South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1400-1600 Thursday 16 July 2026
(Teams meeting)

Co-Chairs: George Verghese and Ceri Jacob

Quorum: 50% of members (10) need to be attendance with at least one representative from each Local Care Partnership.

Agenda

#	Area	Lead	Time
1	**Introduction and apologies for absence**	Chair	1400
2	**Declarations of interests relevant to the business on the agenda**	All	1402
3	**Minutes of the meeting held on 22 April 2026 (Enc 1)**	Chair	1405
4	**Actions and matters arising (Enc 2)**	Chair	1410
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**Update on the People Workstream including Clinical Risk Document (Enc 3)**	L Demeda/ C Harris	1415
6	**Lewisham's approach to transferring the Neighbourhood Development team from the ICB to the Integrator (Enc 4)**	C Jacobs/ L Jenner	1440
7	**Modelling Workstream update including demonstration of the tool (Enc 5)**	N Kennett-Brown/A Wall /K Aghajani	1505
8	**ICB Governance Review update (Enc 6)**	G Verghese	1530
9	**Any other business.**	Chair	1555
10	**Date of next meeting** ***To be confirmed.***	Chair	1600

Enclosure 1

Neighbourhood Based Care Board
Draft Minutes of the meeting held on Thursday 22 April 2026 MS Teams

Present:

Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	**CJ**
Angela Bhan	Bromley LCP rep	**ABh**
Vanessa Burgess	Medicines Management representative	**VB**
Oge Chesa	Lambeth LCP representative	**OC**
Gaby Darby	Greenwich LCP representative	**GD**
Gemma Dawson	Community Provider rep	**GDa**
Lynn Demeda	Workforce Representative	**LD**
Holly Eden	Director of Delivery – Neighbourhoods and Population Health	**HE**
Kallie Heyburn	Bexley LCP representative	**KH**
Toby Garrood	ICB Medical Director	**TG**
Neil Goulbourne	Acute Services Representative	**NG**
Rebecca Jarvis	Southwark LCP representative	**RJ**
Laura Jenner	Lewisham LCP representative	**LJ**
Neil Kennett-Brown	ICB System Sustainability Team Representative (non-voting)	**NKB**
Raj Matharu	Community Pharmacy representative	**RM**
Denise Radley	Adult Social Services representative	**DR**
Tal Rosenzweig	Voluntary Sector Representative	**TR**
Kelly Scanlon	Communications representative (non-voting)	**KS**
Nisha Wheeler	Digital representative	**NW**

In attendance:

Lesa Bartlett	SLaM (for 026/2026)	**LB**
Tim Borrie	Strategic and Operations Estates Director	**TB**
Raphael Broughton	Observer	
William Clayton	PPL	**WC**
Rupinder Dev	ICB Acting Joint Director of Planning (for 026/2026)	**RD**
Mark Cheung	One Bromley Programme Director	**MC**
Philippa Galligan	SLaM (for 026/2026)	**PG**
Chloe Harris	Head of People and Culture SEL ICS	**CH**
Nick Harris	Head of Clinical Effectiveness SEL (CESEL)	**NH**
Sian Howell	Clinical Lead for Healthy London Partnership	**SH**
Nancy Kuchemann	Deputy ICB Medical Director	**NK**
Julie Lowe	Integrator rep	**JL**
Kate Lillywhite	SLaM (for 026/2026)	**KL**
Colin Nash	Governance Manager (Minutes)	**CN**
Nigel Smith	Integrator rep (for L. Dark)	**NS**

Apologies for absence:

Andrew Bland	ICB CEO (non-voting)	**AB**
Sarah Burchill	Mental Health Provider representative	**SB**
Louise Dark	Integrator rep	**LD**
Imogen Setter	PPL	**IS**
George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	**GV**

No	Item	Action
021/2026	**INTRODUCTIONS AND APOLOGIES**	
	CJ welcomed members to the meeting. Apologies were noted as above.	
022/2026	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
023/2026	**MINUTES OF THE MEETING HELD ON 19 MARCH 2025**	
	The minutes were **APPROVED.**	
024/2026	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log for this meeting: - 4/26 - HE agreed to report on the refinement of the BMI metric at the July meeting. 5/26 – As no suggestions for the broader evaluation of neighbourhood health had yet been received this action was kept open. HE asked for NBCB members to volunteer to join a neighbourhood metrics evaluation group.	**HE** **ALL** **ALL**
	IMPLEMENTING NEIGHBOURHOOD CARE	
025/2026	**MANAGING RISKS TO NEIGHBIOURHOOD DELIVERY**	
	HE presented an update following a desktop review of risks across place, programme and SEL registers, aligned to emerging ICB governance. There were a range of risks that needed to be effectively managed to support the delivery of Neighbourhood Health. As the ICB Board reviews its governance, there was a need to review risk related to Neighbourhood Health and ensure these were aligned against the developing governance arrangements. A desktop review of risks currently set out in place, programme and SEL level risk registers had been undertaken to identify shared risks that may be appropriately managed through developing neighbourhood delivery governance at a System level. These were set out in section 7 of the paper on pages 12 and 13 of the pack.	

	It was proposed that these risks, and any further risks that the NBCB advise, are reviewed with the Primary Care Plus group, to score and explore mitigations and controls. The risk register would then be approved via the new ICB governance and managed through appropriate Committees. NBCB members highlighted additional risks relating to: - o Evaluation capacity and sustainability o Data quality and coding consistency o Visibility and use of data from community pharmacy	
	The Board **NOTED** the update and **SUPPORTED** the proposed next steps. HE would work with the Primary Care Plus group to develop a draft neighbourhood risk register for approval at a future NBCB. She also asked for volunteers to assist with this risk management work.	**HE ALL**
026/2026	**MENTAL HEALTH AND NEIGHBOURHOOD BASED CARE**	
	RD took the Board though her paper setting out a broad approach to how mental health should be considered as part of the neighbourhood-based care development programme, both in terms of INT development and the broader neighbourhood care agenda. The paper suggested Viewing both mental health and through the following three lens: - 1. Development of the existing INT approach to include a mind and body focus. Specifically, this should consider expanding the existing INTs in adults to include a mind and body approach and to then expand the multi-morbidity INT to include severe mental illness (SMI) with a particular prioritisation of people on antipsychotic long-acting injections. 2. The role of neighbourhood-based care in improving health outcomes for people with SMI in the community and reducing the mortality gap for peopled with SMI. The paper suggested (a) maximising the existing offer for health checks for people with a diagnosis of SMI including via the core prevention offer; and (b) undertaking a new pilot for physical health support via Early Intervention in Psychosis (EIP) services at the point of diagnosis. 3. Considering secondary care mental health services provided in the community forming part of the wider wrap around community offer, as part of neighbourhood-based care. The paper recommended that the two mental health trusts take a system leadership role in defining what services sit as part of a core neighbourhood offer and to respond to national asks regarding mental health neighbourhood health centres. Recognising that funding has been made available via the Strategic Investment Fund (SIF) for mental health in neighbourhoods in 2026/27, and that this is currently being held by the two mental health trusts, the paper recommends that this funding is prioritised specifically for: (i) expanding the existing INTs to include a mind and body approach; and (ii) the expansion of the multi-morbidity INT to include SMI.	

	Should this approach be endorsed a template will be issued to the mental health trusts to develop their SIF proposals by early June in accordance with the agreed ICB timetable. The following points were made in discussion; - • The evidence base supporting physical health checks for those with SMI needed to be demonstrated. • The importance of place-based governance, VCSE involvement and local authority engagement in neighbourhood mental health plans was emphasised. • Plans needed to be aligned with existing Integrated Care Partnership and Mental Health Alliance arrangements. • It was recognised that SIF allocations were limited and required Places to decide which of the three lenes should be the development focus in each borough.	
	• Following a comment from ABh, CJ and RD agreed to discuss outside the meeting, whether an overarching framework for neighbourhood development including mental health, would be helpful.	**CJ/RD**
	• It was noted that the very tight deadline for agreeing SIF proposals would severely limit engagement with key stakeholders. HE, RD and GD agreed to discuss what could be done to mitigate this outside the meeting.	**HE/RD /GD**
	The Committee: • **ENDORSED** the key priority areas for mental health and neighbourhoods as set out in this paper. • **ENDORSED** the key priority areas for investment in 2026/27 via the SIF as set out in this paper. **Lewisham 24/7 Community Mental Health Model Pilot** KL and LB made a slide presentation (slides circulated separately before the meeting). The Lewisham 24/7 pilot aimed to transform mental health care in the community, offering a new service delivered by an integrated and expanded community and primary care team. It aimed to develop a 24/7 model for general adult community mental health services often referred to as Community Mental Health Teams (CMHTs), and the services that work closely with them, such as crisis and home treatment teams. The model reflected leading national and international models of community mental health care and was one of six NHSE funded national pilot sites. The aims of the pilot mirrored the broad aims of neighbourhood health, with joined up care delivered closer to home, outside of hospitals where possible.	

	The pilot included the renovation of an existing Trust site at Heather Close to provide a dedicated mental health centre for the new team, similar to the design of neighbourhood health centres. An overview of the pilot was set out in slide 3. An evaluation of the pilot was scheduled for September. Independent national and academic evaluations, including of the economic impact, were also underway, with interim findings expected later in the year. Very early indications of progress and impact were set out on slides 4 and 5. Whilst it was noted that a replication of the pilot in every neighbourhood was probably unaffordable, learning from the pilot in terms of changes to practice, did not require additional funding, although it did require sufficient management capacity to be implemented. NKB noted that the potential of the model to release service capacity elsewhere would require implementation across the ICS. TR felt that VCSE leadership in developing the model needed to be strengthened as it still felt to her as being clinically led.	
027/2026	**WORKFORCE WORKSTREAM DEEP DIVE**	
	LD and CH took the Board though their slide presentation providing an update on progress with the staff activation (page 29 of the pack), OD and bespoke workstreams (page 30 of the pack). The slides also reported progress with the SEL Risk and Governance document (current draft included as an appendix) (pages 31 to 37 of the pack). The following points were highlighted: - The staff activation plan had been completed, and well supported Neighbourhood Care webinars were now in progress. A gap in leadership development for middle managers had been identified. Page 30 of the pack set out the work underway to address this. Regarding clinical governance and risk, page 32 of the pack set out the themes that emerged from the Clinical Governance and Risk workshop. LD also highlighted the Staff Movement Flowchart, within the Clinical Governance and Risk document, that aimed to help staff work though the many different staff scenarios that will present themselves. The draft document had been well received. NBCB members supported the work so far and made the following suggestions: - • Clarification of which organisations could use the staff passport would be helpful. LD replied that legal advice was being sought on this with the intention that it could be used by all relevant staff. In response to a question from RM, LD confirmed that that included community pharmacy staff too.	

	• Further clarity on how the risk model will work at the operational level, including what happens when there is a clinical disagreement, would d be helpful. • Peer support for middle managers would be helpful as would the focusing of middle manager support on the key staff most affected. CH added that it was also intended that arrangements would cover SE and SWL. NBCB **NOTED** the report.	
028/2026	**ANY OTHER BUSINESS**	
	NKB reported that INT modelling work was underway and members were invited to contact him if they wished to be involved.	**ALL**
029/2026	**DATE OF NEXT MEETING**	
	1400-1600, Thursday 16 July 2026.	

South East London Integrated Care System

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Enclosure 2

Neighbourhood Based Care Board
Draft Action log from the meeting held on 22.04.26

Item Ref	Minute number	Item title	Action description	Owner responsible	Due Date	Comments	
ACTIONS BROUGHT FORWARD							
2/26	015/2026	Neighbourhoods PMO Report	Schedule cohort selection as the main agenda item for a future NBCB meeting.	**H Eden**	For the 16.7.26 meeting.		
4/26	024/2026	Proposed Outcome Metrics for 26/27	Discuss refinement of the BMI metric.	**H Eden/V Burgess**	For the 16.7.26 meeting.		
5/26	024/2026	Any other business	Inform HE of any suggestions for the broader evaluation of neighbourhood health	**ALL**	As soon as possible.		
NEW ACTIONS FROM THE 22 APRIL 2026 MEETING							
6/26	024/2026	Action Log	Volunteer to be a member of a neighbourhood metrics evaluation group	**ALL**	As soon as possible.		
7/26	025/2026	Managing risks	Work with the Primary Care Plus group to Neighbourhood care risk Register rfor approval though the new ICB governance structure once agreed	**HE**	Once new governance structure is agreed		
8/26	025/2026	Managing risks	Volunteer to assist with Neighbourhood Care risk management work.	**ALL**	As soon as possible.		
9/26	026/2026	Mental Health and Neighbourhood Care	Consider if an overarching framework for neighbourhood development, including mental health, would be helpful.	**C Jacob/ H Eden**	No date set.		
10/25	026/2026	Mental Health and Neighbourhood Care	Consider how best to maximise engagement with stakeholders in formulating 2026/27 SIF plans	**H Eden/ R Dev/ G Darby**	As soon as possible.		

South East London Integrated Care System

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Neighbourhood Based Care Board

Title	**Workforce Workstream Deep Dive**						
Meeting date	16 July 2026		Agenda item Number	**5**	Paper Enclosure Ref	**3**	
Author	**Chloe Harris**						
Executive lead	**Lynn Demeda**						
Paper is for:	Update	**X**	Discussion	**X**	Decision	**X**	
Purpose of paper	It was requested to facilitate a workforce deep dive discussion at the July's Neighbourhood Based Care Board, sharing progress against workforce workstreams and next steps. This workforce deep dive aims to cover: • Overall progress updates with our staff activation, OD and bespoke workstreams • A further detailed update on progress made with the SEL Risk & Governance document – for approval and sign off following subsequent testing at Place o Please note the full document has been included as part of this paper for your reference						
Summary of main points	SEL Places are developing models for Neighbourhood Health and the SEL People Programme developed a plan to support and enable neighbourhood working. This plan (and associated workstreams) was agreed in Spring 2025. Our last workforce deep dive to the Neighbourhood Based Care Board was in April 2026. Since our last update, we have made great progress in our areas of focus, which is covered as part of July's update. This includes: • Significant engagement with our Neighbourhood Care webinars, with 1101 registrations to date across all webinars • Completion of Clinical Risk & Governance guidance document and subsequent test via roundtable discussions at Place • A draft leadership development offer for INT middle managers • Significant influence in shaping London PPL People Task and Finish Group outputs, and use of SEL knowledge and expertise to develop London frameworks						
Potential conflicts of Interest	Nil						
Sharing and confidentiality	Open						
	Bexley	**x**	Bromley	**x**	Lewisham	**x**	

Relevant to these boroughs	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	N/A					
Financial Impact	N/A					
Public Patient Engagement	N/A					
Committee engagement	Some Committee members may have been engaged in specific programmes relating to staff activation webinars and/or testing of the risk and governance SEL document.					
Recommendation	The Committee is asked to **note** progress, with particular reference to **approving** the Clinical Risk & Guidance document for wider circulation, with the view that this is a live document in which we will review in 6-months' time.					

South East London Integrated Care System

Workforce workstream deep dive

Neighbourhood Based Care Board – 16 July 2026

Lynn Demeda – Director of SEL ICS People Programme

Chloe Harris – Head of People & Culture (SEL People Programme)

Introduction

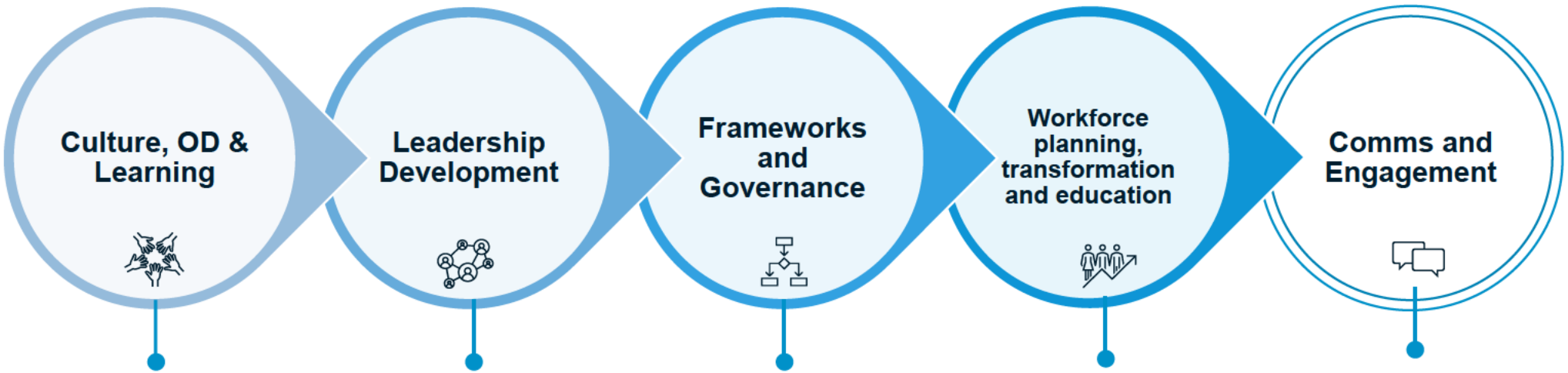
- Neighbourhood working is a fundamental component of the 10-year health plan and reflects a significant transformation of how our system will operate together. It brings Primary and Community Care closer together and is a more place-based approach to how services are organised.
- SEL boroughs are working through their models for delivering neighbourhood care and forming Integrated Neighbourhood Teams (INTs). These are designed to meet the holistic needs of their local population, teams based in the neighbourhood are drawn from a range of partners across the community
- We have made great progress against workstreams in our workforce plan for neighbourhoods – further details are shared as part of this pack.

Contents:

- Recap of Neighbourhoods workforce plan and associated workstreams
- Progress updates
  - OD & Leadership Development
  - Communications & staff engagement
  - Frameworks, governance & risk – deep dive
- Ask of Neighbourhood Care Board and next steps

RECAP: Neighbourhoods workforce plan

Workforce is seen as a key enabler to the effective delivery of neighbourhood working and INTs. The SEL People Programme undertook significant engagement with CPOs, senior leaders, Place teams to develop an **overarching workforce plan to enable neighbourhood working in SEL**. This was approved by SEL People Committee and Neighbourhood Based Care Board in Spring 2025 and activity is being delivered across the following four workstreams:



Culture, OD & Learning

Supporting individuals to feel like '**one team**' and working together in a meaningful way that allows for 'testing and learning'

Leadership Development

Developing our leaders to **'think system',** supporting them to champion and embed neighbourhood working into their areas

Frameworks and Governance

Supporting with staff movement/**working across organisational boundaries**, and stakeholder mapping to support the necessary Governance

Workforce planning, transformation and education

Supporting a spectrum of **workforce planning and transformation activity** aimed at supporting population health priorities.

Comms and Engagement

Interdependency Led by ICB Comms team, acknowledging – comms and engagement is an important first step to supporting the workforce plan

One year on…

Whilst significant progress has been made across these workstreams, our plan is a live document. We will be reviewing our workforce plan against the upcoming national workforce plan and as SEL progresses on its neighbourhoods' journey.

