South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1300-1500 Wednesday 22 April 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	1300
2	**Declarations of interests relevant to the business on the agenda**	All	1302
3	**Minutes of the meeting held on 19 March 2026 (Enc 1)**	Chair	1305
4	**Actions and matters arising (Enc 2)**	Chair	1310
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**Managing Risks to Neighbourhood Delivery (Enc 3)**	H Eden	1315
6	**Mental Health and Neighbourhood Based Care (Enc 4 and presentation on the day)**	R Dev/ K Lillywhite/ L Bartlett	1325
7	**Workforce Workstream Deep Dive (Enc 5)**	L Demeda/ C Harris	1415
8	**Any other business.**	Chair	1455
9	**Date of next meeting 1400-1600 Thursday 16 July 2026**	Chair	1500

South East London Integrated Care System

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Enclosure 1

Neighbourhood Based Care Board
Draft Minutes of the meeting held on Thursday 19 March 2026 MS Teams

Present:

Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	**CJ**
George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	**GV**
Diana Braithwaite	Bexley LCP representative	**DB**
Sarah Burchill	Mental Health Provider representative	**SB**
Vanessa Burgess	Medicines Management representative	**VB**
Oge Chesa	Lambeth LCP representative	**OC**
Mark Cheung	Bromley LCP representative	**MC**
Gaby Darby	Greenwich LCP representative	**GD**
Holly Eden	Director of Delivery – Neighbourhoods and Population Health	**HE**
Kallie Heyburn	Bexley LCP representative	**KH**
Neil Goulbourne	Acute Services Representative	**NG**
Rebecca Jarvis	Southwark LCP representative	**RJ**
Laura Jenner	Lewisham LCP representative	**LJ**
Nancy Kuchemann	Deputy ICB Medical Director	**NK**
Neil Kennett-Brown	ICB System Sustainability Team Representative (non-voting)	**NKB**
Raj Matharu	Community Pharmacy representative	**RM**
Kelly Scanlon	Communications representative (non-voting)	**KS**
Elliott Ward	Bromley LCP representative	**EW**

In attendance:

Tim Borrie	Strategic and Operations Estates Director	**TB**
Amy Bray	PPL	**AB**
Chloe Harris	Head of People and Culture SEL ICS	**CH**
Colin Nash	Governance Manager (Minutes)	**CN**
Vish Valivety	PPL (agenda item 6)	**VV**

Apologies for absence:

Andrew Bland	ICB CEO (non-voting)	**AB**
Lynn Demeda	Workforce Representative	**LD**
Toby Garrood	ICB Medical Director	**TG**
Denise Radley	Adult Social Services representative	**DR**
Tal Rosenzweig	Voluntary Sector Representative	**TR**
Imogen Setter	PPL	**IS**
Nisha Wheeler	Digital representative	**NW**

No	Item	Action
012/2026	**INTRODUCTIONS AND APOLOGIES**	
	CJ welcomed members to the meeting. Apologies were noted as above.	
013/2026	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
014/2026	**MINUTES OF THE MEETING HELD ON 15 JANUARY 2025**	
	The minutes were **APPROVED SUBJECT TO** the correction of the initials OG to OC in 004/2026.	**CN**
015/2026	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log for this meeting: - 30/25 – HE reported she had discussed the shared risk log with Kieran Swann and would report further at the next meeting. Action brought forward. 31/25 – CJ reported that, to maintain momentum, it had been decided to invite integrator members to future NBCB meetings rather than wait for the new governance structure to be confirmed. Action closed 37/25 – HE reported that she had discussed with MH how could contribute to neighbourhood-based care planning. Action closed. 40/25 – HE reported that the paper on clinical governance had been put back to the April meeting. 1/26 – HE reported that the Lewisham model for cohort selection had been shared though the Population Health Group and was included in the Digital Workstream paper on this agenda. Action closed. 2/26 – HE agreed to report back on cohort selection to the July meeting. 3/26 – HE reported that she would be discussing mental health outcome measures with TG and Alison Roberts outside the meeting. Action closed.	**HE** **LD** **HE**
	IMPLEMENTING NEIGHBOURHOOD CARE	
016/2026	**STRATEGIC FORWARD LOOK** **a. National guidance/expectations** **b. London programme and deliverables** **c. SEL Strategic Investment Fund and Requirements and the medium-term roadmap** d. **How this plays into ICB governance and system working at place**	
	HE referred to the paper which had been prepared before the two neighbourhood policy documents published by the government on 17.3.26 and shared with members by email (Wed 18/03/2026 08:26). The following points were highlighted. As part of the development of the Five-Year Strategic Commissioning Plan, place partnerships articulated their high-level neighbourhood development plans across 7 areas. These areas were:	

