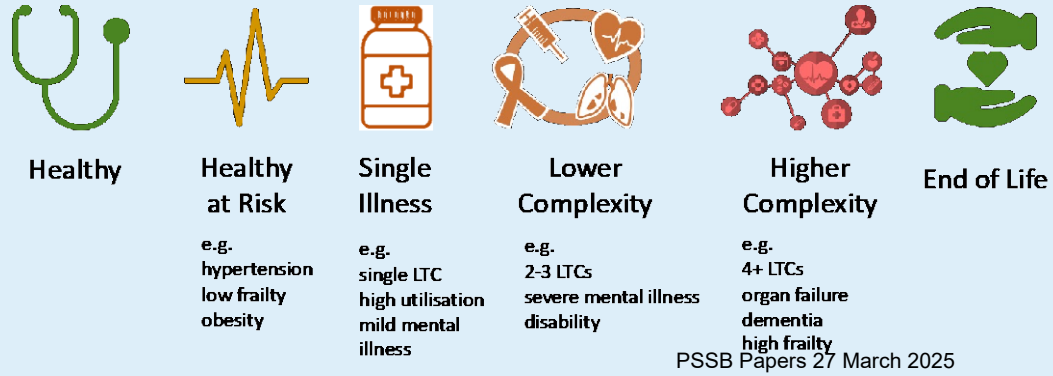
PHM will be used to build up a richer picture of local populations over time, recognising that **data availability may be limited during the mobilisation of INTs** and **processes for continuous learning and adaptation to PHM insights** will ensure INTs remain responsive to changing population health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

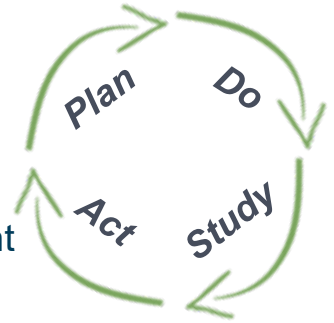


Adopting a test and learn approach

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.

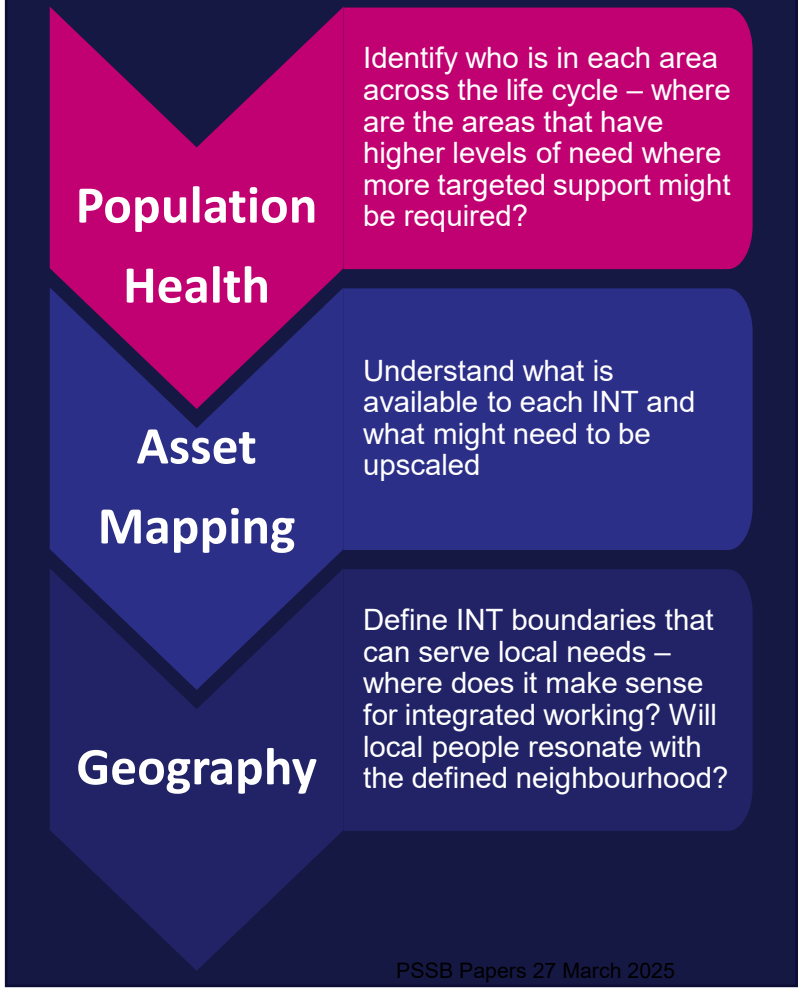
Build on existing networks and local assets. Enhancing integration without requiring new infrastructure where possible is essential to ensure equitable service delivery while maximising existing resources. This will require better use of primary care estates (e.g., community pharmacy consultation rooms) 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).

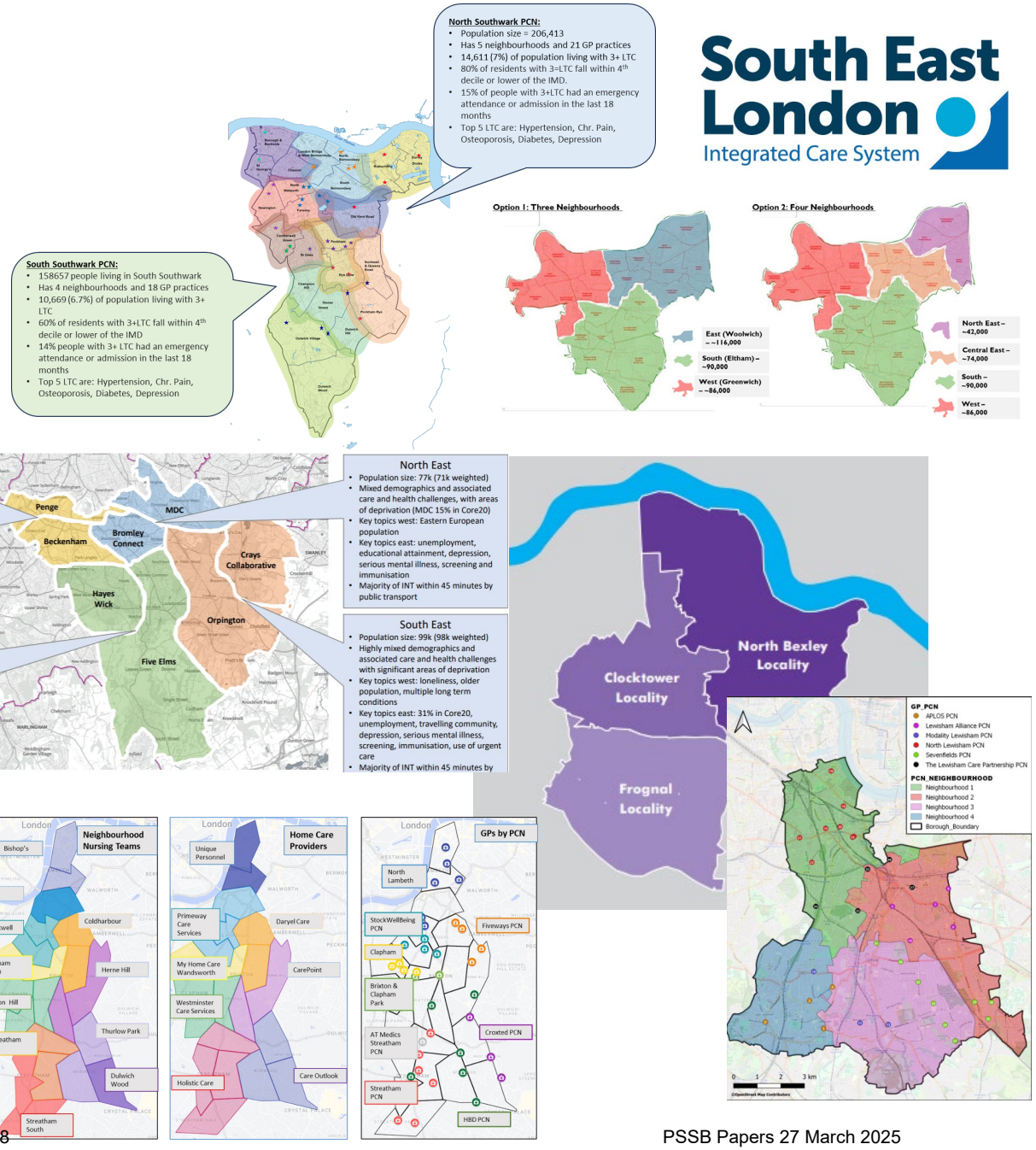
Overview of where Places are

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

South East London Integrated Care System

- **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.

Key assets and challenges within Places

South East London Integrated Care System

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

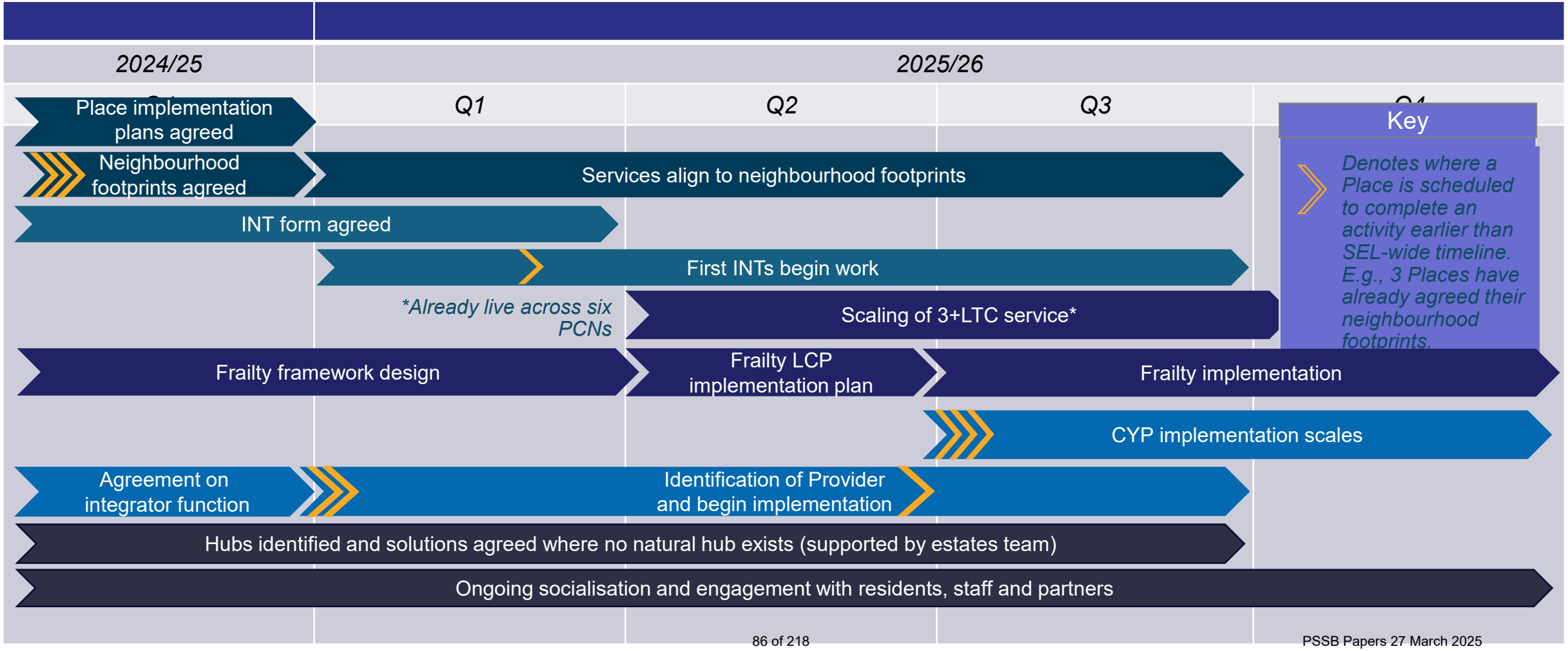
1. **Established PCNs:** In many places, PCNs form the foundation of neighbourhood-based care, providing a structure for GP practices and associated services to work collaboratively within INTs.
2. **Local authority partnerships:** Strong partnerships with local councils are facilitating better integration 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.

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 5
Enclosure: 4

Title:	**Strategic Director for Integrated Health and Care/Southwark Place Executive Lead report**
Meeting Date:	**27 March 2025**
Author:	Darren Summers (Strategic Director for Integrated Health and Care/Southwark Place Executive Lead)
Executive Lead:	Darren Summers (Strategic Director for Integrated Health and Care/Southwark Place Executive Lead)

Summary of main points
This report details key events and activities, that are relevant to Partnership Southwark, that have taken in the past two months.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
	x		

Action requested of PSSB
To note the report and updates.

Anticipated follow up
N/A

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	**x**
Adult mental health	**x**
Frailty	**x**
Integrated neighbourhood teams	**x**
Prevention and health inequalities	**x**

Item Impact	
Equality Impact	The report includes an update on the 'Funding Differently' programme which aims to address health inequalities by funding a range of grass roots VCSE organisations to support hard to reach groups with preventative services.
Quality Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes a new quarterly quality reporting element for the board.

Financial Impact	The report includes information on financial planning for 2025/26 and an update on the recent additional requirement to reduce running costs by 50%.		
Medicines & Prescribing Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes a report from the delegated lead for medicines optimisation.		
Safeguarding Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes a summary of the Q3 safeguarding report.		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	X The board development seminar on environmental sustainability held in February.		

Describe the engagement has been carried out in relation to this item
N/A

Partnership Southwark

STRATEGIC DIRECTOR OF HEALTH & CARE AND SOUTHWARK PLACE EXECUTIVE LEAD REPORT

This report is for discussion and noting; to update the Board on key highlights on Partnership Southwark and the delegated functions.

Reduction in Integrated Care Board running costs

On 12 March 2025, NHS England informed ICBs they needed to make savings of 50% across management and running costs during 2025/6. Much of the detail is still not known. This announcement is in line with wider changes to the centre of our health service, in relation to the abolition of NHS England and similar sized reductions in NHS England and Department of Health and Social Care staff.

Integrated Care Boards (ICBs) were legally established on 1 July 2022 with a clear purpose: to improve outcomes in population health and healthcare, tackle inequalities, enhance productivity, and support broader social and economic development.

At the time of writing, one week after the announcement, national guidance as to how to manage this cost reduction has not been received. South East London ICB is working through options in discussion with local partners in the Integrated Care System. All options are likely to have a significant impact. The immediate response has included briefings for staff and stakeholders, question and answer sessions for staff, as well as recruitment freeze on ICB posts.

Community Southwark Impact Report

Community Southwark have recently published an impact report on the 'Funding Differently' programme for 2024/25, the second year of the initiative. 30 grassroots organisations in the borough received grants of either £5,000 or £10,000. Some of the key insights detailed in the report were the value of the tailored long-term support provided by small community led groups, the importance of the power shift in this funding process to include the VCS in the decision-making process, and the sustainability challenges faced by these organisations.

The report states that the recipients of the grants are directly supporting 3,000 individuals in the borough, but also notes the 'impact beyond numbers' – the long term change and preventative work done by these organisations that is difficult to quantify. Recommendations made by the report include multi-year funding to locally led VCS groups to improve challenges around sustainability, keeping grant processes simple and adaptable, and strengthening the partnerships between VCS groups, funders and statutory bodies.

The full report can be accessed via the following link
https://communitysouthwark.org/funding-differently-2024-25-impact-learning-report-now-available/

Planning Update

The planning update item on the agenda includes a summary of financial planning issues for 2025/26 along with a summary of national priorities and success measures that are set out in the national Operational Plan guidance and Better Care Fund planning guidance. These will inform our local plans for 2025/26. The planning position will need to be reviewed when the recent announcement about the 50% reduction in ICB running costs is translated into changed allocations at place level.

The item also includes a draft of the Southwark section of the ICB Joint Forward Plan refresh for 2025/26, the 5 year strategic plan of the ICB from 2022/23 to 2027/28. It is a requirement for the ICB to update this plan annually and seek endorsement from the Health and Wellbeing Boards confirming the plan aligns with local health and wellbeing strategies. For the refresh process each local care partnership was asked to focus in on no more than 5 priorities and provide high level information on each, hence this was an opportunity to summarise the five priorities the board developed over 2024/25; CYP mental health, adult mental health, integrated neighbourhood teams, frailty, and prevention and inequalities. The Southwark section of the plan was endorsed by the Southwark Health and Wellbeing Board on 13.03.2025.

The revised NHS Long Term Plan is expected to be published later this year following the extensive public consultation exercise. At this point it is expected that ICBs will be asked to draw up new Joint Forward Plans setting out how they will deliver the revised national plan.

Better Care Fund Update

The ICB and the council are in the process of drawing up Southwark's 2025/26 Better Care Fund plans for submission to NHSE at the end of March. The BCF is a pooled budget of £57million which funds a range of core community based health and social care services which are crucial to the objectives of supporting people to live independently and safely in their own home, avoiding admission to hospital and supporting timely and effective discharge from hospital. Given the short turnaround in the planning process it has been agreed to roll forward the vast bulk of funding for specific schemes, with an intention to review by mid-year to identify potential changes for implementing at the start of 2026/27. The revised BCF objectives and metrics are set out in the planning update item and baseline performance on the metrics is included in the Integrated Assurance Report, which will inform discussions about priorities for funding. The governance route for the BCF is that the Health and Wellbeing Board needs to agree the plan following council and ICB Chief Executive's in principle agreement, and the submission at the end of March will be subject to that approval The plan must also be formally approved by NHSE.

Integrated Assurance Report

Under the revised governance arrangements of the partnership we have now developed an Integrated Assurance Report for the board which provides a range of detailed information that relates to the delivery of our board's responsibilities delegated from the South East London Integrated Care Board. The report focusses on performance, planning, quality, safeguarding, risk, finance and delegated responsibilities around continuing healthcare and

medicines optimisation. The Integrated Governance and Assurance Committee (IGAC) has reviewed this report in detail and the covering report highlights some of the key issues that IGAC considered. It should be noted that the Integrated Assurance Report includes information and updates that were previously a part of this Place Executive Lead report, in particular the budget summary report. The new reporting framework is still in development and any comments will be welcome on how we take this forward.

Partnership Southwark Board Development Session on Environmentally Sustainable Healthcare

Last month the Board attended a development session led by Dr Matt Sawyer, a former GP who now runs an environmental sustainability consultancy (SEE Sustainability) working to improve human and planetary health. This was an educational session which aimed to inform board members about the importance of environmentally sustainable healthcare and to provide some practical examples of what they can do as individual and as leaders in health and care to contribute to this important agenda. A key focus of the session was how the health of the planet is intrinsically linked to the health of humans, illustrated by examples such as there are more premature global deaths due to diseases attributed to air pollution than to AIDS, TB and malaria combined. Dr Sawyer shared examples of how good healthcare benefits individuals, society and the environment, as well as reducing cost of healthcare and inequality, such as the introduction of the HPV vaccination to 12-13 year old girls to prevent cervical cancer. The main take-away from the session was that environmentally sustainable healthcare is simply 'good healthcare' and that the work we do on prevention is where we can make the greatest impact

Southwark Health and Wellbeing Board 13th March

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

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

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

Other agenda items included the Healthwatch report on Black Mental Health and the Connect to Work programme, and Department for Work and Pensions funded programme

of support employment whose primary objective is to support people with health and disability related barriers into good quality, sustainable employment.

Darren Summers
Strategic Director of Health & Care & Place Executive Lead

Appendix 1 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Integrated Governance and Assurance Committee (IGAC)

Agenda Items of Note

Meeting date 20 March 2025

Agenda item	**Items discussed**
Finance report	The committee considered a detailed report on the current financial position for 2024/25.
Procurement	The committee received an update on current and planned procurement including the re-procurement of Silverlock and Queens Road practices.
Planning Update	The committee discussed the latest position for Southwark in terms of financial planning for 2025/26 and the associated Operational Plan targets, as well as the Better Care Fund objectives and metrics and the draft Joint Forward Plan refresh for 2025/26. The details discussed are reflected in the Planning Update report for the strategic board meeting of 27th March.
Integrated Assurance Report	The committee considered the draft Integrated Assurance Report and agreed the report to be submitted for the strategic board meeting of 27th March. Further areas for refining the report in future were identified.

Appendix 2 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Partnership Southwark Delivery Executive

Agenda Items of Note

Meeting date 13 February 2025

Agenda item	Items discussed
Health and Wellbeing Strategy Action Plan Refresh	The group received an update on the draft Health and Wellbeing Strategy Action plan. The group was invited to review and comment on the content of the plan as well as the role of the Partnership Southwark Delivery Executive and the Wells groups in terms of supporting delivery of the plan. The group reviewed the actions in detail and provided feedback on the appropriateness of the actions and whether they had the right 'action owners'. Suggestions were also made for how to strengthen and clarify the relationship with the Partnership Southwark Health and Care Plan. The plan will be amended following feedback from the group and will be taken to the March Health and Wellbeing Board for approval.
Report from each of the Wells (Start Well, Live Well, Age & Care Well)	The group received a highlight report for each of the Wells. Highlights included progress on the delivery of the frailty pilot in the Walworth Triangle which has started to see patients and is showing some early promising results. The Delivery Exec noted the issues around obtaining mental health activity data and support was offered from the group.
Mental Health update	The Partnership Southwark delivery team shared a verbal update on how they are responding to the feedback received from the Partnership Southwark Strategic Board when the mental health delivery plans were presented. The group noted the update and written update will be prepared for the next meeting.
Clinical and Care Professional Leads (CCPL) Workplan	An update was provided on the CCPL workplans which set out how the CCPLs are being deployed across Partnership Southwark, and the work they are leading on.

Appendix 3 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Primary Care Committee

Agenda Items of Note

Meeting date 13 February 2025

Agenda item	**Items discussed**
Governance and terms of reference	This was the first meeting of the Committee following the formal approval of the revised TORs and as a subcommittee of the Partnership Board. It is the assurance and governance committee for primary care, where significant decisions will be made for our community and population healthcare.
Finance	The Committee received an update on the quarter three financial position on delegated primary care and other primary care budgets. The delegated primary care budget is forecast to overspend by £307k for 2024/25. The borough has been working through financial recovery plans identifying opportunities for savings and reduce revenue costs. The group received an update on the 2024/25 System Development Fund (SDF) and confirmation that all allocated funds are intended to be spent by year end. It was noted that this funding will no longer be a ring fenced to primary care in the next financial year.
Contracts	Discussions took place on the contractual and succession planning for a single-handed GP practice in the Borough. This is ongoing and is continuing to be reviewed by the Committee. The re-procurement of Queens and Silverlock surgeries is being prepared. The specification supports the primary care long-term strategy, innovation and integration, and development of neighbourhood teams. A direct award process under the Provider Selection Regime regulations will be used to award the Population Health Management contract to the existing provider. The revised contract specification will focus on supporting delivery of the health and care plan priorities Following the procurement process, the Primary Care Interpreting Service across Lambeth, Lewisham & Southwark boroughs has been awarded to DA Languages. This is the incumbent and existing provider.
Estates	The Harold Moody site has now been completed, becoming operational from 10 February 2025, with East Street Surgery, Nexus

	Group and GSTT providing services from the site. An opening event is planned for early April. Regeneration plans for Canada Water include the development of a new health centre. The regeneration of the area will lead to significant population growth. Archus (a consultant group) have asked seven developers for an Expression of Interest to develop the health centre. Three bidders will go forward to the next stage of the procurement process. The primary care practices in the Rotherhithe area, that covers Canada water, have been asked to express an interest in occupying the new health centre. The group noted the proposal for the relocation of a GP partnership to take on new premises at Pasley Park in Walworth. Work is underway to underway the full financial implications of this proposal and to work with stakeholders to understand how the space can best be used to support implementation of integrated neighbourhood working

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 6
Enclosure: 5

Title:	**Planning Update**
Meeting Date:	**27/03/2026**
Author:	Sabera Ebrahim, Associate Director of Finance, SELICB Adrian Ward, Head of Planning, Performance and Business Support, SELICB
Executive Lead:	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

Summary of main points

The purpose of part 1 of the paper is to update the board on the draft 2025/26 allocations and budgets delegated to place. The paper also highlights key risks in 2025/26 and the level of risks that are being managed within our financial plan.

The paper also provides an update on our current position of the SEL ICB requirement to deliver 5% efficiency and savings for 2025/26.

Part 2 of the report sets out non-financial aspects of the planning round including:

- key priorities and success measures from the 2025/26 Operational Plan and Better Care Fund planning guidance.
- the draft Southwark section of the SELICB Joint Forward Plan refresh for 2025/26 covering Partnership Southwark's revised health and care plan priorities and success measures.

Item presented for (place an **X** in relevant box)	Update	Discussion	Decision
	X	X	

Action requested of PSSB

The board is asked to note:

- the high level summary of our draft budgets for 2025/26 and the efficiency savings plans proposed to achieve the 5% efficiency/savings requirement from SEL ICB.
- The priorities and success measures set out in the national Operational Plan and Better Care Fund guidance.
- The draft Southwark section of the SELICB Joint Forward Plan refresh for 2025/26

Anticipated follow up

The board will receive an update on the final budget planning and related decisions at its next meeting.

The Joint Forward Plan will be published on the ICB website in early April.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	**x**
Adult mental health	**x**
Frailty	**x**

Integrated neighbourhood teams	**x**
Prevention and health inequalities	**x**

Item Impact			
Equality Impact	The report does not have a direct impact on these areas but does describe the financial planning issues for 2025/26, and the planning priorities and targets. These will impact on most aspects of ICB business in 2025/26.		
Quality Impact			
Financial Impact			
Medicines & Prescribing Impact			
Safeguarding Impact			
	Neutral	**Positive**	**Negative**
Environmental Sustainability Impact (See guidance)	X - the planning guidance does not cover sustainability however consideration of sustainability issues will be built into our detailed planning process. The delivery of the Joint Forward Plan priorities will take into account any sustainability implications or opportunities.		

Describe the engagement has been carried out in relation to this item
The contents of this report have been reviewed by the Integrated Governance and Performance Committee on 20th March 2025.

South East London Integrated Care System

Partnership Southwark Strategic Board Planning Update Part 1 Financial Plan 2025/26

Southwark Place – March 2025

Final Budgets - 2025/26

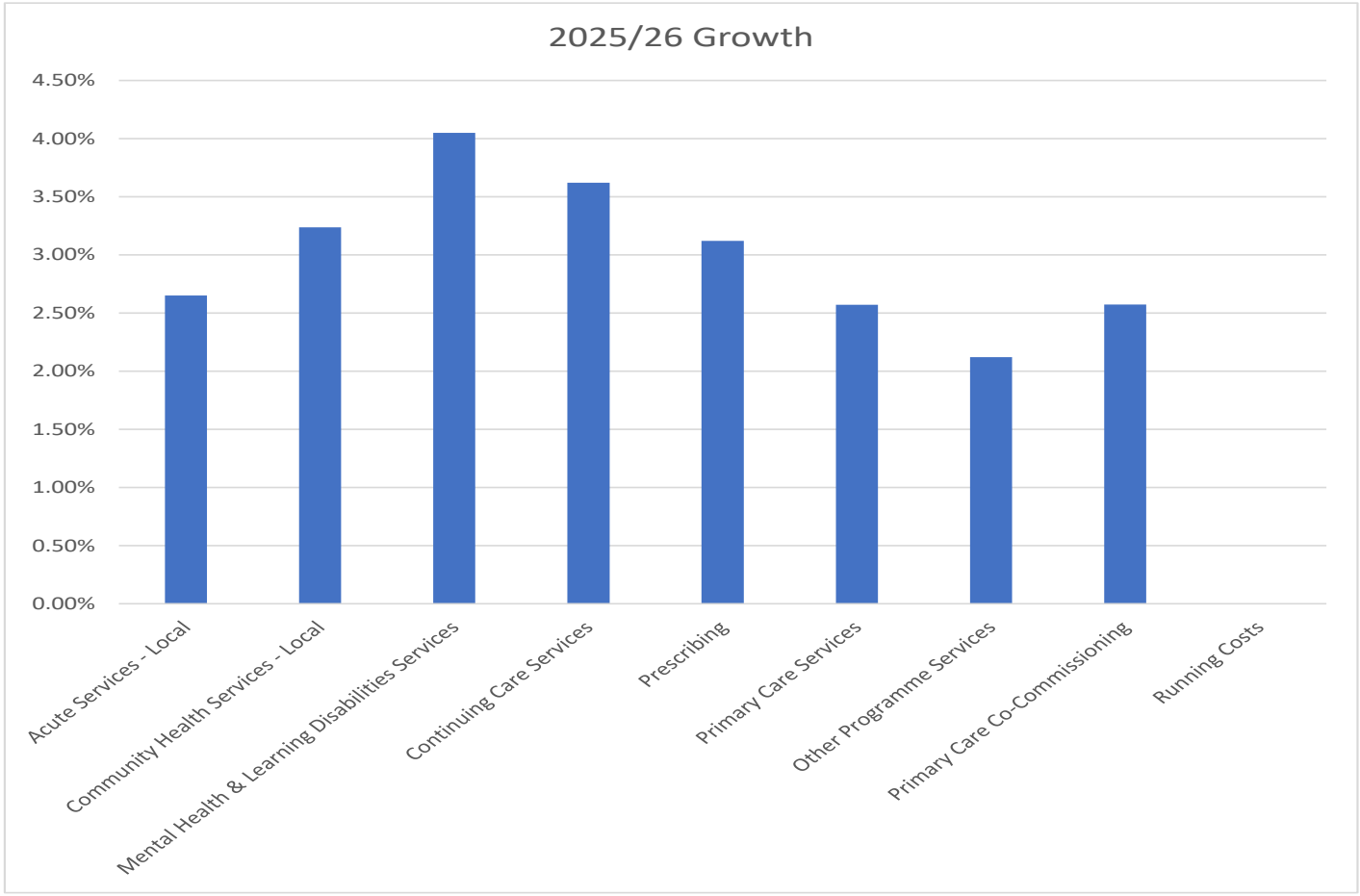
- Place budgets have been based on 2024/25 recurrent budgets brought forward. Various adjustments for tariff and growth adjustments have been made in line with national operational guidance. Total resources delegated to Southwark Place for 2025/26 amounts to £177m. This includes net growth of £5m received for 2025/26.
- Tables below shows the final recurrent budgets issued to Southwark Place. Place Executive Lead has agreed and signed off approval of these budgets on 17th March 2025 . The delegation agreement will be required to be signed once the budgets are final from a SEL ICB perspective.
- As part of finalising our budgets for 2025/26, we have sought to ensure budgets set are at the correct level and reflect likely expenditure. As a result we have transferred additional funding of £500k non recurrently to Mental Health & Learning Disability Services from Community Services. In 2024/25 we transferred £1.2m from Continuing Care to Mental Health & Learning Disability Services to support the rising costs in our placement expenditure

SOUTHWARK	2025/26 TOTAL PLACE MANAGED BUDGET
	£'000
Acute Services - Local	92
Community Health Services - Local	37,271
Mental Health Services & Learning Disabilities	8,047
Continuing Care Services	20,475
Prescribing	36,208
Primary Care Services	200
Other Programme Services	1,116
Primary Care Co-Commissioning	70,259
Running Costs	3,769
TOTAL	177,438

Final Budgets - 2025/26

- Tables below shows the total growth in % per area issued to Southwark Place

Southwark Place	% Net Growth
Acute Services - Local	2.65%
Community Health Services - Local	3.24%
Mental Health & Learning Disabilities Services	4.05%
Continuing Care Services	3.62%
Prescribing	3.12%
Primary Care Services	2.57%
Other Programme Services	2.12%
Primary Care Co-Commissioning	2.57%
Running Costs	0.00%



Risks 2025/26

- There are known inherent risks within the start position which are difficult to manage without restricting investments and growth.
- Key areas of risk continue to be Mental Health & Learning Disabilities, Prescribing and Delegated Primary Care. These areas have significant overspends in 2024/25 that will need to be managed as we move into 2025/26. Increase in activity growth and cost pressures are expected to continue. Inflationary and uplift pressures from external providers within placements and continuing health care also presents significant financial challenge to manage within budget given.
- For Prescribing a uniform uplift across SEL ICB Boroughs of 3.12% has been given however activity and price growth trend is at 6%.. This creates a cost pressure. Medicines optimization team have identified savings but these will not cover the shortfall and this risk will, need to be managed by restricting growth and investment .
- We have a budget shortfall for Delegated Primary Care going into 2025/26 of £463k. In addition the current 7.2% increase in funding to Primary Medical Services announced by government will require additional funding allocation. Currently in our budgets there is a shortfall of 4.63% of uplift which amounts to £2.4m which we are expecting will be fully funded. The borough would not be able to meet this cost from existing resources if additional allocation is not received.
- All of the above risks gives us significant challenges in containing expenditure within our delegated allocation and achieve financial balance. There will need to restrictions on investments and use of growth in order for us to achieve our delegated duty of not spending more than the resources we have been allocated.

South East London Integrated Care System

Efficiency Plans - 2025/26

NHS South East London

The borough is required to deliver 5% efficiency savings for 2025/26. The borough target efficiency savings across all budget areas amount to £8.9m. Within this element there are tariff efficiency deductions and convergence adjustment deductions on budgets of £4.4m. Savings Plans have been identified by budgets holders which together with other budget reductions and uncommitted budgets make up the balance needed to meet the £8.9m.

Once plans have been reviewed and formally agreed, delivery plans will be further developed so that we can be assured plans are in place to meet savings target, A process to review delivery plan will be in place to ensure milestones and outcomes are on track.