South East London Integrated Care System

Progress updates: OD & Leadership Development

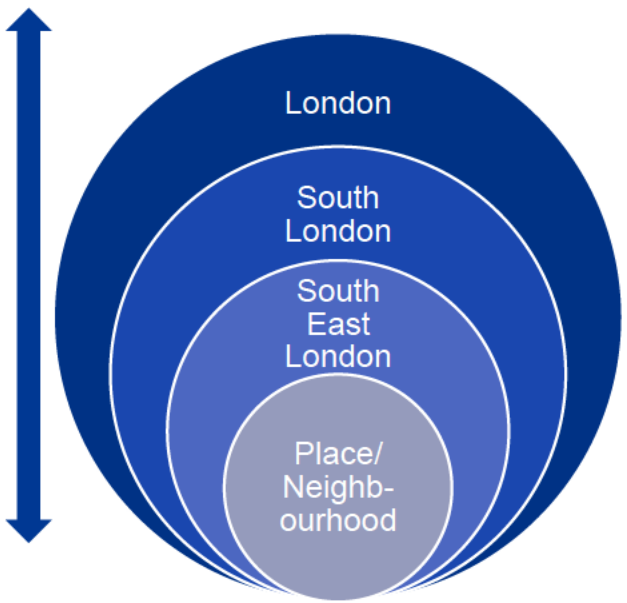


- **Established OD community of practice for neighbourhoods** – this group meets on a monthly basis, convening the OD leads supporting neighbourhoods. The purpose of this group is to:
  - Support sharing on INT/NH OD/Leadership work across Place/Boroughs
  - Identify areas of common work that may benefit a system level approach
  - Agreed focus on INT middle managers
- **Local OD interventions** – each Place is currently involved in delivering and commissioning OD work to support local needs. We're also testing local programmes to spread and scale (i.e. INT induction and values-based recruitment toolkit)
- **Behaviours mapping** - A mapping exercise across NHS Management & Leadership Framework, Leadership Qualities Framework and SEL Systems Leadership Framework helped to identify 6 common domains and 4 personal qualities, crucial for success as an INT middle manager – ***see appendix 1 for full detail***
- **Pan London activity** – SEL play an active role in influencing and shaping London programme of work for Neighbourhoods and workforce such as the behaviours & competency framework for neighbourhood working .

- **Development offer for INT middle managers** – programmes designed for the layer of managers who are closes to the delivery and directly managing INT teams. With aims to
  - Build the knowledge base of system working and neighbourhoods with INT middle manager tier
  - Build opportunities for interaction, shared learning and practice
  - Increase system thinking, leadership and capability for those directly managing INTs
  - Reduce silo'd working

See appendix 2 for full detail

An offer supporting place, delivered at all levels…



Progress updates: Communications & staff engagement

Comms and Engagement

Staff Activation Webinars – *in progress*

- Educating and enabling staff to understand how it affects their role – through interactive webinars, to launch Spring this year.
- Comms and promotion for first session via SEL People Programme network and channels
- **1101 registrations across all sessions to date, 514 attendees across first two sessions**
- Upcoming session sessions:
  - Digital tools – 8th July
  - AI – 16th July
  - Prevention – 10th September
- Planning for future sessions, topics raised to date:
  - Leadership in INTs
  - Spotlights on each priority care pathway (i.e. 3+ LTC, Ageing well, CYP)
  - Strategic commissioning





Progress updates: Frameworks, governance & risk

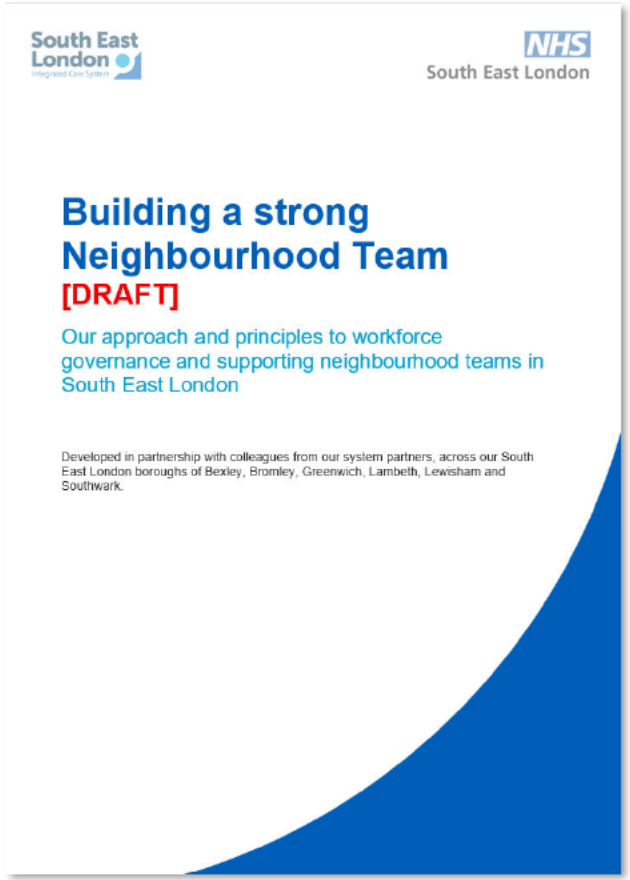
Frameworks and Governance

Clinical Governance & Risk document

- **Phase 1** ***complete*** - Workshops held September 2025 – 76% attendance rate across both sessions, with representation from primary care, SEL ICB and secondary care. Key themes identified
- **Phase 2** ***complete*** – held working groups to support development of SEL document, covering topics such as use of honorary contracts, escalation of risk and performance issues
- **Phase 3** ***complete*** – initial draft of SEL document developed, tested with working group members and presented to NBCB, to which it was well received
- **Phase 4** ***in progress*** – Further testing via a series of roundtable discussions at Place, to really stress test some of the flowcharts, diagrams and explore how the document could be used in practice.

Document consists of:

- Guiding principles - ***see appendix 3 for full detail***
- Flowcharts to support decision making - ***see appendix 4 for full detail***
- Supporting guidance, tools, tips and scenarios for practical application


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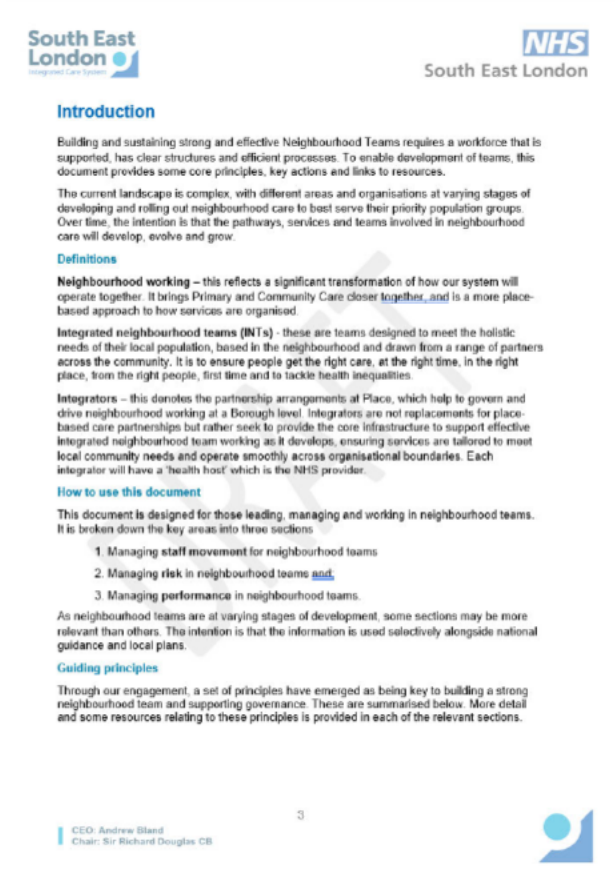
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Building a strong Neighbourhood Team

[DRAFT]

Our approach and principles to workforce governance and supporting neighbourhood teams in South East London

Developed in partnership with colleagues from our system partners, across our South East London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.


South East London

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Introduction

Building and sustaining strong and effective Neighbourhood Teams requires a workforce that is supported, has clear structures and efficient processes. To enable development of teams, this document provides some core principles, key actions and links to resources.

The current landscape is complex, with different areas and organisations at varying stages of developing and rolling out neighbourhood care to best serve their priority population groups. Over time, the intention is that the pathways, services and teams involved in neighbourhood care will develop, evolve and grow.

Definitions

Neighbourhood working – this reflects a significant transformation of how our system will operate together. It brings Primary and Community Care closer together, and is a more place-based approach to how services are organised.

Integrated neighbourhood teams (INTs) - these are teams designed to meet the holistic needs of their local population, based in the neighbourhood and drawn from a range of partners across the community. It is to ensure people get the right care, at the right time, in the right place, from the right people, first time and to tackle health inequalities.

Integrators – this denotes the partnership arrangements at Place, which help to govern and drive neighbourhood working at a Borough level. Integrators are not replacements for place-based care partnerships but rather seek to provide the core infrastructure to support effective integrated neighbourhood team working as it develops, ensuring services are tailored to meet local community needs and operate smoothly across organisational boundaries. Each integrator will have a 'health host' which is the NHS provider.

How to use this document

This document is designed for those leading, managing and working in neighbourhood teams. It is broken down the key areas into three sections

1. Managing **staff movement** for neighbourhood teams
2. Managing **risk** in neighbourhood teams and,
3. Managing **performance** in neighbourhood teams.

As neighbourhood teams are at varying stages of development, some sections may be more relevant than others. The intention is that the information is used selectively alongside national guidance and local plans.

Guiding principles

Through our engagement, a set of principles have emerged as being key to building a strong neighbourhood team and supporting governance. These are summarised below. More detail and some resources relating to these principles is provided in each of the relevant sections.

3

CEO: Andrew Bland
Chair: Sir Richard Douglas CB

Progress updates: Frameworks, governance & risk (cont.)

Summary from Place roundtable discussions - overview

- Since initial draft of guidance document was developed and tested, we ran further testing through roundtable discussions at Place. This was to allow for active discussion and engagement on key aspects of the document such as flowcharts, decision trees and in the context of live scenarios.
- Participants welcomed the guidance as a practical starting point for supporting workforce governance within INTs and felt it addressed a gap in the current neighbourhood development landscape. Participants consistently reported that:
  - The document is a useful and timely resource for INTs
  - The flowcharts and practical examples help simplify complex governance issues
  - The guidance provides a helpful framework for local implementation whilst allowing flexibility for place-based approaches
  - The document could support a more consistent approach across SEL and reduce duplication of local efforts
- Flowcharts, scenarios and the principles-based approach were particularly well received. Participants also recognised the guidance as an iterative document that should continue to evolve as neighbourhood models mature and implementation experience grows.

South East London Integrated Care System

Progress updates: Frameworks, governance & risk (cont.)

Frameworks and Governance

Summary from Place roundtable discussions - How does the document help to address some of the key challenges raised?

Clarifying accountability across organisational boundaries

Participants identified uncertainty regarding accountability, supervision, risk ownership and clinical responsibility when staff work across multiple organisations. The document supports this through:

- ✓ Clear principles on governance and accountability.
- ✓ Staff movement decision-making flowcharts.
- ✓ Guidance on host and employing organisation responsibilities.
- ✓ Use of RACI approaches to clarify roles and decision-making responsibilities.

Supporting consistent approaches to risk management

Stakeholders described varying local approaches to risk management and escalation. The guidance helps establish greater consistency by:

- ✓ Providing a shared risk management model.
- ✓ Promoting collective discussion of risk within multidisciplinary teams.
- ✓ Encouraging clear escalation pathways and ownership of risks.
- ✓ Reinforcing professional accountability whilst supporting integrated decision-making.

Strengthening workforce management

The complexity of managing staff from different organisations was a recurring theme. The guidance begins to address this through:

- ✓ Clarification of responsibilities between host and substantive employers.
- ✓ Suggested escalation processes for performance concerns.
- ✓ Emphasis on day-to-day supervision within neighbourhood teams whilst retaining formal employment responsibilities with substantive employers.
- ✓ Practical examples illustrating how issues may be managed collaboratively.

Supporting development of neighbourhood culture and identity

A consistent message across places was that successful neighbourhood teams require more than formal governance arrangements. Participants welcomed the document's focus on:

- ✓ Shared purpose.
- ✓ Team culture.
- ✓ Joint ways of working.
- ✓ Effective induction.
- ✓ Psychological safety and relationship-building across organisational boundaries.

South East London Integrated Care System

Progress updates: Frameworks, governance & risk (cont.)

Frameworks and Governance

Summary from Place roundtable discussions – considerations for future 6-month review

1. Staff movement supporting templates

- Participants requested practical resources such as induction templates, staff movement templates and local implementation guides to sit alongside the document.

2. Clarify different categories of risk

- Stakeholders suggested additional guidance explicitly acknowledging…
  - Individual clinical risk
  - Team or operational risk
  - System-level or strategic risk

…And demonstrating how the escalation model applies differently to each.

3. Provide more guidance on informal performance management

- Several groups requested more practical guidance on…
  - Stage 1 conversations
  - Informal performance support
  - Early intervention approaches

…as this was seen as particularly important before issues reach formal organisational processes.

4. Address practical workforce management questions

- Suggested future content included:
  - Who staff report absence to;
  - How leave is authorised;
  - Flexible working arrangements;
  - Day-to-day supervision responsibilities;
  - Escalation routes for concerns.

Ask of Neighbourhood Care Board and next steps

Ask of the Neighbourhood Care Board

- We invite Neighbourhood Based Care Board to discuss and **approve** the Clinical Risk & Guidance document for wider circulation, with the view that this is a live document in which we will review in 6-months' time.

Future work/on the radar

- Continued work on staff activation - planning and promoting all staff webinars
- OD & Leadership - SEL leadership development offer for INT middle managers, peer networking programme and local OD offer of support
- Developing values-based recruitment bank of assessment/interview questions
- Development of INT induction
- SEL People Programme continue to play an active role in London Neighbourhood Delivery People Task & Finish Group including development of London Staff Movement protocol for neighbourhoods
- Review of workforce plan against the upcoming national workforce plan, local need and as SEL progresses in neighbourhood working

South East London Integrated Care System

Appendix

South East London Integrated Care System

Appendix 1: Behaviours mapping exercise

- **There are common challenges for INT middle managers** such as leading across organisational boundaries, influencing without authority, leading effective teams in new ways of working, translating strategy into delivery, and enabling cultural shift needed for neighbourhood working. Also some INT managers don't see themselves as system leaders.
- **There are also some pain points** such as variation in behaviours and standards across organisations, differing expectations across Trusts, Local Authorities, Primary Care, VCSE, etc. leading to inconsistency in capability.
- **National policy** such as the NHS management and leadership framework sets clear expectations for all managers and the need for us to review align development programmes accordingly
- **A development offer for INT middle managers will help** with clarity, consistency, support for development, alignment across our system
- **A mapping exercise** across NHS Management & Leadership Framework, Leadership Qualities Framework and SEL Systems Leadership Framework helped to identify **6 common domains** and **4 personal qualities**, crucial for success as an INT middle manager (see opposite)

Outcome from behaviours mapping exercise*

Common domains

- Leading across traditional organisational boundaries
- Enabling team culture
- Partnership and community working
- Innovation, testing and learning
- Change management
- Strong operational leadership

Personal Qualities

- Resilience
- System thinking
- Curiosity and learning mindset
- Psychological safety

Wellbeing and **Inclusion** are a golden thread in all that we do

*We will review and update this depending on further testing and publication of NHS management & leadership framework

Appendix 2: proposed development offer for INT middle managers

Core objectives

- Build the knowledge base of system working and neighbourhoods with INT middle manager tier
- Build opportunities for interaction, shared learning and practice
- Increase understanding in system thinking, leadership and direct application to ways of working for those managing INTs
- Reduce silo'd working

Design principles

- Programmes should be **engaging** and routed in **practical application**
- **Context led design** around actually challenges/scenarios faced in neighbourhood working
- A **focus on identity, not just skills** as INT managers should see themselves as system leaders too
- A space for **peer learning** and **networking**
- A strong focus on **system thinking** and creating an environment to **test and learn**
- **Local delivery** is critical to embedding learning

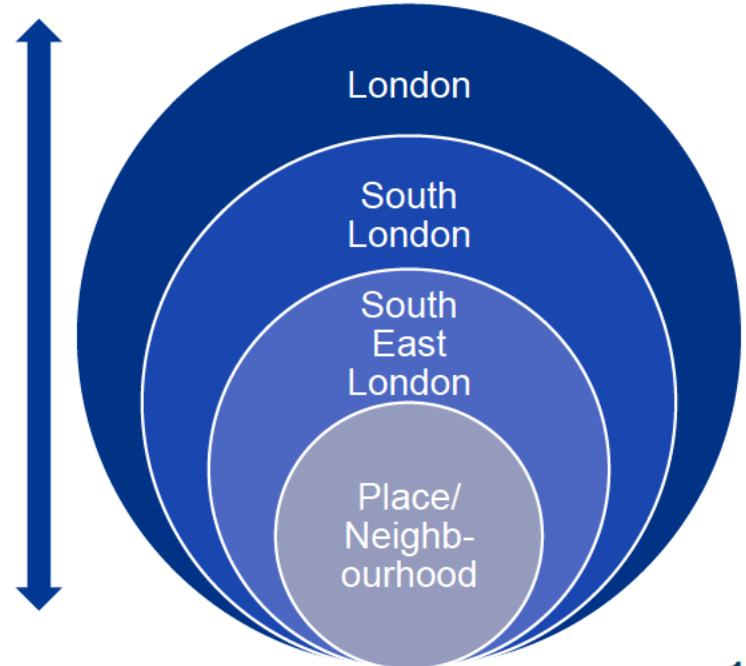
Target audience

- Our programmes will be designed for the layer of managers who are closes to the delivery and directly managing INT teams.

USP

- Most development is focused on very senior leaders or is hyper localised. This approach offers opportunity to bring together those in similar roles from across SEL who may not have the opportunity to interact otherwise.

An offer supporting place, delivered at all levels…



Appendix 2: proposed development offer for INT middle managers (cont.)

0. Develop and testing of development offer (*Jun – Jul 26)*

An iterative development and testing approach to shape a cohesive leadership offer for INT middle managers – including engagement at Place.

1. Development of resources on ways of working (*Sept 26*)

Supporting local delivery of ways of working sessions with local teams. Materials include:

- Workbooks
- Session plans and slides
- Videos and supporting materials

2. Masterclasses (*Sept – Nov 26*)

A targeted masterclass series designed to equip INT middle managers with the practical skills, confidence, and strategic insight to lead effectively through complexity, strengthen decision-making, and translate organisational priorities into meaningful outcomes.

3. Embedding into local development offers (*Sept – Dec 26)*

A package that supports organisations to embed neighbourhood working/system thinking into local offers including:

- e-learning which can be added to LMS'
- Messages for induction and training
- Supporting materials such as videos, infographics, for organisations to use to build shared understanding and drive consistent practice.

4. Mentoring programme for INT middle managers (*TBC 2027*)

A structured mentoring programme designed to support INT middle managers through personalised guidance, reflection, building confidence, and enabling them to navigate complexity and deliver priorities effectively.

Appendix 3: Clinical Governance & Risk Draft document guiding principles

Page 4 – Guiding principles

- Through our engagement, a set of principles have emerged as being key to supporting governance. This isn't an exhaustive list but is sharing a consensus opinion in the SEL system.

Managing staff movement for neighbourhood teams

1. All team members should **understand the shared team's purpose** and ways of working
2. **Governance arrangements are well-defined** with clear accountability and clarity of roles
3. Creation of neighbourhood teams **should not create undue duplication** of governance or processes

Managing risk in neighbourhood teams

4. A shared culture and positive collective behaviours are developed and nurtured - **shifting focus from blame to solution**
5. Responsibility is decentralised and **a collective view on risk is shared**
6. **Staff and resident voice informs decision-making** and shapes strategy in a test and learn environment.

