

Healthier Greenwich Partnership Meeting in Public

Date: 25 February 2026
Time: 13:00-15:00
Venue: MS Teams [Click here to join the meeting](#)
Chair: Kate Heaps

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Verbal	Chair	13:00
2.	Declarations of interest – relating to agenda items	Verbal	Chair	
3.	Minutes of the meeting in private held on 22 October 2025	1	Chair	
4.	Action Log and Matters Arising	10	Chair	
Delivering our Healthier Greenwich Plan				
5.	Developing the CYP Neighbourhood offer, and aligned programmes	11	Dave Borland	13:15
Meeting Administration				
6.	Neighbourhood hubs – for approval	40	Jessica Arnold	14:15
7.	Five year Strategic Commissioning Plan – for noting	56	Chris Dance	14:25
Closing Administration				
8.	Thamesmead APMS contract award – for noting	186	Jessica Arnold	14:40
9.	Neighbourhood Investment plans – for noting	193	Jessica Arnold	14:43
10.	Partnership report – for noting	204	Gabi Darby	14:47
11.	Risk report – for noting	210	Chair	14:50
12.	HGP Forward Planner	215	Chair	14:53
13.	Any Other Business	Verbal	Chair	14:55
	Next Meeting: 25 March 2026 (workshop/seminar)		Chair	
Meeting closes at 15:00				

Healthier Greenwich Partnership Held in Public at Community Hospice Minutes of the meeting held on 22 October 2025

Members		Voting member	Apologies
Kate Heaps (Chair)	Chief Executive, Greenwich, and Bexley Community Hospice (KH)	Yes	
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust (ID)	Yes	
Nayan Patel	PCN Clinical Director (NaP)	Yes	
Niraj Patel	Chair, Greenwich Health (NiP)	Yes	
Gabi Darby	Acting Place Executive Lead, SEL ICB Greenwich (GD)	No	
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)	No	
Florence Kroll	Director of Children's Services (FK)	Yes	Yes
Kate Anderson	Director of Corporate Affairs, LGT (KA)	Yes	
Jo Sutcliffe	Deputy Chief Operating Officer, LGT (JS)	Yes	
Nupur Yogarajah	Clinical and Care Professional Lead for Greenwich (NY)	Yes	Yes
David James	Chief Executive, Greenwich Health (DJ)	No	
Samantha Bennett	Director of Public Health, RBG (SB)	Yes	
Nick Davies	Director of Health and Social Care, RBG (ND)	Yes	
Jenny Ioseliani	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (JI)	No	
Mark Delacour	Metro GAVS (MD)	Yes	
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)	No	
Sarah Burchell	Service Director Adult Community Physical Health Services, Oxleas NHS Foundation Trust (SB)	No	Yes
Lisa Wilson	Integrated Director of Commissioning, Adults, RBG (LW)	No	
Dave Borland	Integrated Director of Commissioning, Children, RBG (DB)	No	
Jessica Arnold	Director of Primary Care & Neighbourhoods, SEL ICB, Greenwich (JA)	No	
Johnson D'Souza	PCN Clinical Director (JdS)	No	Yes

In attendance	
Julie Mann	Business Support (Minutes) (JM)
Jenny Lamprell	Associate Director of Integrated Commissioning, Learning Disabilities and Mental Health, RBG (JL)
Wendy Elcome	Head of Public Health Programmes, RBG (WE)
John McGirr	Senior Public Health Manager, Drugs and Alcohol, RBG (JMc)
Jennifer Banks-Smith	Senior Public Health Manager, Tobacco and Quality Control, RBG (JBS)
Daniella Finch	Senior Programmes Officer (Grants), Groundwork (DF)
Ruth Martin	Team Manager (Grants) Groundwork (RM)
Lindsey Macleod	Chair, LMC Greenwich (LM)
Members of the public	5

DRAFT

1	Welcome, introduction and apologies
1.1	<ul style="list-style-type: none"> • Apologies as noted above
2.	Questions from the public related to today's agenda
2.1	<ul style="list-style-type: none"> • None received
3	Conflicts of Interest - relating to agenda items
3.1	<ul style="list-style-type: none"> • No Conflicts of interest were noted
4	Minutes of the meeting in public held on 23 July 2025
4.1	<ul style="list-style-type: none"> • The minutes of the meeting held on 23 July 2025 were accepted and approved as a true record of the meeting
5	Action Log and Matters Arising
5.1	<ul style="list-style-type: none"> • It was noted that there are no open actions on the Action Log • There were no matters arising
6.	FEEL WELL Papers were circulated in advance This item is for noting
6.1	Introduction and overview <ul style="list-style-type: none"> • Thanks were made to those who contributed to the papers, in true partnership style – Rena Amin, Wendy Elcome, John McGirr, Jennifer Banks-Smith and Oxleas • The Five Wells were shared as a reminder • This paper focussing on Feel Well – particularly mental health in neighbourhoods • Making the most of existing engagement channels to continue the work • There is an overlap between mental health and addiction • The mental health landscape in Greenwich was shared alongside context of population, risk factors, health conditions, mental health conditions and HGP aims to address issues • Mental health review programme will focus on: <ul style="list-style-type: none"> ○ Understanding mental health service landscape and funding, alongside delivering cost efficiencies ○ Partnering with Oxleas to review the mental health provision and define operational improvements ○ Developing the transformation to meet residents needs ○ Governance, stakeholder engagement, co-production and strategy • The SMI dashboard was shared, reflecting: <ul style="list-style-type: none"> ○ SMI target for 24/25 was 3,500 people – only achieved 46% ○ Target for 25/26 is 60% ○ Noting that a Task & Finish group has been established to action the target
6.2	Addictions <ul style="list-style-type: none"> • An insight into what constitutes addiction was shared, noting that addiction is influenced both by genetic and environmental factors • What has gone well in 24/25: <ul style="list-style-type: none"> ○ Policy change around Very Brief Advice (VBA) ○ Funding for drug and alcohol treatments implemented

	<ul style="list-style-type: none"> ○ Combating drugs partnership successful ● There is more work to be done on: <ul style="list-style-type: none"> ○ Very Brief Advice (VBA) to be in every pathway and practitioners' contract ○ Drug and alcohol treatment funding is interim (12 months) with no guarantee of future funding ○ Saving Babies lives work needs more partnership support ● Successes include: <ul style="list-style-type: none"> ○ Improved outcomes ○ Combating drugs partnership ○ LDIS has launched ○ SEL wide Public Health responses to licensing ○ Promoting alcohol awareness week ○ Implementing the smoke free app <ul style="list-style-type: none"> ▪ Working with Oxleas on vulnerable smokers ▪ Working with Peabody – a high amount of people in social housing are smokers ○ Developing a response to gambling addiction ○ Developing an addictions health profile and strategic plane ● Strategic plan development, recommendations from stakeholders and key priorities were shared ● How HGP support the new addictions work: ● Socialise the strategic plan ● Champion the five key priorities: <ul style="list-style-type: none"> ○ Development ○ Prevention ○ Information sharing ○ Collaboration ○ Service delivery ● Ownership of the strategic delivery plan by all system partners
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<p>6.3</p>	<p>Mental Health, Learning Disabilities and Autism</p> <ul style="list-style-type: none"> ● Three High Impact Activities had been identified for 25/26 <ul style="list-style-type: none"> ○ Needs analysis for mental health, learning disabilities and autism, focussing on accommodation (care homes, supported accommodation and community based support) ○ Health and care staff to promote mental health hubs and information and guidance offers for social, financial and relationship support ○ Ensuring support is culturally appropriate, accessible and includes peer support ● What has gone well in 24/25: <ul style="list-style-type: none"> ○ Development of Mental Health Needs Assessment ○ Work with housing and commissioners to model needs for supported accommodation for people with learning difficulties and/or autism ○ Purchase of five learning disability residential homes ○ Success of Greenwich Living Options service for young people – enabling independent living with appropriate support ● There is more work to be done on: <ul style="list-style-type: none"> ○ Finalising the Mental Health Needs Assessment, reviewing mental health services in Greenwich ○ Developing a dashboard to provide more insight into progress and outcomes on all mental health services ○ Recommissioning Learning Disability residential and respite care services ● Six strategic priorities have been identified as part of a two year interim plan, all the workgroups have received good sign-up rates ● Increase local awareness and understanding
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	<ul style="list-style-type: none"> • Tackle health and care inequalities • Education and employment • Community resilience • Personalised support • Professional training and learning
<p>6.4</p>	<p>Live Well & Mental Health Hub</p> <ul style="list-style-type: none"> • The pathway for Adult Social Care, approach to prevention was shared: <ul style="list-style-type: none"> ○ Prevent ○ Reduce ○ Delay • What has gone well in 24/25: <ul style="list-style-type: none"> ○ Make Every Opportunity Count training for staff ○ Social Connection training for staff – 23 staff trained ○ Strength based practice approach emphasising Care Act prevention duties ○ Developed Health and Adult Social Care prevention approach, building on the core offers from Live Well Greenwich and prevention services • There is more work to be done on: <ul style="list-style-type: none"> ○ Rolling out Make Every Opportunity Count ○ Social Connection training ○ Development and embedding prevention and wellbeing approaches • The Holistic Front Door initiative example was shared • RBG provided £100k of S106 funding for adaptations at The Forum, which is new premises for MIND • Equality grants have been awarded to grassroots organisations, funded projects include: <ul style="list-style-type: none"> ○ African Smile – promoting physical and mental wellbeing & community relationships ○ Jeevan Vigyan – supporting Nepalese community with classes and workshops ○ Avant Gardening – LGBTQ+ service discussing mental health issues and health inequalities • Greenwich participated in a pilot for STOMP which received positive comments from service users and carers
<p>6.5</p>	<p>Staff and Resident Communications</p> <ul style="list-style-type: none"> • Communication and collaboration: working with communities and harnessing local knowledge. Developing staff and resident communications and resources, including information for staff so that they are empowered to signpost elsewhere and have the right information and tools to do that • What has gone well in 24/25: <ul style="list-style-type: none"> ○ 15 Local community organisations enabled to become Be Well organisations with mental health and community organising training ○ 140 school staff have accessed Be Well training ○ 105 local residents have accessed Understanding Health Improvement training ○ Oxleas Time to Tal Community Workshops have delivered a wide range of sessions, reaching over 1,300 residents from diverse backgrounds ○ Community groups have received £925k of funding via Greenwich Healthier Communities Fund • There is more work to be done on: <ul style="list-style-type: none"> ○ Recruiting and supporting Be Well organisations ○ Continuing to deliver and improve coordination of community training and capacity building, linking to neighbourhoods work ○ Identifying and engaging with key population groups ○ Delivery community workshops ○ Supporting local people to protect and improve their mental health

	<ul style="list-style-type: none"> • The Learning Disability Partnership Board has been introduced • Referred to as the 'People's Parliament' • Supported by Advocacy in Greenwich • Focussing on: <ul style="list-style-type: none"> ○ Accessible Health Information ○ Meaningful Activities ○ Care and support ○ Community transport and safety • There is a strong focus on sharing information
<p>6.6</p>	<p>Questions, comments and observations:</p> <p>Accommodation:</p> <ul style="list-style-type: none"> • Recognise that this is an operational difficulty • What are you hoping to achieve <p>Addiction:</p> <ul style="list-style-type: none"> • Is there targeted work on vaping • Frontline staff need to be aware of addiction and how to deal with it effectively • Mental health and addiction links are obvious in many cases • Are numbers reducing <p>Mental Health:</p> <ul style="list-style-type: none"> • Needs to align with required improvements • There is a high level of patients with mental health issues presenting at QEH • There is a high level of people with mental health that are unknown to Oxleas – how can this be tracked • Need to ensure coding is correct to help establish why people with mental health problems are presenting at QEH • How do we make mental health work more effective • Mental health is a large spectrum of need – we need to tackle the root cause of what is causing issues for people • What do we want from the hubs and how do they work with GPs etc., are there opportunities to work back into the community • Need to be aware of the impact of bereavement on mental health
<p>6.7</p>	<p>Response:</p> <p>Accommodation:</p> <ul style="list-style-type: none"> • Need to move people into appropriate accommodation • Existing buildings can be made available for those with higher needs • Spot accommodation can be purchased • Working with providers to provide cheaper and effective accommodation <p>Addiction:</p> <ul style="list-style-type: none"> • Want smokers to switch to vaping • Vaping is preferable to smoking • Need an effective cessation tool • Need to stop/prevent children from starting to vape – noting it is illegal for children to vape • Those with complex needs are harder to work with on cessation • Some people who have addictions also have complex needs • Impact of alcohol dependency has increased since Covid <p>Mental Health:</p> <ul style="list-style-type: none"> • Estimate that approximately 60% of people in Greenwich with mental health issues are unknown to services

	<ul style="list-style-type: none"> • There are two hubs in London (one in North London and one in South London) conveying patients to secure suites – currently working with the police on identifying where they go • There is a distinct need to work on how to get people from arrest into treatment • GPs need to be more involved so they can refer patients more effectively • Hubs are dealing with volumes beyond their capacity • Data reflects where the need is, but current practice is not sustainable • Review has shown that funding is available, but needs to be better utilised
7	<p>NEIGHBOURHOOD PROGRAMME UPDATE Papers were circulated in advance Item is for noting</p>
7.1	<ul style="list-style-type: none"> • Although to be noted in Agenda item 9, worth noting here too that Oxleas NHS Trust were appointed in August into the Integrator role by HGP, and this has been endorsed by the ICB Board • There was a Neighbourhoods launch at Charlton on 15 October which was very successful • There were discussions on assets and linking up • Lots of good connections were made • People are now more aware of neighbourhoods • There are more discussions to be had with residents on the operation model • The Integrator role will operate slightly differently in each borough, but all are learning from each other • Stone King have been appointed to support the development of the HGP and understanding how to use our resources effectively • Programme delivery includes: <ul style="list-style-type: none"> ○ Launch of PMS premium ○ Frailty pathway ○ Adult social care ○ District Nursing alignment ○ Transfer of care from hospital ○ Delivery priorities • The role of the Integrator is to: <ul style="list-style-type: none"> ○ Help support and deliver ambitions across the HGP ○ Coordinate all activities and support and provide organisation ○ Create a delivery team to deliver the operating model • SEL have developed a maturity matrix for the Integrator implementation, this will be a year long process • The matrix will be worked on and raised at the November HGP for further discussion • Noting that the matrix is a large piece of work
7.2	<p>Questions, comments and observations:</p> <ul style="list-style-type: none"> • Congratulations to Oxleas on their appointment • Noting that Oxleas have also been appointed as Integrator in a neighbouring borough, which is a great opportunity for all concerned • What are the hopes and ambitions for the Integrator role • How will the maturity matrix assist
7.3	<p>Response:</p> <ul style="list-style-type: none"> • There is a lot to be achieved • Plan is to start on the maturity matrix, then evaluate and amend throughout the process
8.	<p>HEALTHIER GREENWICH CHARITABLE FUNDS UPDATE Papers were circulated in advance This item is for noting</p>

8.1	<ul style="list-style-type: none"> • The Enabling Strand has supported 31 organisations with £245k awarded • The Delivery Strand has supported 48 organisations with £1,122k awarded • There are also micro-grants available which have supported 16 organisations so far • A full breakdown of grants available, how to apply and awards are listed on the website • There are priority themes that align with HGP priorities: <ul style="list-style-type: none"> ○ Improving Health Outcomes for People with Learning Disabilities and/or Autism ○ Tackling isolation ○ Long-Term Health Conditions ○ Active Healthy Living for Children and Young People • There have been three grantee networking events in the last year, which provides opportunities for grantees to connect with organisations with similar missions; and is an opportunity to get feedback on the fund • Networking events aim to inspire partnership working for future bids and create a community of organisations that work together • A Community panel of 20 individuals has been started with the main aim to ensure the fund meets the needs of Greenwich residents • Community panel members are all local and represent diverse communities throughout the borough • Decision making by the community panel has been a rewarding and successful process • DG Cities have been appointed to provide an independent evaluation of the Greenwich Healthier Communities Fund, which will contribute to the development and improvement of the fund • DG Cities will provide insight into learnings and how to support VCSE organisations • Grantees will be invited to participate in the evaluation process with DG Cities
8.2	<p>Questions, comments and observations:</p> <ul style="list-style-type: none"> • Noting that there are gaps, do you have good insight into the gaps and how to fill them • Are there other funding avenues that could be tapped into
8.3	<p>Response:</p> <ul style="list-style-type: none"> • Have to figure out the best way to gather feedback in a structured way • There are social investors that could be approached – some may come out of the work with Stone King
8.4	<p>Actions:</p> <ul style="list-style-type: none"> • Discussion at HGP Exec on gathering feedback on how to fill gaps in the fund/applications
9.	<p>INTEGRATOR APPOINTMENT Papers were circulated in advance This item is for noting</p>
9.1	<p>The partnership noted the appointment of Oxleas NHS Trust as the Health Host/Integrator for Greenwich, and that this had been endorsed by the ICB Board</p>
10.	<p>HEALTHIER GREENWICH PARTNERSHIP REPORT Papers were circulated in advance This item is for noting</p>
10.1	<ul style="list-style-type: none"> • Members were asked to note the report
11	<p>PERFORMANCE REPORT Papers were circulated in advance This item is for noting</p>
11.1	<ul style="list-style-type: none"> • Members were asked to note the report
12.	<p>RISK UPDATE Papers were circulated in advance This item is for noting</p>

11.1	<p>The Chair noted:</p> <ul style="list-style-type: none"> • This report provides an update on the most recent review of risks on the Greenwich risk register • There are currently 18 active risks on the register, since the last update to HGP two new risks have been added • Since the last update to HGP, 15 risks have been reviewed and updated • The report includes a range of actions that are being undertaken to manage and mitigate risks • Risks are updated monthly • There are currently eight risks that have been reviewed and mitigations updated
12.	<p>FORWARD PLANNER Papers were circulated in advance This item is for noting</p>
	<ul style="list-style-type: none"> • The Chair noted that if anyone wants items included at future meetings, these should be emailed to JM
12.1	<p>Actions:</p> <ul style="list-style-type: none"> • ALL to email JM with any future agenda items
13	<p>AOB</p>
13.1	<ul style="list-style-type: none"> • No additional business was raised
	<p>Next meeting in public: 28 January 2026</p>



Action Log - Open

Date of meeting	Minute reference	Action and updates	Lead	Deadline	Update/Date closed
26/11/2025	5.7	Discussions about Neighbourhood Programme Board membership to be held at HGP Exec	Gabi Darby		
26/11/2025	6.4	PD & KP to have additional discussions with JS, PO and NaP on HomeFirst and UEC flows	Phil Darby/Kirsty Price		
22/01/2025	15.3	All to advise JM of future agenda item requests	ALL	Ongoing	
22/01/2025	5.3	Members to email JM with updates on their items on the action log	ALL	Ongoing	

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: Wednesday 25 February 2026

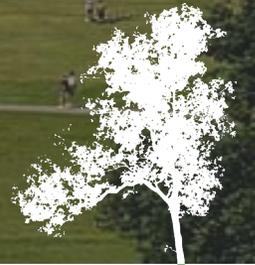
Title	Developing the CYP Neighbourhood Offer	
This paper is for noting		
Executive Summary	<p>This presentation sets out to the Healthier Greenwich Partnership, how the borough is proposing to take forward the development of Integrated Neighbourhood Teams/Working (INTs) for children and young people (CYP).</p> <p>It includes an overview of the broader South East London Framework for CYP INTs, alongside key existing initiatives and arrangements that provide important interfaces and considerations when developing INTs locally. Finally, the presentation sets out the high-level timeline for developing CYP INTs in Greenwich and seeks input from Healthier Greenwich Partnership on how they can be involved in shaping the work.</p>	
Recommended action for the Committee	<p>The presentation is to note, discuss and inform the development of CYP INTs. Specific questions include:</p> <ul style="list-style-type: none"> • How do partners wish to be engaged in the work moving forward? • What are the key sources of information that should be considered as part of identifying the priorities/need? • Are there any other CYP Multi-disciplinary Team / Neighbourhood Arrangements that need to be considered as part of the development? • How do we ensure in the development of adult related INTs that they better support children and young people? 	
Potential Conflicts of Interest	None arise from directly from the report.	
Impacts of this proposal	Key risks & mitigations	<p>Capacity Risk: Ensuring that there is appropriate capacity to coordinate the development of the INTs for CYP</p> <p>Mitigation: Identification of Programme Support to help with the development</p>

		<p>Financial Risk: Ensuring appropriate resources to deliver on the INTs once established Mitigation: Development of INTs to factor in existing capacity and re-shaping as part of maximising current resources to deliver. Identification of other potential funding that supports the development.</p> <p>Duplication Risk: Creation of INTs that duplicate the function of other multi-disciplinary working. Mitigation: Identification and ensuring connection with aligned programmes to avoid duplication and build off existing work.</p> <p>Impact Risk: There is limited impact of the CYP INTs on children and young people Mitigation: As part of the development of the CYP INTs, being clear at the beginning about the projected impact that they are anticipated to have on children and families. Ensuring the evaluation (including feedback from children and families) is built into the model of delivery.</p>
	Equality impact	The development of CYP INTs will be important in addressing specific health inequalities. Analysis of Population Health Information will be used to identify health and wellbeing inequalities that will prioritise where INTs will be focused to have the biggest impact.
	Financial impact	<p>Subject to the development of CYP INTs there may be additional financial implications.</p> <p>There will be associated staff time costs required with the development of the work.</p>
Wider support for this proposal	Public Engagement	There is a significant amount of existing engagement with children, young people and families across existing programmes. It is proposed that this is built upon (to avoid duplication) as part of the development of CYP INTs. Further engagement will take place as part of the development, the nature of this will evolve over time based on how the work develops e.g. if the focus was on the early years, the engagement would differ compared to a focus around adolescence.

	Other Committee Discussion/ Internal Engagement	Workshops took place with different representatives across the children's system (including families) as part of the development of the South East London overarching Framework. Awareness raising discussions have taken place in different children's forums around the concept of Neighbourhood working and what it means.
Author:	Dave Borland – Integrated Commissioning Director (Children and Young People)	
Clinical lead:	Debisi Olunloyo - Clinical and Care Professional Lead CYP & Maternity Various Clinical Leads will inform the development work	
Executive sponsor:	Gabi Darby - Acting Place Executive Lead Greenwich (SEL ICB) Florence Kroll – Director of Children's Services (RBG) Jenny Ioseliani - Director of Children & Young People's Services (Oxleas)	

Healthier Greenwich Partnership Children and Young People and Neighbourhood Working

February 2026



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1. Introduction
2. South East London Children and Young People (CYP) Integrated Neighbourhood Framework
3. Development of CYP INT in Greenwich - Considerations
 - a) Identifying the priorities and need
 - b) Existing working and frameworks
 - a) Families First / Social Care Statutory Frameworks
 - b) Best Start Family Hubs and Children's Centres
 - c) NextGen Greenwich
 - d) Local Child Health Teams
 - e) Education, Health and Care Plans
 - f) Team around the Child/Family
 - c) Think Family and the Adult Interface
 - d) Development Approach and Workshops
 - e) Governance and the interface with HGP
4. Discussion and Questions



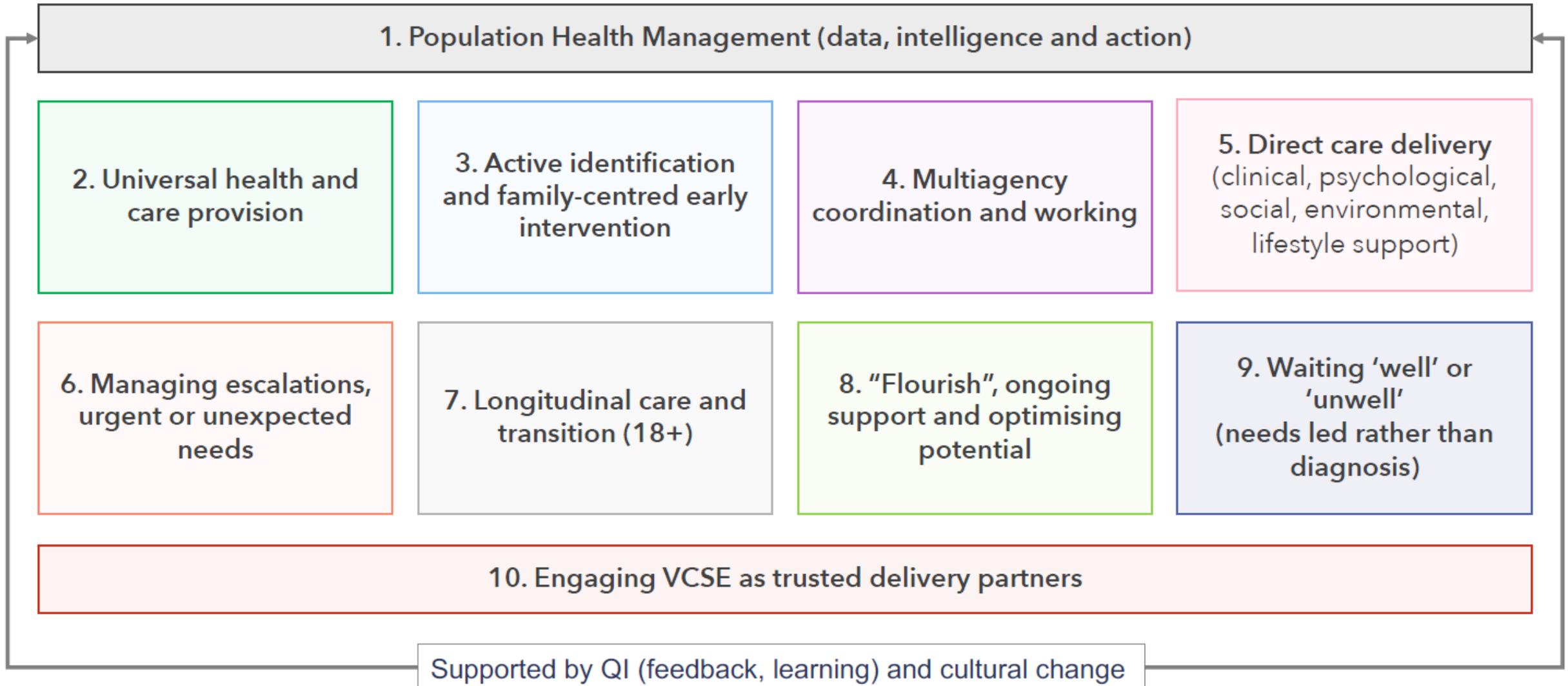
South East London CYP Integrated Neighbourhood Teams



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The CYP Neighbourhood framework - key functions/delivery components



Function	Description	Function	Description
1. Population Health Management	Systematically use data and intelligence, and moving beyond surveillance to actionable insight, informing how we shape delivery.	6. Managing escalations	Create straightforward, aligned and timely approaches to trigger and manage escalation, agreed and understood between multiagency partners, to prevent issues from becoming critical events.
2. Universal health and care provision	Build Universal health and care provision as the foundation of the neighbourhood model, ensuring every child, young person and family has access to the core entitlements that keep them healthy, supported and connected to community life. Provision of information/knowledge is key.	7. Longitudinal care and transition	Provide coordinated, non-fragmented care over time for individuals with chronic and complex needs, ensuring continuity of support, focusing on what matters to the CYP and their families.
3. Active identification and family-centred early intervention	Adopt a proactive approach to identifying emerging issues at the earliest possible opportunity, using early indicators and intelligence to inform timely intervention and ensuring access to appropriate services at the right time.	8. 'Flourish;' ongoing support and optimising potential	Actively support CYP and their families to take a leading role in their own care, enabling informed decision making, with a strong focus on promoting holistic wellbeing.
4. Multi-agency coordination and working	Build relational, value-based collaboration, based on a shared vision, accountability and language across agencies so that practitioners understand each other's roles, trust one another, and work as one 'communicative' system.	9. Waiting well or unwell	Provide support to those waiting for assessment, diagnosis or intervention, helping them to prevent or address issues that may arise in the interim.
5. Direct Care	Deliver coordinated multi-agency care that brings together experts to provide holistic and integrated support to improve outcomes and provide better access by bringing services into the community.	10. Engaging VCSE as trusted delivery partners	Embed VCSE partners as a core to INTs delivery. It's known (and plentiful evidence proves) that the VCSE offer is highly effective for CYP to address the growing prevalence of mental health and neurodiverse challenges that young people face.

Roadmap for implementation: Neighbourhoods should follow a systematic approach based on system maturity

1. Socialising the framework at Place

- Bring together system stakeholders, including CYP, families and community representatives.
- Map current practice and local assets against the neighbourhood functions (e.g. active identification, MDT working).

2. Understanding your local population and agree priority for test phase

- Neighborhood's need to start with a bite-size focus. Year 1 is about testing the concept with one cohort or pathway
- Each neighbourhood to look at their local population data, connect with VCSE, communities, professionals and agree the local priority.
- Priority could be a population cohort (e.g. complex, SEND) or a pathway (mental health crisis, rising risks)

3. Defining the Operating Model

- Each Place and neighbourhood defines how the operating model works locally, building on existing assets (e.g. Family Hubs).
- Work systematically through each function to clarify roles, workflows and interfaces, centered on the agreed priority cohort.

4. Demand and capacity modelling

- For the priority cohort define the baseline for demand and capacity. As neighbourhoods do that, identify the biggest crunch points.
- Use the operating model to define total demand and capacity required to support priority cohort.
- Ramp up demand in stages.
- Define/decide: how do to reallocate existing capacity/resources.
- Final demand and capacity model aligned with the framework operating model.

5. Outcomes dashboard

- Agree a small set of clear outcomes and indicators that demonstrate impact.
- Define system-level dashboards and data points at both Place and SEL level.
- Use regular (e.g. monthly) reporting to support real-time learning and adjustment.

6. Phased implementation plan

- Develop a clear, phased implementation plan with defined stages, deliverables and timelines.
- Establish a robust delivery group representing neighbourhood, Place and SEL partners to support coordination and problem-solving.
- Set out clear expectations for SEL-level enablers and support to Places (e.g. data, learning, facilitation).
- Agree a shared communication approach for transparency and engagement across partners.

7. QI - Test and learn

- Embed a Quality Improvement (QI) approach, including named quality champions, regular QI cycles and monthly learning sessions using a PDSA methodology.
- Put in place proportionate governance and oversight, including meaningful involvement of CYP and family voice.
- Create system-wide learn and share events at SEL and most importantly, acknowledge efforts and celebrate success

Development of CYP Integrated Neighbourhood Teams in Greenwich Considerations



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Identifying Priorities and Need



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Identifying the priorities and need

- Need to consider a variety of sources of data that is held across the partnership to get the best understanding of need
- Examples of cross-Partnership data:
 - Social Care
 - Primary Care
 - Secondary Care
 - EHCP and SEN/D Data
 - Academic Information
 - Housing
- Feedback from children, young people and families
- Intersectionality of needs with parents e.g. parental mental health



Existing working and frameworks

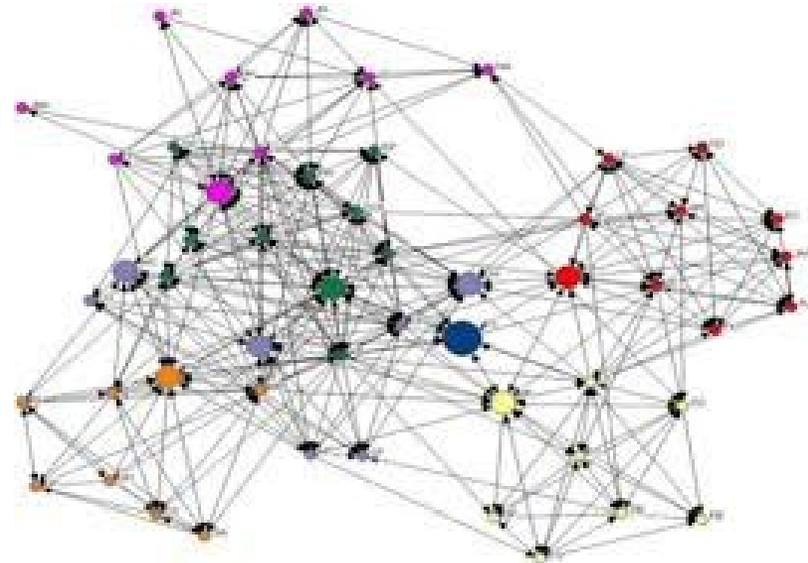


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Existing System of Arrangements

- The development is not happening in a vacuum
- Range of existing frameworks and initiatives that interface with the development of neighbourhood working
- We must build off strong partnership working in place
- Avoid duplication of activities



A) FAMILIES FIRST PARTNERSHIP

The Children's Wellbeing and Schools Bill, introduced in December 2024, aims to enhance children's social care and educational outcomes in England. Here are some of the key points:



Interdisciplinary Family Help

A focus on keeping families together through early intervention, with increased funding for family help services to prevent children from entering care unnecessarily.
Clearer framework and approach to address risks outside the family home



Strengthening Kinship

More financial and practical support for kinship carers (relatives or close family friends) and foster carers to provide stable homes for children.



Multi-Agency Child Protection Teams

Establishing specialist multi-agency teams including social care, health professionals, and police to improve child safeguarding. Corporate Parenting to be extended to public bodies including health and education, family group decision making.



Regulating Private Care Providers

Increased oversight of private children's homes and fostering agencies to tackle excessive profits and ensure high-quality care.



Investment in Workforce and System Improvements

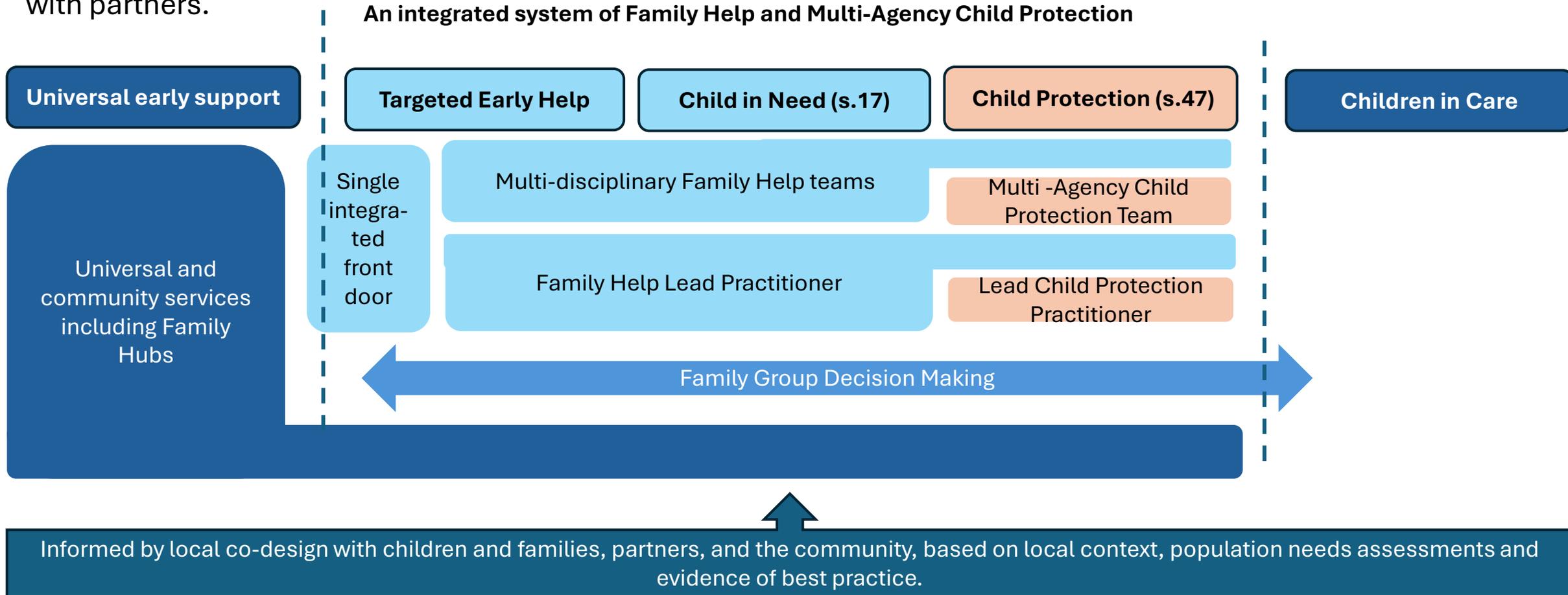
Additional training and recruitment efforts for social workers, plus better data sharing and national standards to improve decision-making and outcomes.

Work has started to develop our local response to the reforms, that has been informed by discussions with partners, children, young people and families as well as learning from other areas.

[The families first partnership programme guide](#)

Local design of an end-to-end system of support and protection to rebalance the system towards prevention whilst keeping children safe

Designing a system locally to meet the needs of the population with effective, integrated and joined up services with partners.



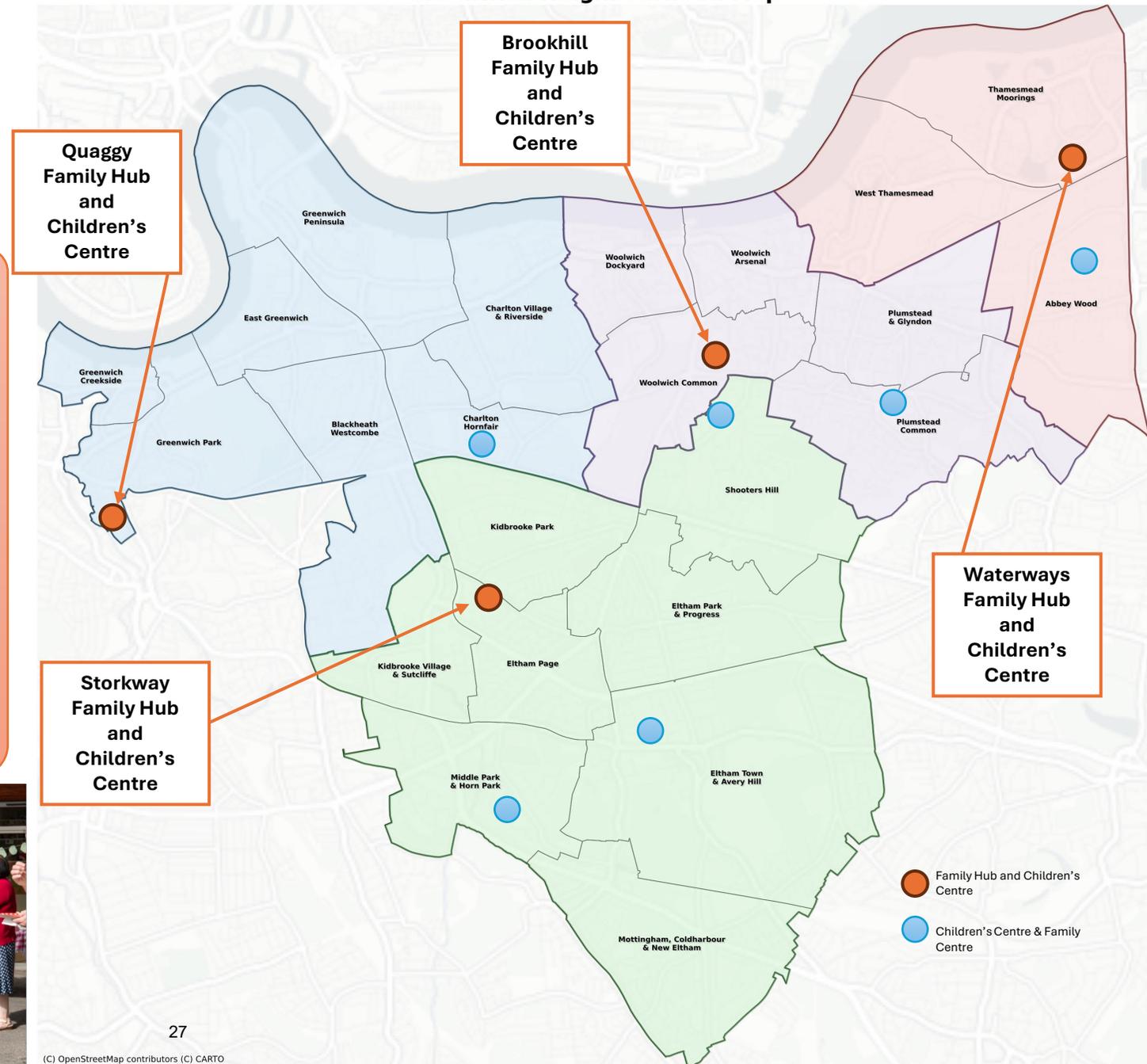
B) Best Start Family Hubs and Children's Centres

- One stop shops for family support
- 'Best Start Family Hubs and Healthy Babies' is a joint Department for Education and Department for Health and Social Care programme. Builds off an existing strong Children's Centre offer.
- Co-location of Children's Centres, Health Visiting and Midwifery
- Enhanced support around:
 - Parenting
 - Infant-Feeding
 - Perinatal Mental Health and Parent-Infant Relationships
 - Home Learning Environment Support
- Early Help Groups – bringing together multi-disciplinary teams of Health Visitors, Midwives, Children's Centres and Nurseries/Schools.
- From 26/27 there is a stronger focus on 3–4-year-olds and Good Level of Development alongside Special Educational Needs and Disabilities (SEND)
- Parent/Carer Panels to shape and design the local offer of support

Part of the Greenwich Family Hubs Network

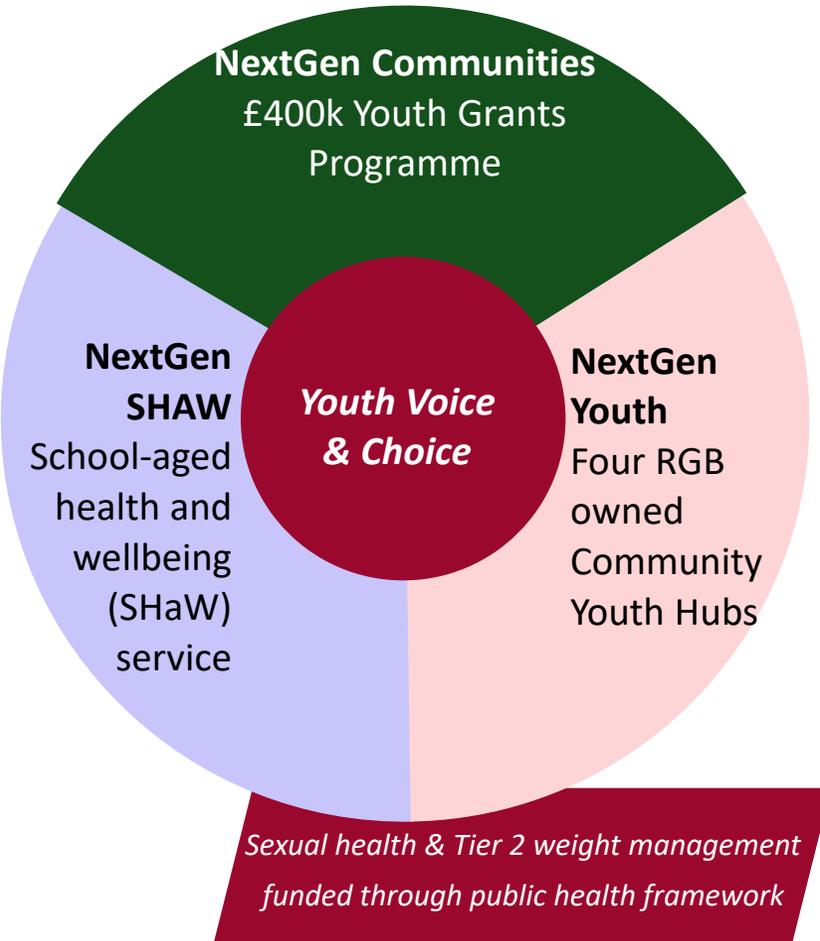


Greenwich Neighbourhood Map



C) NEXTGEN GREENWICH

Our New Model



Under our new model, RBG will work with **young people in dedicated, in-house roles** to keep youth voice at the heart of service design and delivery.

In addition to **working with community partners** to deliver our Community Youth Hubs and SHaW service, **RGB will manage a Youth Grant Programme**, meaning that we will be able to **respond flexibly to changing needs** in our populations and **leverage the strengths of our communities** in responding to challenges.



D) Local Child Health Teams

- In June 2025, HGP received a full update on Local Child Health Teams
- The Local Child Health Team is a team of specialist clinicians from Acute, Paediatric, Primary and Community services working together to review referrals for general paediatrics.
- Provide multi-disciplinary approach to understanding a child's health needs and upskilling in Paediatric care
- Since July 2025 (to December 2025) – 141 children triaged
- Ongoing review on impact will inform wider learning. Early provisional reporting on 65 children seen in triage between October 2024 and June 2025, looking at total GP appointments 6 months before and 6 months after triage there was a 24.9% reduction for this cohort.
- Further work is being done to look at secondary care presentations



E) Education, Health and Care Plans

- Statutory framework bringing together education, health and care around children with more complex needs where existing educational provision is not meeting needs.
- “The purpose of an EHC plan is to make special educational provision to meet the special educational needs of the child or young person, to **secure the best possible outcomes for them across education, health and social care** and, as they get older, prepare them for adulthood” SEND Code of Practice p. 142
- The plan itself will “**specify the provision required and how education, health and care services will work together** to meet the child or young person’s needs and support the achievement of the agreed outcomes” SEND Code of Practice p.142
- “Consideration should be given to:
 - the range of professionals across education, health and care who need to be involved and their availability
 - flexibility for professionals to engage in a range of ways and to plan their input as part of forward planning
 - providing opportunities for professionals to feed back on the process, and its implementation, to support continuous improvement”



THE LOCAL OFFER
in Royal Greenwich



F) Team around the Child / Family



- A coordinated, relationship-based approach that aims to bring the right practitioners together with the child and family to plan, deliver, and review support in a holistic, timely, and consistent way.
- Used primarily in universal and prevention services

How It Works

- A Lead Professional coordinates the plan and is the family's main point of contact.
- Practitioners form a multi-agency team around the child/family based on need.
- A single, integrated plan sets out outcomes, actions, and review points.
- Regular TAC/TAF meetings ensure progress, problem-solving, and shared decision-making.

Think Family and the Adult Interface



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Think Family and the Adult Interface

- The development of Integrated Neighbourhood Working for Adults will impact on children (intentionally or not).
- When exploring adult needs it's keeping in mind the impact children (e.g., from substance misuse to domestic abuse and financial stress).
- The primary reason for children coming into care in Greenwich is Parental Mental Health
- Build off the strengths of adults to support the wellbeing of children



Development of Approach and Workshops



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Implementation roadmap

- This roadmap sets out a phased, **test-and-learn approach**. The overall timeframe is set out by NHS England that CYP INT's need to be in place by 2029. As part of this expectation, the phasing below has been proposed for South East London.

Phase 1: Test - 2026/27

Launch test INTs (minimum 1 per Place) for a priority cohort.