Southwark	Recurrent Baseline £'000	Efficiency Savings (5%) 2025/26 £'000	Total Savings Planned £'000	Balance £'000
Acute Services - Local	257	13	171	158
Community Health Services - Local	37,271	1,864	1,937	74
Mental Health Services - Local	8,047	402	767	364
Continuing Care Services	20,475	1,024	1,114	91
Prescribing	36,208	1,810	2,178	368
Primary Care Services	232	12	31	19
Other Programme Services	920	46	704	658
Primary Care Co-Commissioning	70,259	3,513	1,781	-1,732
Running Costs	3,769	188	188	-0
Total	**177,438**	**8,872**	**8,872**	**0**

South East London Integrated Care System

Planning update part 2

Planning guidance, priorities and metrics

- NHS Operational Planning Guidance 2025/26
- Better Care Fund Planning Guidance 2025/26
- SELICB Joint Forward Plan Refresh 2025/26

Key objectives, priorities and targets

Operational Planning Guidance 2025/26

The national priorities to improve patient outcomes in 2025/26 are:

- **reduce the time people wait for elective care**, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026
- **improve A&E waiting times and ambulance response times** compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- **improve patients' access to general practice,** improving patient experience, **and improve access to urgent dental care,** providing 700,000 additional urgent dental appointments
- **improve patient flow through mental health crisis and acute pathways,** reducing average length of stay in adult acute beds, **and improve access to children and young people's (CYP) mental health services**, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

In delivering these priorities we also need to:

- **drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future**. For 2025/26 we ask ICBs and providers to focus on:
  - reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
  - making full use of digital tools to drive the shift from analogue to digital
  - addressing inequalities and shift towards secondary prevention
- **live within the budget allocated, reducing waste and improving productivity**. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity
- **maintain our collective focus on the overall quality and safety of our services**, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of 'Three year delivery plan', and continue to address variation in access, experience and outcomes

Operational Plan Priorities and Success Measures 2025/26 (1)

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Local commentary
Targets set at SELICB level with trusts. Not a place level element although support to improve patient flow through admissions avoidance and discharge support and, in the longer term, ill-health prevention at place will play a role in delivery.

Operational Plan Priorities and Success Measures 2025/26 (2)

Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Targets set at SEL level. Not a place level element but the guidance makes specific reference to the key role of the wider urgent care system in reducing A&E demand, the role of the BCF in reducing delayed transfers and length of stay and the establishment of the neighbourhood health model.

Construction of this measure not yet known. However key Operational Plan targets relate the ICB total number of GP appointments which may be cascaded to place. There are also established measures around the time taken to get an appointment and several pertinent GP patient survey questions. See Integrated Assurance report.

Dental targets not yet delegated to place

Operational Plan Priorities and Success Measures 2025/26 (3)

Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)

Places not directly responsible for targets but delivery role in supporting discharge from mental health inpatient setting including through the BCF.

Overall strong alignment with our CYP mental health priorities, but not same measures as local focus on waiting times.

SEL led delivery of this target but key role in supporting community placements.

Key local place delivery challenge – see finance section

Operational Plan Targets 2025/26 (4)

Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'	Indirect place role, link to maternity commission and start well.
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	Success measure not defined. Local development of Core20 tools for adult health – see example reporting in Integrated Assurance Report. CYP model not developed locally.
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	These are included in dashboards in Integrated Assurance Report. See agenda item.

Note that this represents a considerable reduction in targets from previous years, and the number of targets that will cascade to place is lower.

Better Care Fund Planning Guidance

The Better Care Fund (BCF) planning submission is currently being agreed between the council and the ICB, for submission by 31st March. The plan is due to be agreed by the next Health and Wellbeing Board in June.

The pooled budget funds a range of core community based health and social care services and for the most part these will be rolled forward. These come to a value of £57m.

There was no growth in the funding for NHS services within the budget.

A key change to the planning guidance this year is that the Hospital Discharge Funding within it is no longer ringfenced, enabling a potential longer term shift to admissions avoidance to be considered.

Also there are 2 new targets which will be key place level targets not just for the BCF but also Integrated Neighbourhood Teams.

The objectives of the BCF have also been re-worded to reflect the changing NHS agenda, as set out overleaf.

Better Care Fund Planning Guidance

New BCF Objectives

Objective 1: reform to support the shift from sickness to prevention

Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Objective 2: reform to support people living independently and the shift from hospital to home

Local areas must agree plans that:

- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

New BCF Targets – will be key to place and neighbourhoods

For 2025/26, HWBs will be asked to set improvement goals against three new headline metrics, with six related supporting indicators:

1. Number of emergency admissions to hospital for people aged 65+ per 100,000 population

a) Unplanned hospital admissions for chronic ambulatory care sensitive conditions
b) Emergency hospital admissions due to falls in people over 65

2. Average length of discharge delay for all acute patients, derived from a combination of:

- Proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD).
- For all those adult patients not discharged on DRD, average number of days from DRD to discharge.

c) Percentage of patients not discharged on their DRD and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more
d) Average length of delay by discharge pathway

3. Number of admissions to long-term residential and nursing home care for people aged 65+ per 100,000 population

e) Hospital discharges to usual place of residence (P0/1)
f) Outcomes following short-term support to maximise independence

These metrics are aligned to the two objectives of the BCF for 2025/26:

1) To support the shift from sickness to prevention
2) To support people living independently, and the shift from hospital to home

Baselines for these targets are covered in the Integrated Assurance Report, which demonstrate that the targets are areas of challenge for Southwark.

Joint Forward Plan Refresh 2025/26

- The SELICB 5 year strategic plan 2022/23 – 2027/28 sets out how the ICB will meet the needs of the population, improve outcomes, tackle inequalities and deliver its statutory responsibilities in line with the NHS Long Term Plan
- It is a statutory requirement to have the plan published and it has to be refreshed annually and endorsed by the local Health and Wellbeing Boards. Southwark's board meeting endorsed the Southwark section on 13th March.
- The plan includes SEL level pathway and enabler plans and sections on each Local Care Partnership's priorities.
- For this refresh places were asked to focus on only 4 or 5 key priorities and address the template ser out in annex 1. For Southwark a straightforward summary of the recently agreed Health and Care Plan priorities refresh was applied to populate the template:
    - CYP Mental Health
    - Adult Mental Health
    - Frailty
    - Integrated Neighbourhood Teams
    - Prevention and Health Inequalities
- Draft plan and success measures overleaf. A number of these are covered in the current Integrated Assurance report and those that are not will be developed in future drafts. The full Southwark section is attached in annex 1.
- Next steps**:** Following engagement with Health and Wellbeing Boards a final version of the Joint Forward Plan will be published at the start of April.
- **Note: It is anticipated that upon the publication of the renewed NHS Long Term in the summer the ICB will be required to refersh its Joint Forward Plan.** It is also anticipated that the plan will need to be reviewed to take into account recent NHSE announcements about ICBs reducing staff by 50% by October.

Joint Forward Plan Refresh -

Partnership Southwark – key outcomes and impact metrics

South East London Integrated Care System

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
Children and young people's mental health	For CYP who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	• Increase in % achievement of the 4 week wait standard • Improvement of parent/ patient reported outcome measure • Reduction in number of CYP waiting more than 52 weeks
Adult mental health	For adults who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	• Increase in % achievement of a system wide 4 week wait standard • Reduction in number of patients waiting 72 hours in ED • Improvement in patient reported outcome measure
Frailty	For older people living with frailty to have their needs identified sooner, to receive treatment and support at a neighbourhood level tailored to their individual needs.	• Reduction in unplanned / emergency appointments (GP and Secondary Care) • Reduction in ambulance conveyances • Reduction in outpatient appointments • Patient experience – quality of life
Prevention and health inequalities	Core20Plus5 communities to have easier access to support for the five leading causes of poor health.	• Increase in uptake of Vital 5 checks by people from Core20Plus5 communities • Increase in uptake of people from Core20Plus5 communities taking up interventions
Integrated Neighbourhood Teams	To implement an agreed model of Integrated Neighbourhood Teams that helps improve outcomes across a range of outcome metrics linked to improved prevention and management of long term conditions.	• Reducing the rate of avoidable hospital and care home admissions from identified at risk cohorts.

South East London 2025/26 Joint Forward Plan Refresh

Partnership Southwark

draft 27.02.2024

DRAFT

PARTNERSHIP SOUTHWARK - PLAN ON A PAGE

South East London Integrated Care System

Our vision is:	**Our vision is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years.**				
Our priority areas are:	**Children and young people's mental health**	**Adult mental health**	**Frailty**	**Integrated neighbourhood teams**	**Prevention and health inequalities**
In 2025/26, we will:	Reduce waiting times for children and young people who need help with their mental health. The support will be easy to access and coordinated around their needs.	Reduce waiting times for adults who need help with their mental health. The support will be easy to access and co-ordinated around their needs.	Pilot an integrated neighbourhood team for the frailty pathway in the Walworth Triangle. Use the learning from the pilot to inform spread and scaling to other neighbourhoods.	Launch a new model of care for Integrated Neighbourhood Teams (INTs) in Southwark.	Work in partnership so that Core20Plus5 communities will be more easily able to access tailored support for the five leading causes of poor health (the Vital 5).
This will support population health and inequalities by:	Enabling earlier access to mental health support and interventions and reduce escalation to crises and more costly acute health and social care intervention, with a focus on harder-to-reach young people.	Bringing together existing services and increasing the-involvement of the VCSE to streamline and increase capacity, providing a more holistic and accessible service for all residents.	Utilising outreach to identify vulnerable and hidden cohorts prone to health inequalities, alongside a population health based targeted approach to mild, moderate and severe frailty.	Providing proactive joined up health and care services focused on local inequalities, improving outcomes by providing services at an earlier stage before deterioration leads to hospital admission.	Tackling the leading cause of death; and driving a focus on residents most at risk of poor health outcomes in our local communities.
This will support system sustainability by:	Reducing demand on acute services, modernising pathways, improving system navigation, and improving the use of resources (staffing, training and estates).	Adults who need help with mental health will not have to wait as long. The support will be easy to access and co-ordinated around their needs.	Promoting independent health and wellbeing for mild frailty to focus on prevention and providing coordinated care closer to home.	Shifting the balance of care from acute to community and from treatment to prevention through efficient integrated neighbourhood care.	By early identification of high-risk residents and preventing crisis stage, it will reduce demand on high-cost acute sector services.
We will measure our impact by:	Increase in % achievement of a system wide 4 week wait standard.	Increase in % achievement of a system wide 4 week wait standard. Reduction in number of patients waiting 72 hours in ED..	Improved proactive care reducing need for Emergency Care. Patient outcomes – Experience and Quality of Life. Improved proactive care meeting unmet needs	Metrics to be confirmed but will focus on reducing the rate of avoidable hospital and care home admissions.	Increase in uptake of interventions for people from Core20Plus5 communities with identified Vital 5 risk factors.

DRAFT

Partnership Southwark

South East London Integrated Care System

Vision

Our vision is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years .

Deliverables / Improvements since 2023/24

Start Well: 1001 days project completed, and learning being taken forward in Family Hubs programme. Improvements in CYP Mental Health access and support for patients on waiting lists.

Live well: Vital 5 hypertension targets and health checks improvements, including via health promotion van. Community Mental Health Transformation programme complete and mainstreamed.

Age Well: Lower Limb Wound Care pilot successfully implemented - to be mainstreamed in 2025/26. Frailty workstream initiated focusing on an integrated pathway.

Clinical Care and Professional Leads recruited across all priorities.

Partnership Southwark plans refreshed and rationalised to focus on 5 key priorities by the newly established partnership team.

Integrated Neighbourhood Teams programme established to further develop integrated MDT working in line with expected government plans.

Key Challenges / Opportunities Remaining

Embedding system sustainability, prevention and health inequalities: Budget pressures impact significantly on the potential to invest in community based preventative care models and address health inequalities.

Mental health: Too many children and adults are still waiting far too long to access mental health services. Escalating costs in the provision of complex adult mental placements remains a barrier to the joint commissioning of more appropriate local services.

Capacity for change: The capacity of partners to fully engage in transformation workstreams due to immediate delivery pressures remains a barrier to progress towards integrated solutions. System complexity adds to the challenge.

Data: there remain challenges with lack of robust data and analytics capacity impacting on development of comprehensive outcomes frameworks and population health approaches including Core20Plus5. Shared care records also perceived as too limited for efficient integrated working.

Integrated Neighbourhood Teams: the local and national drive towards the development of more integrated neighbourhood teams provides a key opportunity for addressing system challenges.

Financial challenge: significant shortfall in the budget means that there is limited scope for investment in growth and development opportunities.

DRAFT

Partnership Southwark

South East London Integrated Care System

	What are our priority areas for 2025/26	Why has this been identified as a priority areas?
1	**Children and young people's mental health**	The growing, local and national, mental health crisis for children and young people, with demands for mental health services continuing to exceed availability. Unacceptable long waits for Children and Adolescent Mental Health services (CAMHS), including for diagnostics of neurodevelopment disorders such as hyperkinetic disorders and attention deficit hyperactivity disorder (ADHD).
2	**Adult Mental Health**	Waiting times for community mental health services are a challenge, with over one third of adults waiting over a year to receive treatment in 2024. We know that a significant proportion of these are referrals for neurodevelopmental problems.
3	**Frailty**	Almost half of Southwark's residents over 65 report that they are not in good health, with this cohort of residents having poorer healthy life expectancy than the national average. Frailty is not an inevitable part of ageing, but it is highly prevalent and frailty healthcare costs an estimated £5.8 billion a year. The ageing population in Southwark amplifies these pressures and highlights the need for coordinated care.
4	**Integrated Neighbourhood Teams**	The development of integrated care at a local level has long been recognised as a key priority for improving outcomes. However, the complexity of systems has limited progress in establishing a consistent agreed neighbourhood model. Partners have agreed that now is the time to prioritise this in the wider context of system level programmes for neighbourhood team development in line with national priorities.
5	**Prevention and health inequalities**	Prevention and health inequality forms a critical part of national and local policy, with the NHS calling for systems to update plans for the prevention of ill-health and incorporate them within Joint Forward Plans, with a particular focus on improving outcomes for the Core20Plus5 populations and NHS England's high impact interventions for secondary prevention.

DRAFT

Partnership Southwark

South East London Integrated Care System

Priority Area:

Children and young people's mental health

What are the actions we will deliver in 2025/26

- Work with the Nest to identify what investment is needed to reduce waiting times.
- Use recommendations from the evaluations of the Nest and the Well Centre in Lambeth to inform how to make services easier to navigate and to improve access for less engaged groups.
- Carry out focused engagement and co-design with adolescents and early adulthood to inform future service developments.
- Work with SEL to develop the pathway for Neuro Developmental Disorders.

Population Health and Inequalities Impact

- An aim to improve the equity of access through an integrated community offer and to reduce long waits for CYP, especially for Neurodevelopment disorders, will help to tackle health inequalities.

System Sustainability Impact

- Likely to include a shift in investment from acute, intensive and costly health and social care, to preventative strategies through modernised pathways, co-location of services, improved navigation, and improving the use of resources such as staffing, training, facilities, and estates.

Priority Area:

Adult Mental Health

What are the actions we will deliver in 2025/26

- Improve access to community mental health services by developing a coordinated, easy-access mental health service, with input from primary care, VCSE organisations, SLaM and social care.
- Reduce waiting time for Neuro Developmental Disorders (NDD) and develop support to those whilst waiting.
- Enhance the mental health offer in neighbourhoods.

Population Health and Inequalities Impact

- An aim to improve the equity of access through an integrated community offer and the enhancement of mental health offering at neighbourhood level will help to tackle health inequalities.

System Sustainability Impact

- Moving to a neighbourhood approach likely to lead to improvement in system to sustainability.

DRAFT

Partnership Southwark

South East London Integrated Care System

Priority Area:

Frailty

What are the actions we will deliver in 2025/26

- Pilot an integrated neighbourhood team for the frailty pathway in the Walworth Triangle. This will involve:
  - Identifying and developing datasets to define frailty groups
  - Testing case finding tools
  - Developing mild, moderate and severe frailty pathways at local level
  - Ongoing evaluation and monitoring of success
- Use the learning from the pilot to inform spread and scaling to other neighbourhoods.

Population Health and Inequalities Impact

- Using a population health based approach and a range of different data sources to support identification of mild, moderate and sever frailty will allow inequalities to be tackled.

System Sustainability Impact

- Promoting healthy living and a focus on preventing frailty through moving care closer to home and earlier identification of frailty.

Priority Area:

Prevention and health Inequalities

What are the actions we will deliver in 2025/26

- Deliver a review of link workers across the NHS and Council, including Social Prescribers and Community Health Ambassadors, considering their capacity and capabilities with a view to developing a more integrated approach.
- Co-design with residents and health and social care partners interventions for people from Core20PLus5 groups with risk factors identified through a vital 5 check
- Pilot the intervention(s) in targeted areas based on population health data.
- Apply iterative learning for future scaling and spread.
- Align with and support the SEL Vital 5 initiative.

Population Health and Inequalities Impact

Using a population health-based approach and a range of different data sources to support hard-to-reach communities.

System Sustainability Impact

- Early detection and management of high-risk residents closer to home, will reduce demand on high-cost acute sector services.

DRAFT

Partnership Southwark

Priority Area:

Integrated Neighbourhood Teams

What are the actions we will deliver in 2025/26

- Define population needs and services to include in Core INT
- Agreed Southwark INT model and defined neighbourhood footprints
- Agree INT Integrator Function within the Southwark lens
- Gap analysis from current working and shape high level 12 to18 month Implementation Plan
- Engagement and socialisation of INT model and implementation plan to build momentum and engagement and further refine and shape a detailed implementation plan, building on existing examples of neighbourhood working and lessons learnt
- Organisational Development to organise existing staff and services into Teams and build joint visions and ways of working
- Recruitment of team managers to support each INT
- INTs launch, under a programme of iterative testing and learning

Population Health and Inequalities Impact

Working in Southeast London to agree a population health management (PHM) approach and PHM functions and tools to address health inequalities through neighborhood working.

System Sustainability Impact

Shifting the balance of care from acute to community and from treatment to prevention through an efficient model of integrated neighbourhood care.

DRAFT

Partnership Southwark

South East London Integrated Care System

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
Children and young people's mental health	For CYP who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	• Increase in % achievement of the 4 week wait standard
Adult mental health	For adults who need help with their mental health to not have to wait for so long. Support will be easy to access and co-ordinated around their needs.	• Increase in % achievement of a system wide 4 week wait standard • Reduction in number of patients waiting 72 hours in ED
Frailty	For older people living with frailty to have their needs identified sooner, to receive treatment and support at a neighbourhood level tailored to their individual needs.	• Reduce the rate of avoidable hospital and care home admissions from identified at risk cohorts. • Reduction in unplanned / emergency appointments (GP) • Reduction in ambulance conveyances • Reduction in outpatient appointments • Patient experience – quality of life
Prevention and health inequalities	Core20Plus5 communities to have easier access to support for the five leading causes of poor health.	• Increase in uptake of interventions for people from Core20Plus5 communities with identified Vital 5 risk factors.
Integrated Neighbourhood Teams	To implement an agreed model of Integrated Neighbourhood Teams that helps improve outcomes across a range of outcome metrics linked to improved prevention and management of long term conditions.	• Reduce the rate of avoidable hospital and care home admissions from identified at risk cohorts.

DRAFT

Partnership Southwark

What do we need from enablers and partners to deliver?

- **Data and digital:** improved access to timely data in accessible formats which supports the development of the neighbourhood model and our population health management approach, including Core20Plus5. Solutions to data sharing to support multi agency working and the development of innovative digital approaches to support efficient health and care provision.
- **Workforce**: development of an ICS workforce strategy that supports integrated team models and improves recruitment and retention in key front-line roles.
- **Estates:** further develop our collaborative estates strategy to support integration, including the development of neighbourhood team facilities options.
- **Finance:** development of the system sustainability work to enable a shift to investment in neighbourhoods and preventative services.
- **Communications & Engagement**: support in developing our comms strategy to support the five priority workstreams.

How will we work in collaboration with our system?

- **Wells Leadership:** develop diverse and proactive groups, impactful collaboration.
- **Community Networks:** grow these networks around each priority.
- **Professional Networks:** grow these networks around each priority.
- **Planning and delivery:** establish robust communications and engagement plans, influential working groups, and fully co-designed approaches.

We will also seek to obtain input from Health Innovation Network, Applied Research Collaborations, Kings Health Partners.

How will we engage with our population?

- **Engagement:** build on recent community engagement (including Southwark 2030) and agree next steps as we scope and develop delivery plans.
- **Lived-experience and community panels:** establish fully co-designed approaches, embedding lived-experience and community voices in design and delivery.
- **Partnership:** work with Community Southwark and voluntary sector organisations as key partners in engaging with residents.

How will we monitor and share progress?

- **Governance and reporting:** regular monitoring and reporting via governance structures and wider stakeholders, around a timeline and a set of agreed quantitative and qualitative measures, evidencing codesign approaches, and short-term and long-term outcomes (including for example community surveys and feedback mechanisms).
- **Communications and engagement:** establish robust plans to promote and communicate ambitions and achievements.

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 7
Enclosure: 6

Title:	**Integrated Assurance Report**
Meeting Date:	**27/03/2026**
Author:	Adrian Ward, Head of Planning, Performance and Business Support, SELICB
Executive Lead:	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

Summary of main points

Overview

This report provides a draft of the new Integrated Assurance Report that under the revised governance arrangements will be considered by the Integrated Governance and Assurance Committee and form the basis of an assurance report to each subsequent Partnership Southwark Strategic Board. The focus of the report is to provide assurance to the board on the delivery of delegated ICB responsibilities, other than primary care (which will be reported via the Primary Care Group) and delivery of the Health and Care Plan (which will be reported on by the Partnership Southwark Delivery Executive).

This report was reviewed in detail by the Integrated Governance and Assurance Committee at its meeting of 20th March and key points have been highlighted in the executive summary.

The report focusses on performance, planning, quality, safeguarding, risk, finance and delegated responsibilities around continuing healthcare and medicines optimisation. The report is in development and will be built upon iteratively in each quarterly reporting cycle.

The structure of the report is as follows:

Executive Summary:

Appendix: Integrated Assurance Report

Section 1: Performance Metrics
Section 2: ICB Southwark Operational Plan
Section 3: Quality Report
Section 4: Safeguarding Q3 report
Section 5: Risk Report
Section 6: Summary of Financial Position
Section 7: Other reports from designated leads for delegated responsibilities:

- Continuing Health Care
- Medicines Optimisation

Item presented for (place an **X** in relevant box)	Update	Discussion	Decision
	X	X	

Action requested of PSSB

The board is asked to note the Integrated Assurance Report and comment on the approach taken.

Anticipated follow up
The next board will receive a year end Integrated Assurance Report from the Integrated Governance and Assurance Committee.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	x
Adult mental health	x
Frailty	x
Integrated neighbourhood teams	x
Prevention and health inequalities	x

Item Impact				
Equality Impact	The Integrated Assurance Report does not have a direct impact on services, however it is a report that that provides information on a range of delegated responsibilities including aspects of quality, health inequalities, finance, safeguarding and medicines optimisation.			
Quality Impact				
Financial Impact				
Medicines & Prescribing Impact				
Safeguarding Impact				
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**	
	No direct impact but note the inclusion of a sustainable prescribing dashboard in section 1.1			

Describe the engagement has been carried out in relation to this item
The contents of this report have been reviewed by the Integrated Governance and Performance Committee on 20th March 2025.

Integrated Assurance Report

Executive Summary

Background

This report provides a draft of the new Integrated Assurance Report that under revised governance arrangements will be considered by the Integrated Governance and Assurance Committee (IGAC) and form the basis of an assurance report to each subsequent Partnership Southwark Strategic Board. The focus of the report is assurance on the delivery of delegated ICB responsibilities, other than primary care (which will be reported via the Primary Care Group) and delivery of the Health and Care Plan (which will be reported on by the Partnership Southwark Delivery Executive). The current scope of the report covers performance and key metrics, progress on delivery of operational plan priorities, quality, safeguarding, risk management, continuing health care and medicines optimisation.

The full report was considered in detail by the Integrated Governance and Assurance Committee on 20th March and this report summarises any key issues for the board to be aware of.

The full report reviewed by IGAC is attached in **appendix 1.**

Summary of key issues

1.1 Performance metrics – SELICB place level targets

IGAC reviewed the latest scorecard showing progress against key ICB targets from the SEL Operational Plan that are delegated to place.

The scorecard reflects the successful delivery of key targets in areas including dementia diagnosis, breast cancer screening, bowel cancer screening and learning disability annual health checks.

However it also shows that a number of areas are behind target and red flagged as a result. In particular to note:

- **Talking Therapies:** the 3 targets relating to numbers of discharges, reliable improvement and reliable recovery rates are below target. This service is commissioned through the SLAM contract and performance issues are being explored with the local commissioning team. Identified factors include a reduction in online services uptake and complexity of case mix impacting on improvement and recovery rate. Additional group clinics have been established to expand capacity.
- **SMI physical health checks:** The year-end target for SMI physical health checks is 70% for 24/25 and Q3 is below trajectory at 53%. However, it is known from previous years that this is a metric that increases significantly in Q4 and it is expected that the gap with the target will be substantially narrowed by year-end. 70% was achieved last year with a similar Q3 profile.
- **CHC 28 day assessment target:** performance dipped below the Q3 target, as discussed in the report from the delegated lead in section 7 of this report.
- **Childhood Immunisations:** In common with most London boroughs the 90% efficiency standard is not met across the range of immunisations measures, and performance is in fact above the London average. Improving uptake is a key priority that is subject to an extensive action plan through the Southwark immunisations group working with the South East London immunisations programme. The

associated risk of vaccine preventable outbreaks is recorded on the Southwark risk register.

- **Flu vaccination rates:** latest published data shows that the corporate objective to increase flu immunisation rates has not been met. The last published over 65's rate for Southwark stood at 54% against a target of 60%. This is also managed by the immunisation group as per children's
- **Cervical cancer screening:** rates are very marginally below the trajectories set Southwark for this corporate objective. As previously noted, the breast cancer and bowel cancer screening rate targets are being met in Southwark following recent improvements.
- **Management of hypertension in line with NICE guidance:** in common with all SEL boroughs the December data shows that the trajectory towards the new 80% national target was not met, with performance at 68% against 71% target, a decline on previous years. However Southwark is the joint highest on this measure in South East London. As this is a corporate objective detailed analysis of performance has been undertaken, which linked the drop in performance to Synnovis data issues earlier in the year.
- **Primary care access:** latest published data shows performance on the measure of GP appointments provided within 2 weeks shows performance at 89.7%, marginally below the 91% planning target. Local data for improvement plans focuses on the extent of GP variation.

All the above areas are covered as part of operational priorities and fall under business as usual plans.

Note: Personal Health Budgets: this is also under trajectory and flagged red but has not been an operating plan priority for some time, and is not in the latest national operational plan guidance. Current volumes reflect the numbers of qualifying service users who are predominantly continuing health care cases, wheelchair users and mental health S117 patients. The target is not met across South East London and Southwark's levels compare favourably with neighbouring budgets.

1.2 Performance Metrics - Local Performance Dashboard

In addition to the SEL metrics report IGAC reviews the local analysis of additional metrics relating to key priorities. The data comes from a range of sources including the ICB BI dashboards, NHSE and other published data.

Particular metrics focussed on in the March meeting were:

- **Better Care Fund (BCF) targets set for 2025/26**: The revised BCF arrangements includes focus on 2 new targets on which baseline data suggests Southwark is facing significant challenges:
    - Rate of emergency admissions of Southwark residents aged over 65 per (third highest in London)
    - Average days of delay in hospital after discharge ready date by Southwark residents (second highest in London)

  The Better Care Fund Plan will set out services that support admissions avoidance and support discharge and as these target are monitored and the data is analysed further opportunities for improvement will be identified.

- **Unplanned admissions for Ambulatory Care Sensitive Conditions:** It was noted that the latest data suggests that the 5% reduction target set in the current BCF will be safely met, with significant reductions in respiratory related admissions. However the data for **admissions due to falls** in older people has shown significant increases in 2024/25 and the reduction target will not be met.
- **Cholesterol management for people with CVD in line with NICE guidance:** this target is referenced in the new Operational Planning guidance. PCN level data shows South Southwark to be in the top quartile for SELICB whilst bottom quartile for North Southwark.
- **Core20Plus:** the data showing the main areas where performance is worse for those living in the 20% most deprived boroughs was reviewed, with progress in narrowing the gap evident in breast screening and cervical screening. The significant difference in flu uptake was also highlighted.
- **CQC inspection ratings:** two significant improvements were noted since the previous report:
    - The Acorn and Gaumont GP practice was rated "Good" after a period of being "Inadequate". This was the borough's only inadequate rated practice. As the practice has one of the highest proportion of Core20 patients this is welcome news.
    - The Camberwell Lodge Care Home rating improved from "Requires Improvement" to "Good"
- **Children and Young People mental health waiting times:** data for Q3 from the SEL BI dashboard suggests a significant decline in Q3, whilst **adult mental health waiting times** performance is relatively unchanged. Improving these metrics is a key priority for Partnership Southwark.

2 Operational Plan update

IGAC noted that the Southwark operational plan is currently being redeveloped for 2025/26 and will be presented to a future meeting, including a summary of year end 2024/25 position.

Progress on key metrics relating to the plan are covered in section 1.

3 Quality

IGAC reviewed the new Q3 report provide by the SEL quality team, and welcomed the development of a borough level report. More work will be done with the team to help ensure that the report focuses on priorities.

4 Safeguarding

IGAC reviewed a high level summary of the detailed Q3 report provide by the Safeguarding team that the Senior Management Team had reviewed, and welcomed the development of the borough level report. More work will be done with the team to help ensure that the report focuses on priorities around the delegated safeguarding responsibilities. A specific section on SEND is also in development.

5 Southwark Place Risk Register

IGAC noted the current risk on the register and changes since the last meeting. No risks are currently very high, and following mitigation a number of risks had been reduced in rating, including those linked to achieving financial balance in 2024/25, community equipment

services and the impact of GP collective action. The risk relating to the completion of the Harold Moody health centre has been closed.

Following the 2025/26 planning round a new set of risks will be assessed around financial pressures, management cost reductions and the delivery of priorities.

6. Finance summary report

IGAC receives a detailed Finance report which is reviewed in full. The report to the board includes a summary of the key issues discussed.

7. Reports from delegated leads for Continuing Health Care and Medicines Optimisation

IGAC noted the reports included in the attached report.

Partnership Southwark

Integrated Assurance Report - March 2025 Appendix

Partnership Southwark

Integrated Assurance Report - Appendix

March 2025

Section 1.1:
SEL ICB dashboard of key metrics and targets delegated to place

Attached is the full place report provided by the ICB assurance team on 14.3.25 showing the position on 24/25 metrics, targets and benchmarking.

Local commentary on areas flagged as red rated is provided as an annex.

Contents

Overview of report

Summary:

- This report is produced by the SEL ICB assurance team and is intended to be used by LCPs as part of their local assurance processes.
- The latest position against key areas of local performance is presented, highlighting achievement against national targets, agreed trajectories and other comparators. An overview of performance and wider SEL context is provide to support interpretation of the data.
- This report is intended to be used by the responsible LCP committee/sub-committee to identify areas where performance is not in line with expectations and where members/teams may be required to provide additional explanation and assurances that issues are being addressed either locally or as part of a wider system approach.

Contents and structure of report:

- The report covers a range of metrics where LCPs either have a direct delegated responsibility for delivery or play a key role in wider SEL systems. It covers the following areas:
    - Areas of performance delegated by the ICB board to LCPs.
    - Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities LCPs.
    - Metrics requested for inclusion by LCP teams.

Structure

- A dashboard summarising the latest position for the LCP across all metrics is included on page 4.
- This is followed by a series of more detailed tables showing performance across south east London with explanatory narrative.
- Metrics are RAG rated based on performance against national targets, agreed trajectories or national comparators (where included in the tables). Arrows showing whether performance has improved from the previous reporting period is also included.

Definitions:

- Definitions and further information about how the metrics in this report are calculated can be found here.

Southwark performance overview

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↔	Jan-25	National standard	67%	72%
IAPT discharge	↓	Dec-24	Operating plan	406	295
IAPT reliable improvement	↔	Dec-24	Operating plan	67%	60%
IAPT reliable recovery	↑	Dec-24	National standard	48%	45%
SMI Healthchecks	↑	Q3	Local trajectory	68%	53%
PHBs	↑	Q3 - 24/25	Local trajectory	586	335
NHS CHC assessments in acute	↔	Q3 - 24/25	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↓	Q3	Local trajectory	75%	62%
CHC - Incomplete referrals over 12 weeks	↔	Q3 - 24/25	Local trajectory	0	0
Children receiving MMR1 at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	78%
Children receiving MMR1 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	83%
Children receiving MMR2 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	73%
Children receiving DTaP/IPV/Hib % at 12 months	↑	Q2 - 24/25	PH efficiency standard	90%	87%
Children receiving DTaP/IPV/Hib % at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	85%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	61%
Children receiving DTaP/IPV/Hib % at 5 years	↑	Q2 - 24/25	PH efficiency standard	90%	86%
LD and Autism - Annual health checks	↑	Jan-25	Local trajectory	710	893
Bowel Cancer Coverage (60-74)	↑	Jul-24	Corporate Objective	62%	63%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	64%	64%
Breast Cancer Coverage (50-70)	↑	Jul-24	Corporate Objective	57%	59%
Percentage of patients with hypertension treated to NICE guidance	↑	Feb-25	Corporate Objective	71%	68%
Flu vaccination rate over 65s	↑	Jan-25	Corporate Objective	60.9%	55.4%
Flu vaccination rate under 65s at risk	↑	Jan-25	Corporate Objective	33.2%	31.7%
Flu vaccination rate – children aged 2 and 3	↑	Jan-25	-	-	37.1%
Appointments seen within two weeks	↓	Jan-25	Operating plan	91%	89%
Appointments in general practice and primary care networks	↑	Jan-25	Operating plan		121613
Appointments per 1,000 population	↑	Jan-25			351

Dementia Diagnosis Rate

SEL context and description of performance

- The 2024/25 priorities and operational planning guidance identifies improving quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025 as a National NHS objective. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. January 2025 performance was 69.8%.
- There is, though, variation between boroughs. Greenwich has not achieved the target in 2024/25 (or during 2023/24).