Managing performance in neighbourhood teams

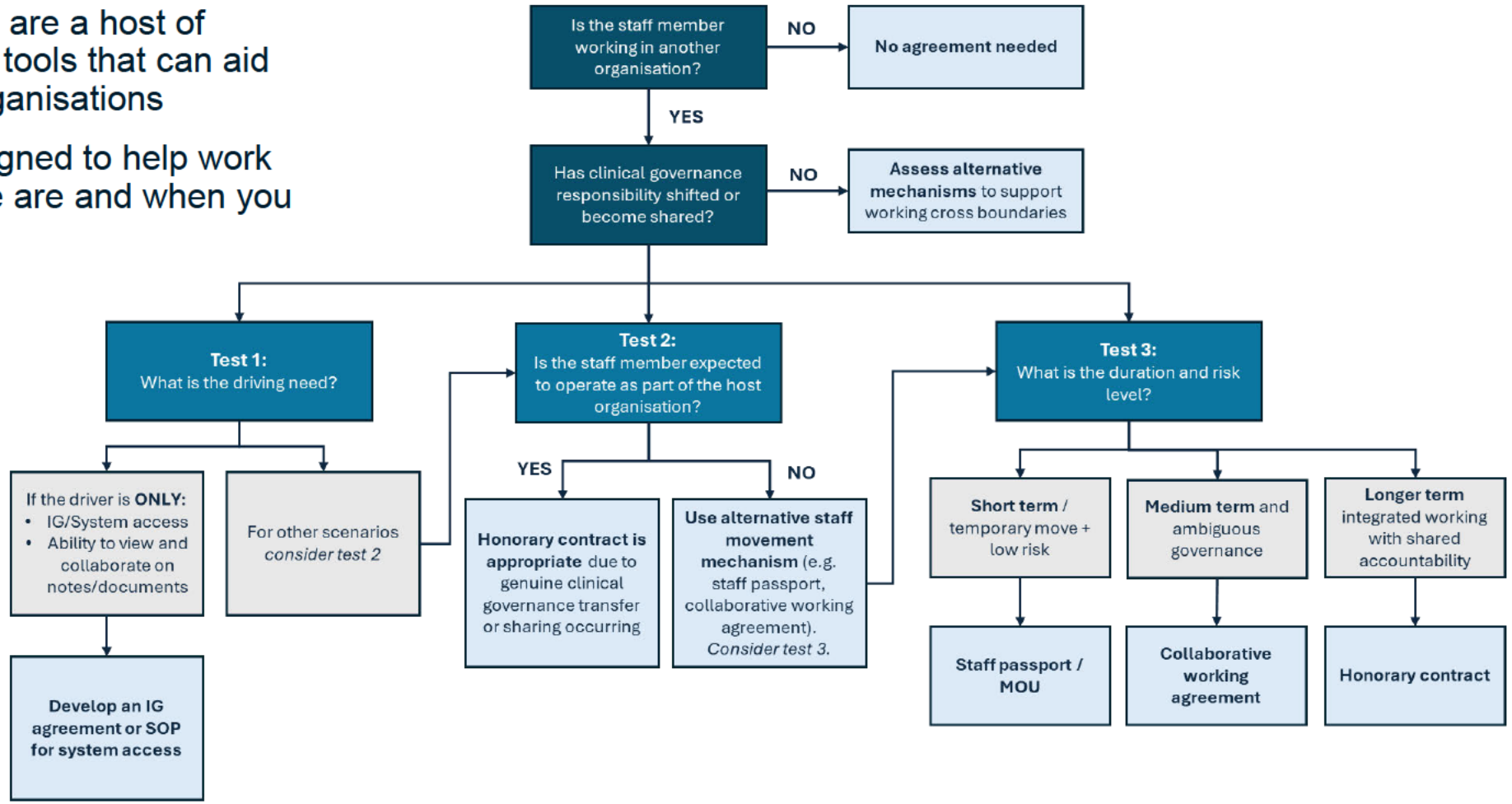
7. **Substantive employers retain responsibility** for all formal HR processes
8. **Neighbourhood teams provide day to day support** and supervision
9. Teams provide **psychologically safe environments** and foster mutual trust

South East London Integrated Care System

Appendix 4: Clinical Governance & Risk Draft document guiding principles supporting flowcharts

Page 6 – Staff movement flowchart

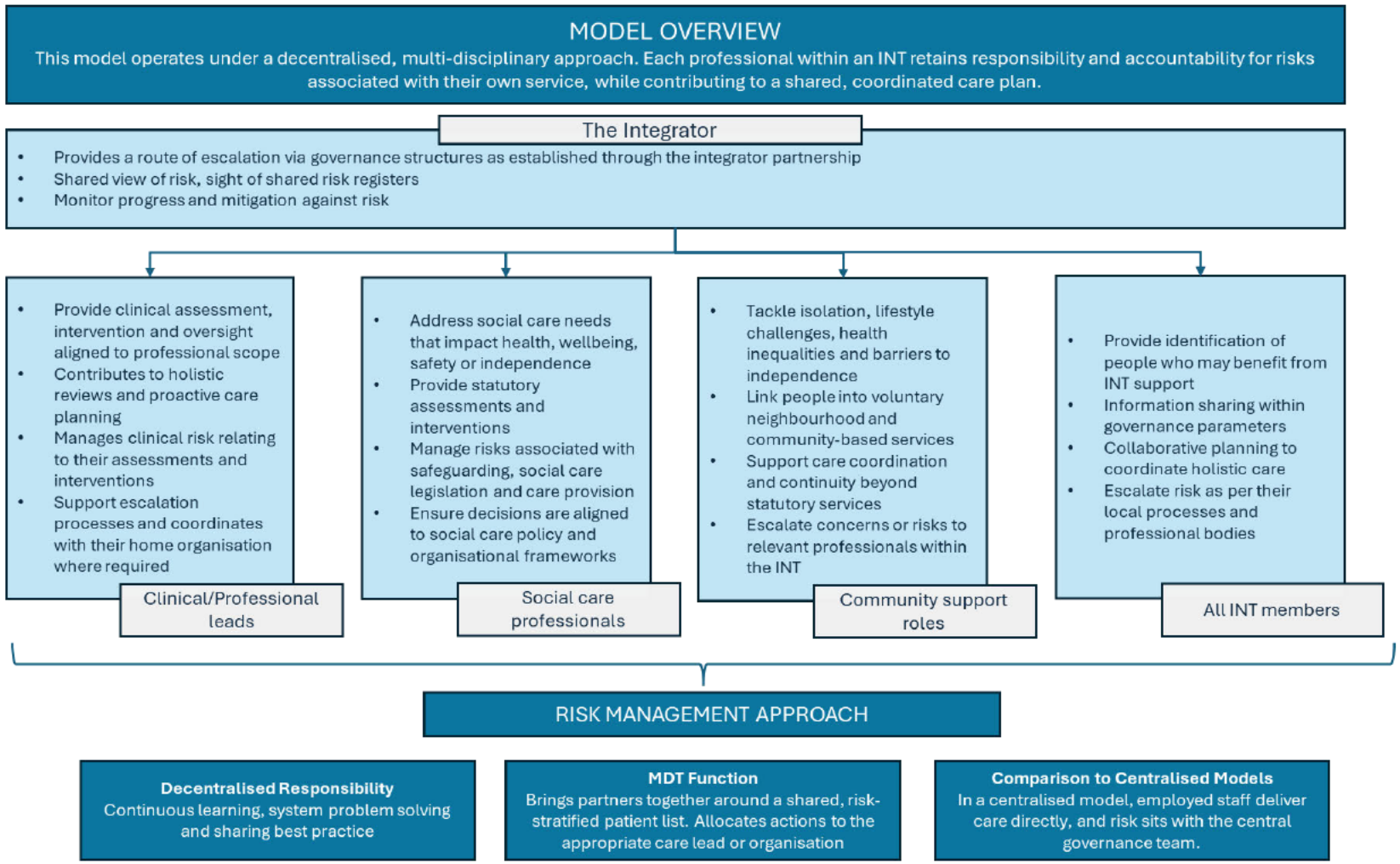
- Engagement showed there are a host of arrangements and existing tools that can aid the movement between organisations
- The decision tree was designed to help work through what each of these are and when you may want to use them



Appendix 4: Clinical Governance & Risk Draft document guiding principles supporting flowcharts (cont.)

Page 9 – Managing Risk flowchart

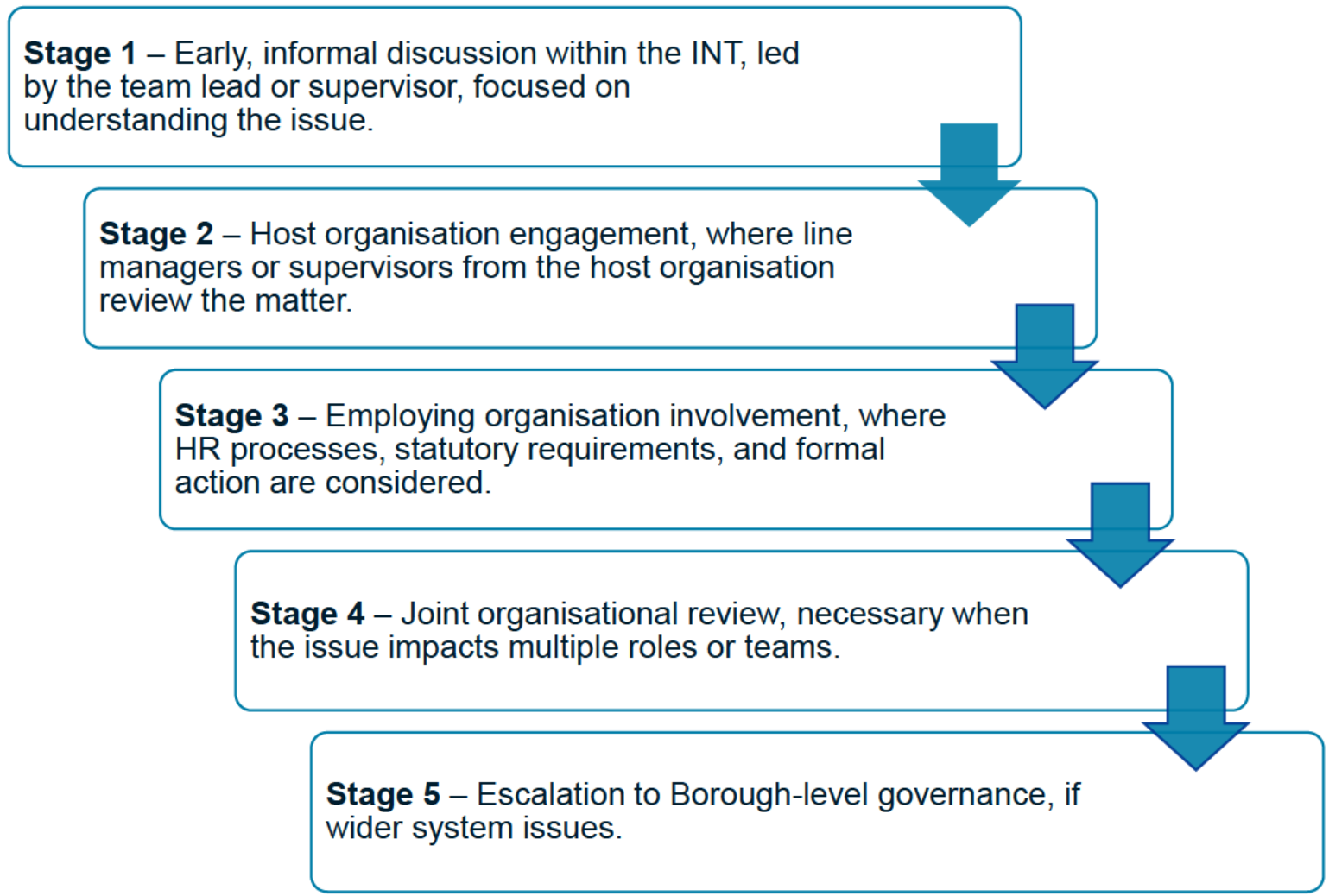
- Developed based on the Bexley Ageing Well/Frailty Model
- It clarifies how risks are identified, discussed, and escalated within the team, while ensuring that each professional retains responsibility and accountability in line with their organisational frameworks



Appendix 4: Clinical Governance & Risk Draft document guiding principles supporting flowcharts (cont.)

Page 15 – Managing Performance flowchart

- Sets out the principles and actions that support early, constructive conversations; maintain organisational responsibilities; and enable safe, confident escalation where needed.



South East London Integrated Care System

NHS South East London

Building a strong Neighbourhood Team

[DRAFT]

Our approach and principles to workforce governance and supporting neighbourhood teams in South East London

Developed in partnership with colleagues from our system partners, across our South East London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

Contents

Introduction **3**
Definitions 3
How to use this document 3
Guiding principles 4
Managing staff movement for neighbourhood teams **5**
Core principles 5
Working across organisational boundaries 5
Bringing to life – example scenarios 6
Further information and resources 7
Managing risk for neighbourhood teams **8**
Core principles 8
Developing team culture and a shared sense of purpose 8
Managing risk 9
Supporting individual risk management in neighbourhood working 10
Establishing roles and responsibilities 10
'Nothing about you, without you' – involving residents in decision making 11
Bringing to life – example scenarios 11
Further information and resources 13
Managing performance in neighbourhood teams **13**
Core principles 13
Escalation pathway 13
Supporting and developing staff through supervision 14
Bringing to life – example scenarios 14
Further information and resources 15
Further resources **16**
Existing staff movement agreements 16
Guidance, reports and useful links 17
Glossary of terms 18

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Introduction

Building and sustaining strong and effective Neighbourhood Teams requires a workforce that is supported, has clear structures and efficient processes. To enable development of teams, this document provides some core principles, key actions and links to resources.

The current landscape is complex, with different areas and organisations at varying stages of developing and rolling out neighbourhood care to best serve their priority population groups. Over time, the intention is that the pathways, services and teams involved in neighbourhood care will develop, evolve and grow.

Definitions

Neighbourhood working – this reflects a significant transformation of how our system will operate together. It brings Primary and Community Care closer together, and is a more place-based approach to how services are organised.

Integrated neighbourhood teams (INTs) - these are teams designed to meet the holistic needs of their local population, based in the neighbourhood and drawn from a range of partners across the community. It is to ensure people get the right care, at the right time, in the right place, from the right people, first time and to tackle health inequalities.

Integrators – this denotes the partnership arrangements at Place, which help to govern and drive neighbourhood working at a Borough level. Integrators are not replacements for place-based care partnerships but rather seek to provide the core infrastructure to support effective integrated neighbourhood team working as it develops, ensuring services are tailored to meet local community needs and operate smoothly across organisational boundaries. Each integrator will have a 'health host' which is the NHS provider.

How to use this document

This document is designed for those leading, managing and working in neighbourhood teams. It is broken down the key areas into three sections

1. Managing **staff movement** for neighbourhood teams
2. Managing **risk** in neighbourhood teams and;
3. Managing **performance** in neighbourhood teams.

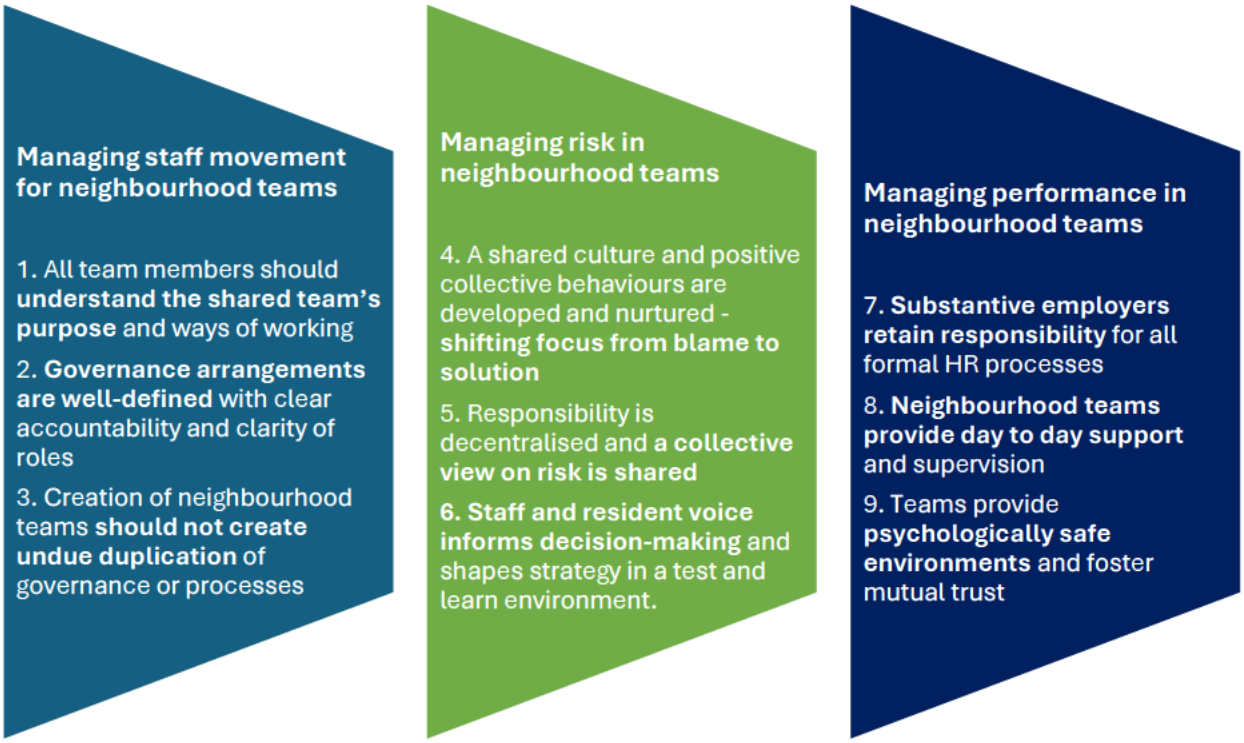
As neighbourhood teams are at varying stages of development, some sections may be more relevant than others. The intention is that the information supports local considerations and is used alongside national guidance and plans.

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Guiding principles

Through our engagement, a set of principles have emerged as being key to building a strong neighbourhood team and supporting governance. This isn't an exhaustive list but is sharing a consensus opinion in the SEL system. It is not professional, legal or mandatory guidance. More detail and some resources relating to these principles is provided in each of the relevant sections.

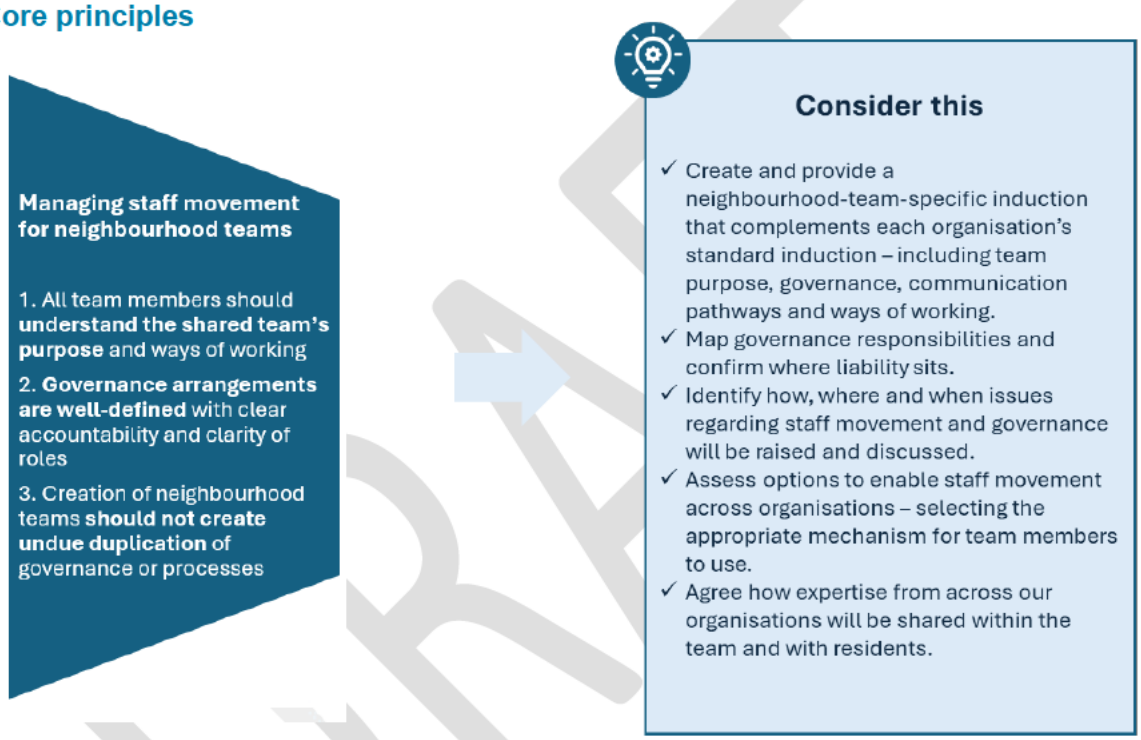


1. Managing staff movement for neighbourhood teams

As neighbourhood teams are being set up, developing and expanding, it a likely there will be an increase in staff working across traditional organisational boundaries. To ensure this is done well, organisations contributing to INTs should ensure that mechanisms to manage governance and risk are appropriate. The principles below set out the key considerations when setting up a neighbourhood team.

