South East London Integrated Care System

NHS South East London

South East London 2025/26 Joint Forward Plan

Executive Summary

April 2025

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What is the Joint Forward Plan

Our Integrated Care Board Joint Forward Plan sets out our **medium term objectives and plans**, at both a place level and from the perspective of our key care pathways and enablers at ICS system level, to ensure that we are developing a service offer to residents that:

- **Meets the needs of our population.**
- Demonstrates and makes tangible progress in **addressing the core purpose of our wider integrated care system** - **improving outcomes** in health and healthcare, **tackling inequalities** in outcomes, experience and access, **enhancing productivity and value for money** and helping the NHS support broader **social and economic development**.
- Delivers **national Long Term Plan and wider priorities**, all of which resonate from a South East London (SEL) population health perspective.
- Meets the **statutory requirements** of our Integrated Care Board.

We published our first Joint Forward Plan in June 2023. This is a five year plan that is intended to be refreshed each year. For 2025/26 we want to ensure that the work we do supports the two key priorities we have as an Integrated Care Board:

- Improving population health and reducing health inequalities across the population we serve
- Ensuring the sustainability of health provision now and as demand continues to grow.

Our refreshed plan providers the following:

- A strategic overview of how our local care partnerships and care pathway programmes will **improve population health and inequalities and system sustainability**
- A high level summary of the **actions** that we will take this year, working with partners, to make progress; and
- The measures that we will use to **track the impact** of our actions on our population

How does it all fit together

Overall context of the SEL System plans

The SEL Joint Forward Plan sits within a suite of strategic and operational documents and plans developed by our Integrated Care Board and wider Integrated Carew Partnership. These have differing objectives but importantly are interlinked with a clear golden thread across them.

Integrated Care Strategy

- Integrated Care Partnership developed plan covering the NHS and Local Authorities.
- Work supported by significant engagement over summer 2022 and beyond.
- Medium term focussed - 3-5 year timeframe.
- Secures an agreed vision, mission and the identification of 5 key strategic priorities for the SEL integrated care system, with further detail around the 5 priorities now developed.
- Gives overarching consideration to key enablers and ways of working.

Published February 2023
2023/24 work to develop the detail around our five strategic priorities.

Joint Forward Plan

- Integrated Care Board medium term NHS focussed plan - 5 year timeframe.
- Is the ICB response to the integrated care strategy identified priorities
- Sets out how we will improve population health and reduce health inequalities whilst improving the sustainability of our health system
- Ensures what we do aligns to the delivery of national and local priority
- Sets out the key actions we will take and how we will measure our progress
- Refreshed every year with new actions and measures but no material changes to our objectives

First Joint Forward Plan published in June 2023. A refresh is published annually. The publication of the NHS Long Term Plan later in 2025 will require a full review of our Joint Forward Plan.

Operational Plan

- Integrated Care Board (ICB) operational plan – an overarching ICB plan and underpinning plans for the ICB's five major NHS providers.
- Short term 2025/26 focussed plan, building on the plan from 2024/25 and encompassing:
  - how we will deliver national planning priorities and targets
  - key actions from our ICS Strategy and Joint Forward Plan
  - A financial plan for 2025/26, inclusive of the agreed application of the ICB's allocation.
  - Detailed activity and workforce planning and performance trajectories.

Draft plan submission end of March 2025, final submission end of April 2025

How we have built our Joint Forward Plan

Borough Plans

- **A plan for each of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark boroughs.**
- Driven by local health and wellbeing and local care partnership plans.
- Set out the key objectives and actions that will be taken forwards on a borough basis.
- Reflect needs of the population and a focus on reducing inequalities in access, experience and outcome.

Shared Delivery

Care Pathway/Service Plans

- **A plan for prevention, urgent and emergency care, mental health, children and young people, women's health, learning disability and autism, planned care, maternity, cancer, long term conditions, primary care and end of life.**
- Sets out the SEL vision, objectives, framework and approach for particular pathways and population groups.
- Drives forwards our commitment to reducing inequalities in offer and experience, improving outcomes and value across our system

Enablers

- Set out how key enabler functions **workforce, estates, digital / data** are supporting the delivery of our plan plus our approaches to **population health management, sustainability, the green agenda, wider social and economic development and the development of our integrated care system.**
- Our **Medium Term Financial Strategy** that sets out our planned allocation of ICB funding over the next five years.

Our 2025/26 refresh focuses on **how our plan supports delivery of our two major overarching priorities of population health and inequalities and system sustainability**. We also want to make the plan **more concise and accessible** for our population and stakeholders.

Our 2025/26 plan consists of:

- An **executive summary document** that focuses on our context and our combined approach to population health and inequalities and system sustainability as our two major overarching priorities. This executive summary includes a plan on a page for each of our places and care pathway which outlines how they will contribute to our shared objectives around population health and inequalities and system sustainability
- A set of appendices, which enable readers to delve more deeply into the plans of our places and care pathways with a focus on the actions we will take, the impact we will have and how this will be measured.

NHS Long Term Plan

This refresh of our Joint Forward Plan has been undertaken prior to the publication of the anticipated NHS 10 Year Health Plan which we anticipate will be published later in 2025. At that point a more extension revision of our Joint Forward Plan will be required aligned to wider reform of the nationally coordinated NHS planning processes.

Within our current refresh, we have taken into account the outputs of the Darzi Review and independent investigation of the NHS in England undertaken in 2024. We have also reflected on the three strategic shifts that we would expect to see within the NHS 10 Year Health Plan:

1. **Moving care from hospitals to communities,** for example:
   - Delivering more services at places like GP clinics, pharmacies, other neighbourhoods based locations and in people's homes
   - Supporting people to lead healthier and more independent lives, reducing the likelihood of serious illness and long hospital stay

2. **Making better use of technology,** for example:
   - using shared electronic records to improve the patient experience and make it easier for staff
   - virtual appointments with healthcare professionals

3. **Focussing on preventing sickness, not just treating it,** for example:
   - increased screening services to identify and better manage disease earlier
   - more support for those wanting to live healthier lifestyles

South East London Integrated Care System

Overview of our people and communities

NHS South East London

- Southwark is ranked amongst the 15% most deprived local authority areas in the country
- Southwark has the third largest lesbian, gay and bisexual communities in the country
- 46% of Southwark's population are from a Black and Minority Ethnic background

- Lambeth is ranked amongst the 15% most deprived local authority areas in the country
- Lambeth has the second largest lesbian, gay and bisexual communities in the country
- 60% of Lambeth's population are from a Black and Minority Ethnic background

- Lewisham is ranked amongst the 15% most deprived local authority areas in the country
- 22.6% of children in Lewisham live in low-income families
- 47% of Lewisham's population are from a Black and Minority Ethnic background

- Greenwich is ranked amongst the 15% most deprived local authority areas in the country
- 21.8% of children in Greenwich live in low-income families
- 38% of Greenwich's population are from a Black and Minority Ethnic background

- 16% of Bexley's population are aged 65 and over
- 16.3% of children living in Bexley live in low-income families
- Life expectancy is 7.9 years lower for men and 6.7 years lower for women in the most deprived areas of Bexley, compared to the least deprived areas

- 18% of Bromley's population are aged 65 and over
- 13.2% of children living in Bromley live in low-income families
- Life expectancy is 8.1 years lower for men and 6.1 years lower for women in the most deprived areas of Bromley, compared to the least deprived areas

Overview of our integrated care system

About our Integrated Care System

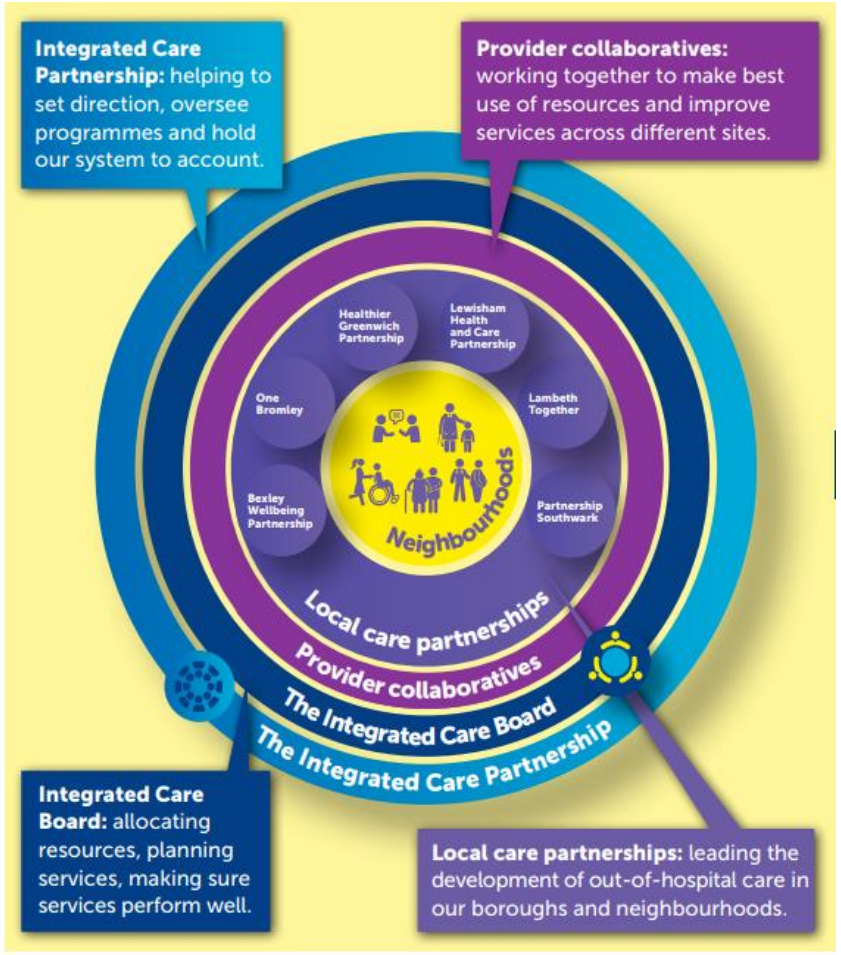
On 1 July 2022, we set up a new Integrated Care Board and a new Integrated Care Partnership, bringing together the leaders of health and care organisations across South East London to plan services and improve care for our population of almost two mission.

Our new board and partnership are responsible for supporting the many organisations delivering health and care services in South East London, which we call the South East London Integrated Care System (ICS). We have four overarching objectives.

1. Improving outcomes in population health and healthcare;
2. Tackling inequalities in outcomes, experience and access;
3. Enhancing productivity and value for money; and
4. Helping the NHS support broader social and economic development.

Our new arrangements are based on partnership working, bringing together the range of skills and resources in our public services and our communities, They are also based on the principles of trust, taking decisions at the right level in our system, giving partnerships and organisations within our system the power to lead and improve their services and working in partnership with our service users.

The diagrams on this slide give an overview of our partnership working within our system, and an overview of NHS provider provision within South East London.



Our System of Systems

NHS provider landscape in South East London

Our approach to Neighbourhood Working

In response to the national drive to deliver a Neighbourhood Health Service, South East London (SEL) has 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.

The overarching aim of this work is to develop a shared approach to INT development across South East London, 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 note the only) element of delivering neighbourhood working will be the establishment of INTs. Places will develop these locally, tailoring them to their local population needs and service, working within an overarching South East London framework

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

What will Integrated Neighbourhood Teams 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.

In 2025/26, the South East London Integrated Care System has chosen to prioritise the development of integrated neighbourhood teams for the following three population groups:

- Children and Young People with complex needs
- People living with three or more long term conditions
- People living with frailty

Population Health and Inequalities

Why is this one of our overarching priorities?

- High levels of health need, with a clear link across to the relatively high levels of deprivation and population diversity found in South East London.
- Life expectancy for South East Londoners is below the London average for all boroughs except Bromley.
- Differences in life expectancy are more marked for those born in the least and most deprived areas across South East London.
- These factors drive significant inequalities, with a variance across boroughs including higher levels of need, challenge and opportunity across our inner South East London boroughs, but with clear inequalities and an inequalities gap evident within each of our six boroughs.
- Known risk factors that drive poor health outcomes plus drive inequalities.
- Inequalities evident in terms of access, experience and outcomes.
- Cost of living crisis has further exacerbated inequalities

How will we make progress through our 2025/26 plan?