		Jan-25						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Dementia diagnosis rate*	66.7%	71.9%	70.9%	64.3%	76.6%	62.3%	71.6%	69.8%
Trend since last report	-	↑	↓	↓	↓	↓	↔	↓

*Nationally reported borough-level dementia diagnosis rates are aggregated based on the postcode of individual GP practices mapped to UTLAs. This does not map exactly to NHS geographies. This means that a single Lambeth practice is included as part of the figures for Southwark, and practices that serve the wider ICB (e.g. SEL Special Allocation Practice) are allocated to an individual borough.

**Reported Lewisham performance has fallen from 69% in September. The new Lewisham Care Home Practice has not been included in the nationally reported data from October 2024, which likely accounts for the reduction in dementia register size.

IAPT/Talking Therapies

SEL context and description of performance

- New metrics to measure performance of NHS Talking Therapies have been introduced for 2024/25. These new targets have been welcomed by services, but they will need to adjust their delivery in line with these. New targets are as follows:
    - Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.
    - Reliable improvement rate for those completing a course of treatment.
    - Reliable recovery rate for those completing a course of treatment and meeting caseness.
- The target for the number of patients discharged following at least two treatments has not been met since April 2024 and is now at its lowest level this financial year. Reliable improvement and reliable recovery targets have been achieved but is variable across individual services.

	Dec-24						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	120	155	320	485	425	295	1765
Trajectory	176	261	321	585	355	406	2119
Trend since last reporting period	↓	↓	↑	↓	↑	↓	↓

		Dec-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	48.0%	45.0%	46.0%	53.0%	47.0%	45.0%	48.0%
Trend since last report	-	↔	↓	↓	↔	↑	↑	↔

		Dec-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	64.0%	65.0%	66.0%	70.0%	70.0%	60.0%	67.0%
Trend since last report	-	↓	↓	↓	↑	↑	↔	↔

SMI Physical Health Checks

SEL context and description of performance

- The south east London ICB board has set Improving the uptake of physical health checks for people with SMI as a corporate objective.
- There was a significant increase in the number of AHCs undertaken for people with an SMI during 2023/24 and the SEL operating planning trajectory was achieved at the end of 2023/24. All LCPs significantly improved their position and delivered health checks to over 60% of their registers. Indicative trajectories, aligning with the SEL operational plan, were met by 3 out of 6 LCPs.
- As part of the operational planning process, a trajectory to achieve 70% uptake by the end of 2024/25 has been agreed for south east London.
- SMI physical health checks is also part of the 2024/25 Quality and Outcomes Framework (QOF) with an aim to reduce health inequalities. QOF rewards practices for delivering all six elements of the check.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Q3 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
SMI Healthchecks	54.4%	47.5%	49.0%	54.6%	45.2%	53.4%	50.6%
Trajectory	67.9%	67.9%	67.9%	67.9%	67.9%	67.9%	67.9%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

***NOTE:** The above figures have been calculated based on published LCP performance for Q3: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

Personal Health Budgets

SEL context and description of performance

- As part of the Long Term Plan, annual borough level targets were submitted for the total number of PHBs to be delivered annually up to the end of 2023/24. The regional team have extended the targets into 2024/25. For SEL the target is to achieve 4,926 by the end of Q4.
- The personal wheelchair budgets offer is in place across SEL and PHBs for mental health service users. This has been introduced through the South London Partnership.
- S117 PHBs have been a 'right to have' since December 2019, but this still needs implementing through SLAM and Oxleas.
- Preventative small PHBs have been introduced, linked to social prescribing in Lewisham for people with low level mental health needs, where an immediate solution or intervention isn't available. The intention is to expand the offer to all PCNs. This is primarily offered through Age UK currently.
- There is ongoing support to LCPs to implement the personalisation agenda and expand their PHB provision. A 'Community of Practice' has been developed to support the workforce to implement personalised care across the ICS. Issues relating to DPIA and data sharing agreements have been resolved.

	Q3 - 2024/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
PHBs	918	1071	498	382	219	335	3438
Trajectory	535	764	662	739	611	586	3898
Trend since last report	↑	↑	↑	↑	↑	↑	↑

NHS Continuing Health Care

SEL context and description of performance

- There are a number of national standards which systems are required to achieve consistently. Where deviating from the standard, there is an expectation that performance will be addressed as a priority. Performance standards are as follows:
  - A national target was previously set to reduce the number of CHC assessments in an acute hospital setting to less than 15%. The aim, however, is that zero assessments should be completed in an acute setting and this is the benchmark that LCP and ICB teams are measured against.
  - Complete assessments of eligibility within 28 days from the date of referral in >80% cases.
  - Reduce the number of outstanding referrals exceeding 12 weeks to Zero
- Recovery trajectories for the 28 day and 12 week metrics have been agreed with NHSE.

		Q3 - 24/25						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
NHS CHC assessments in acute	0	0	0	0	0	2	0	2
Trend since last reporting period	-	↔	↔	↔	↔	↑	↔	↑

	Q3 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Percentage assessments completed in 28 days	74%	93%	81%	41%	80%	62%	78%
Trajectory	75%	75%	75%	75%	75%	75%	75%
Trend since last reporting period	↑	↑	↓	↓	↑	↓	↑

	Q3 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Incomplete referrals over 12 weeks	0	0	0	0	2	0	2
Trajectory	0	0	0	0	0	0	1
Trend since last reporting period	↔	↔	↔	↓	↑	↔	↑

Childhood immunisations (1 of 2)

Description of metric and SEL context

- Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. South East London and our 6 local care partnerships recognise this in the ICS Strategic Priorities and our Joint Forward Plan.
- South East London ICB has recently refreshed its Vaccination and Immunisation Strategy and has embedded within the six boroughs an approach to increase uptake by developing trust and confidence in the childhood immunisation programme with local communities.
- Since December 2023 there have been a number of reported cases of measles across the country resulting in a national and regional response. SEL boroughs and programme team are co-ordinating and aligning plans across the system in response to the concerns. A full report detailing the position and proposed actions was agreed at the ICB Executive Committee in February 2024. Actions include: SRO/director level attendance at London IMT meetings; production of regular sitrep feeding up to London IMT; A sub-group of the SEL board meets on a regular basis with borough leads, public health, communications and primary care leads to co-ordinate the local response and to support local plans. Each borough has produced a local action plan and are using their local place level vaccination groups to support delivery.
- Borough plans are also in place in response to the rise in numbers of whooping cough numbers and the imperative to focus on the full range of childhood immunisations including pertussis and flu.
- The 24/25 operational planning guidance identifies the following as a key action for systems: maximise uptake of childhood vaccinations and flu vaccinations for CYP, achieving the national KPIs in the Section 7a public health functions agreement, including reducing inequalities. The 25/26 operational guidance states that it remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and services aimed at addressing the leading causes of morbidity in all age groups, including CYP.
- The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard is used as the comparator for RAG ratings in the 2024/25 LCP performance below. This is a change in approach compared to previous year (which used the national average as comparator)

		Q2* - 24/25								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR1 at 24 months	90%	84.8%	86.9%	84.9%	79.5%	84.8%	78.3%	83.2%	80.0%	88.8%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR1 at 5 years	90%	86.1%	87.1%	82.7%	79.8%	83.3%	82.6%	83.6%	81.8%	91.2%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	**Efficiency standard**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**	**London**	**England**
Children receiving MMR2 at 5 years	90%	74.5%	81.1%	72.4%	70.0%	76.8%	72.5%	74.7%	69.5%	83.4%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

***Important note: Data now includes unregistered children; previous submissions only included children registered with a GP.**

Childhood immunisations (2 of 2)

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	88.8%	89.7%	87.4%	84.7%	86.7%	87.2%	87.3%	84.5%	90.7%
Trend since last report	-	↓	↓	↓	↓	↓	↑	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	89.4%	91.5%	87.4%	85.8%	88.0%	84.8%	87.7%	85.9%	92.1%
Trend since last report	-	↓	↓	↓	↓	↑	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	73.0%	75.1%	68.6%	63.4%	69.2%	60.9%	68.5%	62.9%	80.8%
Trend since last report	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	85.7%	90.0%	86.7%	83.6%	86.2%	85.6%	86.4%	84.8%	92.6%
Trend since last report	-	↓	↓	↓	↓	↑	↑	↓	↓	↓

*Important Note: Data now includes unregistered children; previous submissions only included children registered with a GP.

Learning disabilities and autism – annual health checks

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective.
- SEL achieved the 2023/24 plan with 7,104 health checks delivered against a plan of 6,018. The SEL plan for 2024/25 is to deliver a minimum of 6,600 health checks.
- All LCPs are currently delivering against the 2024/25 trajectory
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Jan-25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
LD and Autism - Annual health checks	736	885	1128	1130	1202	893	5974
Trajectory	675	695	906	935	1094	710	4825

Cancer screening

SEL context and description of performance

- The south east London ICB board has set improving breast, bowel and cervical screening a corporate objective. At an SEL level, bowel cancer screening coverage is currently above the nationally defined optimal level of screening of 60% for south east London. Cervical cancer screening is currently below the nationally defined optimal level of screening of 80%. Breast cancer screening is currently below the nationally defined optimal level of screening of 70-80%.
- For 2023/24, SEL set overall ambitions for improving breast, bowel and cervical screening a corporate objective. Indicative LCP level targets were also developed for 2024/25 and shared via the six Place Executive Leads (PELs). These are based on a standard proportional reduction in the unscreened population at an LCP level for each cancer cohort. 2024/25 performance will be reported against these trajectories.
- This means that there is an expectation that all LCPs will improve uptake in 2024/25 but those with a lower current uptake will have a slightly larger stretch for the year. Thus, supporting a reduction in inequality between boroughs. LCP and ICB performance is now being reported against the 2024/25 trajectories.
- Screening is directly commissioned by NHS England, and delivery is through regional teams. Changes to programme, workforce, capacity etc. require NHS England to action. Given this, we rely on a joint approach with other London ICBs on common issues within these areas and advocate for regional solutions such as addressing workforce and capacity challenges within programmes, improving processes and operational pressures, and coordinating potential mutual between screening providers. Local actions for SEL require focus on improvements within the current programme structure/resource.

	Jul-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Bowel Cancer Coverage (60-74)	73.8%	75.8%	65.5%	61.8%	63.9%	62.5%	67.6%
Trajectory	72.8%	75.3%	65.2%	62.3%	63.1%	62.2%	67.3%
Trend since last reporting period	↑	↑	↑	↑	↑	↑	↑

	Jun-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Cervical Cancer Coverage (25-64 combined)	71.5%	73.7%	66.0%	62.7%	67.4%	63.6%	66.9%
Trajectory	72.1%	74.4%	66.2%	63.3%	68.0%	64.4%	67.4%
Trend since last reporting period	↓	↓	↓	↓	↓	↓	↓

	Jul-24						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Breast Cancer Coverage (50-70)	70.1%	71.3%	57.7%	56.0%	57.7%	59.1%	62.1%
Trajectory	70.4%	73.5%	59.4%	57.5%	59.0%	57.4%	63.0%
Trend since last reporting period	↑	↓	↑	↑	↑	↑	↑

NOTE: Due to lag in national reporting, local data is shown. This uses the same Open Exeter data source

Management of hypertension to NICE guidance

SEL context and description of performance

- The south east London ICB board has set improving the percentage of patients with hypertension treated to NICE guidance as a corporate objective. The board agreed a 'floor' level ambition of 69.7% as a minimum by March 2024 with the intention to achieve 77% (2023/24 operational plan target) as soon as possible.
- The SEL 'floor' level ambition for 2023/24 was achieved overall and by five of six LCPs individually. Significant improvement was achieved across all LCPs.
- The 2024/25 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 80% by March 2025 as a national objective. For 2024/25, this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 80% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the PELs.
- 2024/25 performance will be reported against straight line trajectories for each LCP to achieve the 80% target by March 2026.
- There is a significant time lag (of approximately 4 months) in the publishing of national reporting (CVD PREVENT) of this metric. To support local monitoring of performance, the SEL LTC team have used the local data as the basis for trajectories up to March 2026.
- Hypertension is predominantly managed in general practice and there is wide variation in achievement across practices, not always explained by demography. People at risk may not have sufficient support to understand the importance of detecting and managing raised blood pressure.

	Feb-25 (Local data reporting)						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	63.0%	65.0%	68.0%	66.0%	60.0%	68.0%	65.0%
Trajectory	69.9%	71.7%	71.4%	71.2%	68.2%	71.0%	70.6%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

Note: Recent data migration has resulted in correction to historic data.

Adult flu immunisation (1 of 2)

SEL context and description of performance

- The south east London ICB board set improving adult flu vaccination rates as a corporate objective. The ambitions for 2023/24 was as follows: improve the vaccination rate of people aged over 65 to 73.7%, improve the vaccination rate for people under 65 at risk to 46.0%.
- Performance in 2023/24 (year 1) was significantly below ambition for both metrics and represented a decrease in performance from the previous year.
- In order to ensure that 24/25 ambitions were informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team have set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season.
- The below table provides targets set at borough level
- The following slide provides the published November borough level performance and the preliminary 12 January borough level performance vs trajectory

Year end targets for 2024/25 proposed by borough teams:

	65+ cohort vaccination target for 2024/25 season	<65 at risk cohort vaccination target for 2024/25 season
Bexley	75.0%	42.0%
Bromley	76.2%	46.5%
Greenwich	66.4%	36.9%
Lambeth	60.0%	32.9%
Lewisham	61.0%	34.3%
Southwark	61.5%	34.2%
SEL	68.1%	37.3%

Adult flu immunisation (1 of 2)

Published January Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.7	72.9	61.5	54.2	53.7	55.4	62.7
Local December trajectory	70.0%	74.7%	66.0%	59.0%	60.8%	60.9	66.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	35.5	39.1	35.1	29.6	28.9	31.7	32.9
Local December trajectory	40.0%	45.6%	34.0%	32.7%	32.6%	33.2%	36.0%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	35.7%	48.7%	38.1%	36.8%	38.4%	37.1%	39.4%

Provisional data to 26 January 2025*

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.6%	72.7%	61.3%	53.8%	53.5%	55.2%	62.5%
Local January trajectory	70.0%	74.7%	66.0%	59.0%	60.8%	60.9%	66.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	35.3%	39.0%	34.8%	29.3%	28.8%	31.3%	32.7%
Local January trajectory	40.0%	45.6%	34.0%	32.7%	32.6%	33.2%	36.0%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	35.9%	48.6%	38.0%	36.5%	37.6%	36.7%	39.2%

*Borough level performance has been calculated from non-mandatory automated practice level data uploads. Coverage for all borough is >95% of practices

Primary care access

SEL context and description of performance

- The 2024/25 Priorities and Operational Planning guidance identifies the following as a national objective for 2024/25:
    - Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
    - Planned number of general practice appointments.
    - Percentage of patients whose time from booking to appointment was two weeks or less for appointment types not usually booked in advance.
- Appointments totalled 790,111 in November against the operating plan of 804,747. SEL did not achieve the planning trajectory for appointments seen within 2 weeks (89.0% vs 91.0% trajectory).

		Jan-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	91.0%	89.8%	85.3%	93.3%	91.4%	86.5%	88.8%	89.2%

		Jan-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	727247	119408	144433	128846	186600	125724	127313	832324
Appointments per 1,000 population	-	456	401	393	412	351	351	392

Partnership Southwark

Section 1.1: SEL ICB dashboard of key metrics and targets delegated to place

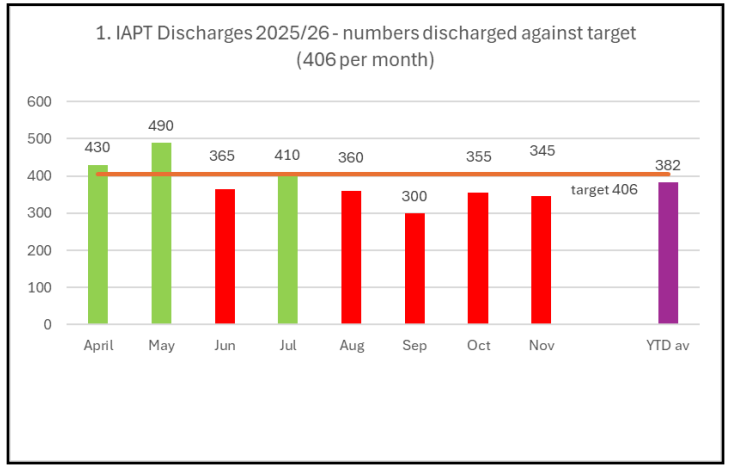
Annex: Local commentary and additional context on areas flagged as red rated in the SEL metrics report

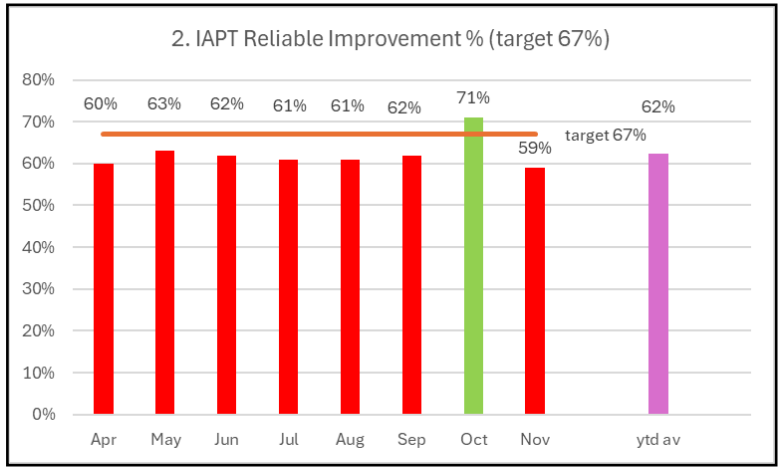
Southwark narrative on red rated metrics highlighted in SELICB place report

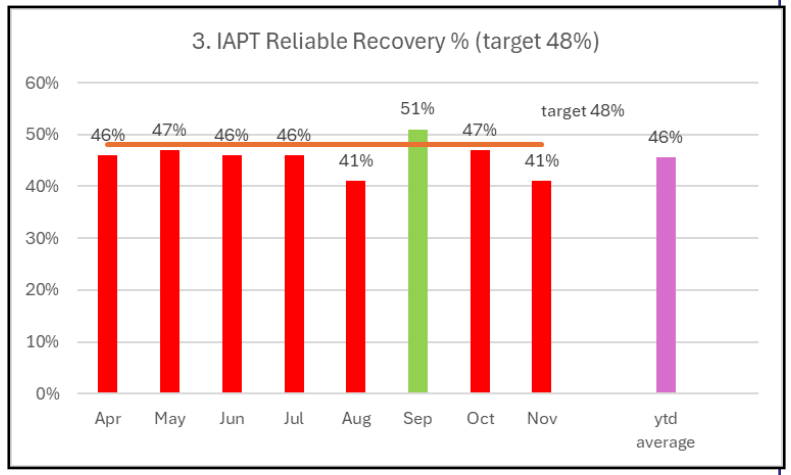
Partnership Southwark

1) IAPT / Talking Therapies – discharges, reliable improvement and reliable recovery

The SEL report shows that IAPT data in Southwark in November was below targets imposed for the 3 IAPT metrics in the national operational plan framework. As the SEL report is just a one-month snapshot for November monthly in-year trends are shown below for context:







1. This shows that **discharge** numbers in the year to date are below target (average of 382 against target of 406 per month. It is notable that the first 4 months of the year were higher than the last 4 months. However, it should be noted that no SEL borough has met the trajectory.
2. Aside from a notable peak in October, **reliable improvement** has been consistently averaging 62% against the 67% target and the benchmarking in the pack shows it to be below the average of neighbouring boroughs, who are on target.
3. Similarly, the **reliable recovery rate** has been consistently under target, apart from September when 51% was achieved. August and November dropped significantly below the SEL average.

Oversight of performance: the IAPT service is commissioned and monitored on behalf of the borough by the SEL commissioning team as part of the overall SLAM contract. Discussions are underway to enhance the provision of place monitoring data to the Joint Commissioning Team to enable performance issues to be identified, discussed and addressed.

To be updated with December data

Southwark narrative on red rated metrics highlighted in SELICB place report

2) SMI Healthchecks

The year end target for SMI physical health checks is 70% for 24/25 and Q2 is 49%. It has been red lit in the SEL report as the Q1 target was set at 66%. However it is known that from previous years this is a metric that increases significantly in Q4. In 2023/24, when the final year performance was strong at 71% against a 60% target, Q2 performance was at 52%.

Note that Q3 data recently publish shows the rate as 53.4%.(against 56% in Q3 last year). This suggests the performance has slightly declined from last year but the extent of Q4 review activity may still mean the target will be met. Hence overall this is not yet an area of significant concern.

SMI Health Checks are delivered through a mixture of checks undertaken by GPs and mental health teams and are a key measure tracked by primary care and SLAM commissioners.

3) Personal Health Budgets (PHB)

It is recognised that PHBs continue to be under the trajectory set in Southwark at 57% of trajectory. This is a long term trend. The rates are very similar or lower in neighbouring boroughs. Personal Health Budgets are provided in 3 main ways; continuing health care (adults and children) which constitute the bulk of budgets, wheelchair budgets issued by GSTT and mental health PHBs. It should be noted that Bromley and Bexley exceed their targets in part due greater numbers of older people receiving CHC and more wheelchair budgets.

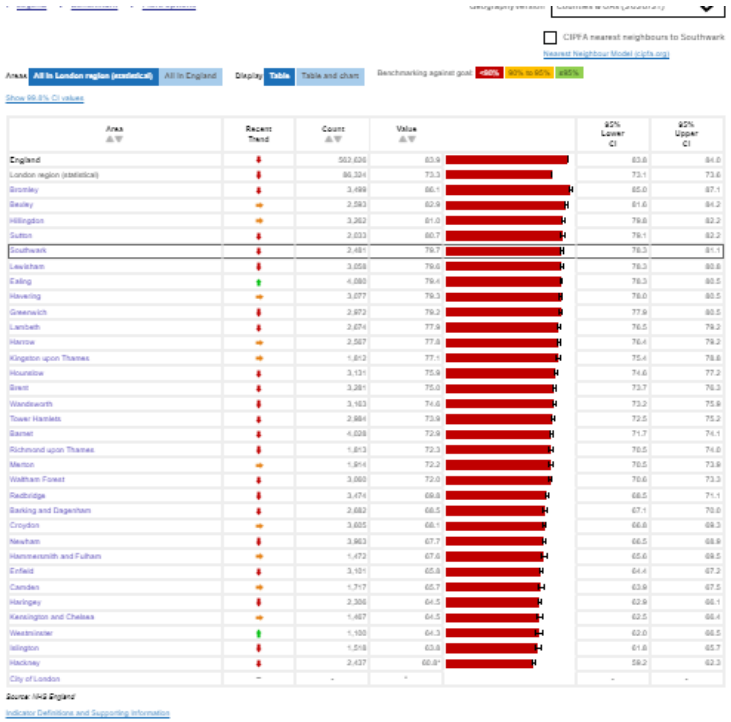
4) **CHC assessments with 28 days**

Performance is below the 75% target. See CHC delegated report slide (87) for details.

Southwark narrative on red rated metrics highlighted in SELICB place report

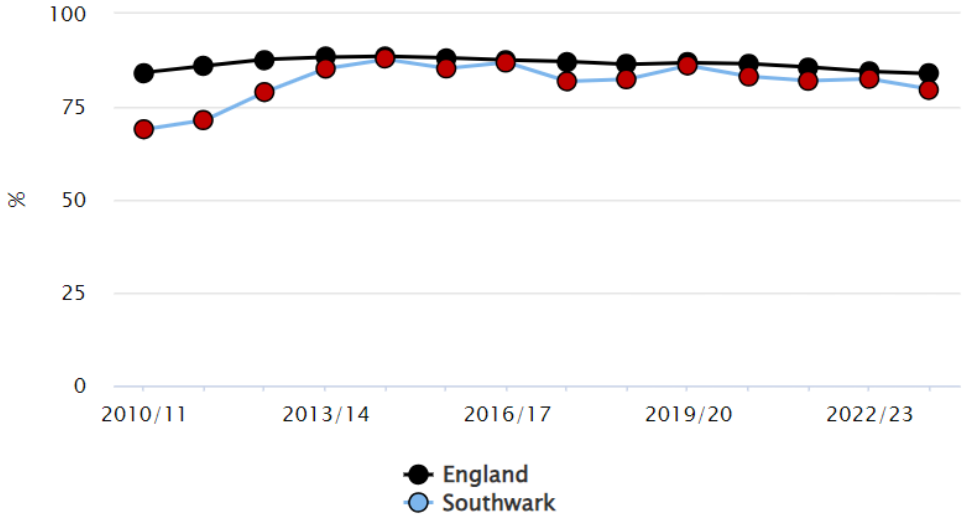
5) **Childhood immunisations:** Southwark does not meet the 90% national standard in any of the 7 childhood immunisations metrics in the SEL scorecard hence is red ragged. However there are recognised challenges in achieving target rates in Inner-London linked to the high mobility of the child population, and the benchmarking shows the rate is higher than the London average in 6 out of 7 cases. Using **MMR2 at 5 years** data from the Public Health Outcomes Framework tool as an illustration this shows that all London "red" and Southwark 6th highest. The trend data shows that the gap with England has narrowed since 2014. Local assurance is provided through the Southwark immunisation group oversees the local delivery of the SEL immunisation strategy, focusing on increased uptake in low uptake groups. This issue has been added to the place risk register and has a detailed action plan.

MMR2 at 5 yrs – London benchmarking



Southwark 6th

MMR2 5 at years - Southwark trend vs England



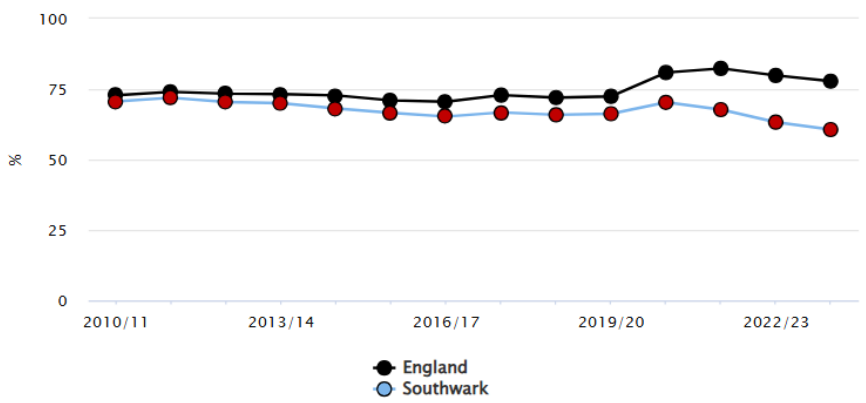
Southwark narrative on red rated metrics highlighted in SELICB place report

6) Flu immunisation

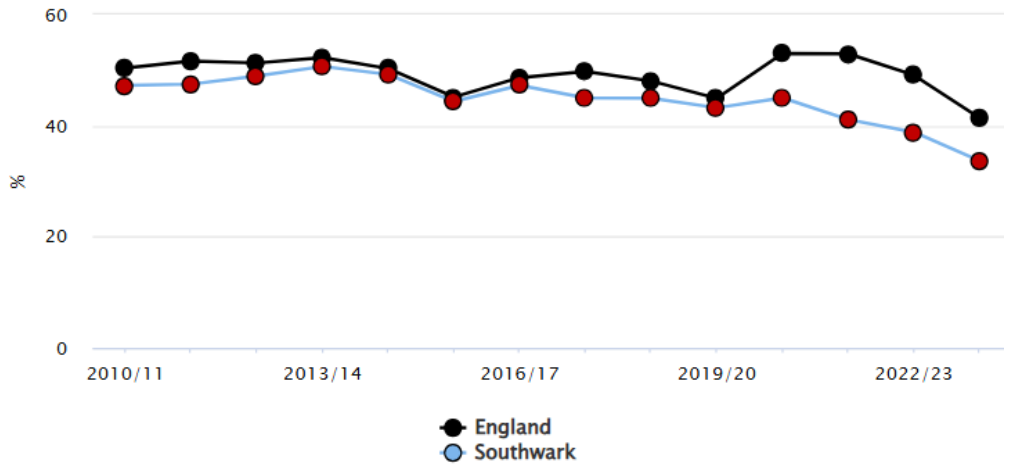
Southwark underperformed on the trajectory set on this corporate objective with 55.4% achieved against the target 60.9% for over 65 year olds, and no further significant growth likely under the current campaign which started in October. This is significantly below the final rate for 2023/24 of 60.6%. The rate for under 65 year olds at risk was closer to the target set at 31.7% vs 33.2%. This is a slightly higher level of coverage to Lewisham and Lambeth, but significantly lower than Bromley and Bexley. Detailed local data (see section 1.2) shows that vaccine hesitancy remains a key issue with 15% of the targeted cohort declining the vaccination offer. The graphs below show the longer term downward trend over the last 5 years.

As with childhood immunisations this has been added to the risk register and subject to an action plan to seek improvements in the next campaign.

Over 65's flu immunisation trends to 23/24



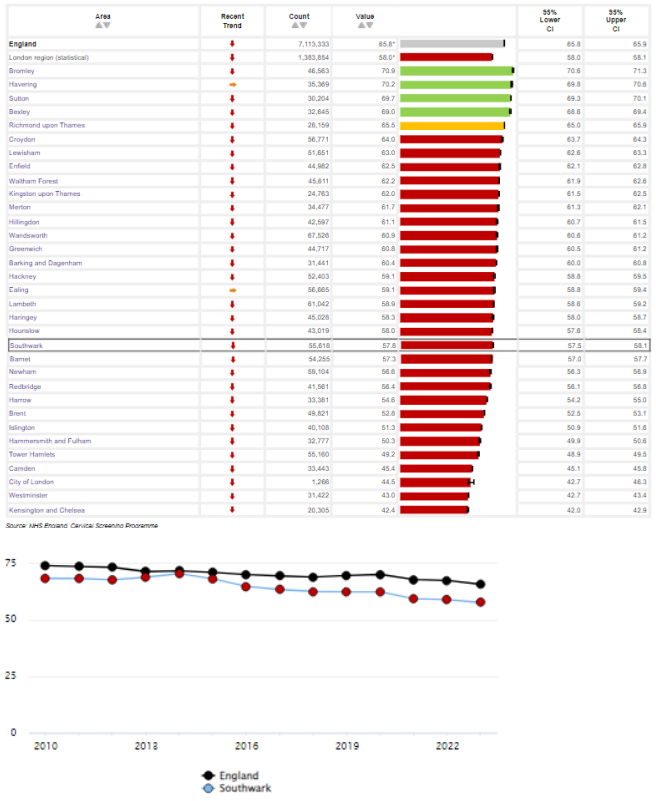
Over 65's flu immunisation trends to 23/24



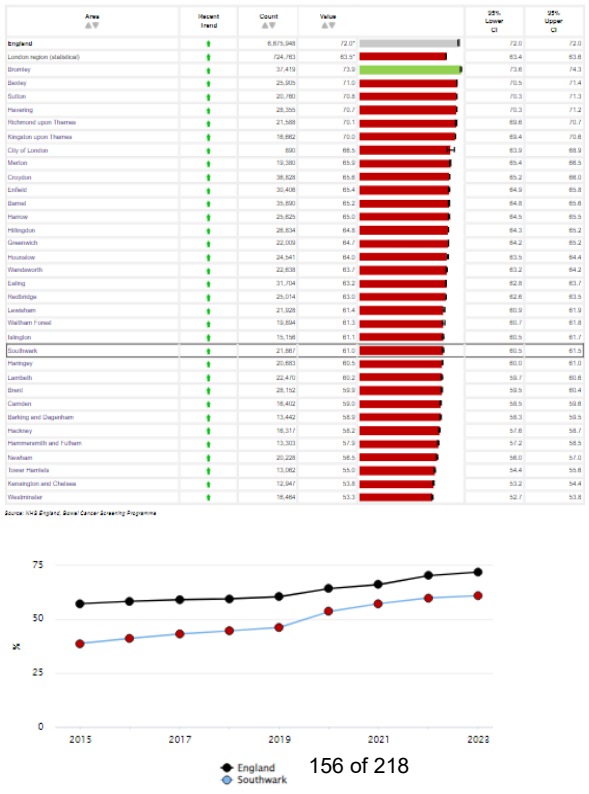
Southwark narrative on red rated metrics highlighted in SELICB place report

7) Cervical Cancer screening: Southwark is below the corporate objectives improvement targets set locally for cervical screening but recent improvements in bowel and breast screening rates have bought these within target. For context the public health outcomes benchmarking charts below that London is challenged on targets with few in the green zone, and Southwark tending towards the bottom third. Cancer screening uptake is a key area of health inequalities and prevention workstreams.

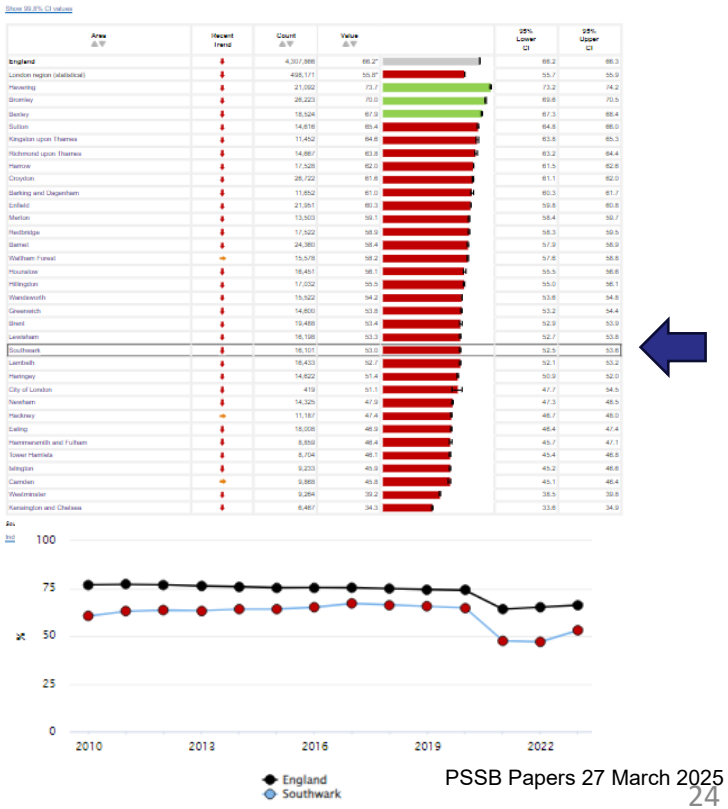
Cervical



Bowel



Breast



Southwark narrative on red rated metrics highlighted in SELICB place report

8. Management of hypertension to NICE guidance: in common with all SEL boroughs the October data shows that the trajectory towards the new 80% national target was not met, with performance at 68% against 71% target in February. The detailed trend data below (chart 1) shows that performance has dropped off since March and can be expected to pick up again – although the 80% target is clearly challenging. Further context is the ongoing monthly increase in the hypertension register (chart 2) (growth of 3% to 39,952 from April to February). It is also encouraging to see the over 80 yr old metric continues to be close to the 80% target (chart 4).