The below assumes that the agreements and contracts relating to neighbourhood and integrated working are established and focuses specifically on workforce considerations including clinical governance and risk management, not commissioning decisions.

Core principles



Working across organisational boundaries

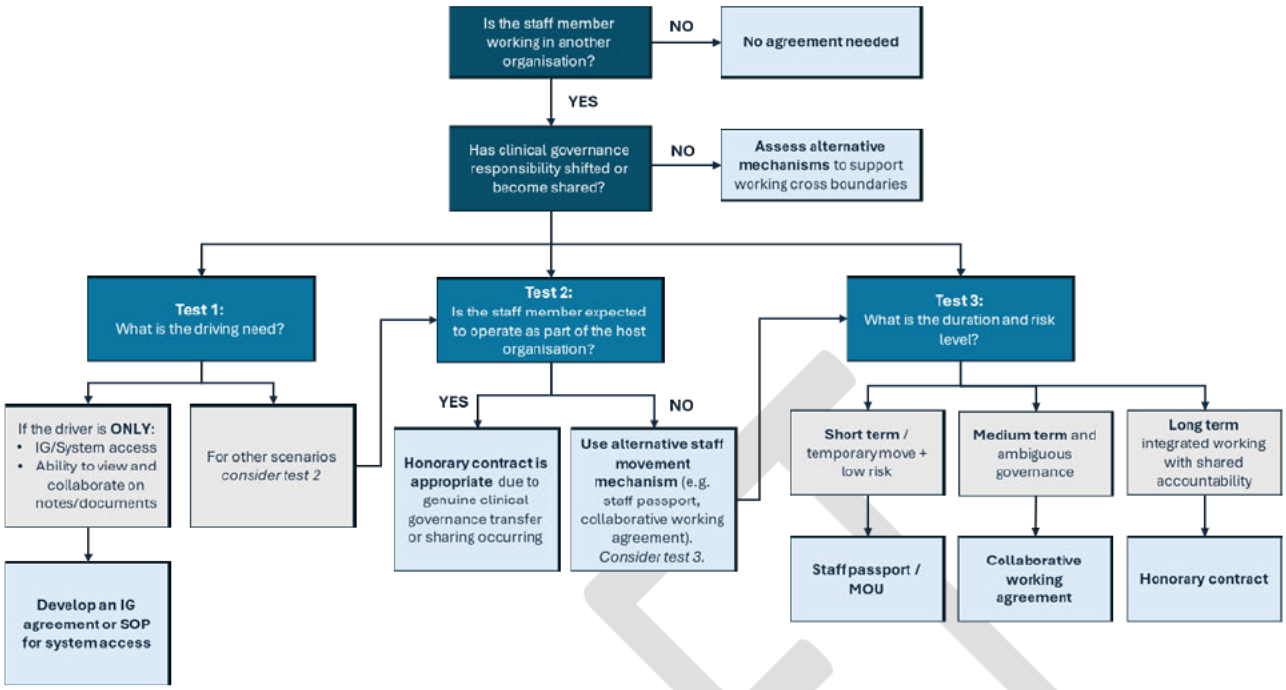
To build successful INTs, staff may need to work in different organisations, settings and premises. Also staff may require access to a range of IT systems.

Across SEL, a range of mechanisms are currently used to support and enable staff to work across organisational boundaries. Examples of these are honorary contracts, secondment agreements, SLAs, dual employment, and local workarounds. There is often significant administrative burden associated with setting up these agreements.

Honorary contracts shouldn't be assumed as the default. This is especially important for PCN/federation staffing models that already have clear accountability. They should only be used where governance responsibility is shared or transferred. There are numerous examples of staff working across organisations without the need for honorary contracts.

There are a host of arrangements and existing tools that can aid the movement between organisations. The decision tree below, helps you to work through what each of these are and when you may want to use them.

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Explaining terms used:

- **Host organisation** – this denotes the organisation in which the employee is working within or providing services. This may differ from the **employing organisation** (that is the organisation in which the employee's contract of employment is held).
- **IG** – abbreviated term for information governance.
- **Staff passport/MOU** – this denotes the different agreements in place between organisations, which can help with staff working into different organisations, without need for a separate agreement. MOU is the abbreviation for memorandum of understanding.
- **Collaborative working agreement** – this denotes an agreement which is drawn up between involved organisations and parties, setting out expectations of each party for the duration of the working relationship.
- **Honorary contract** – this is a formal, unpaid agreement between an organisation and an individual, allowing them to work, research, or train without being directly employed by said organisation. It usually ensures legal liability coverage, defines responsibilities, and ensures compliance with policies.

Bringing this to life – example scenarios

Scenario 1 – Mariam's story: Integrated working within existing governance

Mariam, a PCN-employed First Contact Physio, works across three GP practices as part of the Integrated Neighbourhood Team. She runs MSK clinics, joins MDT discussions, and uses practice systems.

Although she moves between multiple organisations, her employment, supervision and clinical governance all sit with the PCN. The GP practices simply host her clinics and provide access to systems, via IG agreements and other existing processes.

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A quick governance review confirmed that this arrangement is fully covered by the PCN DES, with no transfer of clinical accountability to the practices. Therefore, no honorary contract is required.

Clear communication and consistent induction across practices were put in place, enabling Mariam to work fluidly and safely without additional bureaucracy.

Scenario 2 – Sasha's story: Neighbourhood mobility with a collaborative working agreement

> *Sasha, a Mental Health Practitioner employed by the Mental Health Trust, and supporting several practices through ARRS funding. Initially, she worked entirely under trust governance.*
>
> *As the INT matured, Sasha was asked to deliver joint consultations, contribute to neighbourhood safety planning (e.g. risk mitigation for individual cases), and support neighbourhood-level audits. These activities meant she was increasingly acting within neighbourhood clinical workflows, not just alongside them.*
>
> *A governance review identified that while most of her work still belonged under the trust's governance, the new integrated activities involved shared decision-making and host-led processes.*
>
> *To reflect this, the neighbourhood introduced a collaborative working agreement, setting out clear expectations from all parties, covering the elements where Sasha operates under neighbourhood governance.*
>
> *This enabled greater integration and clarity while avoiding unnecessary or blanket contractual requirements.*

Further information and resources

The following pages provide selected information and resources to help with the suggested actions. A list of the information provided with links is below.

- Existing staff movement agreements - here
- National guidance on contractual mechanisms – here
- NHSE 'enabling staff movement' toolkit - here

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2. Managing risk in neighbourhood teams

As neighbourhood teams develop, effective people management becomes central to building the culture, relationships and shared ways of working that enable teams to function well and for individuals to flourish. However, managing risk in this environment can become increasingly complex.

The following principles outline the core principles for managing risk whilst working in INTs and points to consider.

Core principles

Managing risk in neighbourhood teams

4. A shared culture and positive collective behaviours are developed and nurtured - **shifting focus from blame to solution**

5. Responsibility is decentralised and **a collective view on risk is shared**

6. Staff and resident voice informs decision-making and shapes strategy in a test and learn environment.

Consider this

- ✓ Document team roles and responsibilities (specific to INT).
- ✓ How leads can role model, demonstrating that escalation is supportive, not punitive.
- ✓ Discuss and agree routes for escalation and what policy/guidance needs to be considered.
- ✓ Agree mechanisms and introduce processes for feedback to be gathered from staff, residents and learning to be shared across teams and organisations.
- ✓ Create a shared team risk register.
- ✓ Use reflective practice and coaching based supervision.

Developing team culture and shared sense of purpose

Developing a collaborative culture and a shared sense of purpose for your team is a crucial step in helping to minimise potential risk. It ensures team members are clear on the expectations on them. When doing this, it's important to think about:

Incorporating Culture & Purpose into Job Descriptions (JDs)	• Explicitly reference values and ways of working (e.g., collaboration, person-centered care, population health focus, neighbourhood problem-solving) • Include shared responsibilities across professions such as multidisciplinary decision-making, information sharing, and joint accountability for outcomes • Describe expected behaviours (not just tasks) such as proactive communication, mutual respect,

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	learning mindset, and commitment to integrated working.
Delivering a Good Induction	• Provide a clear narrative of the INT's purpose and model, including local priorities, partner organisations, and how each role contributes. • Introduce team culture intentionally, e.g. shared norms, communication expectations, meeting structure, how decisions are made, and escalation routes. • Offer early relationship-building via shadowing, cross-professional introductions, buddy systems, and time with key operational leads.
Running Effective Team Meetings	• Use a consistent structure (purpose-led agenda, rota of leads, shared actions log) to reinforce culture and predictability. • Balance operational updates with reflective practice, case discussions, and space for learning or raising system issues. • Celebrate successes and shared wins to strengthen identity, motivation, and collective ownership of outcomes.

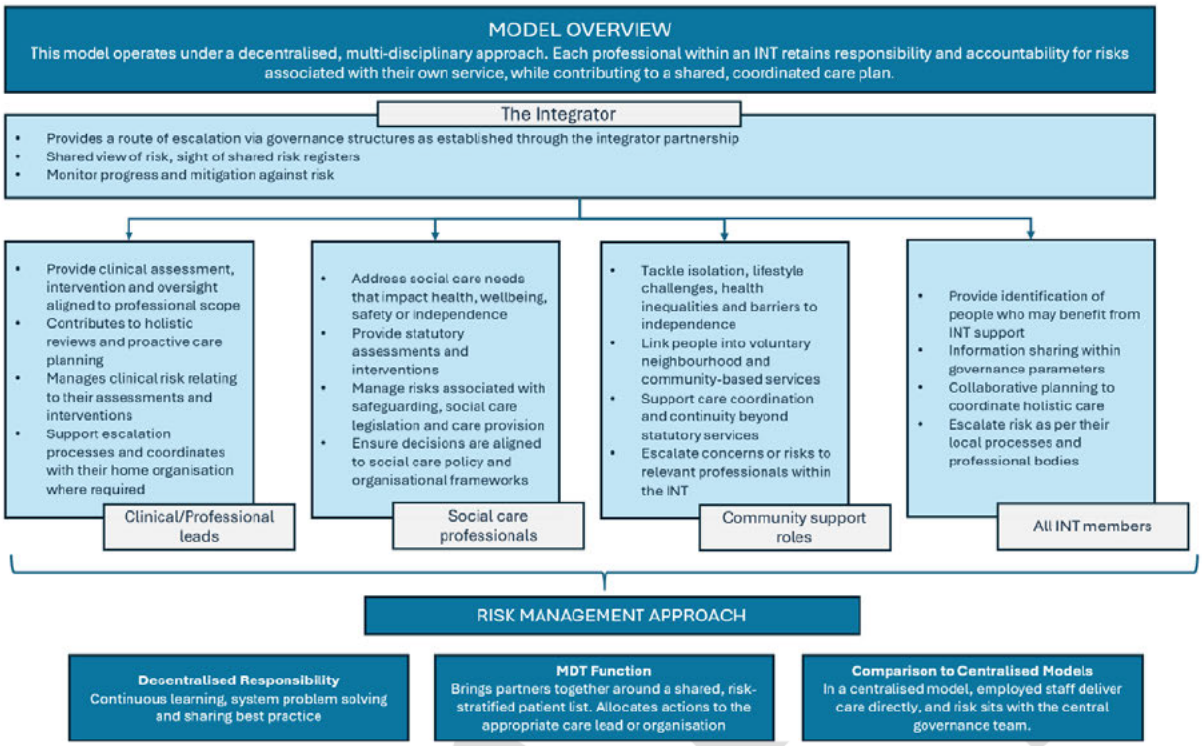
Managing risk

A key challenge for any INT is managing risk. By bringing together professionals from across health, social care, and the voluntary and community sector, the model below enables shared understanding, early identification of concerns, and timely joint interventions.

A core aim of this model is to support consistent and transparent governance and risk management at INT level. It clarifies how risks are identified, discussed, and escalated within the team, while ensuring that each professional retains responsibility and accountability in line with their organisational frameworks.

This model has been adapted from the Bexley Ageing Well / Frailty Model.

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Supporting individual risk management in neighbourhood working

In neighbourhood models of care, where responsibilities are shared across organisational boundaries, there is an increasing need for individual practitioners to actively manage risk within their own scope of practice, rather than relying solely on organisational systems. One practical approach is for prescribers and clinicians to maintain a personal or team-based risk register linked to their clinical activity. This is not intended to replace organisational governance processes, but to complement them by ensuring risks are identified and acted on in real time.

This may include:

- Identifying key hazards within scope of practice (e.g. high-risk medicines, monitoring requirements, transfer of care points)
- Considering likelihood and consequence to prioritise risks
- Recording current mitigations (e.g. shared records, MDT oversight)
- Defining achievable additional actions to reduce risk
- Reviewing and updating their own risks as care pathways evolve

Embedding this approach supports a shift towards proactive, practitioner-led risk management, enabling individuals to recognise and mitigate risks early, particularly in complex, multi-professional environments.

Establishing roles and responsibilities

In any complex working structure, it is important to be clear on roles and responsibilities for different tasks. **The RACI model** is a straightforward tool used for identifying roles and responsibilities and the time taken to undertake each activity.

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Responsible	Accountable
The person who does the work to achieve the task. They have responsibility for getting the work done or decision made. As a rule this is one person.	The person who is accountable for the completion of the task. This must be one person and is often the project executive or project sponsor.
Consulted	**Informed**
The people who provide information for the project and with whom there is two way communication. This is usually several people.	The people kept informed of progress and with whom there is one way communication. These are people that are affected by the outcome of the tasks, so need to be kept up-to-date.

This can support the day to day running of your INT in the following:

- Clarifying roles across multi-agency partners, ensuring everyone knows who is responsible, accountable, consulted and informed on a decision
- Improve team coordination – for example, outlining who is responsible for case identification, MDT preparation, chairing, recording actions and following up
- Support planning, reducing duplication and delays when working across organisational boundaries
- Enhance communication, provides shared language and consistency regarding processes

'Nothing about you, without you' – involving residents in decision making

The 'Nothing about you, without you' approach means that data sharing is de-risked by ensuring residents are directly involved in every conversation about them. Coordinators would seek explicit permission before sharing information with any additional partners who may support the resident (such as a health visitors, social workers, clinicians, or any other relevant community asset). In order to work, it's important that:

- Frontline staff have access to timely support, such as the ability to contact a duty doctor or a named on-call contact
- Flexible systems and a culture of trust that enable staff to escalate concerns appropriately.
- Consistent, open, and reliable communication channels to ensure information flows effectively and support is readily available.

Bringing this to life – example scenarios

Scenario 3 – Mrs Patel's story: managing risk in ageing well

Mrs Patel, an 82-year-old living alone, is identified through the Ageing Well / Frailty Hub process as someone showing signs of increasing frailty. Recent missed appointments, a minor fall, and concerns from neighbours trigger a proactive review by the Integrated Neighbourhood Team (INT).

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Primary Care notes medication non-adherence and a potential deterioration in cognition. Community Nursing highlights a slow-healing wound and reduced mobility. Social Care identifies possible self-neglect and a need to review care support. Ageing Well / Community Support notices that Mrs Patel has withdrawn from social groups, raising wellbeing concerns.

At the weekly team meeting, the team shares information and builds a shared understanding of Mrs Patel's risks while each professional maintains accountability within their own governance framework. They agree a coordinated plan:

- *GP home medication review and simplified regimen*
- *Community nurse wound care and falls assessment*
- *Social care reassessment to reinstate daily support*
- *Ageing Well Navigator reconnecting Mrs Patel with community activities and befriending services*

Within weeks, Mrs Patel's wounds heal, her mobility stabilises, and she reconnects socially. Risks reduce significantly, and she remains on the INT's proactive list for ongoing monitoring.

Scenario 4 – Mr Thompson's story: resident led risk management

Mr Thompson, a 76-year-old resident with three long-term conditions contacts his Care Coordinator early one morning. He is highly distressed, and reports that he has not taken his medications for two days due to feeling overwhelmed and confused by his regimen. He also mentions new swelling in his legs and that he has barely eaten. Recognising the urgency, the Care Coordinator reassures Mr Thompson that they can reach him within 20 minutes. They then phoned the duty GP and their line manager and informing them that they was going to see the resident.

On arrival, the Care Coordinator assesses the situation, noticing a cluttered environment, and signs that Mr Thompson is struggling to manage his self-care. Together they have a conversation and come up with a plan. With Mr Thompson's consent, the Care Coordinator calls the relevant members of the INT team.

As a result, the district nurse (whom Mr Thompson knows well) manages to conduct a same-day home visit and checks Mr Thompson's observations. The duty GP follows up that afternoon with a full clinical review, adjusts his medications, and arranges urgent blood tests. Given concerns about declining functional ability, the social care practitioner also agrees to carry out a home visit the next morning to explore support needs.

The Care Coordinator debriefed with their line manager the same day and calls Mr Thompson the next morning to ensure he was okay and understood the plan.

This scenario reflects the importance of high-trust and highly supportive environments. Strong relationships and communications between INT members enable co-ordinated intervention and ensures the Care Coordinator can remain safe and confident in managing risk within their role.

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Scenario 5 – Alex's story: developing a risk-based approach to prescribing

Alex, a clinical pharmacist working within the Integrated Neighbourhood Team (INT), reflects on several recent cases where responsibility for aspects of care had been unclear. These included missed blood monitoring for high-risk medicines, duplication of medication reviews, and uncertainty during transfer of care following hospital discharge.

Although no harm had occurred, Alex recognises a pattern of risk linked to working across organisational boundaries. As part of their reflective practice, they decide to take a more structured approach to identifying and managing these risks within their prescribing role.

Alex develops a simple risk matrix, outlining common hazards within their scope of practice, including high-risk medicines, monitoring requirements, and transfer of care points. For each, they consider likelihood and consequence, identify existing mitigations (such as shared records and MDT discussions), and define additional actions to reduce risk.

This leads to practical changes in their day-to-day practice. For example, Alex routinely confirms and documents responsibility for monitoring when initiating or reviewing high-risk medicines, and proactively raises potential gaps during MDT discussions. They also begin sharing their approach with colleagues, encouraging a more consistent way of thinking about risk across the team.

Further information and resources

- NHSE assessing and managing risks across ICS - here
- NHSE RACI model template - here
- NHSE introduction to system workforce planning – here

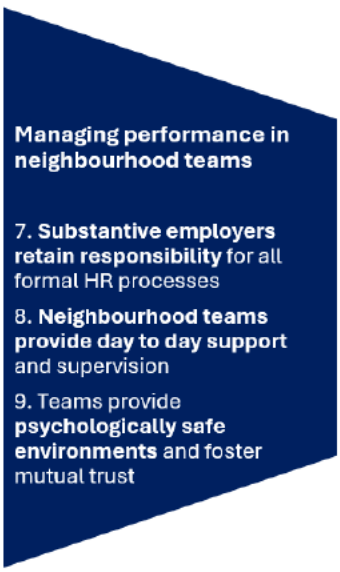
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3. Managing performance in neighbourhood teams

Managing performance of individuals working in neighbourhood teams requires a clear and coordinated approach between substantive employers and the members of the INT providing day-to-day supervision, support and oversight. High performing teams lead to overall better outcomes for staff and residents.

The below sets out the principles and actions that support early, constructive conversations; maintain organisational responsibilities; and enable safe, confident escalation where needed.