	National guidance/expectations Develop **neighbourhood footprints** around natural communities • Ensure good access to **high quality general practice** • Continue to **improve the primary-secondary care interface** and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap' • Establish **Integrated Neighbourhood Teams** (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life). • Agree a **multi-neighbourhood urgent care plan** which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs • **Improving planned care** in the community (linked to work to redesign outpatient care) • **Improving care for children and young people** as part of neighbourhood working These remain consistent with the recently released policy documents referred to above. The expectation that acute elective care would be reduced by 10% had been dropped. The focus for INTs on the top 1.5% of the ICB's population in terms of non-elective hospital activity was not so well articulated in the new documents, but was still being pursued. ***GP contract 26/27*** Information about the GP contract was set out on page 12 and 13 of the pack. The BMA GP Committee had formally voted to reject the contract changes, and a referendum of GPS and GP registrars was taking place during March. ***Better Care Fund*** Page 14 of the pack briefed the Board on Better Care Fund developments. The 2026–27 Better Care Fund (BCF) framework represented the first formal step in aligning BCF with the neighbourhood health service, as set out in the 10 Year Health Plan for England. While full integration was not expected this year, systems were explicitly asked to link BCF plans to priority areas of neighbourhood health, particularly for people with complex health and social care needs. During this transition year focus would be on: - • Strengthening integration without destabilising core services • Maintaining and increasing investment in adult social care • Laying the foundations for deeper neighbourhood-based reform from 2027–28 onwards ***Other Local Authority Guidance*** Other guidance with relevance to the development of neighbourhood-based care included the Local Outcomes Framework, the bringing together of Best Start Family Hubs and Healthy Babies	

	and SEND Reform consultation. This was set out of pages14 and 15 of the pack. ***London programme and deliverables*** The London Neighbourhood Health Delivery Board continues to meet monthly. The key task and finish groups, and their scopes were set out on pages 15 and 16 of the pack. There were clear areas of alignment between London-wide sub-groups, SEL-wide enabling workstreams and then place-led delivery. Sub-groups were building on work that is already underway within ICBs, as well as considering where the scale of London could be useful in driving progress further and faster, or in removing barriers to change. ***SEL Neighbourhoods Medium Term Roadmap*** Work had been undertaken to develop a draft SEL Neighbourhoods Medium Term Roadmap. See page 18 – 65 of the pack. The roadmap aimed to articulate the critical path for neighbourhood development over a 5-year horizon, including clarifying ICB, place and provider milestones. It was intended to act as a strategic planning tool that aligns neighbourhood delivery with ICB (and eventually local authority) planning cycles, regional workstreams and national guidance. It was intended to be maintained as a live, working document that is updated as national policy develops and priorities shift. The roadmap will sit alongside: • the Maturity Matrix which outlines the functional and relational domains that place partnerships and host integrators are expected to develop over the medium term to enable neighbourhood health; and • an implementation framework that will including the trackers, dashboards, engagement cycles and learning mechanisms that will be used to manage risk, updated milestones and keep neighbourhood implementation coordinated. This was further described on page 17 of the pack. ***26/27 Neighbourhood delivery requirements aligned to investment*** The 2026/27 Neighbourhood delivery requirements aligned to available investment via the Strategic Investment Fund (SIF) was set out on pages 66 -89 of the pack. The requirements will be shared with Integrator host organisations on 20th March 2026 who will then co-produce investment and delivery plans with acute, community, mental health, primary care and VCSFE parters and local place governance by 22nd May 2026, for approval through appropriate ICB governance. HE noted that other sources of funding for integrators were potentially available, for example £1.5m for pushing the boundaries of neighbourhood health care and £4m this year for enhanced GP wrap around services. In reply to questions from members HE: - 1. Confirmed that SIF funding was available to each place integrator. Integrators would need to show cohesive investment and delivery plans showing how the funding would be used to deliver the minimum	