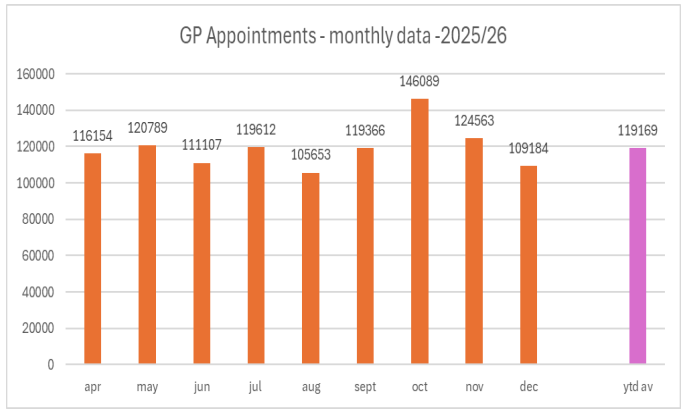
See slide 2.05 for more detail.

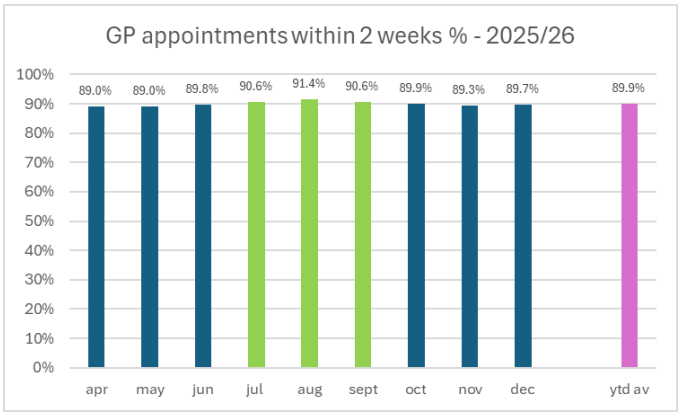
Southwark narrative on other highlighted in SELICB place report

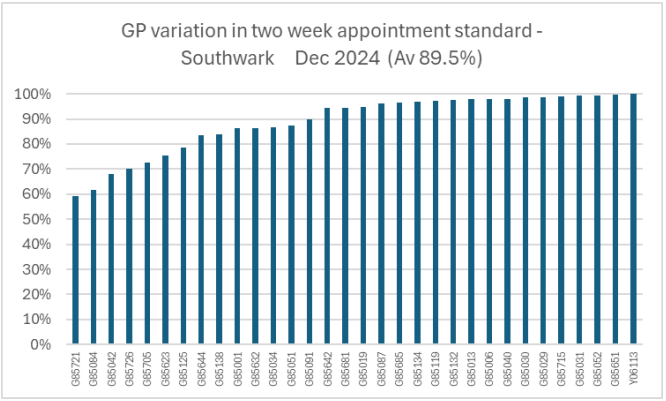
8) **Primary Care Access (not rag rated)** The charts below give more detail on the trends and GP variation in the new GP access figures which in the SEL report shows a snapshot for December.

The first chart shows some volatility in the monthly level of appointments. The high figure in October is clearly linked to the winter flu campaign.

The second chart shows that Southwark is marginally under the 91% target for appointments made within 2 weeks, whilst the 3rd chart shows a high level of GP variation against this target.







To be updated with January data

Partnership Southwark

Integrated Assurance Report

March 2025

Section 1.2: Local metrics – additional data pack

Measures taken from a range of sources including published data and SELICB BI dashboards that relate to our key objectives, in addition to those in the SEL Southwark report (1.1)

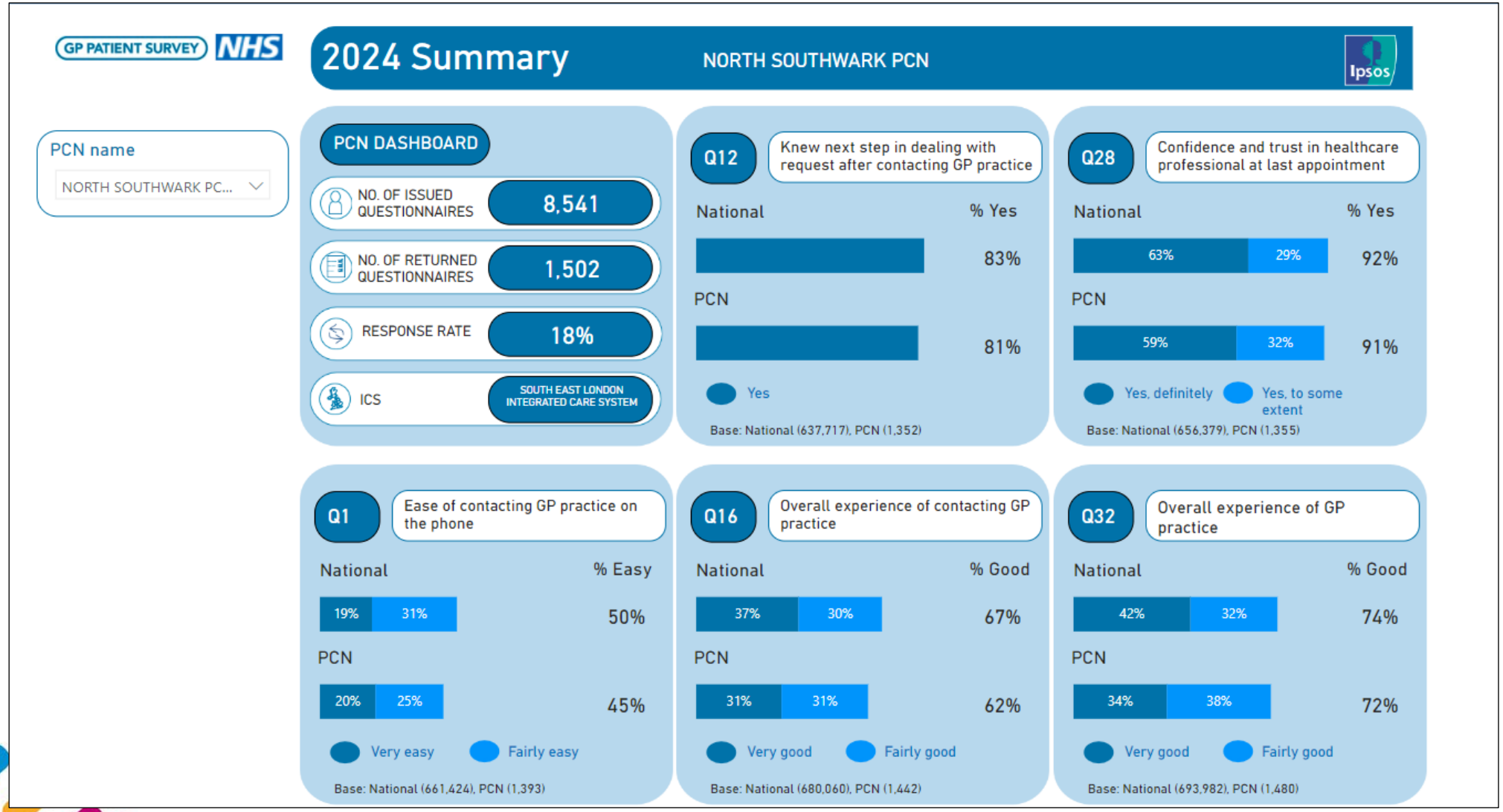
Southwark performance overview – additional local metrics (1)

Metric	2022/23	2023/24	2024/25	period	Trend	Target / benchmark	Link to Op Plan	Latest Details
CQC survey: overall experience of contacting GP practice	-	-	64.5% av	2024 survey	-	SELICS: 64%	Primary Care Access	2.01
ARRS posts – FTE (source PCN dashboard)	97	171	198	To Dec 2024	better (up)		Primary Care Access	-
A&E attendances per 1000 weighted list size (SEL practice dashboard)	346	307	201	to Jan 2025	better (down)		Frailty/INTs	2.03
GP appointments – face to face (SEL GP access dashboard)		Data issue	776,118	To Feb 2025	up		Primary Care Access	2.04
GP appointments – telephone (SEL GP access dashboard)		Data issue	334,945	To Feb 2025	down		Primary Care Access	2.04
Patients on Hypertension Register	36,737	37,668	39,952	To Feb 2025	better (up)	tbc	Prevention/INTs	2.05
Hypertension blood pressure control all ages (OP target)	67.5	71.2	68%	To Feb 2025	worse	71%	Prevention/INTs	2.05
Hypertension blood pressure control over 80 yr olds	70.6%	79.8%	78%	To Feb 2025	Worse		Prevention/INTs	2.05
Hypertension blood pressure control under 80 yr olds	63.5%	65.6%	62.4%	To Feb 2025	Worse		Prevention/INTs	2.05
Cholesterol / CVD management (OP target)	-	-	32.7% av	To Sept	Tbc	tbc	Prevention/INTs	2.06
Diabetes 3 Treatment Tests	34.9%	33.1%	24.4%	Tbc	y/e tbc	above SEL av	Prevention/INTs	2.08
Diabetes 8 Care Processes	72.6%	79.6%	64.9%	Tbc	y/e tbc	above SEL av	Prevention/INTs	2.08
Vital 5 coding completeness	n/a	n/a	Misc	To March 2025	-	-	Prevention	2.09
Core 20 - key metric inequalities – focus on cancer screening and COPD	n/a	n/a	Misc	To	better	reduce gap	Health Inequalities	2.10-12
Unplanned Admissions Ambulatory Care Sensitive Conditions rate (BCF)	858	882	601	To Dec 2024	Better	5% reduction	Frailty/INTs	2.13
Discharge to usual place of residence (BCF)	96.7%	96.1%	95%	To Dec 2024	worse	96.7%	multiple	2.14
Admissions for falls in over 65s (BCF)	481	434	438	To Dec 2024	worse	5% reduction	multiple	2.14
Permanent admissions to care homes (rate per 100,00 over 65's) (BCF)	499	492	377	To Dec 2024	worse	473 (n=154)	multiple	2.14
Non-elective admissions (total) over 65s (New BCF target)	tbc	tbc	1903	To Nov 2024	worse	Tbc	Frailty/INT	2.15
Discharge delays - % discharged on discharge ready date (New BCF target)	-	-	91.4%	Sept-Dec 2025	-	Lond 90.1 Dec.	Frailty/INT	2.16
Discharge delays – average patient delay (all) (new)	-	-	0.95 days	Sept-Dec 2025		Lond 0.65 Dec.	Frailty/INT	2.16
Discharge delays – average patient delay if discharge after ready date (new)	-	-	10.7 days	Sept-Dec 2025		Lond 6.7 Dec.	Frailty/INT	2.16
Sustainability: Carbon footprint per salbutamol inhaler prescription (C02kgE)	18.09	18.24	17.87 (Oct)	Feb 2025	better		Sustainability	2.17
Immunisations dashboard Flu, Covid – BI dashboard – supplementary data			See page	March 2025			Prevention	2.18
Childhood Immunisations BI dashboard – MMR – fully vaccinated %			See page		worse	95%	Prevention	2.19
CQC ratings % practice good	-	-	84%	March	better		multiple	2.20
Reduction in patients over 75 prescribed 10 or more unique medicines	12.1%	12.5%	13.25%	May 2024	worse	To be updated	Frailty	-

Southwark performance overview – additional local metrics (2)

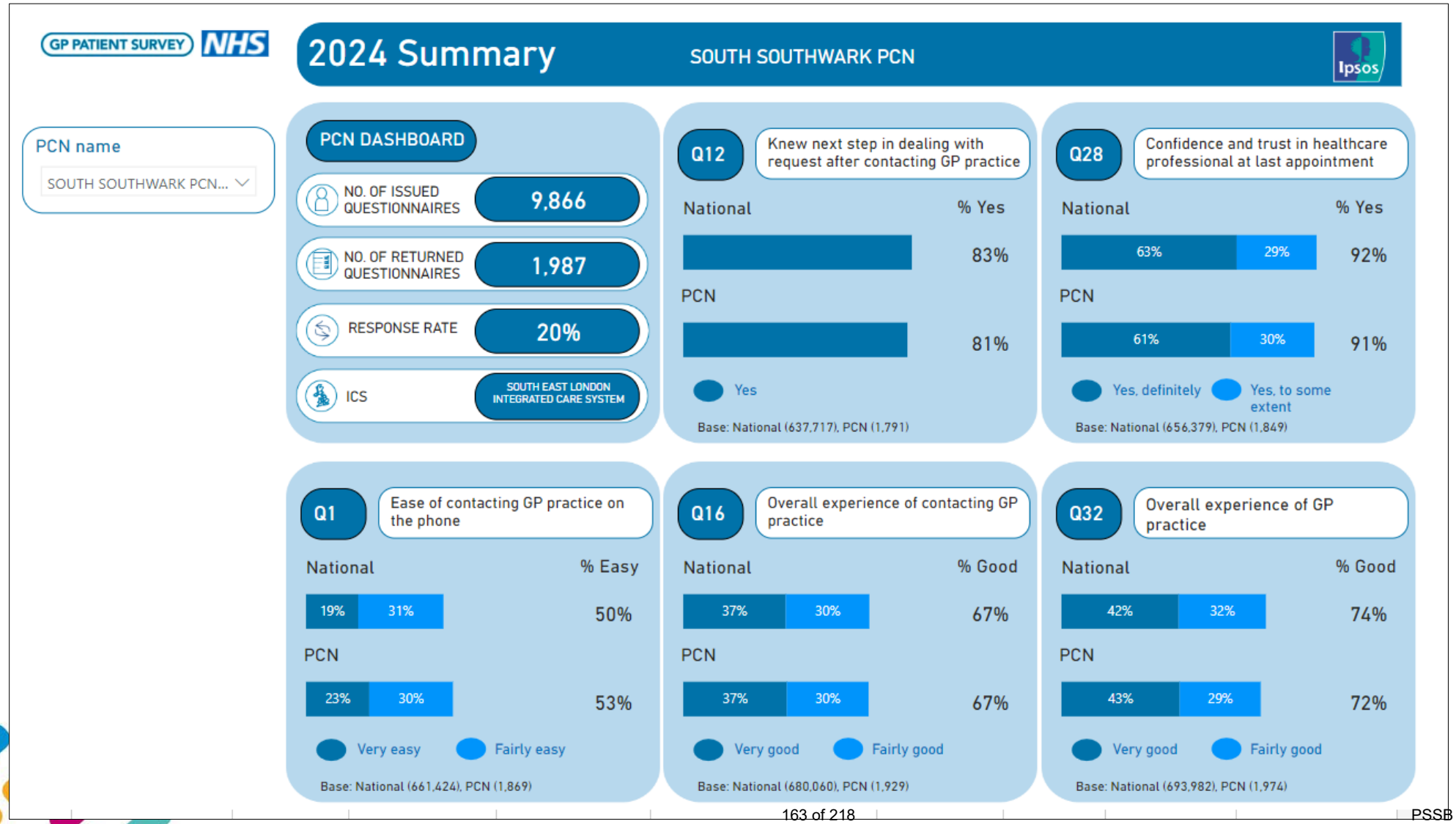
Metric	2022/23	2023/24	2024/25	period	Trend	Target / benchmark	Link to Op Plan	Latest Details
CYP Mental Health Waits > 52 weeks (all referrals)	72	159	243	Dec 2024	worse	0	CYP MH	2.21
CYP Mental Health Waits > 52 weeks (neurodevelopmental)	8	97	145	Dec 2024	worse	0	CYP MH	2.22
CYP Mental Health referrals with contacts in 4 weeks %	68.5%	37.3%	66.0%	Dec 2024	better	Tbc	CYP MH	2.23
Adult Mental Health Waits > 52 weeks (all referrals)	199	256	297	Dec 2024	worse	0	Adult MH	2.24
Adult Mental Health Waits > 52 weeks (excluding neurodevelopmental)	43	84	109	Dec 2024	worse	0	Adult MH	2.25
Adult mental health referrals with contacts in 4 weeks %	80.6%	81.9%	85.2%	Dec 2024	better	Tbc	Adult MH	2.26

2.01 Primary Care Access / GP Patient Survey 2024 North Southwark PCN



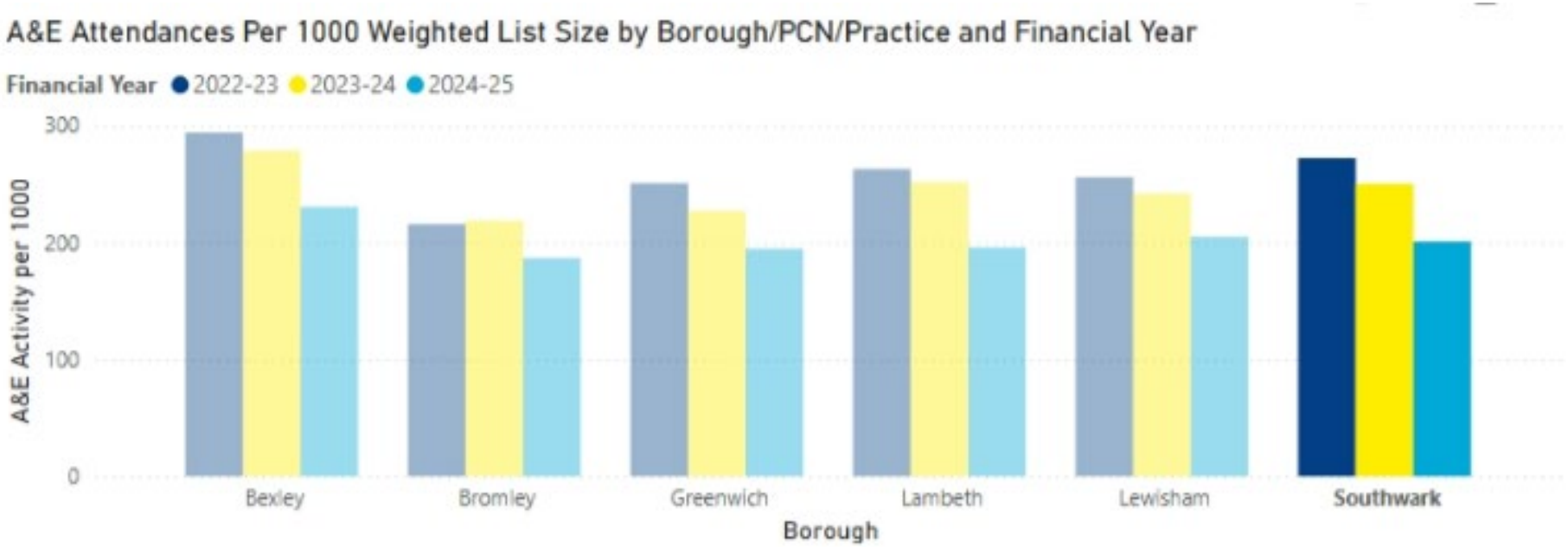
Updated 14.03.25 Source GP survey website gp-patient.co.uk/pcn-dashboard

2.02 Primary Care Access / GP Patient Survey 2024 South Southwark PCN



Updated 14.03.25
Source GP survey website
gp-patient.co.uk/pcn-dashboard

2.03 A&E Attendances per 1000 weighted list size – data to January 2025



Financial Year	North Southwark	South Southwark	Total
2022-23	285.89	254.66	**272.22**
2023-24	261.23	236.58	**250.36**
2024-25	206.37	193.83	**200.84**
Total	**753.17**	**684.74**	**723.07**

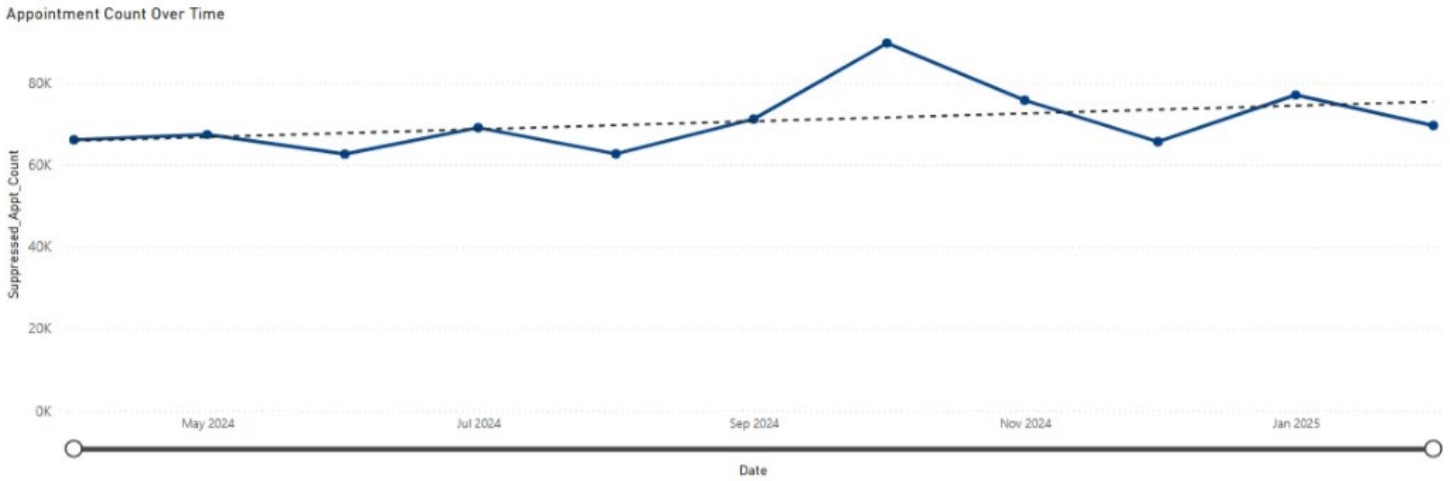
This data shows the comparative position of Southwark on A&E attendance weighted for list size.

Extrapolating 2024/25 to year end suggests an A&E attendance rate of 241 per 1000, which would constitute a reduction on 2023/24, which in turn was a reduction on 2022/23.

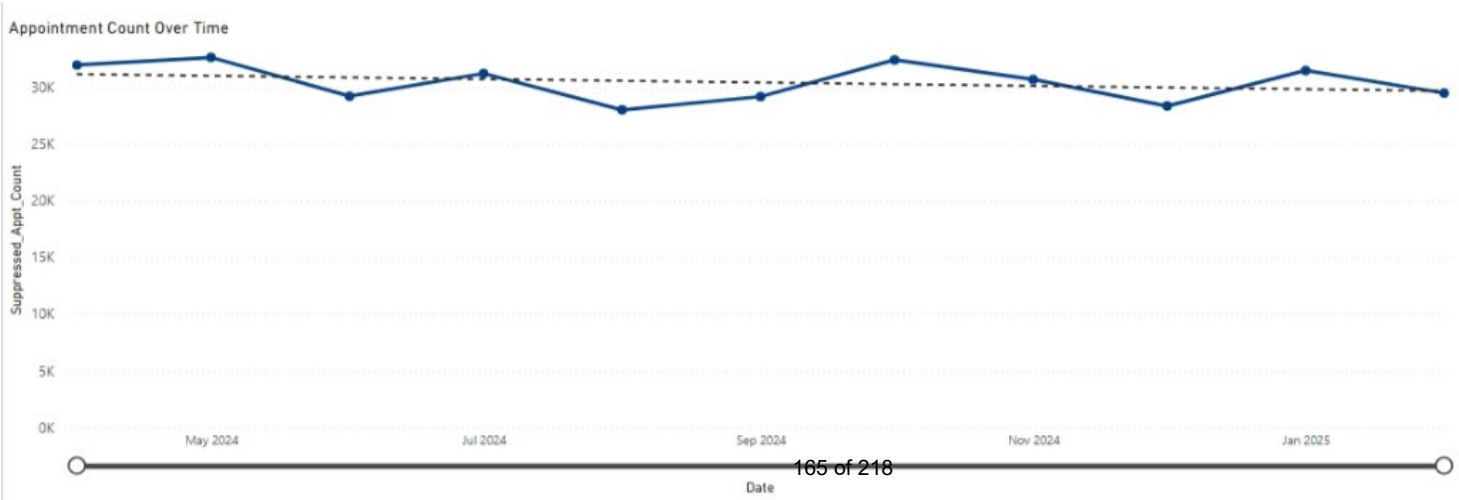
Updated 14.03.25
Source BI dashboard primary care SEL practice pack

2.04 Primary Care Access – GP Appointments (face to face and telephone) 2024/25 data to February

Face to Face – year to date (Feb) 776,118



Telephone – year to date (Feb) 334,945



Updated 14.03.25
Source SEL BI dashboard primary care access

2.05 Management of hypertension to NICE guidance – data to February 2025

The trajectory towards the new 80% national target was not met, with performance at 68% against 71% target in February. The detailed seasonal trend data below (chart 1) shows that performance has dropped off since March 2024 and can be expected to pick up again in March. Further context is the ongoing monthly increase in the hypertension register (chart 2) (growth of 3% to 39,952 from April to February). It is also encouraging to see the over 80 yr old metric continues to be close to the 80% target (chart 4).

Chart 1 – long term trend – all age – latest value 68%

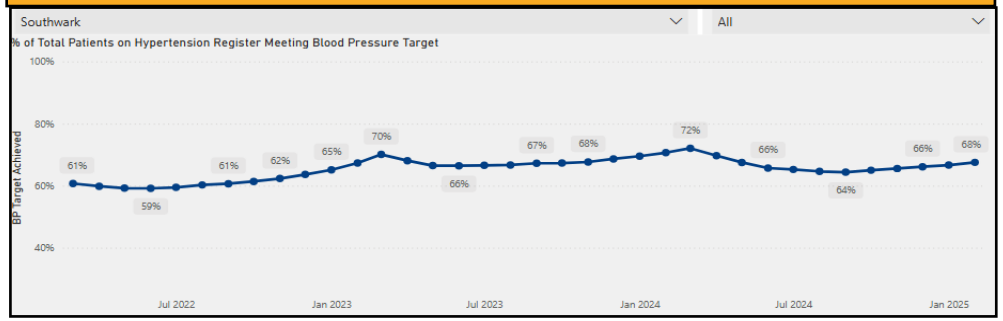


Chart 2 - Numbers on hypertension register - latest value 38,681

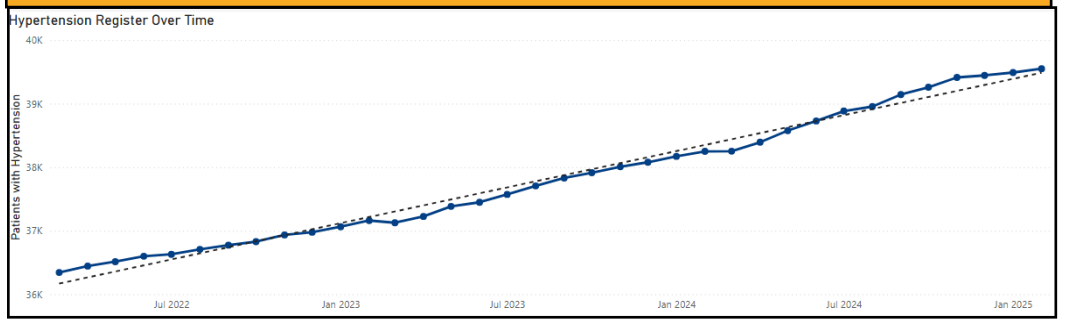


Chart 3 – long term trend under 80 yr old – latest value 65%

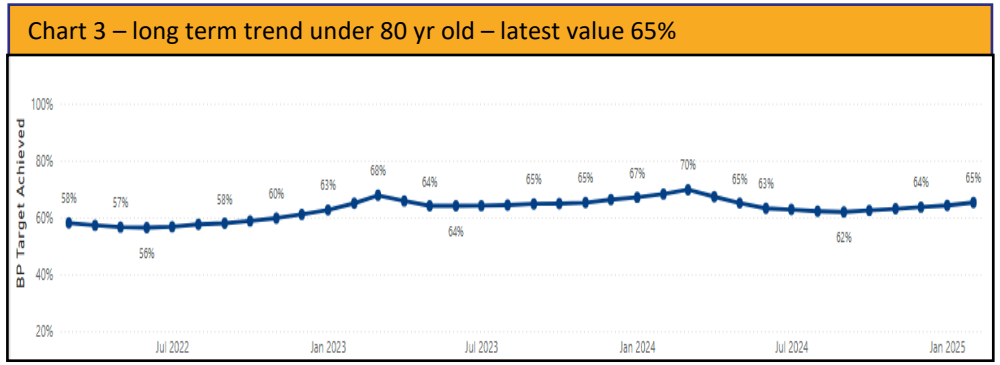
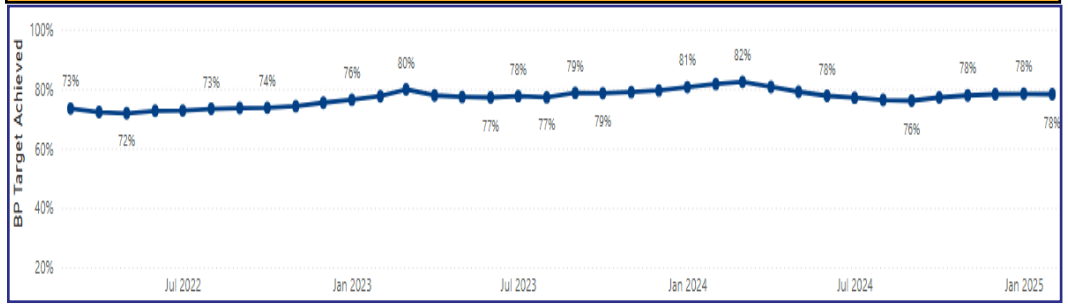


Chart 4 – long term trend over 80 yr old – latest value 78%

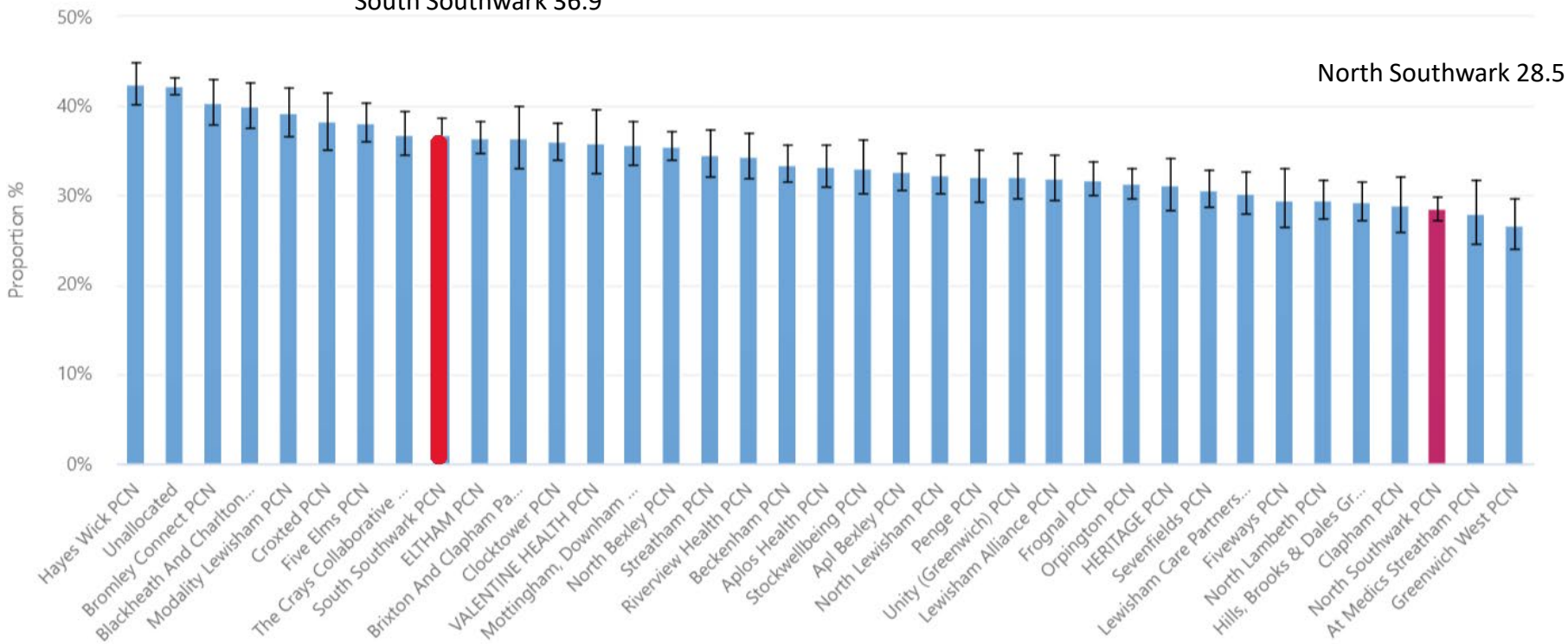


2.06 Cholesterol/CVD management: measure from 25/26 Operational Plan

CVDP012CHOL: Patients with GP recorded CVD (narrow definition), whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months

South Southwark 36.9

North Southwark 28.5



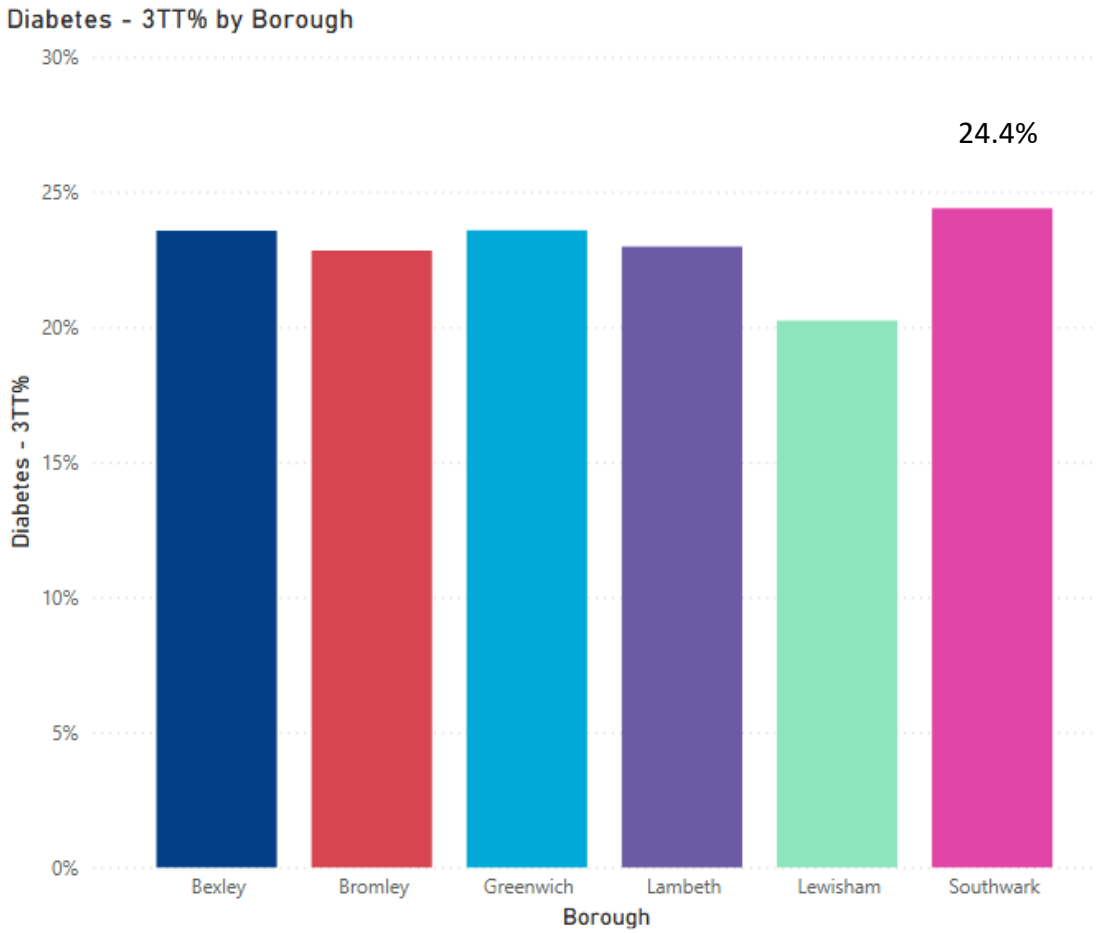
This metric appears in the 25/26 Operational planning guidance. Further clarification of target value to be sought.