- We will be building towards a Neighbourhood Health Service, with care provision organised around neighbourhoods and designed to mee the specific population health needs of their neighbourhoods
- We have been clearer and more specific on how our 2025/26 borough based and care pathway plans will address population health and health inequalities
- We will be strengthening our Population Health Management capabilities across our system during 2025/26 to support the shift to neighbourhood care. This includes how we will start to plan care around specific population segments consistently across the ICS and how we will support front line teams to use shared data and insight.
- We will be building on progress made since 2023 on prevention and early intervention increasing access to both universal offers for the whole population and culturally tailored offers for communities experience the greatest inequalities.
- The themes of partnership and collaboration underline our plan, with the aim of strengthening trust and relationships between health, local authorities and our neighbourhoods to provide integrated and holistic care targeted to specific population need

System Sustainability (1 of 2)

Why is this one of our overarching priorities?

- The South East London system faces significant financial challenges. We will end 24/25 with a system deficit; we currently spend more money than we receive
- In a “do-nothing” scenario, this financial deficit will rise incrementally each year over the next five years.
- As a system, we are committed to the delivery of a sustainable, recurrently balanced, financial position. This remains a key strategic objective and a clear national expectation; a financially sustainable system will enable us to continue providing high quality healthcare to our local population, and those from further afield who access our services
- There is significant work to do through our NHS organisations, and at a system level by working together collaboratively, to develop savings plans which achieve this goal
- In addition to our system’s financial position, we face significant operational challenges across urgent and emergency care, cancer, diagnostics, elective care, and access to primary care and mental health services. Transforming services to ensure they are operationally sustainable and meet nationally required targets, whilst maintaining quality and reducing inequalities, is also a key part of ensuring our system is sustainable
- In South East London, like other areas of London and across the country, there are significant opportunities to improve productivity and efficiency in our services. We need to make demonstrable progress in delivering these opportunities to enable us to meet demand and see and treat more patients, without needing to increase our cost base

How will we make progress through our 2025/26 plan?

- We have been clearer and more specific on how our 2025/26 borough based and care pathway plans will contribute to making our system more sustainable
- In late summer 2024, South East London established a System Sustainability Programme, to provide a framework for bringing organisations together to plan and deliver schemes which can only be delivered by working together
- We now have an agreed list of schemes we will progress through 2025/26; some will be implemented during 2025/26, while some more complex schemes are still in the planning stage
- The work of individual organisations and boroughs, alongside our system level schemes, will contribute to making our system more financially and operationally sustainable

System Sustainability (2 of 2)

Addressing the need to develop long term savings on top of existing provider CIP programmes

The South East London NHS system is under significant financial pressure. There are programmes of work in place to address this challenge in both the short and longer term.

The current provider Cost Improvement Programmes aim to deliver c £250m per annum. Even if these programmes deliver in full, there is still a recurrent financial gap that needs to be filled. This recurrent gap is expected to be c £300m and will need to be mitigated in a 3-5 year time horizon.

A System Sustainability Programme of work has been established by the ICB and system partners. The overarching objective of this programme is to develop plans that will enable the ICB and its providers to move from a position of financial deficit to one of financial balance.

The below summary details some of the main opportunities and approaches to deliver long-term financial savings in the South East London system.

- **Preventative Healthcare** → *Reduce demand on services, absorb unmitigated growth in demand*
- **Release** underutilised resources → *Reduce old estate and collaborate for economies of scale.*
- **Innovation** and technology → *Drive productivity, absorb demand for greater staffing resource*.
- **Simplify** → *Consolidate services and modernise pathways.*

There is clear understanding and agreement that maintaining safety of services is of paramount importance. There will be clinical input into all opportunities that are identified to ensure that patient safety is preserved.

How are we working with our communities and residents?

In 2024-25, the Integrated Care System (ICS) conducted various engagement activities, building on previous efforts. The now established South East London People's Panel and the Anchor Alliance listening campaign provided key insights into experiences and community challenges and have been augmented in 2024 by further insight collated by Mabadiliko CIC from predominantly Black African, Black Caribbean and South Asian communities. This insight is published at What we've heard from local people and communities - South East London ICS to share across programmes and projects.

We have also engaged with local people and communities on a range of other projects including the development of the women's and girls' health hub and NHS 111. Findings from these and other projects are published on our on-line engagement platform Let's Talk Health and Care South East London.

These insights have shaped this refresh of the **Joint Forward Plan.**

As part of our work to build trust with local communities we are partnering with the Voluntary, Community and Social Enterprise (VCSE) Strategic Alliance to work with five grassroot VCSE organisations over three years to co-create a prevention and health-creation collaborative. The aims are to build trust, foster equity and promote wellness within communities who experience the greatest health inequalities.

Over the next year we will build on this and the work of the Anchor Alliance and other initiatives to further develop our approach to engaging with people through working with the VCSE to build trust and develop solutions, as we develop our approach to integrated neighbourhood working.

Key themes from ICB engagement with our communities and residents

South East London Integrated Care System

Healthcare challenges: There are concerns about challenges in accessing services, long waiting times and institutional trust. People are often unaware of how to navigate the complex healthcare system and face barriers including language issues and systemic discrimination.

Use of health services: Many people self-care / go to pharmacies, use NHS 111 though some still use A&E unnecessarily with some communities not aware of NHS 111. People who use the NHS App find it helpful but note limitations, such as the inability to book GP appointments directly. Some concerns about digital exclusion.

Community and mental health: People want more joined-up, proactive services that focus on prevention and treat the "whole person." They also want services to be equitable and locally accessible. There is a call for better mental health support and recognition of the role of family carers.

Loneliness and wellbeing: Both young people and older adults report feelings of loneliness. Financial struggles, lack of employment, poor wages, poor housing and lack of support in areas like healthcare and mental health services are major concerns. People expressed the need for better community support and more accessible services.

Barriers to accessing services: Access to services is hindered by factors like language difficulties, lack of digital access and confidence, and confusion about service eligibility, especially for migrant communities. People with mental health conditions or long term conditions also report poor experiences due to lack of coordination and personalised care.

Maternal health and support: Women, particularly from under-served communities, report inconsistent antenatal and postnatal care, with financial pressures and lack of family support affecting their wellbeing, as well as language and communication challenges.

Partnership and community engagement: There is a need for better collaboration between public services, local communities and the VCSE. This includes addressing health inequalities, especially in marginalised communities, and ensuring services are culturally sensitive and accessible.

Social determinants of health: Wider social issues like housing, safety, and employment are often overlooked but are critical to people's health and wellbeing.

Women and girls' health: people want improved and convenient access offering integrated care which is culturally appropriate, inclusive and incorporates outreach with a hybrid model of both digital and in-person.

Supporting Wider Social and Economic Development

South East London Integrated Care System

Our priorities are to enhance health and socioeconomic well-being in SEL by addressing key health determinants through targeted interventions, creating a system that prioritises prevention, and improves health equity in our disadvantaged communities through:

1. Reducing the magnitude of health disparities between different socio-economic groups, minimising risk factors and consequences of health conditions

Success Measures:

- Reduction in loneliness
- Reduction in infant mortality
- Improvement in life expectancy
- Reduction in premature mortality
- Improved accessibility of healthcare services
- Increase in use of preventative health care services

Black Maternal Health

- Support implementation of a community led intervention e.g. the provision of Doulas for Black women during pregnancy, childbirth and post-partum/fourth trimester (TBC)

Equity zones

- Implementation of health equity zones in collaboration with INT, co-created through local partnerships to tackle the social determinants of health and create more equitable neighbourhoods (TBC)

2. Empowering communities by fostering engagement, building trust and enhancing active participation

Success Measures:

- Increase the number of community leaders
- Participation rates in training
- Increase in residents in targeted communities participating in community initiatives
- Increase in the number of community led interventions
- Development of a community / VCSE organising model

Healthy Dialogue

- creating a model for community & system leaders to come together equitably & empower community voices to effectively shape services

Micro, By and For (capacity & sustainability)

- Capacity, skills and leadership building
- Build and sustain trusted relationship Small one-off grants to sustain and strengthen community-led delivery

VCSE Alliance & Leadership Roles

- Create streamlined access into diverse VCSE strategic leadership
- Support relationships and connections between the VCSE sector and system

Trust and Health Partnership

- Health prevention approach to codesign community /VCSE engagement model

Recognising Involvement

- Renumeration for local people that give their time at level 3 criteria

3. Improving housing conditions for low-income families by increasing access to safe and affordable housing

Success Measures:

- Reduce the number of individuals living in sub standard housing
- Number of new sites identified for affordable housing
- Number of new affordable housing units developed
- Increase in housing improvement initiatives

Housing Coalition

- NHS land identification for affordable homes
- Streamlining of processes and provision of support for housing needs
- Access to Wi-Fi and reducing digital exclusion

4. Enhancing mental health and well being services by increasing the availability of resources to underserved communities

Success Measures:

- Increase in community mental and HWB services
- Reduction in prevalence of mental health conditions
- Reduction in number of mental health related hospital admissions

Be Well

- Grow networks to ensure ongoing sustainability of HWB interventions
- Offer micro grants for community organisations

Mental Health Promotion

- Supporting VCSEs to deliver mental health promotion in culturally and ethnically diverse communities with an anti racism focus

Black Mental Health

- Scoping and delivery of interventions to address mental health in our black communities

Southbank CYP Creative Health Centre

- Creative interventions to support children on CAMHS waiting lists
- Implementation of creative health prevention programmes

5. Increasing access to education and job training, and reducing worker poverty through the London living wage and fair work policies for all

Success Measures:

- Increase in income levels
- Increase in employment rates
- Increase access to education and job training programmes in disadvantaged areas
- Increase number of organisations across SEL paying the LLW

Work and Wages

- Increase accreditation of London Living Wage organisations across SEL
- Widen access to quality work

6. Developing sustainable, healthy communities through promoting environmentally friendly practices, green spaces, and community-driven health initiatives

Success Measures:

- Reduction in smoking rates
- Reduction in alcohol consumption
- Increase in physical activity
- Number of organisations adopting environmentally friendly practices
- Reduction in pollution levels

Access to NHS estates for use by community organisations

- NHS buildings and spaces identified to support communities to deliver services
- Transformation of community-based spaces into community hubs

Procurement and contracting of local organisations

- Improve accessibility of procurement and contracting with small grassroot VCSE organisations
- To strengthen & diversify the partnership with the VCSE sector Reducing the environmental impact

Be Well

- Bring together community leaders and NHS/LA to act on issues creating most strain on mental health and wellbeing

The SEL Integrated Care Strategy – which is reflected in our JFP

Our Integrated Care Partnership has agreed its mission, vision and strategic priorities – set out in our January 2023 SEL Integrated Care System Strategy.

The strategy identified five key areas of priority - these areas have been selected on the basis of a number of criteria, including requiring cross system working to make demonstrable progress. Our Joint Forward Plan sets out the ICB's contribution to delivery of these priorities, and the slide reference below each priority sets out where this information can be found within our overall JFP.

These five strategic priorities are a sub-set of the work the ICB will be progressing within these pathway areas; for example the mental health (MH) section of our JFP covers work we will be progressing in addition to priorities around "ensuring quick access to effective support for common MH challenges in children and young people" and "making sure adults have quick access to early support". In addition, the ICB will be progressing work outside of these care pathways / population groups, in line our overall ICB responsibilities.