Phase 2: Grow - 2027/28

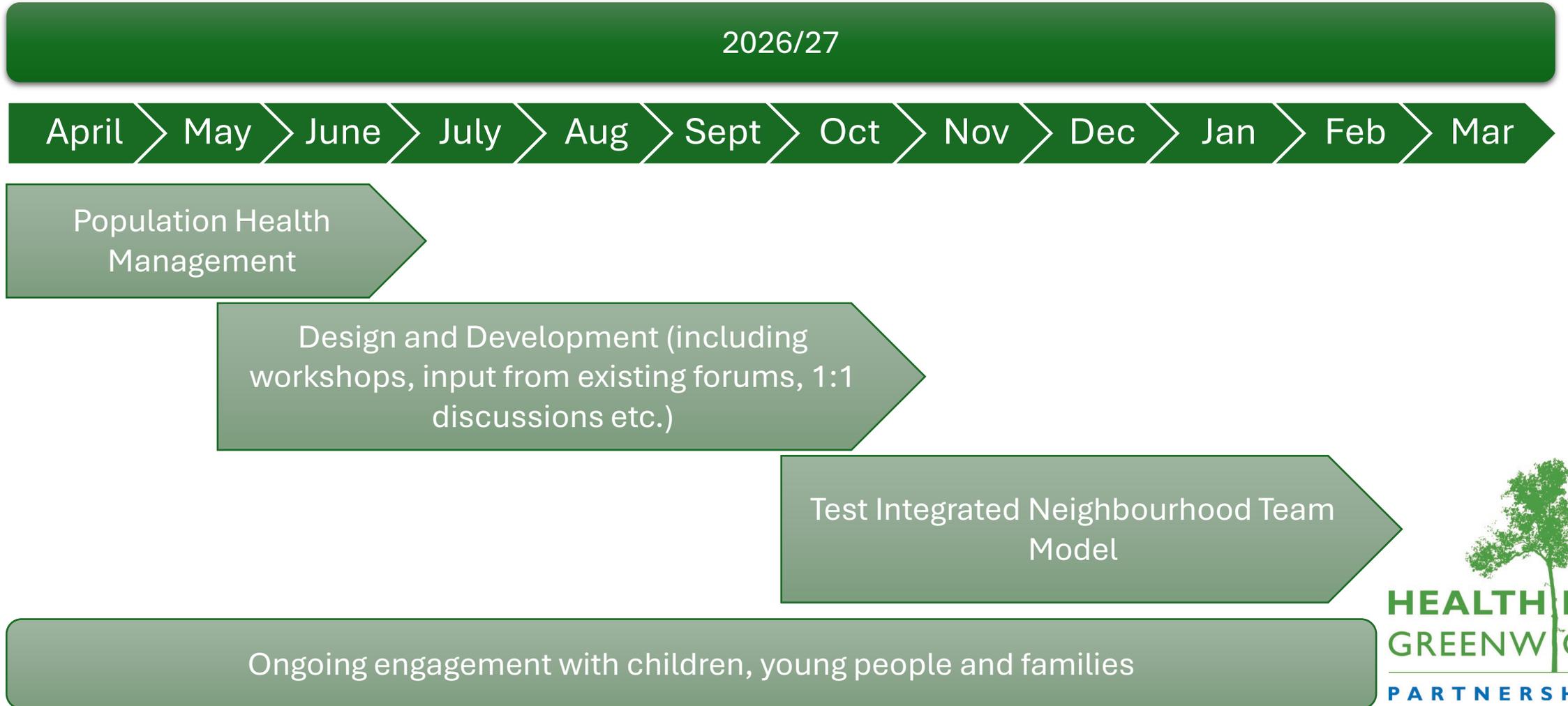
Share and learn from pilots and expand across priority cohorts

Phase 3: Embed - 2028/29

Full delivery CYP INTs across SEL with clear operating model, governance and outcomes framework



Development of the Approach 2026/27



Governance and the interface with HGP



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Children and Young People's Governance

- Several strategic oversight groups that interface with children and young people's overall health and wellbeing



- Children and Young People's Partnership Board to provide strategic oversight on the development
- Healthier Greenwich Partnership to receive updates and input on the development
- Wider groups to be involved in feeding into the shaping of the INTs. Extent of involvement may vary subject to the cohort of focus



Discussion and Questions



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AGENDA ITEM: 5

Healthier Greenwich Partnership

Date: Wednesday 25th February 2026

<p>Title</p>	<p>Development of Neighbourhood Hubs for Greenwich: Update on Progress to Date and Recommendation for Approval</p>
<p>This paper is for approval.</p>	
<p>Executive Summary</p>	<p>The NHS England Neighbourhood Health Guidelines 2025/26 emphasised the importance of exploring the use of neighbourhood buildings across all partners.</p> <p>These will be spaces that:</p> <ul style="list-style-type: none"> • accommodate direct service delivery of health, care and wider wellbeing support to residents and communities, in a financial and logistically efficient manner; • house integrated teams of staff from multiple organisations, to work collaboratively and innovate; and • provide a valuable community asset for use by residents, community groups and the voluntary sector, linked to wider wellbeing goals. <p>The enclosed presentation outlines the work undertaken to date to identify the challenges and opportunities around Neighbourhood Hubs in Greenwich, the progress over the past 12 months to place Greenwich in a strong position strategically and practically to forge ahead with Hub implementation; and the preferred sites to move to the next phase of Hub development – detailed, aligned plans for investment and prioritisation of sites in each of the West, South, East and Central Neighbourhood geographies.</p>
<p>Recommended action for the Committee</p>	<p>The HGP Board is asked to:</p> <ol style="list-style-type: none"> a) Note the requirement for Greenwich to develop a portfolio of Neighbourhood Hubs to support INT working, service delivery and community assets in line with national directive. b) Note the context and progress made to date by partners across the borough. c) Approve the position outlined for each of Greenwich's four Neighbourhoods, with caveats that development of estates and spaces is ongoing and may be subject to change as funding, availability and strategy dictates. d) Note the next steps, milestones and external factors relating to risk and finance.

Potential Conflicts of Interest	Greenwich providers with an ownership stake in buildings that accommodate health and care services, such as partner-owned GP practices, may have a direct Conflict of Interest.	
Impacts of this proposal	Key risks & mitigations	<p>The major risks related to the development of Neighbourhood Hubs include:</p> <ul style="list-style-type: none"> a) Lack of adequate, available, timely funding for the significant investments required to realise the potential of key buildings in each of the four Neighbourhoods. b) Risk of overspending the general practice rent reimbursement budget. c) Geographical access, public transport and parking availability are important considerations that are not always easy to optimise given the urban and high density development of Royal Borough of Greenwich. d) Willingness of different demographics, communities and disease cohorts to engage with health and care services at Neighbourhood Hub sites, affecting ability to establish these as multi-faceted community assets.
	Equality impact	To be conducted for each site on a case-by-case basis as detailed plan emerge and edge closer to implementation.
	Financial impact	Financial impacts include the need for significant investment into buildings and also, potential ongoing costs of rent reimbursement; however, overall the Greenwich Neighbourhoods estates approach should improve efficiency and value for money of funding as it supports the Partnership to share, optimise and jointly utilise Greenwich's estates and spaces. This includes estates being a direct enabler of all three 'left shifts' of the NHS Ten Year Plan.
Wider support for this proposal	Public Engagement	Public and patient engagement will form part of the development of individual sites within Neighbourhoods, rather than consulting or engaging on the whole approach. This will enable detailed discussions at local level about what residents and community groups, including the voluntary sector, want to see prioritised in their local Nhood Hub/s.
	Other Committee Discussion/Internal	<p>System wide stakeholder workshops were held in April and May 2025 to identify and explore options.</p> <p>Site visits by multiple Greenwich system partners to explore the options.</p>

	Engagement	Ongoing updates and discussions at the Greenwich Local Estates Forum, jointly chaired by the ICB Place Executive Lead and the RBG Director of Regeneration.
Author:	Jessica Arnold, Director of Primary Care and Neighbourhoods, Greenwich	
Clinical lead:	n/a	
Executive sponsor:	Gabi Darby, Greenwich Place Executive Lead	

Development of Neighbourhood Hubs for Greenwich:

Update on Progress To Date and Recommendation for Approval

Healthier Greenwich Partnership Board meeting in public
Wednesday 25th February 2026

Jessica Arnold, Director of Primary Care and Neighbourhoods,
NHS South East London ICB (Greenwich)



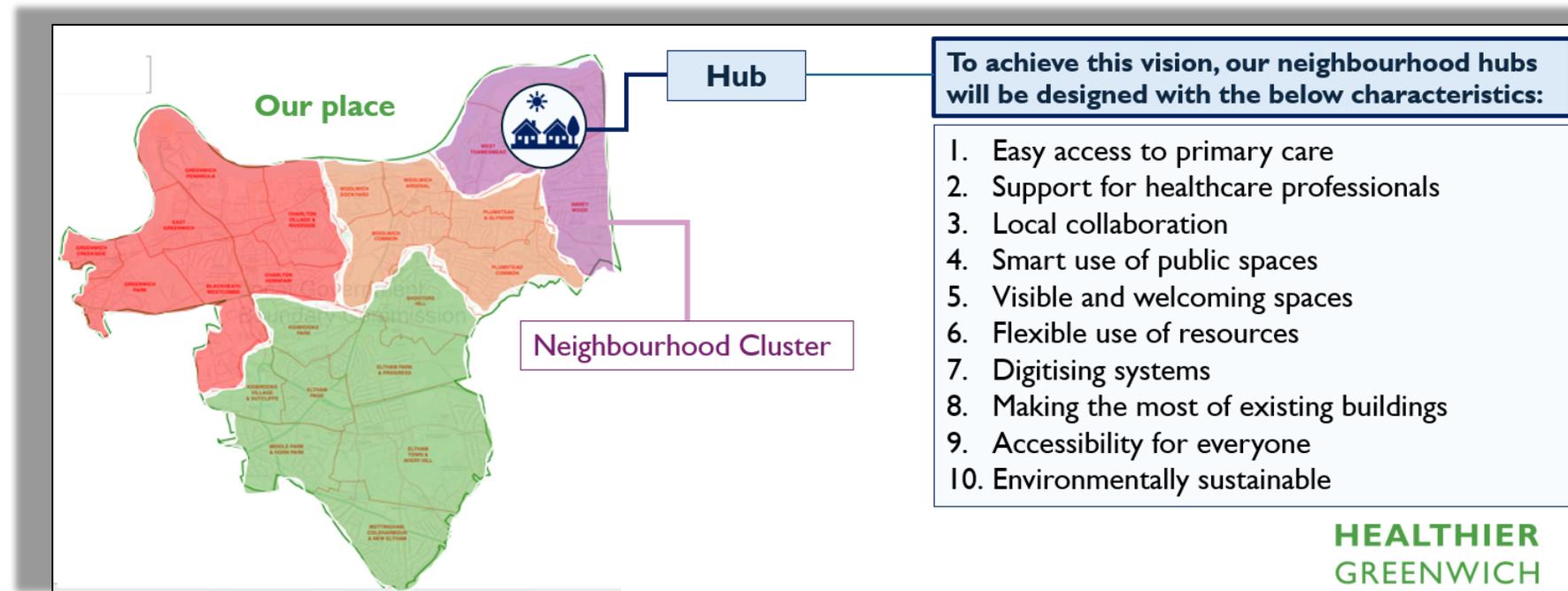
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What is a Neighbourhood Hub?

The NHS England Neighbourhood Health Guidelines 2025/26 emphasised the importance of exploring the use of neighbourhood buildings across all partners, as outlined in published Joint Forward Plans.

- Co-location of proactive, integrated teams, and the relationships and collaborations that come from this
- Sites of service delivery to residents, provided by public health and care services and wider wellbeing and community organisation (including the voluntary sector)
- Optimal use of the public estate given system-wide space and financial pressures
- Hubs develop in the psyche of local areas as centres of community access/ibility, coalescence and holistic wellbeing



! Estates vs. Spaces...

Context: Estates challenges in Greenwich

1. Disproportionately poor quality of general practice estates in Greenwich, with many sites not fit-for-purpose as modern healthcare facilities
2. Pressure on estates and spaces is being experienced across many general practice and community provider sites, impacting upon recruitment and accommodation of workforce, and direct service delivery to residents
3. Estates-related costs (including void space) are increasing for public, voluntary and community tenants
4. Available funding for rent, refurbishment and development of sites is minimal to meet identified need
5. Many VCSE organisations report struggling to find or retain affordable, accessible estates
6. Gap in understanding of community pharmacy estates challenges
7. Some geographies within the borough simply do not have 'obvious choices' with relatively easy potential to develop into Neighbourhood Hubs
8. Specific risks existing at some healthcare sites, e.g. related to eviction or long-term building viability



Context: Estates opportunities in Greenwich

Greenwich General Practice Estates Strategy 2025-2030



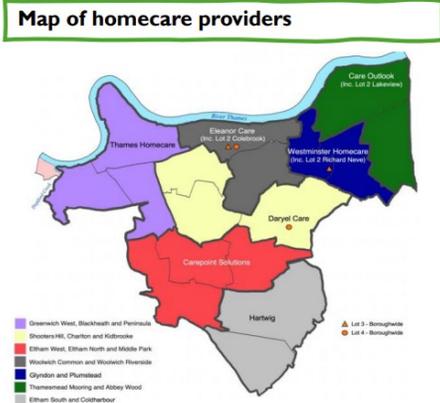
April 2025

1. The Greenwich General Practice Estates Strategy was signed off in April 2025, outlining a robust approach to:
 - ✓ Managing existing general practice sites, especially poor quality premises
 - ✓ Proactively planning ahead of large housing and regeneration developments in the high-growth borough
 - ✓ Agreeing the principles for future investment into estates, given the complex pressure and funding landscape
2. Successful applications for investment were made in 2025 as part of the Utilisation and Modernisation Fund (UMF), London Improvement Grant (LIG), and Greenwich Section 106 programme. We await hearing about our success with Capital Pipeline grants.



Progress towards Neighbourhood Hubs in Greenwich to date

- ✓ Greenwich was the first SEL borough to progress Neighbourhood Hub development as a Partnership, starting with:
 - a Strategic Needs Assessment and Asset Mapping exercise by PPL
 - an ICB-led, PPL-facilitated stakeholder workshop in April 2025
- ✓ Two follow-up workshops were held thereafter to explore further opportunities in:
 - West Neighbourhood
 - Children and Young People’s estates
- ✓ Multi-disciplinary site visits took place to discuss opportunities and strategic fit with Neighbourhood working at:
 - Wensley Close and Eltham Community Hospital
 - Goldie Leigh
 - Lakeside (Bexley border)
 - Various general practices
- ✓ Upcoming:
 - Planned visits to Plumstead Health Centre and Garland Road branch (12th March)
 - Discussion with Regeneration about opportunities for both estates and spaces arising from Urban Development Frameworks (25th Feb)



Recommendations: West Neighbourhood

Preferred option:

Twin hubs at:

**The Greenwich Centre,
East Greenwich, and
Millenium Health Centre,
Greenwich Peninsula.**



Both

- ✓ Currently there are voids and underutilization of space
- ✓ Well-connected by public transport
- ✓ Opportunity for voluntary sector delivery
- ✓ Opportunity for flexible, collaborative workspace for staff
- ✓ General practices located at both sites

The Greenwich Centre

- ✓ Building on existing community assets such as the library and leisure centre
- ✓ Oxleas staff already located here
- ✓ High quality premises

Millenium Health Centre

- ✓ Offers parking for highly mobile community service colleagues
- ✓ Opportunity for diagnostics or urgent care delivery
- ✓ Investment through the LIG currently, and future re-development to fulfil site potential would be relatively minor

Recommendations: South Neighbourhood

Preferred option:

Taking a healthcare 'campus' approach across the combined footprint of:

**Eltham Community Hospital, and
Wensley Close, Eltham.**

Both

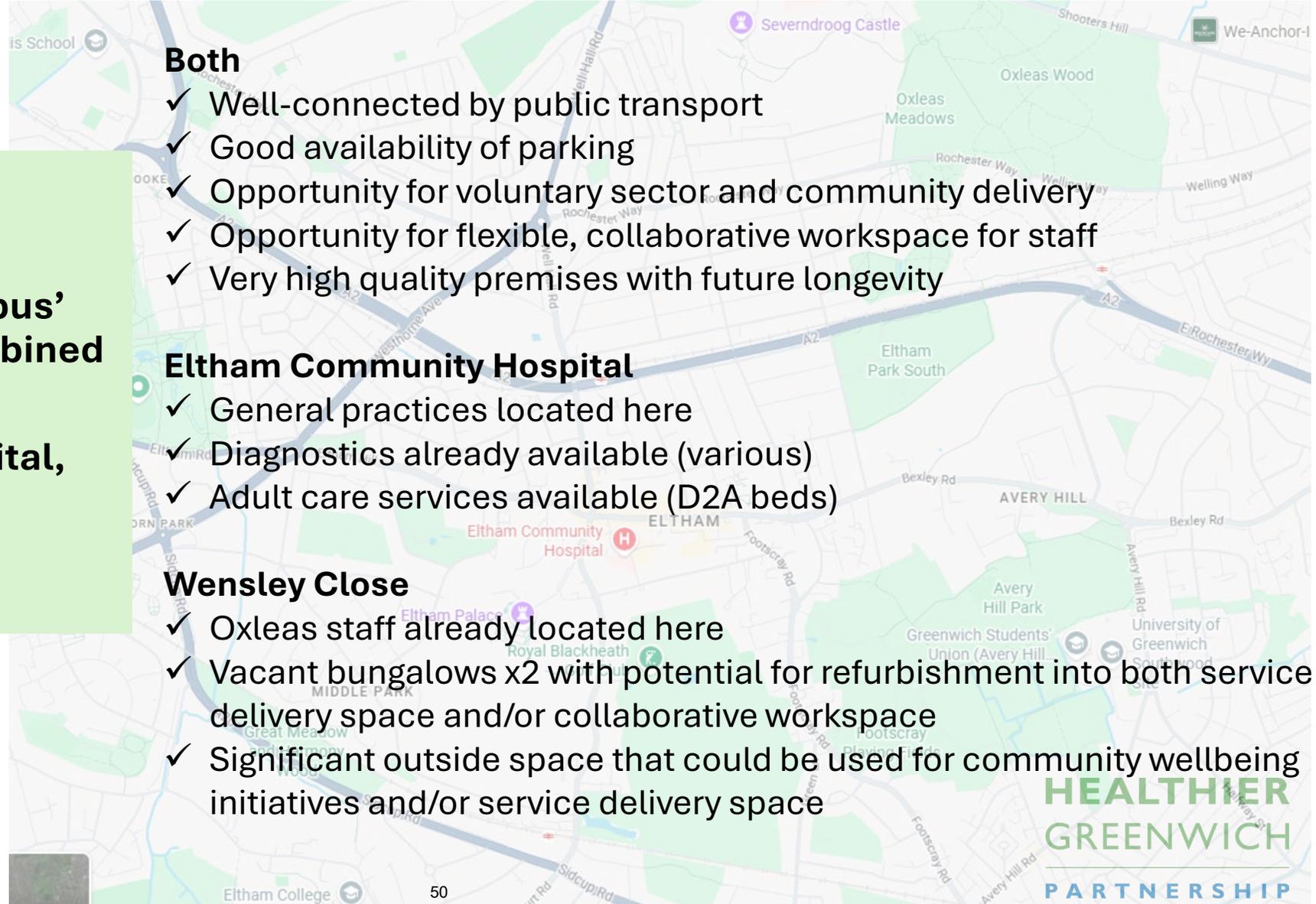
- ✓ Well-connected by public transport
- ✓ Good availability of parking
- ✓ Opportunity for voluntary sector and community delivery
- ✓ Opportunity for flexible, collaborative workspace for staff
- ✓ Very high quality premises with future longevity

Eltham Community Hospital

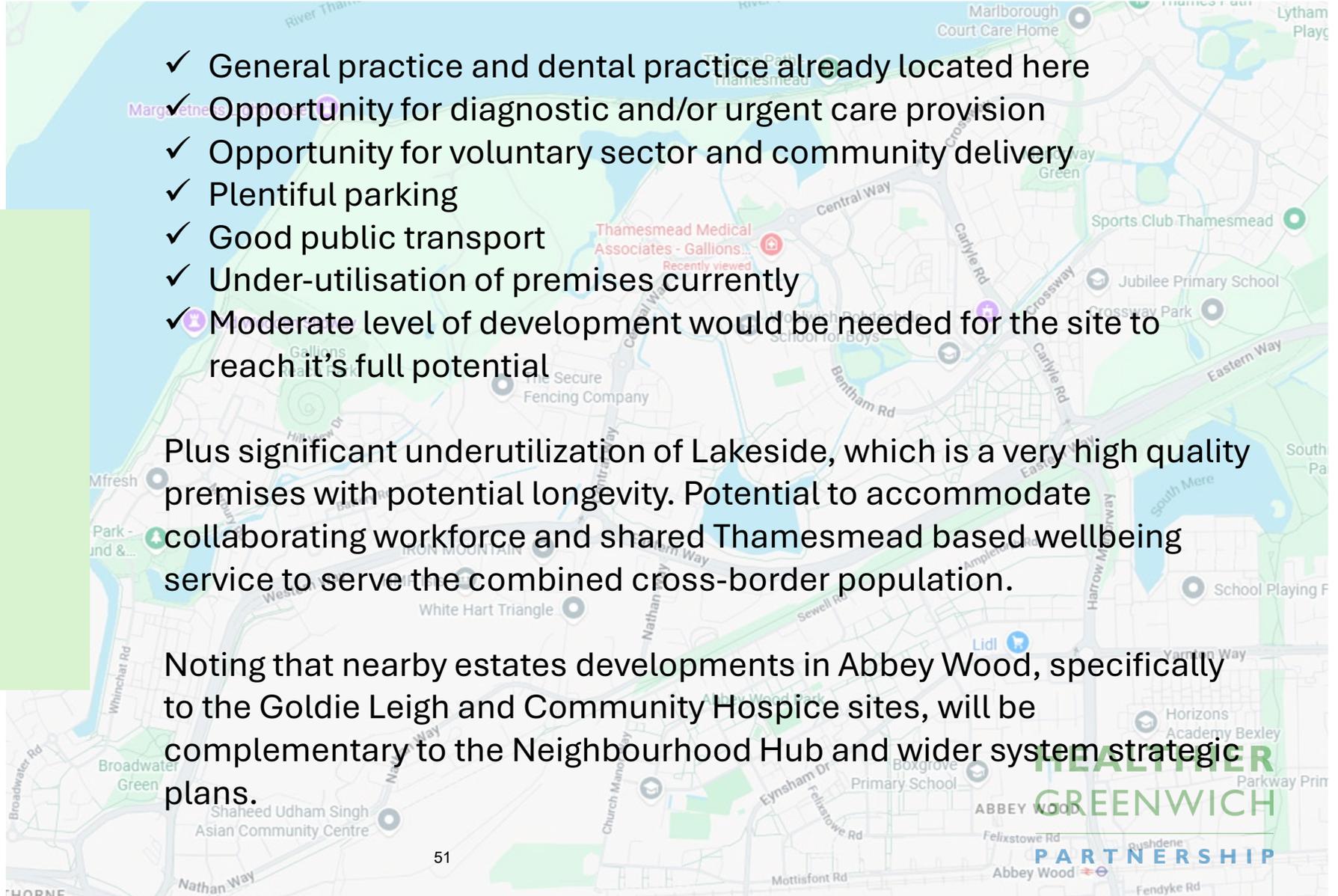
- ✓ General practices located here
- ✓ Diagnostics already available (various)
- ✓ Adult care services available (D2A beds)

Wensley Close

- ✓ Oxleas staff already located here
- ✓ Vacant bungalows x2 with potential for refurbishment into both service delivery space and/or collaborative workspace
- ✓ Significant outside space that could be used for community wellbeing initiatives and/or service delivery space



Recommendations: East Neighbourhood



- ✓ General practice and dental practice already located here
- ✓ Opportunity for diagnostic and/or urgent care provision
- ✓ Opportunity for voluntary sector and community delivery
- ✓ Plentiful parking
- ✓ Good public transport
- ✓ Under-utilisation of premises currently
- ✓ Moderate level of development would be needed for the site to reach it's full potential

Plus significant underutilization of Lakeside, which is a very high quality premises with potential longevity. Potential to accommodate collaborating workforce and shared Thamesmead based wellbeing service to serve the combined cross-border population.

Noting that nearby estates developments in Abbey Wood, specifically to the Goldie Leigh and Community Hospice sites, will be complementary to the Neighbourhood Hub and wider system strategic plans.

Preferred option:

Gallions Reach Health Centre

...potentially alongside Lakeside (Bexley) as twin hubs that serve the combined Thamesmead population.

Recommendations: Central Neighbourhood

Preferred option:

No single preferred option has emerged through the evaluative approach to date. Therefore, several spokes will be explored and feasibility assessed of these potential sites.

The longlist of options currently stands at:

Plumstead Health Centre (Plumstead)

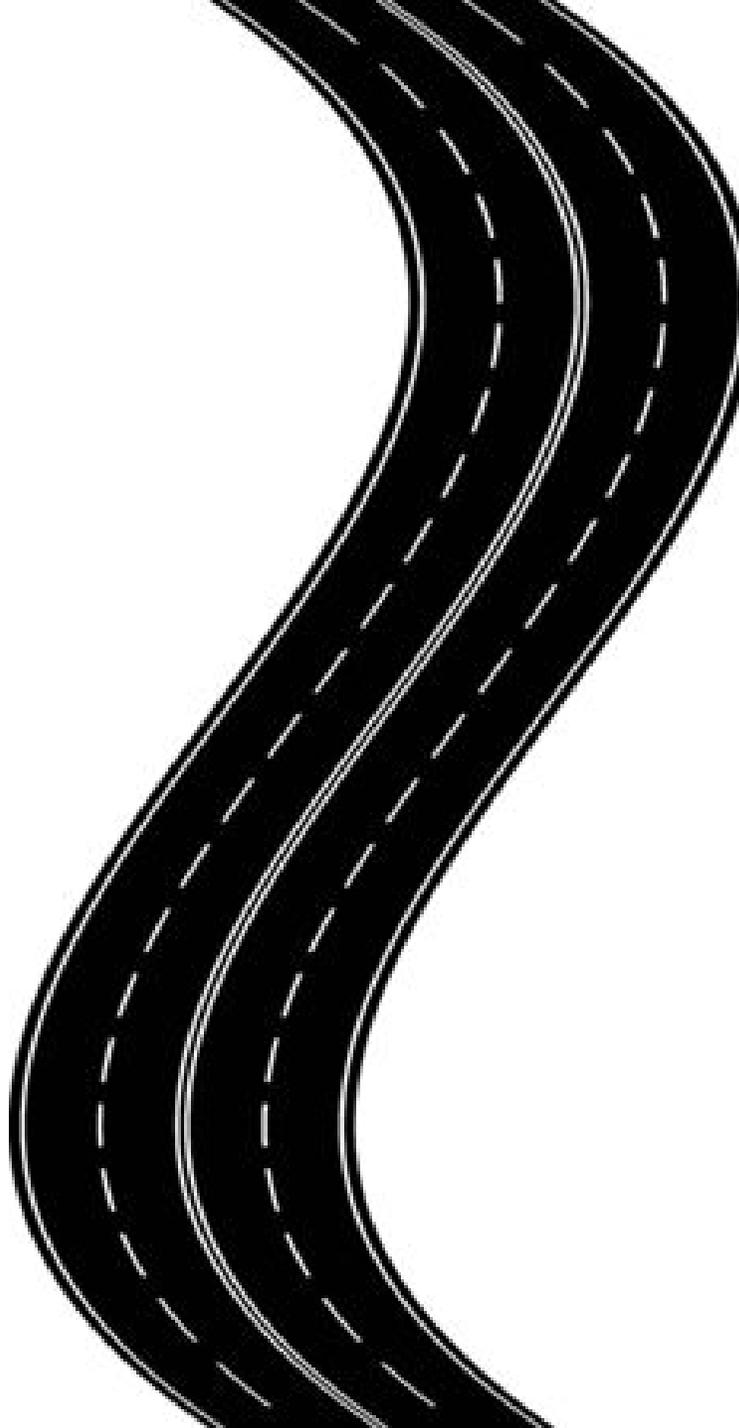
Garland Road Clinic (Plumstead)

Ferryview Health Centre (Woolwich)

Plumstead Common Road (Woolwich)

...and could expand/pivot toward other opportunities in the area as may emerge.





Next steps and milestones

- ❑ 25th Feb: Gain HGP approval to continue development of the identified sites outlined in this paper as potential Neighbourhood Hubs.
- ❑ March/April: Run a second series of stakeholder workshops with relevant system leaders and estates leads to progress towards said detailed plans.
- ❑ By 30th June: Develop a detailed plan of how estates and spaces will be developed and utilized in each Neighbourhood, including the demise of each service/organization, voluntary or community sector uses, communal resident areas, and un-ringfenced space for collaborate and creative working.
- ❑ Ongoing: Continue to actively source funding, including leveraging and utilizing maximal Section 106 receipts, to invest into Neighbourhood Hubs.
- ❑ Ongoing: Continue to apply the Greenwich General Practice Estates Strategy to primary care estates as required, e.g. when new lease requests are made.

Recommendation to the HGP Board

The HGP Board is asked to:

- A. Note the requirement for Greenwich to develop a portfolio of Neighbourhood Hubs to support INT working, service delivery and community assets in line with national directive.
- B. Note the context and progress made to date by partners across the borough.
- C. Approve the position outlined for each of Greenwich's four Neighbourhoods, with caveats that development of estates and spaces is ongoing and may be subject to change as funding, availability and strategy dictates.
- D. Note the next steps, milestones and external factors relating to risk and finance



With Thanks for Listening and Discussion



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AGENDA ITEM: 6

Healthier Greenwich Partnership

Date: Wednesday 25 February 2025

Title	ICB - 5 Year Strategic Commissioning Plan	
This paper is for noting		
Executive Summary	<p>This paper sets out the ICB's 5-year strategic commissioning plan as submitted to NHSE in mid-February</p> <p>This was a requirement for all ICBs as part of the 2/27 Planning Cycle. The commissioning plan sets out the ICB's key objectives, priorities, deliverables and intended outcomes across population health, service improvement and transformation</p>	
Recommended action for the Committee	The report is for noting	
Potential Conflicts of Interest	None arise from directly from the report.	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	None arise directly from the report
Wider support for this proposal	Public Engagement	
	Other Committee Discussion/ Internal Engagement	SELICB Board
Author:	Chris Dance	

Clinical lead:	
Executive sponsor:	Gabi Darby, Acting Place Executive Lead, Greenwich

SEL ICB Five Year Strategic Commissioning Plan

Version: 1.0

Status: **FINAL**

Table of contents

Section heading	Slide numbers
Introduction	3 - 7
About south east London	8 - 12
Our ambitions and population outcomes	13 - 22
Our population health improvement plan	23 - 31
System transformation	32 - 34
<i>Hospital to community</i>	35 - 42
<i>Sickness to prevention</i>	43 - 48
<i>Analogue to digital</i>	49 - 56
<i>Sustainable acute and specialised care</i>	57 - 64
Enabling the change	65
<i>Quality improvement and oversight</i>	66 - 67
<i>Our allocative strategy and developing our contractual approaches</i>	68 - 71
<i>Working with our partners and population</i>	72 - 74
<i>Workforce</i>	75
Conclusions	76

Introduction

Context and Background

- The NHS 10 Year Plan sets a clear ambition to change the way in which the NHS organises, delivers and funds services. In response to this ambition, all NHS organisations have been asked to shift their focus towards a rolling five-year planning horizon and to prepare integrated five-year plans which support transformational change, delivery the three shifts set out in the NHS 10 Year Plan and demonstrate how financial sustainability will be secured over the medium term.
- The role of ICBs within planning is one of strategic commissioners with a core focus on improving population health, reducing health inequalities and improving access to consistently high-quality services.
- **This plan is SEL ICB’s first five-year strategic commissioning plan and sets out how the ICB will secure improvements for its population in line with its key responsibilities as a strategic commissioner.** This plan replaces and draws in the ICB’s previous ambitions as set out in our Joint Forward View.
- The plan has been developed in partnership with our system partners and incorporates the findings from previous engagement and feedback from our residents and patients on their access and experience of care. In developing this plan and determining our commissioning priorities for the next five years, we have:
 - Undertaken a population health needs analysis to understand local need and in doing so, identified the healthcare interventions that will have the biggest impact on our population both now and in the future.
 - Brought together insight and intelligence on our existing commissioned health care services to ensure we continue to focus on the delivery of consistent, equitable and high quality services.
 - Reviewed our current strategy and financial sustainability plans to ensure our approach is fit for purpose for the next five years and supports delivery of our commissioning priorities.
- It is recognised that ICBs will be developing its strategic commissioning approaches and capabilities over the next 12 – 18 months.
- We will be refreshed and updating this plan on an annual basis as the ICB matures and in the context of the evaluated impact of our commissioning actions.
- Our five-year strategic commissioning plan was approved by the ICB⁶¹ Board on 10th February 2026

Our overall planning approach

- Our strategic commissioning plan forms one part of the ICB’s overall medium-term planning approach and process. In line with national expectations, the ICB has also completed an operating plan for 2026/27 to 2028/29, which covers the following:
 - Performance and activity measures, in line with the expectations set out in the NHS medium term planning framework (a framework based on the NHS 10 Year Plan but focused on the first few years initially).
 - Finance, setting out how we will use our commissioning budget for the next three years.
 - Our planned workforce numbers with a specific focus on primary care and mental health staff who are not employed by NHS trusts.
- Our strategic commissioning plan and the operating plan for 2026/27 to 2028/29 are inter-linked both in terms of our commissioning priorities and allocative approach to funding.



Our plan on a page

Our transformation plans

Planned care

Cancer

UEC

Long term conditions

Maternity

Palliative and end of life care

Children and young people

Mental health

Learning disability, SEND and autism

Prevention, wellbeing and equity

Primary care

Medicines optimisation

Our overall delivery priorities

Hospital to community

Sickness to prevention

Analogue to digital

Acute and specialised sustainability

Our ambitions

Improving population health

Improving experience of care

Addressing system sustainability

Securing the Commissioning and Delivery of High Quality and Safe Services

Population and System Outcomes

Extend healthy life expectancy of South East London residents by delaying the onset of preventable long-term conditions and proactively addressing health issues and illness

Reduce health inequalities for South East London residents across the life course by targeting those at greatest risk of poor health (including those in the Core20PLUS groups)

Every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life

Children and young people thrive in their physical, mental and emotional health, able to seize opportunities

Children and young people with long-term and / or complex conditions lead active, engaged lives, supported by a system that actively manages their needs

Adults live healthier lives for longer: avoiding premature heart disease, stroke & diabetes and other long-term conditions

Adults navigate their life and work with confidence, enabled by a responsive system that identifies health issues early and delays progression of long-term conditions

Adults with physical and mental health conditions live confident, independent lives, achieving equity with others

Older people are safe and independent, living in their own homes for longer

Older people maintain their quality of life through the early detection and holistic clinical management of acute illness and long-term conditions

Older people with frailty or complex needs stay safe, well, and in control of their own health and care

All residents experience dignity, comfort, and respect at the end of their lives

All residents possess the capability and confidence to sustain healthy lifestyles and manage their own health and wellbeing at every stage of life

Commissioned services in south east London are accessible, sustainable, effective and deliver value for our population

There is strong alignment of commissioning activities across partners with joint endeavours on tackling the wider determinants of health

How are key delivery priorities will help us to achieve our ambitions



Our strategic commissioning plan will improve population health by

- Taking a targeted approach to improving care for **three priority population cohorts** identified through our population needs analysis
- Delivering a more integrated model of preventative and proactive care through **neighbourhood based care**. This core offer should support our residents to stay well for longer. This will be supported by our **digital** plans for Population Health Management analytics which will enable us to better plan and deliver proactive care, improving our population's health by targeting early intervention.
- Increasing our focus on commissioning core **preventative** interventions. This will help keep our residents healthier for longer and our supplementary targeted approaches for particular population cohorts will focus support on those that need it most
- Ensuring our population can access and receive care in a timely way. Our **care pathway appendices** set out steps we will take to support operational sustainability over the next five years



Our strategic commissioning plan will address system sustainability by

- Setting out how we will **work with NHS Trust partners**, recognising that the majority of our system underlying financial deficit sits within our acute providers and this is where we have a number of long standing performance challenges
- Helping to manage future demand for healthcare services through our plans for **neighbourhood care and prevention**, providing a more preventative and proactive approach that keeps people well for longer.
- Allowing our workforce to focus on patient care; our **digital** plans have the potential to increase productivity through technology which works effectively and deploying AI as a supportive tool



Our strategic commissioning plan will secure the commissioning and delivery of high quality and safe services by

- Taking a strategic approach to commissioning **neighbourhood based care and prevention** interventions, with a focus on ensuring the commissioning approach acts as an enabler.
- Ensuring **access to alternative services** which mean that only patients who need hospital based care need to access these services, supporting delivery of high quality acute services
- Driving adoption of **technological and digital solutions** to fundamentally improve our ability to provide high quality care to patients e.g single patient records so information can be seen and shared across settings
- **Working with our Trusts** to support them to achieve operational sustainability and deliver on core targets, which is key to ensuring our population can access high quality and safe services



Our strategic commissioning plan will improve people's experience of care by

- Ensuring our population can access and receive care in a timely way. Our population tell us that they wait too long to access care; our **acute services review and care pathway appendices** set out plans to support operational sustainability
- Delivering more care in community settings or at home through our plans for **neighbourhood care** and wider pathway changes. This will deliver care in a more integrated and holistic way which is what our population tell us they want.
- Better connecting care professionals and care records through our **digital** plans so people don't have to tell their story multiple times. The new NHS App will support people to access self care information and navigate the healthcare system more easily.

About south east London

Overview of the South East Health Care System

Our Population

- South east London has a **highly diverse and vibrant population** of approximately 2.1 million people registered across six London boroughs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark).
- The **population of south east London is growing by approximately 4% each decade**, but this growth masks a profound demographic shift (see Figure 1 left). The proportion of children and young people (0-18 years) is projected to shrink from 20.8% to 18.3% by 2035, while the proportion of older people (people aged 65 years and above) will increase from 12.5% to 15.3%, equivalent to around 63,00 additional individuals aged over 65 years. Without change, this is likely to result in increasing demand for healthcare. Of the six boroughs in south east London, Greenwich and Southwark are projected to be the fastest growing boroughs between 2025 and 2035.
- There are **marked levels of deprivation** across south east London (see Figure 2 in the next slide). A generational gradient is observed with younger people more likely to live in the most deprived postcodes, and 1 in 5 children in south east London live in low income households. Deprivation is a known marker of poorer health outcomes including for factors such as life expectancy and healthy life expectancy.
- We are an **ethnically diverse region** with substantial Black communities in Lambeth (27%), Southwark (25%), Lewisham (24%) and Greenwich (21%). The proportion of children and young people is considerably more diverse than the older population (see Figure 3 in the next slide) and a significant proportion of our residents were born outside of the UK. Other communities of note include LGBTQIA+, unpaid carers and those in temporary accommodation.

Figure 1: South east London Population Projections by age groups



	Since 2015	2025	By 2035
0-4	-19.8%	97,568	+1.4%
5-12	-6.1%	157,756	-10.9%
13-18	+14.8%	126,068	-12.6%
19-34	+1.3%	490,352	+3.3%
35-49	+1.6%	410,763	+4.6%
50-64	+19.0%	325,172	+2.3%
65-74	+17.2%	125,232	+32.6%
75-84	+15.3%	75,887	+20.1%
85+	+5.5%	29,204	+24.1%
Total	+4.3%	1,838,002	+4.0%

Overview of the South East Health Care System

Figure 2: Geospatial visualisation of south east London boroughs by national decile of index of deprivation (2019) for lower super output area (LSOA, 2021)

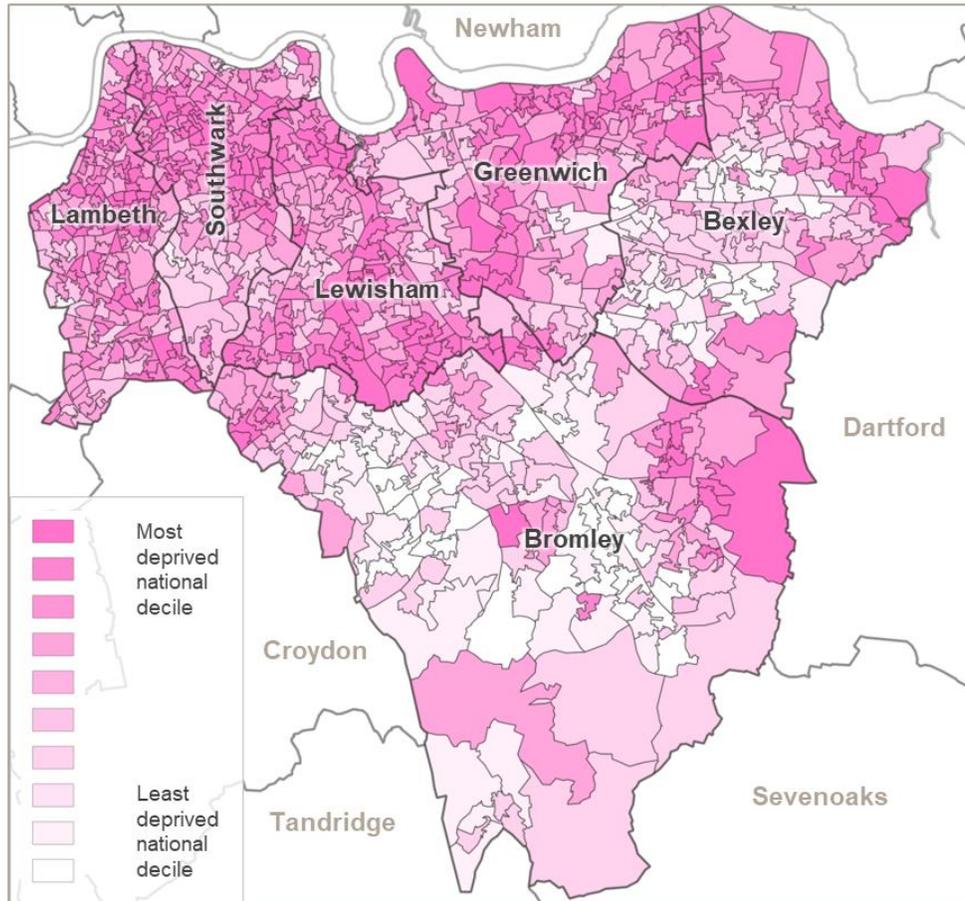


Figure 3: Proportion of the SEL population by ethnicity, by age group (Start Well, Live Well and Age Well) and by borough, compared to London.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London
Start Well (0-18 years)								
Asian	11.2%	9.3%	11.8%	6.2%	8.9%	9.0%	9.5%	23.0%
Black	17.3%	9.8%	29.0%	35.5%	32.4%	36.3%	26.2%	17.0%
Mixed	8.3%	12.4%	12.5%	16.1%	16.5%	14.2%	13.3%	11.6%
White	60.8%	66.5%	42.8%	36.0%	37.7%	33.8%	46.8%	41.6%
Other	2.4%	2.1%	3.9%	6.2%	4.5%	6.6%	4.2%	6.8%
Live Well (19-64 years)								
Asian	10.6%	9.1%	14.2%	7.2%	9.3%	10.5%	10.0%	20.7%
Black	12.8%	8.4%	20.0%	21.0%	25.5%	22.5%	18.8%	13.1%
Mixed	2.3%	4.0%	4.4%	6.7%	6.2%	5.9%	5.1%	4.5%
White	71.6%	75.9%	57.0%	59.3%	54.1%	54.6%	61.4%	55.2%
Other	2.6%	2.6%	4.5%	5.8%	4.9%	6.5%	4.6%	6.5%
Age Well (65+ years)								
Asian	5.0%	3.8%	9.3%	9.1%	5.8%	5.7%	6.0%	16.0%
Black	2.7%	2.0%	8.7%	26.0%	22.9%	22.3%	11.4%	8.9%
Mixed	0.0%	0.2%	0.4%	1.5%	0.6%	0.7%	0.5%	1.3%
White	91.0%	93.0%	78.7%	59.7%	67.3%	67.1%	79.7%	69.3%
Other	1.2%	1.0%	3.0%	3.7%	3.4%	4.2%	2.4%	4.5%

Overview of the South East Health Care System

Our Commissioned Healthcare Services

- Healthcare services in south east London span primary, secondary and tertiary care are delivered through:
 - Three acute trusts - Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust
 - Two mental health trusts - South London and Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust
 - Four providers of community services with three integrated NHS trusts and one standalone community provider – Guy's and St. Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust, Oxleas NHS Foundation Trust and Bromley Healthcare
 - 194 General Practices, 198 General Dentist Practices and 341 Community Pharmacies
 - A wide range of commissioned voluntary and community sector providers including local, grassroot organisations through to national charities.
 - Several independent providers.
- The majority of our patients access care within these services, however, some south east London residents also access care in other parts of London and into Kent and Medway.
- Because of the specialist nature of service provision within our NHS Trusts, south east London is a net importer of patients into the sector

Figure 4: NHS Trust Landscape in south east London



NHS provider landscape in south east London

Overview of the South East Health Care System

Outcomes and Access to Care in our System

- There are significant variations and inequalities in life expectancy across our boroughs with communities in the least deprived areas of south east London living between four and nine years longer than people living in the most deprived areas. This inequality is greater among males than females.
- The “vital 5” metrics (tobacco, alcohol, healthy weight, blood pressure and mental health) are the risk factors which cause the greatest loss of years of life due to disability or premature death in south east London.
- Timely access to care remains a challenge in south east London. We have struggled to deliver against the key national and operational performance metrics for several years, and noticeably since Covid. There have been pockets of improvement, but a number of long-standing performance issues across UEC, elective, diagnostics, cancer and mental health services that are likely to continue without significant changes to pathways, radical changes in delivery models and / or investment.

Feedback from our patients, residents and our community work tell us that:

- We need to rebuild trust in the system; too many people feel unheard, unseen and let down by healthcare services. There are ongoing challenges with racism, stigma and inclusivity faced by some communities which fuels distrust and disengagement.
- There are challenges in accessing services and long waiting times. Our communities are unaware of how to navigate the complex healthcare system, particularly for people from minoritised communities. People want closer links between services and do not want to have to tell their story multiple times across different health and care services and settings.
- Prevention is important to our communities and this should be targeted to communities with highest needs, based on data and insight and include a focus on children and young people. Community based education which is built on trusted relationships and culturally sensitive is seen as key to support both prevention and self management.
- We need to improve our communication with our communities - there is a desire for jargon-free, inclusive, plain and respectful language for leaflets, posters and educational materials, using visuals.