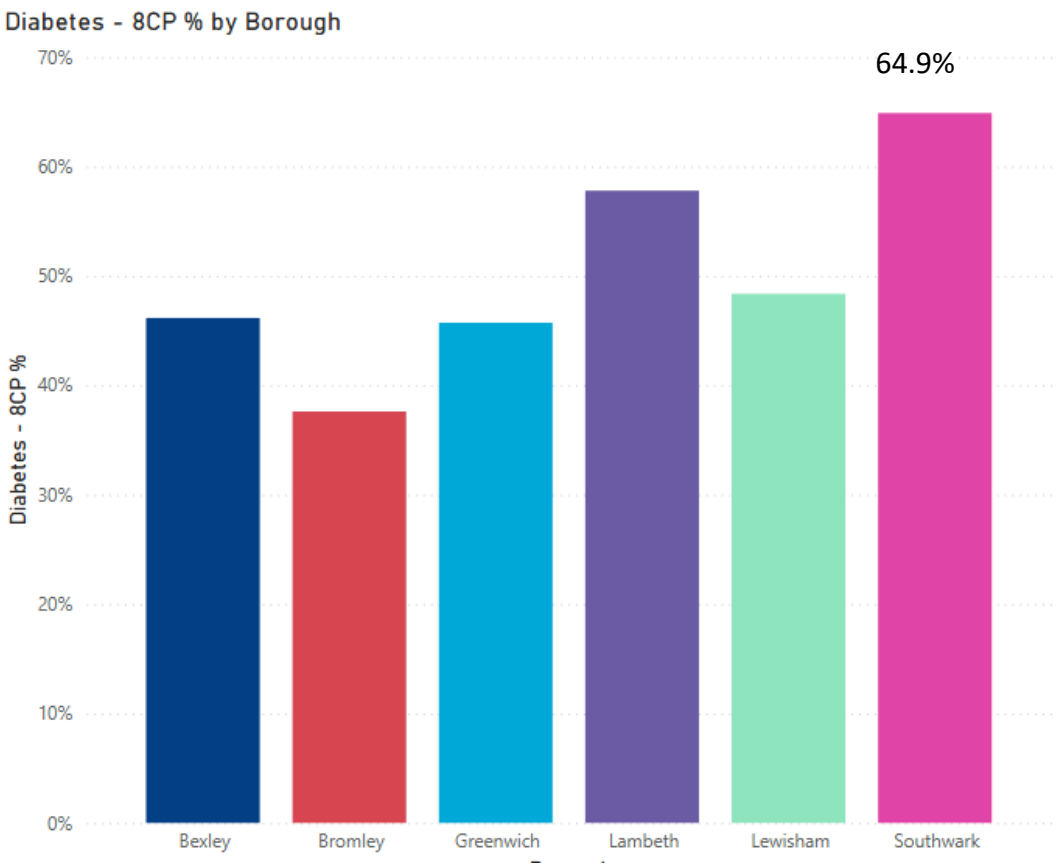
Data to Sept 2024, downloaded 14.3.25

Source: https://www.cvdprevent.nhs.uk/data-explorer?period=20&level=7&area=8059&indicator=54

2.08 Diabetes: 3 Treatment Targets and 8 Care Processes 2024/25 - SEL benchmarking (Primary Care Quality Dashboard)

This data shows that Southwark practices are performing well compared to South East London boroughs.

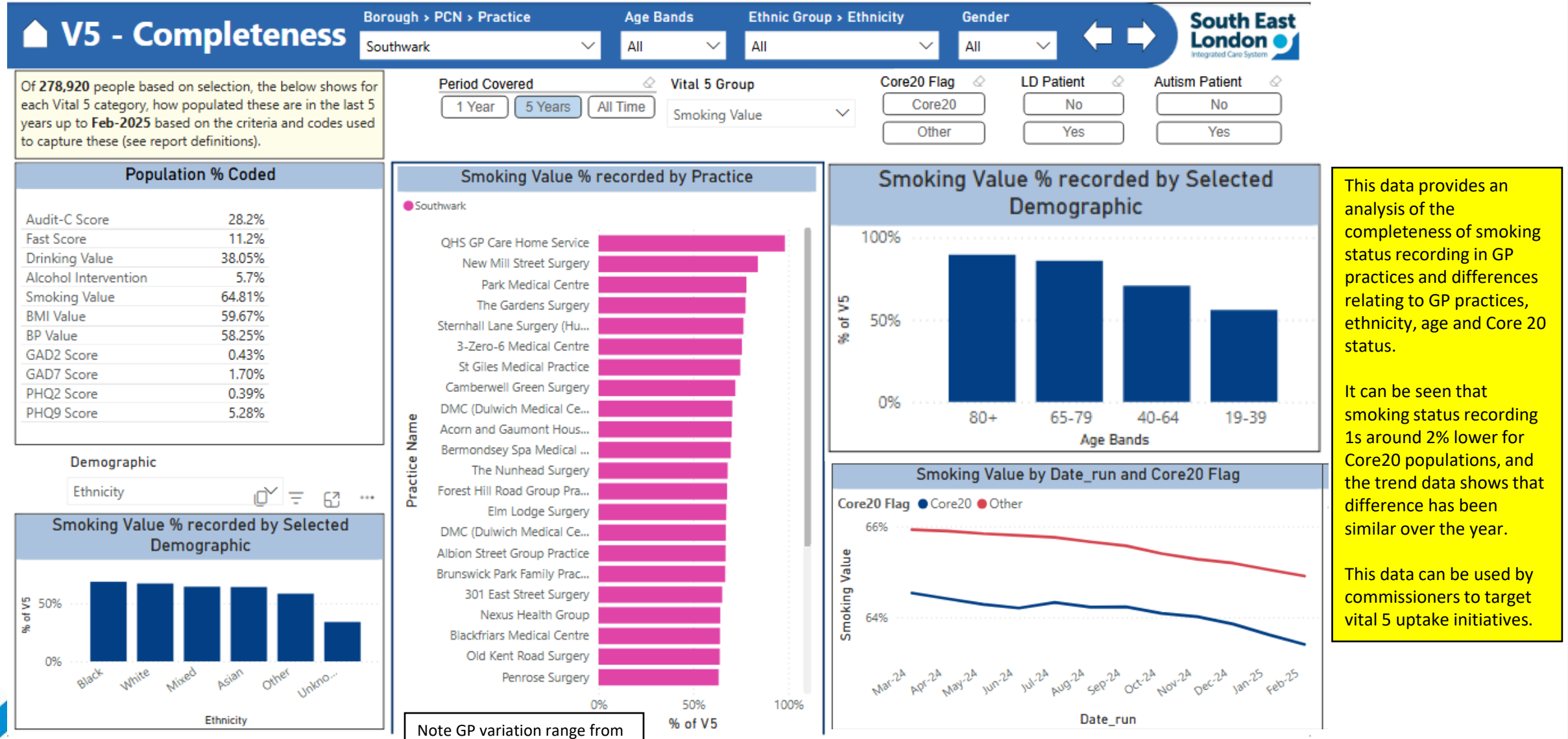




Updated 14.03.25 source SELICB BI dashboard, primary care quality. Dashboard refreshed 14.3.25
Data period to be confirmed.

2.09 Vital 5 – coding completeness – example report (smoking status focus)

Updated 14.03.25 source BI dashboard Vital5



Note GP variation range from from 45% to 98%

This data provides an analysis of the completeness of smoking status recording in GP practices and differences relating to GP practices, ethnicity, age and Core 20 status.

It can be seen that smoking status recording 1s around 2% lower for Core20 populations, and the trend data shows that difference has been similar over the year.

This data can be used by commissioners to target vital 5 uptake initiatives.

2.10 Core 20 - key metrics – difference between Core 20 cohort and overall population

Updated 14.03.25
Source SEL BI dashboard Core20

Core20 Summary

Age Bands: All | Ethnicity: All | Gender: All

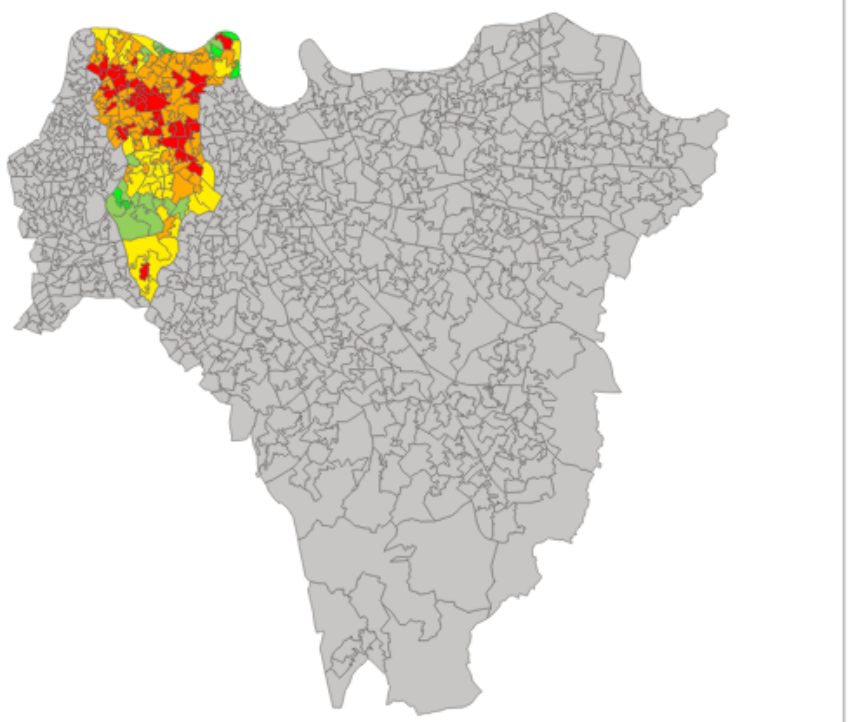
South East London Integrated Care System

Borough of Practice Reg> PCN > Practice: Southwark | Relevant Month: Feb-2025 | Residential Borough: Southwark

Below table shows a breakdown of key metrics within the report, showing difference between the total SEL pop, and people in Core20 Deprived Areas, highlighting the differences between the two.

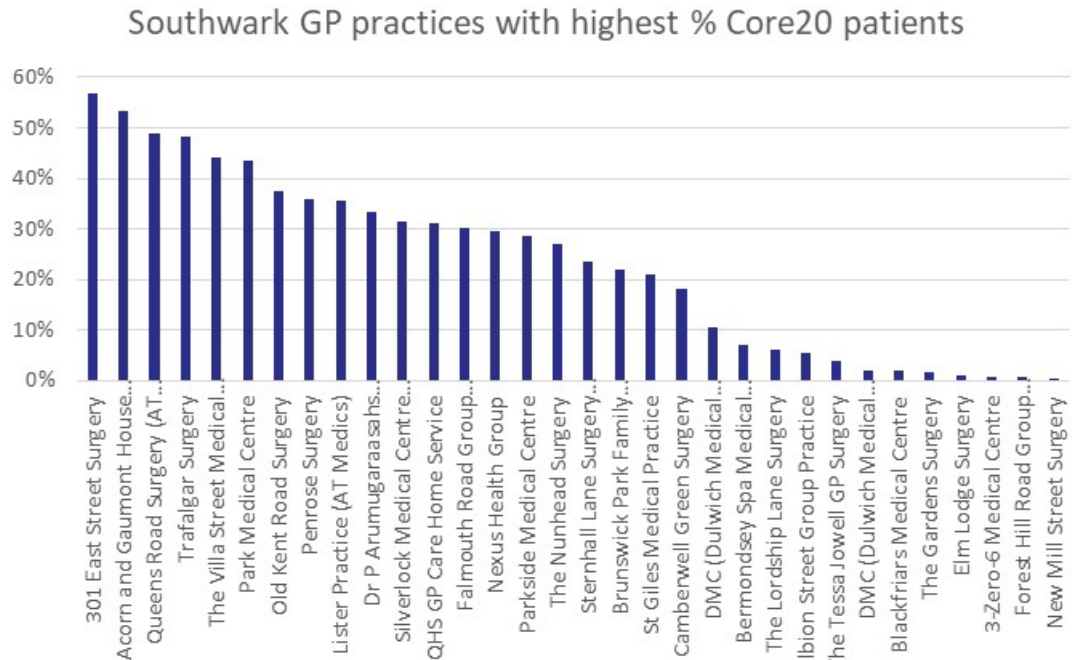
Metric	Metric % (SEL)	Metric % (Core20)	% Difference
Bowel Screening Coverage	60.46%	57.06%	-3.40%
Breast Screening Coverage	52.50%	50.45%	-2.06%
COPD Autumn Booster Uptake	33.10%	31.10%	-2.00%
COPD Exacerbations	24.68%	23.79%	-0.89%
Cervical Screening Coverage	66.05%	65.36%	-0.68%
COPD Spring Booster Uptake	14.67%	14.00%	-0.67%
SMI 0 Health Checks	9.31%	8.92%	-0.39%
Cancer Prevalence	2.45%	2.35%	-0.10%
SMI 6 Health Checks	44.16%	44.19%	0.03%
SMI Prevalence	1.26%	1.46%	0.20%
BP Target Achieved	62.21%	62.44%	0.23%
COPD Prevalence	1.25%	1.53%	0.28%
COPD Pneumonia Vaccine Uptake	5.51%	5.99%	0.47%
COPD Flu Vaccine Uptake	58.33%	59.49%	1.16%
BP Reading Valid	83.03%	84.33%	1.31%
Hypertension Prevalence	10.88%	12.43%	1.55%

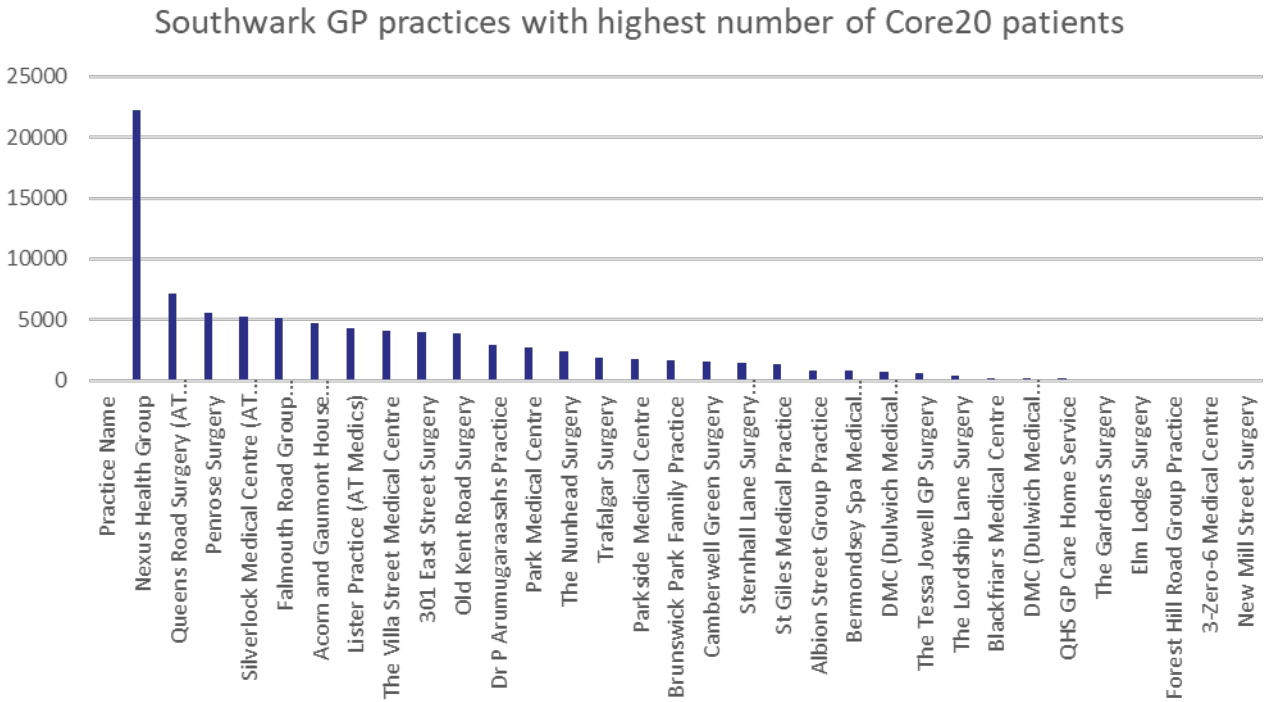
Deprivation Quintile Map by LSOA



This data shows the difference on key Core20plus indicators between Southwark areas falling into the top 20% most deprived nationally and the overall Southwark population. The top 3 differences relate to bowel cancer screening, breast cancer screening and autumn covid boosters for people with COPD. However the differences are relatively minor.

2.11 Core 20 - key metrics – GP distribution of Core20 patients



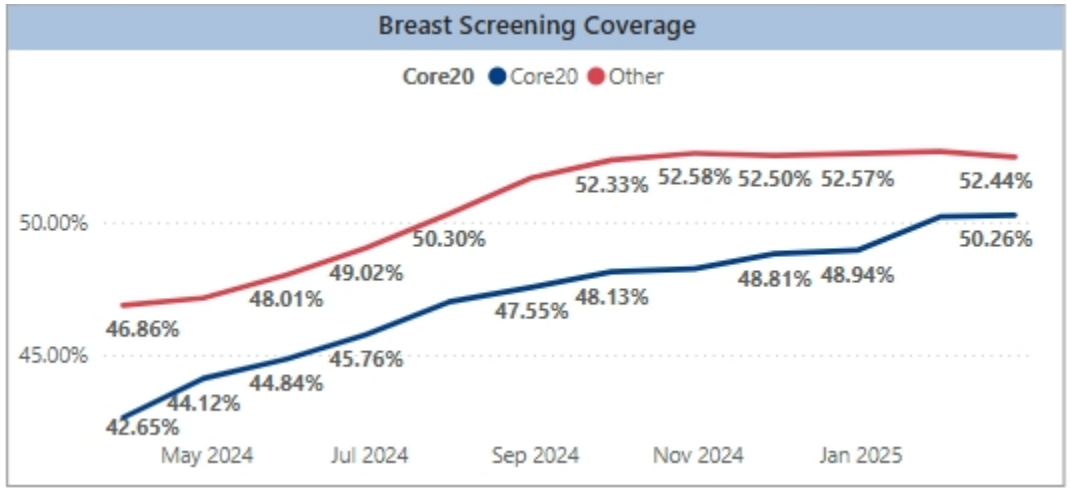


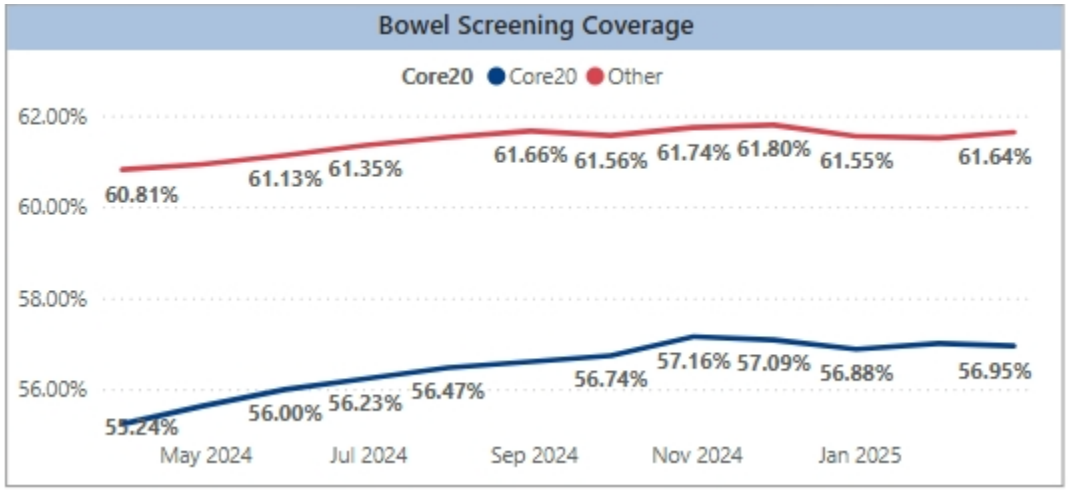
This data shows which practices have the highest proportion of Core20 patients and which have the highest number overall. This can be used for targeting resources in a Core20 approach to inequalities.

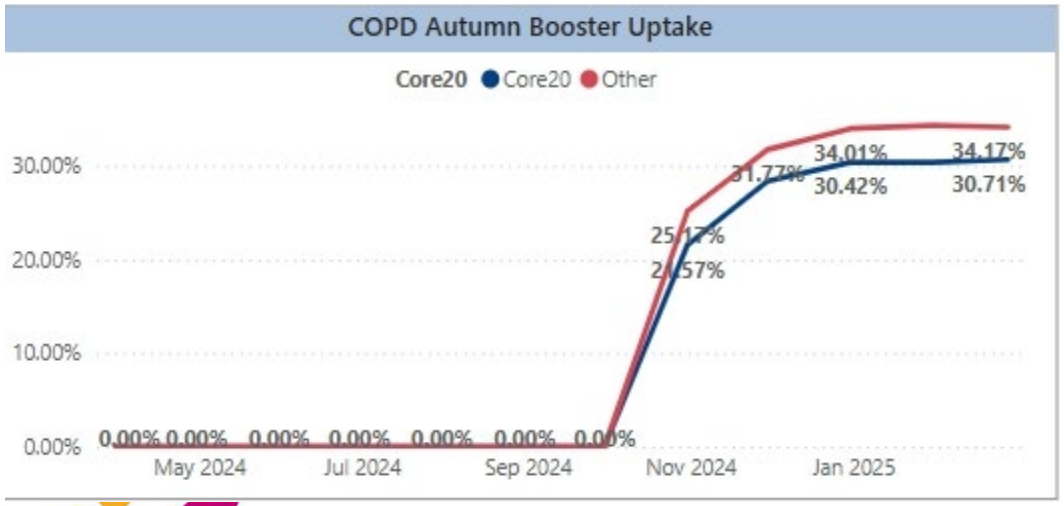
Updated 14.03.25
Source SELICB BI dashboard Core20

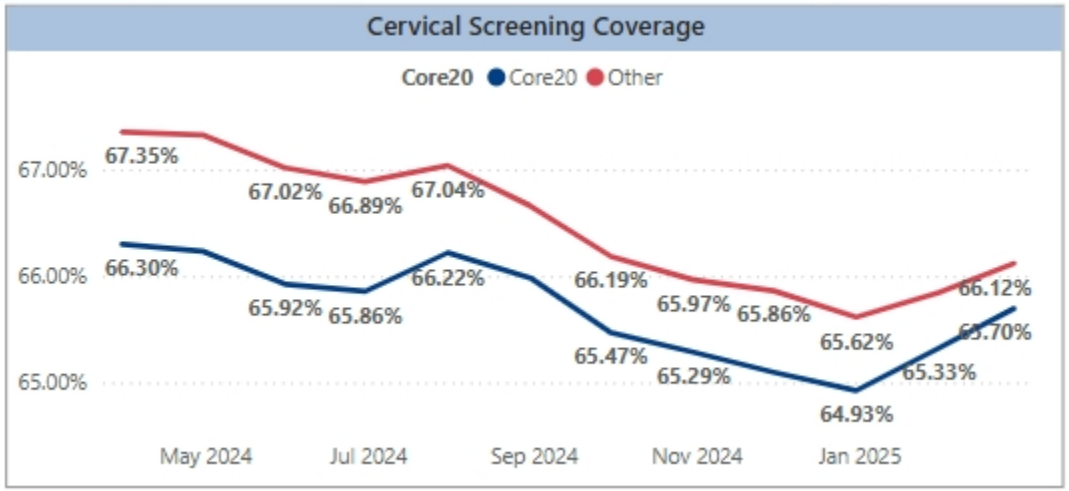
2.12 Core20 gap – trend analysis – Bowel, Breast Cancer Screening and COPD autumn booster

Updated 14.03.25
Source SEL BI dashboard
Core20









This data shows recent trends in the difference in the gap between Core20 and other populations in 4 areas of concern. The gap can be seen to have narrowed on breast and cervical screening.

2.13 BCF "Avoidable Admissions" - overall trend (ambulatory care sensitive conditions)

Updated 14.03.25
Source SEL BI dashboard unplanned care.

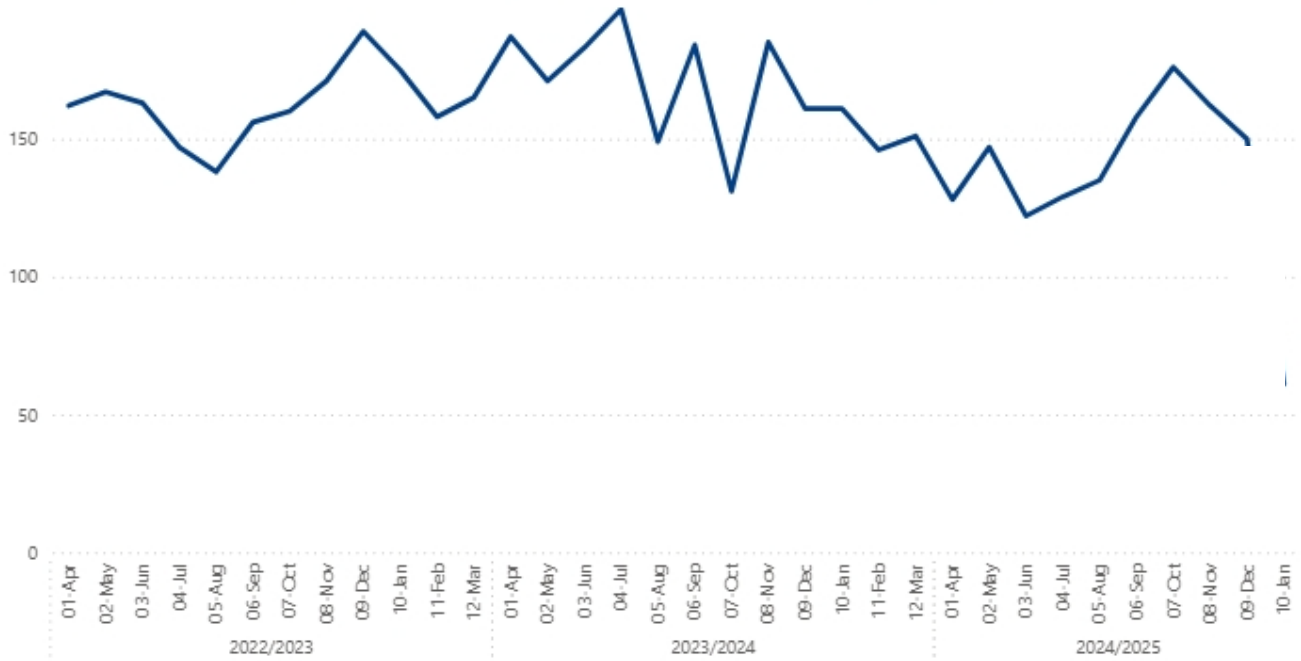
Unplanned ACSC Admissions Summary

South East London Integrated Care System

Borough of Residence

Bexley | Bromley | Greenwich | Lambeth | Lewisham | Southwark

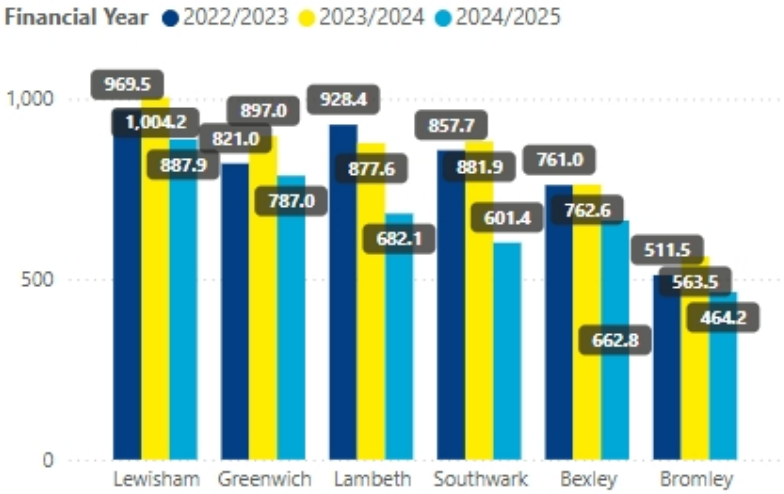
Number of Unplanned Admissions Related to Ambulatory Care Sensitive Conditions (Rate)



Financial Year	01-Apr	02-May	03-Jun	04-Jul	05-Aug	06-Sep	07-Oct	08-Nov	09-Dec	10-Jan	11-Feb	12-Mar	Total
2023/2024	187	171	183	197	149	184	131	185	161	161	146	151	2,006
2022/2023	162	167	163	147	138	156	160	171	189	175	158	165	1,951
2024/2025	128	147	122	129	135	158	176	162	150	61			1,368
Total	**477**	**485**	**468**	**473**	**422**	**498**	**467**	**518**	**500**	**397**	**304**	**316**	**5,325**

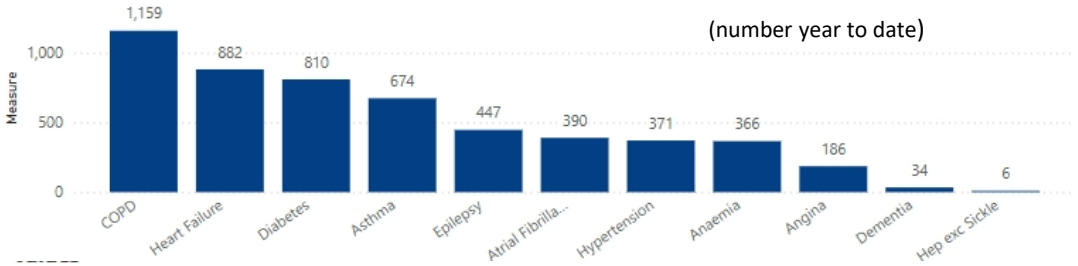
For SEL, there have been 61 admissions related to Unplanned ACSC Conditions in the latest month.
Compared to **previous month**, this is **89 Less.**
Compared to **same month last year**, this is **100 Less.**

Unplanned Admissions Related to ACSC Conditions - Rate per 100,000 Population by Borough



Avoidable Admissions Condition Type

(number year to date)

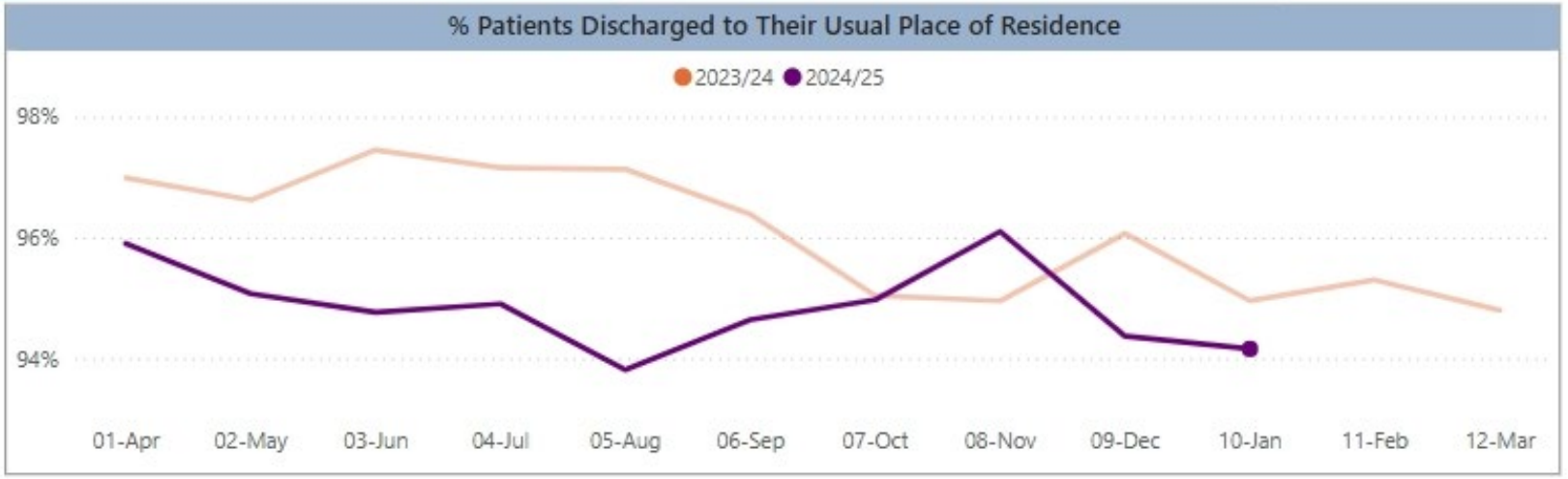


Data show that on track to comfortably on track to surpass the BCF target which equates to a 5% reduction on 23.24.
Key conditions remain COPD, heart failure, diabetes, asthma.