South East London Integrated Care System

Place Plans on a Page

Bexley Wellbeing Partnership

South East London Integrated Care System

Our vision is:	Our vision is to improve the health and wellbeing of our population by creating a *Neighbourhood Health Service* that is better for everyone, supporting people to ***start well, live well and age well***.			
Our priority areas are:	Supporting **Children & Young People** *throughout life*	Supporting people living with **Mental Health** challenges	Supporting people to maintain a **Healthy Weight**	Supporting older people living with **Frailty**
In 2025/26, we will:	• Commission Integrated Child Health Model of care • Enhance CAMHS support through adoption of the THRIVE framework	• Implement Phase 2: Community Mental Health Transformation • Continue the 'bed recovery' programme	• Embed healthy lifestyles: • Provide tailored support for individuals	Development of Integrated Neighbourhood Teams with a focus on: Long-term conditions and Frailty
How will this support population health and inequalities:	Offering targeted proactive, personalised and preventative healthcare for our communities, targeting care and support to those who need it or will benefit from it the most to make the biggest impact on improving outcomes.	Addressing the close links between mental and physical health, particularly among vulnerable groups, and tackling the wider determinants of health and access to healthcare with the aim of creating a more equitable health and care system for everyone.	Targeting underserved communities including areas of deprivation, primary schools with higher levels of overweight children with the aim of improving individual physical and mental health and improve access to health-promoting resources across diverse populations.	Population health approach to target support, care, and services based on who needs it or will benefit = addressing variation, with a focus on prevention and health deterioration to make the biggest impact on improving outcomes.
How will this support system sustainability:	Focus on prevention, early intervention, targeted support and coordinated care ensuring healthier populations and a more sustainable healthcare system by improving efficiencies, reducing duplication and reducing costs associated with acute based care.	Integrating services to improve coordination, optimising resources and enhancing patient outcomes. Locally provided community care with faster access reduces demand for emergency services and reduce the need for hospitalisation.	Addressing obesity ensures the long-term viability of our healthcare system by avoiding increasing costs, improving resource allocation, and promoting healthier populations.	Risk stratifying our population to focus on our high risk and rising risk population, ensuring our interventions are targeted appropriately for a more sustainable healthcare system by reducing immediate costs associated with acute based care.
We will measure our impact:	• Reduction in waiting times • Increase in community-based care • Reduction in hospital-based activity	• Reduction in acute inpatient admissions • Reduction in waiting times • Increased number of patients with an SMI who receive an annual health check	• Increased referrals to support services • Increased number of resident participation and engagement in healthy initiatives • Improved recording of weight	• Improved frailty score recording • Appropriate admissions and Emergency Department attendances • Delaying admissions to long-term care

Bromley Joint Forward Plan

South East London Integrated Care System

Our vision:	Help everyone in our population live longer, more independent lives with less variation in health outcomes across Bromley			
Our priority areas are:	Establish joint working in integrated neighbourhood teams	Use population health management tool & approach to risk stratify and better target interventions	Transform all age learning disability services and mental health & welling prevention and early intervention services	Improve universal and targeted service to meet the needs of Children and Young People (CYP) at earliest stage
In 2025/26 we will:	• Build neighbourhood teams across primary, secondary, community, mental health, social care and VCSE. • Adult initial focus: prevention, proactive care and management of multiple long-term conditions and frailty, including on discharge from hospital	• Place agreement, including public & health and social care, on population health management tool to utilise. • Secure PHM tool and expertise. • Agree data sharing arrangements across place partners	• Embed Bromley-Y/CAMHS: step down, prevention, transition to adult services. • Adult MH: improve discharge & access to work, expand single point of access, recommission talking therapies, • Adult LD: support more adults in the community and at home	• Develop local children's health team (B-CHIP) into CYP INTs to meet specific and challenged areas where we wish to improve outcomes. • Review long term condition pathways focussing on prevention and hyper-localised working to target need.
How will this support population health and inequalities:	• Focus on local population need and work with communities. • Research identifies a connection between people with multiple long-term conditions & health inequalities. • Improvements for frail and Core20	• Identification of individuals with high health and care needs, and those predicted to have those needs in the future: allowing targeted proactive and safeguarding interventions	• All target group is Core20PLUS5. • Improved access in all age MH access will improve outcomes for key groups. • Further targeted outreach and inequalities offers with focus on areas of relative deprivation	• Targeted to areas where greatest improvement to CYP health and wellbeing could be made as identified through 2024/25 refreshed CYP and mental health joint strategic needs assessments
How will this support system sustainability:	• Better manage biopsychosocial, medical and mental health factors. • Earlier identification and management : mitigating overall costs and delivering better outcomes • Improved resident resilience, self and family management	• Identification of individuals who may benefit from earlier intervention and proactive management, supporting the shift away from urgent acute and long-term social care.	• Improved prevention offer to reduce hospital admission & CAMHS activity, shifting to third sector & support education outcomes. • Support people in employment and living independently in own homes and or with support to unpaid carers	• Supporting family resilience, safeguarding and reduced acuity of need. • Through B-CHIP a significant reduction in acute instances of care, making every contact count and increase community working.
We will measure our impact:	• A&E attendances; rates not seen in primary care; social prescribing referrals • % 65+ receiving clinical frailty scoring at healthcare interaction; % 65+ CFS 5+ getting Comprehensive Geriatric Assessment, care admissions, safe-guarding interventions, staff resilience	• PHM tool agreement in place. • Place partners to agree to share data to improve population health outcomes and reduce inequalities. • Utilisation of tool commences	• CYP: reduced hospital admissions, CAMHS caseload, reduced referral to specialist services and residential provision • Adults: reduced hospital and care home admissions, reduced referral to specialist services	• B-CHIP: reduced post intervention primary & secondary care attendances; reduced waiting times & lists • Long Term Conditions (LTC): Reduction in LTC exacerbation.

Greenwich

South East London Integrated Care System

Our vision	To improve lifelong outcomes for Greenwich residents by reducing risks and strengthening protective factors, with a focus on neighbourhood-level delivery.				
Our priority areas are:	Start Well: Ensuring CYP get the best start in life and can reach their full potential.	Be Well: Everyone is more active and can access nutritious food.	Feel Well: Integrated neighbourhood community teams provide the right support when & where needed.	Stay Well : Fewer residents are affected by poor mental health (MH).	Age Well: Services support people and carers to live fulfilling & independent lives.
In 2025/26, we will:	• Review universal provision to meet evolving needs. • Improve access to the Family Information Directory and Local Offer. • Improve the core offer and build a cohesive system for ASD and ADHD.	• Update and deliver the Royal Greenwich Get Active Strategy, tackling activity inequalities with community-focused solutions. • Improve the local food environment across neighbourhoods, highs streets, and organisations through integrated commissioning.	• CYP: Establish a SPA for MH and well-being, improve school-based support, embed the Thrive approach, and Waiting Well initiatives. • Adults: Conduct a mental health and learning disability needs analysis, promote key services and equip staff with signposting resources. • Addiction: Integrate VBA into practice and strengthen communication.	• Expand Making Every Opportunity Count (MEOC) • Align neighbourhood development with existing service footprints. • Implement the new Social Prescribing and Live Well integrated model. • Strengthen End of Life and Frailty support pathways.	• Procure a trusted assessor service. • Test the neighbourhood working with integrated teams. • Expand the use of Assistive Technology. • Roll out the Home First communication strategy and staff training.
How will this support population health and inequalities:	• Improving access to information and support for families. • Enhancing service quality and timeliness.	• Ensuring equitable access to physical activity and nutritious food. • Building healthier environments.	• Improving MH service access for CYP. • Address care gaps through "Waiting Well" initiatives. • Providing tailored support for underserved groups.	• Integrating holistic, community-focused approaches. • Strengthening end-of-life and frailty pathways.	• Advancing preventive, proactive care. • Expanding Assistive Technology. • Implementing Home First.
How will this support system sustainability	Strengthening early intervention, improve service access, and reduce long-term demand.	Promoting a healthier lifestyle Reducing future healthcare demand.	Developing efficient, coordinated mental health services across all age groups. Strengthening early intervention to reduce long-term service demand.	Promoting integrated, community-based care models to enhance efficiency and eliminate service duplication.	Prioritising prevention and early intervention to lower future care costs and service demand.
We will measure our impact	• Improving Childhood obesity and breastfeeding rates. • Reducing diagnosis waiting times.	• Increase activity levels. • Strengthening resident engagement in strategy development.	• Monitoring drug use and alcohol intake and increasing sign-ups for treatment. • Expanding community interventions • Reducing MH A&E attendances. • Shortening waiting times for CYP MH.	• Improving vaccination rates. • Increasing diagnoses of long-term conditions (LTCs). • Strengthening neighbourhood community services. • Reducing resident falls.	• Increasing reablement rates. • Monitoring high-intensity care pathway activity. • Tracking P3 admissions.

Lambeth Together Care Partnership

South East London Integrated Care System

Our vision is:	We are committed to improving health and social care outcomes for all communities, ensuring that everyone, regardless of background or lived experience, can reach their full potential, feel valued, and have access to safe, positive choices. We proudly celebrate our rich diversity and actively listen to our communities' voices, making sure they are heard and represented. Our focus remains on advancing equality, diversity, and inclusion to create a more equitable and supportive environment for all		
Our priority areas are:	People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible	Physical and mental health conditions are detected early, and people are supported and empowered to manage these conditions and avoid complications	People have access to and positive experiences of health and care services that they trust and meet their needs
In 2025/26, we will:	• Work with local communities, to ensure residents have access to advice and support in the community • Implement our Tobacco Control strategy • Develop our local health improvement services including weight management/obesity Diabetes, Substance Misuse Young Person services • Launch new Suicide Prevention Strategy • Deliver actions in our Childhood Vaccination Strategy	• Develop our Integrated Neighborhood Teams • Further develop the Child Health Integrated Learning and Delivery System (CHILDs) Framework. Further develop the Primary Care Alliance Network (PCAN) • Increase uptake of NHS Health Checks for those with highest risk • Explore options to scale up the Pain Equality of Care and Support in the Community (PEACS) programme • Expand urgent and emergency care initiatives	• Integration the Patient and Carer Race Equality Framework (PCREF) within mental health provision • Launch the Lambeth Offer to support General Practice to provide high quality, equitable services. • Enable expansion of Hospital @Home services • Improve uptake of the Pharmacy First scheme • Scale up the Children and Young Person's Alliance (CYPA) wellbeing & mental health pilot partnership • Deliver Carers & Age Friendly initiatives Strategies
How will this support population health inequalities	Prioritising those at greater risk, including people from Black, Asian, multi-ethnic backgrounds. Address wider health determinants e.g. supporting employment, skills development, food security/cost-of-living initiatives.	Enabling earlier detection of physical and mental health conditions in high-risk groups, helping to improve outcomes. E.g. the PEACS programme supporting people with chronic pain, particularly Black individuals, who face greater health inequalities	Improving access, experience, and outcomes for underserved groups. For example, the PCREF on mental health for Black and Multi-Ethnic communities
How will this support system sustainability:	Prioritising early interventions that address inequality in outcomes and reduce costs. E.g. the National Institute for Health and Care Excellence (NICE) advises tobacco control measures generate a return on investment and Lambeth is investing an additional £400,000 in support.	Enabling early detection, timely care, reduced costs empowering patients to enable self-care. Our PCAN and Staying Well Service reduce pressure on community mental health services. while the CHILDs Framework provides early intervention to prevent acute care	Working in partnership across our local system to optimise resources shift from hospital-based care closer to home. Our Hospital@Home Service helps enables more patients to receive support at home, reducing costly hospital stays
We will measure our impact by:	Smoking prevalence reduction / Substance Misuse successful treatment / NHS Health Checks uptake / Childhood Immunisations / Mental health support Services / STI diagnosis and testing	Cancer screening programmes / Pre-Exposure Prophylaxis (PrEP) activity / Diabetes 8 Care Processes / Long Term Condition programme / Structured Medication Reviews / Improving Access	Access to General Practice / Pharmacy First / Hospital@Home activity / Reablement and carer assessments/ Infant and maternal mortality / Maternity patient experience / Learning Disabilities discharges from Inpatient units / Individual Placement Services

Lewisham Health & Care Partners

South East London Integrated Care System

Our vision is:	Lewisham Health and Care Partnership aims to achieve a sustainable and accessible health and care system, to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high-quality care, when they need it. **Our commitment is to make Community Based Care that is proactive and preventative, accessible and co-ordinated.** https://www.selondonics.org/in-your-area/lewisham/			
Our priority areas are:	To strengthen the integration of primary and community based care	To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	To address inequalities throughout Lewisham's health and care system and tackle impact on health & care outcomes	To maximise our roles as 'anchor organisations' as employers
In 2025/26, we will:	Establish or develop key services and approaches in: • Integrated Neighbourhood Teams (INTs) • Admissions Avoidance and Home First • Proactive Ageing Well Service • Mental health services early intervention and support and community model	• Review the GP Youth Clinic model • Establish key elements of the Start for Life Perinatal and Infant Mental Health programme • Bring wider Children and Young People (CYP) community health services and primary care into the Family Hub	• Focus on wider determinants areas in line with new Health and Wellbeing Strategy • Pilot debt/benefits advice based in health and social care settings • Work closely and invest in VCSE groups • Work with partners to prevent ill health	• Establish entry level roles in the community workforce and INTs • Co-ordinate joint recruitment initiatives • Joint training to improve joint working and making every contact count
How will this support population health and inequalities:	Supporting patients to manage their long-term conditions (LTCs); identifying people who do not regularly access health and social care services to help prevent ill-health and improve well-being.	• Community based activity closer to families and CYP can help remove barriers to access • GP Youth Clinic model shows positive uptake by Black and Mixed heritage young people	• Reduces the gap between the worst and best off in the borough • Populations will feel more able to self-manage their LTCs, living longer with less time in poor health	• Increased entry level employment opportunities for local populations • Roles that contribute to health needs at a neighbourhood level, connecting with local populations
How will this support system sustainability:	Taking a preventative approach to prevent, delay, stabilise frailty; reduce hospital admissions, demand for mental health beds, Emergency Department attendance and admission to residential care	Family Hubs and GP youth clinics help by redirecting activity away from more intensive and costly interventions and support	• The use of services for acute reasons should decrease as people live healthier, longer lives • Offering people safe and trusted spaces to discuss early signs and symptoms	• Better use of apprenticeships and ARRS funding opportunities and training opportunities across the partnership
We will measure our impact by:	• Reduction in unplanned admissions, and improved management of LTCs • Improved referrals, appointments and waiting times	• Uptake of childhood immunisations • Children with excess weight at Reception and Year 6 • Range of locality-based and digital wellbeing offers	• Cancer screening rates • Reduction in smoking rates • Use of non-health related data	• Numbers of local people starting entry level roles

Partnership Southwark

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).
How will this support population health and inequalities:	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.
How will this support system sustainability:	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 Vital 5 checks by people from Core20Plus5 communities and increase in uptake of interventions.