Our Ambitions and Population Outcomes

Defining our Ambitions and Objectives

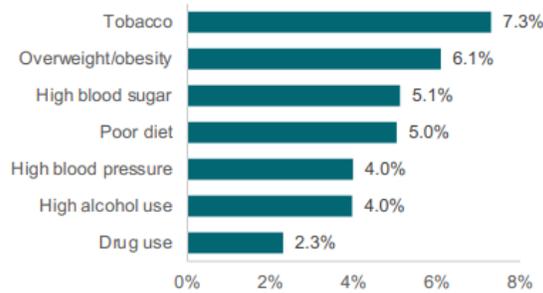
- In developing our underpinning and cross-cutting ambitions we have reviewed, in line with the NHS medium term planning framework, the following domains:
 - Population health and need – to ensure that we build all our plans with this at the forefront of our thinking. This included considering our current and future population demographics and need, inequalities in health and outcomes for our population, and synthesising feedback from our patients, residents and communities on their experience of care in south east London.
 - Our current service provision – this included understanding the current status of our commissioned services across quality, performance, access and finance.
 - Our commissioning spend and financial strategy.
 - Our existing strategies and plans, recognising that we have solid platforms to build from including our Joint Forward Plan and our Medium Term Financial Strategy.
- This combined analysis has revealed a strong level of alignment in key messages from the different data sets; they each have a particular lense but the overall messages are consistent.
- From the analysis, we have identified four cross-cutting ambitions which underpin our strategic commissioning plan:
 - 1. Improving Population Health**
 - 2. Addressing System Sustainability**
 - 3. Improving Experience of Care**
 - 4. Securing the Commissioning and Delivery of High Quality and Safe Services**
- We have also identified a set of population health outcome measures, based on our population health need analysis and will be developing associated key performance indicators against which to track progress and impact.
- The following slides set out the key messages from our read across of the data and the main information that contributed to us identifying these cross-cutting priorities, along with a summary of each of the four underpinning ambitions and objectives and our population health outcome measures. We anticipate that each of our commissioning actions and interventions will contribute to one or more of these ambitions and objectives, and will contribute to the delivery of the population outcome measures.

What the data tells us about prevention and early intervention

1

The “vital 5” metrics are the risk factors which cause the greatest loss of years of life due to disability or premature death in SEL

X.1 Approximated risk factors causing the greatest loss of years of life due to disability or premature death in SEL, 2021.



6

In our community engagement work, people have stressed the importance of targeting (prevention) services on communities with highest needs, based on data and insight and focussing on children and young people. Community based education which is built on trusted relationships and culturally sensitive is seen as key to support both prevention and self management.

2

While hospital admissions for falls among the elderly is better than London averages, preventable mortality is a problem across the inner SEL boroughs. SEL cancer screening rates are below national averages in all areas, although above London averages.

SEL		BEX	BRO	GRE	LAM	LEW	SWK
AW.6	Emergency hospital admissions due to falls in those aged 65 and over (2023/24)	Green	Green	Green	Green	Green	Grey
AW.7	Hip fractures in people aged 65 and over (2022/23)	Red	Grey	Grey	Grey	Grey	Grey
AW.8	Dementia QOF prevalence (2023/24)	Red	Red	Green	Green	Grey	Green
AW.9	Under 75 mortality from cancer (2021-23)	Red	Green	Red	Red	Red	Red
AW.10	Under 75 mortality from causes considered preventable (2022)	Red	Green	Red	Red	Red	Red

3

There are significant variations in life expectancy (LE) across SEL boroughs. There are demonstrable inequalities in LE by deprivation, with communities in the least deprived areas of SEL living between 4 and 9 years longer than people living in the most deprived areas. This inequality is greater among males than females.

There needs to be an explicit focus on work around prevention, early detection and intervention to improve population health; specifically targeting health inequalities and a focus for our Core20Plus populations across adults and children, to demonstrably improve equity of access, experience and outcome

4

Vaccination rates are low across SEL and are lower for people from Black and marginalised communities.

5

SEL		BEX	BRO	GRE	LAM	LEW	SWK
SW.1	Proportion of children in relative low income families (2023/24)	Green	Green	Red	Red	Red	Red
N/A	SW.2 Proportion of children with special educational needs (2023/24)	Green	Grey	Red	Red	Red	Red
SW.3	Prevalence reception children overweight (incl. obesity) (2023/24)	Red	Green	Red	Red	Red	Red
SW.4	Proportion of 16-17 year olds NEE I (2023/24)	Green	Green	Red	Red	Red	Red
SW.5	First time entrants to youth justice system (2023)	Green	Green	Red	Red	Red	Red

Prevalence of reception children overweight (incl. obesity) is higher than regional and national averages, and is highest in the inner SEL boroughs, correlated to higher prevalence of deprivation

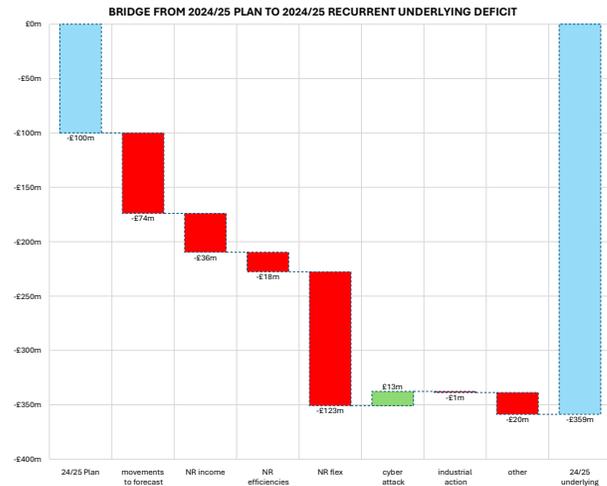
72

SEL	Benchmarked against goals	BEX	BRO	GRE	LAM	LEW	SWK
Red	Population vaccination coverage for two doses of MMR at age five (2022/23)*	Red	Red	Red	Red	Red	Red
Red	Population vaccination coverage for Dtap, HiB and HepB at age two (2023/24)*	Red	Red	Red	Red	Red	Red
Red	Population vaccination coverage for HPV amongst 12-13 year-old females (2023/24)*	Red	Red	Red	Red	Red	Red
Red	Population vaccination coverage: flu for at risk groups (2023/24)*	Red	Red	Red	Red	Red	Red
Red	Population vaccination coverage: flu for people aged 65 and over (2023/24)*	Green	Green	Red	Red	Red	Red
Green	Immunisations for children in care (2023/24)	Red	Green	Green	Grey	Red	Red

What the data tells us about the system's sustainability

1

The underlying financial position of the system has improved since 2024/25 but with considerable non-recurrent local and national support and the use of non-recurrent flexibilities to support the delivery of provider cost improvement plans.



2

A number of changes to the financial framework of the NHS are expected which may be significant, including a potential fast-tracking of national pace of change policies to move ICBs towards their 'fair share' allocations. For SEL this represents a particular risk.

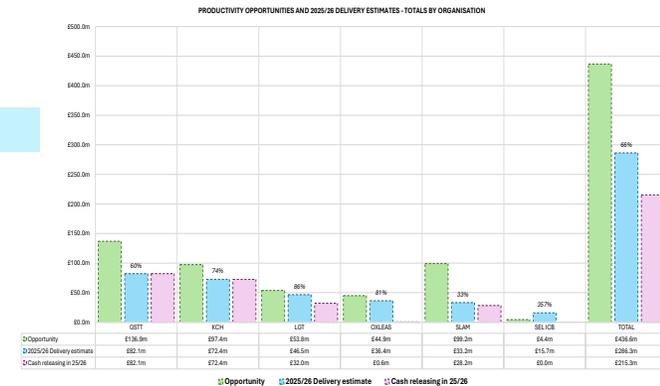
3

Exercise to deconstruct block contracts is underway to ascertain differences between underlying costed activity and agreed contract values

4

National productivity packs for 25/26 showed a SEL system opportunity of £436.6m. Our 25/26 plans assume delivery of 66% of this total opportunity, equating to £286.3m.

We need to address the system's long-standing challenges around sustainability; both financial and operational



6

People have told us they have challenges in accessing services and long waiting times, and are unaware of how to navigate the complex healthcare system, particularly for people from minoritised communities.

5

SEL system has some long standing performance challenges across a number of acute and mental health pathways. There are notable opportunities to improve productivity and efficiency, as well as transformational change to pathways and models of care, including the opportunity to maximise use of community services and left shift, as set out in the 10 year plan.

What the data tells us about local people's views and experiences

1

We need to rebuild trust in the system; too many people feel unheard, unseen and let down by healthcare services. There are ongoing challenges with racism, stigma and inclusivity faced by some communities which fuels distrust and disengagement.

7

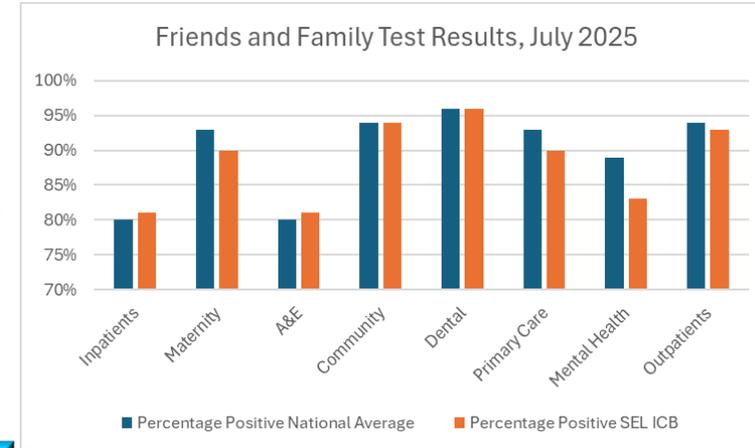
There is a general welcoming of technology that is easy to use for patients and staff, as well as securely integrated between organisations. There are concerns about digital tools exacerbating health inequalities.

2

Communication; there is a desire for jargon-free, inclusive, plain and respectful language for leaflets, posters and educational materials, using visuals. People do not want to tell their story multiple times across different health and care services and settings.

3

Our Friends and Family Test results are in line with national averages for inpatient care, A&E attendance, outpatients and community services. However, response rates are variable and can be low for some providers. Mental health services, maternity, and primary care services Friends and Family Test results are below the national average for positive results.



We need to improve experience of healthcare services for our patients and residents

6

People want more proactive services that focus on prevention. Mental health is often limited to moments of crisis with little attention to prevention. Some people have stressed the importance of targeting (prevention) services on communities with highest needs, focussing on children and young people.

5

People face challenges in accessing services; long waiting times with people unaware of how to navigate the complex healthcare system, particularly for people from minoritised communities. People want closer links between and across services, mentioning the importance of integrated care, care navigation support (virtual or in-person) and continuity of care for people with long term conditions, and others who may be vulnerable.

4

Women from Black and minoritised communities have poorer experiences of pre-pregnancy, pregnancy, birth, postnatal care. People also report poor experiences with mental health services and long-term conditions due to lack of coordination and personalised care.

What the data tells us about access and outcomes

1

SEL system has struggled to deliver against the key national and operational performance metrics for several years, and noticeably since Covid. There have been pockets of improvement, but a number of long-standing performance issues across UEC, elective, diagnostics, cancer and mental health services that are likely to continue without significant changes to pathways, radical changes in delivery models and / or investment

Metric	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
A&E Performance	75.21%	76.68%	73.26%	72.49%	73.82%	73.46%	73.99%	74.75%	75.69%	75.53%	76.81%	76.57%	76.86%
12 hour trolley waits	1,219	787	1,462	1,706	1,644	1,700	2,184	1,818	1,851	1,433	1,628	1,711	1,368
Percentage of attendances in A&E over 12 hours	9.1%	8.2%	10.1%	11.6%	11.1%	11.9%	12.2%	11.9%	10.3%	10.1%	10.1%	10.0%	8.4%

Metric	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
% of incomplete pathways waiting less than 18 weeks	58.1%	57.6%	57.0%	57.3%	58.0%	59.1%	59.7%	60.8%	61.3%	61.5%	60.8%	61.0%	62.3%
Percentage of patients waiting over 52 weeks	4.2%	4.52%	4.47%	4.24%	3.62%	3.06%	2.57%	2.50%	2.49%	2.48%	2.57%	2.73%	2.74%
Total number of incomplete pathways	23,512	23,300	23,275	23,000	24,866	24,834	24,346	24,017	24,110	23,986	23,210	22,835	22,880
Number of patients waiting over 52 weeks	12,125	11,621	11,540	10,642	8,897	7,380	6,324	5,930	5,874	5,852	5,963	6,248	6,137
Number of patients waiting over 65 weeks	2,593	2,181	2,113	1,884	1,033	747	613	552	337	309	476	476	463
Number of patients waiting over 78 weeks	315	342	340	337	309	93	63	66	29	26	54	54	36
Number of patients waiting over 104 weeks	4	0	0	1	1	1	1	0	1	1	0	0	1

Metric	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	
Diagnosics: % of patients waiting more than 6 weeks (9 key modalities)	37.72%	37.10%	37.57%	36.52%	35.10%	33.34%	35.79%	33.93%	27.14%	28.81%	27.20%	25.99%	27.73%
Diagnosics: Total activity (9 key modalities)	63,179	68,400	72,048	71,093	78,550	75,665	70,630	78,553	73,320	80,203	73,117	76,475	76,687

Metric	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	
18 Day Fracture Diagnosis Compliance	74.3%	75.2%	75.2%	73.9%	76.4%	76.8%	76.9%	71.3%	73.0%	73.3%	77.2%	75.2%	77.3%
% of patients with first treatment within 62 days (Combined)	83.80%	83.77%	86.86%	84.43%	89.72%	89.84%	87.86%	81.60%	80.81%	80.10%	89.34%	82.46%	83.33%
% of patients with treatment within 31 days (Combined)	89.93%	90.61%	88.97%	85.96%	88.61%	94.01%	92.87%	90.75%	95.29%	94.73%	92.82%	92.05%	93.93%
FDS with Cancer	39.0%	43.3%	46.5%	48.9%	45.2%	44.4%	43.9%	38.2%	43.9%	43.9%	40.3%	46.5%	46.2%

2

SEL ICB remains on track to deliver our planned increase in primary care appointments. However, our system does not perform as well as the England or London average on the overall experience of general practice.

3

The latest CQC ratings of SEL providers 4/5 Trusts are rated as requires improvement for “safe”. A number of inspections are currently underway. A number of care homes, GP practices and domiciliary care providers are also rated as RI. Key themes from quality alerts reveal challenges around appointment and referral issues, diagnostics and treatment delays, communication with patients and between providers, challenges around transfer of care and discharges, and medication errors, delays or supply issues

We need to focus on securing access to high quality and safe health care services for our population

5

We need to support our residents to access care at the right time; people from Black and underserved communities access more unplanned care and are overrepresented in emergency admissions and A&E attendances and on our elective waiting lists. MH act detentions higher for people from Black and underserved communities. SEL are below plan on community standardised referrals

4

Community insights indicate that our population have challenges in accessing services and face long waiting times. Some still use A&E unnecessarily with some communities not aware of 111 and other options.

ICB	Provider Name	Category	Publication Date	Overall	Caring	Combined Quality Rating	Effective	Responsive	Safe	Use of Resources	Well-led
SEL ICS	Guy's and St Thomas' NHS Foundation Trust	Acute	23 July 2019	Good	Outstanding	Good	Good	Good	Requires improvement	Good	Outstanding
	King's College Hospital NHS Foundation Trust	Acute	12 June 2019	Requires improvement	Good	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Good
	Lewisham and Greenwich NHS Trust	Acute	22 February 2023	Requires improvement	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Good
	Olesea NHS Foundation Trust	Mental Health	05 July 2020	Good	Good	Good	Good	Good	Good	Good	Good
	South London and Maudsley NHS Foundation Trust	Mental Health	26 March 2019	Good	Good	Good	Good	Good	Good	Good	Good
			30 August 2021	Good	Good	Good	Good	Good	Requires improvement	Good	Good

Our Ambitions



1. Population health: We will focus on work around prevention, early detection and intervention to improve population health; specifically targeting health inequalities and a focus for our Core20Plus populations across adults and children, to demonstrably improve equity of access, experience and outcome

- We will increase our focus on prevention for the whole population based on the health risk factors that we have identified. From our insights work, this is likely to focus on the Vital 5
- We will develop a dedicated approach to increasing prevention, early detection and intervention for our Core20 and other population cohorts that experience the worst health outcomes, to address health inequalities in our population. Based on the triangulation of our insights data this is likely to particularly include people from Black and underserved communities, who currently experience worse outcomes across a range of metrics.
- Our work will be underpinned by a financial strategy that supports us to target resources at these identified populations to drive improvements, enabling the shift to prevention and then also considering the availability of commissioned services for our Core20 populations and Black communities



2. System sustainability: We will actively address the long-standing challenges around system sustainability, both financial and operational

- We will drive a focus on delivering organisational productivity opportunities. Our 25/26 plans assume delivery of 66% of the opportunities identified in national productivity packs. We will need to understand in-year delivery, ensure delivery on a recurrent basis from 26/27 and continue to maximise further opportunities going forward, before considering difficult commissioning decisions.
- We will work in partnership to ensure our system is sustainable from a financial and operational perspective. Local people need to have access to services which are sustainable over the long term, and delivered by sustainable organisations
- We will focus on driving the development of integrated neighbourhood care, as well as supporting and progressing the acute and mental health collaborative work being developed through our system sustainability programme and the work we have underway on acute specialised services
- In doing so, we will ensure we build and develop a collective understanding of the benefit this work is expected to deliver and whether this is sufficient to address the system's financial and operational sustainability challenges or if further radical solutions are required

Our Ambitions



3. Experience: We will improve experience of healthcare services for our patients and residents

- There are common key themes from our community engagement work and these have not changed over time
- Over the next five years, we will make demonstrable progress in addressing some of the key themes related to service provision in south east London. We will improve access to services, increase our focus on prevention and enable a shift to a model of integrated care which is easier for people to navigate
- We will work with our commissioned providers to develop approaches to some of the feedback we received about people's experience of our services, particularly around racism, stigma and communication
- We will actively work with organisations embedded in our communities to rebuild trust in the healthcare system and increase knowledge and awareness of services available so people can access appropriate services in a timely way.
- We will ensure that the services we commission are culturally appropriate, ensuring that we work with people and communities to design services and solutions that work for people



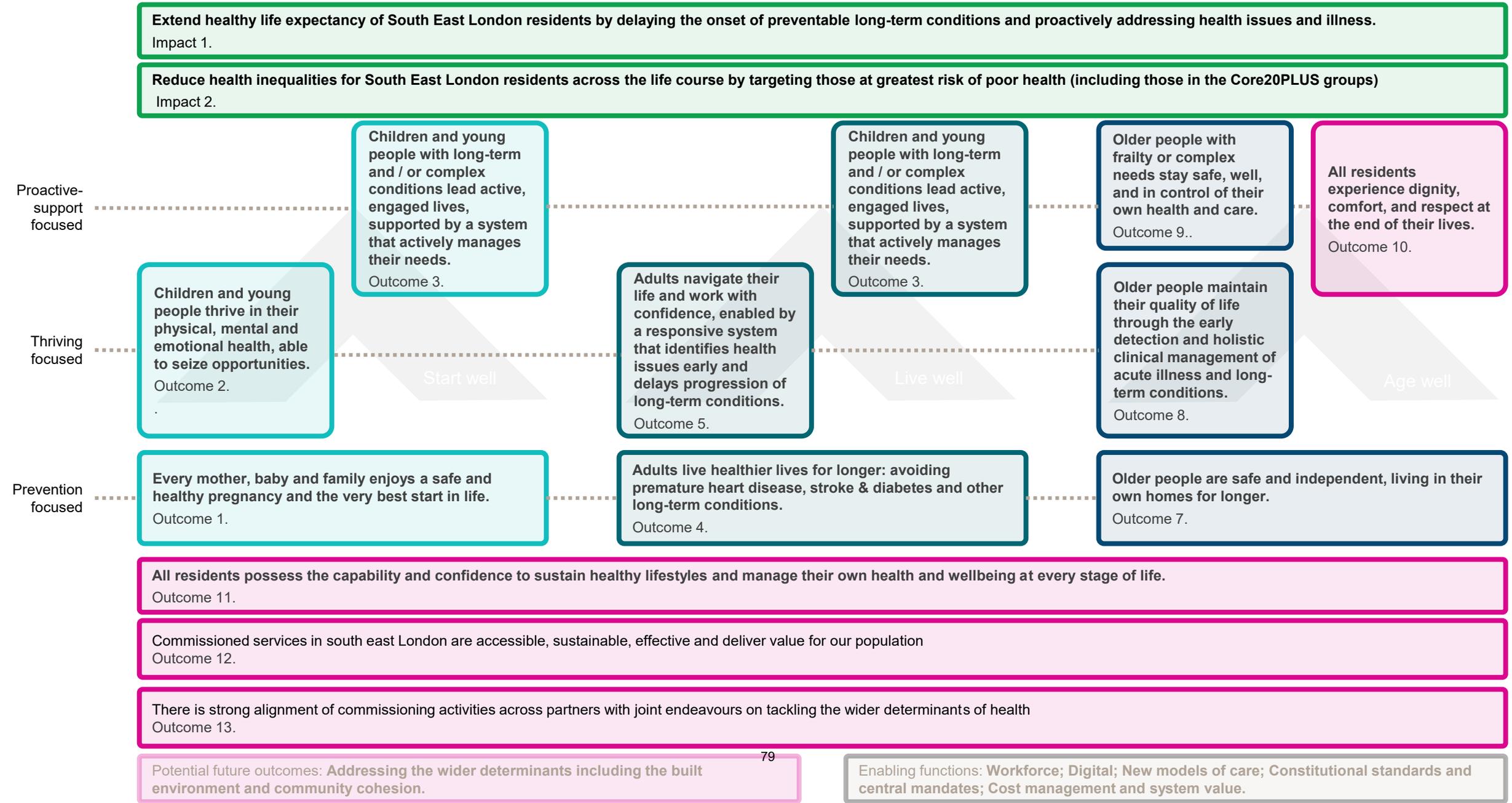
4. Access and outcomes: We will secure access to high quality and safe health care services for our population

- We will drive a range of improvement actions across our care pathways to ensure our residents can access high quality and safe health care services. Specifically for primary care, urgent and emergency care, elective, diagnostics, cancer and mental health services, we will have an enhanced focus on waiting times for these services to ensure timely access to care.
- We will focus on how to improve access to and knowledge of available services for our Core20 and other population cohorts, as well as undertaking engagement work, with and supported by trusted organisations embedded in our community, to develop an ongoing approach to build trust with underserved communities who find it difficult to access services
- We will target resources to improving access for these identified populations, alongside wider transformation activities to improve access for the population as a whole, and ensure this approach is reflected in our medium term financial strategy.
- We will work with our providers to ensure plans are in place where safety concerns have been raised through CQC inspections about some of our commissioned services

Developing our Outcomes and Key Indicators

- Our outcomes and key indicators will help us ensure we deliver our ambitions not only for our population but also for our local health and care system. Our outcomes are cross-cutting across our four ambitions and are integrated in terms of overall delivery.
- In developing our outcomes we have primarily focused population health outcomes, aligned to population health needs analysis. We have considered these on the basis of the following principles and across the following domains:
 1. Population health outcomes across the life course – these outcomes are relevant to all ages of our population.
 2. Population health outcomes that enhance our focus on prevention.
 3. Population health outcomes which are support focused for our population considered across the three domains of Start Well, Live Well and Age Well.
 4. Population health outcomes which focus on ensuring our population can thrive, again considered across the three domains of Start Well, Live Well and Age Well.
- However, it is also important that as a strategic commissioner we secure the sustainability of our healthcare services ensuring accessibility and value for the population.
- Furthermore, it is important that we recognise the role health can play in working with partners to influence and address the wider determinants of health.
- For each outcome, we need to define the key indicators which will help monitor delivery and measure our success. We will work collaboratively with our partners to do this over the course of the next six months. We will prioritise indicators based on their measurability in the medium term, however, we appreciate there will be a wider and broader range of indicators that will contribute to these outcomes and will work to ensure visibility of these over the course of the five years of our strategic commissioning plan.

Our proposed strategic outcomes framework



Our Population Health Improvement Plan

Developing Our Population Health Improvement Plan

- Our work to date has identified four cross-cutting ambitions which will underpin and sit across all our work.
 - In addition, our analysis of our population health needs and outcome data from across all six boroughs in south east London has identified three key population groups/cohorts. These populations represent a short-term population health challenge but are crucially important when we consider future health need, demand and outcomes. Our strategic commissioning therefore needs to focus on the here and now but also start investing to address the increase in complexity and need forecast over the next 10 years.
1. **Children and young people with complexity and in living our most deprived neighbourhoods** – our future demographic projections demonstrate that although the total number of children and young people living in south east London will over the next 10 years, the complexity within this age range will increase. Furthermore, children and young people will account for higher proportions of our Core20 populations, where outcomes are known to be worst.
 2. **Our working age adult population who have rising health risks** – our analysis shows that we have the most substantial opportunity to improve health and wellbeing in adults aged between 19 – 64 years of age. This includes targeted work aimed at the leading drivers of premature death and disability in south east London including cardiovascular risk factors (particularly tobacco use and obesity), diabetes and severe mental illness (SMI).
 3. **Frailty, multiple long term conditions and dementia care** – the projected growth and expansion of our older population could overwhelm our health and social care system. We therefore need to focus on reducing health risks in our working age adult population as set out above, but also ensuring our services for older people enable our population to stay living healthy and well.
- The following slides provide further detail on these population groups and set out the actions and interventions we will look to secure over the next five years to improve population health for these three group.
 - The six boroughs in south east London are however extremely diverse and therefore we have also developed borough specific population improvement plans, as set out in Appendix 1. These plans have some specific actions for the three target population groups above, but also consider and respond to local need aligned to existing Health and Wellbeing Strategies.

Children and Young People with Complexity (1/2)

Why children and young people with complexity

- Over the next 10 years, the population of children and young people (aged between 0 – 18 years of age) will decline from 20.8% of the population to 18.3%, driven by a decade-long fall in birth rates.
- Activity for 0-18 year olds has also been declining, particularly within the acute sector including attendances at our emergency departments and referrals into elective services. However, there have been significant increases in demand for children and young people's mental health services, neurodiversity and special educational needs.
- Despite the above, complexity within the 0-18 age range is likely to increase. This is for the following reasons:
 - Children and young people are more likely to be from an ethnic minority background (over a quarter of our 0-18 year olds identify as black, compared to nearly 19% of those aged 19-64 and 11.4% of those aged 65+). Our data tell us that childhood asthma is higher in these populations, and that these population groups are more likely to experience emergency admissions to hospital. Furthermore, there are significant inequalities in vaccination uptake for these population groups including vaccinations for flu, measles, mumps and rubella (MMR), Diphtheria, Tetanus, and Whooping Cough (DTaP), polio vaccinations, and Human Papilloma Virus HPV).
 - Children and young people are more likely to reside in our most deprived communities. Again, people residing in these communities are more likely to experience emergency admissions to hospital and primary care contacts are higher for people living in our more deprived communities. Our data tells us that the Core20 population is over-represented in the children and young people's asthma population.
- Without significant and targeted policy interventions in areas such as affordable housing, education, and local economic development, these patterns of ethnic and spatial inequality are likely to persist. Ongoing economic pressures and urban development could exacerbate these trends, further concentrating deprivation within the most affected communities in the coming years.
- Furthermore, the correlation between obesity rates, poverty and oral health are well known and understood. For south east London, high levels of obesity, coupled with poverty, are likely to worsen oral health in the near-term and increase demand for secondary care dental services.

Children and Young People with Complexity (2/2)

What action will we take

To make demonstrable improvements for children and young people with complexity we will:

- Systematically commission an integrated neighbourhood team in each of our boroughs, centred around a core20 neighbourhood and supported by the relevant contracting approaches to enable delivery.
- Deliver improvements in vaccinations for children and young people, commissioned as part of our wider prevention offer and with a family approach to the delivery of care. This will also include a focus on the services available for pre-conception care recognising the impact maternal and paternal health has on children and young people alongside early years support.
- Invest proactively in prevention and treatment services to enable children and young people to transition into adulthood as healthy as they can, including investment in:
 - Healthy weight services for children and young people;
 - A health check specifically targeted for teens;
 - Neurodiversity;
 - Mental health and emotional wellbeing services; and
 - Broader community services for children and young people.

What will be different for this population group in five years

- Children and young people will experience improved physical and mental health with measurable reductions in health inequalities and current prevalence e.g. of childhood obesity.
- Children and young people will be able to access a consistent community based service offer. This will be supported by clear commissioned integrated care pathways for children and young people across primary care, children's community services, children's mental health and the voluntary and community sector with local authorities being key partners to enabling delivery, underpinned by the relevant contracting structures and financial levers and incentives.
- There will be improved access and a reduction in waiting times for children's services across the sector including acute, community and mental health services supported by community based models of care (as described above), digital support and stepped care approaches, alongside clear coordinated support for those with complex or long term conditions.
- We will see an improvement in some key health indicators including children and young people's vaccination rates, particularly for our Core20 populations and our Black and Ethnic Minority Groups.

Working Age Adults with Rising Risk (1/2)

Why working age adults with rising risk

- Our population health needs analysis shows that although the size of the population (in % terms) of people aged between 19-64 years will reduce over the next decade, the absolute numbers of individuals in this group will increase. This group will be the older population of the future.
- Across south east London, there are notable inequalities in life expectancy (see Figure 5 to the left) and healthy life expectancy across the six boroughs in south east London. Communities in the least deprived areas of south east London live 4-9 years longer than people living in the most deprived areas. This inequality is greater among males than females.
- The risk factors causing the greatest loss of years of life due to disability or premature death in south east London are set out in Figure 6 with tobacco being the biggest driver of premature death. These risk factors are differential for different population groups including people from ethnic minorities and those living in our most deprived communities.
- Data from our commissioned services continues to highlight differences in uptake of preventative services including cancer screening services across different population groups and unplanned care (including attendances at emergency departments and emergency admissions) are highest for our core20 populations.
- Risk factors and poor health in middle age is likely to negatively affect healthy and independent ageing, making prevention in this cohort key.

Figure 5: Healthy life expectancy at birth by borough and gender, 2021-23

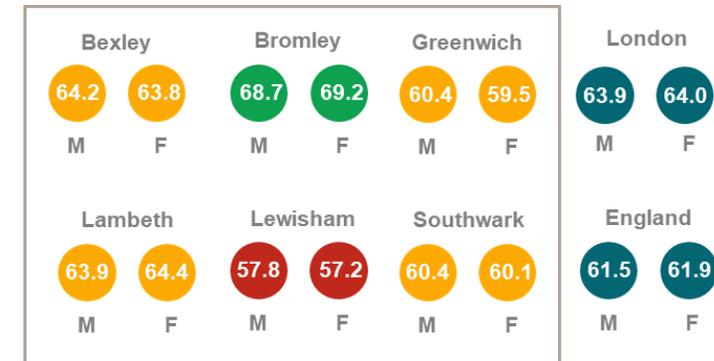
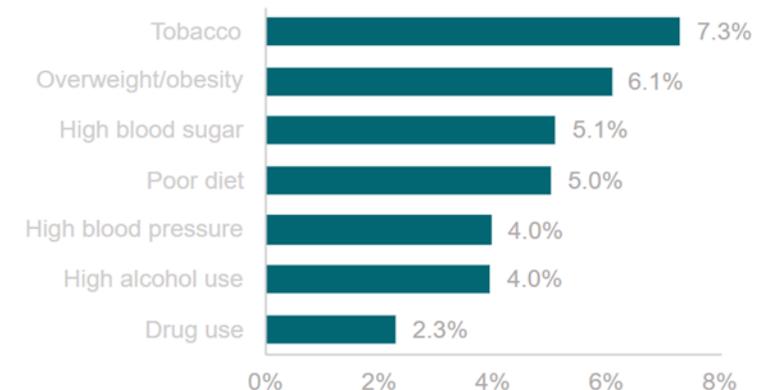


Figure 6: Approximated risk factors causing the greatest loss of years of life due to disability or premature death in south east London, 2021



Working Age Adults with Rising Risk (2/2)

What action will we take

We will systematically commission interventions that address the leading drivers of premature mortality. Specifically we will:

- Commission services with a focus on proactive case finding, detection and management of risk factors (e.g. through Vital 5 check, hypertension and lipid testing, health checks for learning disabilities and severe mental illness). We will seek to drive these approaches through the proactive commissioning of our neighbourhood core prevention offer, implemented on a phased basis from 2026/27, targeting our Core 20Plus 5 populations.
- Work in partnership with voluntary and community sector partners to support residents to access to screening services such as cancer screening and health checks.
- Incentivise through our contracts the optimisation of identification and management of high blood pressure in all healthcare settings.
- Commission waiting well services to support healthy lifestyle and behaviour change and readiness for treatment/surgery.
- Expand our commissioning of dedicated prevention services to provide increased and enhanced support to residents e.g. Tier 2 and 3 weight management services, the Ottawa model from hospital to community to support smoking cessation for our population.

What will be different for this population group

- Residents will have access to a universal prevention offer for which focuses on the risk factors causing the greatest loss of life/impact on the quality of life due to disability or premature death. A tailored offer will be available for our Core20 populations which will be culturally specific. This will be supported by the relevant contracting structures and financial levers and incentives and will be integrated as part of the wider neighbourhood based care offer.
- We will see an improvement in the management and control of specific markers relating to diabetes, hypertension, lipids and cardio-vascular disease.
- Residents in south east London will report better self-management of their own health and wellbeing, with timely support available from health and care professionals across the sector as required.
- Residents will report an increase in trust in health and care services across the sector.

Frailty, Multiple Long Term Conditions & Dementia (1/3)

Why frailty, multiple long term conditions and dementia?

- Our population health needs analysis indicates that the most important demographic change for south east London over the next decade is the rapid expansion of the older population (65 years and above) which will increase to 15.3% by 2035. The fastest growth will be in the 65-74 and 85+ age groups. All boroughs in south east London will experience this demography change, however, there will be marked expansions of the population overall specifically in Greenwich and Southwark who will see a growth in total population in the order of 10% each. The highest numbers of individuals aged 65 years and above will remain in Bexley and Bromley.
- This demography shift will create increased pressure on health and social care services for older adults, particularly for frailty and long-term conditions. For example:
 - Risk of stroke increases with age and is associated with greater medium and longer-term health and care needs. Our data shows that our inner-London boroughs report persistently higher rates of stroke admissions than the London average. Given our ageing population, the incidence of stroke is likely to increase with time.
 - The number of people with multiple long-term conditions also increase with age with 57% of people with multiple long-term conditions are aged over 65, compared with only 11% of the overall south east London population. With an ageing population, the number of people with multiple long-term conditions are likely to increase.
 - Our data shows that emergency attendances for those aged 65 years and over has increased by roughly 4% year on year since 2022/23. Assuming that the rate of emergency attendances per 1,000 of the 65+ population remains the same and given the project increase in this age group, south east London could see as many as 135,000 emergency attendances for people aged 65 years and above by 2035, a rise of 44% (see Figure 7 on the next slide). This could be higher without any further mitigations.
 - There could be a significant impact on district nursing in south east London, a service already experiencing demand and capacity challenges. In 2022/23 the rate of referrals for district nursing was 196 per 1,000 population and in 2025/26 this increased to 208 per 1,000 population. If the rate of referrals and contacts per 1,000 of the 65+ population remains static, with the projected increase in the 65 and over population, south east London could see 63,000 referrals a year to district nursing (see Figure 8 on the next slide) and 1.24 million contacts a year by 2035.

Frailty, Multiple Long Term Conditions & Dementia (2/3)

Why frailty, multiple long term conditions and dementia cont.

Figure 7: Projected emergency department attendances in south east London for patients aged 65 years with no change to current service provision (i.e. current rates of attendance remain the same)

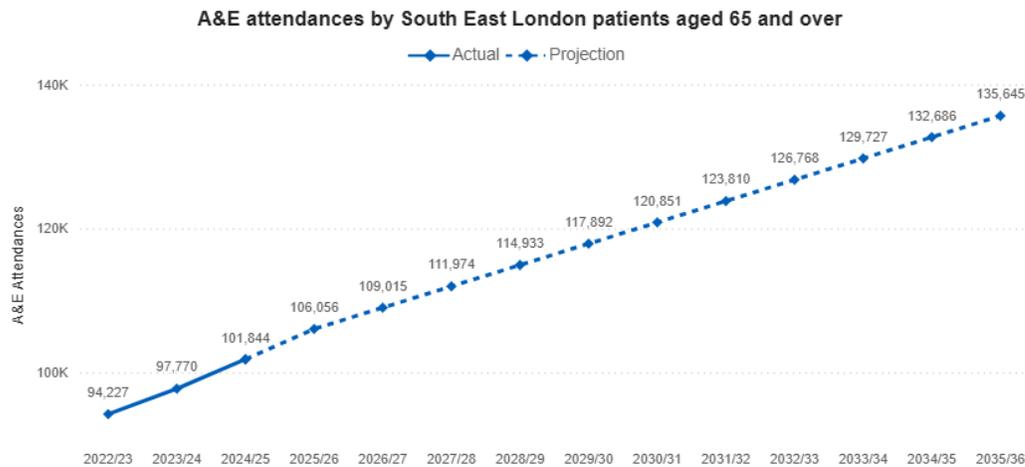
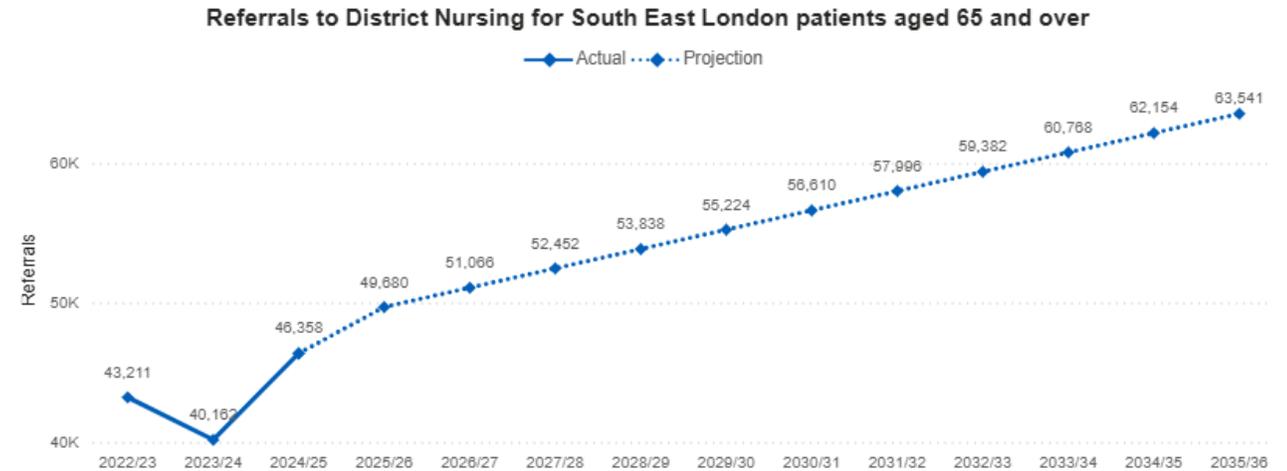


Figure 8: Projected referrals to district nursing for south east London should current rates of referral remain static and the over 65 population increases as per demographic projections



Frailty, Multiple Long Term Conditions & Dementia (3/3)

What action will we take

We need to focus both on improving care for our current older people's population to support them to stay independent and well in their communities, but also to focus on adults with rising health risks to support them as they age.

We will:

- Commission to ensure our integrated neighbourhood teams for frailty and multi-morbidity are embedded across the system, with a proactive and holistic mind and body approach. We will ensure these teams have a specific focus on falls prevention and management.
- Invest in community based services to support residents to be supported in their own homes wherever possible and to access timely reablement after a period of ill health or treatment admission.
- Invest in services to improve timely access to dementia services and post-diagnostic support. This will also help ensure our services are able to respond to the future pipeline for medicines for dementia and Alzheimer's care.
- Work in partnership with voluntary and community sector partners to support residents to access to screening services such as cancer screening and health checks.

What will be different for this population group

- People over 65 years of age will be able to access a range of services in their local community which are integrated and holistic across mind and body.
- We will see an improvement in the management and control of specific markers relating to diabetes, hypertension and cardiovascular disease.
- We will see a steadying of the number of people over the age of 65 years attending emergency departments and admitted to hospital to access care and support.
- There will be timely access to dementia diagnostic services and there will be a consistent post-diagnostic support offer available across all six boroughs as part of a wider neighbourhood based care offer.

System Transformation

Our four enabling delivery priorities

- The following sections of our plan set out the priority actions we are going to take forward to deliver our cross-cutting ambitions and population health outcome improvements.
- We will focus on **four programmes of work** to transform how we commission and deliver care to our population. These programmes of work sit alongside and will be underpinned and driven by our transformation care pathway programmes (see next side and Appendix 2), which also contribute to achieving our overarching objectives.
- The four programmes of priority focus and the rationale for them are:
 1. **Moving care from hospital to the community;** Our population have told us they want more care delivered close to home and in this section we set out our underpinning plans for developing a neighbourhood health system in SEL, delivering a more integrated model of preventative and proactive care, supporting our residents to stay well for longer, and contributing to overall sustainability of our healthcare system.
 2. **Moving from sickness to prevention;** a comprehensive approach to preventative care is key to making progress against our selected population health outcomes, supporting our residents to stay well for longer, managing demand for healthcare services and supporting overall sustainability of our system. This section sets out our SEL Prevention Framework and prioritised prevention interventions we will seek to deliver consistently over the next five years, with offer targeted where appropriate to ensure we are addressing inequalities as well as improving overall population health.
 3. **Moving from analogue to digital;** we aim to drive adoption of technological and digital solutions, which will enable us to make progress towards our overarching ambitions and improve overall experience of the system for our patients and clinicians.
 4. **Securing sustainable acute and specialised services;** the majority of the financial deficit in the SEL system sits within our acute sector, where we have also struggled to deliver on key performance and access targets for many years. This section sets out an approach which providers and the ICB will take to explore and identify solutions to these challenges, which will then be incorporated into our strategic commissioning plans.

Underpinning care pathway transformation

- Our care pathways are a key to delivering our four ambitions and span care sectors and pathways of care across multiple sectors and providers with an end-to-end commissioning approach.
- There is strong intersectionality across these care pathways with some providing core infrastructure and services for other care pathways. We will therefore ensure that priorities and improvements for these care pathways are considered as one where appropriate to do so.
- Our care pathways include:- (i) cancer; (ii) children and young people's services; (iii) learning disabilities, autism and special educational needs (SEN); (iv) long-term conditions; (v) medicines optimisation and pharmacy; (vi) mental health; (vii) palliative and end of life care; (viii) planned care; (ix) primary care (including general practice); (x) pre-conception, maternity and neonates; (xi) prevention, wellbeing and equity; and (xii) urgent and emergency care.
- All care pathways have a clear focus on improving patient experience of care, and securing the commissioning and delivery of high quality and safe services, and they all have their respective contributions to improving population health and addressing system sustainability.
- All care pathways include commissioning priorities and improvements that will:
 - Result in more care being delivered in the community;
 - Drive a shift towards preventative activity;
 - Enhance the use of digital tools within clinical services; and
 - Support the overall sustainability of our system.
- Pathway specific/service specific commissioning priorities and improvements for all care pathways can be found in Appendix 2.

Hospital to Community

Moving care from hospital to the community

Over the next five years we will develop a neighbourhood health system across SEL, improving collaboration, coordination and transforming how our system operates. Our initial focus will be implementing integrated neighbourhood teams to improve care for three priority population cohorts

- Our population have told us they have positive views on moving care into community settings or delivering care at home, acknowledging that social care and VCSE are key partners, but that not everyone's home is suitable for receiving care. Our population also tell us they want better communication across services and for services to take a more integrated and holistic approach
- In south east London, development of neighbourhood health is a key priority through which we will deliver what our population want, as well as enabling us to deliver a more integrated model of preventative and proactive care, through a population health management approach, which supports our residents to stay well for longer, and contributes to overall sustainability of our healthcare system.
- All Places in south east London have been working for a number of years to increase levels of collaboration and integrated working between health, social care and the VCSE through community based care and this work is a continuation of that improvement and change journey.
- Our neighbourhood approach 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 will be a significant transformation in how our system will operate.
- A key (but not the only) element of delivering neighbourhood working will be the establishment of integrated neighbourhood teams (INTs). We have developed an overarching INT Framework to shape and guide how neighbourhood ways of working and the INTs that are central to this are implemented in SEL. This provides a consistent narrative on the approach being taken across SEL and a clear articulation of the common end point all Places are working towards, noting that starting points are different for each Place.
- The following slides set out some key information around what we mean by neighbourhood working in SEL, what we want our INTs to do and our initial INT priorities.
- Further information on our plans to move care from hospital to community can be found in our care pathway sections in appendix 2; this is a particular focus for many pathways, particularly planned care and urgent and emergency care

What we mean by neighbourhood working

A neighbourhood health service will bring people, services, and communities together to help everyone live healthier, more active, and independent lives. Neighbourhood working is not an additional service that sits alongside or overlays existing care pathways and services. Instead a key focus is on joining up care and support through integrated neighbourhood teams, especially for those who need extra help. This reflects a significant cultural change in how our system will operate together.

But, neighbourhood working must go beyond treating illness. It needs to support people to stay well throughout their lives by addressing the wider factors that affect health, such as housing, employment, education, and social support. Local councils and voluntary and community organisations play a vital role alongside health services to provide support that fits people's daily lives.

Neighbourhoods

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

Multi-disciplinary working

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

Integrated Neighbourhood Teams

Representatives from different disciplines (e.g., health, social care, voluntary sector) working as a single team to deliver coordinated and person-centered care to individuals within a defined neighbourhood or locality. There is an emphasis on integration and continuous collaboration around prevention for growth and pro-active care to improve outcomes, reduce duplication and address complex needs more efficiently.

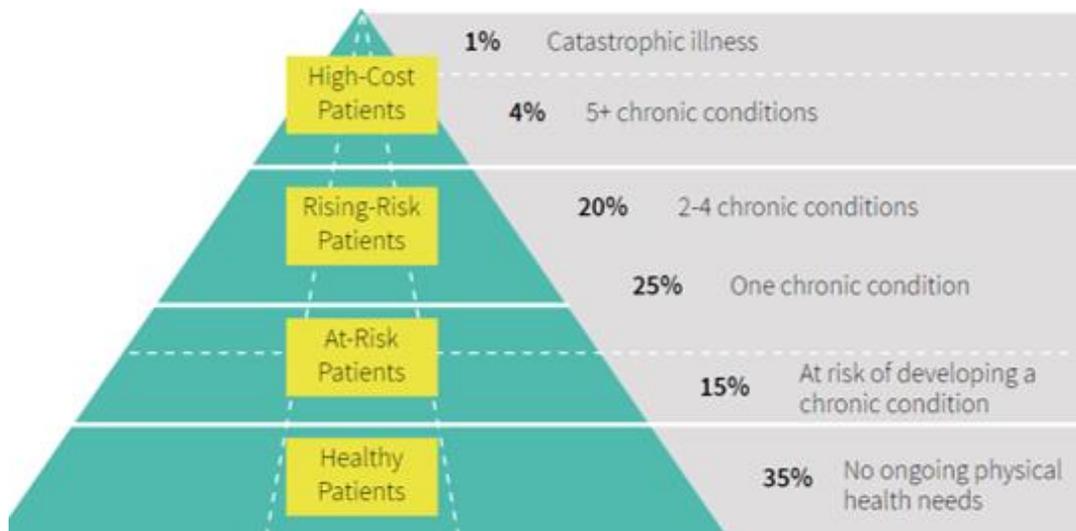
Building our approach to neighbourhoods over the medium term

Ongoing development of neighbourhood care will fundamentally change how care is delivered to our residents in SEL. As with other ICBs, our priorities for neighbourhood health and care are aligned with local population need and our 5 year strategic commissioning plan. This plan **supports a 'modular build' of neighbourhood working in an incremental and staged way.**

1. For phase one of neighbourhoods approach, we have been focussing on redesigning care and developing integrated neighbourhood teams for three priority populations. People living with 3+ Long Term Conditions – initially starting with those living with 3 or more renal cardio-metabolic conditions and then expanding out aligned to local population needs
 - People living with frailty and those approaching the end of life
 - Children and young people – initially starting with those living with complex physical needs before expanding out to other children and young people who require additional support
2. Over the medium term, we will move forward with seven key delivery priorities that will set the foundations for neighbourhood working, to ensure a consistent approach across SEL and delivery of a robust core offer for our population. There will of course be nuance in delivery at local level based on specific population need and local neighbourhood delivery plans. The delivery priorities are based on national requirements as well as local SEL need. The delivery priorities are set out below, and more information on borough delivery plans for these areas can be found in Appendix 3 .
 1. Develop neighbourhood footprints around natural communities
 2. Ensure good access to high quality general practice
 3. Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'
 4. Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).
 5. Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs
 6. Improving planned care in the community (linked to work to redesign outpatient care)
 7. Improving care for children and young people as part of neighbourhood working
3. As the foundations for neighbourhood working embed consistently across South East London, we will widen our focus to an all-age, whole population approach. This will include ensuring ever-increasing integration between neighbourhood health services and wider public and voluntary and community services within a neighbourhood.