Note: Frailty outcome metric.

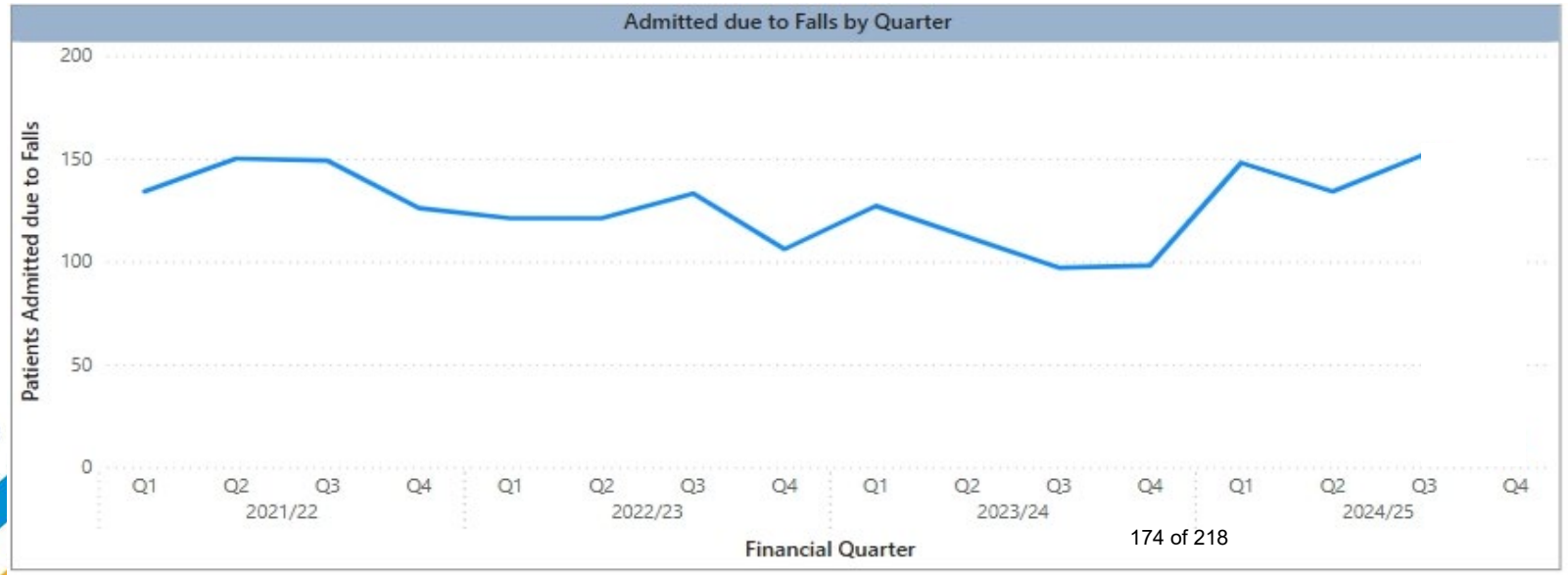
2.14a BCF target – discharges to usual place of residence (%)

Updated 14.03.25
Source SEL BI dashboard BCF.



94.9% to January against target of 96.8%. Slight reduction - link to increased step-down bed options and use of "unknown" coding. Benchmarks as very strong performance reflecting robust home first approach. Not an area of concern.

2.14b BCF target – admissions due to falls aged over 65



Not on track to meet 5% reduction target Q1 to 3 data suggest a 33% increase. Q3 year to date total 438, total in 23/24 434.

Potential frailty outcomes metric.

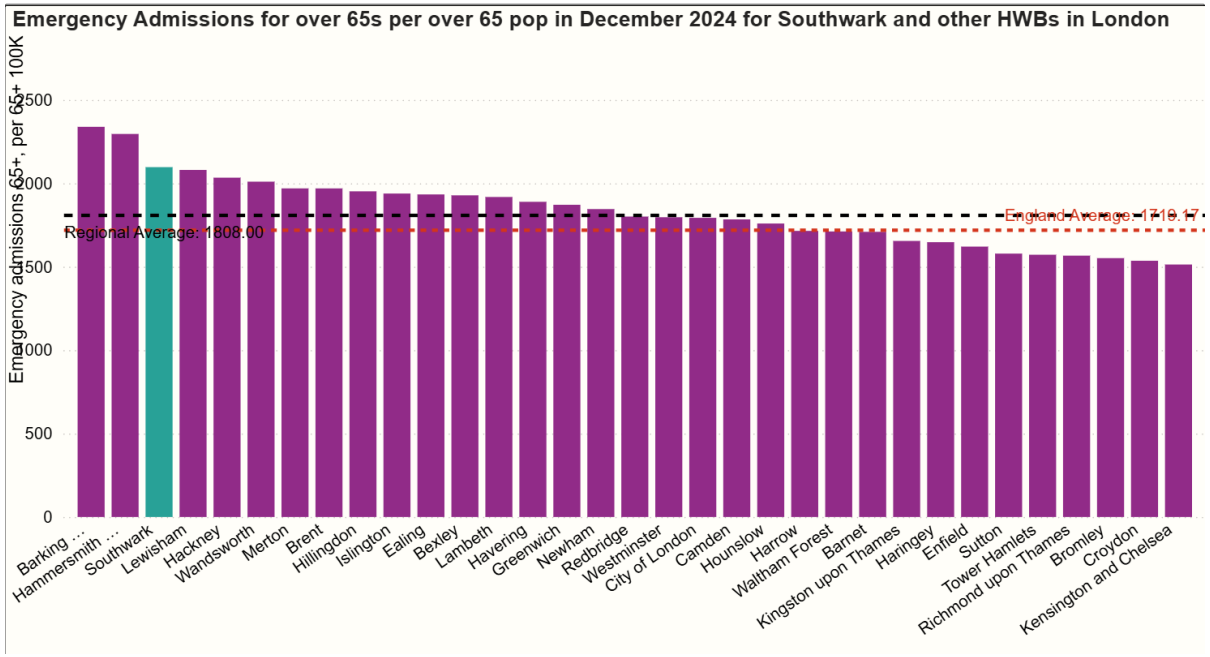
Note: **2.14c**: BCF target on council permanent care home admissions: Q3 forecast to exceed target of no more than 154 placements by 10.

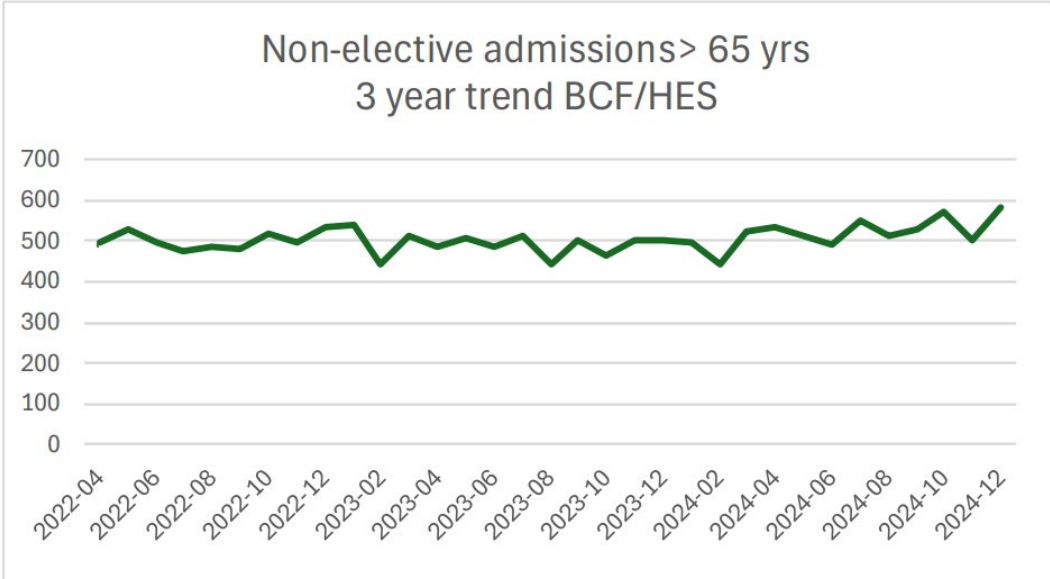
Frailty outcome metric

(source Q3 BCF return)

2.15 NEW BCF TARGETS 2025/26 – London Benchmarking – Non-elective admissions > 65 yrs

(new BCF dashboard DHSC, HES 6/3/25)





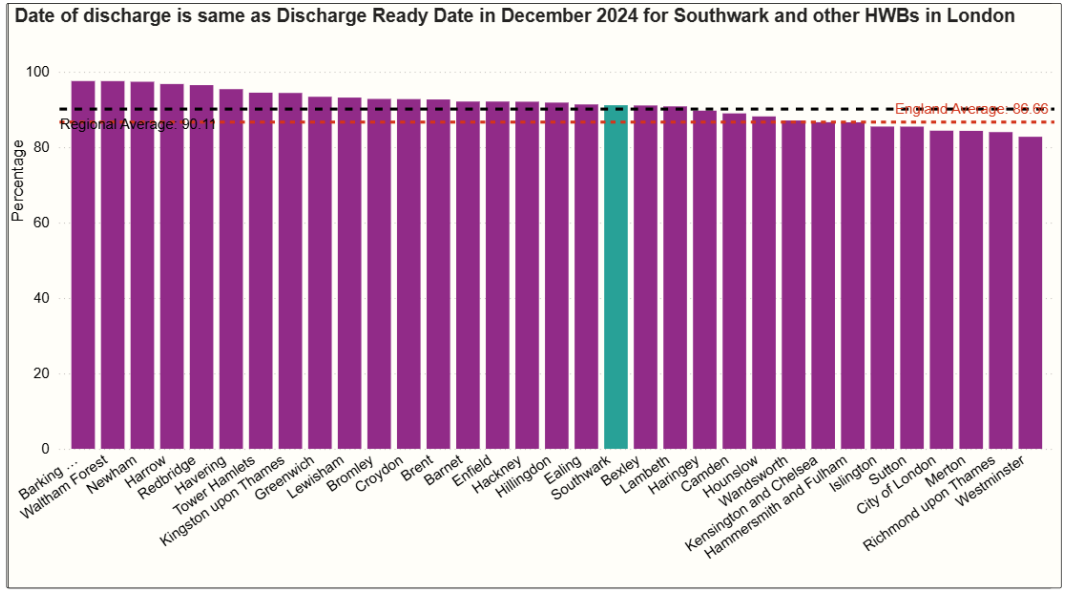
One of 3 key BCF targets on which places will be expected to make progress.

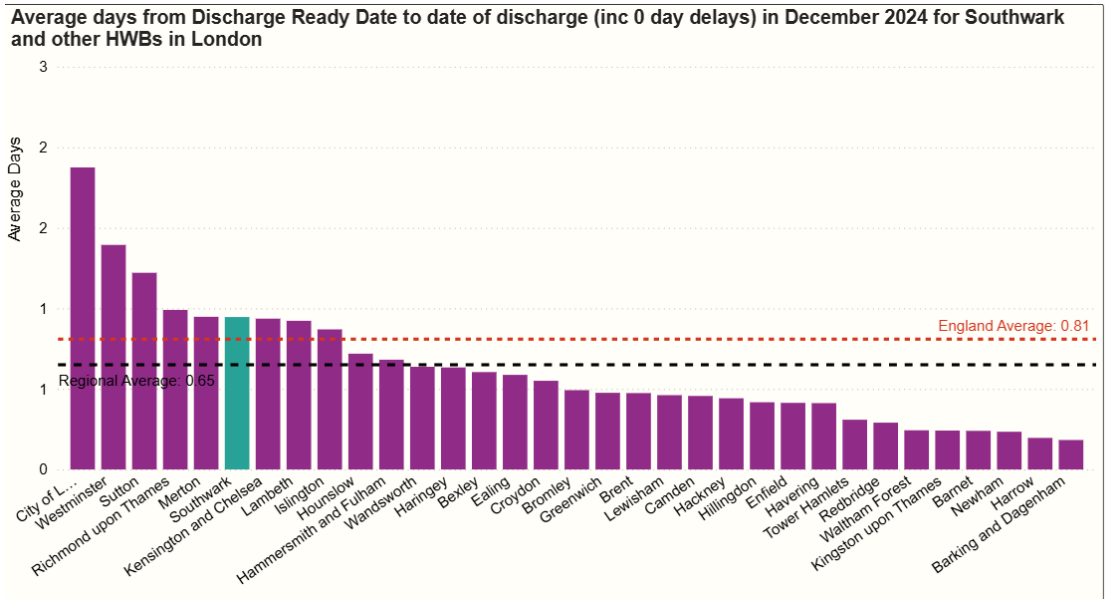
Poor comparative position may lead to challenges, especially on basis of December data above. . Rate of 1903 in year to date vs regional average of 1808 in December. 2024/25 trend is significantly upward.

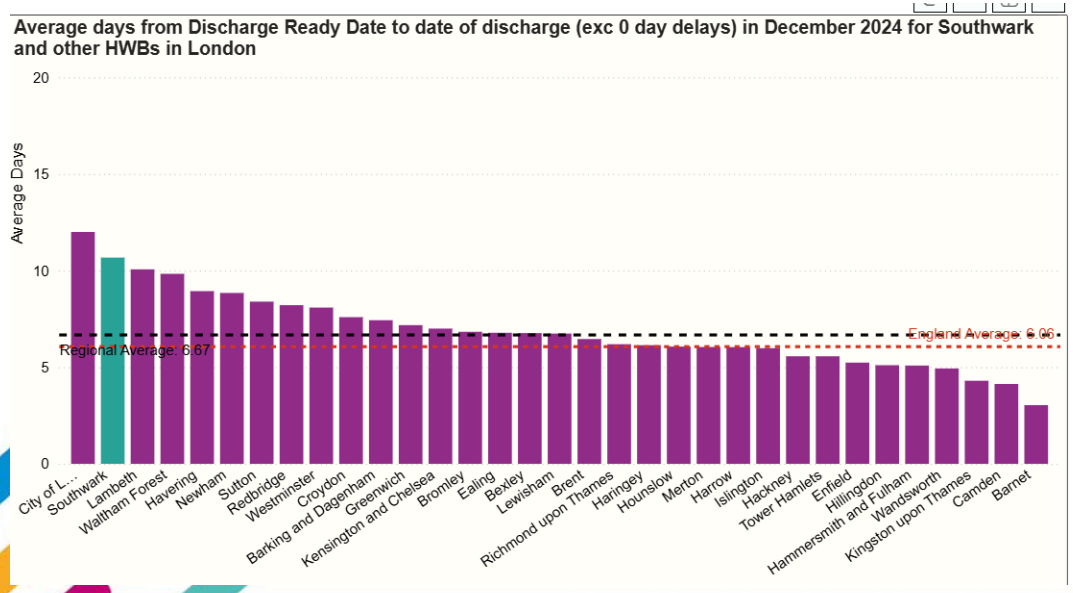
To be a key outcome metric for frailty and Integrated Neighbourhood Teams

2.16 NEW BCF TARGETS 2025/26 – London Benchmarking – Discharge Delays

(new BCF dashboard DHSC 6/3/25)







This data shows that although the proportion of people discharged on their discharge ready date is in line with benchmarks, for those who are not the average days delay is high – 2nd highest in London.

This is a new data set with just 4 months of borough level data and there are significant concerns nationally about data accuracy. More work to be done with trusts to understand data.

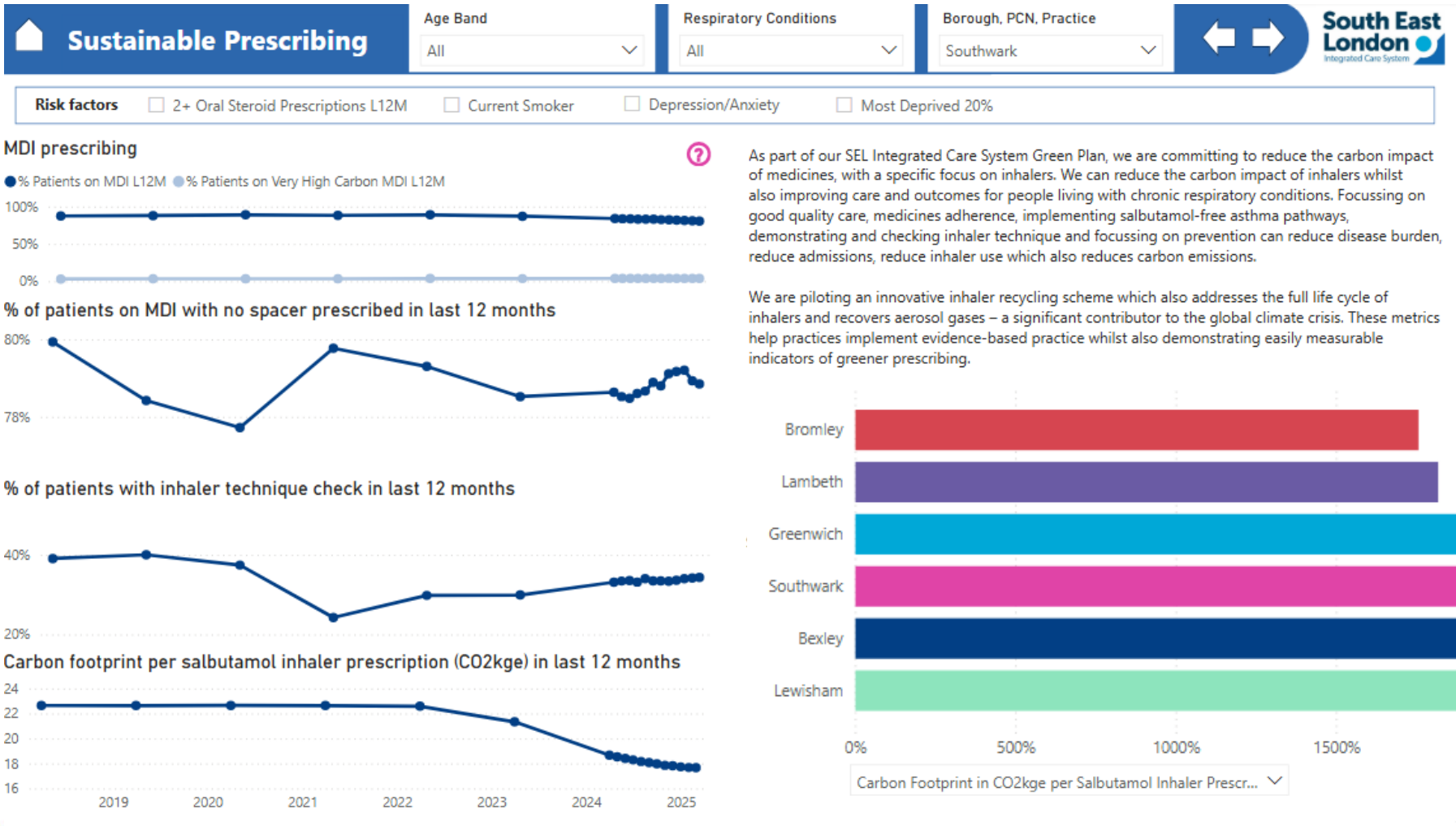
2.17 NEW BCF TARGETS 2025/26 – London Benchmarking – Discharge Delays (source NHSE published data 6/3/25)

Dec-24	% patients discharged where, between the Discharge Ready Date and Discharge Date								Total bed days after Discharge Ready Date for patients discharged within -					
	No delay	1 day delay	2-3 day delay	4-6 day delay	7-13 day delay	14-20 day delay	21 days or more		1 day	2-3 days	4-6 days	7-13 days	14-20 days	21 days or more
Bexley	90.8%	3.9%	2.1%	1.2%	1.0%	0.3%	0.6%		60	76	92	141	90	417
Bromley	92.9%	3.2%	0.9%	1.3%	0.9%	0.4%	0.4%		64	42	128	153	112	264
Greenwich	90.9%	4.1%	2.3%	1.0%	0.5%	0.6%	0.6%		70	94	86	67	165	391
Lambeth	90.7%	2.8%	1.6%	1.6%	1.4%	0.4%	1.4%		45	64	116	196	98	825
Lewisham	91.8%	2.6%	1.8%	1.0%	1.3%	0.4%	1.1%		46	74	80	230	121	853
Southwark	92.1%	1.4%	2.2%	1.0%	1.2%	0.7%	1.3%		25	94	96	194	215	889
Average	91.6%	3.0%	1.8%	1.2%	1.0%	0.5%	0.9%		52	74	100	164	134	607

This detailed data shows that Southwark have a significantly higher % of patients waiting over 21 days leading to the highest number of lost bed days from this small cohort.

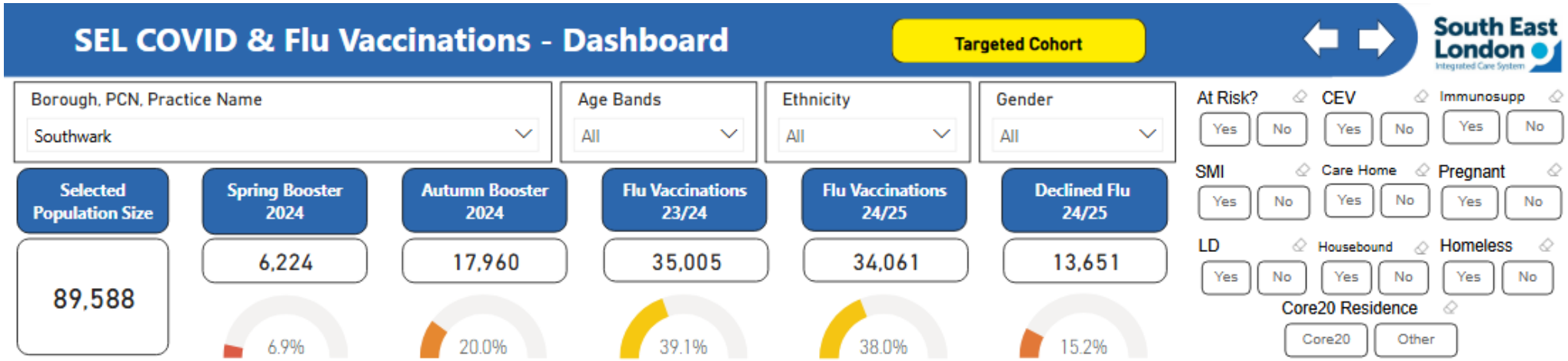
2.17 Sustainable prescribing – including carbon footprint per salbutamol inhaler prescription

Update 14.03.25
Source SEL BI dashboard, Respiratory



Data shows steady progress on inhaler prescribing carbon footprint.

2.18a Immunisations dashboard Flu, Covid – supplementary data - BI dashboard



Vaccination Uptake by Age Band

Age Bands	Population	% COVID Spring 2024	% COVID Autumn 2024	% Flu Vaccines 23/24	% Flu Vaccines 24/25
80+	6,777	39.2%	38.9%	67.8%	62.9%
75-79	5,527	34.0%	39.2%	67.0%	63.5%
70-74	7,528	3.9%	33.5%	60.1%	57.1%
65-69	12,349	2.4%	27.1%	47.3%	48.1%
60-64	8,560	3.5%	22.3%	45.3%	44.0%
55-59	8,466	2.8%	17.6%	38.4%	37.7%
50-54	6,903	2.9%	14.9%	34.1%	33.0%
45-49	5,771	2.2%	12.5%	28.4%	27.4%
40-44	5,327	1.7%	11.0%	24.0%	23.4%
30-39	10,394	1.0%	10.3%	17.8%	20.8%
18-29	7,449	0.5%	5.6%	12.3%	14.0%
16-17	727	0.0%	2.1%	22.4%	10.7%
12-15	1,262	0.0%	2.7%	26.4%	17.5%
04-11	2,289	0.0%	1.0%	28.7%	18.3%
02-03	178	0.0%	0.0%	15.7%	33.7%
Total	**89,588**	**6.9%**	**20.0%**	**39.1%**	**38.0%**

Vaccination Uptake by Borough

Borough	Population	% COVID Spring 2024	% COVID Autumn 2024	% Flu Vaccines 23/24	% Flu Vaccines 24/25
Bexley	84,368	16.5%	35.3%	51.8%	50.3%
Bromley	116,726	19.9%	39.9%	56.9%	56.2%
Greenwich	86,594	9.3%	23.5%	44.2%	43.7%
Lambeth	107,113	7.5%	20.3%	36.9%	36.4%
Lewisham	97,275	7.6%	21.2%	36.9%	36.0%
Southwark	89,588	6.9%	20.0%	39.1%	38.0%
Total	**581,664**	**11.5%**	**27.0%**	**44.5%**	**43.7%**

Vaccination Uptake by Ethnic Group

Ethnic Group	Population	% COVID Spring 2024	% COVID Autumn 2024	% Flu Vaccines 23/24	% Flu Vaccines 24/25
Asian	5,165	4.6%	14.6%	41.5%	42.1%
Black	30,543	2.6%	8.9%	31.2%	29.3%
Mixed	3,746	2.6%	10.7%	25.1%	24.5%
Other	5,950	4.1%	14.0%	36.6%	36.7%
Unknown	2,205	2.9%	11.0%	22.2%	23.1%
White	41,979	11.4%	31.0%	47.0%	46.0%
Total	**89,588**	**6.9%**	**20.0%**	**39.1%**	**38.0%**

Data highlights year on year decline on adult uptake of flu immunisations.

Over 65s total 56% vs 60.6% last year.

2.18b Immunisations dashboard Flu, Covid – supplementary data - BI dashboard

Updated 14.03.25 SEL BI flu covid

SEL COVID & Flu Vaccinations - Vaccines by Ward

Targeted Cohort

South East London Integrated Care System

Borough Of Residence

Southwark

Age_Bands

80+	75-79	70-74	65-69	60-64	55-59
50-54	45-49	40-44	30-39	18-29	16-17
12-15	04-11	02-03	00-01		

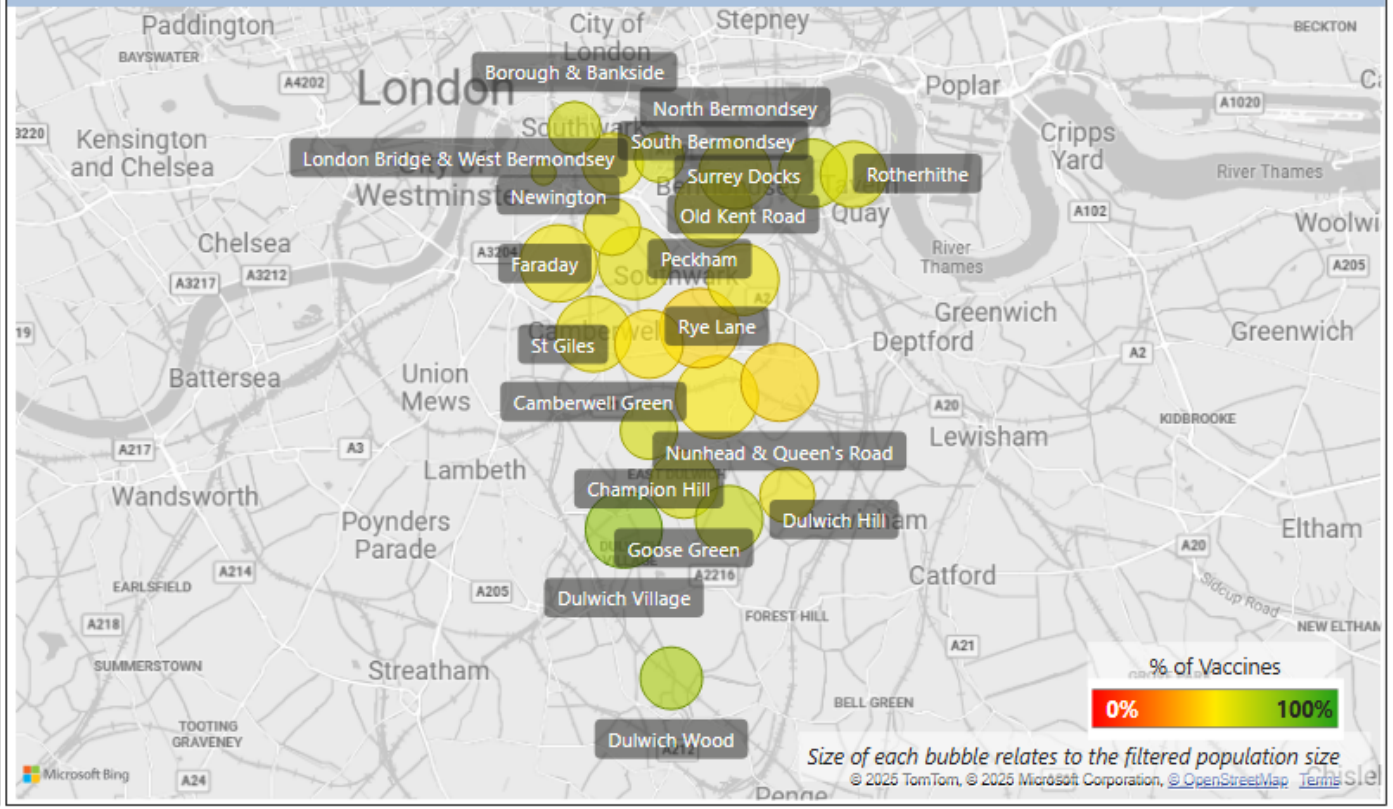
Spring Booster 2024 | Autumn Booster 2024

Flu Vaccines 23/24 | Flu Vaccines 24/25

Ward Vaccination Uptake

Ward Name	No. of Vaccines	Population	% Vaccines
Borough & Bankside	611	1,018	60.0%
Camberwell Green	931	1,753	53.1%
Champion Hill	663	1,119	59.2%
Chaucer	683	1,237	55.2%
Dulwich Hill	914	1,445	63.3%
Dulwich Village	1,335	1,803	74.0%
Dulwich Wood	880	1,268	69.4%
Faraday	901	1,623	55.5%
Goose Green	873	1,468	59.5%
London Bridge & West Bermondsey	563	948	59.4%
Newington	963	1,823	52.8%
North Bermondsey	957	1,631	58.7%
North Walworth	605	1,116	54.2%
Nunhead & Queen's Road	856	1,844	46.4%
Old Kent Road	847	1,589	53.3%
Peckham	881	1,930	45.6%
Peckham Rye	575	1,075	53.5%
Rotherhithe	906	1,481	61.2%
Rye Lane	1,046	2,068	50.6%
Total	**18,929**	**33,604**	**56.3%**

Ward Vaccination Uptake Map - Uptake with Population Size



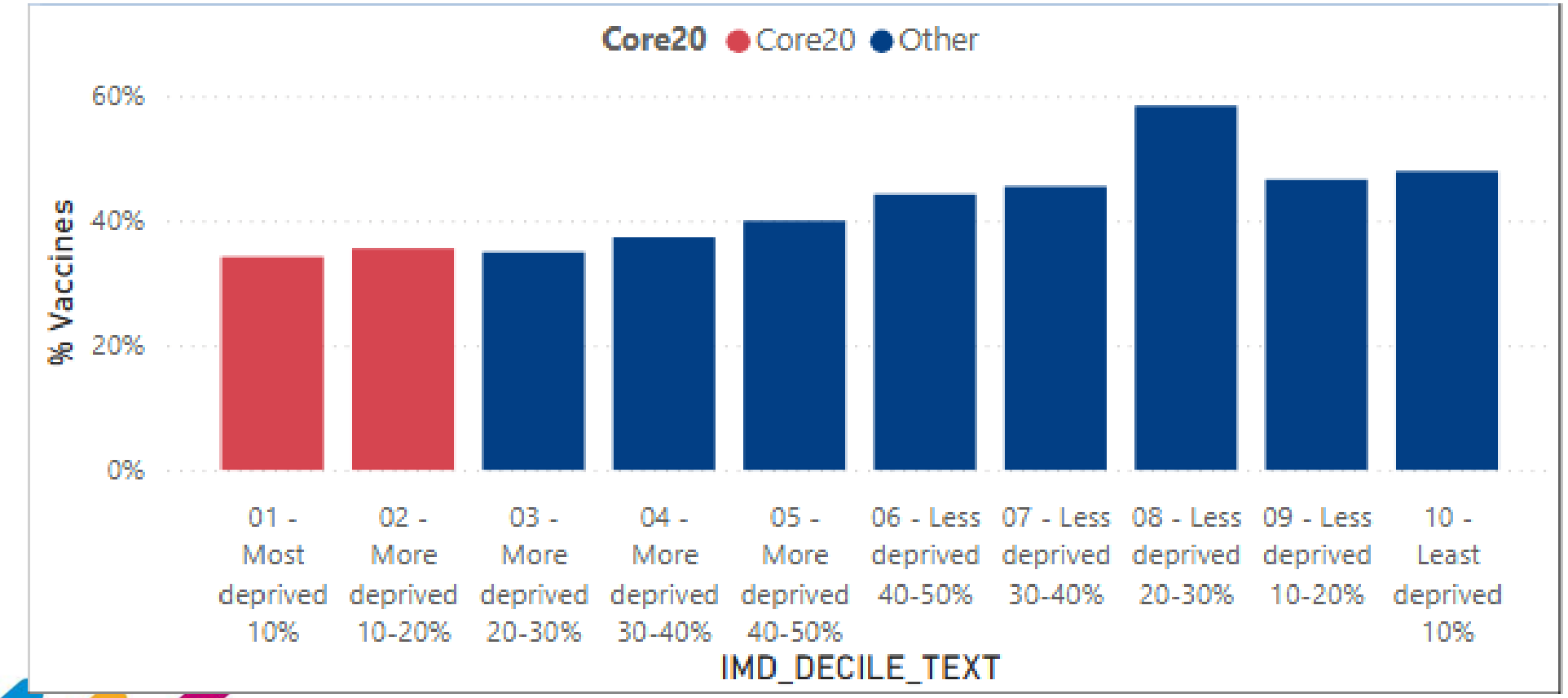
Data available by council ward to assist neighbourhood targeting.