Core principles



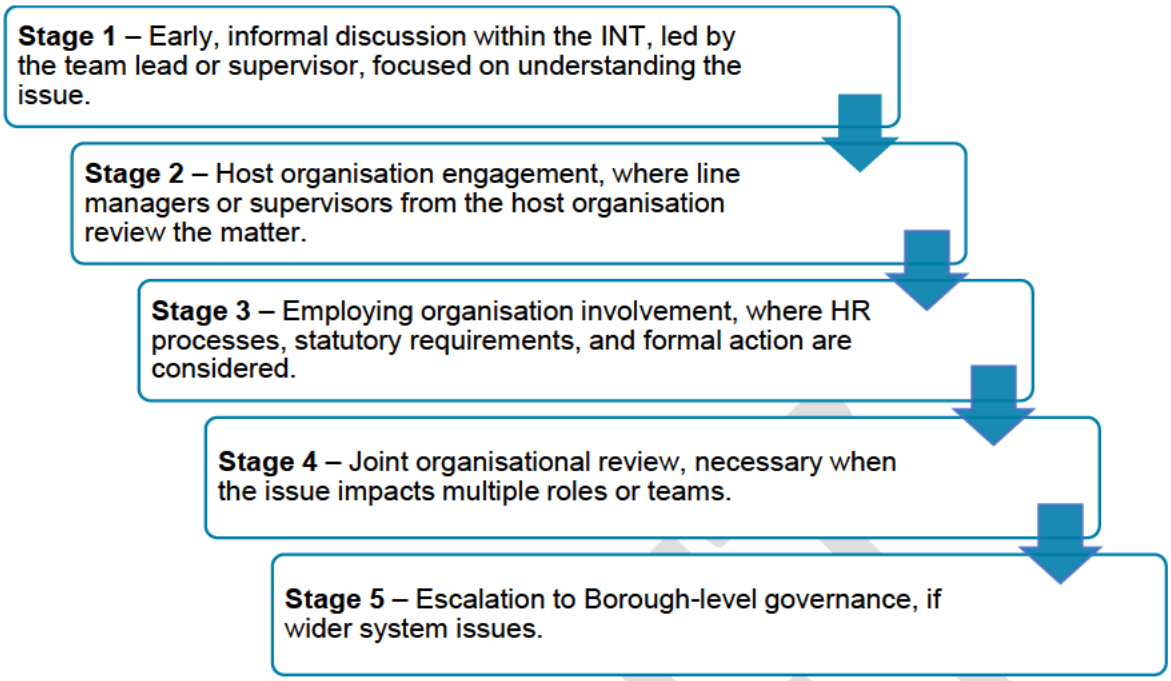
Consider this

- ✓ Ensure that staff understand who their formal employer is and how HR processes work across organisational boundaries.
- ✓ Agree, document and use a shared escalation framework- aligning informal neighbourhood level processes (e.g., early conversations) with the formal HR pathways used by employing organisations.
- ✓ Facilitate cross organisational workshops to build shared norms and behaviours.

Escalation pathway

Whilst neighbourhood working provides an opportunity for us to optimise our collective strengths, in situations where performance challenges emerge, it's important to ensure that this is caught and communicated early, and a supportive conversation takes place to resolve. However in the case this should be escalated, we recommend the following staged process:

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Supporting and developing staff through supervision

- The **INT team lead** should manage day-to-day supervision, early performance conversations, and support for improvement.
- The **employing organisation** retains responsibility for formal HR actions, legal processes, capability procedures, and documentation.
- **Host organisation** where necessary should share timely info, to ensure informed decisions are made.
- **Joint meetings** between the organisations contributing staff to the INT should occur for any issue that may progress beyond informal management.

Bringing this to life – example scenarios

Scenario 6 – Sam's story: Managing performance

Sam is an INT Team Lead begins to notice concerns about one of their team members who works day-to-day within the INT but is employed by a partner organisation. Over several weeks, the Sam has observed a pattern of missed follow-ups, inconsistent documentation, and an overall reduction in output from this team member. Although this team member is not employed by Sam's organisation, these issues are affecting the quality of service delivery for the INT.

Sam arranges an early and supportive conversation with the team member, exploring workload, expectations, and any barriers. The discussion is documented, and with the team member's knowledge and agreement, Sam contacts the line manager in the employing organisation to share discussion outputs transparently.

A joint meeting is arranged between all parties and together, they agree a shared improvement plan: clearer expectations, protected time for documentation, buddying with an experienced colleague, and regular check-ins led by Sam but monitored jointly

by both organisations. This allows the Sam to oversee day-to-day improvement while the employing organisation retains ownership of any formal processes.

With structured support and clarity on expectations, Sam makes the required improvements and returns to full performance. A final joint review closes the process, confirming ongoing supervision arrangements and a shared understanding of escalation routes.

Through transparency and clear roles and responsibilities from Sam (operational oversight) and the employing organisation (HR and contractual processes), all are able to support individual and team performance in an effective way.

Further information and resources

- NHS Employers toolkit for people performance management (co-developed by NHS Employers and Skills for Care) - here

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4. Further resources

Existing staff movement agreements

Below provides an overview of existing cross-Borough staff movement agreements and mechanisms.

Name	Description	Organisations covered	Further information
London Staff Movement Agreement	The London Staff Movement Agreement (LSMA) was devised to allow NHS staff to work at different hospitals across the region.	It is intended for any NHS organisation based in any London borough, any ICS and other participating bodies involved in the provision of healthcare services.	This agreement is annex D - www.england.nhs.uk/wp-content/uploads/2019/08/PRN01565v-annex-d-london-staff-movement-agreement.docx.
Kings Health Partners – honorary passport	Enables all current members of staff to work at another King's Health Partners Founder organisation without having to go through pre-employment checks with the host employer, provided the duties being performed are similar. It is an honorary arrangement between the staff member's primary employer and the host organisation.	- King's College London - Guy's and St Thomas' NHS Foundation Trust - King's College Hospital NHS Foundation Trust - South London and the Maudsley NHS Foundation Trust May apply to clinical and non-clinical duties, including staff who provide care to patients or services to departments.	www.kingshealthpartners.org/get-involved/staff-and-student-benefits/khp-honorary-passport
Honorary contracts	Honorary contracts are used to enable staff movement across organisations.	An honorary contract can be used for individuals coming for a period of work, research or training at an organisation, but will be paid directly by another organisation.	www.nhsemployers.org/articles/honorary-contract-template#:~:text=An%20honorary%20contract%20can%20be,paid%20directly%20by%20the%20organisation.

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Guidance, reports and links

The table below provides a range of links to relevant guidance for those involved in setting up and managing neighbourhood teams have found beneficial.

Type	Description	Link
Guidance		
NHSE London workforce guidance – May 2025	Guidance on developing neighbourhood teams.	www.england.nhs.uk/london/our-work/a-neighbourhood-health-service-for-london/a-neighbourhood-health-service-for-london/the-structure-of-the-operating-model/workforce-developing-our-teams/
DHSC Neighbourhood health framework	Policy Paper setting out details relating to neighbourhood health.	Neighbourhood health framework - GOV.UK
NHSE - Fit for the future: towards population health delivery models	Sets out new population health delivery models to facilitate this change, supporting ICBs to commission providers around the needs of defined populations.	NHS England » Fit for the future: towards population health delivery models
SEL ICS guidance on primary/ secondary care interface	Guidance on improving the primary/ secondary care interface. Includes a variety of links e.g. to a SEL ICB consensus document.	www.selondonics.org/icb/healthcare-professionals/connected-primary-secondary-care-interface/
NHSE - Principles for assessing and managing risks across integrated care systems	Sets out key principles to use when assessing risks in environments or scenarios that are rapidly changing or based on multiple factors (e.g. multiple services/organisations involved).	www.england.nhs.uk/long-read/principles-for-assessing-and-managing-risks-across-integrated-care-systems/
NHSE WTE Workforce planning guidance	The three-phase methodology is a practical application of the approach to system workforce planning.	System workforce planning guidance NHSE WTE Workforce planning guidance
Reports		
London Neighbourhood Health simulation report	Report summarising the approach, experience, insights and recommendations for Implementing neighbourhood health across London and the rest of England.	The-London-Neighbourhood-Health-simulation-learning-report.pdf
Community of practice		
Neighbourhood health network – Community of Practice	Part of the National Neighbourhood Health Implementation Programme (NNHIP). This Community of Practice will be central to accelerating the spread and scale of neighbourhood health.	Join the Neighbourhood Health Network Community of Practice – Fill in form Neighbourhood Health - Home

Glossary of terms

Term	Definition
ARRS Roles	Additional Roles Reimbursement Scheme posts funded to expand multidisciplinary teams in primary care.
BCF – Better Care Fund	A pooled NHS/local-authority funding mechanism for integrated community-based services.
Clinical Governance	The framework ensuring quality, safety and standards in clinical practice.
Escalation Pathway	A structured process for raising and managing performance or safety concerns across organisations.
Federation	A provider organisation that may employ staff on behalf of multiple PCNs and deploy them across practices.
Governance	Structures, processes and responsibilities that ensure safe, effective and accountable decision-making.
Honorary Contract	An agreement allowing staff to work in another organisation without transferring employment.
HWB – Health and Wellbeing Board	A statutory local partnership responsible for joint health and care planning, including developing Neighbourhood Health Plans. [
IHO – Integrated Health Organisation	A provider holding a population-level budget to plan and deliver integrated care across a wider geography.
INT (Integrated Neighbourhood Team)	A team model bringing together health, care and community partners to coordinate support around neighbourhood populations.
MNP – Multi-Neighbourhood Provider	A provider coordinating consistent delivery of neighbourhood services across multiple neighbourhoods.
Neighbourhood Health Centre (NHC)	A local hub bringing together GP, community, local authority and VCSE services to provide joined-up neighbourhood care.
Neighbourhood Team	A multi-disciplinary group working across organisational boundaries to deliver integrated care within a defined local area.
NP – Single Neighbourhood Provider	A provider commissioned to deliver neighbourhood-level services for a defined population, working through integrated neighbourhood teams.
PCN (Primary Care Network)	A group of general practices working together with partners to deliver primary care services at neighbourhood scale.
Staff Movement Agreements	Mechanisms enabling staff to work across multiple organisations, such as honorary contracts or secondments.

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South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**Proposed transfer of the Lewisham Neighbourhood Development Team to the Lewisham Integrator host - Lewisham and Greenwich NHS Trust**					
Meeting date	16 July 2026	Agenda item Number	**6**	Paper Enclosure Ref	**4**	
Author	**Laura Jenner**					
Executive lead	**Ceri Jacob**					
Paper is for:	Update		Discussion	**x**	Decision	
Purpose of paper	To update the NBCB on proposals to transfer the Lewisham Place Neighbourhood Development Team to the Lewisham Integrator Host - Lewisham and Greenwich NHS Trust (LGT).					
Summary of main points	The purpose of this paper is to update the NBCB with Lewisham Place plans to transfer the SEL ICB Lewisham neighbourhood development functions and responsibilities to Lewisham & Greenwich NHS Trust (LGT). This includes the proposed transfer of associated responsibilities, budgets, and staff. Approval has been received from the ICB SMT to progress to more detailed work such as legal due diligence, examining delegation procedures, assessing financial impacts, and conducting necessary consultation about staff transfers. The NHS 10-year plan and the ICB blueprint set out an expectation that ICBs would establish a neighbourhood health (and care) service and that they would transfer certain functions, over time, to other NHS organisations. The London neighbourhood Target Operating Model set out the requirement for neighbourhood integrator organisations to be established. In Lewisham, the Integrator is a partnership between Primary Care, VCSE, SLaM, London Borough of Lewisham and Lewisham and Greenwich NHS Trust (LGT). LGT acts as the integrator host. Lewisham Place is progressing plans to transfer the Neighbourhood Development Team (encompassing primary care development) with a view to transferring in April 2027.					
Potential conflicts of Interest	Lewisham Place representatives on the NBCB are impacted by the proposed changes.					
Sharing and confidentiality	Not confidential.					
Relevant to these boroughs	Bexley		Bromley		Lewisham	**x**
	Greenwich		Lambeth		Southwark	
Equalities Impact	Not relevant for this paper					

Financial Impact	Development budgets of c£2m for neighbourhood development and primary care development will transfer to the Integrator host.
Public Patient Engagement	Public and patient engagement is taking place in relation to services being delivered through the neighbourhood model but is not required for the function transfer.
Committee engagement	Proposals approved for further detailed work at the ICB SMT on 11 June 2026.
Recommendation	The Committee are asked to note and discuss proposals set out in the paper.

Approval for the Transfer of Lewisham Neighbourhood Development to Lewisham & Greenwich NHS Trust

1. Purpose

The purpose of this paper is to update the NBCB with Lewisham Place plans to transfer the NHS South East London Integrated Care Board (SEL ICB) Lewisham neighbourhood development functions and responsibilities to Lewisham & Greenwich NHS Trust (LGT). This includes the proposed transfer of associated responsibilities, budgets, and staff. Approval has been received from the ICB SMT to progress to more detailed work such as legal due diligence, examining delegation procedures, assessing financial impacts, and conducting necessary consultation about staff transfers.

The following paper provides the background and context to the proposed change, an outline proposal for the transfer, the legal and governance framework considerations, proposal for governance oversight, the implementation approach and key milestones, draft risks and mitigations, and recommendations and next steps.

2. Background & Context

The proposed delegation is consistent with national and regional strategic plans, including:

- NHS 10-Year Health Plan for England sets the national direction to shift care from hospital to community, with a "neighbourhood health service" as a core model for more coordinated, preventative, and local care.
- The Model ICB Blueprint reframes ICBs primarily as strategic commissioners while signalling that a number of "delivery/enablement" functions should transfer out of ICBs over time. The Blueprint explicitly identifies neighbourhood partnership development and primary care operations & transformation (including medicines management and optimisation, estates, and workforce support) as functions expected to transfer to neighbourhood health providers.
- The Neighbourhood Health Framework strengthens expectations that neighbourhood health will be delivered jointly by the NHS, local authorities and partners, providing clearer national direction on implementation and reinforcing the "left shift" to community-based care and away from hospital settings.
- London Target Operating Model (TOM) (Neighbourhood Health Service for London) provides the London-wide operating model and roadmap for implementing neighbourhood health. The London TOM identified a need for an "integrator" to host integration "functions" required to enable primary, community, mental health, acute specialist, local authority, Voluntary, Community & Social Enterprise Sector (VCSE) and other partners to work together effectively at the neighbourhood level.

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In Lewisham, a Memorandum of Understanding (MoU) has been agreed that sets out the commitment from all Partners to develop the governance, operational frameworks, shared delivery and accountability for the integrator form and associated functions, as outlined in the TOM. The signatories to the MoU are:

- Lewisham Council: Adult Social Care, Children and Public Health
- Lewisham and Greenwich NHS Trust (LGT)
- Primary Care, initially through the Primary Care Leadership Forum
- South London and Maudsley NHS Foundation Trust (SLaM)
- Voluntary and Community Sector (VCS) Lewisham Local

The Integrator partnership in Lewisham will act as a strategic partnership, understanding the local population's needs and facilitating collaboration across health, social care, and community sectors to deliver person-centred, equitable, and proactive care at a neighbourhood level.

The structure of the proposed Lewisham Neighbourhood Development team is currently under consultation as part of the wider proposals for changes to the organisational structure of the SEL ICB. The proposals state that the Neighbourhood Development Team will work alongside the new Integrators to support the development, improvement, and delivery of a Neighbourhood Health Service at Place.

3. Proposal

It is proposed that, subject to detailed preparatory work, appropriate governance approvals, and staff consultation, the ICB will:

- Delegate authority for the management of the Lewisham Neighbourhood Development team and associated budgets to LGT.
    - LGT would function as the host organisation for these functions, including the employment of staff and administration of budgets, and would manage delivery against the priorities of SEL ICB and the Lewisham Integrator Partnership.
    - This model ensures that, whilst LGT provides operational infrastructure, decision-making remains collaborative across the Lewisham system, maintaining a strong place-based governance approach.
- Include neighbourhood and primary care development funding, as well as inequalities funding, within the scope of the proposed delegation.
- Agree to the governance model for oversight and assurance outlined in Section 5, including the integration of the Lewisham Health and Care Partnership and the Health and Wellbeing Board into a single strategic board to oversee the delivery of the Neighbourhood Health and Care Plan

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Strategic planning and commissioning for the local system will remain the responsibility of SEL ICB, including decisions relating to resource allocation and use of multi-neighbourhood models.

4. Legal & Governance Framework

To enable this delegation, a formal legal framework will be established. Initial legal advice has been obtained (see Annex 1) that advises that the delegation of functions by the ICB does not require a contract award and therefore would not be subject to any procurement process. The legal framework is expected to include:

- Clearly defined delegated authorities from the ICB to Lewisham & Greenwich NHS Trust (LGT).
- Joint governance arrangements between the ICB, LGT, and the Lewisham Integrator Partnership.
- A formal agreement, or suite of agreements, setting out roles, responsibilities, financial controls, and accountability mechanisms.

The governance model will ensure that:

- Decision-making authority rests with the Lewisham Integrator Partnership.
- LGT operates within the agreed scope in its role as host organisation.
- Robust financial management and performance oversight are maintained.

5. Oversight & Assurance

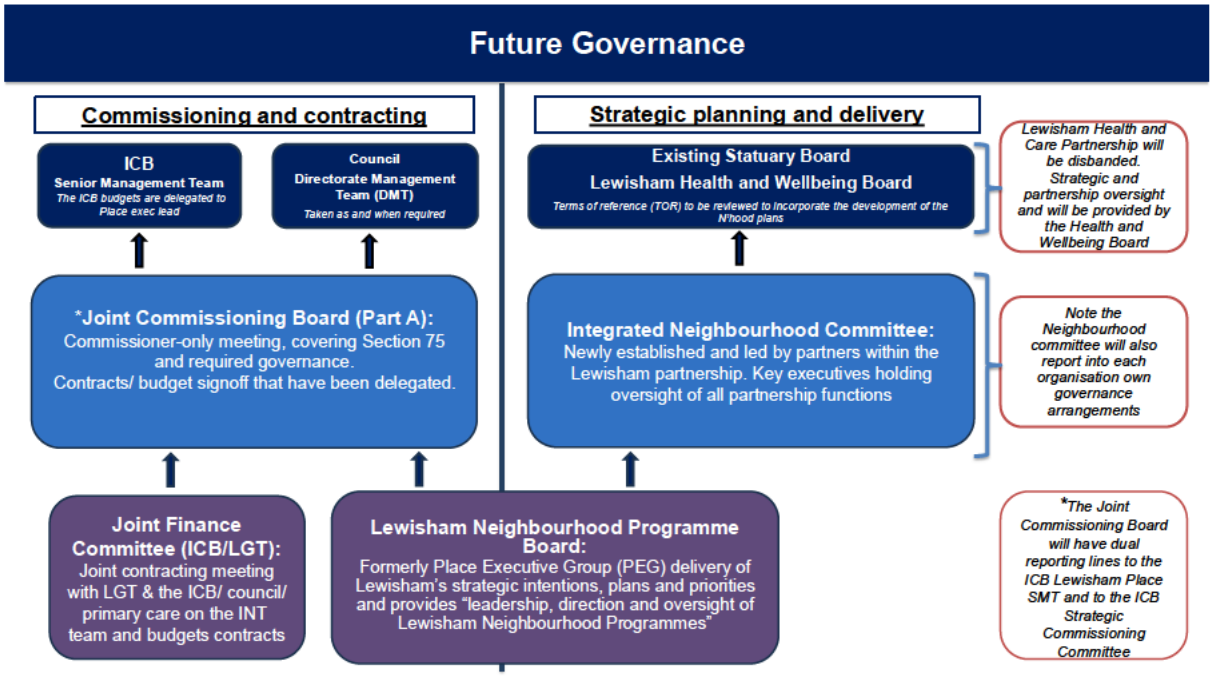
The proposed governance model (see figure1) includes the establishment of a new Joint Commissioning Group to provide a formal forum for commissioner decision-making, including oversight of delegated budgets, Section 75 arrangements, and relevant contractual approvals. This group will operate as a commissioner-only forum, ensuring clear accountability for commissioning functions. It will report jointly to the ICB and the Local Authority.