	requirements for a prevention focused pathway of care. These were set out on page 82 of the pack. A one-page proforma for integrators to demonstrate this was being developed. The process aimed to ensure consistency whilst enabling local flexibility. CJ noted that investment plans would need to be signed by all integrator partners. 2. Mental health neighbourhood funding would also require a co-produced investment plan agreed by all local stakeholders. 3. With regard to ensuring a "left shift" in NHS resources, HE replied that the ICB had maintained a rigorous approach to acute care investment to free resources for neighbourhood care in the SIF. Next year this would amount to £45m. HE concluded by welcoming comments from members on the Roadmap and noting that the development of neighbourhood care would be modular over time. NBCB **ENDORSED** the 26/27 delivery requirements for neighbourhood health aligned to the Strategic Investment Fund, as set out in the paper.	
017/2026	**DIGITAL WORKSTREAM UPDATE** **a. Digital Roadmap and EPR/Digital Solutions for INTs** **b. Specific around clinical system integration (INT, EPR and PHM)**	
	VV took the Board though the paper (pages 90-157 of the pack). This 1. set out the approach to optimise digital solutions already within the SEL estate alongside outlining key transformational digital programmes that will promote the advancement of SEL neighbourhoods to a higher degree of maturity than that of the present day. These optimisation and transformation workstreams had been brought together in a single digital roadmap for integrated neighbourhood teams. 2. set out the context, challenges and digital principles for operationalising neighbourhood health teams, and a small number of credible options for digitally enabling neighbourhood health in SEL. 3. provided an update on the population health management workstream, including the proposed approach to SEL's data architecture and proposed approach to networked analytics capacity The recommendations for taking the Digital Workstream forward were described on page 102 and the asks from the NBCB on page 103. In response to questions from members: - i. NKB replied that governance arrangements for the digital enabler were described on page 122 of the pack. CJ, GV and HE would be discussing this further. ii. VV noted that there were challenges to enabling VCSE partners to access health records and ensuring risk and IG compliance, that needed to be overcome. iii. CJ confirmed that integrators would have a digital convening role with partners.	

	The NBCB: - • **ENDORSED the digital roadmap for INT**s supporting these as key digital priorities for the system to take forward and in so doing enabling INTs to mature in their digital footprint • **ENDORSED the case for change** set out in this paper, recognising that the current digital and EPR landscape in SEL is not sufficient to fully support integrated neighbourhood working at scale. • **AGREED the proposed digital vision and guiding principles** for digitally enabling neighbourhood health in SEL, to act as system-wide guardrails for future decisions. • **ENDORSED a phased, system-led approach** to digitally enabling neighbourhood health, using the options set out in the paper to prioritise near-term improvements that support INT delivery and reduce friction for staff and residents; and set a long-term direction that avoids further fragmentation and aligns with national policy and planning expectations. • **ENDORSED the next phase of work**, including more detailed appraisal of the preferred option(s), implementation sequencing, affordability, risks and dependencies, to be brought back to NBCB and the Digital Committee as appropriate. The NBCB noted that endorsement did not commit the system to immediate procurement or a single technical solution, but provided clarity of direction, pace and coherence as neighbourhood health moves into full operational delivery.	
018/2026	**PROPOSED SEL OUTCOME METRICS FOR 26/27**	
	HE took the Board though the paper proposing metrics for monitoring Long Term Conditions and Frailty activity across SEL during the 2026-27 transition and implementation period. She noted that, for this financial year, they only included metrics that were currently being measured at least quarterly. Other suggestions were welcome for possible incorporation in future iterations. NHIP measures were included as the ICB expected to be asked to report on these. HE was currently working with the BI Insights Team to develop a single dashboard that could be analysed by cohort and GP registered list. It was planned that the NBCB would consider a subset of the metrics quarterly. In the discussion the followed points were noted: - • HE agreed to include the percentage of patients aged over 75 who were on 10 or more unique medicines, as a metric.	
	• HE would discuss refining the BMI measure with VB outside the meeting.	**HE/VB**
	• It was **AGREED** that, in this first year, it was important to understand the impact neighbourhood-based care initiatives were having and identify variations, rather than establish targets to be achieved. • HE would check the outcome measure data before it was reported to the NBCB. • With regard to measuring fragmentation of services, NKB suggested a future metric might look at the number of those over 70 with many separate outpatient appointments on different days and at different locations.	