26/27 priorities

- We will need to balance effective and well-targeted support for our patients with the highest need - where there are more immediate opportunities to support a “left-shift” between care delivered within the hospital and care delivered within neighbourhoods – with building the foundations for a broader neighbourhood model that meets the need of our whole population and ensures support is provided earlier to avoid poorer health and wellbeing outcomes in the future. The picture below outlines how we will target investment to achieve this balance in 2026/27.



Team of teams approach for patients with highest need integrating proactive care via INTs, multi-speciality input, physical and mental urgent and reactive care services and end of life

Proactive integrated Neighbourhood teams supporting patients living with multiple Long-Term Conditions – a core team with specialist in reach

Strengthening consistency, and **levelling up primary and community support for LTC** identification, care planning and management

Targeted proactive care and support model for those at risk of developing chronic conditions in the future due to entrenched health inequalities

Neighbourhood Asset-Based Health Promotion and Prevention (including work and housing) Offers tailored to specific need of resident neighbourhood population

Underpinned by **core capacity infrastructure and support for integrated neighbourhood development and delivery**. Investment priorities are driven by areas of development identified in the maturity assessment/neighbourhood development plan and includes investment in integrator partnerships to support system leadership and change management capability and specific areas of infrastructure support that address gaps or needs identified in the neighbourhood development plan.

What we want our INTs to do

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

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

In SEL, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g., addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs**, through a combination of integrated working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities**, to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders**, holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all SEL residents receive the same standards of care**,⁹⁷ wherever they live and whatever their individual needs.

Supporting and enabling delivery

Ambition	How will this priority support delivery?
 Improving Population Health	Neighbourhood based care will deliver a more integrated model of preventative and proactive care across SEL. This core offer should support our residents to stay well for longer. A core population health management approach alongside development of integrated neighbourhood teams will support at those with highest needs through an integrated approach designed to manage their care in the community
 Addressing System Sustainability	A more preventative and proactive approach to care will help to manage future demand for healthcare services. Delivering more care in the community will support sustainability of our acute sector, recognising that acute sector transformation will be needed to support and respond to neighbourhood working.
 Improving Experience of Care	Our population have told us they have positive views on moving care into community settings or delivering care at home. Our population also tell us they want a more integrated and holistic approach to care.
 Securing the Commissioning and Delivery of High Quality and Safe Services	We will take a strategic approach to commissioning neighbourhood based care, with a focus on ensuring the commissioning approach acts as an enabler. Neighbourhood based care will also support delivery of high quality acute services but ensuring only patients who need hospital based care need to access these services

Enablers	How will we enable delivery of this priority?
Financial approach	We have committed to core inflationary uplifts being applied to all relevant budgets and contracts and core annual baseline growth to support the delivery of required service and care pathway changes. This will support ongoing delivery of services which underpin neighbourhood delivery. Alongside this, we have included “supporting development of neighbourhoods” as a key priority for use of our Strategic Investment Fund. This investment will be used to support development of both infrastructure required for neighbourhood care and development and delivery of integrated neighbourhood teams
Contractual approach	We await new national contract forms and guidance related to neighbourhood working. In the mean time, locally we will develop a commissioning and contracting approach, that works through existing contracts and Memorandums of Understanding to build shared accountability across partners for neighbourhood working
Working with our population	Our “working with people and communities strategic framework” sets out how we will work differently with our communities. People will engage in development of neighbourhood based care through borough based engagement approaches, including through an increasing role for Health and Wellbeing Boards
Working with our partners	We will continue to work with our Integrator organisations and local partners to develop and deliver a core consistent approach to neighbourhoods which can be tailored for local need

Commissioning Principles

1. **Neighbourhoods are one part of an overarching strategic commissioning plan:** need to be triangulate across whole care pathway transformation, population cohort/segment approaches and broader neighbourhood working within defined geographical footprints to deliver neighbourhood care in a way that effectively contributes to other strategic objectives.
2. **Commission strategically:** invest in population cohorts (*adults with complexity, CYP with complexity*) built from data capturing a range of need and risk factors.
3. **Commission coherently:** Gradually move away from individual provider plans & activity. Neighbourhoods as one of the core units of delivery (alongside. Net costs supported to create a scaled integrated pathway – (with partners) align interventions, design a contract ‘wrapper’ & share outcomes.
4. **Ensure time to develop and embed for maximum impact.** We need to take a long term approach to neighbourhood planning and commissioning, including strengthening the foundations for neighbourhood care at scale whilst building interventions through a modular approach. Plan for a multi-year transformation
5. **Invest boldly and prove concept:** Prioritise refinement & full implementation of evidence-based 'big bets' over a long list of new initiatives, pilots and/or existing approaches that are not delivering. Start with higher complexity / risk + interventions that generate a faster / higher ROI. This will improve system confidence in longer-term plans and generate savings to reinvest and scale
6. **Measure success on outcomes rather than activity:** noting this may need to be supported by shorter-term process or output measures to understand impact trend.
7. **But understand impact on activity and cost:** We need this to enable sustainable resourcing plans to be enacted. Noting particularly that activity shift does not lineally equate with provider cost-base reduction. We will need to be smart about how we use our collective resources differently to underpin delivery plans (particularly workforce planning and estates planning). Longer-term ambitions on cost reduction need to be aligned with achievable provider transformation plans which will reduce cost base.
8. **Pace of change will differ** by population, and is dependent on readiness of neighbourhoods to respond. Equally investment may also need to be differential. These sensitivities should be built into system modelling and planning and over-time allocative approaches and we must balance need, opportunity and readiness.
9. **We must be agile and learning-focussed:** Not everything we do will work for all our population. We need to have systems and processes to track impact in real-time and adjust plans in-line with evidence.

Sickness to prevention

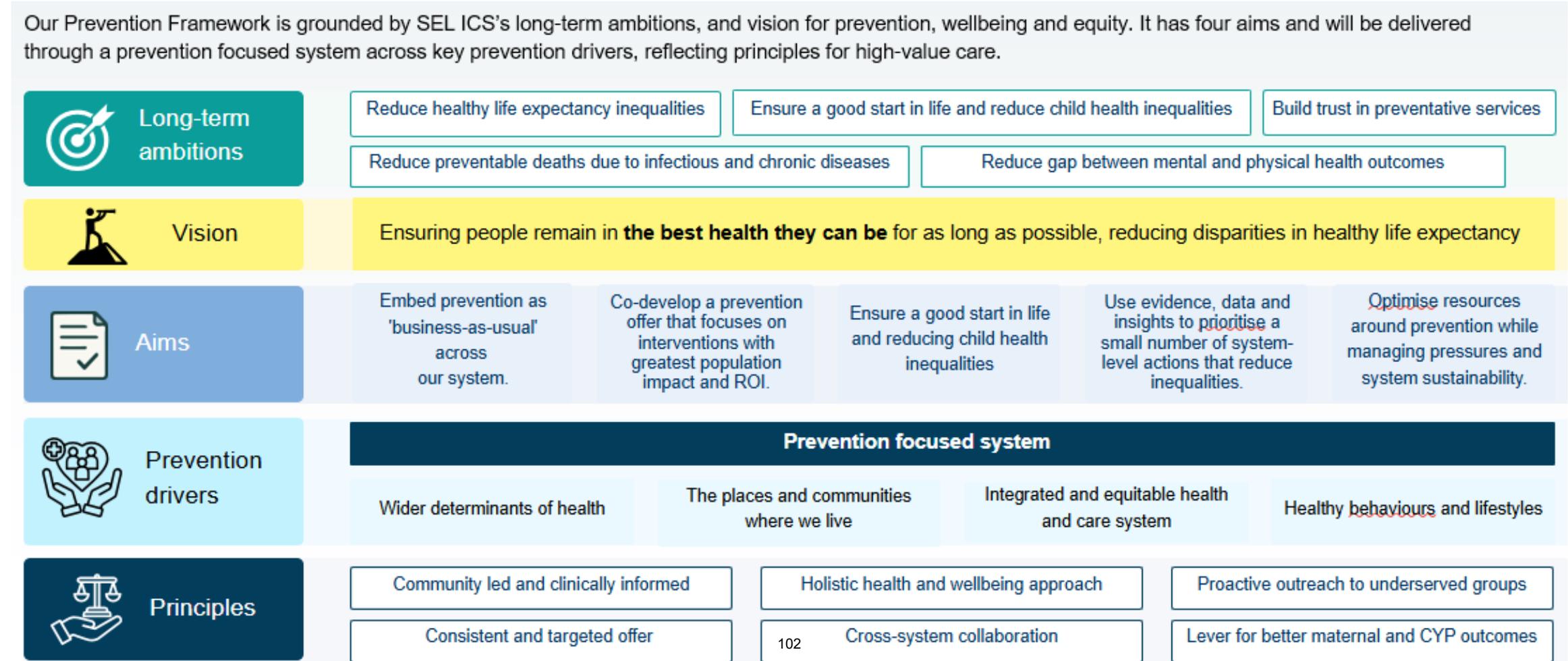
Moving from Sickness to Prevention

Over the next five years we will implement our south east London Prevention Offer across the life course, taking both a universal and targeted population approach to commissioning key preventative interventions for our key population groups which will support improvements in population health

- A shift in focus and resource from sickness to prevention has the potential make a material difference to the health of our populations, as well as managing the increase in demand that we see for healthcare services, ensuring we can deliver sustainable accessible and responsive services for the future. Although there are many current positive examples of impactful prevention initiatives we currently lack an outcomes-based, systematic, coordinated and consistent approach to prevention and existing efforts are not doing enough to drive population health improvement and address health inequalities.
- We know that the “vital 5” indicators in adults (tobacco dependency, alcohol, unhealthy weight, high blood pressure and mental health) are key health risk factors which cause the greatest loss of years of life due to disability or premature death in south east London. They are significant contributors towards the variation and inequality in life expectancy that we see across our boroughs, alongside other determinants of health and further impact on quality of life for many residents.
- We also know that prevention needs to be considered across the life course and that one of the biggest impacts on a person’s overall life expectancy is childhood. We therefore need to ensure we have an emphasis on securing the best outcomes for children and young people and also at pre-conception to give our residents the best possible start to life, which will have further benefit as those children and young people move to adulthood.
- The following slides set out a summary of our south east London prevention framework, key aims and priorities, and prioritised interventions that we will seek to commission over the next five years. This has been developed with input from a wider range of partners and stakeholders and given prevention spans more than just health, we will continue to work in partnership with Local Authorities through place-based partnerships to facilitate aligned commissioning for public health and wider determinants.
- Further information on our plans to move care from sickness to prevention can be found in our care pathway sections in Appendix 2; this is a particular focus for many pathways, particularly cancer, long term conditions, children and young people and maternity and neonatal.

South East London Prevention Framework - Aims

Our Prevention Framework is shaping strategic commissioning with a ‘multi-year’ horizon focused on population health equity and system sustainability, and in partnership with our local authorities.



South East London Prevention Framework - Priorities

Our Prevention Framework and offer is built on three interconnected tiers:

1. **Universal prevention** – interventions under this tier are all eligible residents, regardless of risk status or post-code, with an aim to promote overall health and wellbeing, reduce lifestyle risks and prevent infectious disease.
2. **Targeted prevention neighbourhood offer** – this will enable early detection and intervention targeted and tailored to the needs of neighbourhoods most at risk of rising healthcare needs and those experience inequalities, in particular our Core20PLUS5 populations.
3. **At scale secondary and tertiary prevention** – interventions in this tier will be delivered across neighbourhoods or pan-borough with links back into community-based services

In developing our prevention priorities, we have:

- Considered the range of interventions available across these three tiers, identifying opportunities to work in partnership with local authorities to align our commissioning priorities ensuring we have a consistent approach to universal prevention across all six boroughs in south east London.
- Ensured we have an all ages approach to prevention across a life course.
- Considered our priorities across the three tiers from the lens of:
 - Modifiable behaviours – these are interventions and actions that will have a much longer impact on population health (i.e. beyond 10 years).
 - Risk factor identification and management – these interventions and actions will have an impact within 10 years.
 - Cardiovascular disease - recognising this is leading cause of premature death and disability and a wide range of associated long term conditions. Reducing deterioration in those with multiple of single long term conditions and providing proactive care and support will be vital in terms of supporting quality of life, improving health outcomes and managing healthcare demand.

South East London Prevention Framework – Priorities

Cont.

1. Universal

- Vaccinations and immunisations for maternity, children and young people and adults.
- Consistent health promotion campaigns and messaging (e.g. encouraging healthy lifestyles and choices, raising awareness of preventative support and services).
- Increasing number of brief interventions and advice – with a Making Every Contract Count and ‘if you see it act on it’ philosophy and approach.
- Screening and detection (including cancer screening, antenatal screening, health checks and diabetic screening).
- Implementation of infant feeding strategy across SEL.
- Universal support offers for CYP mental health and emotional wellbeing.

2. Targeted through Neighbourhoods

- Proactive case finding, detection and management of risk factors (e.g. through Vital 5 check, hypertension and lipid testing, health checks for learning disabilities and severe mental illness).
- Pilot teen health-checks.
- Targeted outreach including roll-out of community health and wellbeing worker models and outreach linked to women’s and girls’ health hubs.
- Structured medication reviews.
- Targeted lung health checks.
- Health input to support first 1001 days through family hubs.
- Access to point of care testing.

3. Secondary & Tertiary Prevention

- Optimisation of identification and management of high blood pressure in all healthcare settings.
- Weight management and obesity pathway across all ages.
- Access to community-based rapid access heart valve assessment clinics to ensure timely diagnosis and treatment of aortic stenosis.
- Expansion of integrated smoking cessation pathways including Ottawa.
- Falls prevention and management.
- Pulmonary rehabilitation and cardiac rehabilitation programmes
- Roll out of waiting well services to support healthy lifestyle and behaviour change and readiness for treatment/surgery.

Supporting and enabling delivery

Ambition	How will this priority support delivery?
 Improving Population Health	Increasing our focus on commissioning core preventative interventions will help keep our residents healthy for longer. Our supplementary targeted approaches for particular population cohorts will focus support on those that need it most, reducing the inequalities in access and outcomes that we currently see
 Addressing System Sustainability	A more preventative approach to care will help to manage future demand for healthcare services, reducing or delaying the need for more intensive and costly interventions
 Improving Experience of Care	Our population have told us that increasing our focus on prevention is important, alongside better support for people to access these services in a way that works for them
 Securing the Commissioning and Delivery of High Quality and Safe Services	We will take a strategic approach to commissioning preventative care, considering what we already commission and how that can be improved alongside ensuring that new offers deliver high quality and safe services which are integrated as part of a whole system and whole person approach

Enablers	How will we enable delivery of this priority?
Financial approach	We have committed to core inflationary uplifts being applied to all relevant budgets and contracts and core annual baseline growth to support the delivery of required service and care pathway changes. This will support ongoing delivery of existing preventative services. Alongside this, we have included “prevention” as a key priority for use of our Strategic Investment Fund. This investment will be used to support commissioning of key evidence based system wide prevention interventions; roll out of our SEL core prevention offer and targeted approaches focussing on specific neighbourhoods which experience health inequalities
Contractual approach	We will embed clear expectations around prevention outcomes and intervention delivery in contracts – including through aligned incentives and new multi-provider contract forms.
Working with our population	Our “working with people and communities strategic framework” sets out how we will work differently with our communities. Specifically for prevention, we will partnership with VCSE to support community engagement and health creation and put in place mechanisms for feedback from residents and service users to inform strategic commissioning.
Working with our partners	We will work with our partners including public health and local authorities to ensure we have aligned commissioning approaches to enable delivery of the framework across the system. We will also actively collaborate with the voluntary and community sector alliance and our commissioned providers to support delivery of our ambitions.

Analogue to digital

Analogue to digital: our case for change

Over the next five years we will drive adoption of technological and digital solutions, which will enable us to make progress towards our overarching ambitions and improve overall experience of the system for our patients and clinicians

- The NHS 10 year plan makes clear that the digital and technological changes that have impacted other areas of our lives, and other healthcare systems around the world, have not yet come to the NHS at scale.
- Through our strategic commissioning plan, we aim to drive adoption of technological and digital solutions, which will enable us to make progress towards our overarching ambitions.
- The following slides set out additional detail for our priorities for digital improvement over the next five years:
 - Ensuring core and mandated digital GPIT services
 - Delivering national digital priorities locally in SEL
 - Supporting the adoption of AI in the system
 - Enabling Neighbourhood Health Services through Connected Care
 - A strategic approach to supporting adoption and inclusion of digital solutions in our commissioned care pathways

Ensuring Core and Mandated Digital GPIT Services

GPs are a cornerstone for people and communities across SEL. One of our priorities is ensuring we deliver the Digital services and tools practices need to support high quality patient care. Below are the key priority areas we will address.

We will provide practices with access to all core and mandated digital capabilities described in the GPIT operating model

Including:

- Foundation and non-foundation digital systems and transformation services (clinical systems, document management and referral management platforms, demand capacity planning tool, care navigation, interoperability for PCNs, patient online services)

We will maintain Local Policy and Operational Controls

Including maintaining, developing and enforcing ICB-level policies to govern:

- GP IT asset management
- Software standards and patching
- Authentication and identity systems and integration with the National Shared Tenancy
- Business continuity planning
- Supporting the rollout and adoption of the National Digital Services e.g. e-Rs, GP connect

We will commission GP IT Enabling Services

Including:

- IT infrastructure (networks, devices, connectivity)
- Managed GP IT support services including Service Desk and Registration Authority
- Specialist support (clinical safety, cyber security, information governance)

We will use approved procurement routes

Including:

- engaging with the NHS England Commercial and Procurement Hub when procuring digital tools and systems that meet the required national capabilities.

Enabling Neighbourhood Health Services through Connected Care

Enable digital solutions for improving interoperability across Neighbourhoods

- Defining the direction of travel to enable digital solutions for interoperability and integration of key strategic EPRs to support at scale neighbourhood health services work aligned to the NHSE 10-year plan through alignment of existing EPRs across primary, secondary and community care settings.

Population Health management and risk stratification platform

- We will continue to build on our collaborative work with partners in London to bring data together and then use this to support population health analysis. This will enable us to improve our Population Health Management analytics and to plan and deliver proactive care, via Integrated Neighbourhood Teams. This will also improve the tools available to INTs to support people and communities.

Improved referral management

- A unified and streamlined referral and self-referral platform integrated with electronic patient records in SEL.
- Working with NHSE to understand the path for integration of the NHS e-Referral Service for all providers ensuring integration with electronic patient records in SEL.

Unified Care record and Care Plan

- Continued expansion and adoption of London Care Record and universal care plan across health and care settings and partners, in collaboration with London partners.

Remote monitoring and wearables

- Enable seamless patient care across all settings by establishing step-up and step-down pathways between virtual wards and remote patient monitoring services. Including extending the use of wearable technologies as standard practice for preventative, chronic, and post-acute NHS treatment.

Infrastructure and equipment to support INT

- Support INT, PCN's, Care Homes and other Community services to deliver optimal care by minimising delays to care by speeding up workflows and enabling quick access to patient records and clinical data.
- We will also enable a single Wi-Fi solution across SEL such as Gov Roam as an 'overlay' to all existing Wi-Fi solutions across the ICS for a seamless access in all participating organisations.

National priorities

We are working with national and regional teams to deliver digital capabilities aligned with the NHS 10 Year Plan as follows:

The Single Patient Record
<ul style="list-style-type: none"> • SEL will work with the regional and national teams to offer a secure, unified health history accessible by clinicians and patients alike, promoting coordinated care. The architecture of SPR is currently being defined and could utilise existing technologies such as the Federated Data Platform, London Data Service, London Care Record and/or other shared care records. • SEL is in a strong position to feed into the Single Patient Record as it has the second largest utilisation of the shared care record nationally and continues to work on advancing coverage as well as increasing usage through service enhancements and user feedback.

NHS App
<ul style="list-style-type: none"> • NHS SEL has a strategic plan to improve the patient journey by improving usage of NHS app features and empowering people to manage health by giving them targeted access to prevention services such as vital 5 healthchecks, remote monitoring and self-management via wearable integrated with NHS app. • SEL partners are working with the NHSE Wayfinder team to integrate their existing patient portal solutions within the NHS app by the end of March 2026 with the longer-term plan being to digitise, connect, and transform health and social care in SEL by offering more features, personalising care, and giving patients greater control over their health management.

London and SEL Secure Data Environments (SDEs) and PHM decision support
<ul style="list-style-type: none"> • SEL are working with partners across London to bring health and care data together into a single integrated dataset. This will be used to support the development of population health management priorities and decision support tools for INTs and care professionals in SEL.

Federated Data Platform (FDP)
<ul style="list-style-type: none"> • All NHS acute, community, and mental health providers are reviewing the FDP's tools and use cases. There is an expectation it will start to be used by 2028/29. SEL ICB have an FDP tenant available and are reviewing the tools and products which may support future planning and commissioning requirements.

Artificial Intelligence (AI) in the SEL health and care system

We will continue to build on adoption of and effective use of AI and automation tools which will support our workforce and our clinicians to enhance patient experience, patient care and outcomes by:

AI assisted digital triage

- Enable the AI assistant embedded in the NHS App offering personalised support to patients and clinicians.
- Align primary care remote consultation procurement to the delivery of the My NHS GP - using AI-assisted triage models and data-driven pathways

Implementing the SEL AI Framework

- SEL has engaged the AI Centre for Value Based Healthcare to coordinate the governance and implementation of AI across our system, in accordance with the AI Framework ([AI framework](#)) which was developed collaboratively with stakeholders across the system earlier this year. This will support the effective and safe implementation of AI tools in a coordinated manner.
- We will use the framework to implement AI platforms for predictive analysis and in genomics to identify high-risk cohorts and predict disease-linked genetic variants to prevent ill health before it occurs.

AI Supporting Clinicians, Care Professionals and admin staff

- AI support to develop our data foundations and population health management, decision support and proactive care capabilities
- Develop and implement comprehensive strategies of Ambient Voice Technology (AVT) based on the current pilots taking place at many trusts and practices across SEL. This will reduce bureaucracy, admin workload and support clinical decision-making effectively.
- Incorporate AI/decision support tools into commissioning modelling.
- Operationalise the SEL AI Framework embedding cyber security, ethical AI and privacy controls as a matter of standard practice

Digital assurance and inclusion in commissioned care pathways

To support our care pathways effectively, we need to ensure the correct processes and support for staff and communities to interact with digital tools and systems are in place. We will be working on:

Digital inclusion
<ul style="list-style-type: none">• Collaborate and codesign, with voluntary sector and communities, tailored digital inclusion strategies at scale, starting with Women and Girls health hubs• Utilising charities such as Community Tech Aid and Good Things Foundation to support the digital inclusion programme• Develop cross-system inclusion strategy with targeted interventions

Ensuring System Resilience, Data Integrity, Cyber Security and Clinical safety
<ul style="list-style-type: none">• Maintain and develop robust clinical safety assurances and local clinical safety officer network (CSO network) for digital platforms through an ICB level framework aligned to the clinical safety standard• Ensuring robust delivery of the cyber security and system resilience strategy across SEL

Digital Confidence in NHS Workforce and Enable Outcomes-Led Commissioning
<ul style="list-style-type: none">• Success of digital milestones depends on NHS staff being confident with new healthcare digital tools and solutions. SEL plans to focus on workforce digital literacy through a digital framework supporting workforce development collaboratively.• Discovery workshops with digital and training leaders to define the digital literacy requirements for the SEL workforce as personalised career plans, AI literacy, and competency alignment empower the healthcare workforce for digital change• Enable outcomes led commissioning by using digital evidence to drive commissioning decisions, market shaping, and provider performance agreements.

Supporting and enabling delivery

Ambition	How will this priority support delivery?
 Improving Population Health	Bringing data together and then using this for population health analysis will enable us to improve our Population Health Management analytics, and to plan and deliver proactive care, which will improve our population’s health by targeting early intervention. Improving usage of NHS app features will give people the tools they need to manage their own health
 Addressing System Sustainability	Digital tools have the potential to allow our workforce to focus on patient care; increasing productivity through technology which works effectively and deploying AI as a supportive tool e.g. AI assisted digital triage. Technology to support neighbourhood care is also key to delivering the sustainability benefits of that priority
 Improving Experience of Care	People tell us how frustrated they are about having to tell their story multiple times. Better connecting care professionals and care records will improve this. New NHS App features will support people to access self care information and navigate the healthcare system more easily. We are conscious of managing risks around digitally inclusion
 Securing the Commissioning and Delivery of High Quality and Safe Services	<p>Driving adoption of technological and digital solutions will fundamentally improve our ability to provide high quality care to patients e.g.:</p> <ul style="list-style-type: none"> ensuring we deliver the digital services and tools that GP practices need to support high quality patient care, such as core infrastructure and referral systems Ensuring technology is used to enable and support our ambitions around neighbourhood care Continuing expansion of the London Care Record, universal care plans and single patient records so information can be seen and shared across settings

Enablers	How will we enable delivery of this priority?
Financial approach	We have committed to core inflationary uplifts being applied to existing budgets. Alongside this, we have included “digital” as a key priority for use of our Strategic Investment Fund. This investment will be used to support areas such as ongoing development of population health management, remote monitoring tools and CYP MH digital access
Contractual approach	We will engage with the NHS England Commercial and Procurement Hub when procuring digital tools and systems that meet the required national capabilities.
Working with our population	Our “working with people and communities strategic framework” sets out how we will work differently with our communities. We will collaborate and codesign, with voluntary sector and communities, tailored digital inclusion strategies.
Working with our partners	We will work with our partners to continue to shape our plans around analogue to digital, in particular engaging to ensure we have tailored digital inclusion strategies

Sustainable Acute and Specialised Care

Sustainable acute and specialised care

Over the next five years we will work with our five NHS Trusts to identify and implement solutions to address the underlying financial deficit and ensure Trusts are operationally sustainable

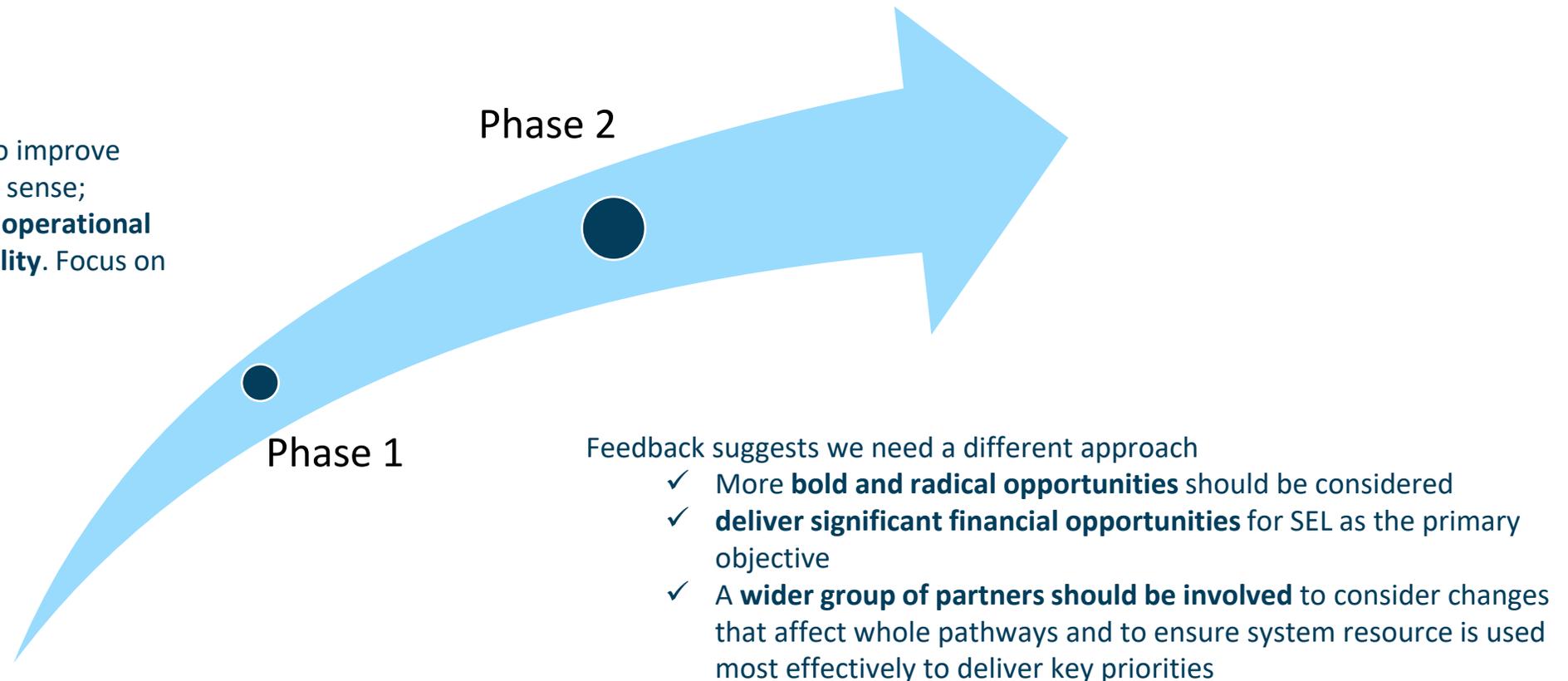
- In January 2024, the SEL Medium Term Financial Strategy for the SEL system was formally updated and described that, without the delivery of efficiencies and savings, SEL had an unmitigated system deficit of c.£300m. Most of this underlying deficit sits within our acute sector, however, there are financial and operational sustainability challenges in the mental health sector.
- Alongside this financial challenge, we have struggled to deliver against the key national and operational performance metrics for several years, and noticeably since Covid. There have been pockets of improvement, but a number of long-standing performance issues across UEC, elective, diagnostics, mental health access, and cancer services that are likely to continue without significant changes to pathways, radical changes in delivery models and / or investment.
- Whilst the ICB no longer has a role in supporting the overall system financial position, it is not beneficial to our local population if the Trusts they receive care from are not financially sustainable. It is therefore a priority for the ICB to work with our Trusts to identify and deliver changes which address the underlying financial challenge they face.
- Over 2025, the Trusts have worked collaboratively in SEL through our System Sustainability Programme, and more broadly across South London, to identify opportunities for transformation through collaboration and service. This has led to identification and delivery of specific projects but, so far, has not identified opportunities that will tackle the scale of sustainability challenge facing the system and make material inroads to the current and forecast underlying deficit, particularly for our acute providers.
- Given the ongoing scale of the challenge in the acute sector, the Trusts and the ICB have agreed that a detailed data analysis will be commissioned for acute and specialised services. The purpose of this analysis will be to point us to care pathway, service transformation and reconfiguration options which would reduce overall spend on hospital-based services and make our system financially sustainable.
- The options will build on and align to key themes within the commissioning plan, particularly around changes to pathways and opportunities to deliver more care in the community, to set out potential approaches to achieving financial sustainability. This will sit alongside and complement our care pathway transformation work which sets out approaches to operational sustainability, particularly around UEC, cancer and planned care.

Acute Clinical Services Collaboration

In recognition of the imperative to deliver large scale financial savings, the three acute trusts in SEL have been working together to identify strategic clinical collaboration opportunities to support system sustainability. The Trusts have also been collaborating with St George's in south west London, as part of a south London approach to potential opportunities within specialised services and more information on this can be found on the next slide

Identified opportunities to improve sustainability in its widest sense; **financial savings but also operational and workforce sustainability**. Focus on four services:

- ✓ **Breast**
- ✓ **Gynae**
- ✓ **Imaging**
- ✓ **Orthopaedics**



South London Specialised Services Sustainability Review

- The South London Office of Specialised Services (SLOSS, of which SEL ICB is a funding partner) has launched a sustainability review, to identify areas within the specialised portfolio that can be delivered more efficiently and sustainably, by taking a joined-up approach across the whole of South London.
- The aims of this work include:
 - **Financial sustainability:** Assess the financial viability, efficiency, and effectiveness of specialised services across South London.
 - **Performance and equity:** Review performance, equitable access, and outcomes across the specialised portfolio.
 - **Transformation and redesign:** Inform future transformation programmes, including opportunities for prevention, early detection, and care pathway redesign ("shift to the left").
 - **Strategic alignment:** Support whole system strategic and sustainability planning within South London and the wider South East region.
- Following a mapping exercise of existing projects and a significant amount of data analysis, two key areas of cardiovascular and paediatrics have been identified, with a number of proposals being worked-up through pan-South London workshops.

Step 1: Gather Insight

- Collated **existing projects and known opportunities** that are currently being progressed, to support networks with their delivery and consider expansion (e.g. paediatric and cardiac procurement).
- Conducted a **holistic data review** to understand where specialised services are being delivered across multiple sites, or with unwarranted variation in delivery/outcomes.
- Sought **provider, ICB and network insights** to supplement data analysis.

Step 2: Review & Assess

- Agreed **four opportunity types** for exploration (service reconfiguration, standardisation of clinical thresholds, amending referral flows, joint procurement).
- Agreed **two key specialities** to prioritise, due to their size and existing changes occurring in their South London provider landscape (paediatrics and cardiovascular).
- Worked up **potential opportunities** and discussed with partners at **two workshops**, to gain agreement to progress.

Step 3: Propose & Agree

- Working with key provider and ICB colleagues to **finalise proposals** including:
- **Paediatrics** – reviewing delivery models of several key sub-specialties, e.g. hub/spoke arrangements or elective-focused sites; protocol standardisation for MRI under GA.
- **Cardiovascular** – further joint procurement of medical devices; delivery of varicose vein treatments outside of hospital sites; ensuring effective use of all catheter lab capacity across South London, including at DGHs.

Acute Clinical Services Collaboration

Progressing our Acute and Specialised Sustainability Work

- The work undertaken to date, whilst helpful, has not delivered material inroads to the current and forecast underlying deficit across SEL's acute providers. The acute Trusts and the ICB have therefore decided to collaboratively commissioning a piece of detailed data analysis.
- The overall purpose of this analysis will be to point us to care pathway, service transformation and reconfiguration options which would reduce overall spend on hospital-based services to make the South East London system financially sustainable.
- The outputs of this work will be:
 - **Current State Assessment;** Baseline analysis of system-wide activity, cost, and productivity, benchmarked against peer and national averages
 - **Population Health Assessment;** Analysis of current and future population need, with impact on acute and specialist services modelled. Scenario modelling of opportunities to reduce demand and increase equity.
 - **Clinical Service Insights;** Identification of specialties or pathways with the largest improvement potential, and recommendations for redesign, transformation and/or consolidation which would deliver financial benefit.
 - **Actionable Recommendations;** Prioritised actions for system leaders. Assessment of impact of interventions with relevant forecasts.
 - **Monitoring & Evaluation;** Key metrics and dashboards to track progress, plus recommendations to strengthen data collection and reporting

Acute Clinical Services Collaboration

Links to our Care Pathways

- Our work on an acute clinical services review to identify proposals to support sustainability of the acute sector in SEL will sit alongside and complement our care pathway transformation work
- Over the last few years our care pathways have focused on national, regional and local delivery priorities, often around operational sustainability and improving performance against key targets
- Appendix 2 sets out our care pathway priorities for the next five years and how we will build on work to date to support a more sustainable acute sector over the coming years. Some examples are set out below:

We need to reduce demand and reliance on acute urgent and emergency care services and shift appropriate urgent care from the hospital into the community. We will:

- Work with system partners to commission whole pathway approaches, e.g. reducing risk of admission by working with INTs and maximising community alternatives
- Implement commissioning incentives that maximise use of same day urgent care provision available in other parts of the system
- Commission services that enable patients to navigate services based on need including pathways for patients with complex social and health needs, e.g. high frequency users.

We need to ensure that people at the end of life, carers and professionals can access appropriate services 24/7 – with non-specialist palliative care support being the first port of call, so that specialists can support those with complex needs. We will:

- Work with partners to implement and monitor improvements to the current Out of Hours service provision across South East London
- Commission a sustainable solution to access to injectable medicines for symptom control at the end of life
- Develop a standard service specification, building on learning from other parts of the country, for what a widely recognised and accessible to all 24/7 phone line should deliver, resulting in a pilot of a 24/7 advice line

We will Reduce Waiting Times to Diagnosis and Treatment. We will:

- Work with providers to increase diagnostic capacity where modelling indicates sustained demand pressures and to prioritise Cancer patients within available capacity.
- Increase access to early diagnostics and specialist advice in primary care, reducing unnecessary referrals and improving first-contact decision making.
- Support providers to implement digital tools (AI triage, ITT tracking) to identify delays and improve pathway flow

We will prioritise optimising access to hospital elective care so people are assessed promptly and seen in the most appropriate setting first time. We will:

- Expand access to high-quality advice and self-management offers, using system improvement and oversight forums to set priorities and monitor delivery.
- Work with providers to embed referral assessment in appropriate specialties.
- Support the agreement of standardised referral criteria across SEL in priority specialties to promote consistency in referrals and triage outcomes
- Support the development of community-based alternatives in high-volume pathways, reducing avoidable hospital referrals.

Mental Health Services Collaboration

- It is recognised that mental health services are not experiencing the same pressure as the acute sector, however, the sector has seen a growth in demand and referrals for most services since the Covid pandemic which is not sustainable without service transformation and change.
- There are also significant opportunities to consider productivity and efficiency gains across these services, including the integrated front door offers across mental health services, consistent and core standards and use of digital/AI both for workforce but also within clinical care pathways.
- Collaboration across the two mental health trusts through the system sustainability programme has focused on the following areas to date, noting that the Trusts also collaborate in other areas, including through the South London Partnership with SWL and St George's.

Acute & Crisis Care

- Reducing duplication across NHS 111 Press 2 services and Crisis Lines
- Ensuring an equitable and consistent offer is place for children and young people in crisis across south east London

Children and Young People's Mental Health Services

- Ensuring an equitable and consistent offer is place for community child and adolescent mental health services across south east London
- Developing and testing new approaches for digital therapy delivery within children and young people's mental health services

Adult ADHD Services

- Development of consistent referral guidelines across the sector, embedded into a new Referrals Triage Service
- Sharing of best practice and models of care to reduce waiting times for ADHD assessment and treatment

- These priority areas will remain a focus of partners over the medium term and are reflected as part of the Mental Health and Learning Disabilities, Autism and SEND care pathway sections in Appendix 2.

Supporting and enabling delivery

Ambition	How will this priority support delivery?
 Improving Population Health	It is not beneficial for our population if the Trusts they receive care from are not financially sustainable. Operational sustainability is key to population health, ensuring our population can access and receive care in a timely way
 Addressing System Sustainability	The core purpose of this priority is to address the sustainability of our NHS Trusts, recognising that the majority of our system underlying financial deficit sits within our acute providers and where we have a number of long standing performance challenges
 Improving Experience of Care	Our population tell us that they wait too long to access care. Achieving operational sustainability is key to ensuring our population can access and receive care in a timely way
 Securing the Commissioning and Delivery of High Quality and Safe Services	Working with our Trusts to support them to achieve operational sustainability and deliver on core targets is key to ensuring our patients can access high quality and safe services

Enablers	How will we enable delivery of this priority?
Financial approach	We have committed to core inflationary uplifts being applied to all relevant budgets and contracts and core annual baseline growth to support the delivery of required service and care pathway changes. Alongside this, we have included “acute and specialised services” as a key priority for use of our Strategic Investment Fund. This investment will be used to pump prime and recurrently support initiatives which support delivery of a sustainable acute sector. For 26/27 this is likely to include targeted schemes in advance of funding for proposals identified through the commissioned work
Contractual approach	We currently contract with our acute trusts on a fixed API basis. As the priorities set out in this plan progress, we will continue to review and consider the contractual approaches which best enable us to meet our overarching delivery objectives
Working with our population	Our “working with people and communities strategic framework” sets out how we will work differently with our communities. We will involve our communities in early discussion about proposed changes to the way services are delivered
Working with our partners	The ICB and Trusts have a collaborative relationship and will work together to identify proposals and develop approaches to enabling delivery

Enabling the change

Quality Improvement and Oversight

We will focus on ensuring the services we commission are safe, effective and provide a positive experience of care with quality improvement and oversight embedded into every stage of the strategic commissioning cycle.

Quality improvement and oversight is already embedded within this strategic commissioning plan.

- ✓ Our strategic commissioning plan is based on our **population health needs assessment** to ensure that we understand the needs of our residents and communities, and are focusing the commissioning of services to truly improve population health and reduce health inequalities.
- ✓ Our cross cutting ambitions have been developed not only by building **an understanding of the existing quality of our commissioned services**, but also in **response to feedback we have received from our residents and communities** on what is important to them.
- ✓ In identifying our commissioning actions, we are actively responding to feedback from our residents, but also ensuring we are **commissioning evidence-based interventions** with a focus on **delivery of key population-based outcomes** over a longer period of time.

In taking forward our commissioning strategy and in our role as strategic commissioners, we will:

- Use a data driven approach to understand the impact of our strategic commissioning plan for our population, supported by a robust evaluation framework with quality at the heart of this.
- Develop and implement a quality oversight model for our commissioned services that uses data to identify, monitor, and escalate risks proportionately across providers and sectors, aligned to national strategies including the National Quality Board guidance. We will use a tiered approach which ensures timely identification of concerns, targeted intervention, and a consistent return to improvement and learning cycles. A high level summary of this approach is set out in Appendix 4.
- Ensure we have the relevant processes in place to embed learning from patient safety insights, feedback and benchmarking to drive ongoing commissioning improvement. This will include learning from our ongoing ICB statutory duties for quality.
- Embed Equality Quality Impact Assessments as part of our commissioning cycle (see next slide).

Understanding and addressing Equality Quality Impact

Equality Quality Impact Assessments (EQIAs) are important risk assessment tools which will help ensure that the services we commission are equitable, inclusive, accessible and safe for the communities we serve, and consideration is given to the quality of provision and effect that this may have on patient outcome or experience and staff experience.

Our Overall Approach for EQIAs

- EQIAs are an enabler to support strategic commissioning and will form a key part of our decision-making. We do already have an established EQIA process, however, we have an opportunity bring together our existing tools to evaluate effectiveness, and fairness simultaneously
- As an ICB, we will be using EQIAs across a two tiered approach:
 1. To assess our commissioning plan to assess our overarching and general principles for commissioning and to ensure our allocative approach ensure equitable access.
 2. For individual commissioning or service changes that stem from our commissioning. This includes the commissioning of new services, decommissioning of existing services, review/changes to existing commissioned services, procurements and contracts for commissioned services.
- Our approach is guided on the principles of proportionality and value adding, with a risk-based assessment that considers the level of service provision/change being proposed, financial risk and the level of inequalities.

EQIA Approach for our Commissioning Plan

- Our commissioning plan is based on our population health needs assessment which includes identifying areas of inequalities and our under-served communities. This has therefore formed the basis of our EQIA.
- We have undertaken an equality and quality impact assessment screening tool for our commissioning plan. This indicates positive outcomes for people with protected characteristics, particularly for age, disability, race, pregnancy/maternity, socio-economic/deprivation and digital inclusion. Furthermore, the commissioning plan is considered to have a positive impact on patient safety, clinical effectiveness and patient experience.

ICBs as strategic commissioners and the enabling role of our allocative strategy

Medium Term Financial Strategy

In developing strategic commissioning approaches ICBs have a key role as ‘Intelligent healthcare payors’ – allocating resources, contracting and procuring for services, and driving efficiency and performance through cost, market and contractual management; translating payment reform nationally; and driving change locally to ensure incentives align to local need.

Our Medium Term Financial Strategy (MTFS) has a key enabling role in balancing the need to meet our financial responsibilities and supporting the delivery of our strategic priorities – representing a significant enabling investment opportunity but also a challenge and constraint.

Building from our existing MTFS

Prioritisation of specific population groups and areas of care – children and young people (CYP), mental health, community-based care and inequalities - with a commitment to additional and disproportionate investment in these areas.

Increasingly allocating our resources on a weighted population basis, resulting in shifts in the relative share of the growth allocation across inner and outer SEL boroughs.

The MTFS further established a strategic investment fund of £30m per annum over the five-year period of the MTFS, although we were unable to support this level of investment in agreed plans due to our overall financial challenges and system deficit.

Whilst representing a material departure from previous allocative approaches, resulting in Increased and above average investment in CYP, mental health and community-based care, plus some more limited investment in inequalities, it has driven a relatively small change in the relative share of ICB spend made up by acute and non acute services.

This has demonstrated that allocative approaches that focus solely on the way annual ICB growth funding is allocated, whilst making a difference in terms of absolute investment in areas such as mental health, result in a slow incremental pace of overall change.

Summary of our allocative approach

Our MTFs and allocative approach is driven by our SEL and national health and strategic commissioning priorities plus the learning from the last few years. Our proposed approach seeks to take the best of our existing MTFs approach but refresh it to:

- Ensure **alignment to local and national strategic objectives**.
- **Better reflect population need** including a focus on a combination of targeted and generic investment approaches.
- **Recognise the reality of current operational delivery challenges** in ensuring investment to support the delivery of the care pathway and services changes required to underpin the delivery of our 3 year operational plan targets

Allocations will make provision for:

Core inflationary uplifts being applied to all relevant budgets and contracts.

Core annual baseline growth to support the delivery of service and care pathway changes required to underpin the delivery of our operational plan commitments.

A **Strategic Investment Fund** to drive the delivery of our strategic priorities and outcomes. The funding would:

- Be used flexibly across the four priority areas across the strategic period but with a major focus on prevention and neighbourhood health.
- Secure differentiated universal and targeted funding, linked to population health need and with due regard to our priorities around Children & Young People and Mental Health.
- Be contractualised inclusive of clear commitments around the combined use of existing and new funding and the associated return on investment and outcome deliverables.

We envisage the Strategic Investment Fund (SIF) increasing over the next three years, from a start 2026/27 commitment of £30m aligned to our existing MTFs, to £60m. Base growth funding will be tapered down over this same period.