Strategic oversight of the wider system will be strengthened through the Health and Wellbeing Board, which will assume an enhanced role in overseeing place-based planning and integration, ensuring alignment between NHS and local authority priorities and supporting a more joined-up approach to improving population health outcomes. The existing Lewisham LCP Board will be merged with the HWBB.

A dedicated monitoring meeting will oversee delivery against the delegation agreement, agreed KPIs for the neighbourhood team, and associated budgets, with clear performance indicators in place and the ICB retaining the authority to revoke the delegation where these are not adhered to.

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Figure 1



Please note the governance may change reflecting further changes to SEL/SWL governance

6. Implementation Approach

A project group will implement and monitor an overarching project plan for the transfer from the ICB to LGT. This group will provide updates to the ICB Transition Committee as required. Final approval for the transfer will be by the LGT Board, Local Authority (noting the neighbourhood development team includes shared posts) and the ICB Board following recommendation from the ICB Transition Committee.

Key provisional milestones include:

- Governance sign-off.
- Service specification defined and approved.
- Legal framework sign-off.
- Funding flow and envelope agreed.
- Staff consultation completed.
- Go-live and staff transfer.

This will be followed by a one-year period from April 2027, during which the delegated arrangements will operate in a controlled phase. A dedicated monitoring meeting will oversee delivery against the delegation agreement:

  - Test governance, decision-making and reporting, including operation of the Joint Commissioning Group and interfaces with the Health and Wellbeing Board and Integrator Partnership

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- Confirm financial flows, controls, and performance measures; identify and mitigate operational, workforce, contractual and delivery risks ahead of full implementation.

An initial review will take place after six months to confirm that the monitoring process is effective.

7. Risks & Mitigation

An initial risk assessment (see table 1) has identified the key risks to the successful transfer process. During due diligence, the following risks and their mitigations will be further detailed and monitored through the transfer programme's governance, with designated owners managing each risk.

Table 1

Risk	Potential impact	Mitigation / controls
Governance complexity	Delays to agreement/sign-off; reduced flexibility; unclear escalation.	Confirm decision rights, delegated authorities and escalation routes
Financial accountability	Lack of clarity on budget envelope and reporting; partners (including general practice) perceive loss of influence; risk of overspend or misallocation.	Agree budget scope and funding flows, define financial controls and reporting cadence and audit requirements
Organisational clarity	Roles/responsibilities unclear; slower decision-making.	Document roles and responsibilities, confirm interfaces with Integrator Partnership
Workforce transfer and consultation	Staff uncertainty, delays due to consultation requirements	Early HR/legal advice, agreed staff engagement and consultation plan
Information governance and data sharing	Delays or non-compliance relating to access to systems and sharing of personal/confidential data; operational disruption if system access is not in place.	Complete IG due diligence, agree data sharing and processing arrangements, ensure system access and information asset ownership are confirmed ahead of go-live

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Contracting and legal framework	Agreements not completed or not fit for purpose, unclear liabilities, delayed go-live.	legal review and timetable aligned to governance approvals

8. Summary

The proposal set out above supports national and London direction to strengthen neighbourhood health delivery, reflects the ICB Blueprint expectation that delivery/enablement functions transfer out of ICBs over time, and aims to provide clearer hosting arrangements while retaining collaborative place-based decision-making through the Lewisham Integrator Partnership and strengthened commissioner oversight.

Further detailed work will be carried out over the coming months with an aim of transferring the function in April 2027.

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Appendix 1

Pros and cons of contractual model versus delegation

	Contractual Model	Delegation
Legal basis	ICBs have general powers to enter into agreements under schedule 1B to the NHS Act 2006.	ICBs may delegate functions to "relevant bodies" including NHS Trusts and Foundation Trusts under section 65Z5 of the NHS Act 2006.
Procurement	Contract award will require ICB to undertake a procurement. Given the nature of the services in scope this may be under the Procurement Act rather than the PSR.	No requirement to carry out a procurement exercise in order to delegate functions to a provider.
Requirement for NHSE approval/support	No formal requirement for NHSE approval in respect of a contract award to a provider.	NHS England guidance "*Arrangements for delegation and joint exercise of statutory functions*" indicates that ICBs should not seek to use powers to delegate functions to NHS providers in financial year 2024/25. Proposals for such delegation will be subject to a risk based assurance review by NHS England. Guidance has not been updated for 2025/26.
Mechanism for transfer of staff	Contract award will amount to a "service provision change" under TUPE and will therefore	Delegation of functions from the ICB to the Trust will amount to a "business transfer" and/or "service

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	result in staff that are	

	assigned to the service transferring by operation of law.	provision change" under TUPE and will therefore result in staff that are assigned to the service transferring by operation of law.
Responsibility and Accountability	The Trust is responsible for providing the services that are specified in the contract. The ICB remains responsible and accountable for the exercise of its commissioning functions.	The Trust is responsible for the exercise of the delegated functions but the ICB remains accountable for those functions.
Liability	The Trust is liable under the contract for losses arising from its performance/non-performance of the specified services.	The Trust is liable for those functions that are delegated to it. Section 65Z5(6) of the NHS Act 2006 provides that any liabilities incurred in respect of the exercise by a body of any function that is delegated to it by virtue of this section are enforceable against that body (and no other person).
Financial arrangements	Under a contractual arrangement, the ICB would usually pay the Trust for the performance of services in accordance with the contract specification. However, the NHS England delegation guidance indicates that a	Where a function is delegated by the ICB to a Trust it can also delegate the budget associated with that function.

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	commissioner can lawfully give providers a wide degree	

	of latitude as to the services they provide under a contract, both in terms of which services are delivered and how they are delivered. The commissioner will still set the broad scope of what the provider is expected to achieve (clinical outcomes, for example) under a contract. A contract that confers discretion on a provider in respect of some or all services under the contract may be a useful alternative or precursor to delegation to trusts or foundation trusts under s65Z6 of the NHS Act 2006.	
Flexibility	Limited flexibility dependent on contractual terms and any variation provision in the contract. Contracting allows the ICB to maintain stricter control over specific service specifications.	Likely to be greater flexibility, particularly in respect of innovation and the redesign of services.
Nature of relationship	"Purchaser/Provider" contractual relationship.	Collaborative partnership with scope for integrated decision-making.

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Annex 2 budgets and staff budgets

BUDGETS

Please note this is subject to further consideration *[Redacted]*



PAY COSTS

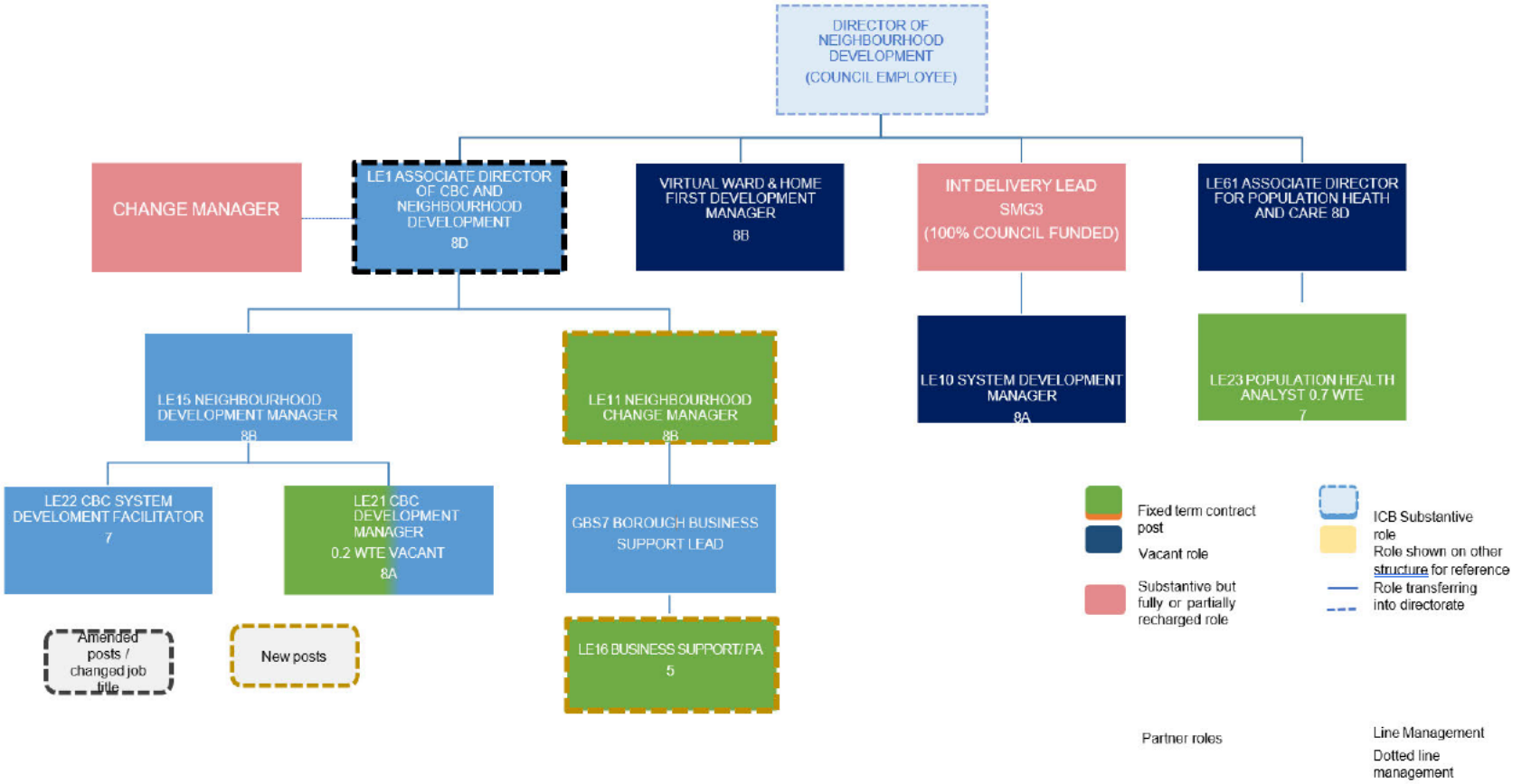
Please note this is subject to further consideration

Job Title	WTE	AFC Band	Spine point at 01/04/2026	Structure No.	Actual Total Budget 2026/27	
Director of System Development	1.00	Band 9	XN1204	LE0	**82,266**	Director of Neighbourhood Development ICB 50% share (Council Employee)
Associate Director of Community Based Care & Primary Care	1.00	Band 8d	XN1106	LE1	**151,347**	Associate Director of CBC and Neighbourhood Development
Virtual Ward Delivery Manager	1.00	Band 8b		LE12	**98,998**	Virtual Ward & Home First Development Manager
Neighbourhood Development Manager	1.00	Band 8b	XN0903	LE15	**96,709**	Neighbourhood Development Manager
Head of LTC and Cancer Service Development	1.00	Band 8b	XN0906	LE25	**110,663**	Neighbourhood Change Manager
System Development Manager	1.00	Band 8a	XN0802	LE10	**84,994**	System Development Manager
CBC Development Manager	1.00	Band 8a	XN0806	LE21	**94,151**	CBC Development Manager *(Increased to 1.0 WTE in new structure)*
Population Health Analyst	0.70	Band 7	XN0705	LE23a	**54,428**	Population Health Analyst *(Increased to 0.7 wte in new structure)*
CBC System Development Facilitator	1.00	Band 7	XN0709	LE22	**84,121**	CBC System Development Facilitator
Business Support Lead - Lewisham	1.00	Band 6	XN0603	GBS7-e	**64,722**	Borough Business Support Lead
Business Support/PA - Lewisham	1.00	Band 5	XN0508	GBS8-e	**60,222**	Business Support/PA
	1.00	Band 8d			**0**	Associate Director for Population Health & Care *(no budget transfer as already 100% funded by integrator)*
					64,722	Change Manager *(This post is employed by OHL)*
					0	INT Delivery Lead (100% Council Funded) *(LBL will need to transfer the budget)*
				Total	**1,047,343**	

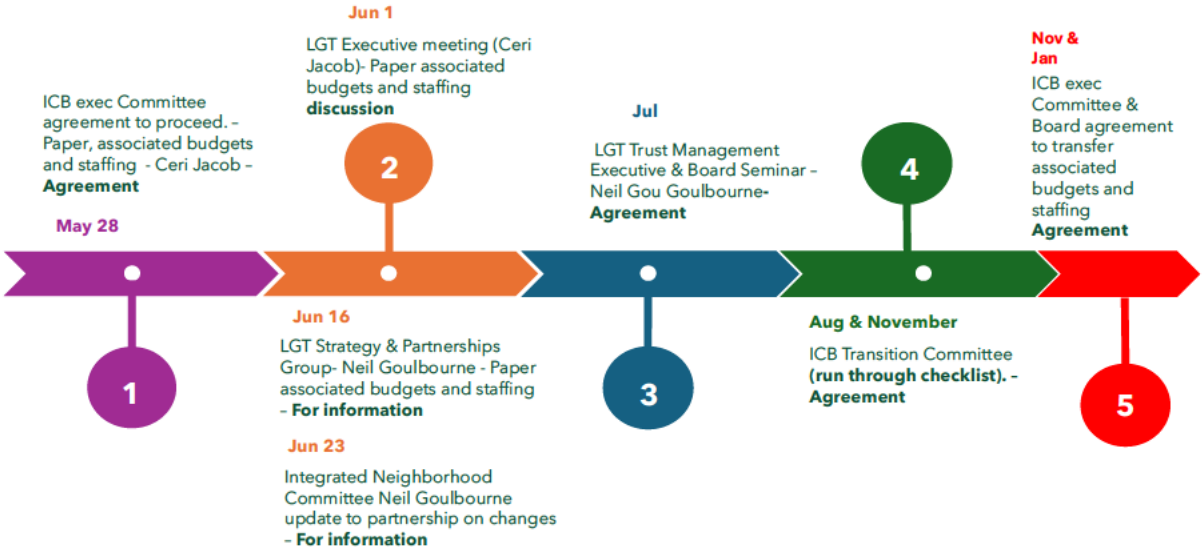
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Annex 3 Lewisham Proposed Neighbourhood Structure Plan

Please note the structure is currently out for consultation and may have further changes



Governance timeline Sign off Delegation – ICB N'hood team and associated budgets (May –April 2027)



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South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**INT Modelling Workstream update including demonstration of the tool**					
Meeting date	16 July 2026	Agenda item Number	**7**	Paper Enclosure Ref	**5**	
Author	**Adam Wall, Head of Data Analytics, PPL**					
Executive lead	**Neil Kennett-Brown, Programme Director, System Sustainability**					
Paper is for:	Update	**X**	Discussion		Decision	
Purpose of paper	To provide an update on the INT Benefits Realisation tool that has been developed over the past year. The presentation will include a live demo of the tools functionality.					
Summary of main points	• The SEL ICB Neighbourhood Benefits Modelling Tool is due to launch this month, following focused user testing and quality assurance over the past month. It has been developed with PPL and the LGT PHM team to support planning and integrator/commissioning use cases by modelling the impact of the shift to Neighbourhood care. • The tool provides whole-system insights for priority Neighbourhood cohorts, initially focused on frailty, multiple long-term conditions and children and young people living in the 20% most deprived LSOAs, using linked resident-level pseudonymised data that cannot re-identify individuals. • It includes a standardised database of Neighbourhood interventions, with core interventions locked in for all modelling and additional interventions that can be switched on or off when building scenarios. Assumptions on impact and delivery costs are transparent and can be customised. • Users can create scenarios for current or planned interventions and model potential impacts on future activity over a one to ten year period, taking account of baseline activity, population growth, non-demographic growth and intervention effects. • The tool includes financial modelling using PLICS data to estimate the potential scale of activity and resource "left shift", including the implications for variable, semi-fixed and fixed costs. Outputs can support business cases for investment in Neighbourhood interventions. • Social care and mental health data are being integrated into the tool. • The current phase will conclude in the next few weeks, with the launch of the tool, a final report on the potential impact of current and planned interventions, and a technical handover from PPL to the SEL BI team. • Further support is being scoped, to Place and Integrator teams in using the tool to inform their planning and implementation work, as it is important that the tool is used. • A related INT business case is being currently being developed by Lambeth & Southwark and will build on the understanding from this work, and we are ensuring assumptions are aligned.					
Potential conflicts of Interest	None					

Sharing and confidentiality	The paper can be shared.						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	The tool enables assessment at a neighbourhood level, which can help inform differential impacts						
Financial Impact	The tool enables assessment at a neighbourhood level, which can be aggregated across various neighbourhoods, and help inform differential impacts						
Public Patient Engagement	None						
Committee engagement	Previous presentations to NBCB over the past 12 months						
Recommendation	The Committee are asked to note the update						

South East London Integrated Care System

SEL ICS INT Benefits Realisation Modelling

Update for Neighbourhood Based Care Board

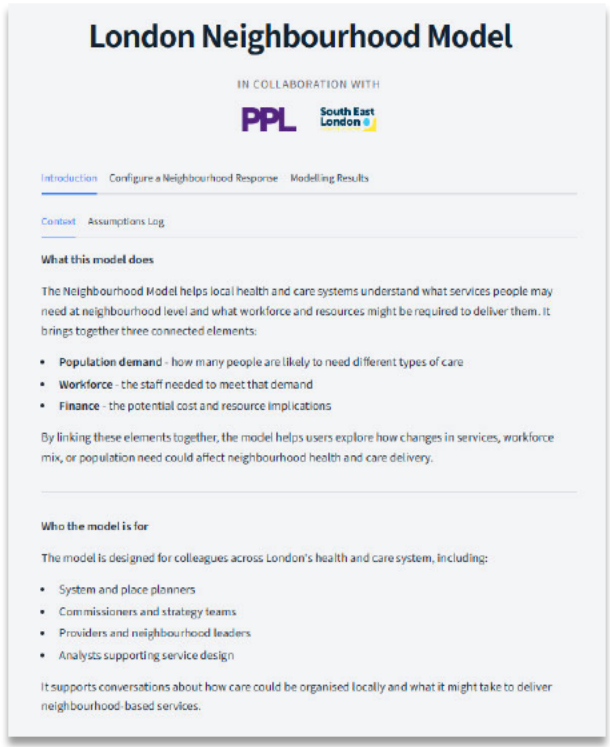
16/7/2026

PPL

Update on SEL ICB Neighbourhood Benefits Modelling Tool

This month SEL ICB will launch the Neighbourhood Benefits Modelling Tool it has been developing in partnership with PPL and the LGT PHM team over the last year, after a period of focused user testing and quality assurance. **The tool is intended for use by the ICB and by Integrators to model the impact of the shift to Neighbourhood care** for planning and commissioning use cases.

- Provide whole-system insights on key Neighbourhood cohorts (Frailty, MLTC, CYP)
- Standardise and codify Neighbourhood interventions and associated assumptions
- Create a tool that allows scenario modelling for current and future Neighbourhood interventions
- Embed financial modelling that accounts for true costs associated with service delivery



Explore granular data for priority Neighbourhood cohorts

The tool allows granular exploration of population health data, drawn from **acute, community, and GP records**, focused on the three priority cohorts for Neighbourhoods.

The tool uses the **standard SEL definitions** for these cohorts:

1. Residents flagged as ‘mild’, ‘moderate’, or ’severe’ according to the frailty index
2. Residents with 3 or more long term conditions (excluding those who are flagged as frail)
3. All children and young people who live in the 20% most deprived LSOAs

The tool uses a linked, resident-level, pseudonymised dataset. **The tool cannot re-identify specific individuals**, but can produce aggregate insights on the needs profile of each Neighbourhood population.



Use the standardised intervention database and associated assumptions

The tool contains a standardised set of ‘Neighbourhood interventions’, along with standard assumptions around their impact, and the cost of their delivery.

There is a **core set of Neighbourhood interventions** (e.g. MDTs) which are locked in, so that all modelling exercises account for the interventions that all Neighbourhoods are delivering.

There is a set of **additional interventions** which users can turn on and off as part of the creation of new scenarios.