	• Although challenging, GV noted the importance of developing quality of care metrics in future years. • HE noted that it was open to Places to measure other things if they wished to do so. NBCB **AGREED** the proposed priority metrics for Long Term Conditions and Frailty, for onward incorporation into a performance dashboard. Once developed, this dashboard would be received by the SEL ICB on a quarterly basis for information and to inform assurance.	
019/2026	**ANY OTHER BUSINESS**	
	i. HE reported the possibility of a research opportunity around neighbourhoods arising. She would circulate details if it was confirmed. ii. HE asked members to let her know of any suggestions for the broader evaluation of neighbourhood health.	**ALL**
020/2026	**DATE OF NEXT MEETING**	
	1230-1430, Wednesday 22 April 2026.	

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Enclosure 2

Neighbourhood Based Care Board
Draft Action log from the meeting held on 15.01.26

Item Ref	Minute number	Item title	Action description	Owner responsible	Due Date	Comments	
ACTIONS BROUGHT FORWARD							
30/25	015/2026	Quarterly Highlight Reports	Work on a shared risk log between place and SEL	**H Eden**	For 22.4.26 meeting.	On the agenda	
40/25	015/2026	Workforce Deep Dive	Bring a further paper on clinical governance to the March meeting.	**L Demeda**	For 22.4.26 meeting	On the agenda	
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.		
ACTIONS FROM THE 19 MARCH 2026 MEETING							
4/26	018/2026	Proposed Outcome Metrics for 26/27	Discuss refinement of the BMI metric.	**H Eden/V Burgess**	No date set.		
5/26	019/2026	Any other business	Inform HE of any suggestions for the broader evaluation of neighbourhood health	**ALL**	No date set.		

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Neighbourhood Based Care Board

Title	**Strategic Neighbourhoods Forward Look – Managing Risks to Neighbourhood Delivery**						
Meeting date	22nd April 2026		Agenda item Number	**5**	Paper Enclosure Ref		**3**
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 work underway to review risks to neighbourhood delivery and ensure that these are being effectively managed across the programme.						
Summary of main points	There are a range of risks that need to be effectively managed to support the delivery of Neighbourhood Health. As the ICB Board reviews its governance, there is a need to review risk related to Neighbourhood Health and ensure this is effectively aligned against the developing governance arrangements. A desktop review of risks currently set out in place, programme and SEL-level risk registers has been undertaken to identify shared risks that may be appropriate to be managed through developing neighbourhood delivery governance at a System level. It is 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 new ICB governance and managed through appropriate Committees.						
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	N/A
Recommendation	To discuss the risks and approach: - Set out any additional risks that the Board would like to explore. - Agree that the next steps can be delegated to the Primary Care Plus group to take forward, collaborating with the Director of Delivery – Neighbourhoods and Population Health.

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Managing risks to Neighbourhood Delivery

Background and Context

1. The implementation of integrated Neighbourhood Health and Care is complex, operating at multiple geographical levels and requiring coordinated delivery through providers, place teams, SEL teams and enabling programmes which may be led by providers across the system.

2. Implementation is also impacted by national policy, ongoing disputes between contractors and the NHS, and entrenched sustainability and resilience challenges impacting frontline services.

3. The Director of Delivery for Neighbourhoods and Population Health were asked by the ICB to undertake a review of the risks related to Neighbourhood delivery and to ensure that risks are appropriately managed within the ICB's revised governance arrangements that are due to take affect in Q2 of 2026/27.

Review

4. A desktop review has been undertaken of all risks held within place, programme and SEL risk registers which may impact on Neighbourhood delivery. This includes risks that are already being managed by a different part of SEL via established risk management processes, as well as risks flagged through reporting into the Neighbourhood-based Care Board by place and programme teams.

5. This review has been undertaken in partnership with risk leads within the ICB's corporate team.

6. Risk discussions that have been undertaken within the Primary Care Plus group have also been recognised within this desktop review.