South East London
Integrated Care System

Care Pathway Plans on a Page

Cancer

Our vision is:	To deliver high quality cancer services across community, primary, and secondary care to ensure that: Fewer people get cancer; patients receiving timely diagnosis; More people survive cancer; More people have a positive experience in their pathway; everyone receives the same high-quality services, no matter who they are or where they live; more people are supported to live as well as possible post treatment.			
Our priority areas are:	Reducing waiting times to treatment	Improving Cancer Screening Rates to Support Earlier Diagnosis	Embed and Improve Personalised Cancer Care and access to support	Deliver Sustainable Cancer Pathways –Focus on Breast
In 2025/26, we will:	• Improve pathways & process to support faster diagnosis. • Embed Inter-Trust Transfer policy • Mitigate challenges on highest volume or most complex clinical pathway inc. Lung, LGI and Skin • Continue to work with SEL providers to identify barriers to timely treatment	• Deliver communications campaigns, targeting non responders & communities with low engagement. • Support implementation of new technologies & age extension. • Develop a SEL HPV & Cervical Screening implementation plan.	• Evaluate remote follow up (PSFU) and support further roll out • Widen access to psychosocial care and physical activity • Develop improvement plan for prehabilitation • Improve support for people on endocrine treatment	• Evaluate current service configuration. • Work across hospital teams and system partners to agree the "problem statement" for Breast. • Identify opportunities to improve patient experience, and financial and physical pathway delivery.
How will this support population health and inequalities:	• Reduce variation in waiting times and outcomes across our population • Reducing inequity of access by ensuring consistent pathways across all sites • Supporting attendance and reducing do not attend rates.	• Reducing variation in access and early diagnosis of cancer. • Increased screening uptake Prevention/secondary prevention through bowel and cervical cancer screening and smoking cessation opportunities in lung.	• Increased take up, with benefit to other long-term conditions • Reducing unnecessary hospital appointments • Enabling patients to be better prepared and fitter for their treatment • Impact cancer incidence/recurrence	• Reduce variation for Breast pathway waits to Treatment • Improve access to specialised care • Improve outcomes for patients by improving waits for treatment.
How will this support system sustainability:	• More efficient use of resources. • Reduce additional costs • Optimising non-recurrent funding. • Reduce time to treatment & better health outcomes	• Diagnose cancers earlier, which reduces time in hospital, improves quality of life and increases the number of people back in work.	• release clinic capacity • service usage optimisation • reduce on the day cancellations, length of stay, complications • positive impact on other LTCs	• Reduce additional cost Improved resilience of workforce • Reduce administrative burden to support patients through their care pathways.
We will measure our impact by:	• Best Practice Timed Pathways and Inter Trust Transfer dashboards. • Constraints and inequalities dashboard	• Screening uptake and coverage, including by demographic. • HPV vaccination uptake.	• PSFU evaluation • National Quality of Life survey and local patient experience work • Cancer Patient Experience survey	• Cancer Patient Experience Survey • Cancer waiting times. • Cancer outcomes

Children and Young People

South East London

Our vision is:	**To deliver an integrated, informed and proactive model of care for children and young people (CYP) with expert community and primary care services that enable CYP to stay well in their local communities, supported by timely access to high quality specialist services**			
Our priority areas are:	**Improve waiting times** for CYP into health services across acute services (*Reforming elective care for patients)*, community-based care and mental health care	Develop pathways and services that support safe, effective and appropriate CYP **access to Urgent and Emergency Care (UEC)** (ref. UEC programme)	Develop and embed **population health management** approaches including models of care which are proactive, support self management and the prevention agenda	Ensure we provide the best start in life for CYP by focusing on the impact of health in **early years subsequent life course events**

In 2025/26, we will:	• Review of CYP waiting times in acute, mental health and community services
	• Develop and implement a measurable plan and trajectories for reducing waiting times in key areas
	• Develop a plan to reduce waiting times over next 5 years
		• Prioritise work on
		  • Same Day Emergency Care (SDEC) services
		  • Out of hospital care pathways
		  • Implement the 'Healthier Together' website
		  • Implement the RCPCH guidance on CYP with complex medical needs
			• Prioritise work on
			  • SEL wide uptake of CYP integrated care models
			  • Asthma and Epilepsy bundles of care and the Diabetes Hybrid Closed Loop (HCL) system
			  • Teen health checks
			  • Develop a CYP health inequalities dashboard to support delivery of core20+5
				• Prioritise work on
				  • the health of parents pre-conception and the health of the infant
				  • Reducing risk factors for infant mortality, specifically maternal obesity
				  • Develop and test models for a teen health check programme (ref. vital 5 programme)

How will this support population health and inequalities:	• Improving access into services allowing CYP to be treated in a timely manner • Ensure CYP needing care can be seen in the right place first time	• Improving access and flow into UEC services • Provision of single CYP platform for information for CYP / Families and health professionals	• Population health management approach to care, with focus on the core 20 and Send populations	• Ensuring equity of access to preconception healthy weight support • Preventing future health inequalities by intervening earlier
How will this support system sustainability:	• Ensuring CYP are seen by the right service first time, reducing inappropriate referrals into acute systems , improving process to ensure sustainable services	• Ensure CYP are seen in right place first time, • Reduce pressures / improve flow and increase access to information	• Moving care from acute to community settings • Providing a proactive care model to target core populations for early intervention	• Early years interventions to impact on later life outcomes • Reducing the number of pregnant women who are obese/overweight with weight related complications
We will measure our impact by:	• Monitoring waiting times for acute OPA, elective care and community services against a trajectory plan	• Monitoring waiting times • Monitoring access to the Healthier Together website	• Monitor the impact of integrated clinics on referrals into acute services	• Proxy indicators for maternal and infant health • Reduction in infant mortality figures

Learning Disability, Autism and SEND

Our vision is:	People with a learning disability, Autistic people and all children and young people with Special Educational Needs and Disability (SEND) achieve equality of life chances, live as independently as possible as they transition to adulthood and have the right support from health and care services, through early identification of needs, improved coordinated multi-agency working, information sharing and support to access the right care at the right time.			
Our priority areas are:	Strategic response to Autism and Neurodiversity	Develop the SEL Care and Support offer in the community with ICS partners and development of workforce	Reduce inpatient care by reducing reliance on inpatient beds by admission prevention and improving quality of life by delivering co-ordinated care.	Development of the SEL SEND Network to support implementation of SEND priority actions at Place as described in the SEND ICS Work Plan.
In 2025/26, we will:	• Continue implementation of Adult Autism pathway by reducing variation and improve equity for assessments across all six (6) boroughs. • Work with each borough to ensure provision of community services meets the needs of the Autistic population and can be evaluated.	• Build on the analysis of inpatient and community provision costs. • With ICS partners – local authorities, ICB and provider collaborative implement community housing and accommodation • Delivery of Oliver Mc Gowan Mandatory Training (OMT) to SEL workforce. • Implement Care Education Treatment Reviews (CETRs) and Dynamic Support Registers (DSR) across SEL	• Ensure business as usual for DSRs, place based steering groups, inpatient surgery reviews and undertake reviews of admissions and discharges. • Fully embed good quality effective AHCs in primary care networks (PCNs). • Implement learning from LeDeR reviews across SEL • Undertake quality oversight of inpatient hospital.	• Strengthen ICB Governance and relationships with Place for SEND and support risk escalation. • Share learning to support improvement of health outcomes • Strategically commission with Place. • Improve workforce capability and capacity. • Data and intelligence and a SEL SEND Dashboard
How will this support population health and inequalities:	Ensuring autistic people have access to timely assessments, interventions and support to meet needs in local communities.	Ensuring population can be repatriated by to South London as close to home as possible and in the least restrictive setting.	Preventing admissions to hospital and by supporting discharge from hospital and reducing the length of stays in hospital.	Ensuring reduced variation in and improved access to SEND Local Offers and delivery of good quality, education, health and care pathways.
How will this support system sustainability:	Reducing the reliance on non-contracted activity with Right to Choose providers.	Care and Support on discharge from hospital are high cost and of variable quality across SEL. Understanding the market leads to better management and delivery of quality services	Specialist learning disability and autism inpatient bed costs are high. By reducing the number of people in inpatient settings, this will release funds to the system to enable improved community offers.	Creating opportunities to commission differently across the ICS to secure value for money and quality outcomes.
We will measure our impact by:	Autism Dashboards Reported waiting times for all boroughs.	Affordable community placements and accommodation and value for money. Reduction/No readmissions to hospital	NHSE Assuring Transformation (AT) data NHS Digital AHC reporting	SEND Inspection Outcomes

Long-term Conditions (LTCs)

South East London Integrated Care System

Our vision is:	We want holistic, personalised, proactive care for people living with one or more LTCs in SE London, that improves outcomes and reduces inequalities		
Our priority areas are:	**Spreading & Scaling holistic, personalized, proactive multiple LTC care**	**Reducing health inequalities and unwarranted variation in LTC care**	**Identifying support and enablers needed for Integrated Neighbourhood Team working with a focus on multiple LTCs**
In 2025/26, we will:	• Support our boroughs to implement integrated neighbourhood working for people with 3 or more LTCs, through consistent Implementation • Develop a new primary care/ community-based offer for weight management, including some access to new obesity drugs, incorporating the principles of integrated neighbourhood working • Further Cardiovascular disease prevention work, improving Blood Pressure control	• Replicate proven approaches to reducing unwarranted variation • Ensure that the developing community-based offer for obesity prioritises groups at risk of experiencing Health Inequalities • Tailored approaches across LTC services that specifically address the needs of communities at risk of suffering Health inequalities	• Support all 6 SEL boroughs to spread and scale integrated neighbourhood working, with a focus on LTCs, by: • Producing Toolkits and other support resources (podcast tutorials, Primary Care training, video resources) • Supporting expanded Point of Care testing for people with LTCs,
How will this support population health and inequalities:	• Implement approaches that transform current care models, such as Point of Care Testing and systematic risk stratification and optimising patients' medicines • Targeted approach to areas of Health Inequalities	• Ensure better use of data that allows a clear approach to risk stratification of people most at risk of health inequalities • Improving data collection for areas where Health inequalities exist, but where known data is not robust (e.g. obesity in primary care)	Ensure better use of data in agreed integrated neighbourhood working priority populations, that allows a targeted approach to risk stratification that reduces health inequalities
How will this support system sustainability:	• Consistent integrated neighbourhood working approach to 3+LTCs will release savings in acute and community services in the medium/ longer term	• By focussing on reducing unwarranted variation in agreed population cohorts, we will drive better 'ageing well' and reduce use of healthcare, including acute services.	• Consistent integrated neighbourhood working approach to 3+LTCs will release savings in acute and community services in the medium/ longer term
We will measure our impact by:	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)	• Improvement in healthy years of life for people with LTCs • Improved life expectancy • Improved patient activation (how engaged a patient is with their health and care)

Local Maternity and Neonatal System (LMNS)