- **A ring fenced annual strategic investment fund (SIF)** – to secure systematic investment aligned to our strategic commissioning objectives, priorities and outcomes.
- **Increased level of funding over the next three years.**
- For commissioned services, the investment approach will be a **combination of universal funding** – aligned to weighted population need – and **targeted funding** – aligned to Core20Plus5 populations, to reduce inequalities and improve overall health.
- Allocation across the four areas of priority will change in each year, aligned to agreed priorities and underpinning or incentivising investment required.
- Allocation will also take account of other sources of funding e.g. other nationally ring-fenced funds.
- SIF assumptions will be reviewed annually aligned to any changes to national guidance or local plan refreshes.

What will need to be true to enact our MTFS approach

Our proposed MTFS approach is dependent on the following supporting factors:

- **National policy** – national, regional and SEL system support for the separation of ICB allocations and provider Control Totals will be required – otherwise the risk continues around the ICB’s population-based allocation being used to support provider bottom line financial gaps.
- **System endorsement and adherence to the MTFS allocative plan** – success will also depend upon system partners recognising the strategic commissioning and allocative approach as we move into operational planning and contracting for 2026/27. We will need to collectively hold on to our strategic intent and avoid compromising our planned use of ICB growth funding to support short term financial challenges.
- **Making national finance and business rules work for us** – national policy direction around acute contract tariffs (e.g. UEC activity/funding and elective funding) runs the risk of chasing income as block contracts are deconstructed. We will need to work together to ensure these arrangements do not drive income driven approaches to acute activity that result in the ICB being unable to secure the required population-based investment in prevention and neighbourhood health, or to secure the underpinning left shift in funding that will be required.
- **Rigour around service transformation, productivity and cost improvement** – pace of change, the securing of sustainable recurrent savings and associated productivity and care pathway changes will be essential in supporting the sustainable delivery of operational delivery targets in a cost-effective way, with associated transformation e.g. around outpatients and UEC access further supporting a shift to community-based care.
- **Taking a leap of faith** – if we agree the national direction of travel as being important in improving population health, bringing care closer to home and modernising our care models inclusive of the use of digital, we need to collectively take a leap of faith in ensuring we invest in these areas. We will need to further drive the pace of change through ensuring we are shifting core recurrent as well as growth funding and pre-empting the impact of the changes we are seeking to secure. For example, when we implemented @home-based community services in Lambeth and Southwark many years ago, acute providers contributed funds to enable the required investment and further reduced their bed base to drive the required behaviour change.
- **Enabling approaches** – this could be through the embracing of new contract forms, but we could equally challenge ourselves around driving change within existing mechanisms through pooled budgets, pre-emptive left shifts and agreed risk/gain share arrangements.

Developing our contractual approaches

- Historically, contracts have been largely planned and delivered on annual cycles; with a large area of focus being activity and finance. The shift to strategic commissioning requires us to think differently about our contractual approaches and levers, and how we can use them to support, enable and incentivise delivery of our overall ambitions and priorities
- We will need to think differently about how we use contracts to reflect our long-term population health objectives, incentivise outcomes, equity, and prevention and support overall system sustainability and service transformation. Our intent is therefore to increasingly use contracts as enablers of long-term change, not just mechanisms for annual performance review / management.
- Over 26/27, SEL ICB will work with partners to consider how contracts and different contractual forms can best support delivery of the priorities set out in this plan. This will include consideration of a range of contracting approaches, including:
 - **Alliance or collaborative contracts**; for neighbourhood care and multi-provider pathways (e.g. Mental Health Alliance in Lambeth), including considering our use of the new national contract models around single neighbourhood providers, multi neighbourhood providers and integrated healthcare organisation contracts
 - **Lead provider / integrator models**; which could be used to support pathway coordination and accountability across multiple providers
 - **Outcomes-based and aligned incentive approaches**; which could be used to link funding to delivery of priority outcomes and transformation objectives
 - **Population-based or cohort-focused arrangements**, which could support delivery of outcomes and overarching objectives for key population cohorts – including the population cohorts identified in our population health improvement plan
- Approaches would be selectively applied where they add value and align with provider readiness, ensuring we maintain a focus on the change we are attempting to secure, rather than seeing use of a new contract form as an end in itself

Working with our partners

- Our system has a long history of collaborative working with partners and we will build on this as we progress delivery of our strategic commissioning plan
- The healthcare system is inherently complex and our “partners” cover a wide range of very different organisations, all of which will be important in securing delivery of the priorities set out in this plan.

NHS partners: Our system has a long history of collaborative working with partners and we will build on this as we progress delivery of our strategic commissioning plan.

We have a number of established collaborative forums in place, both at an operational and strategic level, which support our system working and will be key to driving delivery of many of our priorities. We will work collaboratively on the detailed work up and delivery of our priorities to ensure they support the system as a whole.

Our integrators: each borough has identified an integrator organisation to provide overall coordination and leadership for the development of neighbourhood health. Collaborative working with these integrators will be key to ensure we make progress in this priority area, ensuring a consistent approach across SEL that can be adapted for local need

Voluntary, community, faith and social enterprise sector: the VCFSE sector are already a key partner for our ICB and we are keen to build on this and maximise the opportunities to work with the sector - in new and different ways where needed - to support delivery of our priorities. Not only do our VCFSE partners have strong and trusted relationships with our residents and communities, but they also have valuable insight on people’s experiences of care which will inform the refinement of our ambitions and priorities over the years to come.

Our residents and communities (our population): we need to shift the dynamic of seeing our residents and communities as passive recipients of healthcare to active partners who can help shape the design and delivery of services, tailored for their local needs. Feedback from our patients and residents demonstrates that they want to be empowered to take control of their own health and care, especially with regards to prevention. ***The next two slides set out how we will work differently with our residents and communities to deliver the ambitions within this strategic commissioning plan.***

Working with our population

- The priorities in this plan are rooted in insight from our population, and the recurrent messages we hear about what needs to change in our healthcare system. We are committed to continuing to work with our population as we further develop and deliver on the priorities set out in this plan; this is key to ensuring that services are designed around the needs of our residents and to support us in achieving our overall ambitions
- We believe that working with people and communities to understand experiences, needs and aspirations of people and communities and working together to create actionable solutions will help to:
 - **Develop trust and relationships** – through developing actions and making changes together with local people and communities so people can see that they can make a difference and that we are listening, meaning that services are better aligned to the needs of local people
 - **Address power issues** - through enabling people and community partners to help lead change and be a greater participant in developing solutions to help manage their own health and wellbeing.
 - **Support in reducing health inequalities** – there are complex reasons why people and services don't match up and understanding this and what people want from health and care services helps move to a place where we recognise the strengths and resources that exist in communities enabling people to be treated more holistically
 - **Better service design which works for local people** – leading to improved access, experience and outcomes
 - **Build partnerships** – improving trust and transparency which in turn drives innovation

Working with our population

- We have developed an engagement toolkit to support us in taking a robust and consistent approach to working with local people and communities.
- More detail on our engagement approach and our full engagement toolkit can be found on the SEL ICB website.

Our commitments

At South East London level we have committed to working in **genuine partnership** with our communities, and to be **ambitious** in how we do this.

We know joint working with our communities will help us make better **strategic decisions**, better **allocate resources** and better **plan** services.

We also know that developing our relationship with local communities offers our most powerful **form of accountability**.

Where we are heading

We have some excellent recent examples of working collaboratively with local people and communities.

However, there are things we can still do to improve as a system:

- Use insights as a starting point and move to co-designing pathways and services based on what people have said
- Demonstrate listening and collaborative working by keeping all participants and the wider community informed through on-going dialogue throughout the process
- Actively recognise and address the impact engagement has on communities (emotionally, psychologically, financially) through using trauma-informed approaches
- Actively address power dynamics, build relationships, develop trust, be open and honest and have transparent decision making
- Develop a more systematic approach to engagement (whilst still allowing creativity) to reduce duplication, use existing insight and engage people at the beginning of projects
- Use community organising approaches to create actionable solutions with communities over time

How we will get there

Our 'working with people and communities strategic framework' sets out how we will work differently.

This toolkit is a key part of embedding a strategic approach at the very earliest stages of our work.

The guide to community organising outlines in more detail how to share power, develop relationships, build trust and use trauma informed approaches.

In addition to our own standards, current legislation requires us to involve the public in our work.

Workforce

- Across our system we have a diverse and vibrant workforce
- To deliver our ambitions and priorities as set out within this strategic commissioning plan we recognise that we will need to:
 1. Work with our existing commissioned providers to **enable cross-organisational working and the development of integrated teams** across the sector. We will use our commissioning and contracting levers (e.g. use of different types of contractual forms) to incentivise providers to work in a cross-organisational, hybrid manner and consider alternative models for workforce deployment, ensuring that the patient (resident) is core to the delivery of care.
 2. Actively **invest in enhanced roles** to deliver our ambitions particularly for prevention and neighbourhood based care. This will include expansion and diversification of roles including specialist clinical roles as well as non-clinical but patient facing roles including care co-ordinators and social prescribers (to name a few). Some of these roles may be better delivered by non-traditional health care providers including voluntary and community sector providers and wider primary care staff (e.g. community pharmacy).
 3. Ensure we fully **maximise opportunities emerging from changes to national training programmes** as part of our wider care pathway development. For example, prescribing qualifications for both pharmacists and nursing offers the ability to consider alternative models of care particularly for some conditions and diseases.
 4. Support all our commissioned providers with **training, development and organisational development** opportunities. As a collective south east London system we have already invested in a system workforce team and have developed online training platforms and tools for staff working across our all our sector . We will need to work collaboratively with our providers to understand the needs of their workforce to ensure we can effectively deliver our ambitions and the outcomes we desire for our population.

Conclusions

- This pack sets out our first five year strategic commissioning plan. It covers:
 - Background information “About South East London”
 - Our overarching ambitions for this plan
 - Our population health improvement plan, focussing on three identified cohorts
 - Our system transformation plans and four delivery priorities
 - How we will enable the change, including our strategic financial and allocative approach, contracting approaches, quality and working with our partners
- We will take forward our plans through the operational planning process, including further detail on how we will use our strategic investment fund to support delivery of our ambitions and priorities.
- Over 26/27, we will focus on and track delivery, including evaluating the impact and outcomes of our plans.
- We will refresh our five year plan annually to take account of progress, as well as further insights and intelligence gathered and this feedback received over 26/27.

Five Year Strategic Commissioning Plan:- Greenwich

Population Health Improvement Plan (1/3) South East London Greenwich

Ambition

To improve lifelong outcomes for Greenwich residents by reducing risks and strengthening protective factors, with a focus on neighbourhood-level delivery

What do we know about our local population and residents?

Population: 308,051 (2027 projection):12th youngest in London

Ethnicity: 55.7% White; 44.3% had a Black, Asian or other non-white ethnicity. The latter is predicted to increase by 20.7% in the ten-year period to 2027.

Life expectancy and quality of life: Life expectancy is 78.9 years (9 in poor health) for males and 82.5 years (23 in poor health) for females.

Deprivation: Central (27%) and East (35%) Neighbourhood LSOA's (population subsets) are in the most deprived quintile nationally (IMD 2025)

Causes of death: Cancer (25.6%); CVD (24.4%); Respiratory diseases (11.2%). 42% all deaths under 75 preventable. These are linked to areas of health opportunity within Autism and ADHD diagnosis, addiction or dependence, physical activity, nutrition, mental health of all ages, access to services, community neighbourhood team integration, reducing inequalities, ageing well.

What outcomes are we looking to secure over the next five years?

To support residents in living the life they want, to do what matters to them, and ensuring that health challenges are not a barrier to leading a full and meaningful life. This will be achieved by ensuring residents are included as valued members in the community and feel empowered to support with a coordinated care system whereby professionals, residents and services work effectively with each other.

Ensuring the system is financially sustainable by driving an increased uptake by residents for community services to ensure that residents, especially from disadvantaged communities, stay well, independent, and involved in the economy and community for longer. Further, ensuring support is available to residents where needed with targeted intervention before entering a crisis stage, alleviating the need for intensive care packages. People are supported to manage their health in a way that makes sense to them

Carers must feel supported as partners in their loved one's care, and support an increased confidence with residents in support for managing their health, through valued involvement in service design, leading to a reduction in the current inequalities in health outcomes. Staff must feel support to work well to ensure we attract and retain the workforce to realise this vision .

Population Health Improvement Plan (2/3) South East London

Greenwich

Priority Area	What are we aiming to achieve?	Why does this matter?
Start Well: Ensuring CYP get the best start in life and can reach their full potential.	<ul style="list-style-type: none"> 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. 	Strengthening early intervention , improve service access, and reduce long-term demand on resources.
Be Well: Everyone is more active and can access nutritious food.	<ul style="list-style-type: none"> Update and deliver the Royal Greenwich Get Active Strategy, tackling activity inequalities with community-focused solutions and improve local food environment 	Promoting a healthier lifestyle . Reducing future healthcare demand .
Feel Well: Fewer people experience poor health from addiction or dependency; fewer adults and CYP are affected by poor mental health	<ul style="list-style-type: none"> CYP / Adults: Develop a SPA for MH and well-being, improve school-based support, embed the Thrive approach, and Waiting Well initiatives. Conduct a MH, ASD and LD needs analysis. Addiction: Integrate VBA into practice and strengthen communication about the new strategy. 	Developing efficient, coordinated mental health services across all age groups. Strengthening early intervention to reduce long-term service demand. Improving access to local offers earlier but promoting them in accessible ways to residents
Stay Well : Access to services is equitable; neighbourhood teams provide the right support when needed; reduce unfair and avoidable differences	<ul style="list-style-type: none"> Rollout newly developed Social Prescribing and Live Well integrated model. Develop neighbourhood working in 3+ Long Term Conditions, End of life & frailty pathways. 	Promoting integrated, community-based care models to enhance efficiency and eliminate service duplication. To increase prevention and support the population to maintain their health and independence.
Age Well: Health and Care Services support people and their carers to live fulfilling and independent lives.	<ul style="list-style-type: none"> Increase capacity of carers assessments and develop market for a Carers trusted assessor service. Expand the use of Digital Health and Care Technology within new integrated teams. 	Prioritising prevention and early intervention to lower future care costs and service demand.

Population Health Improvement Plan (3/3) South East London Greenwich

How will these priorities contribute to the NHS three shifts?

Hospital to Community; the Greenwich LCP is moving in this direction with virtual wards, a strengthened Home First approach, an implementation of Neighbourhood working and a UTC run by the GP Federation that loops learning back into primary care.

Sickness to prevention; the Greenwich LCP also reflects this all-ages approach with the 5 Well Pillars structure, combining early years focus with proactive work on frailty and ageing well, so prevention is thematic and we work with colleagues across the Council to address the wider determinants of health – including housing and supporting economic growth

Analogue to digital; the Greenwich LCP lines up with this direction through its commitment to securing the infrastructure and analytical capability to undertake Population Health Management, and for this to inform the activity of clinical teams so that resource can be well targeted. Our residents will be digitally empowered, for example through consistent online access to 111, general practice and the Digital Health and Care Technology (DHACT) service for those who need it.

How will our priorities improve access to high quality, safe care?

Our priorities enable us to take a whole life-course approach to improving access to high quality and safe care. Throughout these priorities we have embedded:

- Co-production with communities as the mechanism for ensuring services are well designed around resident needs and experiences
- Close collaboration with VCSFE partners, recognising that our local community organisations are often best able to identify and support needs of residents and that we can enable more tailored outreach and access across all our diverse communities by working alongside community networks
- Mature collaboration across our Partnership so that teams can work together to do the right thing for people agnostic of the employing organisation, and collectively work to build a strong Greenwich workforce, with a sense of shared purpose and identity
- Making increasingly sophisticated use of data and embedding continuous improvement techniques and support improvement in quality and safety of services
- Active market development and management to secure a strong local market from which to secure high quality services with shared social values

We will achieve this through the work of a highly skilled strategic integrated commissioning team securing excellent human-centred services in collaboration with residents we serve.

How will we monitor and share progress?

N.B This box may not be published in the final commissioning plan but useful for internal sharing

Utilising the SELICB BI dashboard to monitor the impact on prevention and maintenance of health, for example hypertension and diabetes management, outpatient activity data and non-elective admissions

Neighbourhood Delivery Plan (1/4)



South East London

	Local Actions In Year 1	Local Actions In Year 2	
<p>Develop neighbourhood footprints around natural communities</p>	<ul style="list-style-type: none"> • 4 geographical neighbourhoods agreed in Feb 2025 • Establish neighbourhood level leadership teams, supported by a programme function to operationalise pathway improvements • Expand & align the current frailty and 3+LTC offer to neighbourhood footprint supported by consistent borough wide offers such as equipment or digital health and care • Redesign Mental Health community services including the Hub and to ensure they align into integrated neighbourhood teams (INTs) • Link Learning Disability and Mental Health Supported Living and Residential care providers into their local INT • Design and deliver culture change programmes to support the workforce 	<ul style="list-style-type: none"> • Develop neighbourhood-based leadership and governance in partnership with communities • Continued alignment of service delivery footprints to neighbourhood footprints including social care • Test and develop new model of MH neighbourhood working in one or two neighbourhoods • Redesign community offers such as homecare and reablement, aligned to neighbourhood model 	<ul style="list-style-type: none"> • Embed new ways of working across INTs and adjust based on learning • Roll out new MH neighbourhood model to all neighbourhoods • LD and MH provision and residents fully involved with their local INT
<p>Ensure good access to high quality general practice</p>	<ul style="list-style-type: none"> • All practices delivering Modern General Practice including meeting Online Consultation requirements during core hours • Introduce Depot Service into GP surgeries • Develop plans to ensure 90% target for same day appointments for all clinically urgent patients is achieved by April 26 • Determine additional capacity needed to meet demand out-of-hours and over surge periods including bank holidays and weekends • Increased use of digital and AI tools to improve access and free up time 	<ul style="list-style-type: none"> • Learning from Year 1 Depot Service and aligning to Localities • Incorporate learning from analysis of people attending ED in MH crisis (see below) • Further develop contract monitoring mechanisms • Improved National Patient Survey results • Development of a range of support offers including mechanisms to measure impact 	<ul style="list-style-type: none"> • Continue to promote use of the NHS App • Review of BI dashboards to identify unwarranted variation • Review Mental Health Practitioner roles to enable more seamless pathway between Primary and Secondary Care • Support transition of Crisis Lines from local to central working

Neighbourhood Delivery Plan (2/4)

Local Actions In Year 1

Local Actions In Year 2

Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'

- Deliver on locally identified (core RTC) priorities:
- Reduce inappropriate requests
 - Building on timeliness and quality of discharge summaries
 - Improving A&G access, referral optimisation, elective recovery, PIFU and other support with hospital demand
 - Shared Care Prescribing across the interface

Consolidate Year 1 development of local priorities while maintaining a strong performance against current and future national and SEL priorities. The strengthening of Integrated Neighbourhood working based on clear and sensible interfaces between health and care services, that work efficiently, amiably and safely by default. Patients will experience seamless care therefore, with fewer delays, incidents or near misses.

Greenwich aspirations for a Neighbourhood/INT approach to urgent and same day care pathways will be developed in Year 2 to reflect early urgent care interface work. Explore interoperability between digital systems to improve the seamless transfer of information.

Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).

- Development and implementation of Local Enhanced Service (LES) for Frailty to facilitate the risk stratification of patients
- Design of new model of homecare and re-ablement services aligning opportunities for home based intermediate care.
- Improve S117 and Care Act discharge planning
- Mental Health Supported Accommodation Pathway developed with more high needs capacity

- Expansion of condition coverage for INTs
- Commission and mobilise new homecare and reablement services, deliver changes to district nursing model
- Modelling of borough Integrated Delivery Unit (IDU) for 111
- Formal launch of MH Alliance: redesign of system to reduce crisis and inpatient activity and spend by shifting support to prevention in the community
- Develop the LDA supported accommodation offer for residents with complex needs

- Align resources and funding to the population demands and priorities of neighbourhood working
- Further develop neighbourhood working through Neighbourhood Hubs with co-located staff
- MH Alliance delivering plan to shift MH support from hospital to community through service provision expansion.
- New LDA supported accommodation available for complex needs
- LDA Provider market developed with trusted, quality partners

Neighbourhood Delivery Plan (3/4)

Improving planned care in the community (linked to work to redesign outpatient care)

Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs

Local Actions In Year 1

- New Greenwich LeDeR Steering Group to establish and deliver learning from LDA deaths
 - Increase the uptake of LD and MH Annual Health Checks, and continued reduction of unnecessary medication (STOMP programme).
 - ASD/ADHD diagnostic Services market control
 - Mobilise new MSK service
 - End of life improvements (hospice upgrades & OOH support)
 - Develop a neighbourhood focused planned care model
 - Further develop women's health and community gynaecology offer

- Implement new discharge to assess pathway incorporating step up provision
- Complete intermediate care, virtual ward and reablement reviews and implement outcomes
- Design phase for community equipment offer, learning from provider failure
- Design and implement recommendations from the BCF support programme including new reporting to track demand and capacity and coordination via TOCC
- Develop further understanding of the profile of those attending ED in MH Crisis and identify missed opportunities to support them in advance.

Local Actions In Year 2

Continue to develop planned care on a neighbourhood footprint, integrating physical health, mental health, community services and social care to support early help and prevent escalation
 Expand early intervention, self-management, and carer/community support programs to reduce the need for outpatient care
 Standardise referral routes, shared assessments, and MDT links with neighbourhood teams

- Develop roadmap for virtual wards
- Develop remote monitoring capacity through DHACT to support care at home and step down
- Implement new community equipment offer
- Launch new all age carers strategy and delivery plan
- Ensure implementation of prevention solutions to reduce ED MH attendance
- Improve MH community support for hospital discharge
- Ensure data enabled practices are embedded across INTs and community offers which enable more proactive care

Local Actions In Years 3 -5

Deliver a fully integrated planned care neighbourhood model which has proven positive outcomes for local residents and the system with reduced waits and improved health outcomes
 A continuous neighbourhood improvement model adopted by all to scale up good practice, have a community of practice, strengthen prevention, self management and reduce the need for emergency care

- Review outcomes achieved from intermediate care offer and make adjustments as required
- Implement recommendations from virtual wards roadmap
- Continue roll out of DHACT and remote monitoring capacity to further resident cohorts

Neighbourhood Delivery Plan (4/4)

Local Actions In Year 1

- Evaluate and develop the model of Local Child Health Teams in Greenwich to identify opportunities for enhancement and alignment with the wider integrated neighbourhood development work.
- Re-commissioning of Family Hub and Children’s Centre provision, aligning with the Neighbourhood development
- Implement the new health roles within the proposed Multi-agency Child Protection Teams (MACPT) and Family Help (FH) provision to support families and identify opportunities for better health system and neighbourhood working for those cohorts.
- Implement a new Single Point of Access for children’s mental health and emotional wellbeing to improve identification and support to children.
- Re-commission a new Children and Young People’s Homecare provision to strengthen the offer and practice
- Implement Programme (STARSS) to strengthen inclusivity and support for SEND children.
- Review Asthma pathways and opportunities

Local Actions In Year 2

- Alignment of the Family Hub and Children’s Centre provision in line with Neighbourhood developments.
- Review the new health roles within the MACPT and FH provision to identify impact and sustainable future models
- Review and potentially implement new ways of working with SEND subject to the development of the Schools White Paper.
- Align Transitions Workers to improve transition arrangements between CAMHS and Adult Mental Health services
- Opening of Transition Learning Centre for young adults (18-25) with SEND to improve the local offer of provision.
- Review the impact of the new Single Point of Access for children’s emotional health and wellbeing.
- Implementation of improvements to the mental health offer for education settings.
- Review the effectiveness of improvements to the Autism and ADHD pathways.
- Identify opportunities to support children and young people as part of the DHACT development

- Align resources and funding to the population demands and priorities of neighbourhood working
- Review impact of the Families First Reforms in strengthening support around families within the community.
- Implementing opportunities for greater pooled funding for children and young people including those with complex care outside of S.117 and Continuing Care.
- Review the impact of the new Youth Offer in supporting improved prevention and health and wellbeing for children.

Improving care for children and young people (CYP) as part of neighbourhood working

Appendix 1: Borough population health improvement plans

Ambition

Working with our communities and partners, we will help people in Bexley stay healthier for longer by making care more preventative, more local, and easier to understand and access.

What do we know about our local population and residents?

Population: Bexley's population is projected to grow by a further 14,700 by 2035. The borough has a higher proportion of children and older people than the London average, with a 21.9% increase expected in the 65+ population and rising frailty. Bexley has a comparatively high number of care homes (18; a total of 1,247 beds), attracting people into the borough and increasing demand on community provision.

Growth and need are uneven, with higher deprivation in north Bexley. The population is increasingly diverse, with minority ethnic groups increasing by 9.9% over the past decade. Around 1 in 10 residents are from a Black African background and 1 in 10 from an Asian background, with diversity greatest in younger age groups and in the north of the borough.

Life expectancy and quality of life: Life expectancy is 80.1 years for males and 83.3 for females. On average, residents spend between 15.9 and 19.5 years in poor health, often with multiple long-term conditions, with outcomes varying significantly between neighbourhoods. 5.5% of the population live in a Core20 area: Thamesmead and Erith.

Causes of death: The main causes of premature death is cancer followed by CVD. On average, 276 preventable deaths occur in Bexley each year. Mortality rates are higher in the most deprived fifth of the borough, particularly for cardiovascular disease, respiratory conditions and cancer, highlighting the need for targeted prevention across the life course.

What outcomes are we looking to secure over the next five years?

Fewer preventable illnesses and more years lived in good health *Measured by:* lower preventable mortality (under 75), longer healthy life expectancy, improved management of long-term conditions, and reductions in tobacco dependency, obesity, and undetected hypertension.

Narrower health inequalities between neighbourhoods. *Measured by:* a reduction in the life expectancy gap between the most and least deprived areas, lower preventable mortality rates in Core20 or the most deprived quintile, and increased uptake of prevention and screening services in deprived neighbourhoods.

Residents are supported and empowered to manage their health and wellbeing. *Measured by:* increased patient activation scores, increased uptake of self-management programmes, social prescribing and prevention offers, improvements in health literacy and digital access where available, and more positive patient-reported experiences of involvement in care decisions.

Care is more accessible, joined-up and delivered closer to home. *Measured by:* reduced emergency admissions for ambulatory care-sensitive conditions, fewer A&E attendances and non-elective admissions among people aged 65 and over, shorter delayed discharges and overall length of hospital stay, and improved patient-reported experiences of care coordination and access.

Bexley (2/3)

Priority Area	What are we aiming to achieve?	Why does this matter?
Supporting Children & Young People <i>throughout life</i>	Every child has the best start in life, with reduced inequalities, better mental health, strong family and community support, and smoother transitions into adulthood.	<ul style="list-style-type: none"> • Giving every child the best start has lifelong benefits for health, education and opportunity. • Early intervention and prevention reduces inequalities seen from pregnancy through adolescence, particularly in the north of the borough. • Improving mental health, safety and resilience now shapes stronger, healthier adults in the future.
Supporting people living with Mental Health challenges	Improved mental wellbeing across all ages, with earlier support, better access to community-based care and reduced crises.	<ul style="list-style-type: none"> • Poor mental health affects people of all ages and is closely linked to deprivation, discrimination and poorer life outcomes. • Early help and community-based support prevent crises and reduce demand on emergency and inpatient services. • Good mental wellbeing improves physical health, productivity, relationships and long-term life chances.
Supporting people to maintain a Healthy Weight	Healthier weight across the population, especially children, by creating environments that support active living and healthier diets.	<ul style="list-style-type: none"> • Obesity is one of Bexley’s biggest health challenges, driving higher risk of diabetes, heart disease, cancer and poor mental health. • Rates are highest in our most deprived communities, widening health inequalities. • Creating healthier environments in childhood prevents illness in adulthood and improves lifelong wellbeing.
Supporting older people living with Frailty	More older residents living independently for longer, with fewer falls, slower progression of frailty and dementia, and better support for carers and end-of-life care.	<ul style="list-style-type: none"> • Our population is ageing and more residents are living with dementia, frailty and long-term conditions. • Preventing falls, slowing decline and supporting independence improves quality of life and reduces avoidable hospital use. • Carers and families play a vital role and need support to stay well themselves.

Bexley (3/3)

How will these priorities contribute to the NHS three shifts?

Our population priorities drive how we expand care into the community, prevent illness, and use digital tools to reach more people effectively.

- **Hospital to community:** our plan will bring services closer to home for people of all ages, ensuring timely access to care and reducing the need for hospital visits. We will strengthen community-based support for children, mental health, and ageing well by integrating primary care, social care, and voluntary sector resources.
- **Sickness to prevention:** the focus is on early intervention across all life stages, preventing illness through targeted initiatives, such as healthy lifestyle programmes, social prescribing, vaccination campaigns, and proactive management of long-term conditions, empowering residents to make informed choices about their health.
- **Analogue to digital:** incorporating digital tools in our care pathways alongside improved digital literacy will support residents with access, engagement, and self-management.

How will our priorities improve access to high quality, safe care?

- **Children and young people** – Bexley will see more services delivered closer to home, reducing waiting times, preventing complications, and supporting joined-up multi-professional and multi-agency care, with a focus on reaching children and families in underserved communities.
- **Healthy weight** – we are providing community-based programmes and early lifestyle interventions, helping people access support for diet, exercise, and long-term condition prevention, empowering residents to manage their health and reduce future illness.
- **Mental health** – we are expanding local mental health services, integrating support across health, social care, schools, and voluntary sectors, improving timely access, crisis support, and safety, while using local data to monitor and improve outcomes.
- **Ageing well / frailty** – we are strengthening proactive community care, home-based assessments, and multidisciplinary teams to manage frailty, prevent avoidable hospital admissions, and help older adults maintain independence safely and die well.

How will we monitor and share progress?

We will monitor progress through:

- Tracking against our success metrics and outcome measures
- Embedding robust governance processes and frameworks, including oversight via the Bexley Executive Leadership, Health and Wellbeing Board and the Bexley Community Based Care Delivery Board

We will share progress by:

- Monitoring and oversight via our existing Programme Boards/Partnerships including flagging risks, issues and barriers as well as sharing lessons learnt
- Utilising agreed communication channels to ensure alignment and visibility

Bromley (1/3)

Ambition

Taking a whole life course approach to help everyone in our population live longer, more independent lives with less variation in health outcomes across Bromley.

What do we know about our local population and residents?

Population: Bromley has the oldest population in London and largest over 65s population in South East London. The population size (335,580) is projected to remain static to 2035, but with significant changes within: 9% decrease in under 18s, 15% rise in over 65s and 33% rise in over 85s. (2022-based ONS).

The population is 24% non-white, of which the Black African population is the largest group (4%). The younger population is significantly more ethnically diverse than the older population: 34% 0-4 year olds are non-white compared to 9% 65+ year olds (Census 2021).

Life expectancy and quality of life: Life expectancy is 81.5 years for males and 85.3 for females, with a slope index of inequality of 8 and 6 years. On average men live for 13 years in poor health and women 16 years (OHID). 8% of the population live in a Core20 area: North West, North and North East Bromley has LSOAs in most deprived quintile nationally (IMD 2025).

Causes of death: The main causes of all deaths are cancer (25.3%); CVD (23.5%); dementia (12.8%). Of these deaths 45% all deaths under 75 are preventable (2021-23) with the top three causes being CVD, respiratory and cancer (OHID). These are linked to areas of health opportunity in obesity, diabetes, smoking (including in pregnancy), alcohol, dementia, tackling infectious disease, adolescent & adult mental health.

What outcomes are we looking to secure over the next five years?

Reducing the variation in healthy life expectancy and reducing preventable chronic and infectious disease deaths. *Measured by:* improved management of long-term conditions to reduce incidence and complications, reduced prevalence of overweight and obesity in adults and slowed the rise in diabetes incidence, and people supported to live well and independently throughout their life course.

Improving outcomes for all child health outcomes and development measures. *Measured by:* reduced the prevalence of obesity; improved emotional wellbeing of parents, caregivers, children and young people; reduced smoking during pregnancy, and improvement towards meeting national targets for immunisation.

Reducing the gap between physical and mental health outcomes. *Measured by:* more people at risk of and with depression, anxiety, and/or other mental health issues have accessed the right early help and resources; reduced the risk of developing dementia and live well with dementia; improved quality and uptake of LD and SMI health checks; delivered Bromley suicide prevention plan and the recommendations of the National Drug Strategy.

Build trust and confidence in preventative healthcare services in our communities. *Measured by:* improved cancer screening and early diagnosis rates, mitigated growth in use of urgent care services for long term conditions and ambulatory care sensitive conditions, improved vaccine uptake (all age), and more voluntary, community and social enterprise (VCSE) led health and wellbeing support.

Bromley (2/3)

Priority Area	What are we aiming to achieve?	Why does this matter?
<p>Universal and targeted services to meet the needs of Children and Young People (CYP) at the earliest stage</p>	<ul style="list-style-type: none"> Improved co-ordination and collaboration across Bromley to make every health, social care and education contact count to deliver our health and emotional wellbeing objectives, ensuring safeguarding. More acute care provided in the community, including through broader multi-professional, multi-agency working. Improved immunisation and management of long-term conditions with a reduction in exacerbations. 	<ul style="list-style-type: none"> Children and families tell us that our services have greater impact when they are co-ordinated across the public sector. Delivering more acute care in the community is showing reduced waiting lists, less travel and time off school and work, and improved national outpatient target delivery with a better patient experience. Immunisation and long-term condition management significantly reduces lost school days and overall health system demand.
<p>All age learning disability services and mental health and wellbeing prevention and early intervention services</p>	<ul style="list-style-type: none"> CYP: Improved prevention offer reducing hospital admission and CAMHS activity, including shift to more accessible third sector offer. Adult: reduce hospital length of stay, admissions and re-admissions; shift to VCSE with more people in employment and living independently in own home; reducing people’s need for specialist care at home support. 	<ul style="list-style-type: none"> CYP: Emotional wellbeing of children and young people, and their care givers is essential to having a high quality start to life. By linking schools, health and other services with a strong prevention offer we will deliver improved wellbeing and education outcomes. Adult: Supporting people early and in their community helps more people stay well and, where possible, in employment.
<p>Sustainable integrated urgent care in a model easier to navigate for professionals, residents and carers</p>	<ul style="list-style-type: none"> Urgent care shifts to a neighbourhood-led model via primary care, urgent community response, hospital at home, virtual wards and intermediate care as default in acute episodes outside hospital. Residents have and know how to use same day and emergency care across Bromley spanning physical and mental health, social and third sector care. 	<ul style="list-style-type: none"> People receiving the right care, in the right place, at the right time reduces escalation of need and hospital admission, which is particularly beneficial for frail, elderly and higher users of services. This approach will drive productivity and mitigate growth in costs to the Bromley health and care budget while supporting the sustainability of our urgent care providers.
<p>Multiple long-term conditions AND frailty, dementia and end of life</p>	<ul style="list-style-type: none"> Earlier identification of people in poor health, allowing interventions through a bio-psycho-social approach to reduce increases in complexity of need. Where there is a complex need, to co-ordinate across agencies for efficiency, improved outcomes and embedding safeguarding approaches across INTs. Support unpaid carers including through carers’ contingency planning and involvement in care planning for those they care for. 	<ul style="list-style-type: none"> Early identification, holistic assessment and better co-ordination will enable earlier and more rounded support for our residents. This will help people maintain health, wellbeing and independence longer and mitigate costs in urgent, acute and long-term social care, including for people in the last year of life. Opportunity to further benefit from pharmacies, among others. Carers are an integral part of the ‘care team’, often round the clock.

Bromley (3/3)

How will these priorities contribute to the NHS three shifts?

Our life course approach embeds a preventative approach based in people’s local communities and supported by digital tools for staff and residents:

- **Hospital to community:** each of our priority areas aims to move care closer to where people live. This covers the full pathway from Vital 5 screening in community centres, self help, no longer needing to travel to hospital for outpatient appointments, relational care co-ordination of expertise for complex needs and community urgent and emergency care.
- **Sickness to prevention:** the focus is to help people stay well for longer and ensuring a preventative approach is taken at each step in interactions with health and care services. Such as in pre-conception and postnatal prevention or in mental health through improvements in education and employment outcomes, independent living and self reported wellbeing.
- **Analogue to digital:** Bromley’s population has shown a remarkable interest in digital tools to help with management of health at home, from MyChart to virtual ward offers. We will build on this and enhance digital inclusion.

How will our priorities improve access to high quality, safe care?

- **Children and young people** – we are building on our success delivering outpatient care closer to home more quickly meaning less chance of complications developing, upskilling staff and supporting more joined-up multi-professional, multi-agency working.
- **Learning disabilities and mental health** – our shift to prevention more accessible in the community will mitigate escalation of need and therefore reduce risk. In turn this will support us ensuring those needing specialist care are able to access this in a more timely way.
- **Urgent and emergency care** – our plans will help us to move away from high utilisation of acute hospital services which see corridor care and overcrowding towards more care in the community, and where appropriate delivered by teams with a good knowledge of the patient.
- **Multiple long-term conditions and frailty** – our plans will reduce outpatient appointment waiting lists and help us to deliver earlier intervention in a planned way rather than in an acute environment.

How will we monitor and share progress?

- **Strategically aligned:** Our One Bromley Local Care Partnership Strategy from which this plan flows is owned by our Local Care Partnership Board. It has a joint delivery plan with the Health and Wellbeing Board, which is supported by a small programme management function and delivery overseen by One Bromley Executive and Health and Wellbeing Board. This cements a cross-system approach to change management and issue mitigation.
- **Monitoring and sharing:** One Bromley programme management office monitors key delivery and enabler programme progress and shares learning.
- **Evaluation:** As part of INT development in particular the system is utilising evaluations of existing services to inform design and exploring its approach to a Quality Management System linked with Quality Improvement to establish psychologically safe, improvement focussed multi-agency teams.

Greenwich (1/3)

Ambition

To improve lifelong outcomes for Greenwich residents by reducing risks and strengthening protective factors, with a focus on neighbourhood-level delivery

What do we know about our local population and residents?

Population: 308,051 (2027 projection):12th youngest in London

Ethnicity: 55.7% White; 44.3% had a Black, Asian or other non-white ethnicity. The latter is predicted to increase by 20.7% in the ten-year period to 2027.

Life expectancy and quality of life: Life expectancy is 78.9 years (9 in poor health) for males and 82.5 years (23 in poor health) for females.

Deprivation: Central (27%) and East (35%) Neighbourhood LSOA's (population subsets) are in the most deprived quintile nationally (IMD 2025)

Causes of death: Cancer (25.6%); CVD (24.4%); Respiratory diseases (11.2%). 42% all deaths under 75 preventable. These are linked to areas of health opportunity within Autism and ADHD diagnosis, addiction or dependence, physical activity, nutrition, mental health of all ages, access to services, community neighbourhood team integration, reducing inequalities, ageing well.

What outcomes are we looking to secure over the next five years?

To support residents in living the life they want, to do what matters to them, and ensuring that health challenges are not a barrier to leading a full and meaningful life. This will be achieved by ensuring residents are included as valued members in the community and feel empowered to support with a coordinated care system whereby professionals, residents and services work effectively with each other.

Ensuring the system is financially sustainable by driving an increased uptake by residents for community services to ensure that residents, especially from disadvantaged communities, stay well, independent, and involved in the economy and community for longer. Further, ensuring support is available to residents where needed with targeted intervention before entering a crisis stage, alleviating the need for intensive care packages. People are supported to manage their health in a way that makes sense to them

Carers must feel supported as partners in their loved one's care, and support an increased confidence with residents in support for managing their health, through valued involvement in service design, leading to a reduction in the current inequalities in health outcomes. Staff must feel support to work well to ensure we attract and retain the workforce to realise this vision .

Greenwich (2/3)

Priority Area	What are we aiming to achieve?	Why does this matter?
Start Well: Ensuring CYP get the best start in life and can reach their full potential.	<ul style="list-style-type: none"> 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. 	Strengthening early intervention , improve service access, and reduce long-term demand on resources.
Be Well: Everyone is more active and can access nutritious food.	<ul style="list-style-type: none"> Update and deliver the Royal Greenwich Get Active Strategy, tackling activity inequalities with community-focused solutions and improve local food environment 	Promoting a healthier lifestyle . Reducing future healthcare demand .
Feel Well: Fewer people experience poor health from addiction or dependency; fewer adults and CYP are affected by poor mental health	<ul style="list-style-type: none"> CYP / Adults: Develop a SPA for MH and well-being, improve school-based support, embed the Thrive approach, and Waiting Well initiatives. Conduct a MH, ASD and LD needs analysis. Addiction: Integrate VBA into practice and strengthen communication about the new strategy. 	Developing efficient, coordinated mental health services across all age groups. Strengthening early intervention to reduce long-term service demand. Improving access to local offers earlier but promoting them in accessible ways to residents
Stay Well : Access to services is equitable; neighbourhood teams provide the right support when needed; reduce unfair and avoidable differences	<ul style="list-style-type: none"> Rollout newly developed Social Prescribing and Live Well integrated model. Develop neighbourhood working in 3+ Long Term Conditions, End of life & frailty pathways. 	Promoting integrated, community-based care models to enhance efficiency and eliminate service duplication. To increase prevention and support the population to maintain their health and independence.
Age Well: Health and Care Services support people and their carers to live fulfilling and independent lives.	<ul style="list-style-type: none"> Increase capacity of carers assessments and develop market for a Carers trusted assessor service. Expand the use of Digital Health and Care Technology within new integrated teams. 	Prioritising prevention and early intervention to lower future care costs and service demand.

Greenwich (3/3)

How will these priorities contribute to the NHS three shifts?

Hospital to Community; the Greenwich LCP is moving in this direction with virtual wards, a strengthened Home First approach, an implementation of Neighbourhood working and a UTC run by the GP Federation that loops learning back into primary care.

Sickness to prevention; the Greenwich LCP also reflects this all-ages approach with the 5 Well Pillars structure, combining early years focus with proactive work on frailty and ageing well, so prevention is thematic and we work with colleagues across the Council to address the wider determinants of health – including housing and supporting economic growth

Analogue to digital; the Greenwich LCP lines up with this direction through its commitment to securing the infrastructure and analytical capability to undertake Population Health Management, and for this to inform the activity of clinical teams so that resource can be well targeted. Our residents will be digitally empowered, for example through consistent online access to 111, general practice and the Digital Health and Care Technology (DHACT) service for those who need it.

How will our priorities improve access to high quality, safe care?

Our priorities enable us to take a whole life-course approach to improving access to high quality and safe care. Throughout these priorities we have embedded:

- Co-production with communities as the mechanism for ensuring services are well designed around resident needs and experiences
- Close collaboration with VCSFE partners, recognising that our local community organisations are often best able to identify and support needs of residents and that we can enable more tailored outreach and access across all our diverse communities by working alongside community networks
- Mature collaboration across our Partnership so that teams can work together to do the right thing for people agnostic of the employing organisation, and collectively work to build a strong Greenwich workforce, with a sense of shared purpose and identity
- Making increasingly sophisticated use of data and embedding continuous improvement techniques and support improvement in quality and safety of services
- Active market development and management to secure a strong local market from which to secure high quality services with shared social values

We will achieve this through the work of a highly skilled strategic integrated commissioning team securing excellent human-centred services in collaboration with residents we serve.

How will we monitor and share progress?

Utilising the SELICB BI dashboard to monitor the impact on prevention and maintenance of health, for example hypertension and diabetes management, outpatient activity data and non-elective admissions

Lambeth (1/3)

Ambition

We aim to create a Lambeth where everyone can live well, feel valued, and benefit from accessible, safe, high-quality health and care, underpinned by our commitment to diversity, inclusion, and equality

What do we know about our local population and residents?

Population; Lambeth is an inner London borough with around 316,000 residents and a GP-registered population of approximately 450,000, reflecting high mobility. The population is relatively young, with 43% aged 20–39, but is ageing. Between 2011 and 2021, residents aged 45+ increased by 25%, while children under 10 fell by 20%. Population is projected to grow by around 6% (18,000 residents) over the next 15 years, driven by a 15% increase in those aged 45+ and a 54% rise in residents aged 65+.

Deprivation; Lambeth experiences high levels of deprivation. 8% of residents live in areas within the most deprived 20% nationally, and 59% live in the most deprived 40%. Deprivation is unevenly distributed and closely linked to poorer health outcomes and lower healthy life expectancy.

Life expectancy, inequalities and causes of ill health; Life expectancy has increased by around 5 years over the past 20 years, despite COVID-19. However, residents spend around 20 years in poor health, with worse outcomes in more deprived communities. Long-term conditions are a major driver: around 50% of residents aged 50+ live with at least 1 long-term condition and around 33% with 3 or more. Hypertension and diabetes are most common, particularly among Black and Other ethnic groups. The life expectancy gap is largely driven by circulatory disease, cancer, respiratory disease, mental health conditions including dementia, and deaths from injury, poisoning and suicide.

What outcomes are we looking to secure over the next five years?

Through our Lambeth Together Health and Care Plan, we are seeking to secure 15 outcomes that support people in Lambeth to live healthy, fulfilling lives.

Full details of our current Lambeth Together Health and Care Plan, including the full set of 15 outcomes can be found here [Our Health, Our Lambeth: Year 2 Review and Action Plan for 2025/26](#)

These outcomes **span the whole life course** and **focus on supporting positive health behaviors and community connection; preventing illness and harm** through immunisation, **early diagnosis**, addressing substance misuse; improving mental, emotional, sexual, and reproductive health; enabling people to manage long-term conditions, **live independently, and age well**; and delivering **joined-up, neighbourhood-based care**.

They **prioritise reducing inequalities**, improving maternal outcomes, supporting people with learning disabilities and/or autism to achieve equal life chances, **promoting mental health recovery, wellbeing, and participation**, and improving health outcomes for people who are homeless or at risk of homelessness. Progress will be measured through a range of metrics focused around health care access, early diagnosis, prevention initiatives, and effective management of health conditions

Lambeth (2/3)

Priority Area	What are we aiming to achieve?	Why does this matter?
<p><i>People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible</i></p>	<ul style="list-style-type: none"> • Implement Phase 2 of Reducing the Strength to restrict high-strength alcohol and reduce harm. • Broaden access to HIV testing and PrEP across a range of settings with a focus STI prevention • Continue delivery of targeted Tier 2 lifestyle programmes such as Fits Me Well and community men’s groups. • Deliver the Combatting Drugs Partnership plan; increasing engagement, continuity of care & reducing harm. • Evaluate the 2025/26 Flu Outreach Strategy to inform improved deployment for future years • Expand stop smoking support through enhanced specialist, pharmacy, mental health digital offers • Implement award of NHS Health Checks to GPs, building on pilot learning to reach high-risk groups • Operationalise community-pharmacy-led HPV vaccination, with targeted engagement 	<p>A wide range of factors, including income and ethnicity, impact people’s health and lead to poorer outcomes. Targeting prevention across obesity, mental health, smoking, alcohol and vaccinations will have the greatest impact and deliver strong value for the system.</p>
<p><i>Physical and mental health conditions are detected early, and people are supported and empowered to manage these conditions and avoid complications.</i></p>	<ul style="list-style-type: none"> • Embed an updated community model closely aligned to neighbourhood working. • Enhance medicines value, safety and stewardship including preparation for innovative medicines • Improve uptake of Serious Mental Illness (SMI) Health Checks, focusing on Black / multi-ethnic communities. • Position community pharmacy as a key neighbourhood asset, expanding prevention and clinical services Support implementation of Learning Disability Phase 2 of the Digital Dynamic Support Register (DDSR). • Deliver the All-Age Autism Strategy with early family support to reduce escalation and build confidence. • Deliver the Lambeth Carers Strategy to support carers to maintain their health and wellbeing. 	<p>Many people now live with several long-term conditions, and some communities are affected more. With earlier diagnosis and the right help, these can be managed well as part of daily life. We want to empower and support people to manage their health and wellbeing.</p>
<p><i>People have access to and positive experiences of health and care services that they trust and meet their needs</i></p>	<ul style="list-style-type: none"> • Use population data to inform targeted support and neighbourhood maternity models. • Advance the Act Early South London programme using health inequalities insights to guide interventions • Embed a consistent general practice access model to improve access, experience and reduce variation. • Increase the proportion of black people receiving support and reduce their Mental Health crisis services use • Maintain urgent care system resilience, aligning with new 111 Integrated Delivery Unit (IDU) pathways. • Strengthen GP and community service integration within Integrated Neighbourhood Teams (INTs) through aligned access flows, MDT coordination and seamless referral and follow-up. • Reablement; commission revised model to continue to deliver excellent outcomes and to a wider group of service users including people in the community to help them avoid hospital admission 	<p>Disjointed services mean many people still experience disjointed care and poorer outcomes. Strengthening integration and improving access will ensure people receive timely, appropriate support, helping them stay healthier for longer and reduce pressure on the health system.</p>

Lambeth (3/3)

How will these priorities contribute to the NHS three shifts?