The tool sets out the mechanics of how each intervention feeds into the modelling results, along with general assumptions about the scale of that effect and the cost of delivering the intervention. **The assumptions around impact and cost are customisable.**



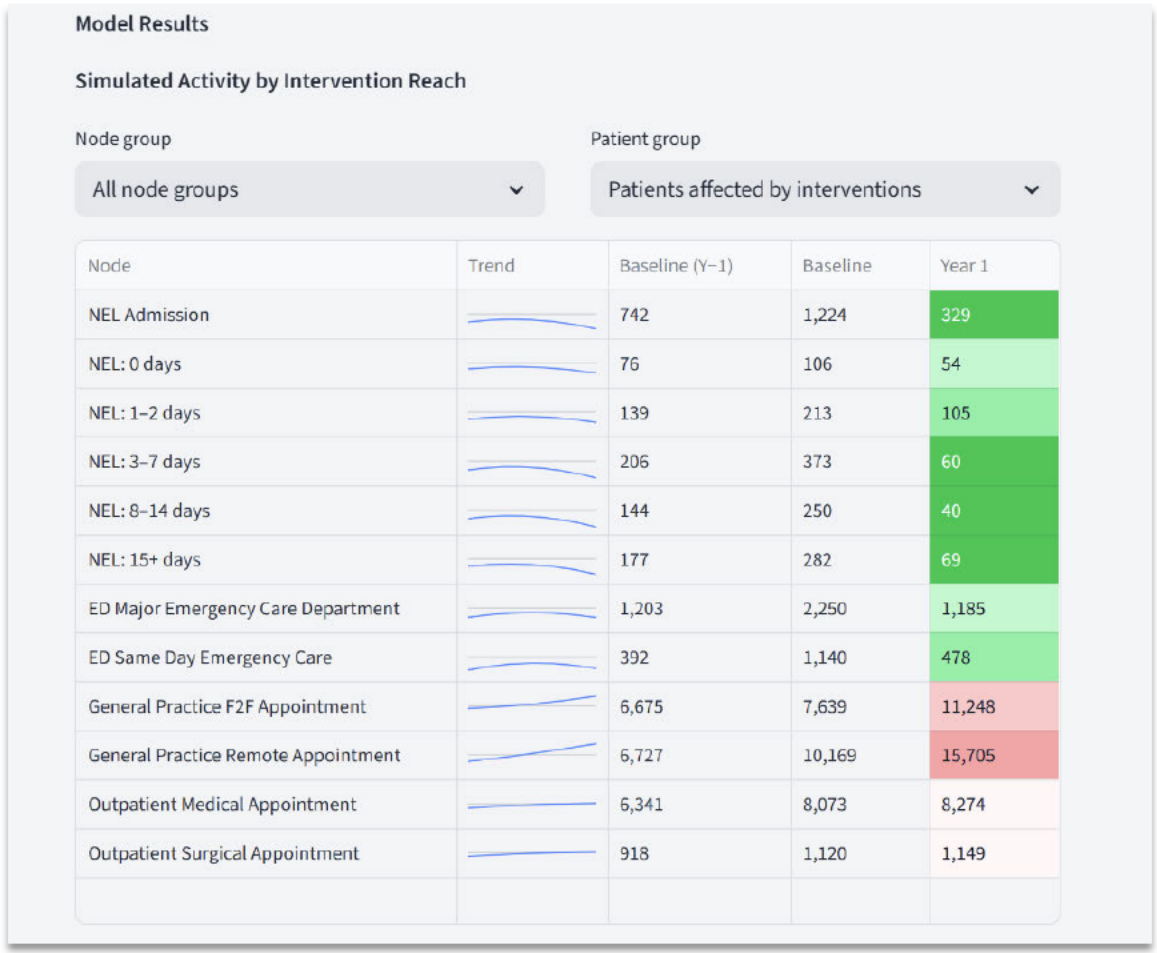
Build scenarios in the tool to model their potential impact on future activity

Users can build scenarios that reflect current or planned Neighbourhood interventions and run the model to **automatically create forecasts of impact on future activity in health settings**.

These forecasts account for baseline activity, including population and non-demographic growth, and the impact of the interventions selected by the user as part of the scenario set-up.

The model can be run for any period between 1 to 10 years in the future. Users can drill down into the future activity for those cohorts that did receive an intervention or explore the overall projected activity for the entire cohort.

Social care and mental health data are currently in the process of being integrated into the tool.



Model Results

Simulated Activity by Intervention Reach

Node group: All node groups

Patient group: Patients affected by interventions

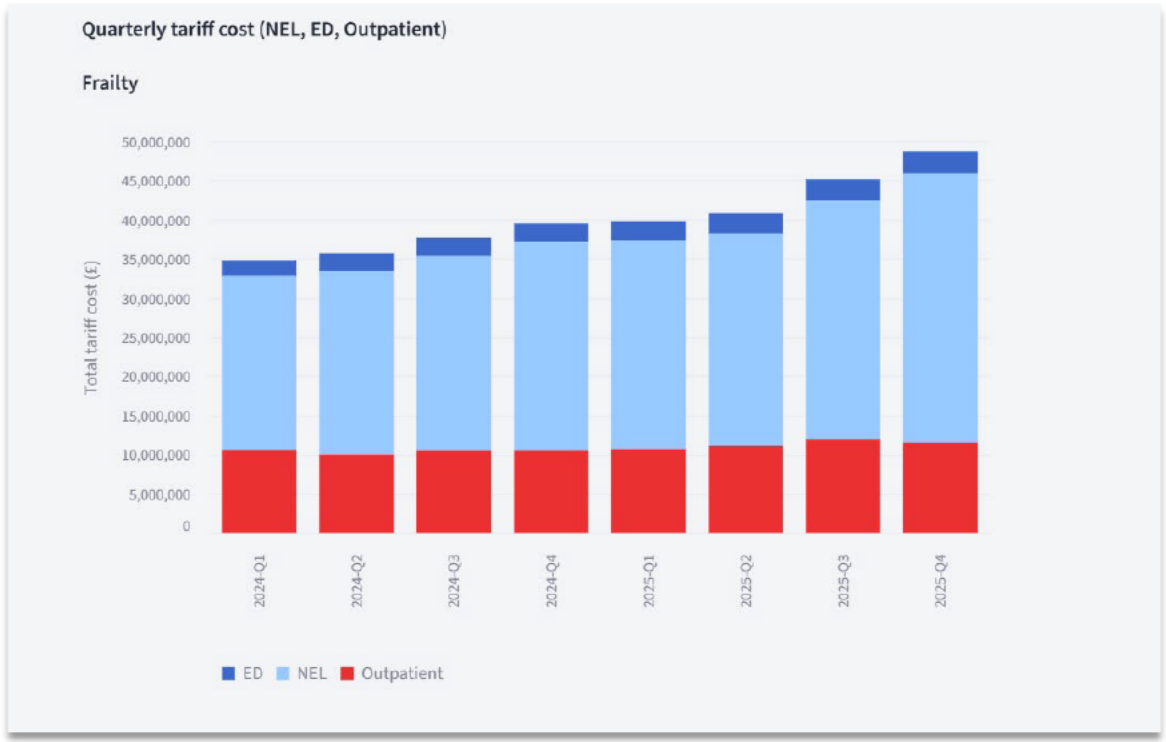
Node	Trend	Baseline (Y−1)	Baseline	Year 1
NEL Admission		742	1,224	329
NEL: 0 days		76	106	54
NEL: 1–2 days		139	213	105
NEL: 3–7 days		206	373	60
NEL: 8–14 days		144	250	40
NEL: 15+ days		177	282	69
ED Major Emergency Care Department		1,203	2,250	1,185
ED Same Day Emergency Care		392	1,140	478
General Practice F2F Appointment		6,675	7,639	11,248
General Practice Remote Appointment		6,727	10,169	15,705
Outpatient Medical Appointment		6,341	8,073	8,274
Outpatient Surgical Appointment		918	1,120	1,149

Understand the potential financial impact of shifts in activity driven by interventions

Once the user has run a scenario and generated a forecast of future activity, those results will flow into a financial model that **sets out the potential scale of 'left shift'** resulting from those interventions.

The financial modelling draws on **PLICS data from NHS Trusts** to model the impact on variable, semi-fixed, and fixed costs to account for the realities of resource reallocation.

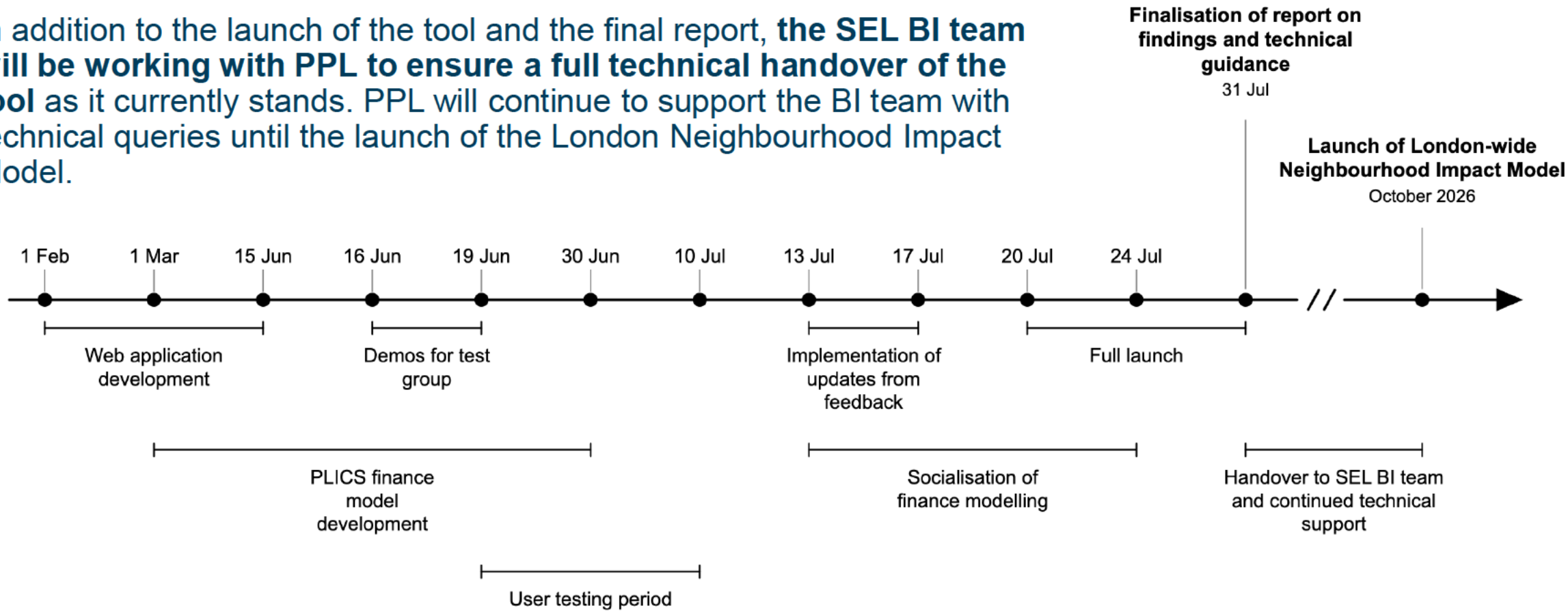
Outputs from the financial modelling **can be used directly in business cases** that make the financial case for investment in new Neighbourhood interventions, as well as understanding the shift in resources between settings.



Timelines for the remainder of this phase of work

The launch of the benefits realisation tool, and the use of a tool to generate a final report with key findings on the potential impact of current and planned Neighbourhood interventions, represents the end of this phase of work.

In addition to the launch of the tool and the final report, **the SEL BI team will be working with PPL to ensure a full technical handover of the tool** as it currently stands. PPL will continue to support the BI team with technical queries until the launch of the London Neighbourhood Impact Model.



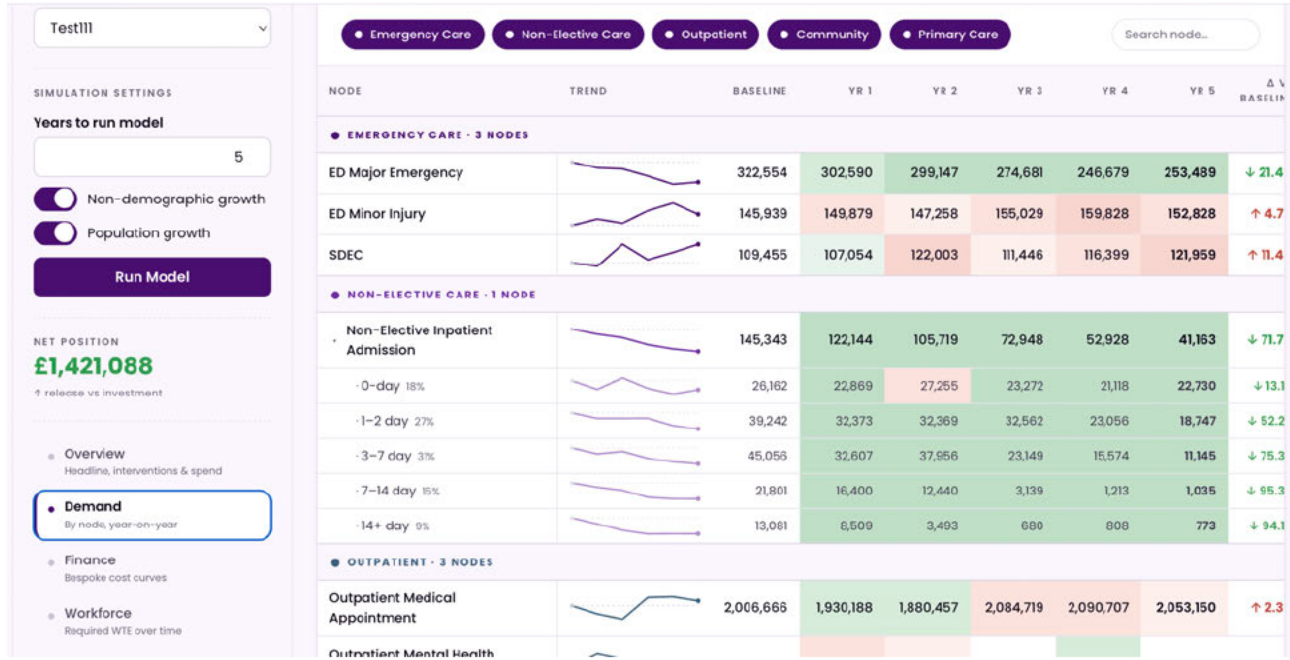
How this work has informed the London Region Neighbourhood Impact Model

The development of this tool has directly informed ongoing work to develop a London-wide equivalent on the OneLondon Secure Data Environment.

The tool is being developed as part of the London Region's Neighbourhood Health Delivery Programme and will introduce additional features and allow colleagues from across London to benefit from the functionality being made available to SEL colleagues in the coming weeks.

The London tool is due to be launched later this year, and will supersede the SEL tool. This means centralising and streamlining the cost and management of predictive tools, ensuring that the London Neighbourhood Model serves as a single predictive analytics platform and creates parity of access to data and tools across all health & care partners in London.

Until the London-wide tool is fully launched, we will continue to maintain and develop the SEL Benefits Realisation Tool for use by all SEL colleagues.



South East London Integrated Care System

Annex

Background

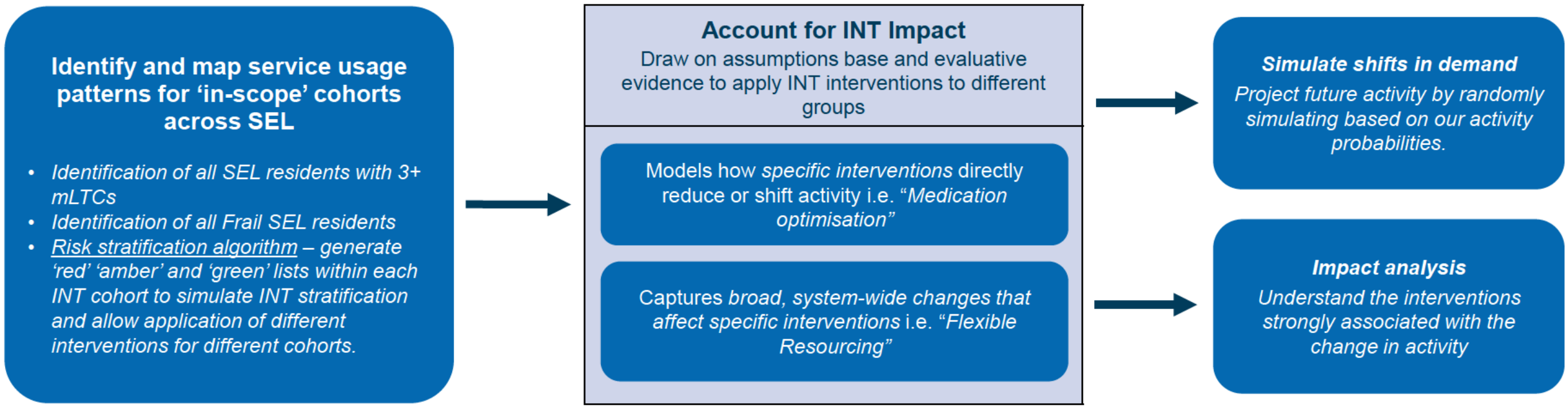
Last year a blended team with colleagues from the ICB's BI team, Lewisham & Greenwich Trust (LGT) and PPL worked to develop a **model to quantify the impact of INTs on the financial sustainability of South East London** as a system. The team have delivered:

- **Initial engagement** with 30+ stakeholders across all six SEL places, plus a document review, to assess INT maturity and existing modelling.
- **Logic models** linking INT inputs to system sustainability outcomes, building on engagement outputs and SEL's INT Theory of Change.
- **Targeted data request** informed by engagement and logic mapping, identifying required datasets and specifying patient/contact-level data
- **Three-tier modelling approach** to assess the impact of INTs on system sustainability:
    - Core model simulating INT-driven changes in health and care utilisation, including exogenous demand, with linked patient level data
    - Workforce assumptions constraining impact based on delivery capacity
    - Financial model translating demand and workforce shifts into 'pure commissioning' cost savings
- **Place-level intelligence gathering** across all six SEL places on delivery models, capacity plans, and capabilities to inform model inputs.
- **R-based model** build with an Excel front-end for user testing within the blended team.
- **Preliminary results** generated using provisional inputs for key interventions, workforce, and capacity (cohort size).

Previous phase: The model will simulate INT-driven changes in health & care service usage

Our model starts by accounting for demand dynamics unrelated to INTs, including unmet demand and natural growth. Then our model **applies changes to demand patterns for each cohort based on the expected impact of INT interventions** on service usage patterns. This will allow a simulation of the aggregate shifts in demand across the system, and an analysis of the differential impact of each INT intervention.

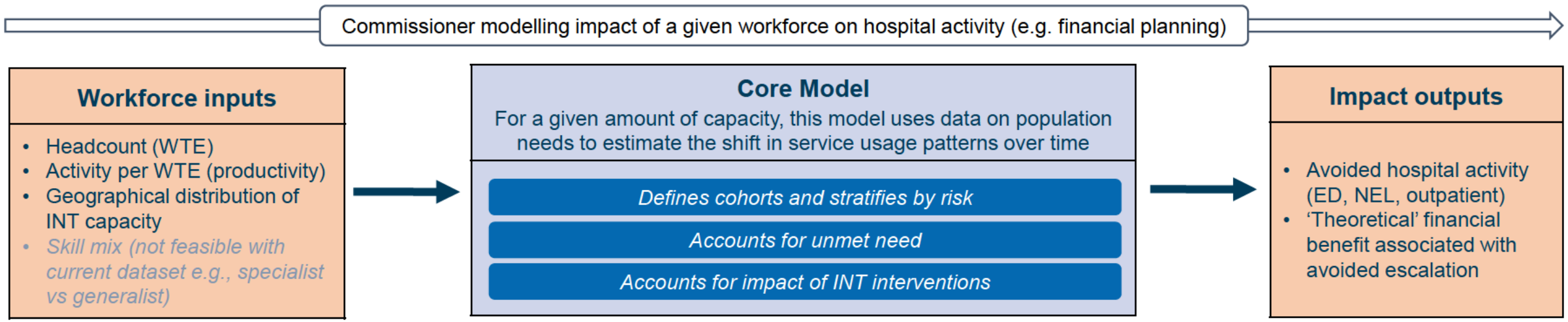
The diagram below sets out what is the '**core model**' which segments the SEL population by need and applies the expected effects of INT working on their service usage patterns. The precise set of interventions that generate INT impact will **vary by Place and Neighbourhood**.