Key risks identified

7. Through the desktop review, we have identified the following core risks to neighbourhood implementation that may require more coordination and management through system-wide governance to maintain effective controls.

    - Risk that there is a **lack of sufficient modern and quality out of hospital estate** capacity to support the delivery of neighbourhood care
    - Risk that there is a **lack of appropriate population health management tools** are not available to support direct care, reducing the expected impact of neighbourhood care
    - Risk that the **lack of digital interoperability between the electronic patient record systems** and unclear data flow pathways and controls reduce the benefits

of neighbourhood care or contribute to incidents that lead to poorer clinical outcomes

- Risk that **shared/joint clinical and operational governance arrangements are unclear or ineffective** impacting on collective decision-making, management of patient care or contribute to incidents that lead to poorer clinical outcomes
- Risk that some **general practice contractors disengage from delivery of neighbourhood care**, due to disputes related to the national contract
- Risk that **general practice contractors are not able to uniformly deliver improvements in proactive care** to identify the patients requiring neighbourhood care, due to variable workforce, variable investment and competing national contract expectations.
- Risk that **the organisational and cultural change required to underpin neighbourhood care is not achieved or is achieved at a slower timescale**, impacting on pace of change and outcomes associated with neighbourhood care
- Risk that **ICB and provider capacity constraints delay the implementation of neighbourhood care**, reducing the outcomes expected with a knock-on impact on system sustainability and provider financial positions
- Risk that **neighbourhood care shifts activity without shifting resources**, exacerbating capacity challenges in primary care, community services, VCSFE and social care providers with quality, performance, and financial impact as well as an increased risk of overall provider failure
- Risk that **limited clarity in roles, responsibilities, and operating models for INTs, leads to inconsistency in implementation**, **or conversely that the specified requirements for the operation of INTs are too significant, reducing ability to flex models appropriately** for local need or innovate.

8. The Neighbourhood Based Care Board are asked to:
   - Consider whether these are the key risks that could impact on the delivery of integrated neighbourhood health and care
   - Highlight any other risks that the Board would like to be further reviewed.

Next Steps

9. Following on from this discussion at the Neighbourhood-Based Care, it is proposed that the Director of Delivery for Neighbourhoods and Population Health works with the Primary Care Plus group to review each risk and agree:
   - Current risk rating
   - Target risk rating
   - Controls currently in place
   - Gaps in controls
   - Recommendations for how gaps in controls can be filled.

10. The Director of Delivery will then review the product with ICB corporate leads before taking this through revised ICB governance once this is in place.

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Neighbourhood Based Care Board

Title	**Mental Health and Neighbourhood Based Care**					
Meeting date	22 April 2026	Agenda item Number	6	Paper Enclosure Ref	4	
Author	Rupi Dev, Acting Joint Director of Planning/Director for Mental Health, CYP and Health Inequalities					
Executive lead	Rupi Dev, Acting Joint Director of Planning					
Paper is for:	Update		Discussion	X	Decision	X
Purpose of paper	This paper sets 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 seeks approval of the proposed areas of focus to then enable and support mental health trusts to work up proposals for use of the Strategic Investment Fund which has specifically been allocated for mental health and neighbourhoods.					
Summary of main points	The paper suggests that mental health and neighbourhoods is considered from the following three lens: 1. Development of the existing INT approach to include a mind and body focus. Specifically this should be considered in terms of expanding the existing INTs in adults to include a mind and body approach and to then also 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 suggests this is considered twofold: (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. Secondary care mental health services which are provided in the community and should therefore form part of the wider wrap around community offer, as part of neighbourhood-based care. The paper recommends 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 then a template will be issued to the mental health trusts to develop their SIF proposals by early June as per the agreed ICB timetable.					
Potential conflicts of Interest	Not applicable					
Sharing and confidentiality	Not applicable					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	An inequalities impact assessment has not been specifically carried out for this paper. However, it is well known that people with SMI have a 10-15 year life expectancy gap compared to the general population. It is therefore important to ensure we have parity for mental health across our sector and that we take specific actions to reduce the mortality gap for people with SMI as part of the our neighbourhood development agenda.					
Financial Impact	None to note – the SIF allocation has already been made as part of the 2026/27 operating plan.					
Public Patient Engagement	No specific public/patient engagement has been undertaken to date for this paper, however, there will need to be alignment to broader approach for engagement for neighbourhood development as required.					
Committee engagement	Not applicable – Neighbourhood Based Care Board is the first time this paper has been tested and engaged with a Committee.					
Recommendation	The Committee are asked to: • Support and endorse the key priority areas for mental health and neighbourhoods as set out in this paper. • Support and endorse the key priority areas for investment in 2026/27 via the SIF as set out in this paper.					