2.18c Immunisations dashboard Flu, Covid – supplementary data - BI dashboard

SEL COVID & Flu Vaccinations - Vaccines by LSOA | Targeted Cohort | Click to show filters | *Tables and Maps filtered to exclude Non-SEL LSOAs* | South East London Integrated Care System

Updated 14.03.25 SEL BI flu covid

Southwark Flu 24/25



Data show a significant Core20 difference (although is not a CORE20 main indicator).

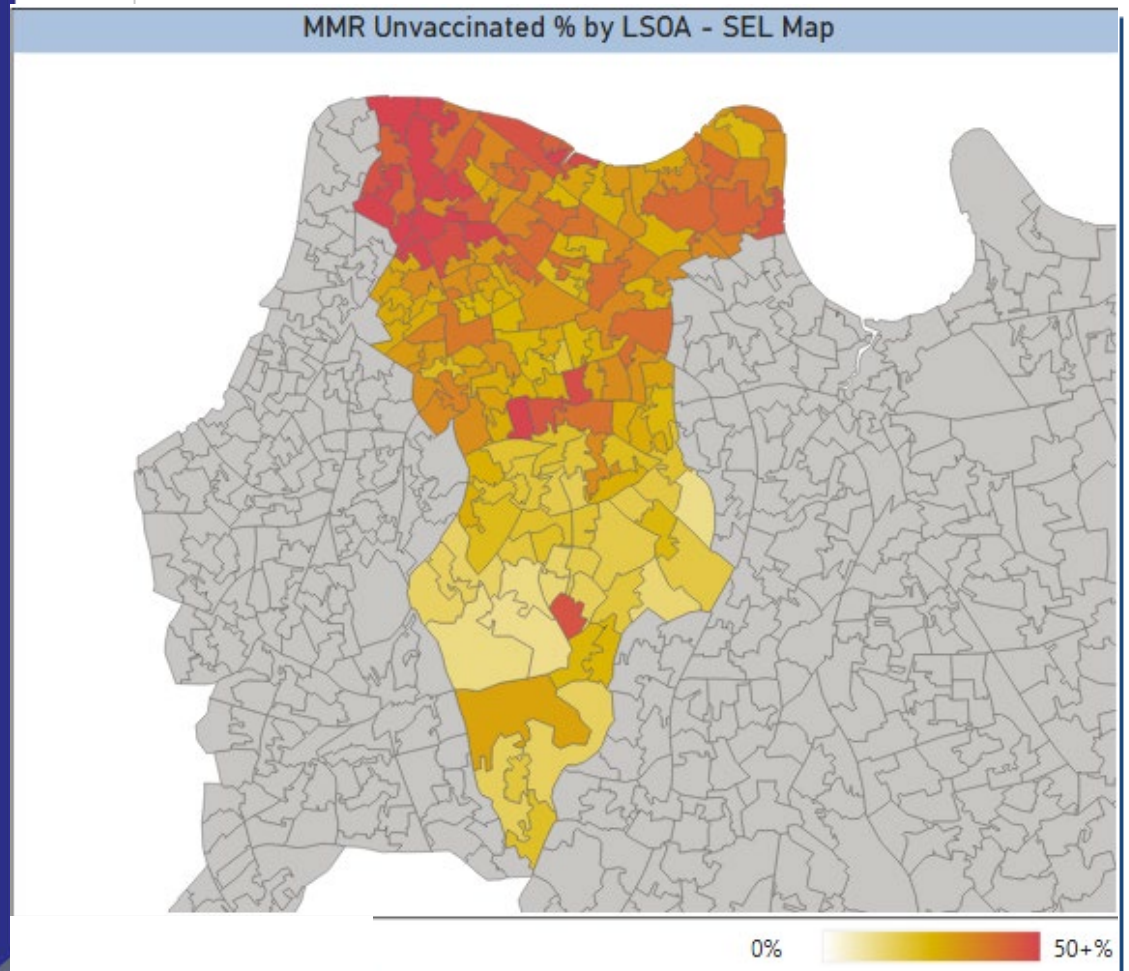
2.19 Childhood Immunisations BI dashboard – supplementary data example report - MMR

Updated 14.03.25 source SELICB BI dashboard childhood imms

Summary of MMR Vaccination uptake for ages 1 to 29 yrs.

Latest data refresh : 12/03/2025

South East London Integrated Care System



Borough	Gender	Ethnic Group	Age Band
Southwark	All	All	All

MMR Summary Breakdown

Gender

	Female	Male
Unvaccinated %	35.0%	31.8%
MMR Unvaccinated	23,226	19,991
Population Count	66,397	62,824

Age Band

	01-04	05-10	11-17	18-29
Unvaccinated %	20.6%	13.1%	14.5%	47.6%
MMR Unvaccinated	2,413	2,554	3,650	34,606
Population Count	11,741	19,517	25,245	72,734

* Children whose gender is 'unknown' or 'other' have been omitted from the table above due to statistically insignificant numbers

Borough of GP Registration

	Southwark
Unvaccinated %	33.4%
MMR Unvaccinated	43,226
Population Count	129,241

Ethnicity

	Asian	Black	Mixed	Other	Unknown	White
Unvaccinated %	50.2%	23.6%	28.5%	58.7%	43.3%	27.6%
MMR Unvaccinated	5,517	7,894	3,156	9,228	3,825	13,606
Population Count	10,997	33,396	11,061	15,712	8,833	49,242

Index of Multiple Deprivation

	1	2	3	4	5	6	7	8	9	10
Unvaccinated %	44.5%	32.5%	32.0%	37.6%	35.5%	31.0%	25.0%	26.7%	29.5%	48.6%
MMR Unvaccinated	2,393	8,842	12,359	8,469	4,278	3,804	1,115	1,140	497	154
Population Count	5,375	27,166	38,647	22,505	12,041	12,281	4,454	4,273	1,684	317

* Children whose IMD decile is unknown have been omitted from the table above

Data available by area to assist neighbourhood targeting.

Unvaccinated cohort over 18 most significant.

IMD data shows interesting pattern with the least deprived decile having lowest uptake.

2.20 CQC ratings

updated 14.03.25

South East London Integrated Care System

NHS South East London

GP practices	Outstanding	Good	Requires Improvement	Inadequate
GP Practices	0% (0/32)	84% (27/32)	16% (5/32)	0%
Patients list	0% (0)	69% (250,742)	30% (110,987)	0%

- One new report since November meeting: Acorn and Gaumont – moved up from Inadequate to Good
- Inadequate: Acorn & Gaumont. Requires Improvement: Tessa Jowell, DMC, DMC Chadwick, Lordship Lane, Nexus

Home care agencies commissioned by Southwark	Rating	change
Core providers:		
Supreme Care	Good	n/c
London Care*	Good	n/c
Sage Care	Requires Improvement	n/c
Medacs	Requires Improvement	n/c
Supplementary providers:		
Unique Personnel	Good	n/c
Care Outlook	Requires Improvement	n/c
Carepoint*	Good	n/c
MiHomecare	Good	n/c
Thames Homecare	Good	n/c

*no updates

Care Homes	Latest Rating	change	beds
Tower Bridge Care Ctre	Requires improvement	n/c	128
Camberwell Lodge	Good	Up from RI	98
Greenhive House	Good	n/c	64
Rose Court Care Home	Good	n/c	64
Bluegrove House	Good	n/c	48
Waterside	Good	n/c	48
Aspinden Care Home	Requires improvement	n/c	26
The Elms	Requires improvement	n/c	26
Athol House	Good	n/c	21
Three C's Support	Good	n/c	7
Glengarry Road	Good	n/c	6
Mundania	Good	n/c	6
Gaywood Street	Good	n/c	5
Orient St Adult Respite	Good	n/c	5
Fenwick	Good	n/c	3

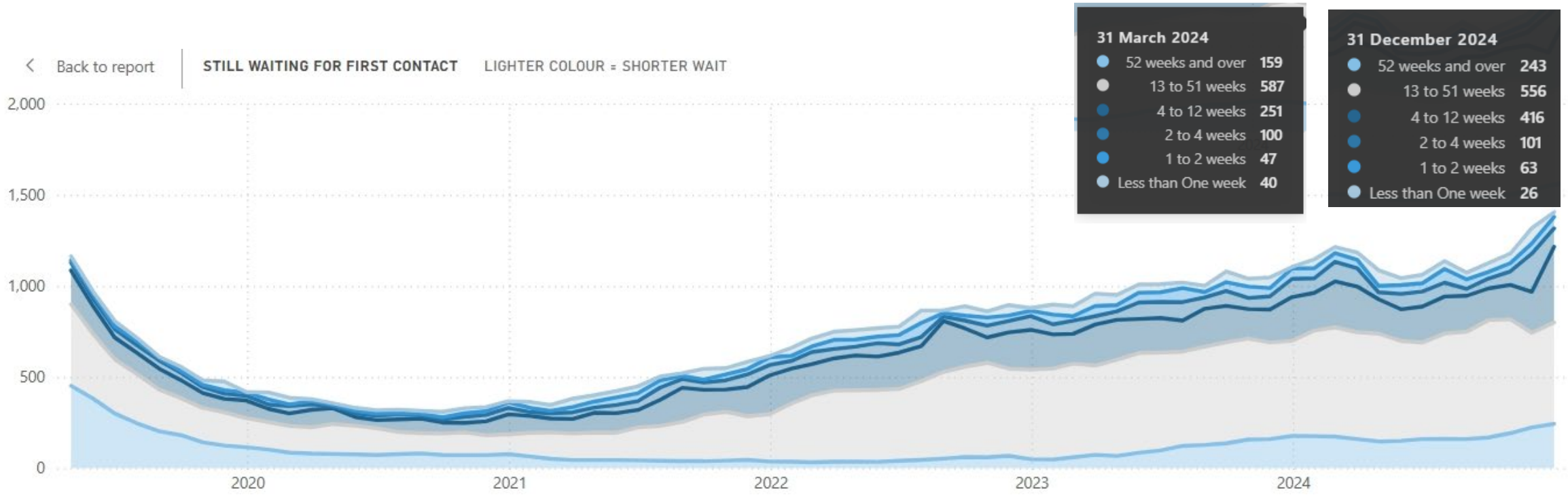
Camberwell Lodge report issued 4/12/24 – upgraded from RI to Good

Hospital Trusts	Latest Rating	change
SLAM	Good	n/c
KCH	Requires improvement	n/c
GSTT	Good	n/c

No reports issued, KCH (RI on effective, responsive and safe domains)

2.21 Children and Young People Mental Health BI dashboard: Waiting times for first contact – all referrals

Updated 14.03.25 source SELICB CYP BI dashboard

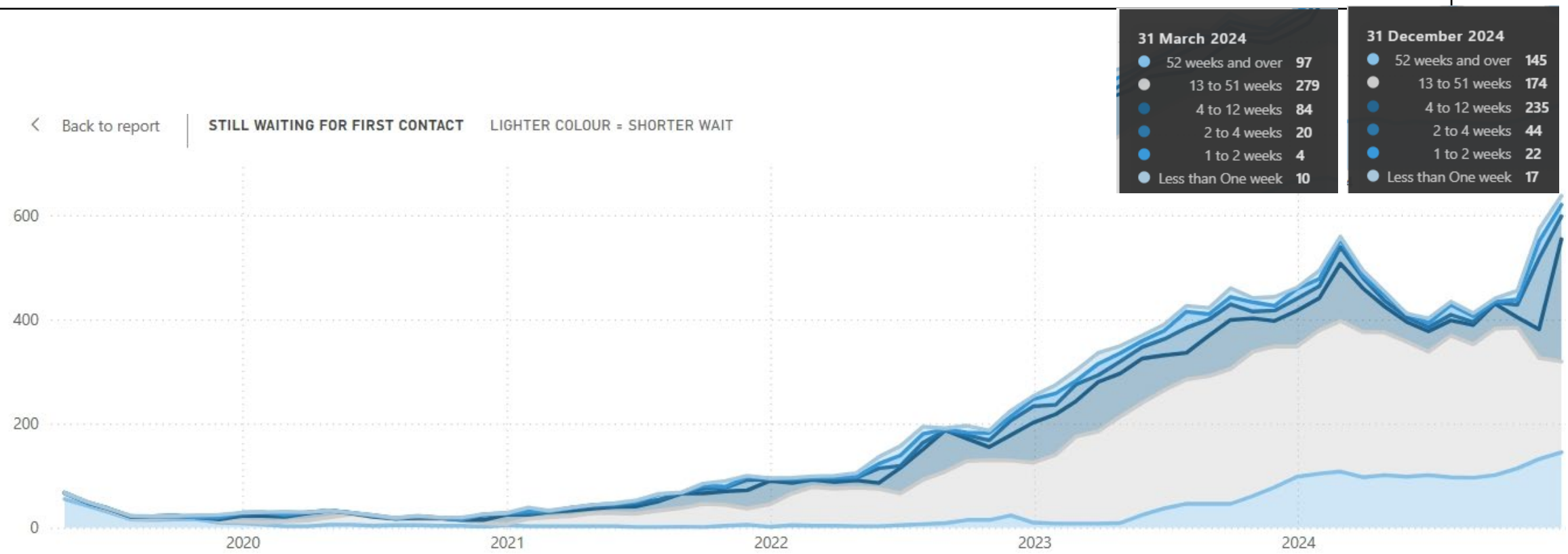


Data caveat: some differences with local trust data, and published data being investigated.

Data shows an increase in CYP waiting especially the 52 week plus and the 4 to 12 week category since March.

2.22 CYP Mental Health BI dashboard
Waiting time for first contact: neurodevelopmental referrals (excluding autism)

Updated 14.03.25
source SELICB CYP BI dashboard

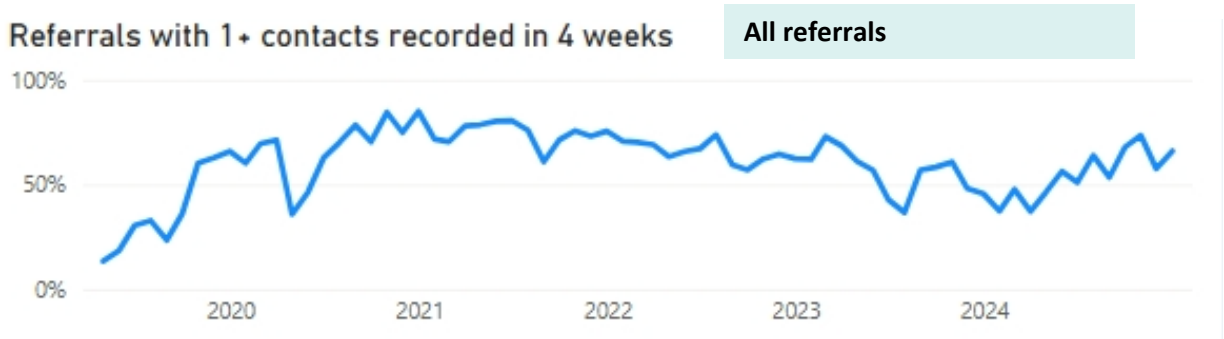


Data caveat: some differences with local trust data, and published data being investigated.

Data shows an increase in CYP waiting for neurodevelopment services especially the 52 week plus and the 4 to 12 week category since March – but reductions in 13 to 51 weeks group

2.23 CYP Mental Health BI dashboard: Referrals with 1+ contacts in four weeks

Updated 14.03.25
source SELICB CYP BI dashboard



31 December 2024

% in four weeks:

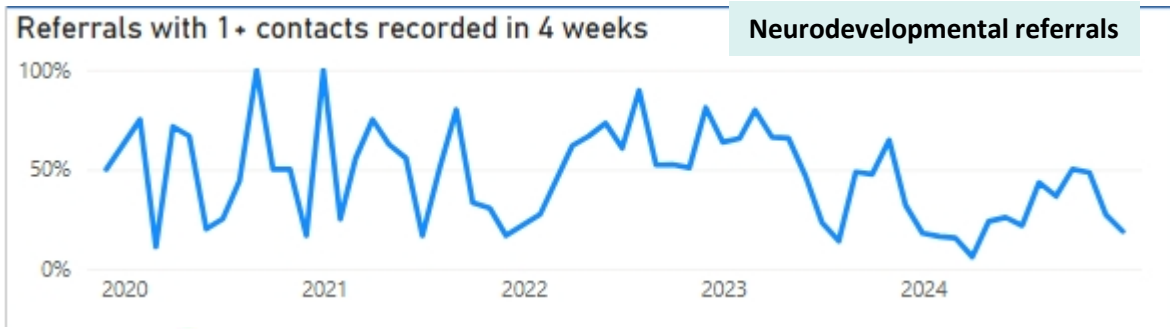
66.0%

Referrals with 1+ contacts recorded in four weeks:

134

Referrals with 1+ contracts recorded:

203



31 December 2024

% in four weeks:

18.8%

Referrals with 1+ contacts recorded in four weeks:

6

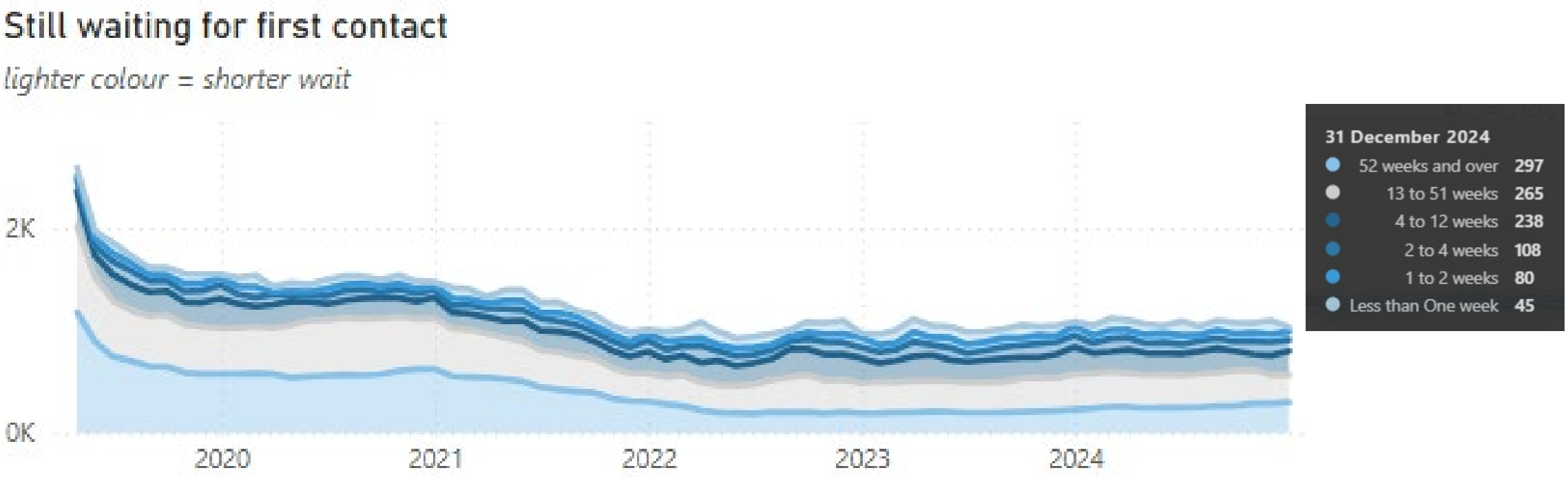
Referrals with 1+ contracts recorded:

32

Data caveat: some differences with local trust data, and published data being investigated.

2.24 Adult Mental Health BI dashboard: Waiting time first contact - all referral reasons

Updated 14.03.25
source SELICB Adult MH BI dashboard

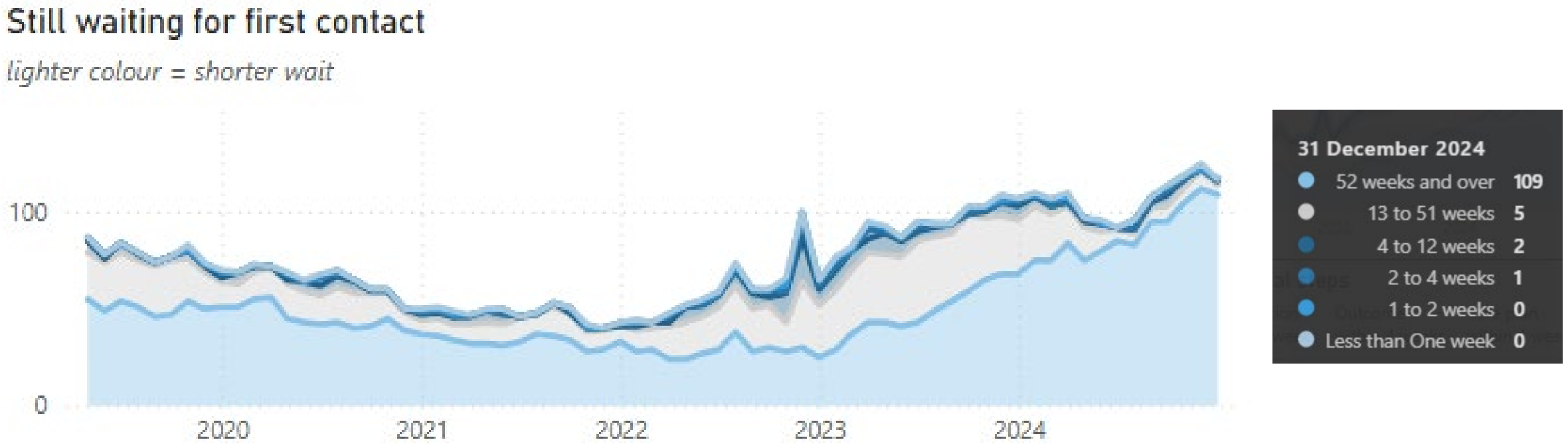


Data caveat: some differences with local trust data, and published data being investigated.

Data shows a relatively unchanged position during the year overall.

2.25 Adult Mental Health BI dashboard: Waiting time first contact – Neurodevelopmental referrals

Updated 14.03.25
source SELICB Adult MH BI dashboard

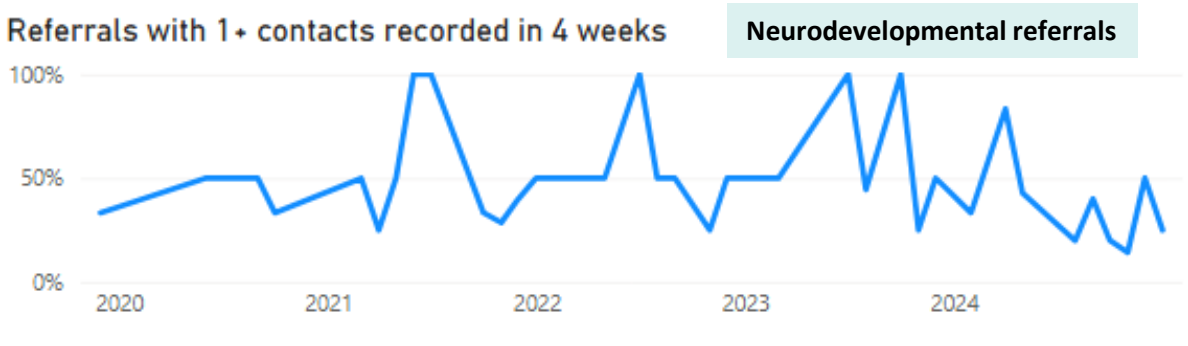


Data caveat: some differences with local trust data, and published data being investigated.

Data shows an increase in 52 week waiters

2.26 Adult Mental Health BI dashboard: Referrals with 1+ contacts in four weeks

Updated 14.03.25
source SELICB Adult MH BI dashboard



Data caveat: some differences with local trust data, and published data being investigated.

Partnership Southwark

Integrated Assurance Report

March 2025

Section 2: Operational Plan update

Note: the Southwark operational plan is currently being redeveloped for 2025/26 and will be presented to a future meeting, including a summary of year end 2024/25 position.

Progress on key metrics relating to the plan are covered in section 1.

Partnership Southwark

Integrated Assurance Report

March 2025

Section 3: Quality Report

The attached draft format of the quality report for Q3 will be subject to further discussion with the quality team to ensure the focus is on key delegated responsibilities and objectives.

South East London Integrated Care System

NHS South East London

SEL System Quality Summary Report

Prepared for the Southwark Integrated Governance and Assurance Committee 20 March 2025

Contents

Contents

Southwark Q3 Key updates

Quality Updates

Quality In Primary Care

Quality Support is being provided for the AT Medics GP Practice Procurement. Quality Questions will focus on Patient Safety Incident Reporting systems and culture for reporting. Alignment of policies and understanding to the Patient Safety Incident Response Framework. How Learning is identified and used to improve quality outcomes for local are and system.

Rollout of the Patient Safety Strategy in Primary Care

Primary Care colleagues were invited to join a session facilitated by the HiN to learn about the implementation of the Pilot project and there was a further meeting with ICBs across the South East. Currently, the focus is on the guiding practices to sign up to the Learning from Patient Safety Events platform to commence reporting of incidents and development of specific learning tools. A plan on how best to encourage this across SEL is currently being considered with initial thoughts to engage the Primary Care Networks and Primary Care Teams. Villa Street practice are involved in the pilot with the HIN

Quality Alert Learning in Southwark

Incident affecting an elderly frail Care home resident without adequate information included in the discharge letter when being transferred from GSTT back to the Care home. The patient missed a number of medication doses. GSTT apologised for their oversight error and the case is being highlighted to all staff at daily briefings and weekly meetings to ensure discharge information is accurate. This will be monitored for improvement.

Escalations

NRS Healthcare:

NRS is a private provider that supplies several local authorities with equipment for patients in the community and contracts directly with NHS Trusts providing community services. NRS was awarded a unavailable, London contract in April 2023 by the Borough of Kensington & Chelsea on behalf of 20 London local authorities.

Several concerns across the Region, including serious incidents, have been raised in relation to numerous and ongoing delays and problems in the provision of equipment in the service provided by the company and they have recently been issued with a Prevention of Deaths Notice by a Coroner.

Impact for Southwark Residents: KCH has identified an issues with equipment being provided by NRS in the community that have resulted in patient harm. Pressure relieving equipment was ordered for patients on discharge but was replaced by a 'close technical equivalent' by NRS. The equipment provided did not have the correct pressure relieving components required.

The concerns have been escalated to NHSE and Chelsea & Westminster who are leading on improving the service provided by NRS who have been invited to SEL ICB's System Quality Group.

Trust experienced a range of issues with NRS against the KPIs of the contract but were well supported by the Equipment Leads in Bromley, Lambeth and Southwark in addressing these incidents

Southwark Q3 Key updates

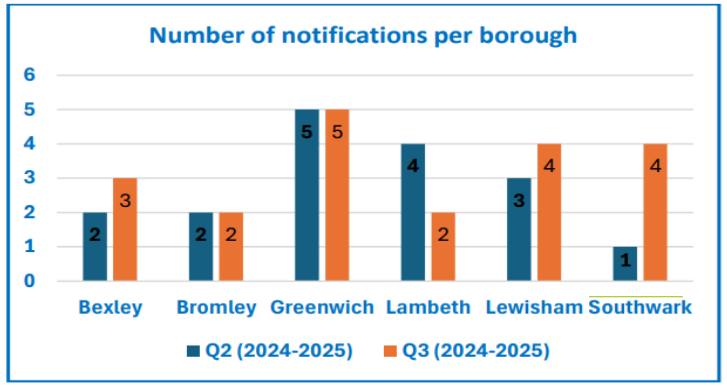
Quality Updates

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) learning from Annual &Q3 Report for Southwark

The LeDeR team have carried out a programme of delivering training to GPs in Southwark, other boroughs and Kings College Hospital End of Life Care (EOLC) Stakeholder committee and Oxleas' Community Mental Heath Team Development Group meeting.

The annual report highlights 1406 Southwark residents with a learning disability, 86% of whom have had an annual health check. The leading Cause of Death for people with an LD in Southwark was Cancer. Bromley and Southwark both had the highest number of cancer related deaths. The Lambeth, Lewisham, and Southwark community team for adults with learning disabilities together with South London and Maudsley and St Christopher's hospice, have set up a Living and Dying Well Group for people to come together to think and talk about Life and Death. The group is incorporating the 'No Barriers Here' arts-based approach to Advance Care Planning. The Oliver McGowan Training Programme in Southwark was highlighted as a positive initiative to improve staff understanding of learning disabilities and autism, ensuring that healthcare providers are better equipped to meet diverse patient needs

Figure 2: Number of notifications received per borough



Southwark

Number of notifications: 4
Type of Review:
3 x Initial
1 x Focused
Type of Patient:
4 x Learning Disability
Gender:
2 x Female
2 x Male
Ethnicity:
4 x White

Learning from Focused Reviews for Southwark: There was one focused review involving a Southwark Resident in relation to care concerns. The cause of death has been recorded as aspiration pneumonia and acute myocardial ischaemia. Several concerns were identified including unsafe swallow, delayed safeguarding referral and a local of documentation of the patient's mental capacity. An action plan has been developed to address the concerns raised.

Positive practice identified was the Learning Disability Acute Liaison Nurses knew the patient well.

Tri-borough Child Death Overview Panel updates

Southwark, Lambeth and Bromley

CDOP	**1. Parental Complaint:** Received a complaint from parents of a child who died at home in February 2024. Parents reported not having been assigned a keyworker and had not been informed of the child death review process. Moreover, parents had specific concerns about the medical care their child received during life, which they were expecting the CDR process to investigate. Individuals acting as the parents' keyworkers were not appropriately informed about the CDR process to manage the parents' expectations. **2. Outstanding Child Death Review Meetings (CDRM):** Have 10 Southwark and Lambeth cases, now several years old. Issues have arisen relating to the responsibility for organising CDRMs and further investigation has revealed a disconnect between the intended resourcing allocated to Designated Doctors and what happens in practice. Designated Doctors were intended to receive 1.5 PAs (6-hours per week) to fulfil their Child Death Review duties, but in practice only have 0.25 PAs (1-hour per week). There appears to be no written job description that outlines the role and responsibility of the Designated Dr, nor a written agreement on the resourcing. The issue only concerns the Southwark and Lambeth Designated Drs. **3. Mortuary Visitation Policies:** Disconnect between local mortuary polices and the recommendations of the pan-London MoU regarding family visitation while their child is in the mortuary. The regional MoU permits parents to visit their children in the mortuary without the glass window if the police or consultant deem the death as non-suspicious. However, local mortuary policy dictates that the deceased is viewed through the glass in all cases involving a referral to the Coroner. **4. No transfer to the ED following death:** There have been four instances in Bromley where, following a death in the community, the Police have not transferred a child to A&E. While the SUDI/C guidance does make provision for Police to transfer older children straight to the mortuary where the cause of death is clear, Joint Agency Response (JAR) process rely on children being conveyed to hospital in order for the process to be triggered.	**Issues to be addressed** 1. Lack of a dedicated provision for a community-based CDR keyworker, who can support and signpost families of children who die outside of hospital. 2. Lack of awareness among key community partners (primary care and hospice). 3. Lack of a complaints process within the CDR process. 4. Several cases are severely delayed in completing the CDR process, meaning that any learning associated with their cases is also delayed in feeding back to the system. A lack of a CDRM also deprives parents with their main opportunity to input into the CDR process. 5. Risk of future cases being affected by the uncertainty over roles and responsibilities when it comes to organising the CDRM. 6. Designated Doctor's have insufficient resources to fulfil their CDR responsibilities. 7. Parents are not allowed to have physical contact with their child at the mortuary and are only permitted to view their child through a glass window. This denies parents the opportunity to grieve and say goodbye to their child. 8. Lack of clarity on how key investigations and samples for a JAR process are taken when a child is conveyed straight to the mortuary.
NDOP	**1. Obstetrician and Neonatologist attendance at Neonatal Death Overview Panel (NDOP):** There has been consistent absence of obstetricians and an irregular attendance from Neonatologists at NDOP meetings for several months. Previous requests have been made for these professionals to attend, but the issue remains unresolved. It would be helpful to understand what is funded at each hospital in terms of time in the job descriptions of these professionals (Obstetricians and Neonatologist) to attend NDOP.	1. NDOP meetings are not quorate, causing delays, cancelled meetings and increasing the case backlog.