South East London Integrated Care System

Our vision is:	That all women and birthing people receive high quality care, individualised to their needs that supports them to have the best outcome and experience			
Our priority areas are:	Reducing avoidable harm	Reducing inequalities and increasing equity	Improving personalised care including access to information	Supporting development of the service user voice
In 2025/26, we will:	• Collaborate with providers and business intelligence to gather the best data for improving outcomes. • Co-produce improvements with women and birthing people	• Continue collaborating with women, birthing people, and community organisations through the LMNS Equality and equity action plan	• Work closely with key stakeholders to improve information for women and birthing people enabling access to services informed decision making.	• Evolve from Maternity Voices Partnerships to Maternity and Neonatal Voices Partnerships (MNVP)
How will this support population health and inequalities:	• Identifying those in South East London with the poorest maternal and neonatal outcomes, allowing targeted projects to reduce variation and improve care	• Ensuring focus on reducing inequalities and supporting women's health • Supporting key support initiatives for underrepresented women and birthing people	• Providing individualised/woman centred and informed care • Supporting stronger relationships between women and birthing people and their care givers	• Ensuring that all voices are heard across maternity and neonatal services and support for co-production on improvement implementation
How will this support system sustainability:	• Understanding the needs of women and birthing people and their babies across SEL • Sharing best practice that will support improvements and reduce poor outcomes and therefore reduce the number of incidents and complaints	• Through the reduction of inequitable and avoidable harm and outcomes • Provision of equitable care for all enabling a more efficient and responsive service. • Reduction in unknown complexity which impacts resource and provision of care	• Enabling women and birthing people to be key stakeholders in their own care and support them with decision making • Ensuring that women and birthing people consider the importance of the choices across the life course	• Clear pathways and processes to support the engagement of service users at both a local and system level • Meaningful co-production across all maternity and neonatal services
We will measure our impact by:	• Key metrics that will track improvements but also facilitate focused intervention as required • Monitoring of service user and staff feedback	• Mortality and morbidity data • Service user feedback • Reduction in complaints and incidents	• The uptake of Personalised Care and Support Plans • Improved service user feedback	• Implementation of the MNVP guidance and localised SEL plans • Feedback from all SEL communities

Medicines Optimisation

South East London Integrated Care System

Our vision is:	For all SEL residents to have access to medicines which are appropriate and effective for their specific health conditions, maximising the benefits of their medicines while minimising any potential risks or harm. Target medicines investment to areas of greatest need, improving outcomes and reducing inefficiencies.			
Our priority areas are:	Developing “one pharmacy workforce”, adoption of digital technology, the neighbourhood NHS	Community Pharmacy integration, moving care closer to home, primary prevention.	Medicines Value, Medicines Safety and Antimicrobial stewardship (AMS)	Long Term Conditions (secondary, tertiary prevention), genomics, overprescribing, sustainability.
In 2025/26, we will:	• Implement “one pharmacy workforce” to drive collaboration, enhance development and retention • Explore safe and convenient ways of supplying hospital medicines. • Support Integrated Neighbourhood teams. • Increase use of digital support	• increasing access to community pharmacy clinical services. • Increase access to prevention services in community pharmacy. • Test community pharmacy independent prescribing,. • Foster collaboration between general practice and community pharmacy	• Deliver high priority medicines optimisation and value opportunities. • Prevent severe harm from medicines and reduce the impact of medicines shortages • Implement the 5-year-action-plan-for-AMR	• Increase access to structured medicines reviews and reduce polypharmacy. • Reduce the environmental impact of medicines and medicines wastage • Enhance early diagnosis, prevention, and management of long-term conditions • Foster personalised medicine approaches tailored to genetic profiles.
How will this support population health and inequalities:	• Leverage technology to improve efficiency, access, and care quality. • Develop flexible, multidisciplinary teams working across organisational boundaries focusing on the person. • Deliver care closer to people’s homes.	• Community pharmacies offering convenient access to health services, especially in underserved communities. • Ensure services are accessible to all, particularly underserved and disadvantaged communities.	• Enhancing medicines safety strengthens public confidence. • Minimising the risk of untreatable infections spreading, reducing the likelihood of global health crises. • Improving access to high value medicines.	• Shift focus from reactive care to prevention and long-term condition management. • Empower individuals to take responsibility for their health • Reduce inequalities in access, experience and outcome.
How will this support system sustainability:	• Reducing avoidable acute demand • Building a robust, diverse, and well supported workforce with the right skills and capacity.	• Reducing avoidable acute service demand • Ensuring rapid access to high quality services when people need them	• Prioritising interventions that deliver the highest value for investment. • Preventing errors to reduce the financial burden of treating complications or hospital stays.	• Ensure services are accessible to all, particularly underserved and disadvantaged communities. • Commitment to achieving net-zero carbon emissions by 2040.
We will measure our impact by:	Regularly assessing the impact through a workforce dashboard. Use data to refine strategies and adapt to emerging challenges.	Community Pharmacy Clinical Services dashboard. Use data to refine strategies and adapt to emerging challenges. Audit and evaluation of new services.	Establishing systems to detect, report, and learn from medication-related incidents. Medicines Value, Medicines Safety and AMS dashboard and metrics.	Long Term Conditions optimisation and overprescribing dashboards Engaging with the public and the voluntary and community sector on medicines use.

Mental Health (All Ages)

South East London Integrated Care System

Our vision is:	**Ensure residents receive mental health and emotional wellbeing support across their life course - timely, culturally appropriate, anti-discriminatory, trauma-informed, co-ordinated and holistic - and enables the development of resilient communities to live longer, healthier and more independently in the community.**			
Our priority areas are:	Community based support offers for AMH, including those who require assertive and intensive outreach care.	Integrated, holistic and consistent mental health care for children and young people (0-25).	Improve quality of care and timeliness of care for inpatient services across all ages to improve patient outcomes.	Working across the sector with partners, sustainably improving care for people who are neuro-divergent.
In 2025/26, we will:	• Delivering value and impact from our community transformation programme, including piloting a new model of care in Lewisham. • Move towards the new 28-day standard for community waits. • Explore opportunities to provide stepdown care via primary care.	• Continue to transform community CAMHS to further reduce waiting times and move towards the new 28-day standard. • Develop a clear/consistent offer for CYP crisis care across the sector. • Deliver co-produced and targeted interventions for children in primary schools.	• Improving access and flow through inpatient services. • Ensuring inpatient services offer effective, holistic and therapeutic care.	• Open a new ADHD Singe Point of Access for Adults and develop the assessment and treatment pathway. • Test and pilot a new integrated offer for CYP neurodiversity assessments. • Reducing waiting times
How will this support population health and inequalities:	• Ensuring residents have access to timely mental health care in the community, providing earlier intervention and support.	• Delivering improved access to community CAMHS (as per the CYP CORE20PLUS5 framework). • Early mental health care and intervention to CYP.	• Enable care in the least restrictive environment. • Ensure care as close as possible to home. • Offer patient-centred and culturally appropriate care.	• Ensuring all patients have equal access to timely assessment and treatment to then enable access to other support services.
How will this support system sustainability:	• Providing pro-active community-based care. • Reducing dependency on inpatient mental health services.	• Intervening earlier in the life course of an individual preventing escalation as adults. • Appropriate and adequate use of secondary care resources.	• Reduction of spend on private bed usage through better flow, including improved length of stay.	• Ensuring appropriate use of secondary care services. • Reducing spend on non-contracted activity for ADHD.
We will measure our impact by:	• DIALOG score for patient outcomes • Community caseloads and contacts • Reducing inpatient admissions for patients known to CMHTS. • Delivery of 28-day community waiting times standard.	• Delivery of the 28-day community waiting times standard and other waiting times standards. • DIALOG score for patient outcomes, and other feedback direct from CYP/parents/schools.	• Out of Area Placements • Length of stay • Waiting times for inpatient admission • DIALOG score for patient outcomes	• Waiting times from referral to assessment and treatment. • Local patient experience and satisfaction surveys.

Palliative and End of Life Care

Our vision is:	To ensure people of all ages at the end of their lives* are identified early so they can be supported to make informed choices, receive 24/7 care in the place of their choice and receive the best quality, personalised care, with people close to them supported by people who are empowered, skilled, confident and timely			
Our priority areas are:	1. Proactive and Personalised Care: We will improve early identification of people approaching end of life and ensure proactive, personalised care and support planning	2. Improve our service offer: We will ensure evidence-based improvements are identified and recommended to make Palliative and End of Life Care services more accessible 24/7 for patients, carers and professionals	3. Improve access: We will identify groups who are marginalised and improve access for these groups	4. Improve palliative care awareness: We will improve awareness of palliative care support with patients / carers, the community and the wider workforce, including harder to reach populations
In 2025/26, we will:	Deliver place-based projects to increase the use of the Universal Care Plan across South East London, alongside other activity to promote the use of the Universal Care Plan	Undertake a review of existing services that provide support to people at end of life in the Out of Hours period, alongside exploring recommendations and new models support, including provision of information advice and guidance	Deliver a range of events and awareness raising activities to improve workforce awareness of marginalised groups and their needs, alongside sharing learning around ethnically marginalised communities	Deliver training and awareness raising activity to the wider clinical workforce to improve confidence in identifying, and having associated discussions with, those nearing end of life, alongside delivering improved online information, advice and guidance
How will this support population health and inequalities:	Targeting specific groups facing inequality with Advance Care Planning resources / improving take up of Universal Care Plan within marginalised groups	Improving consistency of service provision and access to information regardless of geography or demographic background	Improving awareness of the palliative needs and considerations for marginalised groups - leading to improved access and support, plus more culturally competent practitioners	Ensuring all care settings can access relevant training, and information advice and guidance
How will this support system sustainability:	Reducing unwarranted demand on emergency hospital departments and hospital admissions	Moving more care into the community, reducing unwarranted demand on emergency hospital departments and hospital admissions	Reducing unwarranted demand on emergency hospital departments and hospital admissions, also increasing community empowerment	Reducing unwarranted demand on hospital departments and primary care, also increasing community empowerment
We will measure our impact by:	An increase in the proportion of South East London's registered population that have an End of Life Universal Care Plan	A reduction in the proportion of hospital deaths in South East London	An increase in the proportion of South East London's registered population that have an End of Life Universal Care plan	Improvement of understanding within the renal workforce around hospice and palliative care through post-training feedback

Planned Care

Our vision is:	For elective services to be equitable, deliver high quality care and be responsive to the needs of our population. Our aim is to work collectively as a system to ensure that patients have better access to appropriate care when they need it, reduce the number of times patients need to come to hospital and ensure care is offered quickly and, whenever appropriate, close to where patients live.			
Our priority areas are:	Creating improved pathways for patients accessing specialist care.	Maximising the value of secondary care clinical activity.	Minimising waiting times and improving treatment capacity for admitted pathways.	SEL Community Diagnostic Centre (CDC) rollout programme to create additional diagnostic capacity.
In 2025/26, we will:	• Expand the specialist advice offer in SEL and identify variations in utilisation of specialist advice. • Develop the provision of community-based alternatives to planned care.	Develop robust clinical and administrative processes, review and transform pathways, enable patient choice, increase provision of PIFU, reduce do not attend (DNA) rates and better support patients with prevention and self-management.	Increase treatment hub capacity, modify Orpington orthopaedic operating model and increase use of independent sector where financially possible.	Develop business cases for additional CDC capacity, embed Soliton Share+, increase referrals to CDCs, utilise SEL data to improve communications with primary care and review demand and capacity management.
This will support population health and inequalities by:	Ensuring equitable access to specialist advice to support timelier access to care and the management of patients in the most appropriate care setting.	Patients receiving faster care, reducing the risk of worsening health outcomes whilst waiting. Targeting DNA interventions to underserved groups.	Reducing health risks associated with long waits for treatment and the variation in waiting times across Trusts, supporting equitable access and waits across the population.	Supporting equitable and timely access to diagnostic procedures across all population groups and delivering a faster pathway to treatment and management.
This will support system sustainability by:	Efficient use of resources across all tiers of care by ensuring patients are seen in the most appropriate care setting .	Ensuring outpatient and other secondary care capacity is used efficiently, appropriately and with maximum value for our patients.	More efficient use of resources across the whole system and improving resilience to manage increases in demand or other pressures.	Expanding CDC capacity helps improve performance, makes more efficient use of system resources and reduces financial burden of long waits.
We will measure our impact by:	Improved utilisation, provision and turnaround time of specialist advice services (eRS and Consultant Connect).	Analysing the proportion of patients moved to PIFU, DNA rates, waiting times for first appointments.	Monitoring number of patients waiting > 52 weeks, receiving treatment within 18 weeks and number of treatments delivered.	Analysing trends in patients waiting <6 weeks and >13 weeks, vacancy and turnover rates.