Mental Health and Neighbourhood-Based Care

Wednesday 22nd April 2026

1. Background and Purpose

1.1. To date, the primary focus within the Neighbourhood-Based Care Programme has been on the mobilisation of Integrated Neighbourhood Teams (INTs) for the three priority cohorts – frailty, multi-morbidity and children and young people (CYP).

1.2. Apart from CYP which is still largely in its infancy, the models have largely excluded mental health. Severe and enduring illness (SMI) has been identified by the ICB as a priority cohort for INTs as part of the second wave of the work in 2026/27, however, moving forward it is important that mental health is integral to INT development and to the development of the wider neighbourhood-based care programme ensuring a holistic mind and body approach to the development and delivery of services.

1.3. This paper sets out a broad approach to how mental health should be considered as part of the neighbourhood-based care development programme, and considers this from the lens of:

- Development of the existing INT approach to include a mind and body focus.
- The role of neighbourhood based care in improving health outcomes for people with SMI in the community and reducing the mortality gap for people with SMI.
- Secondary care mental health services which are provided in the community and should therefore form part of the wider wrap-around community offer, as part of neighbourhood based care.

1.4. To note, the paper focuses primarily on adult services. This is because the CYP INT framework already includes mental health as a core component of the framework, and as the work programme for CYP neighbourhood-based care progresses, it is anticipated that community child and adolescent mental health services (CAMHS) would be picked up as part of this, though noting that this is still in its infancy and further discussions will be required to ensure this alignment over the course of 2026/27.

1.5. It is also recognised that there are multiple discussions regarding mental health and neighbourhoods including regionally, within the South London Mental Health Provider Collaborative and then locally. It is hoped that this paper will set out priorities and a forward vision for the south east London local system which can then inform other discussions.

1.6. Funding has been identified through the ICB's strategic investment fund (SIF) for mental health neighbourhood development (adults specific). This funding needs to ensure it supports wider capacity and capability building across wider partnerships and primary and community services.

1.7. If supported today, the key components from this paper will then be sent out formally to the mental health trusts who are holding this funding for their local boroughs to then develop and agree proposals with the relevant partners, supported and endorsed by the integrator partnership (which includes sign-off from the lead representative or CEO of the key health partners within the integrator

(acute, community, mental health, primary care, VCSFE) plus the Place Executive Lead. In line with the timeline set out for SIF investment, mental health trusts will need to return their final proposals to the ICB's Planning Directorate by Friday 5th June 2026.

2. Proposed Prioritisation and Approach

2.1. In developing our proposed priorities and overall approach for mental health care in neighbourhoods it is recommended that this is considered in three key areas: (i) developing our existing INTs to include a mind and body approach and to include care for people with SMI; (ii) focusing on health outcomes for people with SMI and in particular, addressing the mortality gap; and (iii) enhancing and re-designing existing secondary care mental health services to align to neighbourhoods and be part of the wider offer available within communities.

A. Developing existing INTs

2.2. Across the system we have put significant focus into establishing INTs for our first two priority cohorts – frailty and multi-morbidity. A key priority for 2026/27 therefore must be to expand these existing INTs to embed a mind and body approach and the following needs to be considered for inclusion into existing frameworks and approaches:

- Securing psychological therapies input into both INTs, including support for depression and anxiety for people with long term conditions. This could support could be via Talking Therapies but also could be secured through working with the voluntary and community sector.
- Integration of memory services/dementia care as part of the frailty INT. These services are primarily provided by the two mental health trusts in south east London with some dementia care provided by acute and community providers.

2.3. There is also an opportunity to expand the focus on the multi-morbidity model. As demonstrated in national data, people with SMI are more likely to also have multiple long term physical health conditions including obesity (three times more likely), diabetes (3.7 times more likely) and hypertension (3.2 times more likely). SMI should therefore be considered as part of the multi-morbidity framework. The SMI cohort overall is however large and diverse and therefore you would need to consider further segmentation or prioritisation of the SMI population.