Southwark - Infection Prevention & Control Update

Southwark report on Urinary Catheters in Community and Adult Social Care Patients

- SEL worked with GSTT and Partnership Southwark leads to map numbers, locations and reasons individuals in community settings had a urinary catheter, and the support services available to them. The report was circulated widely in November and with recommendations for improvement. The group met in January to discuss next steps.

General Practice audit visits

- Southwark Practices had an annual IPC audit during Q3. IPC processes and protocols were of good standard overall with recommendations mainly around cleaning and environmental issues

Outbreaks

- Incidence of influenza in the general population rose sharply in December and comms campaigns continued to promote vaccination. Several clusters and small outbreaks of influenza, COVID and norovirus were reported across acute and mental health settings in December with no incidents of service disruption.
- Respiratory Syncytial Virus (RSV) activity continued to rise, with increases seen in most age groups.

Mpox update

- UKHSA updated Clade 1b Mpox guidance late December. Key to note is the risk of importation of Mpox cases has been revised from low to medium. SEL net Mpox page has been updated to include UKHSA recommendations.

FFP3 fit testing masterclasses for primary care staff

- A series of FFP3 fit testing masterclasses for primary care staff throughout and the sessions formed a 'train the trainer' model where staff were trained how to fit test others working in primary care. Two sessions per borough were scheduled and details circulated through primary care networks. A December Q&A webinar was arranged so masterclass attendees could raise queries or get more information about fit testing in their setting.

World Antimicrobial Awareness Week (WAAW) 18-24 November

- Electronic packs were widely circulated ahead of WAAW with information, posters, email banners, MS teams backgrounds and links to the antibiotic guardian pledge page. SEL ICB communications team promoted WAAW with written information and video clips.

.

Southwark Q3 Patient Safety Incidents

Incident Learning shared at Southwark Care Home Forum

Learning from an After Action Review was shared at the Southwark Care Home Forum in February 2025. Several issues were identified by members of the group around the Universal Care Plan rollout and patients with missing medication/documentation when returning to their Care homes from Hospital.

A Care home resident was conveyed to hospital with a DNACPR in place and the paperwork went with the patient, however, it was not returned following discharge. When the patient arrested in the Care Home, no attempts to resuscitate, in line with the DNACPR were made. However, due to the documentation not being present at the time of arrest the death was escalated to the Police as an unexpected death.

Key Learning Points

- The need for a clinical pathway for patients in the community, especially for those at the end of their life
- The involvement and support of St Christopher's Hospice.
- Recording of personal preferences for current and future care needs
- Ability for all relevant and appropriate health and care professionals to be able to access a patient's record in a timely way
- Use of the Universal Care Plan
- Improved co-ordination of care between services

Incident Learning

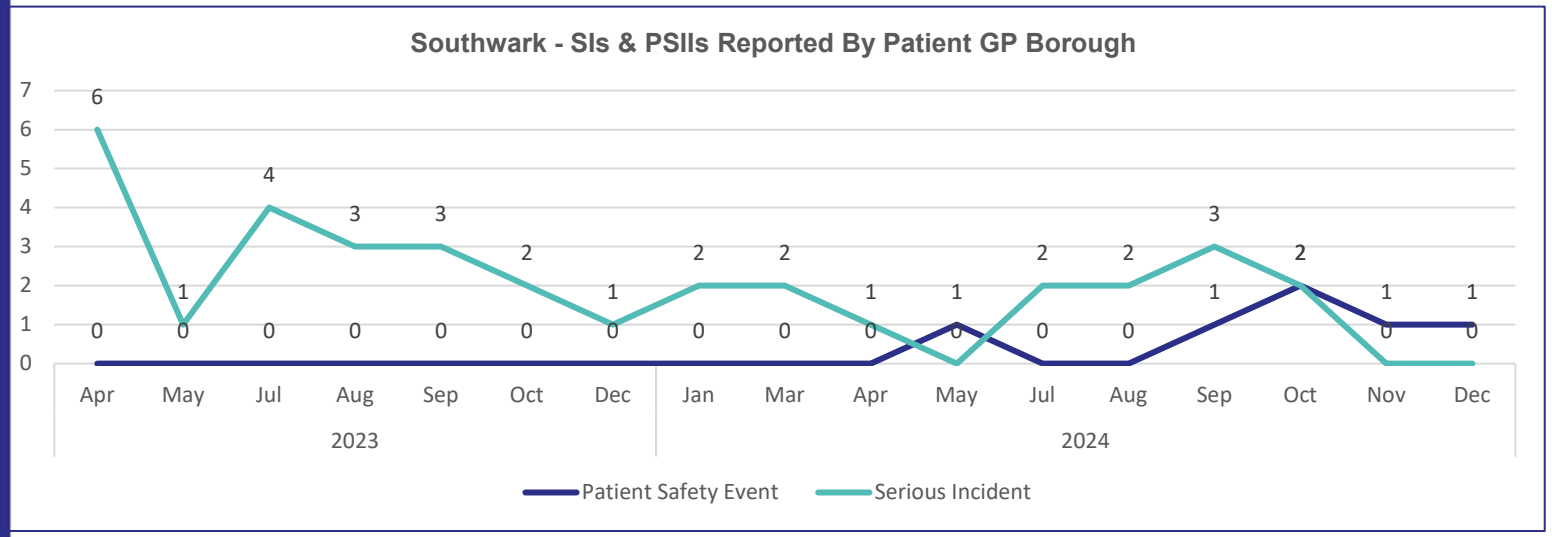
Following a number of After Action Reviews (AARs) related to Emergency Department (ED) Breaches linked to Mental Health waits, several areas for improvement have been identified including: the following areas for improvement which will support improvements for Southwark residents.

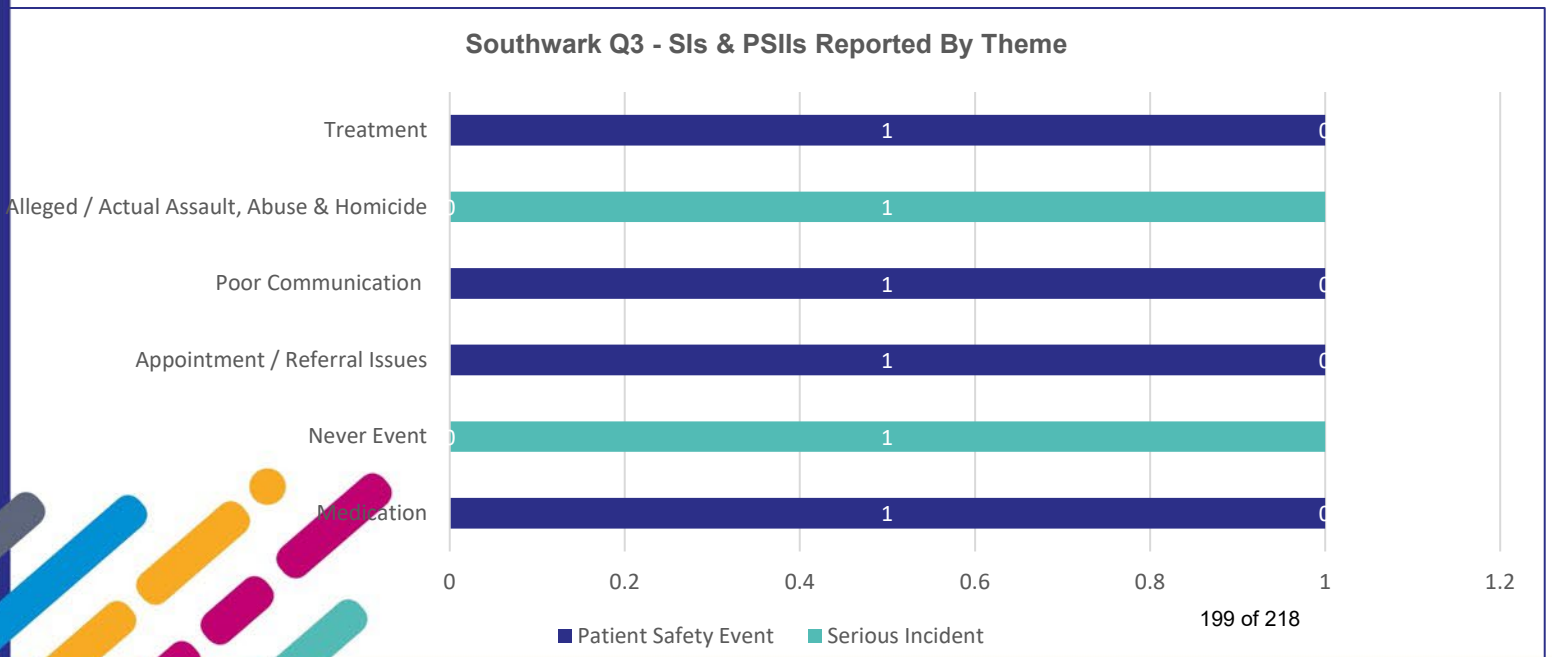
Areas for Improvement

- Local and National standards for CYP in ED to be reviewed, mapped and refreshed - especially for out of hours
- Safeguarding – including options for PAN London trigger plan agreement
- SLaM – To ensure senior review of decision to admit to Tier 4 admission before approval
- Sharing contact information for local CAMHS services
- Safe spaces for Children & Young People presenting to ED
- Reinforcement of protocols/policies relating to sedation and restraint of Children & Young People
- Documentation of rationale for not admitting to a ward after 72 hours
- Mechanisms for patients presenting and unable to engage and police support with identification and information
- Utilisation of the Discharge at St Thomas's Hospital

It is anticipated that the majority of actions will be implemented by March 2025.

Southwark Q3 - Serious Incidents (SIs) & Patient Safety Incident Investigations (PSIIs)





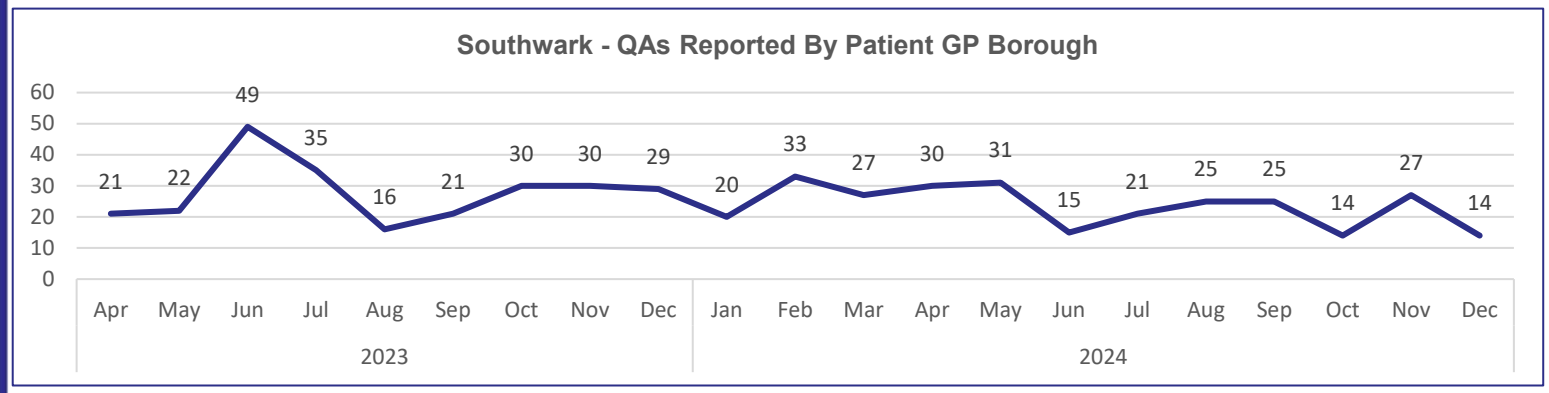
2 SIs / PSIIs are reported on average per month from April 2023 to December 2024.

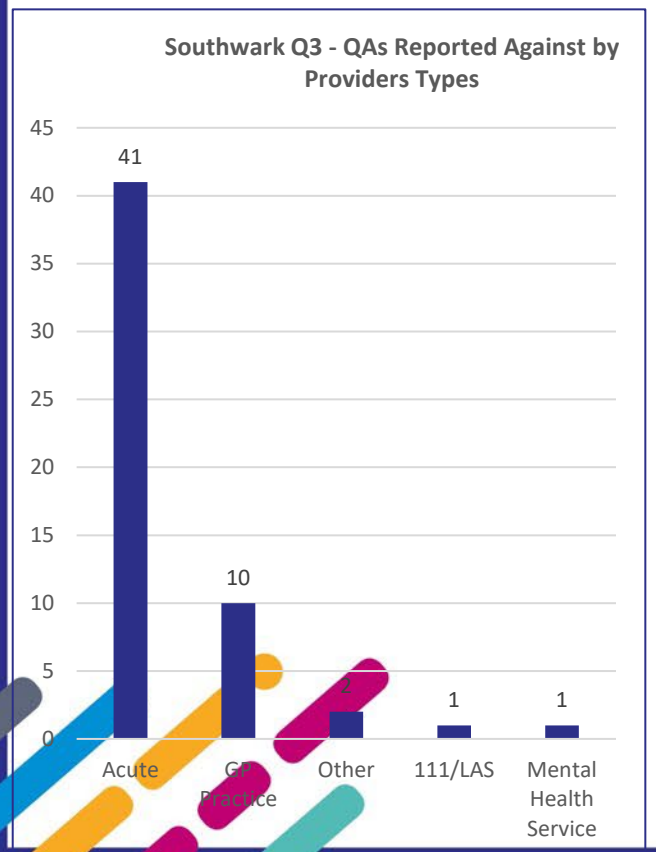
6 SIs / PSIIs was reported in 2024/25 Q3.

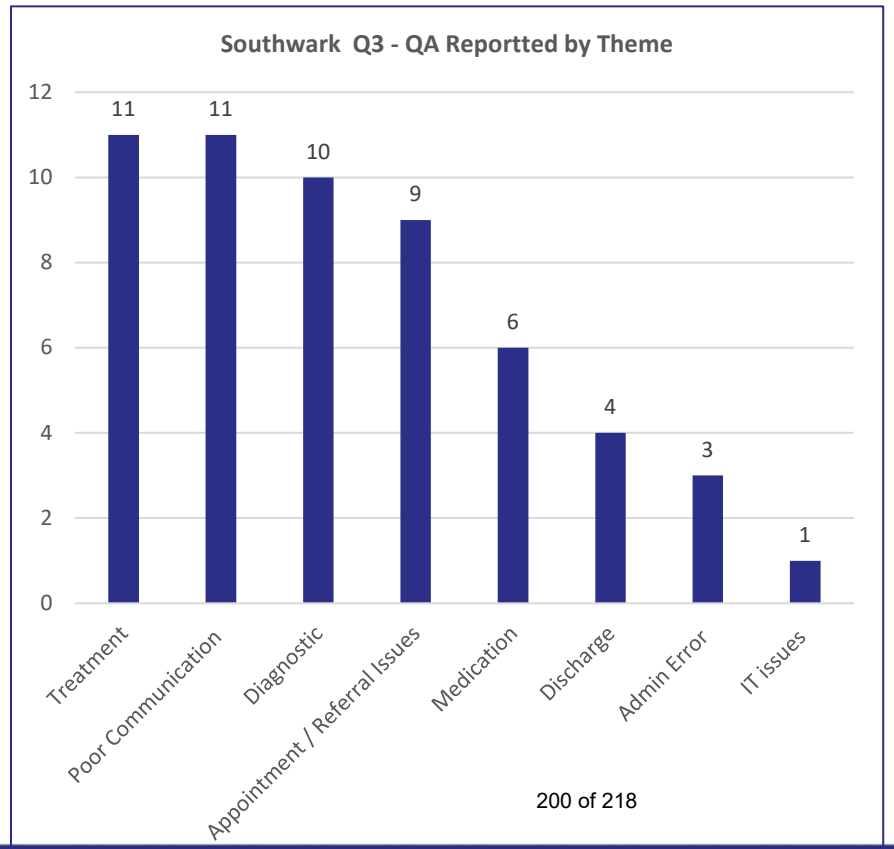
Q3 Sub-Themes Reported:

1. Failure to follow up (1)
2. Test Results Not Shared With GP or Patient (1)
3. Never Event - Retained foreign object post procedure (1)
4. Appointment Rejected (1)
5. Alleged physical assault to third party (1)
6. Discharge without adequate medication (1)

Southwark Q3 Quality Alerts (QAs)







25 QAs are reported on average per month from April 2023 to December 2024. the numbers being reported each month is not seeing a significant increase or decrease.

55 Quality Alerts was reported in 2024/25 Q3.

Q3 Sub-Themes Reported:

1. **Communication between teams / external stakeholders (9)**
2. **Inappropriate Request to GP (6)**
3. **Delayed treatment(6)**
4. **Appointments Rejected (4)**
5. **Medication Supply issue (3)**

KCH and GSTT have convened Task & Finish Groups to improve primary and secondary care interface issues at the local Interface group chaired by the Deputy Medical Director.

Synnovis is currently investigating the difficulties being experienced with the tQuest system such as freezing and slow running of the application. A planned upgrade was undertaken on 16th February 2025, which should support the resolution of the issues. Monitoring will continue with daily meetings between Synnovis, EMIS, ICB and GSTT. Staff are encouraged to raise concerns at tquest@synnovis.co.uk

SEL Quality Alert System

What are the key changes?

Once reported, each QA will be reviewed by the ICB Quality Team, themed and sent through to providers. Responses will be aligned with provider improvement plans. Some QAs may require an individual response or be responded to using PSIRF.

- Reporting will continue to be encouraged by all providers to ensure themes are collected and collated.
- Each QA will be acknowledged to the reporter who will be advised on the categorised theme.
- Monthly reports by theme will be sent through to providers.
- Providers will add the themes to their existing and/or new workstreams in line with PSIRF and their Patient Safety priorities.
- Individual patient clinical concerns should be raised directly with the provider and the reporter will be advised of this.
- Oversight of systemic and pathway themes will be monitored through the ICB's Themes & Concerns Group

Expected outcomes

- Thematic analysis
- System/local improvements
- Key learning streams
- Improved feedback to reporters

Key updates for Quarter 3

Quality area	Key updates and issues to note
PSII	Two cross system PSIIs are in progress. One involves a delayed cancer diagnosis in a patient with learning disabilities and the other involves a failure to follow up of two brothers who are prone to self-neglect.
Quality Alerts	The current process is under review and consultation launched to align it with the Patient Safety Strategy
NRS	There are issues with equipment across the system provided in the community via the NRS contract. A Coroner has issued a Prevention of Future Deaths notice (Reg 28) to NHSE who are leading on the monitoring of the contract.
Sodium Valproate	A paper in response to the NPSA alert has been submitted for review and approval.
Synnovis cyber incident	To note the increase in moderate harms as a result of further investigation. A total of 13 moderate harms have been reported (to Dec 2024)
Paediatric Audiology	Site visits with an SME, NHSE London and the ICB had been scheduled for January in line with the Paediatric Audiology National Improvement Programme; however, one has been rescheduled due to lack of SME availability. Will look to reschedule for February.

Partnership Southwark

Integrated Assurance Report – Option1

March 2025

Section 4: Safeguarding Report

A summary of the more detailed Q3 Safeguarding report reviewed by SMT is attached. The format is to be reviewed for 2025/26

Safeguarding & Looked After Children – Q3 Overview

- Child Protection & MASH Referrals: 271 children under Child Protection Plans (71 under age 5); emotional abuse being the top concern, followed by Neglect.
- 1 ongoing child safeguarding practice review with key learning identified; use of technology, gender identity, family connections and care planning, mental health, education and disruptions to this and the impact of adverse childhood experiences.
- Domestic Abuse & Health Services: 56 families discussed at MARAC; increase in maternity referrals due to domestic abuse & homelessness.
- Safeguarding Training & Supervision: Compliance issues due to misalignment with training requirements; action plans in place.

Key Safeguarding Challenges & Developments

- Extra-Familial Harm & Exploitation: Looked After Children (LAC) vulnerable to grooming, gangs, and exploitation with addition vulnerabilities of undiagnosed learning needs and missing from education.
- Primary Care supporting the fostering team to promote the foster carer role across Southwark utilising the GP waiting room, alongside liaison with North and South extended primary care hub sites.
- Multi-Agency Safeguarding Strategy: Launch of Neglect Strategy & Toolkit in March 2025.
- Training & EPIC System Challenges: Issues aligning safeguarding training; technical challenges with EPIC in health systems.
- Thinking Family and understanding and identifying risks posed by parental mental illness across the health economy continues to be areas for improvement.
- Delay in the delivery of the Multi Agency Safeguarding Hub (MASH) Strategic Leadership meeting continues to hinder oversight of the performance and functions of the Hub

Safeguarding Adults at Risk

- Contributing to **4** Southwark Domestic Abuse Related Death Reviews (DARDR) (formally DHRs) 3 in Borough and 1 out of Borough, emerging themes - Cuckooing, language barrier/communication, Mental Capacity Assessments, Drugs and Alcohol, Mental ill health, No Recourse to Public Funds, Elder Abuse, and lack of professional curiosity
- Challenges with the new DARDR re information sharing information when an alleged perpetrator has not been convicted.
- Development of Pan-London and ICB health dataset for reporting and monitoring which will enable to identify and trends and gaps in services.
- Participated in Southwark Council Peer Review, themes identified – Supporting residents to support healthier lifestyles, working in partnership with the community, understanding safeguarding issues and supporting residents and building good leadership, being innovative and cultivate a learning environment.

- Refugee and Asylum Seekers – This cohort have increasing complex needs (physical, mental, psychological health and language barriers) and can be challenging for them and staff to sometimes navigate the health and social care system. An area for development is better information of Carers/Staff and Partners about the full range of support available and partnership working .

Next Steps & Strategic Actions

- Strengthening Multi-Agency Partnerships: Work alongside safeguarding partners in representing health in co-designing our Multi-Agency Child Protection Teams as part of the new reforms for Children's Social Care
- Continue to gather assurance that there are sufficient mitigation plans in provider services that address any issues EPIC has been causing.
- Enhancing Training & Compliance: Align safeguarding training with roles; address gaps in workforce alignment.
- Addressing Looked After Children Health Gaps: Improve immunization rates and engagement with adolescent health services.
- Gaining further assurance from health providers that routine enquiry into domestic abuse is being embedded further into practice.
- Primary care contribution to multi-agency safeguarding partnership audits, in relation to domestic abuse, ‘stop and search’, alongside sharing key learning back to primary care.

Partnership Southwark

Integrated Assurance Report

March 2025

Section 5: ICB Southwark Place Risk Report

Introduction

- The Southwark borough risk register has been populated from risks identified by teams and programmes. Risks escalated or above the SEL risk appetite levels from the borough register will be included in the SEL risk register or SEL Board Assurance Framework, as appropriate.
- Risks are reviewed with risk owners on a regular basis followed by regular review with the Senior Management Team. At the time of drafting this report all risk reviews were up to date.
- The report summarises the risk register changes since the last report to the Integrated Governance and Assurance Committee in November 2024, which had previously been reviewed by the Senior Management Team.
- Following scrutiny of the full risk register by SMT and IGAC committee this summary is included in the integrated assurance report from IGAC to the Partnership Southwark Strategic Board.
- Borough risk registers are discussed regularly at the corporate risk forum and comparative information is used to help ensure a consistent approach between boroughs.
- The risk register will be subject to a detailed review to reflect 2025/26 budget and priority delivery risks.
- In the next round of reviews, it is likely that the GP collective action risk will be closed given recent contractual resolution.

Summary of Southwark place ICB risk register

Partnership Southwark

Risk ID	Risk Title	Current Likelihood	Current Consequence	Current Rating	Change since last report	Last review date
454	Integrated Community Equipment Service Performance Issues	3	2	6	↓	05/02/25
485	Growth in demand for independent sector Autism and ADHD diagnostic services affecting financial sustainability.	3	2	6	↔	10/02/25
519	CAMHS waiting times	3	3	9	↔	10/02/25
520	Diagnostic waiting times for children and young people	3	3	9	↔	10/02/25
522	Achieve financial balance for 2024/25	2	2	4	↓	06/02/25
523	Delivery of QIPP Savings	3	2	6	↓	06/02/25
540	Prescribing Budget Overspend	5	2	10	↓	25/02/25
553	Southwark Mental Health, Learning Disabilities and Autism placement costs	4	3	12	↔	10/02/25
566	Primary Care GP Collective Action	3	2	6	↓	11/02/25
573	Increase in vaccine preventable diseases due to not reaching coverage across the population	3	3	9	new	n/a New risk

Heat Map	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain					
Likely		1	1		
Possible		4	3		
Unlikely		1			
Rare					

Summary – extreme risks, new and closed risks

Extreme risks

- There are no extreme risks on the current Southwark risk register.

New risks

- A risk has been added relating to Increase in vaccine preventable diseases.

Closed risks

- The risk relating to the delayed completion of building works for the Harold Moody Health Centre has been closed as the building in now complete.

Changes in risk rating

- The risk relating to the quality of the Integrated Community Equipment service has been reduced to 6 reflecting progress in delivery performance.
- The risk relating to GP collective action has been reduced reflecting confidence that this issue is being managed without significant consequences for patient access.
- The 3 finance risks relating to achieving year end balance have been reduced as the end of the financial year approaches and the risks have reduced.

Outstanding risk reviews

- All risk reviews are up to date as at 14/3/25.

Partnership Southwark

Integrated Assurance Report

March 2025

Section 6: ICB Southwark Finance Summary Report

2. Financial Position – Month 11 February 2025

NHS South East London

	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	78	82	(4)	85	90	(5)
Community Health Services	33,389	32,256	1,133	36,424	34,858	1,566
Mental Health Services	9,402	10,617	(1,215)	10,257	11,878	(1,621)
Continuing Care Services	18,114	17,570	544	19,760	19,065	696
Prescribing	32,130	33,049	(919)	35,112	36,352	(1,240)
Other Primary Care Services	1,243	1,260	(17)	1,356	1,375	(19)
Other Programme Services	730	-	730	796	-	796
Programme Wide Projects	237	268	(30)	259	308	(49)
Delegated Primary Care Services	58,140	58,350	(210)	71,330	71,559	(229)
Corporate Budgets	3,159	2,939	220	3,480	3,276	204
Total	**156,622**	**156,392**	**230**	**178,860**	**178,760**	**100**

- Total resources the borough has for 2024/25 in its management amounts to £179m. Community mental health and physical health contracts with local trusts are managed across SEL ICB by the Planning directorate.
- We are reporting a year to date underspend of £230k and forecast underspend of £100k as at month 11. The forecast position is a deterioration from month 10. This position includes overspends in mental health, prescribing and delegated primary care with underspends in continuing healthcare, community and corporate budgets absorbing the overspend. The forecast position on all the three main areas of risk mental health &learning disability services, prescribing and delegated primary care services budget has deteriorated from month 10.
- For mental health we are reporting a forecast overspend of £162m as at month 11. This is a deterioration of £118k from month 10 relating to increased costs for Psychiatry UK and section 12 collaborative fees. The reported position also includes our contribution to mental health placement overspends with South London & Maudsley Trust (SLAM) contract. Most of the overspends within mental health are primarily driven by placements, Right to Choose adult ADHD/Autism pathways, and LD placements. There is a risk of increased pressure in tri-partite Children and Young People mental health costs. We have seen more requests for health contribution on children placements this year at significant costs. The borough will be undertaking a review of all placements paid from place budgets as part of its recovery plan for 2024/25 and planning for 25/26. South London Partnership (SLP) have completed their review of SLAM placements. This has been a beneficial piece of work for Southwark in particular ensuring costs are accurate.
- For Prescribing the borough is reporting a year to date overspend of £919k and forecast overspends of £1.2m at month 11. This is a significant deterioration (£241k) from month 10 . The largest drivers for the increased spend in Mth 11 relates to respiratory and endocrine , infections, CVD, High number of repeat prescriptions and impact of NICE approved tech such as Mounjaro.
- Underspends in corporate and continuing care budgets are absorbing some of the overspends.
- Delegated Primary Care forecast overspend has deteriorated this month and our forecast overspend is £228k. This position is after non recurrent solutions (£325k) have been identified to manage some of this risk for 24/25. The borough is undertaking a review to identify recurrent solutions to manage this deficit and risks for 25/26.
- The borough is forecasting an overall underspend of £100k and has had to implement some non-recurrent solutions in order to mitigate cost pressures in prescribing, delegated primary care and mental health. Growth in community services has been restricted to manage the overall position. The borough has an underlying deficit position, and a series of financial recovery meetings have been held by Place Executive lead focused on opportunities and recurrent savings proposals to support its underlying position and minimise the risk going into 2025/26.
- The borough has received its draft allocation for 2025/26 of £177m delegated to Place. Place Executive Lead is required to sign off these budgets and we are currently in the process of agreeing these budgets and formal sign off.

Final Budgets - 2025/26

- Place budgets have been based on 2024/25 recurrent budgets brought forward. Various adjustments for tariff and growth adjustments have been made in line with national operational guidance.
- Tables below shows the final recurrent budgets delegated to Southwark Place. Place Executive Lead is expected to sign off approval of these budgets by 14th March 2025 . The delegation agreement will be required to be signed once the budgets are final from a SEL ICB perspective.

SOUTHWARK	2025/26 TOTAL PLACE MANAGED BUDGET
	£'000
Acute Services - Local	92
Community Health Services - Local	37,271
Mental Health Services & Learning Disabilities	8,047
Continuing Care Services	20,475
Prescribing	36,208
Primary Care Services	200
Other Programme Services	1,116
Primary Care Co-Commissioning	70,259
Running Costs	3,769
TOTAL	177,438

Partnership Southwark

Integrated Assurance Report

March 2025

Section 7: Delegated leads report

1. CHC
2. Medicines Optimisation

Delegated Statutory Duties: NHS Continuing Healthcare

The Integrated Care Board is required under the National Health Service Act 2006 and supporting regulations and caselaw to arrange care for people whose needs are too complex to be met by social services and to carry out assessments of entitlement for this care

Quality Premium Indicators

The Integrated Care Board is monitored by NHSE on the location and timeliness of its assessments of entitlement for NHS Continuing Healthcare.

Quality Premium Metric	National Target	SEL Trajectory	Jan 2025	Feb 2025
Assessments completed in hospital	0%	0%	0%	0%
Assessments completed within 28-days	80%	Q4 80%	64%	57%
Incomplete referrals over 12 weeks	0	SEL <4 Borough <1	0	0
Incomplete referrals over 28-days – length of delays	-	-	1 2 –4 weeks	1 Up to 2 wks

Appeals

An individual has a right to appeal an Integrated Care Board decision that they are not entitled to NHS Continuing Healthcare. This is a two-stage process: a local review and an independent review facilitated by NHSE.

Indicator	Measure
Total appeals open at month end (February)	4
Local resolution	2
Independent review panel	2

Updated 25/02/2025

Patient numbers

Category	Patients
Adults receiving NHS Continuing Healthcare – snapshot end of Feb	105
Children and young people receiving Continuing Care - snapshot Feb	27
Adults receiving NHS-funded nursing care* - snapshot end of Feb	154

** NHS-funded nursing care is a weekly per patient payment made to care homes with residents who are not entitled to NHS Continuing Healthcare, but who may access to a nurse at any time over a 24-hour period*

Team update

As part of a service transformation project, the CHC Assessment, Review and Case Management functions previously part of GSTT ILS transferred to the ICB joining the existing ICB CHC Commissioning Team on the 1st November 2024 to create a complete in-house CHC offer for the borough of Southwark.

Performance against the SEL trajectory for completion of assessments within the 28-day timeframe has not been achieved during this quarter, which has been a result of a combination of staff leave, the availability of social workers for the completion of assessments, and family delays.

Performance is being closely monitored with relevant actions identified to ensure performance improves.

Medicines Optimisation – delegated lead update

Updated 25/02/2025

- **Finance Update:** SELICB Finance department has been allocated a prescribing budget to Southwark for 2024/25. NICE TAs and long term condition management continue to be a cost-pressure. Cat-M national adjustments will take effect from 1st April 2024 with a downward adjustment on cost of medicines. Medicines shortages, price increases and introduction of new medicines continue to create cost pressures over and above our savings plan.
- **Prescribing Improvement Scheme (PIS) 24/25 :** The PIS for 24/25 was approved and implementation of the scheme began in June 24. The scheme is designed to support the implementation of national guidance published by NHS England and was developed through collaboration with our primary care colleagues and at SEL Medicines Optimisation level. Meetings with all 31 GP practices have been undertaken by the Southwark MOT. Follow up meetings with highest overspending practices in Q3 have also taken place. Prescribing data is being shared with practices to support delivery of the scheme, and Southwark is on track to deliver identified cost savings in prescribing.
- **Community Pharmacy update:** To improve primary care access, work is continuing with community pharmacy colleagues and GP practices to increase delivery of the National Pharmacy First services. These include: the blood pressure check service, the contraception service, minor ailments, and assessment and treatment for 7 common clinical conditions, which all divert activity away from general practice. The MO team is supporting implementation, and working with 4 Southwark Community Pharmacy Neighbourhood Leads (CPNLs) who have been appointed to support this programme and will prioritise this workstream in 2024-25. An increase in referral from GP practices to Community Pharmacists has been seen since launch, with 3,987 referrals for minor ailments or the new clinical over the last year. More work is required however to embed these services as referrals drop off. Additionally, referrals for the new ambulatory blood pressure checking service could be better utilised as part of local hypertension diagnostic pathways.