Prevention, Wellbeing and Equity

Our vision is:	Equitable access to prevention and wellbeing support for all SEL residents through systematic, community-partnered approaches			
Our priority areas are:	PREVENTION FRAMEWORK: System-wide approach to embed evidence-based prevention across SEL and enable better resource alignment and collaborative delivery across key prevention priorities	BUILDING TRUST AND CONFIDENCE WITH OUR COMMUNITIES: Improving partnerships with residents and community groups to meet diverse population needs	VACCINATIONS & IMMUNISATIONS: Working collaboratively to improve vaccination coverage and protect population health	VITAL 5: Systematic approach to identify and support residents with Vital 5 risk factors through health promotion, early identification, self-management, and proactive management
In 2025/26, we will:	• Embed systematic approach make every prevention contact count • Define core prevention offer with prioritised populations, clear metrics and evidence-based delivery • Use data, evidence and insights to shape system-wide prevention priorities through operational planning	• Facilitate partnership development with community-based organisations • Create equitable cross-sector partnership for community-led approaches • Develop indicative community-led outcome measures	• Map provision, coverage and evidence of action • Develop communications and culturally appropriate promotion • Make an integrated offer the default for vaccination catch-up • Maintain skilled workforce	• Strengthen health promotion and awareness of the Vital 5 in communities • Improve detection of risk factors and early intervention with focus on Core20Plus5 • Embed Vital 5 (V5) in SEL care pathway programmes (incl. Vital metrics for CYP)
How will this support population health and inequalities:	• Improve resource allocation to areas of greatest need and inequality • Evidence-based prevention interventions aligned to population need	• Trust building in underserved communities • Transform partnerships with local voluntary sector organisations	• Reducing vaccination inequalities • Ensuring convenient access, with bespoke offers for under-served communities	• Earlier identification of modifiable risk factors • Improved access to and more targeted preventative services
How will this support system sustainability:	• More efficient use of prevention resources • Prevention embedded in system planning in more coordinated and focused way • Sustainable prevention delivery models • Reduced acute-care based healthcare utilisation	• Efficient prevention resource use and return on investment • Community-led solutions aligned to evidence base of improving sustainability	• More efficient use of prevention resources through V&I • Ensuring rapid access to high quality services when needed • Improving care for disadvantaged groups	• Reducing acute service demand • Cost-effective early intervention • Improving workforce capabilities • Better integration of prevention into routine care and SEL care pathways
We will measure our impact by:	• Agreed outcome measures and baseline data for priority areas through a framework for outcomes and benefits tracking	• Co-developed impact measures • Digital outcome tracking capabilities	• Regular qualitative insights from on vaccination uptake	• Number and demographics of V5 checks across different settings • Prevalence of V5 in different communities

Primary Care

South East London Integrated Care System

Our vision is:	All residents of have access to high quality, personalised, integrated primary and community care services when they need it, delivered in a sustainable way.			
Our priority areas are to:	Deliver high quality, equitable primary care that minimizes unwarranted variation in outcomes for all	Improve Access by understanding the drivers of poor access for population groups and co-develop approaches that tackle the issue.	Improve the sustainability of Primary Care as part of the neighbourhood health service	Make the shift to neighbourhoods, working with communities, health & care providers, voluntary organisations to improve the health and wellbeing of a local community
In 2025/26, we will:	• Define consistent standards of care • Measure delivery of the standards by improvement in patient, staff and system outcomes • Better target our resources into areas where outcomes are poorest	• Work with practices, PCNs and patients to understand the core components of access for different populations • Implement plans to tackle issues including making an appointment, waiting times, risk stratification, types of appointments, workforce planning and collaborative working	• Improve recruitment and retention of staff in priority areas • Develop change leadership within primary care • Provide evidence on most effective use of ARRS staff to improve patient, staff and system outcomes. • Develop a framework to improve the sustainability of primary care	• Agree a common population health segmentation approach • Establish neighbourhood teams starting with those living with multiple LTCs, frailty and children and young people • Implement common framework and models of care for priority populations • Establish an outcomes framework and monitoring approach
How will this support population health and inequalities:	Lifting standards of care for the whole population, whilst reducing variation in outcome between populations	Taking a more targeted approach to ensuring that those in greatest need have responsive access and proactive care and support.	Ensuring we are targeting our sustainability support for primary care into the services and areas where this is most needed.	Identifying residents within target populations and connecting them into health, wellbeing and br6ader services that support being to stay well for longer.
How will this support system sustainability:	Optimising prevention, treatment and proactive care across primary care to reduce growth in ill-health over the longer term..	Tackling complex issues impacting on access in general practice, to ensure that people at greatest risk will not need to navigate alternatives and will receive a holistic service.	Tackling the issues within our control affecting the stability of primary care, so that services are able to meet the growing needs of our population for both episodic and proactive care.	Reducing hospital admissions and outpatient appointments by shifting the care from an expensive hospital reactive environment to a more cost effective community model.
We will measure our impact by:	Reducing variation in key treatment and clinical care outcomes across our population (such as blood pressure control, diabetes control, care planning etc)	• Triangulating outcomes from FFT, the GP patient and Health Insights survey • Increasing the number of appointments delivered within 2 weeks	• Increasing and reducing variation in the Identifying number of whole time equivalent roles per 100,000 of our population • Setting out a core offer to primary care by the end of 2025/26	• Tracking the number of patients being supported through new neighbourhood models • Tracking patient and staff experience of new neighbourhood models

Specialised Services

Our vision is:	To provide integrated, high-quality, and equitable specialised services that meet population health needs, reduce inequalities, and ensure system sustainability through collaboration and innovation.		
Our priority areas are:	Delivery of a Specialised Sustainability Review	Sickle cell disease (SCD)	Blood borne virus ED testing and HIV re-engagement / South London HIV network
In 2025/26, we will:	• Create a Compendium of Opportunities, drawing together possible transformation projects. • Undertake a holistic data review, to assess variation and inequalities across all specialised services. • Create an executive summary of opportunities for efficiency, effectiveness, and improved outcomes to feed into ICS financial sustainability plans	• Evaluate and embed learning from existing pilots into wider care pathway planning • Promote the new community service, including via engage with patients, local media and attending Learning Time events for GP practices to raise awareness of enhanced service / CNS coverage. • Ongoing consistent delivery of MDT clinics across the three community providers. • Full implementation and collection of EQ-5D patient outcomes survey across all ages	• Expand opportunities of opt-out testing (e.g. at GP practices) • Building stronger partnerships with primary care across SEL through the GP Champions • Work to improve our linkage to care rates • Continue to build clinical expertise and excellence through our South London HIV Network • Continue to work closely with the hep C network to deliver high quality hep C care • Further close working with primary care to provide holistic care for people living with HIV
How will this support population health and inequalities:	• Ensuring inequalities analysis is at the heart of the holistic data review process, to uncover variation and inequalities • Scoring and prioritising known opportunities with a significant focus on preventing health inequalities.	• Reduction in health inequalities relating to SCD • Improved patient experience of engaging with sickle cell services • Increased awareness of SCD • Increased quality of life for sickle cell patients, their families and carers	• Opt out BBV testing is an effective way of reducing health inequalities – there is evidence that the majority of new diagnoses have not been tested in other venues • Our re-engagement work has effectively reached our Core20PLUS population
How will this support system sustainability:	• Maximising the opportunities provided by delegation to understand where services can be delivered more efficiently. Once identified, it will propose the key projects needed to do this.	• Reduced pressure on acute providers • More sustainable working habits and demands for healthcare services	• Proactive identification of people living with HIV not in care and diagnosing to keep them well to reduce inpatient admissions • Proactive identification of people living with hep B and C to treat them and to reduce costly liver transplants
We will measure our impact by:	• Projects and opportunities will be scored against a set criteria to determine priority. • Those undertaken will be comprehensively evaluated to understand their impact.	• EQ5D-L • Activity data • Emergency care usage	• Activity data • Inpatient admissions (number and Length of Stay) • Viral hepatitis related liver transplant and liver cancer rates

Urgent and Emergency Care

Our vision is:	To deliver an integrated safe and responsive Urgent and Emergency Care model that meets population needs and enables people to access the care they need, in the least intensive setting, when they need it and minimising the time spent in hospital through a resilient and sustainable service offer.		
Our priority areas are:	Front Door – ensuring high quality care, improving the timeliness of UEC responses and sustainability of UEC performance standards (all ages, ref CYP Programme; ref Mental Health Programme).	Discharge – ensuring nobody spends more time in hospital than is necessary with supportive transfers of care and delivery of discharge standards (mental and physical health for adults).	Contributing to the SEL System sustainability plan across UEC pathways by implementing the National Criteria to Admit (CTA) tool for all specialties prior to admission from the ED.
In 2025/26, we will:	Work with partners to support site-based audits, improvements and evaluation to deliver enhancements in performance. Continue to focus on improvements in provision, trusted assessor referrals to SDECs and to improve front door streaming to the most appropriate setting, exploring and optimising digital functionality improvements.	Work with acute partners to improve flow models to reduce discharge delays for those who do not meet criteria to reside, focusing work on patients on pathway zero. Work with local authority partners to improve discharge for patients on pathways 1-3 and meet SEL discharge standards. Support our mental health trusts to embed the 10 principles of mental health discharge	Work with acute partners to carry out clinically-led CTA audits focusing on high-volume specialities initially using the National CTA audit guidance. Implement the CTA tool in ED departments. Evaluate impact.
How will this support population health and inequalities:	Consistency in streaming models across SEL to support the delivery of parity of access to urgent and emergency care. Where required, pilots and pathways supporting those from Core20+ groups to improve access and experience.	Consistency in meeting the SEL discharge standards for both mental and physical health discharges helps us work towards parity for all patients who require supported discharge and transfer of care.	Consistency in the admission threshold/criteria for all specialities prior to admission from ED; reduces variation of practice between individual clinicians. Reduction in Length of Stay in EDs improving the patient experience.
How will this support system sustainability:	Streaming patients to the most clinically appropriate destination will reduce the pressure on EDs and improve system performance against UEC performance standards.	Reducing the number of patients who are clinically ready for discharge but continue to reside in hospital, providing an opportunity to reduce costs around escalation beds, boarding and agency staff if (NB although this may also require investment in some alternative service provision)	Reduction in admissions and reducing bed costs; patients seen in a more appropriate setting; utilisation of alternative pathways.
We will measure our impact by:	• Improvement in performance against 4 hour target • Improvement in performance of ambulance handover times • Improvement in outcomes from missed opportunities audits	• Improvement on the number of admitted patients not meeting criteria to reside • Improvement on number of patients discharged by 1pm • Reduction in SEL costs of escalation beds open/boarding	• Improvement in conversion rate (% admitted from ED) • Reduction in patients admitted in over 12 hours from the time of arrival (%) • Mean time in department - admitted patients

Women's and Girls' Health

Our vision is:	To improve access to health care for women and girls across the life course, enhancing experience, empowerment, and improving health equity and outcomes - with a focus on increasing services and support available closer to where women and girls live, work and are educated in the community.			
Our priority areas are:	Reducing health inequities and improve access to timely care for women and girls in the community	Co-commission pilot women's and girls' health hub models in Greenwich/Bexley and Lambeth to guide future commissioning arrangements and scaling	Upskill the ICS workforce in women's and girls' health through multidisciplinary teams, supporting satisfaction and retention	Improve health education for women and girls with culturally tailored approaches, empowering individuals to make informed choices
In 2025/26, we will:	• Embed population health management approaches within pilot hub models • Work with voluntary sector organisations to deliver in/outreach • Continue to gather resident insights through our Let's Talk About Women and Girls' Health survey, focus groups and outreach	• Launch two pilot hub and spoke models • Embed continuous improvement and evaluation within pilot hubs to inform business case to reinvest from acute-care into community hub models. • Use the Women and Girls' Health Network to share best practice and address challenges	• Create a centralised repository for healthcare providers with current, evidence-based guidelines on the eight core health services for women and girls. • Offer specialised training on these services in partnership with training hubs, Trusts and the Acute Provider Collaborative SEL Gynaecology Network	• Create a centralised repository with trustworthy, easy-to-understand information, advice and guidance available for residents across SEL • Work with schools and voluntary/community sector organisations to develop and disseminate culturally tailored health resources
How will this support population health and inequalities:	Improved access for underserved groups with tailored and culturally competent health care interventions	Improved access to integrated, quality care through pilot hub models, leveraging evaluation and shared best practices to reduce disparities women's health care services across the hub scope of service	Reduce variation of services across South East London so that women and girls don't experience disadvantages in the healthcare they receive based on where they live or which service they access	Improving access to reliable, culturally relevant health information empowering underserved communities to make informed decisions and manage their well-being throughout life
How will this support system sustainability:	Reducing health inequities, improving resource efficiency, and shifting care towards prevention and early health intervention services and treatment.	Sharing in real-time any benefits realised through the pilots and opportunities to commission services in a more joined-up way	Shifting service delivery out of acute settings and into the community where appropriate and upskilling the workforce with specialist women's and girls' health input	Reducing demand for healthcare services through improved health literacy, empowering residents to engage in preventative care, self-management, and early intervention
We will measure our impact by:	Track the number of people accessing pilot hubs and outreach services, capturing ethnicity, age and deprivation data to see improvements in health equity	Tracking demographic data on access, experience and outcomes within hubs against and assessing the feasibility of the hub model through formal evaluation	Uptake of and feedback on training and education	• Resident access and feedback on usability • Number of culturally tailored health resources developed