Previous phase: A key use case for the 'core model' is to link workforce, activity, and impact

A key use-case for this modelling exercise is to **quantify the link between workforce size, workforce capacity and productivity, the amount of activity delivered as part of the new 'INTs', the impact on service usage patterns, and therefore the net financial benefit of the interventions**. Workforce is key to understanding net financial benefit because most of the 'cost' associated with INT delivery will be workforce cost.

To ensure the model's outputs in terms of demand and financial impact are rooted in ongoing work across SEL's six Places to roll out INTs, **accurate information on headcount, capacity, and the scale specific interventions being delivered is critical**. This information is the critical input that integrators across the system will need in order to leverage the data and assumptions built into the model.



How does this phase seek to improve financial impact forecasting?

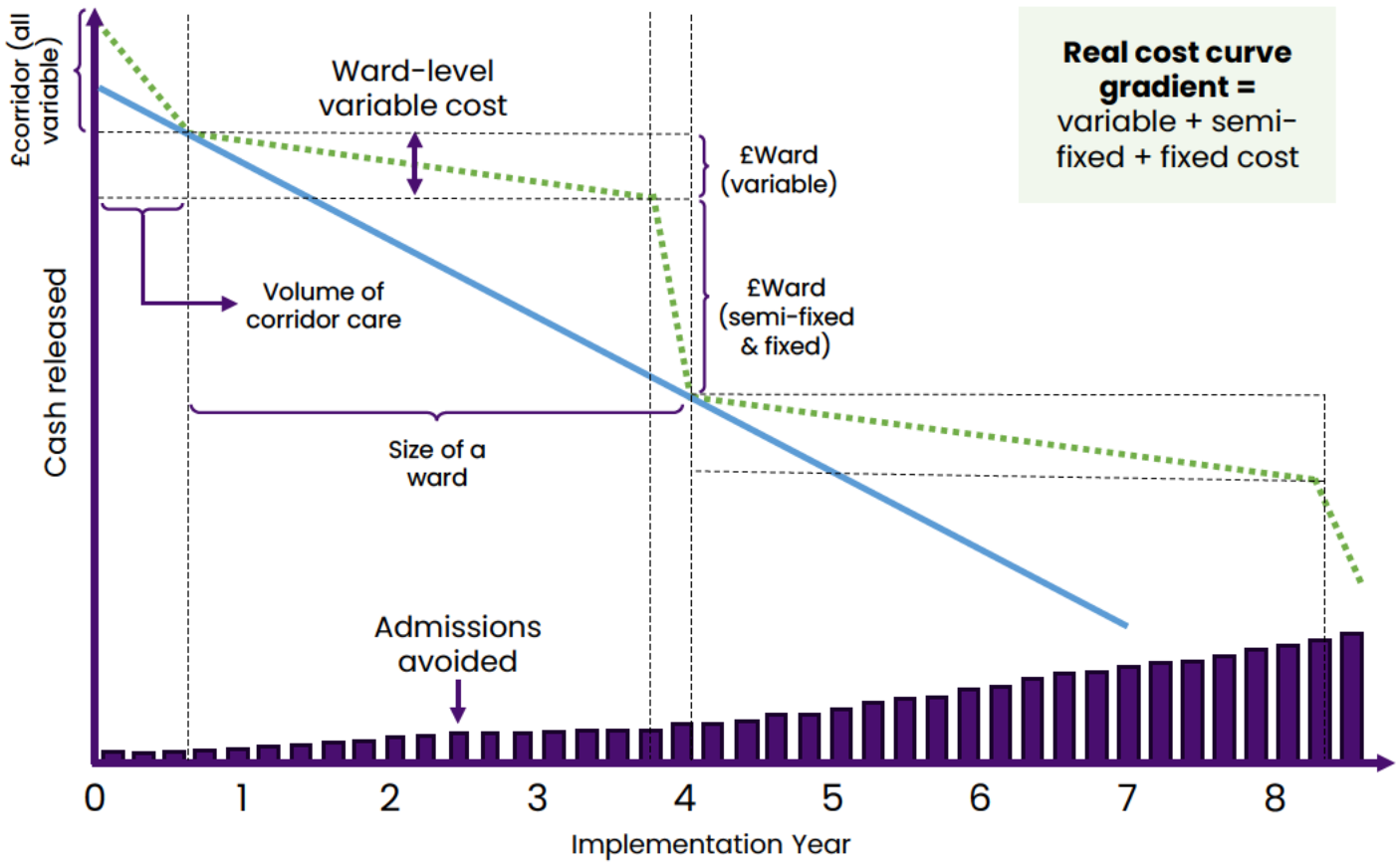
In the previous phase, simplifying assumptions were used to translate shifts in activity into estimates of financial impact on the relevant organisations. This phase will seek to work with providers to **model the real impact of future shifts in activity on costs** based on analysis of real provider fixed, semi-fixed, and variable costs.

Previous phase approach		New proposed approach
Hospital (ED, outpatient, and non-elective admission) costs estimated using **tariff** costs based on HRG codes	→	Hospital costs estimated using detailed **PLICS** costings and assumptions on fixed/variable status of each cost
GP costs estimated using a **flat assumption** on the cost a given GP 'contact'	→	Impacts of changing GP activity estimated based on changing **case mix** and example **real practice financials**
Community service contacts costed using an **undifferentiated flat assumption** on community costs	→	Community contacts estimated using detailed **PLICS** costings and assumptions on fixed/variable status of each

This phase of work will also see additional datasets and sectors integrated into the model, including **social care** and **hospices**. The same 'real cost' approach will be used to model the financial implications of shifting activity.

Why is modelling fixed and variable costs key to modelling future financial trajectories?

Using tariff costs to estimate the impact of avoided activity, particularly avoided hospital activity which constitutes a significant portion of the potential benefits of Neighbourhood working, fails to account for the **non-linear relationship between avoided admissions and real cash releasing savings**.



Real cost curve gradient = variable + semi-fixed + fixed cost

The graph on this slide shows a worked example for a hospital

The blue line in the graph represents the relationship between avoided admissions over time and cash released as defined by the **tariff rate**.

The green line in the graph represents the real relationship between avoided admissions over time and cash released as defined by the **real cost curve**.

To define the shape of the real cost curve for any provider, an understanding of their current cost base, the relationship between fixed and variable costs, and the tipping points they create, is key.

Why does real-cost financial modelling matter for the Benefit Realisation Tool?

A realistic projection of the real-terms cost impact on each provider in our systems, based on activity forecasts modelled using integrated data and assumptions provided by each INT across SEL, will provide a **shared basis for strategic commissioning and integrator conversations** between partners to ensure a sustainable transition to more preventative, proactive, and integrated forms of health & care

Run Model

Activity Over Time

Node	Trend	Baseline Year Activity	Year 2 Activity	Year 3 Activity	Year 4 Ac
A&E		93,447	92,982	94,000	9
Community Contact		204,567	213,036	216,460	21
General Practice		547,909	534,630	551,183	54
Non-Elective Admission		28,927	28,713	27,737	2
Outpatient Appointment		552,835	568,727	552,737	55
Primary Care		264,773	264,190	261,524	26
Social Care Contact		43,736	45,607	45,163	4
VCSE Contact		37,653	38,112	38,530	4



** Dummy data*

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**ICB Governance Review Update**					
Meeting date	16th July 2026	Agenda item Number	**8**	Paper Enclosure Ref	**6**	
Author	**Holly Eden, Director of Delivery – Neighbourhoods and Population Health**					
Executive lead	**Holly Eden, Director of Delivery – Neighbourhoods and Population Health** **Ceri Jacobs, Place Executive Lead for Lewisham (SEL SRO for Neighbourhoods)**					
Paper is for:	Update		Discussion	**X**	Decision	
Purpose of paper	To provide the Board with an update of expected changes to the ICB's Governance resulting from the transition to the Model ICB and the associated operating model.					
Summary of main points	As previously discussed within the Neighbourhood Based Care Board, the ICB has been reviewing its governance aligned to the changes being implemented to move to the Model ICB requirements and associated South East London operating model. This change will impact on the Neighbourhood Based Care Board. This Board was set up as an informal Board in 2023 to support the development of the ICB's Neighbourhood programme. The purpose of the Neighbourhood-based Care Board has been to "define shared outcomes and standards, undertake collective strategic planning that ensures neighbourhood teams are enabled to succeed by taking individual and collective responsibility for the delivery of improved outcomes for people across South East London" Under the new governance arrangements, the ICB Board will establish a Neighbourhood Strategic Delivery Committee as a formal sub-committee. The terms of reference for this Committee are attached at Appendix A for information. Whilst some roles and responsibilities are similar, the Neighbourhood Strategic Delivery Committee will have a significantly greater focus on "assuring delivery of the Neighbourhood Health Service" on behalf of the Board. The Committee will also have new chairing and membership arrangements that reflect its new role and purpose and the national direction to ensure greater local authority involvement in neighbourhood health delivery. This group will meet quarterly. The Neighbourhood Strategic Delivery Committee will not make any decisions on commissioning activities (i.e. the design and award of new contracts). Those decisions will sit with the Strategic Commissioning Committee to ensure we move towards a unified population health commissioning approach. The newly formed Neighbourhood Operational Delivery Group will remain in place to support the Neighbourhood Strategic Delivery Committee, particularly with reference to this delivery assurance role. This group will coordinate delivery plans across place and SEL-workstreams against the Neighbourhood Health Framework and system roadmap, identify where					

	delivery is not moving at sufficient pace, understand delivery barriers and create shared solutions – with escalation into the Neighbourhood Strategic Delivery Committee as required. This group will meet quarterly The Integrator Partnership forum will remain in place as a space in which integrator partnerships comes together to share learning and move forward shared challenges. The aim is that this forum will be increasingly owned by the Integrator Partnerships so that it remains relevant to the experiences of our partnerships as they develop. This group will meet quarterly, subject to Integrator Partnership views.						
Potential conflicts of Interest	None						
Sharing and confidentiality	Appropriate for sharing						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	N/A						
Financial Impact	N/A						
Public Patient Engagement	N/A						
Committee engagement	ICB Board						
Recommendation	To note the expected changes to the ICB Board governance framework and the impacts on the Neighbourhood Based Care Board as currently constituted.						

NHS South East / South West London Integrated Care Board

Neighbourhood Strategic Delivery Committee

Terms of Reference

Document Management

Revision history

Version	Date	Summary of changes
1	April 2026	Initial core parts of ToRs developed by directors of Neighbourhood Delivery in SEL and SWL
2	15 May 2026	Initial draft in ToRs template by SEL governance team for engagement
3	3 June 2026	Updated to incorporate amendments proposed by SWL Director of Corporate and SEL NEM member for governance
4	12 June 2026	Updated to incorporate suggestions from ICB NEMs
5	28 June 2026	CEO review and comments.

Approved by

Version	Date	Committee / Group name

Contents

1. Constitution 4
2. Authority 4
3. Purpose 4
4. Responsibilities of the Committee 5
5. Membership and attendance 6
6. Meeting Frequency, Quoracy and Decisions 8
7. Accountability and reporting 9
8. Conflicts of Interest 9
9. Behaviours and Conduct 9
10. Secretariat and Administration 10
11. Review 10

1. Constitution

1.1 The Neighbourhood Strategic Delivery Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a committee of the Board. in accordance with its Constitution, Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2 These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Authority

2.1 The Neighbourhood Strategic Delivery Committee is authorised by the ICB Board:

- Undertake any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Neighbourhood Strategic Delivery Committee) within its remit as outlined in these ToR;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Neighbourhood Strategic Delivery Committee members. The Neighbourhood Strategic Delivery Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, the Neighbourhood Strategic Delivery Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, except as outlined in these ToR.

2.3 The Neighbourhood Strategic Delivery Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Purpose

3.1 The purpose of the Neighbourhood Strategic Delivery Committee will be to act as the principal forum for agreeing the overall SEL ICB approach to development of the

Neighbourhood Health Service and assuring progress in delivering the Neighbourhood Health Service on behalf of the Board.

3.2 The committee will develop proposals for care models, strategic plans, outcomes and key enablers for integrated neighbourhood health and care.

3.3 The Committee has a role in ensuring alignment of other system plans with the Neighbourhood Delivery Plan and the effective delivery of agreed ICB priorities and outcomes where relevant. Whilst those other plans (e.g. digital, estates and people) may be led by other parts of the system, the Neighbourhood Delivery Committee will work with the relevant accountable bodies across the system with the aim of ensuring that relevant transformation and delivery plans support the delivery of integrated neighbourhood health and care.

3.4 The Committee will be responsible for ensuring the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee. The Neighbourhood Strategic Delivery Committee will not make decisions on any commissioning activities (i.e. the award of new contracts).

3.5 The committee will also operate as a key component of the wider system partnership arrangements, working in close alignment with system groups responsible for system sustainability, workforce, digital and estates. Executive members of the committee will provide the primary link between these forums, ensuring strategic alignment and coordinated delivery across the system.

4. Responsibilities of the Neighbourhood Strategic Delivery Committee

4.1 The committee will undertake the following responsibilities:

4.2 Advise and provide recommendations to the Board on the strategic direction of the integrated neighbourhood health and care, the overall delivery roadmap and milestones and setting of population health outcomes.

4.3 Provide oversight of the development of key neighbourhood strategies and resources including the model of care.

4.4 Approve plans with integrator partnerships for the development of integrated neighbourhood health and care.

4.5 Monitor delivery progress, ensuring plans are adjusted as required to secure delivery of agreed outcome and milestones. This will include driving improvement further and faster where it is feasible to do so.

4.6 Provide assurance to the Board on the delivery of commissioning priorities and actions relating to the development and delivery of neighbourhood care as set by the Strategic Commissioning Committee, managing unwarranted variation in approach.

4.7 Provides assurance to the Board on the ICB's response to NHS England and The Department of Health and Social Care's neighbourhood health requirements.

4.8 Assures the work of ICB executives as part of other groups across London and within South East London to facilitate the development to the tools and infrastructure required to enable integrated neighbourhood health and care.

4.9 Through the committee's executive membership links to system partnership groups in SEL on system sustainability, workforce, digital and estates, and also the London Neighbourhood Board.

5. Membership and attendance

Membership (to be finalised by agreement in SEL and SWL)

5.1 The Neighbourhood Strategic Delivery Committee membership is as follows:

- Non-Executive Director – Co-Chair
- Local Authority representative (executive member representing the local authority sector in SEL) – Co-Chair
- ICB Partner Member (Primary Care)
- Place representatives (including representatives from ICB place leadership and provider integrators) - To be agreed in SEL and SWL ICBs.
- SEL Director of Delivery for Neighbourhoods and Population Health for SEL and TBC for SWL ICB
- Director of Strategic Commissioning
- Director of Public Health
- SEL VCSE Alliance Representative
- ICB Medical Director

5.2 The role of Chair will be undertaken by the ICB Non-Executive Director and the Local Authority Member, who will act as co-Chair.

5.3 Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.

5.4 Members may nominate deputies to represent them in their absence and make decisions on their behalf, subject to the approval of the Chair.

5.5 Members will possess between them knowledge, skills and experience in the issues pertinent to the Neighbourhood Strategic Delivery Committee's business. When determining the membership of the Neighbourhood Strategic Delivery Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.6 The Neighbourhood Strategic Delivery Committee will be chaired by a member appointed on account of their specific knowledge skills and experience making them suitable to chair the Neighbourhood Strategic Delivery Committee.

5.7 Neighbourhood Strategic Delivery Committee members may appoint a Vice Chair who will be nominated by the Chair of the Neighbourhood Strategic Delivery Committee. If the Committee Chair is absent or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside. If the Chair or Vice Chair are absent from any meeting, a Chair shall be nominated by other members attending that meeting.

5.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.9 The Neighbourhood Strategic Delivery Committee shall have the following non-voting attendees (as and when required):

- Other Directors and/or Managers as appropriate;

5.10 Attendees may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.11 Attendees may nominate deputies to represent them in their absence, with agreement of the Chair.

5.12 The Neighbourhood Strategic Delivery Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

5.13 The Neighbourhood Strategic Delivery Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.14 The Chair of the ICB will be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5.15 The Neighbourhood Strategic Delivery Committee Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate discussion of particular matters.

6. Meeting Frequency, Quoracy and Decisions

6.1 The Neighbourhood Strategic Delivery Committee will usually meet once f each quarter. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2 The Board, Chair or Chief Executive may ask the Neighbourhood Strategic Delivery Committee to convene further meetings to discuss particular issues on which they want the committee's advice.

6.3 Meetings will be held in-person, unless previously agreed by the Chair. The Neighbourhood Strategic Delivery Committee may choose to meet online, via MS Teams or suitable alternative platform.

Quorum

6.4 For a meeting to be quorate the following members will be required:

- One of Non-Executive Director – Co-Chair or local authority representative – Co-Chair (proposed)
- Place representatives (including representatives from ICB place leadership and provider integrators) - To be agreed in SEL and SWL ICBs.
- SEL Director of Delivery for Neighbourhoods and Population Health for SEL and SWL ICB

6.5 If any member of the Neighbourhood Strategic Delivery Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

6.7 Decisions will be taken in accordance with the Standing Orders. The Neighbourhood Strategic Delivery Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.8 Only members of the Neighbourhood Strategic Delivery Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.9 Where there is a split vote, with no clear majority, the Chair of the Neighbourhood Strategic Delivery Committee will hold the casting vote.

6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through email or other electronic communication.

6.11 Any decisions taken virtually must be recorded at the next scheduled meeting.

7. Accountability and reporting

7.1 The Neighbourhood Strategic Delivery Committee is accountable to the ICB Board and shall provide reports to the ICB Board on how it discharges its responsibilities and shall draw to the attention to any issues that require disclosure or require action.

7.2 The Neighbourhood Strategic Delivery Committee shall make any such recommendations to the Board as it deems appropriate on any area within its remit where action or improvement is needed.

7.3 The minutes of the meetings shall be formally recorded by the secretary and approved at the next scheduled meeting.

7.4 The Neighbourhood Strategic Delivery Committee will report to the ICB Board at least annually to describe how it has fulfilled its ToR, give details of any significant issues that it has considered, and how they were addressed.

7.5 The committee will, as required and through its executive members, act to ensure there is alignment between its work and that of system partnership Boards for sustainability, workforce, estates and digital.

8. Conflicts of Interest

8.1 Conflicts of Interest shall be dealt with in accordance with the ICB Conflicts of Interest Policy.

8.2 The Neighbourhood Strategic Delivery Committee will have a Conflicts of Interest Register that will be presented as a standing item on the agenda.

8.3 All members and attendees of the Neighbourhood Strategic Delivery Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

9. Behaviours and Conduct

ICB values

9.1 Members will be expected to conduct business in line with the ICB values and objectives.

9.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

9.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Secretariat and Administration

10.1 The Neighbourhood Strategic Delivery Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken, agreed with the Chair, and a record of matters arising. Action points and issues, with progress updates, will be carried forward between meetings;
- The Chair is supported to prepare and deliver reports to the ICB Board and;
- The Neighbourhood Strategic Delivery Committee is updated on pertinent issues / areas of interest / policy developments.

11. Review

11.1 The Neighbourhood Strategic Delivery Committee will review its effectiveness at least annually and recommend any changes it considers necessary to the ICB Board.

11.2 These ToR will be reviewed at least annually and more frequently if required. Any proposed amendments to the ToR will be submitted to the ICB Board for approval.

Date of approval: TBC [to be updated]

Date of next review: TBC [to be updated]