Hospital to community: Our priorities focus on expanding community-based neighbourhood models and strengthening GP integration within Integrated Delivery Teams (INTs) through coordinated access, Our priorities focus around revising pathways to ensure timely care closer to home, reducing hospital reliance and embedding proactive, joined-up support.

Sickness to prevention: Priorities focus on preventing poor outcomes by addressing key lifestyle and health risks. Campaigns such as Reducing the Strength, expanded HIV and STI testing, targeted lifestyle programmes, stop-smoking support, flu outreach, and HPV vaccination reach those at greatest need. NHS Health Checks and community-pharmacy interventions support early detection and risk reduction. By targeting behaviors driving inequalities, these priorities prevent escalation into crisis care, reduce harm, and promote healthier, longer lives.

Analogue to digital: Digital tools will underpin neighbourhood-based services, improving access, efficiency, and coordination. Solutions support early detection and management of long-term conditions, including SMI and learning disabilities, medicines optimisation, and the Digital Dynamic Support Register . Projects such as Operational Dovetail strengthen interoperability and information flow between primary care and acute settings, improving seamless care. Enhanced use of data through Act Early South London informs targeted interventions. Optimising services with digital solutions will enable more accessible, timely, personalised care while freeing system capacity.

How will our priorities improve access to high quality, safe care?

The plan improves **access to high-quality, safe care** by embedding neighbourhood working through Integrated Neighbourhood Teams, a consistent general practice access model and strengthened GP–community integration, enabling **timely access, continuity of care** and **reduced variation** across primary, urgent, maternity and children’s services.

Targeted prevention, including NHS Health Checks, immunisation outreach, sexual health, alcohol, drugs and smoking cessation programmes, uses population data to **reach high-risk groups, reduce avoidable harm** and **prevent escalation**. Improved mental health, autism, learning disability and carers support enables **earlier identification, culturally appropriate care** and **reduced crisis presentations**.

Community pharmacy expansion, medicines optimisation, vaccination delivery and digital access tools improve **patient safety, convenience, and safe use of innovative medicines**, supporting sustainable, high-quality care.

How will we monitor and share progress?

Delivery will sit with our alliance and programme teams and we will monitor progress through our established Lambeth Together governance arrangements. Outcomes will be reviewed at the Lambeth Together Assurance Group (LTAG), **where partners assess delivery, risks, impact measures, and any areas requiring escalation**.

LTAG provides formal assurance to the Lambeth Together Care Partnership Board, which **meets in public, enabling residents, partners, and stakeholders to ensure clear oversight, transparency, and accountability**.

Lewisham (1/3)



South East London

Ambition

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/>

What do we know about our local population and residents?	What outcomes are we looking to secure over the next five years?
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Lewisham has pockets of significant deprivation, according to the Indices of Multiple Deprivation, it is the 63rd most-deprived local authority out of 317 in England, with 26% of our areas amongst the 20% most-deprived nationally, 70% of our population live in the most deprived 40%. The population of the borough is set to grow from 300,000 in 2025 to 309,646 by 2032. The 2021 Census recorded 19,957 unpaid carers in Lewisham, with 9,890 providing more than 20 hours of care per week and 5,133 providing over 50 hours of care per week.

Lewisham is ethnically diverse and the proportion of people from an ethnic minority community will increase from 49.5% in 2025 to 50.1% in 2032. There are significant disparities in health outcomes among different ethnic groups, the percentage of Black African and Black Caribbean people with Hypertension and diabetes is twice as high as for the white population in Lewisham.

The rate of premature deaths (before the age of 75) from conditions like heart disease, cancer, and respiratory diseases is higher in Lewisham compared to the London average and is especially pronounced in more deprived areas with alcohol-related more common and higher smoking rates contributing to a range of health problems, including cancer and respiratory diseases. Mental health issues, including depression and anxiety, are more prevalent among residents facing socioeconomic hardships; those with serious mental illness can also have reduced life expectancy of around 20 years. We have poor vaccination rates and cancer screening rates. There are high obesity rates recorded in reception and Year 6.

The Lewisham Health & Wellbeing Strategy 2025-30 provides the strategic framework to support the health and wellbeing of our local population, particularly those who experience health inequalities. It identifies specific focused actions for each priority area and relevant outcome indicators that will be used to monitor progress and which also underpin the LHCP 5 year strategic plan and outcomes detailed in the following sections.

The priority areas for action within the strategy and how they will be measured include:

- Poverty and employment: percentage of the population with a physical or mental health condition in employment.
- Housing and care: adults with a learning disability living in stable and appropriate accommodation; emergency readmissions within 30 days of hospital discharge; number of days people remain in hospital after being medically ready for discharge.
- Education and prevention: population vaccination coverage (flu in primary school-aged children, HPV vaccine uptake in females and males); under-16 conception rate.
- Prevention: under-75 mortality from cardiovascular disease and cancer; breast, cervical and bowel cancer screening coverage; excess weight in children at reception and Year 6; smoking prevalence; potential years of life lost due to alcohol-related conditions; suicide rate per 100,000 population; proportion of older people remaining at home 91 days after discharge into reablement or rehabilitation services.

System impact: reducing demand for acute care through proactive, holistic support delivered by integrated neighbourhood teams across health, social care and the voluntary and community sector.

Lewisham (2/3)



South East London

Priority Area	What are we aiming to achieve?	Why does this matter?
To strengthen the integration of primary and community based care	<ul style="list-style-type: none"> Proactive, holistic, patient-centred care within a local neighborhood for people with long-term conditions, with personalised care planning. Reduce hospital admissions, cancers, heart attacks and strokes Integrated care for older people, focusing on proactive care, admission avoidance, discharge, and intermediate care Improved access to primary care and reduced community therapy waiting times. 	Local, integrated services are easier to navigate and improve outcomes through more holistic support that tackles health inequalities and wider social needs, particularly when built on trusted relationships with GPs and other clinicians and professionals. Designing integrated services around population health reduces duplication, supports system sustainability, and helps people manage long-term conditions, lowering demand for acute care.
To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	<ul style="list-style-type: none"> Higher immunisation uptake and completion 2% reduction in excess weight among Reception and Year 6 children (2023/24–2025/26) CYP using local and digital wellbeing services as alternatives to CAMHS and specialist social care Delivery of Lewisham All-Age Carers Action Plan (2025–2028) outcomes 	Increasing access to community support such as immunisations, healthy weight services, and early help for emotional wellbeing and mental health can improve poor outcomes for children. Unpaid carers also face major health and wellbeing impacts, with many living with long-term conditions and high levels of loneliness.
To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes	<ul style="list-style-type: none"> Higher cancer screening rates by demographic Reduced smoking rates by demographic Better recording and management of LTC risk factors in primary care Longer, healthier life expectancy Community prevention initiatives targeting obesity, diet, and physical activity More people with SMI and LDA receiving health checks, follow-up support, and engaging in screening and stop-smoking programmes 	Life expectancy inequalities are widening in Lewisham. Leading causes of death are cancer, circulatory and respiratory disease, with under-75 Ischemic heart disease mortality higher than England. Around 26% of residents have a long-term condition, and 10% have multiple conditions. The Birmingham and Lewisham African & Caribbean Health Inequalities Review informs targeted action for Black African and Caribbean communities.
To maximise our roles as 'anchor organisations' as employers	<ul style="list-style-type: none"> Enhance local employment opportunities, make full utilisation for organisations of their apprenticeship levy, and help to overcome workforce challenges in specific areas with high vacancy rates such as community and AHPs 	There are opportunities to create more entry level roles and increasing employability for the community, resolving workforce challenges and contributes to wider local economic development. Working together on joint learning for frontline staff enhances partnership working.

How will these priorities contribute to the NHS three shifts?

Shift 1 – From Hospital to Community:

Lewisham’s Integrated Neighbourhood Teams (INTs), Virtual Wards and UCR deliver coordinated, proactive care closer to home. Expansion of Same Day Emergency Care (SDEC) and pharmacy-led hypertension and AF pathways move long-term condition management into the community. Family Hubs, GP led Mental Health Hub for CYP, and “Ageing Well” services promote access and independence.

Shift 2 – From Analogue to Digital:

Shared Care Records, Population Health Management data and assistive technology pilots are creating the foundations of a digital-first system. Virtual Ward monitoring and digital inclusion programmes connect patients and professionals across sectors.

Shift 3 – From Sickness to Prevention:

Family Hubs and Start for Life support early years prevention, while hypertension detection, social prescribing, and community wellness tackle long-term conditions. The BLACHIR programme and housing/debt advice pilots address inequalities and social determinants, turning prevention into neighbourhood-level delivery.

How will our priorities improve access to high quality, safe care?

Our priorities improve access to safe, high-quality care by expanding neighbourhood services that provide timely support close to home. INTs, Same Day Emergency Care, Virtual Wards, and Urgent Community Response boost local capacity, reduce delays, and offer hospital alternatives. Family Hubs, youth GP clinics, and enhanced community mental health services improve access for children, young people, and underserved groups.

Safety is strengthened through proactive detection of hypertension, AF, and long-term conditions, plus targeted immunisation and screening. Shared care records and multi-agency data sharing improve continuity and decision-making.

Tackling inequalities via BLACHIR programmes, culturally competent support, co-located housing, debt, and benefits advice in neighbourhood hubs, and proactive case finding for LTC and moderate frailty further enhance both quality and safety. These priorities deliver timely, equitable, coordinated care, improving outcomes and reducing avoidable harm.

How will we monitor and share progress?

A set of outcomes have been identified and developed into a framework to measure the impact of the INT programme. To define our outcomes, a theory of change logic model was developed with the aim of clarifying the overarching aims of this programme; from these broader aims, specific & measurable outcomes were then defined. From this logic model, six key areas of focus for the outcomes framework were established: improved clinical outcomes, improved holistic wellbeing & patient experience, tackling socioeconomic ‘wider determinants’ (specifically unemployment), improved integration across system partners, including reduction in unplanned acute presentations, reduction in health inequalities, financial savings. Within these six categories, a list of specific, measurable outcomes was developed with input from clinical colleagues, system partner organisations, and population health data specialists. A high-level economic assessment estimated the prospective benefits of the MDM and INT programmes. For the MDM program, general ED attendances and admissions at UHL were estimated, as well as the number of re-ablement and home-based care packages. For the INT, general ED attendances and admissions at UHL were estimated in a similar manner, however, given the focus of the program on controlling specific CVD targets, separate estimates were also made on the number of STEMI heart attacks and strokes that could be prevented. The long-term value significantly exceeds the initial 5-year savings as many benefits continue to accrue throughout patients' lifetimes, particularly from prevented chronic conditions requiring lifetime management. A new leadership board will provide strategic oversight, while a dedicated Operational Meeting will manage day-to-day delivery, coordination, and performance of neighbourhood teams.

Southwark (1/3)

Ambition

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.

What do we know about our local population and residents?

Our diverse population: Southwark has 315,520 residents; 49% are non-white, with 25% Black/Black British. Diversity is greater among children and young people. 40% were born outside the UK, and over 80 languages are spoken. 53,700 residents have a main language other than English. There are 43 religions: 43% Christian, 40% no religion. Southwark has the 4th largest LGB+ population in England.

Ageing population: Population projections show a comparatively large rise of 39% in over-65s and a 92% increase in 70 to 80 year olds by 2040.

Relative deprivation improving: The 2025 Index of Multiple Deprivation ranks Southwark 67th most deprived borough in England (improving from 43rd in 2019). No areas remain in the most deprived decile nationally, although pockets of severe deprivation persist, especially on measures relating to children and older people.

Life expectancy, inequalities and causes of ill health: Life expectancy is 82.7 year in affluent areas vs. 79.4 in deprived ones, with little improvement over the past decade. Healthy life expectancy is 69.0 vs. 62.6. Potential gains are limited by increasing prevalence of long-term conditions, cancer, cardiovascular, respiratory, liver and kidney disease, and mental health issues. There was an increase of 2,000 residents living with 3 or more long term conditions between 2024 and 2025.

What outcomes are we looking to secure over the next five years?

Our Joint Health and Wellbeing Strategy priority outcomes are:

- **A Healthy Start in Life:** We will ensure families have access to quality maternity care and early years support, improve mental health, and reduce inequalities. Support will focus on children with SEND and families at risk of adverse experiences.
- **Healthy Work and Live:** We aim to increase access to good jobs that promote wellbeing and enable healthy lifestyles through leisure, physical activity, and cultural opportunities.
- **Support to Stay Well:** Accessible, preventive services will help people stay healthy. Unpaid carers will receive support to maintain their own wellbeing.
- **Healthy Communities:** We will strengthen the voluntary sector and create healthy environments and homes that foster social connection and wellbeing.
- **Integration of Health and Social Care:** Through South East London ICS and Partnership Southwark, we will deliver joined-up care, explore neighbourhood-level services, and involve local people.

The delivery plan includes progress on a set of associated [outcome measures](#). These include inequalities in life expectancy and healthy life expectancy, infant mortality, excess weight, admissions, vaccinations and Vital 5 uptake.

The strategy is due for renewal in 2028.

Southwark (2/3)



South East London

Priority Area	What are we aiming to achieve?	Why does this matter?
Integrated Neighbourhood Health and Care	As a pilot borough in the National Neighbourhood Health Implementation Programme, partners are creating an integrated health and care model to deliver the shift of care from hospitals to communities and focusing on prevention. Initial priorities include frailty, long-term conditions, and children.	Delivering neighbourhood health at pace is central to returning patient and community trust in the NHS, breaking down siloed working among our staff and improving urgent care by providing more convenient and appropriate services. This is a central objective of the NHS 10 year plan.
Mental Health	Reduction in waiting times for adults and children who need help with their mental health. The support will be easy to access and co-ordinated around their needs.	There are unacceptable long waits for Children and Adolescent Mental Health services and adult mental health services in Southwark. The delays in diagnosis and treatment have a potentially serious impact on the health and wellbeing of our population.
Frailty	Integrated neighbourhood teams to roll out the successful frailty pilot across all neighbourhoods. This will provide proactive co-ordinated local support to people at risk of losing their independence, preventing ill-health and avoiding the need for urgent care or care home admission.	Almost half of Southwark's residents over 65 report that they are not in good health, with this cohort of residents having poorer healthy life expectancy than the national average. The ageing population in Southwark amplifies these pressures and highlights the need for coordinated care.
Prevention and Health Inequalities	Work in partnership to reduce rates of avoidable illness and inequalities in outcomes between the most and least deprived communities. The most deprived communities will be more easily able to access tailored support for the five leading causes of poor health. Prevention and health inequalities goals will be embedded across all workstreams.	People in Southwark are living 20 years in poor health from a range of long-term conditions and comorbidities. Avoidable deaths account for 44% of all deaths. Common causes are from Cancer, Cardiovascular, Respiratory and Liver disease. Significant differences exist between the least and most disadvantaged areas of Southwark.
Primary Care access	Improve our resident's access to primary care so that people who want to see a GP or other primary care professional are consistently able to make an appointment in a timely way. Unwarranted variation in the time between requesting an appointment and being seen will be tackled.	We know that one of the most frequently expressed concerns of the public about health services is that making a GP appointment can be extremely frustrating and often not lead to a timely appointment. Delays in access can lead to increased pressure on the urgent care system.

Southwark (3/3)

How will these priorities contribute to the NHS three shifts?

Hospital to Community: Southwark’s plan focuses on improving services by developing the neighbourhood model of health and care. This approach is essential to shifting the balance of services from hospitals to the community, as outlined in the 10-Year Health Plan for England. Further details will be provided in the forthcoming Neighbourhood Health Plan, which will build on existing services that help keep people out of hospital.

Sickness to Prevention: A key aim of the neighbourhood model is to improve access to community based services and enable proactive identification of needs, allowing earlier intervention before more intensive care is required. Our prevention and health inequalities priority will directly support this shift from sickness to prevention, in line with the Health and Wellbeing Strategy.

Analogue to Digital: We will promote the adoption of digital tools across all neighbourhood service developments. This includes online access to urgent care and general practice, use of the NHS App, online consultations, shared data systems, population health analytics, and technology for monitoring and managing long-term conditions.

How will our priorities improve access to high quality, safe care?

Our priorities focus is on improving access by reducing waiting times and proactively identifying need. The neighbourhood model aims to enhance quality and safety by integrating and personalising services for people with complex needs, addressing overall individual needs and improving communication between providers.

Co-production with communities and collaboration with VCSE partners will be central to creating services that reflect the needs of our diverse populations.

Quality impact assessments and monitoring systems will remain integral to designing and implementing new service models, with the quality team providing oversight and assurance. Digital tools will support data-driven decision making.

We will adopt the transformed approach to quality outlined in the medium-term planning framework where applicable, including the forthcoming National Quality Strategy, Modern Service Frameworks, and National Care Delivery Standards.

How will we monitor and share progress?

Delivery of priority workstreams will be driven through the Partnership Southwark Start Well, Live Well, Age Well and Mental Health Delivery Groups. The programme will be overseen by the Southwark Neighbourhood Transformation Board which will report on progress to the Partnership Southwark Strategic Board. The Health and Wellbeing Board will also monitor the contribution this plan makes to the Health and Wellbeing Strategy and Action Plan.

The delivery of outcomes is already reflected in our metrics dash boards overseen through our assurance committee, and our current priorities dashboard will be expanded during 2026/27 to reflect key metrics in development for neighbourhood health services reflecting the model we are implementing.

Appendix 3. Borough neighbourhood development plans

Bromley Neighbourhood Delivery Plan (1/4)

Local Actions In Year 1

Local Actions In Year 2

Local Actions In Years 3-5

Develop neighbourhood footprints around natural communities

Align INT commissioning around needs of children & young people, people living with multiple long-term conditions, frailty & those discharged from hospital to promote early planning, prevention and independence.
Promote creative health approach working with VCSE colleagues.
 Launch a **workforce development plan** based on skills gaps and systems thinking.
Develop strategic commissioning leadership and integrator governance to enable INT implementation.

Commission INTs through a single neighbourhood provider contract form, and further align partner contracts.
Build on existing prevention work with communities to support vibrant community connection and resilience, using local knowledge, population health management data and closely working with VCSE.
Support neighbourhood infrastructure as enabler, including estates and digital tools for staff and residents, including cross organisational population health analysis.

Neighbourhood health commissioned as default holistic model of care via multiple neighbourhood provider contract form and with digital by default pathways.
Commission for population health management embedded at scale including prevention in all pathways, creative health promotion, continued support to vibrant VCSE innovation.
Sustainability developed through system-wide digital health and exploring links to genomics and life sciences.

Ensure good access to high quality general practice

Continued delivery of Primary Care sustainability plan, including appointment availability, digital provision, commissioned support for practices to reduce unwarranted variation, embedding target at scale model and maximising Pharmacy First opportunity.
Work with the new Primary Care Collaborative to embed it as the voice of GP leadership across borough to enable commissioning of robust at scale services.
New housebound, home visiting and weight-loss model engagement.

Embed tools for primary care management at scale and associated delivery structures: informed by risk stratification, continuity of care needs, and maximise benefit of community pharmacy.
Develop integrated access hubs, enabling triage of same day care needs at scale and improving estate to support flexible delivery of primary care.
Commission new housebound and home visiting provision and model for delivery of weight loss pathway.

Consistent implementation of primary care at scale across the borough with tailored provision to meet population needs.
Collaborative working between general practice and INTs supported through contract arrangements, driving improved resident outcomes and mitigating growth in care home and hospital admission.
Same day care access hubs delivered at scale and more flexible estate in place.
Establish independent prescribing offer within community pharmacy.

Bromley Neighbourhood Delivery Plan (2/4)

Local Actions In Year 1

Support the primary-secondary interface forum, embedding local interface agreements, delivery of discharge summary standards and continued relationship building as enabler for further improvement.

Agreement of provider timeline for Electronic Prescribing System (EPS)

Improve referral pathways including actions to promote self referral, utilisation of advice & guidance and enabling onward secondary care referrals.

Implement systematic approach to identify people with multiple conditions or frailty, including on discharge from hospital, at risk of needing hospital or social care.

Align incentives and target investment to deliver bio-psycho-social prevention model including holistic assessment with polypharmacy review and if appropriate, early end of life and advance care planning.

Agree tools to support teams working holistically around individual residents.

Support unpaid carers, communities and VCSE sector connection and wellbeing.

Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'

Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life)

Local Actions In Year 2

Commissioners to facilitate community orientated consultant working in the community in support of INT, outpatient and UEC transformation.

Improve pathways to surgical specialities promoting optimisation of patients whilst awaiting surgical intervention, including digital tools.

EPS to be established and in use, enabling patients to receive more care closer to home.

Evaluate adult INT model impact and delivery approach for the target cohorts

Evaluation to inform expansion in scale and scope of adult model to more people within the groups identified, further alignment of pathways to INT working and deer prevention and community working.

Continue developing advice and guidance approach in neighbourhoods.

Improve access to end of life drugs.

Refine digital interoperability between organisations and improve patient digital remote monitoring and self management.

Local Actions In Years 3-5

Expanded community diagnostics available to primary and secondary care as enabler for joint working, bureaucracy reduction and care closer to home.

Consolidating and enabling the further development of the culture of a 'One Bromley' health and care professional team caring for residents in the community through joint pathways, estate, digital and workforce training (e.g. joint teaching opportunities for specialty trainees).

Commissioners to support INTs moving to increased autonomy and accountability.

Further shared development of INTs with our communities and people using services.

Commissioning for the expansion of INT focus beyond initial adult, CYP and urgent pathways to ensure more people benefit from the approach.

Real-time predictive analytics secured to support staff engaging residents.

Support shared care responsibilities through contractual change, including health-health and health-care.

Bromley Neighbourhood Delivery Plan (3/4)

Local Actions In Year 1

Local Actions In Year 2

Local Actions In Years 3-5

Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs

Maximise virtual wards and hospital at home capacity for adults and children through existing contracts.
Commission and mobilise single point of access and embed call before convey with focus on older adult and mental health pathways.
Commission and develop community frailty same day emergency care model.
Re-specify intermediate care model.
Work with providers to enable digital interoperability of UEC pathways.

Shift to digital first in UEC pathways, including clinical prioritisation & booking patients into next day, including UTC.
Mobilisation of community frailty same day emergency care, supporting Urgent Treatment Centre transformation to see, treat and discharge 50% attends.
Establish integrated delivery units covering 111, urgent and emergency care as part of the single point of access.
Further support digital interoperability or shared systems across UEC pathway.

Further shift to digital first UEC pathways through contracting and delivery support.
Continue to realise refocus of urgent treatment centre and same day emergency care estate and funding to manage non-admitted patients.
Urgent care shifts to a neighbourhood led model via primary care, urgent community response, hospital at home, virtual wards and intermediate care as default in acute episodes outside hospital

Improving planned care in the community (linked to work to redesign outpatient care)

Improve diagnostics offer through commissioning community diagnostic services with INTs, integrate community pharmacy tests within local pathways, and extend diagnostics and screening access for housebound residents.
Support providers to engage patients in active health management, offering digital monitoring and holistic management models, including group clinics involving specialist input.
Scale up heart failure virtual ward.

Maximise screening, point of care, home, and pre- and post-operative tests as part of diagnostic & digital offer.
Develop and commission at-scale long-term condition assessment and care in neighbourhood referral hubs, with specialist secondary care input without requiring outpatient referral.
Commission wider virtual ward offer to more long-term conditions, aligning specialist and community teams.
Expand patient-initiated follow-up.

Shift model to further expand home testing diagnostics and screening offer and use of new technology such as wearables.
Further expand LTC care provision via specialist referral hubs in neighbourhoods, using population health insights to offer tailored support and reduce unwarranted variation.
Secure seamless transfer between neighbourhood referral hubs and virtual wards.

Bromley Neighbourhood Delivery Plan (4/4)

Local Actions In Year 1

Scope and specify children and young people's (CYP) INT model including areas, cohorts & aligning Family First and Care, Education and Treatment Reviews, taking a multi-agency physical and mental health approach.

Deliver asthma programme in schools and community diagnostics.

Ensure sustained 18 week wait referral to treatment performance in all sectors.

Review impact of universal, targeted, specialist therapy model.

Fully operationalise agreed autism spectrum disorder (ASD) pathway.

Local Actions In Year 2

Pilot and evaluate new CYP model to test outcomes and impact vs national requirements and Bromley priority areas. Focus will be on efficiencies of processes, patient and family time, and provider resources.

INTs leadership, formal and informal will begin to embed across the partnership, supporting pilots and structural changes required for wider transformation.

Commission changes to therapy model if indicated through review.

Review impact of autism spectrum disorder pathway.

Local Actions In Years 3-5

Commission CYP INTs to consolidate and develop into a mature model, embedded in children's social care, schools and other services.

Work with partners to support consistent expansion into new priority areas, with fluid workforces within robust INT framework. Support Integrator in ensuring enablers scoped and in place.

Monitor for delivery of reduction in need for specialist services and a truly holistic proactive approach to CYP support.

Review development needs, including asthma, therapy, ASD and weight-loss.

Improving care for children and young people as part of neighbourhood working

Bexley Neighbourhood Delivery Plan (1/4)

Local Actions In Year 1

Local Actions In Year 2

Local Actions In Years 3 -5

- **Map system assets** including digital maturity, shared care records, and neighbourhood resources
- **Establish integrator governance and workforce framework** for strategic commissioning leadership and training
- **Use Population Health Management (PHM) to align commissioning priorities** to children & young people, people with multiple long-term conditions and frailty in line with SEL frameworks
- **Build shared infrastructure** across estates, digital tools, and PHM analytics
- **Launch system-wide quality improvement programme**

- **Scale digital tools and PHM infrastructure** for proactive, preventative care
- **Embed INT leadership and workforce development** with competency frameworks
- **Expand PHM cohorts** and deliver preventative interventions in line with SEL frameworks
- **Scale system-wide quality improvement programme** and embed Quality Improvement collaboratives
- **Align contracts, incentives, and workflows** to support coordinated delivery

- **Embed shared leadership, culture, and integrated workforce**
- **Use advanced PHM and interoperable systems** for proactive, population-based care
- **Optimise estates and enablers**, with neighbourhoods contributing to system planning and outcomes
- **Commission for outcomes through value-based care contractual frameworks**, with aligned incentives and prevention investment
- **Implement unified outcomes framework** with real-time reporting

- **Stabilise access** through the Care Sustainability Programme, including reducing variation and expanding Pharmacy First/ independent prescribers.
- **Map estates and digital capability**; increase uptake of national and local digital tools
- **Baseline vulnerable groups and high-frequency users** to inform MDT model

- **Implement neighbourhood estates plans** and strengthen digital access to support delivery of primary care at scale
- **Scale MDT approaches** for high-risk cohorts, informed by risk stratification and early population insights
- **Broaden deployment** of pharmacy independent prescribers and maximise benefits of community pharmacy

- **Embed integrated access models delivering primary care at scale** with fully developed MDTs
- **Deliver optimised estates and digital infrastructure** enabling seamless access, coordination and improved outcomes
- **Scale and spread community pharmacy independent prescribers** supporting people with multiple long-term conditions

Develop neighbourhood footprints around natural communities

Ensure good access to high quality general practice

Bexley Neighbourhood Delivery Plan (2/4)

Local Actions In Year 1

- **Strengthen joint working across all interface pathways**, aligning with INTs and embedding interface actions to improve timeliness and quality of discharge notices
- **Stabilise and expand Advice & Guidance**, electronic referrals and Consultant Connect
- **Commence work on resident optimisation** to support people 'waiting well' prior to surgery

- **Maximise virtual wards, intermediate care, and same-day emergency care** focusing on people with complex needs
- **Strengthen shared pathways** and escalation across physical and mental health; continued Universal Care Plan quality improvements
- **Deliver deep-dive actions** (eg call-before-convey), workforce skills assessment, and workforce capacity development
- **Improve vertical integration** via urgent treatment centres and primary-care redirection; support basic digital interoperability across all pathways

Local Actions In Year 2

- **Implement consistent interface standards**, supported by neighbourhood teams and shared governance
- **Work with providers to scale optimised diagnostics**, Same Day Emergency Care and urgent care processes to reduce variation and unblock flow
- **Embed integrated digital** and referral processes across all neighbourhoods to promote and support waiting well

- **Manage high risk cohorts in the community** by implementing a multi-neighbourhood urgent care plan, including strengthened urgent community response and out-of-hours provision
- **Establish 111 integrated delivery units**, aligned with local community urgent care pathways, integrated neighbourhoods, and local urgent care response functions
- **Standardise shared handovers**, access routes and MDT processes across physical and mental health urgent care
- **Use digital tools to support remote triage, virtual clinical review** and streamlined communication across teams

Local Actions In Years 3 -5

- **Achieve a fully integrated interface** with consistent cross-pathway standards, shared decision-making and mature neighbourhood collaboration to include shared estates, workforce and training
- **Optimise availability of community diagnostics** to support integrated working and provide care closer to home
- **Use population insights and continuous improvement** to refine pathways and reduce avoidable demand

- **Commission a fully integrated urgent care offer** across neighbourhoods to include primary care, urgent community response, hospital at home/virtual wards and intermediate care
- **Embed seamless coordination and delivery across INTs with interoperable data** and shared decision-making
- **Use system intelligence to optimise capacity**, reduce avoidable admissions and improve same-day community-based support
- **Expand digitally enabled community pathways** to divert demand from UEC and support safer, earlier discharge

Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'

Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs

Bexley Neighbourhood Delivery Plan (3/4)

Local Actions In Year 1

- **Consolidate existing initiatives** (3+Long Term Conditions and Frailty) into a single INT framework
- **Prioritise redesigned adult weight-management** pathways, including access to future medications, to tackle obesity's impact on outcomes and LTCs
- **Scale Ageing Well Community Hub and Frailty INT** borough wide and phased roll out of Bexley Frailty end-to-end /end of life model incorporating district nursing service review and care home deep dive actions
- **Codesign neighbourhood health centre model** with focus on complex needs
- **Embed holistic, integrated working** across organisational boundaries and establish personalised care planning and support for self-management and carers
- **Continued co-design**, drawing on relationships with community champions, to introduce 'no wrong door' for integrated care
- **Implement Bexley GP Premium** to support consistent, preventative and digitally supported integrated delivery

Local Actions In Year 2

- **Evaluate and scale the INT model** across all neighbourhoods with consistent multi-disciplinary team processes (involving adult social care, voluntary and community sector and carers) and digitally supported coordination
- **Strengthen shared governance**, data flows and community resource mapping to avoid duplication and improve early intervention with 'prevention-first' approaches
- **Embed shared holistic assessments** and care coordination across partners to support anticipatory, preventative and digitally enabled care
- **Strengthen Population Health Management improvement cycles** to target 'at risk' cohorts and address local inequalities.
- **Continue proactive support to unpaid carers** across neighbourhoods
- **Embed personalised care** as standard practice across all cohorts through co-designed models of care
- **Strengthen digital interoperability** between organisations and enable improved digital support for self-care

Local Actions In Years 3 -5

- **Embed predictive analytics**, advanced risk stratification, and digital coordination to anticipate needs, manage high-risk cohorts, and deliver prevention-first, person-centred interventions beyond initial priority cohorts
- **Seamlessly collaborate** across health, adult social care, and community partners to provide holistic care, reduce duplication, and improve outcomes using INT evaluation insights
- **Commission neighbourhood services via a value-based care framework**, focused on measurable population health outcomes, linking provider payments to quality, prevention, and integration outcomes
- **Embed engagement with residents, carers, and communities in co-design**; address health inequalities; and enable self-management and digital literacy to support inclusive, preventative care
- **Optimise workforce capacity and skills**, leverage interoperable digital tools, monitor performance via clear KPIs, and embed learning cycles to adapt services and scale successful innovations

Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).

Bexley Neighbourhood Delivery Plan (4/4)

Local Actions In Year 1

Local Actions In Year 2

Local Actions In Years 3 -5

Improving planned care in the community (linked to work to redesign outpatient care)

- **Map community physical/mental health pathways** to identify gaps & prevention opportunities, including elective/diagnostic access
- **Develop a neighbourhood planned care model** for high-volume, high-impact conditions, aligned to SEL-wide work
- **Strengthen links** with adult social care, carers, voluntary sector, and community networks to support early help and prevent escalation

- **Implement redesigned pathways** for priority conditions with optimised elective/diagnostic access and integrating physical health, MH, social care, and community support
- **Standardise referral routes**, shared assessments, and multi-disciplinary links with neighbourhood teams
- **Expand early intervention**, self-management, and carer/community support programs

- **Commission fully integrated neighbourhood planned-care model** with consistent elective/diagnostic pathways to reduce waits
- **Embed shared dashboards** and neighbourhood led initiatives to optimise high-volume pathways and reduce outpatient demand
- **Strengthen prevention, proactive carer support**, and community-led approaches to reduce long-term demand

Improving care for children and young people as part of neighbourhood working

- **Evaluate current initiatives** and develop plan for scaling based on insights
- **Map CYP physical and MH service gaps**, including neurodiversity, transition, out-of-hours mental health and SEND.
- **Support development of a family-based tier 3 weight-management** service and prevention offer.
- **Develop integrated transformation** plan based on outputs from joint workshops and the SEL CYP Framework focusing on inequalities and workforce capability.

- **Scale integrated child health initiatives** across all neighbourhoods, including MDT for complex cases
- **Implement redesigned CYP pathways** for priority needs (neurodiversity, transition, obesity and MH) integrated with neighbourhood teams aligned to SEL CYP Framework
- **Improve access, signposting, waiting times** and coordinated support for CYP, families, and carers across neighbourhoods
- **Deliver the joint transformation plan**

- **Commission a fully integrated CYP model across neighbourhoods**, aligned to the SEL CYP Framework
- **Use shared data and proactive outreach** to improve outcomes
- **Embed prevention** and joint working with education, social care, and voluntary partners with inclusive practice for CYP with SEND
- **Integrate new digital tools** and neighbourhood platforms to support coordinated care and communication with families

Greenwich Neighbourhood Delivery Plan (1/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Develop neighbourhood footprints around natural communities	<ul style="list-style-type: none"> 4 geographical neighbourhoods agreed in Feb 2025 Establish neighbourhood level leadership teams, supported by a programme function to operationalise pathway improvements Expand & align the current frailty and 3+LTC offer to neighbourhood footprint supported by consistent borough wide offers such as equipment or digital health and care Redesign Mental Health community services including the Hub and to ensure they align into integrated neighbourhood teams (INTs) Link Learning Disability and Mental Health Supported Living and Residential care providers into their local INT Design and deliver culture change programmes to support the workforce 	<ul style="list-style-type: none"> Develop neighbourhood-based leadership and governance in partnership with communities Continued alignment of service delivery footprints to neighbourhood footprints including social care Test and develop new model of MH neighbourhood working in one or two neighbourhoods Redesign community offers such as homecare and reablement, aligned to neighbourhood model 	<ul style="list-style-type: none"> Embed new ways of working across INTs and adjust based on learning Roll out new MH neighbourhood model to all neighbourhoods LD and MH provision and residents fully involved with their local INT
Ensure good access to high quality general practice	<ul style="list-style-type: none"> All practices delivering Modern General Practice including meeting Online Consultation requirements during core hours Introduce Depot Service into GP surgeries Develop plans to ensure 90% target for same day appointments for all clinically urgent patients is achieved by April 26 Determine additional capacity needed to meet demand out-of-hours and over surge periods including bank holidays and weekends Increased use of digital and AI tools to improve access and free up time 	<ul style="list-style-type: none"> Learning from Year 1 Depot Service and aligning to Localities Incorporate learning from analysis of people attending ED in MH crisis (see below) Further develop contract monitoring mechanisms Improved National Patient Survey results Development of a range of support offers including mechanisms to measure impact 	<ul style="list-style-type: none"> Continue to promote use of the NHS App Review of BI dashboards to identify unwarranted variation Review Mental Health Practitioner roles to enable more seamless pathway between Primary and Secondary Care Support transition of Crisis Lines from local to central working

Greenwich Neighbourhood Delivery Plan (2/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
<p>Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'</p>	<p>Deliver on locally identified (core RTC) priorities:</p> <ul style="list-style-type: none"> • Reduce inappropriate requests • Building on timeliness and quality of discharge summaries • Improving A&G access, referral optimisation, elective recovery, PIFU and other support with hospital demand • Shared Care Prescribing across the interface 	<p>Consolidate Year 1 development of local priorities while maintaining a strong performance against current and future national and SEL priorities.</p> <p>The strengthening of Integrated Neighbourhood working based on clear and sensible interfaces between health and care services, that work efficiently, amiably and safely by default. Patients will experience seamless care therefore, with fewer delays, incidents or near misses.</p>	<p>Greenwich aspirations for a Neighbourhood/ INT approach to urgent and same day care pathways will be developed in Year 2 to reflect early urgent care interface work. Explore interoperability between digital systems to improve the seamless transfer of information.</p>
<p>Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).</p>	<ul style="list-style-type: none"> • Development and implementation of Local Enhanced Service (LES) for Frailty to facilitate the risk stratification of patients • Design of new model of homecare and reablement services aligning opportunities for home based intermediate care. • Improve S117 and Care Act discharge planning • Mental Health Supported Accommodation Pathway developed with more high needs capacity 	<ul style="list-style-type: none"> • Expansion of condition coverage for INTs • Commission and mobilise new homecare and reablement services, deliver changes to district nursing model • Modelling of borough Integrated Delivery Unit (IDU) for 111 • Formal launch of MH Alliance: redesign of system to reduce crisis and inpatient activity and spend by shifting support to prevention in the community • Develop the LDA supported accommodation offer for residents with complex needs 	<ul style="list-style-type: none"> • Align resources and funding to the population demands and priorities of neighbourhood working • Further develop neighbourhood working through Neighbourhood Hubs with co-located staff • MH Alliance delivering plan to shift MH support from hospital to community through service provision expansion. • New LDA supported accommodation available for complex needs • LDA Provider market developed with trusted, quality partners

Greenwich Neighbourhood Delivery Plan (3/4)

Improving planned care in the community (linked to work to redesign outpatient care)

Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs

Local Actions In Year 1

- New Greenwich LeDeR Steering Group to establish and deliver learning from LDA deaths
 - Increase the uptake of LD and MH Annual Health Checks, and continued reduction of unnecessary medication (STOMP programme).
 - ASD/ADHD diagnostic Services market control
 - Mobilise new MSK service
 - End of life improvements (hospice upgrades & OOH support)
 - Develop a neighbourhood focused planned care model
 - Further develop women's health and community gynaecology offer

- Implement new discharge to assess pathway incorporating step up provision
- Complete intermediate care, virtual ward and reablement reviews and implement outcomes
- Design phase for community equipment offer, learning from provider failure
- Design and implement recommendations from the BCF support programme including new reporting to track demand and capacity and coordination via TOCC
- Develop further understanding of the profile of those attending ED in MH Crisis and identify missed opportunities to support them in advance.

Local Actions In Year 2

Continue to develop planned care on a neighbourhood footprint, integrating physical health, mental health, community services and social care to support early help and prevent escalation

Expand early intervention, self-management, and carer/community support programs to reduce the need for outpatient care

Standardise referral routes, shared assessments, and MDT links with neighbourhood teams

- Develop roadmap for virtual wards
- Develop remote monitoring capacity through DHACT to support care at home and step down
- Implement new community equipment offer
- Launch new all age carers strategy and delivery plan
- Ensure implementation of prevention solutions to reduce ED MH attendance
- Improve MH community support for hospital discharge
- Ensure data enabled practices are embedded across INTs and community offers which enable more proactive care

Local Actions In Years 3 -5

Deliver a fully integrated planned care neighbourhood model which has proven positive outcomes for local residents and the system with reduced waits and improved health outcomes

A continuous neighbourhood improvement model adopted by all to scale up good practice, have a community of practice, strengthen prevention, self management and reduce the need for emergency care

- Review outcomes achieved from intermediate care offer and make adjustments as required
- Implement recommendations from virtual wards roadmap
- Continue roll out of DHACT and remote monitoring capacity to further resident cohorts

Greenwich Neighbourhood Delivery Plan (4/4)

Local Actions In Year 1

- Evaluate and develop the model of Local Child Health Teams in Greenwich to identify opportunities for enhancement and alignment with the wider integrated neighbourhood development work.
- Re-commissioning of Family Hub and Children's Centre provision, aligning with the Neighbourhood development
- Implement the new health roles within the proposed Multi-agency Child Protection Teams (MACPT) and Family Help (FH) provision to support families and identify opportunities for better health system and neighbourhood working for those cohorts.
- Implement a new Single Point of Access for children's mental health and emotional wellbeing to improve identification and support to children.
- Re-commission a new Children and Young People's Homecare provision to strengthen the offer and practice
- Implement Programme (STARSS) to strengthen inclusivity and support for SEND children.
- Review Asthma pathways and opportunities

Local Actions In Year 2

- Alignment of the Family Hub and Children's Centre provision in line with Neighbourhood developments.
- Review the new health roles within the MACPT and FH provision to identify impact and sustainable future models
- Review and potentially implement new ways of working with SEND subject to the development of the Schools White Paper.
- Align Transitions Workers to improve transition arrangements between CAMHS and Adult Mental Health services
- Opening of Transition Learning Centre for young adults (18-25) with SEND to improve the local offer of provision.
- Review the impact of the new Single Point of Access for children's emotional health and wellbeing.
- Implementation of improvements to the mental health offer for education settings.
- Review the effectiveness of improvements to the Autism and ADHD pathways.
- Identify opportunities to support children and young people as part of the DHACT development

Local Actions In Years 3 -5

- Align resources and funding to the population demands and priorities of neighbourhood working
- Review impact of the Families First Reforms in strengthening support around families within the community.
- Implementing opportunities for greater pooled funding for children and young people including those with complex care outside of S.117 and Continuing Care.
- Review the impact of the new Youth Offer in supporting improved prevention and health and wellbeing for children.

Improving care for children and young people (CYP) as part of neighbourhood working

Southwark Neighbourhood Delivery Plan (1/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Develop neighbourhood footprints around natural communities	<ul style="list-style-type: none"> • Footprints for neighbourhood health and care teams were agreed in 2025, aligned with local authority neighbourhoods, allowing development of a wider public and VCS offer around neighbourhoods • Identify health centres in each neighbourhood • Redesign community services around neighbourhoods • Determine standard approach to approaching the registered population within general practice when not resident within the neighbourhood or borough • Test ways of information sharing with grassroots voluntary and community sector organisations 	<ul style="list-style-type: none"> • Develop all integrated neighbourhood teams in the five neighbourhoods in Southwark • Embed neighbourhood working within secondary care workplans as business as usual • Integrator to test new financial and contractual models which could allow single or multi-neighbourhood provider delivery models 	<ul style="list-style-type: none"> • Neighbourhoods to roll out new financial and contractual models for single or multi neighbourhood provider delivery models • Embed shared data systems across all partners within neighbourhoods
Ensure good access to high quality general practice	<ul style="list-style-type: none"> • Build a shared understanding of current access performance • Use consistent data to identify variation and agree shared improvement priorities across practices/neighbourhoods • Devise and deliver local Quality Improvement initiatives, supported by the Federation, to improve access in line with national targets (clinically urgent patients) • Support practices to use Ardens Manager to review data on access from previous years, to set benchmark for year 1 • Expand use of Advice and Guidance • Review ARRS-funded workforce and skill mix at neighbourhood level and align roles to support INT • Use Direct Enhanced Services (DES) flexibilities to support a sustained access focus • Embed Pharmacy First pathways • Support practices to optimise digital tools (e.g. online consultations, NHS App) to improve flow and free clinical capacity. 	<ul style="list-style-type: none"> • Expand use of digital tools to streamline demand and support timely clinical assessment • Increase use of population segmentation tools to identify patient cohorts requiring GP care, helping practices to proactively manage demand and improve equity of access • Strengthen the GP contribution to the INTs by coordinating information, referrals and follow-up within neighbourhood networks • Further develop relationships with INTs to deliver multi-disciplinary teams (MDT) and reduce reliance on formal referral processes. • Review patient cohort e.g. focussing on high primary care attenders or depression • Review and refine impact of QI initiatives 	<ul style="list-style-type: none"> • Deliver a mature neighbourhood access model with consistent same day access performance, improved patient experience and digital maturity across practices. • Use population health insights to target unmet need and reduce inequalities. • Establish general practice as a fully integrated INT partner, sharing data and jointly supporting neighbour priorities.