South East London Integrated Care System

Enabler Programme Plans on a Page

Digital

Key themes within the Joint Forward Plan	Empower people through digital and data	Digital solutions for connected care	Deliver data driven insights	Ensure system resilience, data integrity and cyber security	Drive continuous improvement and innovation	Undertake workforce planning to support our digital, data and analytics activities
In 2025/26, we will take the following actions to make progress in these areas	• Increase uptake and usage of the NHS App and increase functionality available in the App • Continue initiatives to improve patient experience in accessing general practice • Support digital inclusion by expanding the laptop donation scheme and continue to support the ICS Digital Inclusion Lead to ensure	• Digital enablement of integrated neighbourhood teams • Progress electronic patient record projects for LGT and SLAM • Convergence of pathology GP ordering onto the radiology GP ordering platform • Supporting integration between general practices and pharmacy • Continue support for the London Care Record and on expansion of the Universal Care Plan	• Launch the first release of the London Secure Data Environment • Facilitate the transition to a consistent population health management data source and tools for SEL • Expand access to the integrated data held to support proactive care and population health in alignment with information governance and data sharing provisions • Define the plan for utilisation of the Federated Data Platform	• Finalise and implement the ICS Cyber Security and System Resilience Strategy • Improve timeliness of data sharing and information governance requests • Review of technical and support infrastructure to identify opportunities to improve efficiency and cyber security and resilience	• Implement the AI Framework in South East London and progress opportunities to increase the use of AI and automation • Pilot the use of ambient voice technology for GPs • Host a second innovation day and digital showcases. • Continue to drive improvements to digital maturity across PC and ASC	• Work with London region to progress development of workforce plans for the Digital, Data and Analytics workforce • Plan for the implementation of the NHS Staff Passport • Identify and promote opportunities to develop digital and data skills in our workforce
We will measure our impact by:	• NHS App registration Number of GPs offering appointment booking and management in the NHS App • Number of laptops repurposed to community partners • ONS Health Insights Survey re GP access	• Evaluation of digital enablement of integrated neighbourhood teams • Business cases approved including benefits defined for LGT and SLAM EPRs • Views of the London Care Record	• Feedback from population health management teams on access to data • Increase in utlisation of the FDP across South East London	• DSPT compliance • Decrease in Windows Defender Score • Time taken to process a data sharing request or data protection impact assessment	• Number of AI projects taken from demand to proof of concept or pilot • Review of pilot results of ambient voice technology • Digital maturity assessment score	• Number of staff on data and AI apprenticeships across SEL • Improvement in digital maturity assessment score for supporting people

Estates

The key supporting themes highlighted in our Joint Forward Plan are:	Maximising the Use of Public Estate, including by: • Exploring co-location opportunities. • Supporting service transformation through efficient estate planning	Supporting Integrated Neighbourhood Care including by: • Ensuring estates facilitate collaboration between primary, secondary, and social care services. • Prioritising solutions that enhance service delivery closer to home	Focussing on Long-Term strategic planning, including by: • Investing in long-term estate solutions that support community health needs • Ensuring estates infrastructure aligns with future population health demands. • Leveraging digital and data solutions to optimise space utilisation	Improving sustainability by: • Implementing carbon reduction initiatives within the healthcare estate. • Exploring energy-efficient building solutions to support NHS sustainability goals.
In 2025/26, we will take the following actions to make progress in these areas	Use the Estates Board for South East London to explore opportunities to plan for joint estate development where possible. Create a financial sustainability plan to save money, generate savings and create additional revenue	Working with place teams to identify current and future neighbourhood hub needs and locations we will: - • prioritise initiatives to enable better colocation of primary care and community services and delivery of primary care at scale • prioritise opportunities to enable delivery of primary care estate that is fit for purpose, supports care models, and is energy efficient to reduce costs and contribute to sustainability targets • Develop a system tool to better understand how clinical spaces are being used in General Practice that could be used	Develop our 10 year capital plan that aligns with the drivers for change that were identified within the South East London Estates and Infrastructure Strategy: • Decompressing acute sites • Development of proximal ambulatory hubs • Delivery of Community Diagnostic Centres • Community properties: using the existing stock of buildings, and developing new facilities, to enable routine care (e.g. outpatients) to be shifted closer to patients Enhanced collaborative working across South East London; acute and community providers, and local authorities working together to make better use of resources (system wide optimisation) Borough priorities - Provider, Local Care Partnership, Borough, and VCSE	Prioritise the use more green energy; consumption of green energy appears to be low across the ICS. Signing up to the national crown commercial services framework for energy. Identify opportunities to reduce flood occurrences across our estate as these pose an increased risk to business as usual Disposal of waste is less cost efficient than our peers, particularly the disposal costs for GSTT and KCH (compared to peers); we must prioritise identification of opportunities to reduce waste disposal costs. Opportunities should be identified to reduce carbon emissions from clinical waste, which are significantly above peer values for GSTT, KCH, and above peer values for LGT
We will measure our impact by:	List of sites in delivery	Formalising our neighbourhood plan	Speaking to our patients and staff and acting on feedback.	Reduced energy bills Reduced property costs Amalgamate contracts to ensure economies of scale

Green Plan delivery/Net Zero

The key areas where we can support the Joint Forward Plan are:	Delivery of the ICS Green Plan and achievement of the NHS net zero targets supports – either directly or indirectly (in partnership or via co-dependencies with other ICS workstreams): • Prevention and wellbeing – creating a clean and healthy environment to support maintenance of good health • Mental health – reducing the impact of climate and environmental change on mental health • Primary care and people with long-term conditions – working with primary care through existing structures, and within medicines workstreams, especially around respiratory care, inhaler usage and recycling • Reduction of health inequalities – a healthy environment reduces exacerbations of health conditions that may drive health inequality • Partnership with our staff and communities – cross-organisation working and inviting our people to learn and act alongside us • Protecting our finances and the environment – reducing waste, and therefore cost, from our system • Contributing to system sustainability – including moves from hospital to neighbourhood-based care • Sustainable digital transformation – realising the environmental benefits of home and self care for patients, and remote working for staff
In 2025/26, we will take the following actions to make progress in these areas	• Refresh the ICS Green Plan (as per NHS England guidance) for 2025-2028, and deliver objectives to drive reductions in waste, energy use, water use, single use consumables, unnecessary treatment and – ultimately - carbon emissions, and to increase climate resilience, circularity and quality of care. • Develop the partnership between the ICS Sustainability Programme and System Sustainability workstreams • Increase engagement with research and innovation activities • Increase the focus on sustainable models of care and/or lean pathways; seeking more clinical leadership to enable this • Identify and follow-up on funding opportunities to improve capacity and expertise to deliver our plans • Find opportunities for pan-London working alongside other London ICBs and Greener NHS, to deliver benefits at scale, where relevant and possible • Foster our relationships with other ICS-led workstreams, to align objectives and strategies • Continue strengthening our governance and networks; using the leadership provided by the (board/exec-led) Sustainability Oversight Board to further drive collaboration across system partners
We will measure our impact by:	• Utilising our networks to follow progress against objectives, upwards reporting to our Sustainability Oversight Board and onwards assurance reporting to Greener NHS • Quantitative assessment of progress against defined targets - reporting metrics as per quarterly Greener NHS dashboard submissions and Estates Return Information Collections • Calculating reductions in carbon emissions against pre-plan carbon baselines • Internal and external air quality measuring • Identification and mitigation of programme and climate risks • Contract monitoring our trusts and our suppliers • Tracking social value measures included in procurement exercises and contract awards • Number of heat and flood occurrences triggering risk assessments

People Programme

Key supporting themes for the Joint Forward Plan	Support the development of integrated community-based workforce models, including: • Flexible employment and reducing turnover. • Apprenticeships and shared employment across heath, social care and VCSFE	Improving recruitment and retention, through workforce development, including: • Attracting and retain healthcare staff. • Developing shared career pathways and promoting careers in health and care.	Reducing inequalities & supporting inclusion including: • Addressing disparities in career progression and training access, particularly for staff from diverse backgrounds. • Anti-racist and culturally competent healthcare initiatives
In 2025/26, we will take the following actions to make progress in these areas	• Work through the ICB governance, People Committee and partnerships formed to actively support community based workforce models • Promote system-wide learning and leadership development through informal networks e.g. OD/leadership collaborative • Build on existing work delivered against the SEL People Strategy and work to support the development of Neighbourhood Care Teams. • Define a model of expanded social care workforce support to aid retention • Expand sharing of educational resources and information across partners through the SEL website and the Hub Online • Utilise the London staff movement agreement (and NHS Digital Staff Passport) • Promote and increase apprenticeship uptake and support smaller providers via apprenticeship levy	• Support delivery of the NHS operating plan by improving productivity system-wide. • Improve and expand the processes of workforce planning and utilisation of workforce intelligence to drive evidence- based decision making. • Targeted action for risks to workforce supply • Retention programme to support flexible working, legacy mentoring, career conversations and reasonable adjustments; further sharing of good practice from retention exemplar programmes. • Delivery of staff Health and Well-being (HWB) strategy, with a focus on Primary and Social Care. • Expand and extend the activity of the Health and Care Jobs Hub. GLA funding and delivery plan confirmed until Sept 2025. • Delivery of the “Volunteering without Barriers” programme led by KCH; with potential to link to Get Britain Working white paper	• Equality, Diversity and Inclusion plan delivered with the EDI committee, sharing good practice from EDI awards, sexual safety plans and anti-racism policy. • Continue expansion and engagement of EDI events and activities and supporting design of London EDI training programmes to ensure return on investment. • Expand and extend the activity of the Health and Care Jobs Hub to deliver the priorities of Anchor Alliance, South London Listens and “Get Britain Working”. • Working with partners in DWP, NHS, LA and VCSE to streamline access to employability & skills support for people with disability/long term conditions and ill health to get into and stay in work. • Develop bids for work well and connect to work funds. • Promotion of leadership academy coaching and mentoring platform and local offers across SEL. • Supporting Care Leavers into work and improving understanding of complex needs to plan future support
We will measure our impact by:	• Co-designing and agreeing a delivery plan for supporting community-based workforce models • Quantify uptake of educational resources • Monitor the utilisation of staff passporting and develop case studies showcasing best practice • Monitor and track apprenticeship uptake and spend, subject to upcoming National changes	• Key workforce data including staff vacancies Utilisation of data to support workforce planning, including use of new roles & workforce models. • Tracking staff turnover and retention • Employers engaged, education delivered and job outcomes through the jobs Hub • Staff satisfaction and uptake of wellbeing initiatives	• Participation at EDI events • Use of online resource monitored through hits, surveys and feedback • Get Britain working programme established with governance and delivery plan set • Number of local people supported into education and employment, including demographic detail

Population Health

The key supporting themes highlighted in our Joint Forward Plan are:	Developing a robust population health management approach, including: • Using data and analytics to understand population health needs. • Supporting early intervention and prevention strategies with data-driven insights	Enhancing Data and Information Governance, including: • Effective data-sharing to enable effective population health interventions. • Establishing infrastructure to support data monitoring and evaluation.	Enabling continuous improvement including: • Sharing insights and case studies to improve learning across the healthcare system. • Regularly reviewing outcomes and adapting strategies to optimize health service delivery	Utilising population health data for health promotion and intervention including: • Using predictive analytics and real-time dashboards to track health trends and service efficiency. • Supporting clinicians with data-driven insights for better decision-making at the point of care
In 2025/26, we will take the following actions to make progress in these areas	• Bring together experts within our system from across data, analytics, digital, clinical leadership and cross-system programmes to define an SEL approach to PHM. • Develop, within the shared approach, a centralised 'enabling arm' for PHM activity.	• Explicitly confirm the use of a single data source (a 'single version of the truth'). • Define our infrastructure to continue supporting PHM across SEL, starting with a clear statement to standardise where practical. • Continue to consider impacts and opportunities from the London Health Data Strategy and subsequent availability of at scale data and analytics capabilities for London.	• Continue developing Community of Practice and use it to provide training, disseminate information on useful tools, and collaborate on resolving some of the system-wide PHM issues	• Continue to work with priority programmes, starting with four strategic priorities (Children and Young People, Frailty, Multiple Long Term Conditions and the SEL Prevention Programme), to understand and meet their needs, particularly through the implementation of Integrated Neighbourhood Teams.
We will measure our impact by:	• Agreement of a single option for each 'consideration' (or component) of the SEL approach to PHM. • The creation and dissemination of a clear process map for clinicians and care professionals to access and use PHM in support of their work.	• Agreement of a single option for each data and information governance related 'consideration' (or component) of the SEL approach to PHM.	• The continuation of the Community of Practice with an explicit focus on the sharing of best practice.	• The use of PHM within the four stated strategic priority programmes (*this will be monitored within the relevant programmes*).

Quality and Safety

The key supporting themes highlighted in our Joint Forward Plan are:	Reducing avoidable harm, including: • Learning from suboptimal care events to improve outcomes. • Identifying and scaling best practice across the system	Strengthening Oversight and Governance, including: • Ensuring clear structures for quality, safety and safeguarding across health services. • Enhancing multi-agency collaboration to protect vulnerable populations.	Improving intelligence on quality, safety and safeguarding, including: • Enhancing data monitoring to improve insight to identify emerging patient safety themes • Using data monitoring to identify safeguarding risks early. • Using analytics to inform interventions and track safeguarding outcomes.	Addressing Inequalities in quality, safety and safeguarding, including by • Improving recognition of the impact of poverty, domestic abuse, and exploitation on safeguarding. • Implementing culturally sensitive approaches to safeguarding interventions. • Providing additional support for groups at higher risk
In 2025/26, we will take the following actions to make progress in these areas	• Implementation and embedding of the national Patient Safety Strategy • Continue to develop the After Action Reviews (AAR) led by the quality team • Lead on cross-system Patient Safety Incident Investigations • Collaborating with partners across the system to share learning from patient safety events	• Working with NHSE and partners to embed the principles of the Oversight Framework • Collaboration with Providers across the system to establish consistent patient safety reporting • Integrate Specialist Commissioning quality oversight into the ICB quality governance framework	• Collaborate with providers and business intelligence to gather the best data for improving oversight and outcomes	• Raise awareness and embed the use of the new Quality Impact Assessment policy • Ensuring focus on reducing inequalities during patient safety learning responses
We will measure our impact by:	• Key metrics that will track safety insight and facilitate focused intervention as required • Monitoring of data inputted via the Learning from Patient Safety Events (LfPSE) platform	• Ensuring oversight is establishing in line with the ICB Quality Governance Framework	• Establishing a system quality and patient safety dashboard • Creating a SEL.net page for ICS colleagues to utilise	• Mortality and morbidity data

Safeguarding

The key supporting themes highlighted in our Joint Forward Plan are:	Reducing avoidable harm, including: • Learning from suboptimal care events to improve outcomes. • Identifying and scaling best practice across the system	Strengthening Oversight and Governance, including: • Ensuring clear structures for quality, safety and safeguarding across health services. • Enhancing multi-agency collaboration to protect vulnerable populations.	Improving intelligence on quality, safety and safeguarding, including: • Enhancing data monitoring to identify safeguarding risks early. • Using analytics to inform interventions and track safeguarding outcomes.	Addressing Inequalities in quality, safety and safeguarding, including by • Improving recognition of the impact of poverty, domestic abuse, and exploitation on safeguarding. • Implementing culturally sensitive approaches to safeguarding interventions. • Providing additional support for groups at higher risk
In 2025/26, we will take the following actions to make progress in these areas	• Improve inputs to the Safeguarding Case Review Tracker (S-CRT), including updates and recommendations. • Ensure that all ICB staff are compliant with mandatory safeguarding training at a level commensurate with their role and grade. This will involve delivering a L3 training programme.	• Strengthen our governance and inputs towards ICB involvement in Domestic Abuse Related Death Reviews (DARDR). • Develop the function and outputs of the newly formed ICB System Safeguarding Group (SSG).	• Develop, implement and share an ICB dataset recording information based on the Information Sharing to Tackle Violence dataset. This will enhance the ICB response to the Serious Violence Duty. • Develop a standardised safeguarding dataset for health organisations across SEL, aiding consistency and reducing variation.	• Further develop the ICB Care Leavers Covenant, ensuring health related employment opportunities for this group of vulnerable children. • Deliver a local pilot project on the Child Protection – Information Sharing system (CP-IS), further developing the uptake and use of the system in South East London.
We will measure our impact by:	• A quarterly audit of inputs to the S-CRT will be undertaken, and learning from the audit shared with the borough based ICB safeguarding teams. • A quarterly audit, benchmarking role against the safeguarding competency framework, and monitoring training compliance.	• Agree a governance framework for ICB involvement in DARDRs. Audit timeliness and quality of inputs to DARD's by ICB employed staff. • In early 2026, conduct a short survey of SSG members to ensure that the group is meeting their needs and expectations.	• The ICB dataset will be complete, updated quarterly and shared on a regular basis with Community Safety Partnerships. • The safeguarding dataset will be completed and agreed upon and used as widely as possible within the health system.	• Audit the numbers of care leavers who have found employment through the Care Leavers Covenant initiative. • The pilot project will be completed and a 'next steps' plan formulated.

Voluntary and Community Sector Development

South East London Integrated Care System

The key supporting themes in our Joint Forward Plan	Partnership Working with VCSE Organisations: • Collaborating with local community groups to enhance service delivery. • Integrating VCSE organisations into healthcare planning and neighbourhood models.	Supporting Community-Led Health Initiatives: • Leveraging VCSE expertise in addressing health inequalities. • Expanding access to mental health and social prescribing services.	Enhancing Public and Patient Engagement: • Co-producing services with local VCSE organisations. • Ensuring diverse communities have a voice in shaping healthcare.
In 2025/26, we will take the following actions to make progress in these areas	• Continue to support Place implementation of agreed plans for utilisation of ICB funded capacity and skills building support for micro 'By and For' VCSEs • Support Place implementation of agreed plans for utilisation of ICB enhanced grant funding programme for micro 'By and For' VCSEs • Launch a SEL 'reflect & learn' space bringing together Place leads delivering ICB funded By and For capacity building work • Co-develop impact measurement indicators for By and For capacity building offer • Work with 5 SEL NHS Trusts to recruit and onboard VCSE leadership roles to be embedded within Trust's strategy teams • Co-develop with Trusts & VCSE Alliance leads impact measurements for embedded VCSE leadership roles • Expansion of estates access pilot across SEL enabling free access to NHS estates for By and For VCSEs who provide services to local communities.	• Launch SEL Trust & Health Creation Partnership (T&HCP) bringing together By and For VCSEs, and ICB & LA V5 & vaccination and immunisations leads • T&HCP to co-develop 'Trust & Health Creation Model' for SEL • Launch pilot testing of SEL co-developed Creative health framework- enabling better access to creative health • Insight sessions with SEL VCSE Strategic Alliance for further development of VCSE sector role in INT • Development of a staff-facing digital directory of SEL wide VCSE provision • Create a cross-system procurement and contracting working group to make ICB funding & procurement processes more accessible and equitable	• T&HCP to start the process of co-creating & testing community-led prevention and health creation approaches which are embedded within VCSE holistic 'life' provision (for communities which experience the greatest inequalities). • T&HCP to co-develop approaches and plans for transformation of traditional health-led prevention services to incorporate community-led health creation approaches • Embed diverse VCSE representation across system sustainability programme task & finish groups • Launch SEL community pharmacy & VCSE overprescribing pilot project • Co-develop VCSE & community pharmacy led approaches to increasing community knowledge of overprescribing and access to Structure Medication Review.
We will measure our impact by:	• More By and For VCSEs access tailored support which strengthen their provision • By and For VCSEs report their provision is more sustainable (serving inclusion communities) • More VCSEs and underserved communities have safe & accessible spaces to deliver & receive services in • Trust & VCSE leaders report having better working relationships • We have more community-led approaches embedded in Trusts and broader system provision	• SEL ICB has a first version of Trust & Health Creation framework setting SEL's approach to trust building with communities. • We have an agreed co-created Trust-building metrics • We have developed an accessible digital way for By and For VCSEs to capture trust-building insight and impact • We have a clearer vision and articulation of the role of VCSEs within SEL neighbourhoods model • We have in place a SEL-wide directory of VCSE provision for use by healthcare staff	• We have co-created and tested approaches for embedding prevention & health creation approaches into existing By and For VCSE provision • We have an agreed approach trust-building with communities • System sustainability programme incorporate VCSE insight into the development of programmes • More local people impacted by overprescribing have more agency over their medication use and more local people feel informed and access SMRs

South East London
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Glossary

Glossary of Terms

South East London Integrated Care System

Term	Definition
DIALOG	DIALOG is a set of 11 questions used within mental health services, where service users are asked to rate their satisfaction and needs for care across different parts of their life and treatment. It helps to guide a structured conversation between a health professional and service user that is patient centred with a focus on change.
LeDeR	Learning from Lives and Deaths - people with a learning disability and autistic people
Consultant Connect	Consultant Connect provides GPs with access to advice from local hospital consultants.
ERS	E-Referral Service
Population Health Management	Population health management (PHM) improves population health through data-driven planning and the delivery of proactive care to optimise health outcomes. It is essentially about moving from a largely reactive system (that is responding when someone becomes unwell) to a much more proactive system (that is focusing on interventions to prevent illness, reduce the risk of hospitalisation, and address inequalities across England in the provision of healthcare)
THRIVE	The Thrive Framework for System Change
Core20 and Core 20plus5	Core20 refers to the most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD). Plus refers to additional groups identified at a local level that may be at higher risk of health inequalities. The 5 refers to 5 clinical areas of focus that require accelerated improvement – Maternity, Serious Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension/Lipids.
Vital 5	.Vital 5 is a standardised and abbreviated health check covering 5 areas healthy blood pressure, stop smoking, safe drinking, healthy mind and healthy weight.
Soliton Share+	An IT solution that enables the cross-site collaboration in the delivery of radiology services
EQ5D-L	A standardised measure of health-related quality of life

Acronyms (1 of 2)

Acronym	Definition
SEL	South East London.
CIP	Cost Improvement Programme
CAMHS	Children and Adolescent Mental Health Services
CYP	Children and Young People
B-CHIP	Bromley Child Health and Integrated Programme (BCHIP).
CFS	Clinical Frailty Scale
SPA	Single Point of Access
VBA	Very Brief Advice (a simple intervention to encourage people to quit smoking)
ASD	Autism Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
MH	Mental Health.
LD	Learning Disability
P3	Priority 3 Admissions
PSFU	Personalised Stratified Follow Up
LGI	Lower Gastro-intestinal
HPV	Human papillomavirus
OPA	Outpatient Appointment
AHC	Annual Health Check
AMR	Antimicrobial Resistance

Acronyms (2 of 2)

Acronym	Definition
CMHTS	Community Mental Health Trusts
PIFU	Patient Initiated Follow Up
ARRS	Additional Roles Reimbursement Scheme
FFT	Friends and Family Test
FDP	Federation Data Platform
LGT	Lewisham and Greenwich NHS Trust
SLAM	South London and Maudsley NHS Trust
PC	Primary Care
ASC	Adult Social Care
DSPT	Data Security and Protection Toolkit
EPR	Electronic Patient Record
ONS	Office of National Statistics
GSTT	Guy's and St Thomas' NHS Foundation Tr4st
KCH	King's College Hospital NHS Foundation Trust
VCSE	Voluntary, Community and Social Enterprise
GLA	Greater London Authority
EDI	Equality, Diversity and Inclusion
DWP	Department for Work and Pensions
SMR	Structured Medication Reviews