Southwark Neighbourhood Delivery Plan (2/4)

	Local Actions In Year 1 2026 - 2027	Local Actions In Year 2 2027 – 2028	Local Actions In Years 3 -5 2028 - 2031
<p>Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).</p>	<p>Scale INT delivery across all neighbourhoods:</p> <ul style="list-style-type: none"> •Expand complex case multi-disciplinary meetings (MDM) and test different Comprehensive Geriatric Assessment (CGA) approaches. <p>Develop workforce and leadership:</p> <ul style="list-style-type: none"> •Refocus capacity to support INTs. •Broaden INT multi-disciplinary teams (MDT) to include social care, nursing, pharmacy, community, link workers, and mental health. •Measure INT impact on key targets, e.g., hospital admissions for over 65s. <p>Support from SEL led enabler programme:</p> <ul style="list-style-type: none"> •Use comms, digital, training, competency frameworks, and estates to aid INT delivery. <p>Partner with VCSE for frailty screening in the community.</p>	<p>Strengthen the frailty INT model in each neighbourhood by:</p> <ul style="list-style-type: none"> •Embed suitable CGA interventions for assessment. •Embedding a sustainable approach to frailty identification and proactive management •Ensure full borough coverage of frailty INTs, engaging any remaining GP practices. <p>Continuously measure outcomes and INT effectiveness.</p> <p>Expand workforce skills through training and competency frameworks for all staff, including VCSE.</p>	<p>Achieve full maturity of the Frailty INT model in every neighbourhood, with all GP practices engaged.</p> <ul style="list-style-type: none"> • Integrated teams share leadership across health, social care, and VCSE. Identify frailty at the population level, focusing on prevention and healthy aging. • Sustain workforce through skilled neighbourhood teams, new multidisciplinary roles, and VCSE prevention staff. • Regularly monitor and evaluate long-term INT impact.
<p>Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'</p>	<p>Integration and Process Optimisation:</p> <p>Interface forum oversees SEL priorities locally.</p> <p>Standardise communications: discharge summaries (24h), clinic letters (10 days), fit notes by secondary care.</p> <p>Implement "Waiting Well": clear patient information on waiting times and points of contact. Improve advice/guidance quality. Maintain directories and apply prescribing policy</p>	<p>Sustainability and Continuous Improvement: Review KPIs for impact. Develop shared care protocols. Improve referral pathways and digital systems. Strengthen patient engagement and appointment management. Support training and cultural alignment.</p>	<p>Sustainability and Continuous Improvement: Review KPIs for impact. Embed joint health promotion initiatives. Scale best practice models. Secure ongoing funding for workforce and digital roles.</p>

Southwark Neighbourhood Delivery Plan (3/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Improving planned care in the community (linked to work to redesign outpatient care)	<ul style="list-style-type: none"> To establish models of care for Frailty, Multiple Long Term Conditions (MLTC) and CYP within each neighbourhood To review use of all the community estates and activity at each centre To develop a future strategy and plan informed through public and patient engagement and VSCE Linked to existing community services 	<ul style="list-style-type: none"> Set key milestones to deliver against the agreed strategy Agree beyond Frailty, MLTC and CYP what else should be delivered in the community Understand what the independencies are and how to address these 	<ul style="list-style-type: none"> All chronic conditions to be supported and managed out of hospital and in local hubs where appropriate Use of digital to support patient care and support patients to manage their own care
Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs	<ul style="list-style-type: none"> Fully utilise virtual ward and @Home capacity, review opportunities to maximise usage Work with SEL to confirm future budgets for Virtual Wards, @Home and remote monitoring Evaluate the 2025 expansion of Urgent Community Response (UCR) capacity with a view to making further investment Develop 2026/27 winter plans with year-round focus on Urgent Emergency Care recovery and reducing A&E pressure Develop Neighbourhood same day access plans Work to develop Single Point of Access (SPOA) for same-day urgent care Work with Ambulance Services on trusted assessor models and “call before convey” 	<ul style="list-style-type: none"> Continue to review @home capacity and move activity to business as usual Continue to work to identify the most efficient and cost-effective remote monitoring technologies Deliver strong multi-specialty SPOA. Develop Neighbourhoods same day access plans Develop 2027 winter plans Shift to digital first in UEC pathways, including clinical prioritisation & booking patients into next day, including UTC Prepare for 2027 111/Integrated Delivery Unit (IDU) go-live 	<ul style="list-style-type: none"> Annual winter planning and UEC recovery to meet targets Collaborate with the IDU provider to enhance integration with other services, leveraging technology and AI and linking with neighbourhood teams and pathways Further shifts to digital first UEC pathways

Southwark Neighbourhood Delivery Plan (4/4)

Local Actions In Year 1

- Further develop the CYP INT working group programme under the Southwark Neighbourhood Transformation Board with clear decision-making and accountability
- Plan/develop the bi-borough model by linking Early Help and Early Years panels in Family Hubs and Families First Partnership Programme with GP-hosted child health MDTs using the Child Health Integrated Learning and Delivery System (CHILDS) framework
- Continue delivering integrated child health teams for every GP practice in Lambeth & Southwark
- Progress the agreed CYP INT pilots with relevant partners and simple evaluation plans
- Identify CYP health inequality priorities with support from Act Early South London
- Agree on a mid to long term plan and set milestones for rolling out CYP INTs across the five neighbourhoods

Local Actions In Year 2

- Implement integrated working across health and social care through the bi-borough model
- Evaluate the bi-borough model and the agreed CYP INT pilots and use learning to refine pathways, roles, and delivery
- Expand INT pilots to more neighborhoods
- Align Family Hubs, Early Help, schools, community health services, and general practice around CYP INT priorities within each neighbourhood
- Reconfigure integrated child health teams to neighborhood boundaries once IT systems allow
- Deploy shared care records and population health tools; build extended MDT capacity including VCSE partners
- Develop enhanced metrics and reporting to monitor access, experience, and outcomes for CYP and families

Local Actions In Years 3 -5

- Maintain and refine the CYP INT model across all neighbourhoods, using evaluation, data and feedback to ensure it remains fit for purpose
- Adjust cohorts, pathways, and access routes across Family Hubs, social care, schools, and health services) in response to emerging needs and inequalities
- Align funding and commissioning to secure long-term sustainability; maintain governance and neighbourhood leadership for shared accountability
- Apply routine outcome and experience measures to demonstrate impact and drive continuous improvement

Improving care for children and young people (CYP) as part of neighbourhood working

Lewisham Neighbourhood Delivery Plan (1/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Develop neighbourhood footprints around natural communities	<p>Well-established local neighbourhoods are in place and progress with established INTs for LTCs; further programme to strengthen partnership and integrated working, supported by organisational development. This includes primary care, voluntary and community sector, INTs, mental health, prevention, acute-to-community pathways, estates, digital, population health, and quality improvement.</p> <p>Establish community hubs in four neighbourhoods with co-located clinical and community space, alongside a Lewisham Carers Hub and neighbourhood support offer.</p>	<p>Further develop community hubs in four neighbourhoods to improve access to voluntary groups and local support such as benefits, employment, housing advice and family hub provision. This will require new approaches to using and sharing the estate across the partnership and will include establishing formal links and shared pathways between community hubs and children’s hubs, with plans developed for each hub to support seamless family and adult services.</p>	<p>Continuing development of community hubs and establishing secondary care services into these and other community spaces away from our hospital sites.</p> <p>Enhancing work on neighbourhood focused development with local authority main grants programme for the VCSE to support capacity building and key working with INTs to support vulnerable residents to link into health.</p>
Ensure good access to high quality general practice	<p>Continue delivering the Primary Care Access Plan by embedding Modern General Practice, increasing NHS App and Pharmacy First use, reducing practice variation, maximising PCN Enhanced Access, and clearly communicating this to the public.</p>	<p>Improve links with Community Dental and Ophthalmic services to support patients to be seen in the right setting, by the right person at the right time. Ongoing public communication and engagement to support patients to successfully navigate primary care.</p>	<p>Optimise access through a consistent and streamlined Modern General Practice offer across all practices, maximise NHS APP utilisation and use of increasing Community Pharmacy services.</p>
Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and ‘Bridging the Gap’	<p>Continue primary/secondary care interface plan via established group—covering inappropriate request letters, podcasts, joint grand rounds, WhatsApp group, and “walk in my shoes” exchanges. Begin developing interfaces with mental health, local authority, and VCSE.</p>	<p>Building on the learning from the primary/secondary care interface work and development with mental health, local authority and VCSE. Work across primary and secondary care to reduce gynaecology and cardiology outpatient appointments through joint working, training, and triage.</p>	<p>Mainstream an ongoing focus on interfaces between all providers and services to reduce bureaucracy and increase efficiencies</p>

Lewisham Neighbourhood Delivery Plan (2/4)

Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).

Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
<ul style="list-style-type: none"> • GP-led MDT meeting use risk-ratification list to proactively identify top 0.5% of patients at risk of hospital admission. GPs, DNs, pharmacists, social prescribers, and other allied health professionals (including pilot of mental health professionals in N2) come together to review each flagged patient while maintaining continuity of care through GP. • Establish the Frailty INT team, including PAWS (Proactive Ageing Well Service), Falls Team, and Social Care. Integrate PAWS with Virtual Ward and Urgent Community Response, with clear referral pathways to NHS @ Home and NHS Virtual Plus, to prevent admissions and ED attendances and proactively manage at-risk residents. • Continue development of support people with multiple LTCs through the core INT for LTCs • Partner with Adult Social Care, Council, and VCSE to promote Lewisham as an Age-Friendly Borough • Map and integrate EOLC and urgent care pathways. • Improve timely identification of carers of all caring experiences and populations across health and care settings. 	<ul style="list-style-type: none"> • NHS Virtual Plus expansion: Extend proactive monitoring to high-risk cohorts beyond respiratory (COPD, CHF, frailty). • Integrate existing Virtual Ward services, fully embed pharmacy in INTs, and align with primary care for prevention and proactive outreach. • LTC and Frailty INTs: Develop clear, integrated pathways and SOPs that address co-existing mental health needs (e.g., dementia) and ensure carers are identified and involved. • Ensure that all complex patients known to the CHC Team, ASC, DN and/or living in Care Homes are included in scope for Primary Care MDMs. • The Universal Care Plan should be adopted across Lewisham with widespread training for all staff. • Re-launch the Lewisham Dementia Strategy and Care Pathway, including family carer support and enhanced services from diagnosis to end-of-life care. 	<ul style="list-style-type: none"> • Shared Care Planning Platform: Enable real-time updates across INT and virtual services. • Full Virtual Plus Model: INTs operate hybrid—physical and virtual—with predictive analytics. • AI-Enabled Risk Stratification: Identify patients at risk of deterioration for proactive outreach. • Neighbourhood Hubs: Combine clinical, social, and voluntary services in a digital-first model for LTCs, Frailty and EOLC. • Review the Primary Care Enhanced Health in Care Homes contract and recommend improvements. • Ensure that the Maximising Wellbeing at Home Contract (Domiciliary) Care is strengthened to enable these Teams to have strong links into the Frailty INT and are supported to manage complex patients by Community Nursing Teams.

Lewisham Neighbourhood Delivery Plan (3/4)

Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs

Improving planned care in the community (linked to work to redesign outpatient care)

Local Actions In Year 1

- Map capacity across UCR, VW (Adults & Paeds), intermediate care, MH crisis.
- Launch N2C 24-hour MH crisis pilot and embed referral pathways.
- Develop model of care for frailty INT
- Enhance UCR social worker role for rapid decisions and support; optimise TOCH for discharge planning. Pilot joint MDTs (frailty, paed, MH, social care).
- Digital readiness: shared care record access for all urgent care partners. Align with SEL wide digital front door to enhance accessibility
- Demand forecasting: utilise pop health and predictive analytics to understand demand

Introduction of joint primary/ secondary care delivery through the INT approach. Reduce avoidable outpatient appointments by ensuring that patients are assessed, managed, and supported in the most appropriate setting, with seamless transitions between services through joint MDT/triage hubs, pre-referral decision-support for LTC clinics, and support General Practice to obtain specialist advice before referral and ensure necessary work-up and diagnostics are completed.

Local Actions In Year 2

- Expand Virtual Plus (remote monitoring for adults & potentially paed).
- Create Neighbourhood Urgent Care Coordination Hub integrating established LAS ICC hub, 111, UCR, VW, MH, INTs and EoL
- Cross-training for urgent care, MH, paediatrics, and social care teams
- Launch Virtual MDTs for complex cases across pathways.
- Develop a joint workforce model with rapid access intermediate care pathways and escalation SOP and expand the enablement workforce and flexible bed capacity for urgent step-down during surges.

Collaborative work across the system to review and redesign the current gynaecology (Gynae) pathway, ensuring it delivers timely, person-centered, and equitable care. This will include the development and implementation of a Women's Health Hub model that improves access, coordination, and continuity of care across primary, community, and secondary services. The aim is to streamline pathways, reduce waiting times, and enhance outcomes for women through a more integrated and holistic approach.

Local Actions In Years 3 -5

- Predictive analytics for urgent care demand 24/7 integrated urgent care model (health + social + MH).
- Outcome-based commissioning for urgent care and virtual pathways. Move intermediate care into outcomes-based contracts linked to urgent care KPIs.
- Continuous improvement via patient feedback and system-wide evaluation.
- Dynamic Capacity Planning: Use predictive analytics to flex intermediate care beds and workforce in real time.

- Commission integrated neighbourhood services with proven benefits.
- Expand LTC care via specialist hubs using population health data.
- Deploy digital tools to enhance care and empower patient self-management.
- Increase the outpatient's/ diagnosis services within our INT health and wellbeing hubs

Lewisham Neighbourhood Delivery Plan (4/4)

Improving care for children and young people as part of neighbourhood working

Local Actions In Year 1
<ul style="list-style-type: none"> • Begin the implementation of the Local Child Health Team to support children and young people to be seen in the community. • Implement the LCHT model in at least one Primary Care Network to test and learn ahead of a full-scale rollout. • Continue to develop an integrated neighbourhood team approach, aligned with our neighbourhood Family Hub offer that will provide proactive care to children and families using a population health approach. • Expand GP Youth Clinic to cover the whole borough, which provides preventative adolescent support for mild to moderate mental health conditions.

Local Actions In Year 2
<ul style="list-style-type: none"> • Continue the implementation of the LCHT model across all Primary Care Networks with 100% uptake by the end of the year. • Implement the SEL framework for neighbourhood teams and incorporate the LCHT pathway. • Aim to have one of the four neighbourhood areas operating an CYP INT offer by the end of the year. • Explore how the GP Youth Clinics can be integrated into the CYP INT offer as it develops and embeds.

Local Actions In Years 3 -5
<ul style="list-style-type: none"> • Continue to roll out the CYP INT offer across the remaining neighbourhoods and review the model whilst identifying further opportunities to integrate community health provisions using a population health approach to identify opportunities.

Lambeth Neighbourhood Delivery Plan (1/4)

Local Actions In Year 1

- Establish neighbourhood leadership functions across all system partners to create leadership teams, building on existing primary care and Thriving Communities neighbourhood leads
- Identify health centres in each neighbourhood
- Redesign community services by Neighbourhood
- Determine standard approach to approaching the registered population within general practice when not resident within the neighbourhood or borough
- Test ways of information sharing with grassroots voluntary and community sector organisations

Local Actions In Year 2

- Develop all integrated neighbourhood teams to the five neighbourhoods in Lambeth
- Embed neighbourhood working within secondary care workplans as business as usual
- Test new financial and contractual models which could allow single or multi-neighbourhood provider delivery models

Local Actions In Years 3 -5

- Neighbourhoods to roll out new financial and contractual models for single or multi neighbourhood provider delivery models
- Embed shared data systems across all partners within neighbourhoods

Develop neighbourhood footprints around natural communities

Ensure good access to high quality general practice

- Develop a comprehensive understanding of current access provision and agree shared priorities.
- Strengthen same day access by embedding total triage to support safe prioritisation.
- Support practices to optimise digital tools (online consultations, AI scribe, NHS App) to improve flow and free clinical capacity.
- Use population segmentation tools to inform proactive care and resource allocation.
- Embed the new Lambeth Offer to drive measurable improvements in quality and equity
- Review ARRS-funded workforce and skill mix at neighbourhood level and align roles to support INT

- Improve access by applying shared principles for same day access and triage.
- Expand use of digital tools to streamline demand and support timely clinical assessment.
- Increase use of population segmentation tools to identify patient cohorts requiring GP care, helping practices to proactively manage demand and improve equity of access
- Strengthen the GP contribution to the INTs by coordinating information, referrals and follow-up within neighbourhood networks
- Evaluate the impact of the Lambeth Offer

- Deliver a mature neighbourhood access model with consistent same day access performance, improved patient experience and digital maturity across practices.
- Use population health insights to target unmet need and reduce inequalities.
- Establish general practice as a fully integrated INT partner, sharing data and jointly supporting neighbour priorities.

Lambeth Neighbourhood Delivery Plan (2/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
<p>Continue to improve the primary-secondary care interface and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'</p>	<ul style="list-style-type: none"> • Use the Lambeth & Southwark Interface Forum to oversee local implementation of the SEL priorities. • Standardise communication processes: with timely discharge summaries/clinic letters/Fit notes • Implement the "Waiting Well" approach with clear patient information and contact points • Improve return rate/quality of advice and guidance • Maintain and promote directories, guidelines, and consistent prescribing policies. 	<ul style="list-style-type: none"> • Review KPIs on patient experience and duplication reduction. • Develop shared care protocols • Enhance onward referral pathways • Expand interoperability of digital solutions for communication and referral tracking. • Strengthen patient engagement: accessible waiting time data and appointment 	<ul style="list-style-type: none"> • Review KPIs on patient experience and duplication reduction. • Embed shared health promotion agenda: joint primary/secondary care initiatives • Scale best practices models • Secure recurrent funding for interface improvement roles and digital infrastructure.
<p>Establish Integrated Neighbourhood Teams (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).</p>	<p>Scale INT delivery across all neighbourhoods aligned partner MDTs, shared care planning, coordinated outreach, across priority pathways.</p> <p>Develop workforce and integrated leadership; Refocus capacity and broaden INT multi-disciplinary teams (MDT) to include social care, nursing, pharmacy, community, link workers, and mental health and measure impact vs key targets</p> <p>Strengthen resident and community engagement; establish neighbourhood health and wellbeing networks and activities to improve access including VCSE community screening</p> <p>Build early digital foundations; Strengthen digital-by-default INT working exploring a range of solutions</p> <p>Contract-based working to be implemented to demonstrate clear progress against outcomes.</p>	<p>Strengthen prevention and population health focus on metabolic risk, weight management and online Health Check.</p> <p>Workforce & leadership expand year 1 approach and create INT career pathways</p> <p>Fully digital-by-default system Fully onboard partners to digital solutions.</p> <p>Expand community-based offer establish community hubs/open, access points,</p> <p>Strengthen governance, finance & shared Accountability moving towards aligned budget, shared outcomes approach</p> <p>Consolidated evaluation of outcomes, & modelling long-term productivity gains</p> <p>Ensure full borough coverage of priority INTs pathways</p>	<ul style="list-style-type: none"> • Full maturity of INTs via contract-based teams across all partners with shared leadership. • Population- level prevention and risk reduction measurable improvement in outcomes or priority pathways • Established digital-by-default neighbourhood health system guided by the national and local initiatives. • Workforce sustainability and new roles mature workforce with shared competencies e.g. community pharmacist as prescribers, VCSE prevention, advance care coordinators. • Evaluation and monitoring of the long term impact and investment returns.

Lambeth Neighbourhood Delivery Plan (3/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
<p>Agree a multi-neighbourhood urgent care plan which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs</p>	<ul style="list-style-type: none"> Develop 2026/27 winter plans with year-round focus on Urgent Emergency Care recovery and reducing A&E pressure Work to develop Single Point of Access (SPOA) for same-day urgent care Prepare for 2027, 111/Integrated Delivery Unit go-live Work with Ambulance Services on trusted assessor models and “call before convey” Develop Neighbourhoods same day access plans Fully utilise virtual ward and @Home capacity, review opportunities to maximise usage Intermediate Care Lambeth provision will reduce due to disinvestment. Related service redesign will also be planning for alignment to neighbourhoods 	<ul style="list-style-type: none"> Develop 2027 winter plans 111 platform and Integrated Delivery Units go live (April 2027) Deliver strong multi-specialty (SPOA) Develop Neighbourhoods same day access plans Continue to review @home capacity and move activity to business as usual Continued redesign of the Intermediate Care provision as full disinvestment realised Continue to work to identify efficient & cost-effective remote monitoring technologies Shift to digital first in UEC pathways, including clinical prioritisation & booking patients into next day, including UTC 	<ul style="list-style-type: none"> Annual winter planning and Urgent/Emergency Care recovery to meet targets Collaborate with the IDU provider to enhance integration with other services, leveraging technology and AI and linking with neighbourhood teams and pathways. Further shifts to digital first UEC pathways
<p>Improving planned care in the community (linked to work to redesign outpatient care)</p>	<ul style="list-style-type: none"> To establish models of care for Frailty, Multiple Long Term Conditions (MLTC) and CYP within each neighbourhood To review use of all the community estates and activity at each centre To develop a future strategy and plan informed through public and patient engagement and VSCE Subject to NHSE funding, work up feasibility plans for Community Diagnostic Centre (CDC) 	<ul style="list-style-type: none"> Set key milestones to deliver against the agreed strategy Agree what additional services, beyond priority groups Frailty, Multiple Long Term Condition and Children & Young People, should be delivered in the community. Understand the key interdependencies and agree how they will be managed. Finalise business plans for CDC 	<ul style="list-style-type: none"> All chronic conditions to be supported and managed out of hospital and in local hubs where appropriate Use of digital to support patient care and support patients to manage their own care Mobilise CDC and realise benefits for communities.

Lambeth Neighbourhood Delivery Plan (4/4)

	Local Actions In Year 1	Local Actions In Year 2	Local Actions In Years 3 -5
Improving care for children and young people (CYP) as part of neighbourhood working	<ul style="list-style-type: none"> • Further develop the CYP INT working group programme under the Southwark Neighbourhood Transformation Board with clear decision-making and accountability • Plan/develop the bi-borough model by linking Early Help and Early Years panels in Family Hubs and Families First Partnership Programme with GP-hosted child health MDTs using the Child Health Integrated Learning and Delivery System (CHILDS) framework • Continue delivering integrated child health teams for every GP practice in Lambeth & Southwark • Progress the agreed CYP INT pilots with relevant partners and simple evaluation plans • Identify CYP health inequality priorities with support from Act Early South London • Agree on a mid to long term plan and set milestones for rolling out CYP INTs across the five neighbourhoods 	<ul style="list-style-type: none"> • Implement integrated working across health and social care through the bi-borough model • Evaluate the bi-borough model and the agreed CYP INT pilots and use learning to refine pathways, roles, and delivery • Expand INT pilots to more neighborhoods • Align Family Hubs, Early Help, schools, community health services, and general practice around CYP INT priorities within each neighbourhood • Reconfigure integrated child health teams to neighborhood boundaries once IT systems allow • Deploy shared care records and population health tools; build extended MDT capacity including VCSE partners • Develop enhanced metrics and reporting to monitor access, experience, and outcomes for CYP and families 	<ul style="list-style-type: none"> • Maintain and refine the CYP INT model across all neighbourhoods, using evaluation, data and feedback to ensure it remains fit for purpose • Adjust cohorts, pathways, and access routes across Family Hubs, social care, schools, and health services) in response to emerging needs and inequalities • Align funding and commissioning to secure long-term sustainability; maintain governance and neighbourhood leadership for shared accountability • Apply routine outcome and experience measures to demonstrate impact and drive continuous improvement

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: Wednesday 25 February 2026

Title	Thamesmead GP Primary Medical Services Under APMS Contract (PRJ-2023) PSR Panel recommendation	
This paper is for Noting		
Executive Summary	<p>This paper is being shared again to provide an update</p> <p>SEL ICB has received formal representations from Operose Health, acting on behalf of AT Medics Ltd, regarding the procurement of Thamesmead GP Primary Medical Services Under APMS Contract (PRJ-2023).</p> <p>In accordance with the requirements of the Provider Selection Regime (PSR), a Panel has thoroughly reviewed these representations.</p> <p>After careful consideration of each point raised and based on the information provided, the Panel recommends upholding the original decision to award the contract to Addison Road.</p>	
Recommended action for the Committee	<p>The committee is asked to</p> <ul style="list-style-type: none"> review the information presented in this paper and approve the above recommendation to uphold the original decision to award the contract for Thamesmead GP Primary Medical Services (PRJ-2023) to Addison Road 	
Potential Conflicts of Interest	<p>All Panel members have signed a COI form and no material conflicts were identified.</p> <p>Any person involved with this general practice or working for/with the AT Medics/Operose or Addison Road might be conflicted.</p>	
Impacts of this proposal	Key risks & mitigations	<p><u>Risk of escalation of representation</u></p> <p>There is a risk that the representee might escalate this to the NHSE national panel as is their right under PSR regulations. The Panel is confident that each point of the representation has been considered thoroughly and addressed robustly.</p>

		<p><u>Risk of Judicial Review</u></p> <p>All procurement processes come with the risk of Judicial Review. This risk can only materialise after escalation to the national panel and after their decision. This risk can be mitigated after considering any decision by the national panel and taking appropriate action in alignment with any such decision.</p> <p><u>Risk of change in the proposed offer</u></p> <p>A considerable amount of time has passed since the ITT process has been concluded and there is a small risk that the preferred provider might want to negotiate on any of the terms of their proposed offer. This will be mitigated by having a robust mobilisation plan and carefully managing the process to ensure that the no material changes to the offer are made. There might be some possibility of flexibility on the mobilisation plan submitted in the bid as the dates will not align due to the delay.</p>
	Equality impact	EQIA has been undertaken prior to contract procurement
	Financial impact	A business case for the procurement of the contract was agreed and funding for the contract is within the delegated budget.
Wider support for this proposal	Public Engagement	Members of the Patient Participant Group have been involved in the procurement and members of the Group have formed part of the evaluation of the bids.
	Other Committee Discussion/ Internal Engagement	The Primary Care Commissioning Board have reviewed the papers and been consulted through each of the stages of the procurement
Author:	Ahsan Haji, Head of Procurement Management, NHS London Commercial Hub	
Clinical lead:		
Executive sponsor:	Gabi Darby, Place Executive Lead, Greenwich	

Thamesmead GP Primary Medical Services Under APMS Contract (PRJ-2023) PSR Panel recommendation

1. Introduction

This paper presents an update regarding the procurement process for the APMS Contract for Primary Care Services at Thamesmead Health Centre, following the Healthier Greenwich Partnership (HGP)'s decision on April 24th, 2024, to reprocur this service.

The ICB received two separate representations. After the initial representation, the ICB decided to withdraw the original contract award from the first-ranked bidder as they got eliminated from the process and instead award the contract to the second-ranked bidder. However, this subsequent decision was challenged by the third-ranked bidder through a further representation. This paper details the process involved in the recent representation and recommends continuing with the contract award for the bidder who ranked second.

2. Contract Procurement

The ICB conducted a competitive procurement under the Provider Selection Regime (PSR) for GP Primary Medical services under an Alternative Provider Medical Services (APMS) contract for Thamesmead

The procurement has been overseen by the NHS London Commercial Hub, on behalf of SEL ICB. Various members from Greenwich and SEL ICS as well as patient representatives, have reviewed and scored the submitted bids.

A contract award recommendation report was approved by the HGP on 11th December 2024. Following this, the outcome of the contract award was published. During the standstill period, another bidder, Addison Rd, challenged the award of the contract to Omnes. As a result, Omnes was excluded from the process and Addison Rd became the preferred provider. This outcome was confirmed by sending new notification letters and implementing a new standstill period.

The ICB subsequently received a representation dated 24 June 25 from Operose Medical during this new standstill, contesting the award to Addison Rd. In alignment to the requirements of PSR regulations, a Panel was formed to review the representation. The Panel consisted of members of the NEL Commercial Hub Procurement Team, the Greenwich Contracting lead and members of the Greenwich and SEL Primary Care teams. Legal advice was received from Hill Dickinson.

3. Representation Review

The Panel reviewed each of the points raised in the Representation. Panels response to each point is detailed below.

PCN and Stakeholder Working

The Panel reviewed the original evaluators individual scores/comments and the final moderated comment. The Panel noted that it was clear from those comments that several evaluators did feel the answer was good and correctly allocated the score of '3' but that consensus was reached that it did not meet the 'excellent level'.

This was primarily because the Bidder's answer was not sufficiently detailed to convince the evaluators that everything that was proposed will be delivered and the evaluators did not believe based on the answer given by interviewees on the day that the service will be delivered to an 'excellent' standard.

The Preferred Bidders answer was very strong across all areas and the evidence and detail provided by interviewees on the day gave evaluators the confidence that the service will be provided to an excellent standard.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The Panel finds no evidence to suggest that the scoring was applied inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Health Inequalities and Prevention

The Panel reviewed the original evaluators individual scores/comments and the final moderated comment. The Panel noted that several evaluators had referenced the lack of detail on screening. More detail and data around screening would have benefitted the response by strengthening the evidence. The Bidders answer did not convince the evaluators that the service will be delivered to an excellent standard.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The Panel finds no evidence to suggest that the scoring was applied inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Community Engagement

The Panel noted from the original evaluators' individual comments that the Bidder's answer appeared to cover all areas but was unclear on how they would deliver/implement it (lack of strategic vision). The 'how' element of the answer needed further strengthening and did not convince the evaluators that this was an excellent answer.

The specific comment about Healthier Greenwich partnership was raised by one evaluator and highlighted in the moderated comment. Overall, there was overarching consensus among evaluators that the answer lacked some detail on the 'how' of the answer as referenced by at least two evaluators in their original comments. Another evaluator noted the answer lacked some detail around 'strategy for the future'. On this basis, the Panel considers the score awarded to the Bidder to be appropriate. Even if the minor point around Healthier Greenwich partnership was discounted, the Bidder would have still received the same score of 3 due to the aforementioned reasons. The Panel did not find any evidence of the Bidder being treated differently to any other Bidder including the Preferred Bidder.

Separately, the Preferred Bidder's response was well detailed, with a clearly articulated delivery plan and accompanying evidence of delivery and how to deliver including the use of Population Health Management.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The panel finds no evidence to suggest that the scoring was applied inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Digital Technology

The question required the Bidder to "detail how you have supported staff understanding and use of digital technology as part of the move towards The Modern General Practice Model and evidence steps you have taken to communicate these changes to patients".

The Panel reviewed the individual comments and the final moderated comment. The Panel notes the minor concern that the evaluators raised about the lack of reference to NHS App. Given the wide publicity of the NHS App and a national campaign targeting all GP practices to improve uptake, a reasonably well informed and normally diligent (RWIND) bidder would consider NHS App relevant to a question around digital technology in primary care, even if the question or specification do not specifically refer to it. The Panel finds this minor concern to be valid.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The Panel finds no evidence to suggest that the scoring was applied

inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Prescribing Management

The Panel reviewed the original evaluators individual scores/comments and the final moderated comment. The Panel noted that both the individual evaluators had scored the same for this answer and agreed that whilst this is a good answer as reflected in the positive comments from the evaluators, it did not reach the 'excellent level' to warrant a 4. The Panel received advice from a clinician on this representation point which further assured them that the response was scored correctly.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The Panel finds no evidence to suggest that the scoring was applied inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Information Governance

The Panel reviewed the score and the comments provided. The comments clearly articulate minor concern(s) and any relevant lack of detail which the Panel found to be relevant and valid.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The panel finds no evidence to suggest that the scoring was applied inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Business Continuity

The Panel reviewed the score, the comments provided and the Bidder's response.

Both the evaluators provided a score of 2 for this response. The minor concern around the failure to reference any communication to the ICB in the provided example was noted. The Panel believes this is a valid point given the question specifically required "an example of how you would ensure business continuity for delivery of services in the event of an incident that results in the practice premises having to close" The representation states that the response mentions ICB elsewhere, whilst this is accepted but this does not pertain to the specific example referenced by the evaluators.

The Panel finds that both the moderated score and accompanying detail are consistent with the scoring descriptors. The panel finds no evidence to suggest that the scoring was applied

inappropriately or inconsistently with the published methodology and mechanism and the Panel agreed not to uphold this representation on this point.

Patient Access

The Panel reviewed the score, the comments provided and the Bidder's response. The Panel finds that the Bidders response refers to using AccuRx for services such as blood tests, medication reviews & LTC reviews. This part of the representation is accepted, however the response does indeed make no reference to the NHS App and given the wide publicity of the NHS App and a national campaign targeting all GP practices to improve uptake , a reasonably well informed and normally diligent (RWIND) bidder would consider NHS App relevant to a question around Patient Access in primary care, even if the question or specification do not specifically refer to it.

In light of this, the Panel finds the scoring is in line with the scoring mechanism. However, the reference to AccuRx is not valid in the moderation comment. Whilst the representation point is partially upheld, the score remains unchanged at 3 which aligns to a good response which lacks some relevant detail but does not cause concerns.

4. Recommendation

The Panel considered three possible outcomes in alignment with the PSR statutory guidance:

- Uphold the original award
- Restart procurement from a defined point
- Abandon and rerun the procurement

After careful consideration of each point raised and based on the information provided, the Panel recommends upholding the original decision to award the contract to Addison Road.

The HGP is requested to review the information provided in this paper and formally endorse the recommendation put forth by the Panel.

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 25 February 2026

Title	Greenwich Neighbourhood Investment Plans	
This paper is for noting		
Executive Summary	<p>The paper provides information about the Greenwich Neighbourhood Investment Plans detailing:</p> <ul style="list-style-type: none"> • How we will use the £250,000 funding to support Integrated Neighbourhood development, ringfenced as part of Integrator establishment; • funding identified from various existing budgets that will be directed towards the same, including implementation of INTs and integrated pathways for frailty, LTCs, CYP and prevention. 	
Recommended action for the Committee	HGP to note that the Neighbourhood Investment Plan was discussed and approved by the HGP during their meeting in private of 28 th January 2026.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	As outlined in the enclosure.
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	<ul style="list-style-type: none"> • SEL Neighbourhood Based Care Board – 15 January 2026 • Healthier Greenwich Partnership – in private – 28 January 2026
Author:	Jessica Arnold, Director of Primary Care and Neighbourhoods, Greenwich	
Clinical lead:		

Executive
sponsor:

Gabi Darby, Acting Place Executive Lead, Greenwich

Greenwich Neighbourhood Investments Plans

Healthier Greenwich Partnership – in private

28 January 2026



Greenwich Integrator

Maturity Matrix

In November 2025, to inform our assessment of the maturity of our system to deliver neighbourhood-based care in Greenwich, members from the Healthy Greenwich Partnership Executive were sent an online questionnaire to consider the maturity levels criteria against each domain asking them to highlight Greenwich's stage of development for each of the priority domains. The anonymised responses were reviewed and discussed at the HGP meeting on 26 Nov 2025 which identified key priorities and informed how the £250,000 grant was allocated. **Summary of survey results on next slide.**

Investment

The £250,000 that has been made available to support Integrator arrangements will be spent on five priority areas, which include securing operational, clinical and programme expertise to further INT pathways/systems in each of the four Neighbourhoods, as well as borough-wide support for VCSE development and comms and engagement.

The key risk is that £250k does not stretch far enough to deliver the desired outcomes within the wider Greenwich plans for integrated Neighbourhood development. However, it is important to note that these are not the only funds available, and we will seek to maximise both existing resource and other new sources of investment.

Governance

Development of Memorandum of Understanding.

Planned workforce development efforts across the Partnership including establishing a Workforce Board for Neighbourhoods, and outlines the roles, responsibilities and governance for the programme overall.

Clarifying responsibility between ICB and Integrator on enabler functions.

Build on the mature interface group's successes by sharing best practices and lessons learned across neighbourhoods.

Maturity Matrix: Summary of Survey Results

The survey identified that most areas of maturity of integrated neighbourhood arrangements in Greenwich are mainly at the 'emerging' stage with a few domains at the 'developing' stage.

Functional Domains: These reflect the potential functions of place partnership arrangements supported by host integrator organisations based on the London Target Operating Model and the South-East London Integrator Functions.

Domain	Subdomain	Emerging	Developing	Maturing	Thriving
Supporting Operational Co-ordination	Operating Integrated Functions	93%	7%	0%	0%
	Shared Clinical Risk	93%	7%	0%	0%
Facilitating Population Health Management	Facilitating Data Sharing	73%	27%	0%	0%
	Promoting Use of Data	53%	47%	0%	0%
Improving the Interface	Process and Pathway Mapping	67%	33%	0%	0%
Driving Equity	Understanding Variation	47%	47%	6%	0%
Leading Delivery	Integrated Neighbourhood Teams	100%	0%	0%	0%
Essential Infrastructure	Digital Optimisation	93%	0%	7%	0%

Domain	Subdomain	Emerging	Developing	Maturing	Thriving
Building Relationships & Trust	Codesign ways of working	53.3%	33.3%	13.3%	0%
	Parity of Voice	67%	20%	13%	0%
	Shared Accountability	67%	33%	0%	0%
Organisational Development and Culture	Embedding Holistic & Personalised Care	60%	40%	0%	0%
Residents & Neighbourhoods	Supporting Neighbourhood Infrastructure (community assets, VCSE services, etc.)	73%	20%	7%	0%



Greenwich Integrator Development Key Priorities

Developing our Core INTs

- Design and agree on the new operating model for INTs with clear alignment of neighbourhood teams, particularly Homecare, Reablement, Frailty, District Nursing and ASC services.

Shared Clinical Risk

- Develop a shared approach to clinical risk management.
- Establish a working group to map current approaches to clinical risk management and governance structures.

Promoting use of data, based on understanding need and unwarranted variation

- Review and update historic data sharing agreements to ensure they support neighbourhood working and comprehensive data integration.
- Build on current collaborative data use in services like JET and DHACT to expand joint data working across Public Health, Adult Social Care, health, housing, and other services.
- Understand which outcomes and services show the greatest unwarranted variation.
- Explore opportunities to link Adult Social Care data with health data.
- Continue to develop partnership structures (e.g., S75 agreements, HGP initiatives) that facilitate integrated working and data sharing to anticipate and address community needs.

Pathway mapping and Embedding holistic & personalised care

- Redesign care pathways with front-line teams that better enable holistic and personalised care.

Using enablers to realise plans in each INT

- Maximise use of estates, community relationships, digital and community assets and relationships in each INT.
- Programme and Quality Improvement methodology to deliver initial core INT and continuously improve processes and pathways.

Greenwich £250k Investment Allocations

Key Priorities of this investment	Funding Allocated
Neighbourhood (executive) leadership resource Oxleas will work with RBG ASC and primary care to establish a management structure for INTs.	£ 75,000.00
Programme/ delivery team capacity – to manage programme pilot and embed change including supporting coordination of health & wellbeing, estates and pathway implementation.	£ 100,000.00
Neighbourhood clinical leadership resource to ensure robust PCN, primary care and provider clinical input, complementary to the clinical leadership already in the system and particularly focusing around areas of clinical / population priority such as LTCs.	£ 25,000.00
Expanding and securing a strong VCSE sector role within integrated Neighbourhood working	£ 25,000.00
Additional comms and workforce OD/ engagement capacity. Workforce Lead has been seconded from SEL ICB into Oxleas (0.4 FTE) to support progress.	£ 25,000.00
Total	£ 250,000.00



Greenwich Priorities in addition to agreed £250k



Greenwich Priorities outside of the £250k

Areas of focus	Funding stream
As part of establishing the operational co-ordination of Neighbourhoods, we will look at different models of clinical risks management. This is likely to include separating a team management role from a professional leadership role - as has been done in the existing integrated JET service.	Not funded separately
Greenwich has established a data workstream, which will utilise the Accelerated Reform Fund (ARF) on behalf of SEL to help build upon the existing data work that has been undertaken as part of Healthy Intent and across SEL. Critically, this will include establishing options for shared data sets across health and care that also help predict, and prevent, use of residential care as well as hospital admissions. The recommended system is the Greenwich and Lewisham Snowflake enclave within the GSTT Snowflake platform which will securely hold identifiable data for LGT and Greenwich & Lewisham EMIS data to support effective PHM. *Existing Healthy Intent platform ends 01 Apr 2026	Funded via existing programmes
We will map existing care pathways against the Frailty and long-term condition frameworks in order to identify gaps and areas for development. Continue mapping and aligning individual staff to appropriate teams, particularly within DN and ASC services. We will also utilise the existing Interface group to smooth and reduce transitions across organisational interfaces in the pathway	This will be covered under the programme team funding allocation.
The public health team have developed detailed population profiles for each Neighbourhood which have been shared with Neighbourhood teams at a recent launch conference. We will develop mechanisms for sharing data with Health and Wellbeing teams, and leadership, to help drive continuous innovation and improvement to address variation across population groups. Close work with communities will help understand how differences can be addressed.	Existing resource
We will expand the frailty service to cover an increasing proportion of the moderately frail cohort in Greenwich and support more consistent collaboration with this service by practices through a new PMS premium. We will implement holistic appointment for patient with multiple LTCs and a more proactive approach with Health & Wellbeing coaches piloted in 2 networks with highest LTC rates (central and east)	Service funding required
We will participate in the SEL wide work to find robust solutions to staff record sharing across organisations, with reduced reliance on multiple log-ons.	To flow from SEL solution works
Map the estates available across the partnership and the current care delivered within this estate. Identify opportunities to optimise our estates supporting shared use of estates from across the public, private and VCSE sector to enable co-location of services	Programme capacity as costed above to supplement existing resource
Working with Stone King, to develop the HGP to form a Partnership in Collaborative in Greenwich that incorporates VCSE expertise and ultimately gives a legal form capable of holding and delivering on future contracts or population budgets in an innovative way. This is a structured 12-month work programme.	Funded separately

Funds Sources (years 1-3)

The sources of funds for the Neighbourhood investment programme are as follows:

Source of Funds

Programme	Yr 1 - 2	Yr 3 (28/29)
3+LTCs	£735,000	£188,000
Frailty	£486,000	£162,000
Integrator	£250,000	£0
VCSE (Age UK funding)	£200,000	£100,000
Total	£1,671,000	£450,000



Application of Funds (years 1-3)

The sources of funds for the Neighbourhood investment programme are as follows:

Application of Funds

	Band	WTE	Yr 1 (26/27)	Yr 2 (27/28)	Subtotal Yr1 - 2	Yr 3 (28/29)
Frailty						
Case Manager (Oxleas)	7	1.00	71,981	71,981	143,962	71,981
Admin (Oxleas)	3	1.20	£47,715	£47,715	£95,430	£47,715
Non-Staffing costs			£12,605	£12,605	£25,210	£12,605
Overheads @ 13%			£15,561	£15,561	£31,122	£15,561
VCSE (Age UK funding)						
Care Navigators (Age UK)			£100,000	£100,000	£200,000	£100,000
Integrator						
NH Executive Leadership Resource			£75,000	£0	£75,000	£0
Prg/delivery team capacity			£100,000	£0	£100,000	£0
NH Clinical Leadership Resource			£25,000	£0	£25,000	£0
Expanding VCSE resource within NH working			£25,000	£0	£25,000	£0
Comms/workforce OD/engagement capacity			£25,000	£0	£25,000	£0
LTCs						
Staff training			£25,000	£25,000	£50,000	£0
Community Hubs			£25,000	£50,000	£75,000	£50,000
4 x Neighbourhood Co-ordinators - Band 7	7	4.00	£287,920	£287,920	£575,840	£143,960
Yr 1 - Slippage to Recruitment			-£71,980	£0	-£71,980	£0
Comms & Engagement for patients, inc. printed materials			£15,000	£15,000	£30,000	£15,000
Sub-Total (Excl. Contingency)			£778,802	£625,782	£1,404,584	£456,822
Contingency/unknown impacts requiring funding			£169,198	£97,218	£266,416	-£6,822
Total			£948,000	£723,000	£1,671,000	£450,000



Healthier Greenwich Partnership

Date: Wednesday 25 February 2026

Title	Partnership Report	
This paper is for noting		
Executive Summary	The paper provides update on news and activities by partners in the Healthier Greenwich Partnership	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
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Clinical lead:		
Executive sponsor:	Gabi Darby, Acting Place Executive Lead, Greenwich	

Partnership Report – February 2026

Table of Contents

1. Healthier Greenwich Partnership.....	1
2. Royal Borough of Greenwich.....	1
3. Oxleas NHS Foundation Trust	1
4. Lewisham and Greenwich NHS Trust (QEH)	2
5. Community Hospice	2
6. Healthwatch Greenwich	2
7. Greenwich Healthier Communities Fund	4

1. Healthier Greenwich Partnership (HGP)

The report that follows provides an overview of the activities of our partners across the Healthier Greenwich Partnership noting some challenges but also highlighting some excellent developments and contributions that have been achieved.

Over the last quarter there has been significant progress in Greenwich to advance Neighbourhood infrastructure and care pathway development for the three priority cohorts: Frailty, Long-Term condition and Children and Young People. The utilisation of the new Digital Health and Technology (DHACT) Service continues to be high, offering good prevention potential.

You can read more about our work [here](#).

2. Royal Borough of Greenwich

The Healthier Greenwich Partnership reports directly into The Royal Greenwich Health and Wellbeing Board which is a statutory committee of the Council bringing together senior leaders from the NHS, Royal Borough of Greenwich, Healthwatch Greenwich, the Metropolitan Police, and the voluntary and community sector to work in partnership.

The Board aims to enhance health and wellbeing in Greenwich and address health inequalities borough-wide

You can find out more [here](#).

For more information on local activities in the Royal Borough of Greenwich follow this [link](#).

3. Update from Oxleas NHS Foundation Trust

Oxleas NHS Foundation Trust works with partners in Greenwich to provide a wide range of physical and mental health services, mostly in community settings.

These include district nursing, frailty and rehabilitation teams, children’s mental and specialist physical health services and adult mental health care including Greenwich mental health hub [Home - Bexley, Bromley and Greenwich Mental Health Hubs](#).

For the latest updates from Oxleas, visit [Oxleas NHS | Oxleas NHS Foundation Trust](#)

4. Lewisham and Greenwich NHS Trust (LGT)

Lewisham and Greenwich NHS Trust, (LGT), is a community-focused provider of local and acute care, delivering high-quality services to over one million people living across the London boroughs of Lewisham, Greenwich and Bexley, providing whole-life care and supporting communities to live healthier lives as well and taking care of them when they need us the most.

Employing almost 7,500 colleagues, affectionately known as Team LGT, we provide services at Queen Elizabeth Hospital in Woolwich, University Hospital Lewisham, and at over a dozen community settings in Lewisham. We also provide some services at Queen Mary’s Hospital in Sidcup.

For full details of the latest Trust news, please see [News | Lewisham and Greenwich](#)

5. Community Hospice

We are pleased to see promising results from the early evaluation of our ED project at QEH. We are learning a lot about what can be done to prevent unnecessary attendance at ED, as well as what needs to change in the department to support more people who are approaching life to be better supported in community settings, avoiding the need for hospital admission. We were especially pleased to secure additional funding from the ICB to enable the project to continue until March 2027 and are looking forward to sharing our learning with other teams across the ICB through interim reports and shadowing of colleagues

For full details of the latest Hospice news, please visit [News | Greenwich & Bexley Community Hospice](#)

6. Healthwatch Greenwich

At Healthwatch Greenwich, we listen to what matters most to local people and use their voices to shape fairer, safer and more inclusive health and care across our borough. The following examples illustrate a small selection of our activity during this period and demonstrate how resident insight has been translated into system dialogue, service improvement and strengthened community capacity.

Engagement

During this period, we engaged with 631 residents through outreach, direct conversations across libraries, advice hubs, foodbanks, schools, community groups, hospital settings and digital platforms. In addition, we provided signposting and practical support alongside listening, supporting residents to navigate services.

Hospital & Patient Experience

At Queen Elizabeth Hospital, Healthwatch Greenwich continued structured engagement supporting patient and family experience to inform quality and governance discussions. While feedback consistently reflected compassionate care and committed staff working under pressure, recurring themes emerged regarding clarity of communication, patient and family understanding of discharge plans, and accessibility for Deaf and hard-of-hearing residents.

In response to our work, the Trust reviewed interpreter access processes and confirmed strengthened arrangements across departments. Work is also underway to improve staff awareness of interpreter booking systems, including out-of-hours access, and Deaf Awareness training has been commissioned for staff.

HPV Project

In partnership with South East London Cancer Alliance, our youth-led HPV project findings were presented at the South East London Early Cancer Diagnosis Forum. The work of our youth peer researchers directly informed senior clinicians and commissioners supporting more coordinated and youth-informed HPV awareness approaches across South East London.

Safeguarding

Healthwatch Greenwich works in partnership with the Greenwich Safeguarding Adults Board to deliver a 'Raising Awareness of Abuse' programme with communities experiencing health and social inequalities. Central to this work is a co-design approach: community groups work alongside us to shape the content, language, format and delivery of the sessions.

Safeguarding messages are developed collaboratively to reflect lived experience and community priorities.

Through this co-design process, residents share insight into barriers that can prevent people from raising concerns. Residents describe low trust in statutory services, concerns about potential consequences of reporting, uncertainty about what constitutes abuse, and limited clarity about reporting routes. This learning directly influences the materials produced and how safeguarding information is framed and communicated. Sessions are delivered in a range of community languages, and a series of materials are produced to support the longer-term sustainability of safeguarding communication and information within these communities.

Be Well Support

In partnership with Royal Borough of Greenwich Public Health, the Be Well Support programme strengthens the capacity of grassroots organisations to lead wellbeing initiatives within their own communities. Through consistent mentoring, practical support and active brokerage with statutory and voluntary sector partners, Healthwatch Greenwich supports groups to move towards more stable, connected and sustainable delivery models grounded in community-identified priorities.

Access to training, small grants and targeted referrals enables groups to strengthen both their organisational foundations and frontline offer. This results in tangible developments, including the creation of community wellness hubs, access to secure and consistent meeting spaces, improved governance and safeguarding practice, greater inclusivity for residents with sensory disabilities, and the delivery of tailored physical and mental health interventions shaped by local need.

Substance Misuse Support

Through sustained, on-site engagement at a local foodbank, Healthwatch Greenwich identified unmet need relating to substance misuse and barriers to accessing existing support. Conversations with residents highlighted low awareness of available services, stigma, and practical difficulties in navigating referral pathways.

Healthwatch Greenwich worked with foodbank leads and system partners to broker and coordinate a more accessible response, leading to substance misuse services providing regular outreach, offering direct engagement and support in a trusted community setting. This shift moved substance misuse support to a more proactive neighbourhood presence, increasing accessibility for residents least likely to engage with formal services.

Children and Young People

Supporting Health Integration Partners, who are working with SEL ICS to develop a unified Children and Young People Integrated Neighbourhood Teams Framework, Healthwatch Greenwich facilitated a discussion group with parents and carers of children and young people with special educational needs and disabilities, including autism, ADHD, learning disabilities and complex health needs.

Parents described systemic challenges across health and care services, including long waiting times, inconsistent reasonable adjustments, poor communication, and lack of follow-up, alongside examples of positive responsive and empathetic practice. The discussion highlighted that what matters most to families is not simply access to services, but being listened to, treated as partners, and seeing requests turn into action in a timely way.

The lived experience gathered will contribute to the framework by ensuring that neighbourhood integration is defined not only by structural alignment but by relational quality, responsiveness and measurable improvement in family experience.

Information and Guidance

During this period, Healthwatch Greenwich provided timely, accessible information to residents in response to system pressures, seasonal demand and emerging local issues. This included guidance during resident doctor strike action, winter service pressures, and helping residents understand how to access urgent and non-urgent care appropriately. We also published explainers on health and care rights and choices, safeguarding routes, men's mental wellbeing support, winter health protection, sexual health access, pharmacy provision, and patient safety initiatives.

Alongside this we amplified prevention-focused messaging including vaccination campaigns, NHS screening programmes, heart health checks, mental health crisis pathways, and community-led wellbeing initiatives.

For full details of the latest Healthwatch Greenwich news, please visit:

<https://healthwatchgreenwich.co.uk/>

7. Greenwich Healthier Communities Fund

Groundwork London is responsible for awarding grants from the NHS Greenwich Charitable Funds to community organisations across the borough that prevent and respond to health inequalities. Since October 2025, we have awarded £55,298 to a range of organisations through the Micro grants and Enabling strand. The Delivery strand closed to

applications on 15 December 2025, with a total budget of £1,037,520 to be allocated across Small, Medium and Large projects. The Medium and Large project will be awarded by a representative panel of community members, ensuring the process remains community-led and transparent.

For more information, please visit our website, [Greenwich Healthier Communities Fund - Groundwork](#)

Healthier Greenwich Partnership

Date: Wednesday 25 February 2026

Title	HGP Risks update	
This paper is for noting		
Executive Summary	The paper provides update about the latest review of some of the risks on Greenwich risk register. A range of actions are being undertaken to manage and mitigate the various risks.	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Business Support Lead Greenwich SM	
Clinical lead:		
Executive sponsor:	Gabi Darby	

Greenwich Risk Report with Review Comments

Enterprise Risk Manager View (with Risk Owner)

Risk ID	Opened Date	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Controls	Current Likelihood	Current Consequence	Current Rating	Assurances	Current Assurance	Target Likelihood	Target Consequence	Target Rating	Review Date and Comment	Next Review Due	
465	13/7/23	Reneeta Campbell-Butler	Dave Borkind	Risk to development of an 11th and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	There is a risk that we don't deliver on all areas of the high impact activity covered within this stand. This is as a result of current commissioning capacity. This has presented significant challenges to drive forward more complex large scale pieces of work. To mitigate against this risk re-prioritisation of other work is being undertaken to support this impact. The impact on HGP would be a higher risk that we don't deliver on all areas within this high impact activity. PLEASE NOTE: This is related to very major strategic projects and risk reviews should happen on six monthly basis.	4	3	12	Temporary utilisation of RBC funded commissioning capacity, alongside use of external capacity to support delivery of Single Point of Access. The establishment of multi-agency task and fish group to take forward the mental health in schools work. Establishment and maintenance of the Children's Mental Health and Wellbeing Partnership Board. Recruitment of partner to develop and implement the Single Point of Access for children's mental health and emotional wellbeing. CAMHS and Commissioner representation on the Entry to Care Panel to inform future support for children in our care at an individual level. ICB representation on the Corporate Parent Partnership Board and leading the Sub-Group on Health and Wellbeing in place.	4	3	12	The Healthier Greenwich Partnership Board has oversight of the delivery plan. Mental Health Steering Group will review and agree phases of delivery for the SPA development and Thrive model	No gaps in assurance have been identified at this time.	3	2	6	09/10/2025 - As at April 2025, the ICB commissioned PPL to develop the Single Point of Access. This will be developed in light of the new Social Care reforms - Families First and aims to improve client's experience in accessing mental health services. In Oct 2024, the discovery phase, including wide engagement with key stakeholders was completed and the Options Appraisal developed. 04/02/2026 - The Mental Health and Wellbeing Partnership Board is well established and beginning to support greater oversight on sub-regional and regionally mental health commissioning and understanding its impact locally. Additional capacity related to the development of the Single Point of Access has increased the speed of development with pathways currently being developed with partners. There are still gaps in the resource related to supporting children's in care's mental health (falling outside S.117), particularly related to residential children's homes but this continues to remain under review.	31/7/26	
474	16/8/23	Phil Darby	Lisa Wilson	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.	There is a risk that the Home First (HF), and associated social care allocations, will be insufficient to meet the needs of the programme moving forward. There is also a risk to the awareness of partners and colleagues across the system of the virtual ward provision. These risks are caused by: * The anticipated financial allocations being lower than anticipated for Virtual Wards (VW). * The shift of acute care into the community increasing costs in social care and other areas of primary and community care that do not have additional funding. * The lack of a fully established dashboard tracking delivery of HF and VW and understanding impacts, the cause relates to a lack of join up and capacity related to data and performance. * The availability of skilled workforce to deliver the specialist and generalist roles needed in the community. * The lack of a communications strategy to widen awareness of the VW programme across partners and the wider workforce. The impact on the Healthier Greenwich Partnership would be challenges in understanding and demonstrating the impact and benefits of the Home First approach. This could lead to a loss of confidence amongst partners and a negative financial impact in other areas of the system.	3	3	9	Operational board overseeing delivery and meets regularly. The Strategic Board receives escalations from the Operations Board and have decision making functions about workforce and financial resources. Oversee the Home first dashboard.	There are no gaps in controls	3	3	9	The Operations Board oversees delivery of Home First, receives progress reports and escalates any concerns to the Strategic Board.	No gaps in assurance identified.	2	3	6	02/10/2025 - The home first strategic group continues to meet on a fortnightly basis, with strong representation from system partners across Greenwich. A review is underway of virtual ward capacity, expected to report back findings and recommendations in November 2025. A transfer of care hub lead is being recruited, with interviews taking place on 3/10/2025. This role will be integral in driving discharge and flow improvements identified through the better care fund support programme review. S106 funding has been awarded to Queen Elizabeth Hospital to improve the streaming capability at A&E and UEC - this will support residents more effectively and support more effective flow. The Digital Health and Care Technology (DHACT) went live on 1st April and has supported over 450 residents in the first month of operation - discussions are ongoing on how the DHACT service can support the development of virtual ward provision. A particular challenge has been identified with the Low Traffic Neighbourhoods, which is impacting home first operations - the integrated commissioning team are liaising with the relevant team in the Council to find a resolution. In remaining the same scoring and review to take place in 2 months. 03/12/2025 - Scoring remains the same. Undertaken a comprehensive review of virtual wards which will be shared with system partners imminently. The Home first group and strategic group continues to meet bi weekly and to have oversight over the programme.	11/3/26
495	29/12/23	Phil Darby	Lisa Wilson	Risk relating to co-ordination of timely discharge support for residents.	There is a risk that patients who are medically fit for discharge are unable to leave hospital. This can be caused by a combination of: internal hospital processes holding discharge up as well as pressures on community and social care services and a changing demographics of the borough. This could impact negatively on Trust A&E and elective performance as well as the best outcomes for residents.	4	4	16	U&EC Board has oversight of winter planning. BCF Planning Group has oversight of BCF which has main targets for discharge and admissions avoidance. Including 22/23 Discharge Fund and 23/24 planning. Home First Board has oversight of TOCC review and initiatives that support discharge processes and outcomes. ISEL Discharge Solutions and Improvement Group looking for sub regional solutions to common challenges such as data analysis and insight.	U&EC Board has oversight of winter planning and budget resources being financially unsustainable and needing a system solution. -15short term and short notice nature of winter and discharge funding flows. -15Specific pressures on system such as industrial action, Covid-19 outbreaks, staff shortages etc.	4	3	12	U&EC Board, UEC Board, SEL Discharge Solutions and Improvement Group rolling out improvement plans for acute and mental health settings. -15Discharge framework issued across SEL for implementation in borough	Lack of accurate and reliable data insight on delayed transfers of care and demand and capacity planning - this is however under development	3	3	9	12/06/2025 - Nick noted the risk remains on the register and that the BCF support work recommendations are being implemented to support the mitigation of the risk through 4 workstreams. 17/07/2025 - The four workstreams now have task and fish groups established, taking forward the recommendations from the BCF Support Programme. Winter planning has commenced for 2025/2026. We will monitor and review monthly through the next six months. 04/09/2025 - Risk being transferred to Mike and Phil to manage as the owner. Nick noted that there has been no change in the risk and this to be reviewed in November. 03/12/2025 - Scoring remains the same. U&EC Support Leadership programme group and meet regularly. Data group is exploring data availability across the health and care system. U&EC winter plans in place to support effective discharge. LGT are running an incentive scheme to support discharge over the winter period and a range of Greenwich schemes have received funding including the community hospice, Oxeas and CACT.	11/3/26
574	11/2/25	Jessica Arnold	Gabi Darby	Primary care premises lost / insecure lease agreements / other estates issues	Across the borough, there are a number of general practice estates that have leases coming for renewal or that may not be renewed, practices at risk of closure due to persistently poor CQC ratings, and practices that are in an excessively poor state of repair and no longer fit for purpose. Resolving these challenges is a costly and long term endeavour, such that unexpected problems at short notice are difficult to manage.	4	3	12	premises strategy approved by primary care commissioning board. Neighbourhood Hub development is focusing on mitigating risks on a geographic basis. Proactive approach to attracting s106/CLT to improve primary care estates	Alignment of neighbourhood hub development to the general practice risks. Responding to the Greenwich local plan to influence prioritisation of development in geographies of general practice risks.	Time scales of neighbourhood developments may not marry up with timescales for mitigating some of the general practice risks.	03/09/2025 - Premises development is being reviewed in the Estates working group. Practices stratified has core flex or tail and are being reviewed and developed inline with the strategy. 08/10/2025 - The mitigations are being worked on proactively and we dont see any short term high impact risks at this point. The primary care team will continue to review the situation and liaise with GP Practices as required. 15/01/2026 - Scoring remains the same. Updates to the controls and assurances - see section. U&EC still remains. To note joint working with Bexley colleagues to mitigate risks in the Thamesmead area.	22/4/26							
596	5/5/25	Chris Dance	Gabi Darby	Achievement of Financial Balance 2025/26	During 2024/25 Greenwich delivered in line with the delegated borough budget. However given material and escalating prescribing, and activity driven pressures within Mental Health (Adults) and Continuing Care Placements (Children), substantial non recurrent mitigations were required to achieve financial balance. The cost pressures trajectory is expected to continue into 2025/26, hence a material risk the borough will not be able to achieve recurrent financial balance if the full scale of the savings/efficiency plan is not delivered in full	4	4	16	Monthly budget meetings with budget holders to review expenditure, progress of saving schemes and to ensure mitigation plans are in place where appropriate. Commissioning leads have been fully engaged with the 25/26 planning process, and through coordination with service leads, have prepared & assumed full ownership of the efficiency saving plans. PEL has set up a dedicated Financial Recovery Board to enable in depth review of all key departments that are contributing to the overspend. Particular pressures are noted in Mental Health and Prescribing.	No gaps.	3	3	9	Additional mitigations developed to address emerging pressures via the SEL Finance Sub-Group. Outcome of financial recovery board discussions will feed into Q2 financial projections. This will then facilitate those required commissioning decisions to ensure we remain on plan.	07/10/2025 - Risk reviewed by PELs on 6 October 2025, following ExCo discussion on 1 October 2025 - additionally confirmed with finance lead in Greenwich, due to review of provisional M6 numbers. 23/10/2025 - Due to initial outputs from the financial recovery board, the collective Greenwich view deemed it appropriate to downgrade the risk to a likelihood and consequence score of 12. This will be closely monitored and reviewed monthly to ensure that all appropriate actions are being taken and mitigation are in place. U&EC monthly. 08/01/2026 - Scoring remains the same. U&EC Financial position indicates a stabilised position of in-year pressures. This evidences the effects of outputs of the financial recovery board and other mitigation strategies in place. Will continue to closely monitor as we go through Q4 period. U&EC At this stage if all continues we are projecting to achieve financial balance with a good degree of confidence. 12/02/2026 - Scoring reduced to 9 (Possible & Moderate). U&EC Result of seeing the mitigations through finance recovery board and other forums. U&EC indicators are showing we should achieve financial balance. U&EC Review in March with a view to close by April.	11/3/26				
599	16/5/25	Phil Darby	Lisa Wilson	Greenwich Dementia Diagnosis Rate	The current dementia diagnosis rate in Greenwich is 64%. The target rate is 67% so there is a risk that we are not supporting people living with dementia to get a timely diagnosis	2	4	8	Working with primary care to ensure residents diagnosed with dementia are coded correctly on GP IT systems. Working with Oxeas Memory Service to identify any issues. Continue to work with Dementia Action Group to raise the awareness of dementia in local communities. continue with numerous activities to raise awareness of dementia	No gaps. No gaps.	2	4	8	Oversight will fall under the home first board	No gaps.	1	4	17/07/2025 - An increase of 4% which is positive. U&EC Conversations are being had with Primary Care to discuss coding. 02/10/2025 - The dementia diagnosis rate currently stands at 63.4%, which is consistent with the level over the last 3 months. A review of our dementia services is planned to identify any opportunities for further improvement. U&EC Scoring remains the same and a further review will take place in 3 months. 28/01/2026 - Scoring remains the same. U&EC Diagnosis rate has increased to 63.7%. We have a GP fellow currently mapping the dementia pathway to identify areas of improvement. Dementia Action Week is taking place in May 2026 with a focus on increasing diagnosis. Planning is starting and an event is planned to be held in this week.	10/6/26	
614	9/6/25	Jenny Lamprell and Rena Amin	Lisa Wilson	Risk of not achieving the National/Local trajectory for SMI Primary Health Checks	Based on local position against key areas of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target physical health checks. There seems to be a slight disconnect with different providers and/or disconnect with SMI patients and/or their carers. There is a lack of co-ordination in call and recall across various providers/primary care. The impact of not providing a comprehensive PHC is potentially significant in terms of health outcomes leading to co-morbidities, hospital admissions and premature death. The role of Mental Health Practitioners is key to this task but again there was significant variance in their clinical portfolio across various practices. The lack of digital interoperability is another gap leading to data lost due to IT systems not able to communicate across Oxeas, Primary Care and occasionally VCS. The last reported performance for SMI PHC for year ending 2024/2025 was 49% across a SEL trajectory of 68% across the 6 core health check components.	3	3	9	Developing a robust awareness programme across Primary Care and Voluntary Care Sector, Developing a Task & Finish group with stakeholders to support this programme and achieve the performance target. A regular agenda item on the Mental Health Oversight Committee to review performance, manage challenges and barriers and provide timely strategic support where required. Roll out a patient engagement event in collaboration with expert patient group/MIND etc to raise the importance of having annual physical health checks for patients with SMI. Work with SEL and explore any avenues that can improve the workforce (eg. ARRS staff) capabilities within primary care to undertake robust SMI PHC to ensure sustainability of improving health outcomes. Empower care providers to promote PHC for clients they manage through their care settings	There are no major gaps in controls however it is important to note that the SMI physical health checks is NO longer part of the 2025/26 Quality and Outcomes Framework (QOF), the aim of which was to reduce health inequalities. The risk therefore is SMI PHC may be impacted and will invariably have huge variance across Primary Care.	3	3	9	Mental Health Oversight & Co-ordination Board	There are no major gaps in controls however it is important to note that the SMI physical health checks is NO longer part of the 2025/26 Quality and Outcomes Framework (QOF), the aim of which was to reduce health inequalities. The risk therefore is SMI PHC may be impacted and will invariably have huge variance across Primary Care.	2	3	6	03/12/2025 - Reviewer Name: Rena Amin/Comments: Steady progress has been made with this risk. Established a T&F SMI group with clear deliverables, progress is submitted to the Mental Health Oversight Committee, and the last update showed a performance of 41% for SMI PHC. YTD, which is a significant improvement. Whilst not yet near the target achievement of 60%, it is indeed progress in the right direction. The SMI T&F group is equally working on patient engagement events and collaboration with stakeholders to improve workforce support, e.g. utilising the skills of Mental Health Practitioners. Will retain the risk grading of 9 for this review, and there is a strong possibility of downgrading it at the next review due to significant progress made on this risk at a local level in collaboration with the Integrated Commissioning team, RBG and the NHS via the CCPL role and others. 21/01/2026 - Risk Score remains at 9. U&EC December data is 48% indicative trajectory is 55%. All but two boroughs decreased 1% in this period. SMI PHC YTD, which is a significant improvement. Whilst not yet near the target achievement of 60%, it is indeed progress in the right direction. U&EC Tasks being undertaken: 15scope engagement plan with VCS and residents with lived experience to co-produce well attended events in non-clinical settings. U&EC Develop and deliver a communication plan including outreach activities in primary care bulletins, secondary care, and provider settings. U&EC Review again in March.	25/3/26
615	9/6/25	Jenny Lamprell & Rena Amin	Lisa Wilson	Risk of not achieving the National/Local trajectory for LD Annual Health Checks	Based on local position against key areas of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target annual health checks. There seems to be a slight disconnect with different providers and/or disconnect with LDA patients and/or their carers. There is a lack of co-ordination in call and recall across various providers/primary care. The impact of not providing a comprehensive AHC is potentially significant in terms of health outcomes leading to co-morbidities, hospital admissions and premature death. The lack of digital interoperability is another gap leading to data lost due to IT systems not able to communicate across Oxeas, Primary Care and occasionally VCS. The last reported performance for LD AHC for year ending 2024/2025 was 69.5%, it was an increase from previous dataset. Actual performance of 1128 Vs Trajectory = 908, for Greenwich. However the GP DES contract expects a 75% target for patients over 14 years of age LD population 1998.	3	3	9	Developing a robust awareness programme across primary and VCS. Developing a Task & Finish group with stakeholders to support this programme and achieve the performance target. Roll out a patient engagement event in collaboration with LD Partnership Board etc to raise the importance of having annual health checks for patients with LD. Work with SEL and explore any avenues that can improve the workforce (eg. ARRS staff) capabilities within primary care to undertake robust LD AHC to ensure sustainability of improving health outcomes. Empower care providers to promote AHC for clients they manage through their care settings.	Based on local position against key areas of local performance, (Q3/Mar 2025 data) from SEL ICB, Greenwich has not achieved the target for annual health checks. Due to an error in the national Primary Care Data (PCD) ref set, the current reported LD figures are potentially overstating the numbers in this inclusion group. The data will be refreshed once the PCD ref set has been updated. It is equally vital to note that the date provided from primary care is reliant on the completeness and consistency from practice coding across different GP systems. Therefore there are cases where figures may not match up to other sources.	2	3	9	Learning Disability & Autism Oversight Board.	There are no major gaps in controls	2	3	6	09/06/2025 - Awaiting information on the LD AHC dataset to assess how near or far Greenwich performance was to the trajectory. June 2025 update the LD Awareness Week to promote LD AHCs. U&EC Plans: July 2025/Sept 2025: Would be appropriate to liaise with Clinical Directors and LD MPs to gauge their support for completion of AHC. 03/09/2025 - Risk scoring has not changed and no update to risk remains the same. U&EC No data available as yet to review. U&EC Next Review November, 03/12/2025 - Reviewer Name: Rena Amin/Comments: Greenwich has established a fully operational Learning Disability & Autism Oversight Committee, which has galvanised a lot of the controls required to achieve the AHC target. August 2025 data shows that currently, Greenwich is on track and achieving 30% of AHC and achieving higher than the operational target set for this period. There is a definitive plan to highlight and support practices achieving less than 10% of AHC to date. A comprehensive support pack has been created to raise awareness at a practice level. The Learning Disability Partnership Board has a workstream on Health Matters, and through this forum, patient/carer awareness is increased, and they are empowered to seek appointments for the AHC. Significant training sessions have been delivered to the Local Authority teams to empower care home staff to engage actively with the client's GP for a comprehensive AHC. Quality of AHCs is also assessed via the Local Authority. Quality Improvement Teams, and collectively, at all these measures are enabling improvement in uptake. There is still a significant long way to go before achieving the national target of 75% so retaining the risk grading of 9 for this review. 21/01/2026 - Scoring has been downgraded to a 2. We have met the target rating. U&EC We are keeping this open until the end of the financial	15/4/26
618	2/6/25	Alex Piel	Jin On	Risk of an overspend of the Greenwich Prescribing Budget for 2025/26	There is a risk that there may be an overspend of the Greenwich Prescribing Budget for 2025/26, this is caused by a number of contributing factors SEL launching MOP September 2025. Long Term Condition Management, new drugs coming to market especially for obesity management. Increased prescribing and needs optimisation needed to improve outcomes for patients with Diabetes, Respiratory, Hypertension (to NICE Guidance) and Lipid Management. Drug shortages - hard to mitigate against these, impacting many clinical areas still impacting ADHD medication and HRT. Drug price rises. NCSO/price concessions and Category M Increased patient demand for self care items to be prescribed rather than purchased as cost of living increases OptimiseRx Depends on practice engagement and individual clinician action at point of prescribing. The impact on the ICB would be that Greenwich practices are overspent compared to prescribing budget.	4	3	12	MOP 25/26 practice visits completed, (2 practices scheduled) Regular engagement through GIPN, PLT, Nurse Forum and Practice Manager Forum and others when required. Increased uptake of pharmacy first services to alleviate pressures on GP services and prescribing. Regular searches and monitoring of mitigation plan drugs and targeted approach to practices	No gaps.	4	3	12	Bi Weekly Team meetings discussing prescribing, MPG Meetings every 6 weeks - Governance Group, ADOF & ADMO Meetings	Deep dive into the top overspending practices identifying areas of improvement and action plan created for the seven practices. U&EC Search into additional savings taking place. U&EC Meds ops teams have carried out PCN Visits to discuss med ops and national priority areas.	3	2	6	03/09/2025 - Scoring remains the same. U&EC Deep dive into the top overspending practices identifying areas of improvement and action plan created for the seven practices. U&EC Search into additional savings taking place. U&EC Meds ops teams have carried out PCN Visits to discuss med ops and national priority areas. 03/12/2025 - CPN workstream has been relaunched across SEL. Two CPNs working in Greenwich to support relationships between community pharmacy and GP. Greenwich PLT November to upskill and support Greenwich Primary Care workforce for potential new ways of working. U&EC Team has been completing practice visits, and promoting the MOP and areas of prescribing anomalies. Continuing to monitor drugs coming of patient and QIPP savings. U&EC Scoring remains the same and will be discussed with all boroughs as this is a generic risk for all boroughs. 28/01/2026 - Scoring remains the same at present however savings forecast to put Greenwich in a better position by year end. U&EC Increased forecast of patient savings (new and legacy). U&EC NHS price difference reimbursement of GLP-1/PP QIPP Savings and national priorities.	25/3/26
621	23/6/25	Nicky Skeats	Jessica Arnold	Risk of insufficient appointments in primary care creating delays in accessing clinical care or advice and which might result in possible harm or increase dissatisfaction with care delivery by patients and practice staff.	The possible risks of delay in access to appointments are (1) Increased use of other services such as A&E and LTC (2) Increase in stress and reduced staff well being resulting in increases staff attrition (3) patients not accessing appointments leading to delays in diagnosis and avoidable harm.	3	3	9	6 practices due to participate in national Practice Level Support (PLS) programme which includes implementation of Modern General Practice Model. PCNs working with Digital and Transformation leads to implement CAIP plans which includes equity of access for patients no matter how they contact the practice and improved access to e consultations. Monitoring and identification of practices needing additional support through use of Ardens Manager and through the national Practice Dashboard. Practices moving towards total triage all practices implementing online consultations and availability of OC continues to be monitored	Unexpected increase in patient demand outside of GP control.	2	2	4	Primary Care Commissioning Board reviews reports access as reviewed through the Quality and Improvement Group, Concerns and Resilience Group reviews individual practice performance, PCNs are encouraged to deliver their CAIP plans via regular review meetings with Primary care Commissioning team, Greenwich practices offering appointments in a	No Gaps	2	2	4	03/09/2025 - Meetings are taking place with PCN Clinical Directors reviewing their CAIP plans. Discussions ongoing with practices regarding contract changes and response to national patient surveys. 15/01/2026 - Scoring has decreased from 9 to 4 following contract changes and adoption by practices of online consultations. U&EC Controls and Gaps have been updated. U&EC Final review in 3 months along with results of 2026 patient survey.	22/4/26

622	15/7/25	Farrel Green	Jessica Arnold	Risk of MMR Outbreaks in Greenwich	Insufficient MMR vaccination coverage in under 5s to maintain herd immunity. London has a multicultural population with communities where scepticism around vaccination is historically more prevalent. It is highly unlikely in London brought to reach the national 95% target coverage. Furthermore GP practices experience a range of workforce issues which undermine capacity to proactively or personally engage with communities.	3	3	MMR campaigns advertising clinic locations targeting parents in low uptake wards. MMR vaccinations offered in 3 community pharmacies. MMR booster vaccinations bought forward to 18 months of age. Initial pilot with a couple of practices to enhance recall for children aged 12 & 18 month via birthday cards in the month of September. Standards for childhood mms to be included in practice contract premiums. SDP has been completed and shared with all practices. This is now being used with individual practices to review and enhance delivery of vaccines. MMR vaccine changed to MMRV on 1 January 2026, awaiting to see impact on vaccine uptake.	Work ongoing with public health team to develop greater community engagement to enhance vaccinations.	3	3	Health Protection Board	ICB restructuring poses a risk to accountability, without clear ownership of immunisation performance in future organisation.	1	2	03/09/2025 - Scoring remains the same. Please note that system changes in 14 UTLAs in London earlier this year, as well as changes to the way multiple dose courses are calculated, mean that the coverage in London for some vaccines, particularly the pre-school (dTap/IPV) booster and MMR2 is likely to be underestimated. Reported falls in coverage in these vaccines in the current year should not be used for local vaccination performance management or in isolation to direct public health action. Greenwich is one of the UTLAs affected. Inconcomitantly due to MCR processes. 15/01/2026 - Scoring remains the same at 9. Controls have been updated. Risk of MMR outbreaks remain. Increase to vaccine delivery is being promoted with practices. Awaiting to see what impact the chicken pox vaccine will have on the uptake of the MMR.	22/4/26
623	15/7/25	Farrel Green	Jessica Arnold	Risk of apathy in the community towards flu vaccinations	Low public confidence in vaccination programmes and vaccine fatigue has increasingly impacted the success of vaccination campaigns since the COVID pandemic.	4	2	Developing a winter comms plan prior to September, including targeted advertising campaigns to reach at-risk cohorts. Utilise positive, clear messaging using the 'Why we get vaccinated campaign' toolkit. Work with voluntary groups to increase reach of positive messaging. Tailor Communication styles to local communities. Offer more convenient access with pop-up clinics in low-uptake areas. Leverage reminder systems in primary care, such as text messages and phone call reminders for flu appointments. Performance will be reported in the bulletin and Ardens Manager reviewed to direct supportive discussions with practices. The Big Week campaign media coverage of increasing flu cases and hospitalisations helped increase flu uptake	Engagement with the Community. The reach of comms social channels, relationships with community leaders are not longstanding	3	2	SEL Operational Group. Monitoring Vaccination rates by practice through ARDENs Manager	ICB Restructuring (Permanent Vaccine Coordinator not appointed to)	2	2	03/09/2025 - Autumn Winter campaign has commenced, working with communications team on outreach clinics and Oxeas for the immune suppressed. SEL winter comms campaign has started early. Practices are being encouraged to be proactive and offer online appointments for vaccination. Work ongoing with practices to book vaccinations for care home residents. 23/10/2025 - Scoring remains the same at present. Chasing practices and care homes to ensure provision is in place for home visits. Still awaiting ARDENs reporting to be updated which will enable practices and the ICB to oversee current achievement once live. 03/12/2025 - Scoring remains the same. Winter Health Bus attending Cannon Retail Park offering opportunistic Flu, Covid and Vital 5 health checks - 4/12/25 to target residents in Thamesmead. Leaflets have been sent out in 5 languages to Community Centre to support residents for Flu uptake. Leaflets languages have been identified by Community Site Manager for the targeted low uptake residents. School Vaccine Team are working to increase uptake in CYP. Care homes - contacted each to ensure they have offered to all residents to have a vaccine. 15/01/2026 - Scoring has lowered to 6. Uptake of vaccines increased towards Christmas. Uptake has improved in the under 65s, and closing the gap on the over 65s. The Big Week campaign, media coverage of increasing flu cases and hospitalisations helped increase flu uptake.	25/3/26
624	15/7/25	Michelle Barber	Jessica Arnold	Risk to achieving the cancer screening target	There is a risk that Greenwich may not achieve the cancer screening trajectory (bowel, cervical and breast) as set out in the LCP performance data report. The cancer screening is commissioned by NHS England and there is always a significant lag in the reporting - current data is from September 2024 for bowel and breast, and June 24 for cervical.	2	3	Based on the data in the LCP performance report, Greenwich is only 1% below the trajectory for each of the cancer screening programmes. In order to increase public awareness and uptake of cancer screening, the following actions have been taken, and continue to be: 'Bowel Screening we are meeting the national target 62% - Greenwich currently at 65.4%. The national Cervical Screening or Breast Screening target is not currently being met across SE	No gaps.	3	3	Integrated working between ICB staff (Greenwich Place), Greenwich Public Health team and the CCPL for cancer on a targeted work plan to increase awareness of the importance of cancer screening and increase uptake. Greenwich won a bid to purchase breast models to take out in the community to show women how to look for lumps in their breasts. These will be used in outreach work and other opportunities to make improvements to breast screening. RBG colleagues have identified other workplaces to offer cancer screening information and training where interest found. Head and Neck Cancer - Training has been provided to interested barber shops in Greenwich with merchandise currently being distributed. PH are currently looking to undertake an evaluation. Cancer Alliance have provided some funding to do training around community champions and connectors to talk to people about the first signs of	No gaps identified	2	2	10/09/2025 - The target for cervical and breast screening is 80% and bowel screening has recently increased from 60% to 76%. Local data from June 25, shows Greenwich performing as follows: Cervical 67.6%, Breast 55.7%, Bowel 63.5%. Greenwich is on performing, on average. 3rd out of the 6 SEL boroughs. There is continued outreach awareness raising of the importance of cancer screening with the public, through Public Health and the Cancer CCPL. There will also be a cervical cancer improvement incentive in the new GP premium, which will hopefully increase awareness and uptake. Scoring changed from 6 to 9. 03/12/2025 - Scoring has not changed since the last review. Cancer Workshop taking place on 4 December which may have some outcomes which will be updated in the next review. 11/02/2026 - Scoring remains the same. We do not have any updated data showing on the dashboard, current figures are for April 2025. This has been raised and is a national problem. Continued outreach work has been taking place through public health and the CCPL. Review in April in hope for refreshed data.	8/4/26
625	15/7/25	Michelle Barber	Jessica Arnold	Risk to achieving the ICB target (73.4%) and the national NICE target (85%) for the management of hypertension to NICE guidance	There is a risk that lower than target hypertension management within primary care may increase cardiovascular risk and contribute to poorer health outcomes for residents and future avoidable demand on secondary and acute health care services.	4	3	Clinical Excellence South East London (CESEL) and the Greenwich LTC team work with practices and PCNs to ensure that they have the latest data regarding their hypertension management. Together with a resource pack and best practice guidance on how to improve hypertension management. SEL also support with 'Call to Action' webinars to increase awareness with clinicians, showcase best practice and provide expert clinical advice. Increasing awareness with the general public through community outreach events (working with public health and the comms & engagement team) concerning the importance of having blood pressure checked and controlled. The 2025/26 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 85% by March 2026 as a national objective. For 2025/26, this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 73.4% for Greenwich. The current achievement is 68%.	No gaps.	4	3	The hypertension target is monitored by CESEL and is a regular agenda item on the LTCs Programme Group - to support improvements. Further outreach and engagement via the Comms & Engagement team and Charlton Community Trust. LTC CCPL and LTC Programme Lead have arranged a series of meetings with the PCN CDPs over the next couple of months to discuss the hypertension management and opportunities to make improvements and understand any ongoing challenges.	No Gaps in Controls	3	3	10/09/2025 - Current achievement (Sept 25) is 65% for under 80 year olds (same achievement as Lambeth & Southwark; highest current achievement in SEL is 67%) and 80% achievement for over 80 year olds (joint highest in SEL with one other borough). Working with CESEL and CCPL to support Practices in increasing the number of patients with blood pressure readings in the target range, through sharing best practice, benchmarking against other Practices and education webinars. 03/12/2025 - Scoring remains the same and has not changed. Greenwich scores in 65% under 80s - joint third with Southwark. 79% over 80s - joint third. Sitting joint third in SEL with Southwark. 11/02/2026 - Scoring remains the same. Current hypertension performance data shows for Greenwich currently under 80s - 67.29% over 80s - 82.35%. None of SEL boroughs are forecast to meet the target. Review again in April.	8/4/26
635	4/8/25	Jenny Lamprell, Rena Amin, Rosetta Campbell	Lisa Wilson, David Borland	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults	There is a risk that residents experience excessively prolonged waiting times for autism and ADHD diagnostic assessments. This is due to sustained increases in demand, historical backlogs, and limited diagnostic workforce capacity. The delays adversely affect children and adults, increase reliance on private providers through 'Right to Choose', and create financial pressures for the ICB arising from non-contracted activity. Prolonged waits also undermine public confidence and impact delivery of national and local improvement commitments for mental health and neurodevelopmental services.	5	2	Greenwich is just formalising the Autism Strategy, and as part of the newly established integrated commissioning team, a performance tracker on the waiting times and financial impact will be created. Data analytics will need to be supported by Oxeas as the local provider for ADHD/ASD diagnosis to track the impact of these delays, as well as the financial impact. Data analytics will need to be supported by Oxeas as the local provider for ADHD/ASD diagnosis to track the impact of these delays, as well as the financial impact. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. SEND Improvement Board oversight with joint leadership from local authorities and Directors of Children's Services to drive delivery of local improvement plans and monitor performance trajectories. Waiting well and early support offers publicised through local offers and all-age autism services to provide information, advice and support before diagnosis.	No data for ADHD (waiting list or post-diagnostic). Autism, no register required, within QOF, akin to LD or SMI, and so very reliant on each practice to code accurately, hence the clinical variation. Whilst national RTC is in place, no control over volume and diagnosis asked for. Cannot control GP shared care with private contractors. Workforce capacity across community specialist diagnostic teams remains below demand. Limited ability to influence activity and quality within private 'Right to Choose' pathways. Data completeness and standardisation across providers and places not yet consistent. Workforce capacity across community paediatrics and specialist diagnostic teams remains below demand.	4	4	Oversight through the SEND Improvement Board, Place SEND Partnerships, and the SEL CYP MH and Wellbeing Partnership Board. Monthly contract and performance meetings with key providers. Regular reporting through ICB performance and finance structures on diagnostic activity, spend and trajectories. Periodic deep dives and review sessions through SEL CYP MH Delivery Group and borough governance. Autism Partnership Board reporting into Learning Disability and Autism Oversight Board and Mental Health Oversight and Co-ordination Board when appropriate	Inconsistent and incomplete BI reporting across places pending full implementation of the SEL wide dashboard. Limited independent verification of data accuracy and trajectory modelling. Assurance over 'Right to Choose' activity and spend still under development.	5	4	03/09/2025 - May 25 new integrated commissioning team in place to work on detail of Autism Strategy and implementation plan. Autism Partnership Board relaunch May 25. New team will establish how best to collate and analyse data. New Community Autism Service being designed by ICB to support those with more complex needs. 09/10/2025 - Risk score increased to 16 - following discussion of risk area at PELLs on 6 October 2025 - agreement by all PELLs that LCP risks on this area should be escalated to the BAF. 03/12/2025 - Reviewer Name: Rena Amin. Comments: The SEL wide neurodevelopment improvement programme and the new integrated diagnostic pathways, whilst established, there is still a significant demand and backlog in the system. Workforce capacity and specialist diagnostic teams are not able to demonstrate a demand reduction coupled with variability across providers, makes this risk even more complex to manage. Whilst it is early days, for these programmes to fully embed and make a noticeable difference, there is still no ability for local teams to influence the Right to Choose, including its quality and activity. Risk scoring has therefore not changed and the risk grading remains the same. 21/01/2026 - The pilot is at recruitment phase. Further updates can be given if still remains at the same level of risk.	15/4/26
641	1/10/25	Philip Darby	Gabi Darby	Integrated Community Equipment Service	There is a risk that issues with the current Integrated Community Equipment Service provider, including financial instability and operational concerns, will disrupt timely provision of equipment to residents. This could delay hospital discharges and prevent people from receiving the right equipment to support safe recovery at home. The risk is heightened by the provider's liquidation (effective 31 July 2025), which threatens service continuity and creates uncertainty around future delivery arrangements.	4	5	Attending and participating in the London Consortium meetings to agree contract monitoring and improvement plans. 3x weekly and additional exceptional meetings as needed. Additional local contract monitoring meetings in place 3x weekly. Daily meetings with SEL/SWL colleagues to monitor and agree plans for best next steps for alternative provision. Strategic review of service.	None	2	3	London Consortium. Local contract management meetings. Joint Commissioning and Operational Oversight Group	Lack of effective response nationally	3	2	03/12/2025 - Scoring has reduced from a 9 to a scoring of 6. The new service is operating on a business as usual footing, there are no concerns regarding service delivery. Plans are being developed for future commissioning options of the service.	11/3/26
645	6/1/26	Jane Thurston	Lisa Wilson	Community MSK Procurement	There is a risk that delays or challenges within the Community MSK procurement process (including representations, legal challenge, or mobilisation slippage) could result in service disruption, reduced continuity of care, and adverse impact on patient access, waiting times, and outcomes. This may also create financial, reputational, and operational risks for the ICB if interim arrangements are required or if the procurement timetable cannot be delivered as planned.	3	4	Procurement conducted in line with the Provider Selection Regime (PSR) and published ITT documentation. Clear governance structure, including evaluation panels and representation panel. Legal and procurement oversight throughout the process. Contingency planning for contract extension or interim arrangements to maintain service continuity. Regular engagement with incumbent provider to support continuity of service. Clear mobilisation planning built into the procurement timetable	Dependency on timely resolution of representations or challenges outside commissioner control. Limited flexibility if mobilisation timelines are compressed following delays. Potential reliance on short-term contractual extensions which may not fully address service improvement ambitions. Workforce stability risks during extended procurement or uncertainty	3	4	Regular reporting through programme and governance meetings. Legal advice confirming compliance with procurement regulations. Commissioner oversight of service performance during any interim period. Contractual safeguards (e.g. no-fault termination clauses) within interim arrangements. Clear communication plan with providers and	No absolute assurance on timescales for resolution of representations or legal challenges. Limited assurance on provider workforce retention during prolonged uncertainty. Reduced ability to assure delivery of transformational service improvements during interim arrangements. Potential reputational impact if delays are perceived externally as poor system planning			11/02/2026 - Representation has been made resulting in time slippage to contract award and mobilisation. Financial risk due to delay in contract award. Scoring remains at present, further meetings are to take place regarding the procurement of the service. Risk to be reviewed in 4-5 weeks.	25/3/26
646	14/1/26	Rachael Smith	Gabi Darby	Population Health Platform - Funding and Contract Position	Funding for the population health management (PHM) platform is due to end in March 2026. It is unlikely that current local arrangements can sustain the platform beyond this date. The contract itself continues until March 2027, but a strategic decision is needed on whether to end early, extend temporarily, or continue through to contract end. Without continued access to the platform or a suitable alternative, there is a risk to delivery of key PHM functions, including cohort identification, care planning, and system-wide intelligence. This may affect multi-disciplinary working, proactive care models, and broader transformation objectives. A decision is required between three options: End March 2026 - Serve notice by Sept 2025 Extend beyond March 2026 - Temporary continuation Continue to March 2027 - Full contract term If the contract is ended early, we will need to pause/archive existing work or migrate data and functionality to another environment. The decision depends on platform requirements and transition planning.	3	4	Based on actions in previous update, we have decided to join GSTT's Snowflake as our replacement platform. We have obtained permission through the Data Usage Committee to add our data to GSTT's platform for this purpose. We will enter a discovery phase 2nd-11th February to develop detailed technical plans with all participating organisations (the PHM Team, LGT, GSTT, the AI Centre, NTT and Accenture) for completion of the work. We are requesting quotes to include all possible options, with GP and Acute data as a minimum but also potentially Community data from Rio, as now. We have developed plans for interim solutions for INTs Case Finding and MDMs, which will be built by Ardens. These will be based on GP data only. We are developing interim dashboard internally to replace Elective Recovery, and confirming that there will not need to be full replacements for other work (PAWS and other less regular requests) until we are operational at GSTT. For our internal interim work, we are working to ensure we have access to data from as many GP Practices as possible, by ensuring they sign up	Plans will be developed for full migration, and are being finalised for interim cover, in the interim, the quality of case finding to support MDMs and INTs will be compromised, as it will be based solely on GP data, and will use a different emergency admissions risk model (which drives prioritisation of patients for both, the AI Centre). The quality of case finding to support Elective Recovery and other delivery arms will also be compromised if we are unable to access data for all GPs via EMIS Web, if not all sign up, continue or replicate the work currently being undertaken to generate and maintain cohort lists.	3	4	This period will be used to determine resource and timelines for the work to migrate to the new platform, and to prepare interim cover for all delivery arms until that is achieved.		4	2	8	15/4/26

Greenwich Initial Rating Between 1 And 3
Orange Initial Rating Between 4 And 6
Red Initial Rating Between 8 And 12
Dark Red Initial Rating Between 13 And 25

HGP Risk register update February 2026

There are currently 18 active risks on risk register.

1. Risks recently added to the Risk register *(full details of all risks are available to review in the risk register)*

Risk No.	Risk Title
645	Community MSK Procurement
646	Population Health Platform – Funding and Contract Position

2. Risks reviewed during the period *(full details of all risks are available to review in the risk register)*

Risk No.	Risk Title
465	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer
474	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.
495	Risk relating to co-ordination of timely discharge support for residents.
574	Primary care premises lost / insecure lease agreements / other estates issues
596	Achievement of Financial Balance 2025/26
599	Greenwich Dementia Diagnosis Rate
614	Risk of not achieving the National/Local trajectory for SMI Primary Health Checks
615	Risk of not achieving the National/Local trajectory for LD Annual Health Checks
618	Risk of an overspend of the Greenwich Prescribing Budget for 2025/26

621	Risk of insufficient appointments in primary care creating delays in accessing clinical care or advice and which might result in possible harm or increase dissatisfaction with care delivery by patients and practice staff.
622	Risk of MMR Outbreaks in Greenwich
623	Risk of apathy in the community towards flu vaccinations
624	Risk to achieving the cancer screening target
625	Risk to achieving the ICB target (73.4%) and the national NHSE target (85%) for the management of hypertension to NICE guidance
635	Neurodevelopmental diagnostic pathways (autism and ADHD) - CYP and adults (Risk changed name and includes CYP)
641	Integrated Community Equipment Service
645	Community MSK Procurement

3. Risk recently closed

619	HealthIntent (HI) Platform and Funding Position	04/09/2025 - Agreed notice to be served end of September 2025. Agreed two short term solutions to give continuity from April 2026. Exploring two midterm solutions to enable us to full continuity of work, dates to be established. Costs with short and midterm solutions need to be analysed and can impact on decisions.
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	Mar-26	Apr-26	May-26
Healthier Greenwich Partnership	25/03/2025 12h30-16h30	29/04/2026 12h30-14h30	27/05/2026 12h30-14h30
	Easter Break 30/3/2026-10/4/2026		School Holidays 25/5/2026-29/05/2026
	Development Workshop/Seminar - In Person, Venue TBC	In Public - MS Teams	In Private - MS Teams
		Papers due 21/04	Papers due 19/05
<p>Chair - Kate Heaps (wef May 2025) Business Support - Julie Mann</p> <p>Standard Agenda Items -Welcome -Introductions and apologies -Declarations of interest -Minutes of previous meetings -Action Log -Public engagement: delivering our Healthier Greenwich Plan (focus on 'well' areas) - Quarterly at Public Meeting -HGP Partner's Report.- Quarterly at public meeting -HGP sub-committee report - Public Meeting - HGP Development - Private Meeting</p> <p>Meetings in public At least one meeting a year to be held in person - no hybrid opportunities</p> <p>Developmental Workshops/Seminars; Held every quarter, in person only. Focus on working together across the partnership strategically</p>	One of Neighbourhoods & Place alignment/ HIUs/ Mental health impact on physical health (to define later)	<p>Board meeting in public Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log <i>Positive partnership story</i></p> <p>Main Business/Themed Item</p> <p>Items for noting/limited discussion Public Forum Feedback Healthier Greenwich Charitable Funds update HGP partners report Performance report Sub-committee report Risk register Forward planner</p>	<p>Board meeting in private (on MS Teams) Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log</p> <p>Main Business/Themed Item</p> <p>Items for noting/limited discussion Forward planner</p>
<p>Future Agenda items - not linked to specific meeting CYP focussed workshop Discussion on Autism & ADHD - link on transition from childhood to adulthood Proactive Care MSK Procurement The Wells - Age Well/Lisa Wilson, Stay Well/Jessica Arnold Eltham PMS contract update - Jessica Arnold</p>			