2.4. Over the course of 2025/26 the ICB's Planning Directorate, and with leadership support from a dedicated Clinical and Care Professional Lead for Mental Health Medicines Optimisation and the ICB's Medical Directorate, have been convening a working group to consider how care for people on anti-psychotic long-acting injections (LAIs) could be best shared across secondary and primary care. This is a defined cohort of patients with a strong evidence base which demonstrates that these medicines reduce relapse, and prevent hospital admissions, and so the number of patients on these medicines is likely to increase in coming years. Significant work has taken place through a dedicated multi-disciplinary working group on the workforce and skillset requirement to enable these patients currently on secondary care caseloads to access their care in an alternative local community setting such as primary care.

2.5. Given the work that has been done to date on a proposed operating model and care pathway for this patient cohort (including types of workforce roles/skill mix required and roles and responsibilities

across the primary care and secondary care interface), it is recommended that the LAI cohort be considered in the first instance for integration into the multi-morbidity model with the opportunity to provide a holistic healthcare offer broader than just the medication itself including physical health checks and support in accessing wider prevention services such as cancer screening. Wider roll-out for other patients with SMI would then be considered in subsequent years building on the learning from the LAI cohort.

2.6. In doing so, patient selection would be key, and the following would all need to be true for a service user/resident to be considered as part of the multi morbidity model:

- Service user/resident has a diagnosis of SMI and is on a LAI, currently on a secondary care caseload.
- Service user/resident is agreed to be stable (as per an agreed definition set by the working group referenced above).
- The patient has at least one or more physical health long term condition

2.7. Data challenges will mean identifying this cohort will require test and learn approach, supported by population health management (PHM). The data will primarily be held by community mental health teams in secondary care, but there are known challenges with how this data is held in community mental health teams across both mental health trusts which will require exploration and refinement as part of this work.

2.8. It will also be important to ensure that in developing this model, partnerships consider how clinical risk will be effectively shared and managed across the INT, recognising that this isn't about shifting activity from one sector or partner or another. Partnerships may also want to consider wider SIF funding in the development of these teams both in 2026/27 and in future years.

2.9. During H1 in 2026/27 there would need to be local identification of the patient cohort, aligned to the existing multi-morbidity INTs, and then expansion of roles to support this cohort developed towards the latter part of the year for roll-out. As mentioned in section 2.5 work has already been undertaken to begin to map out operational delivery for this cohort of patients and further information on this can be found in Appendix 1.

B. Improving Overall Health Outcomes for People with SMI

2.10. The mortality gap for people with SMI is well documented in the national literature and the population health needs assessment undertaken to support the development of the ICB's five year commissioning plan again highlighted the 10-15 year difference in life expectancy for people with SMI, which continues to be worse than the national average and London average in south east London. Furthermore, local emerging data from Lambeth demonstrates that where an NHS health check has been completed (of any kind), there is an impact on overall outcomes for an individual and this is impact is greater for people who are living within the most deprived populations further highlighting the importance of health checks.

2.11. Over recent years there has been a focus on increasing the provision and take-up of annual physical health checks for people with SMI as an enabler to identifying physical health needs and providing intervention. These checks are primarily carried out in primary care (circa. 80%). However, across south east London uptake of the health check for people with SMI remains variable across

the six boroughs. It is also recognised that for some people, the health check is perhaps too late to be able to support and modify certain lifestyle factors and therefore it is recommended that a two-pronged approach is taken to addressing the mortality gap for people with SMI which considers optimising health outcomes and then taking a more preventative approach for people with SMI.

2.12. The first approach needs to continue to focus on improving access to health checks and interventions for people with a diagnosis of SMI and on the SMI register within primary care. These health checks form a core part of the system core prevention framework and integrators have all received funding through the SIF to support a phased roll out of this offer, targeted to Core20 populations in 2026/27. It will be important to ensure that health checks for people with SMI are considered as part of the workup of these proposals.

2.13. The second approach needs to take a broader prevention approach. As articulated above, a health check later in someone's SMI journey will help optimise their existing health conditions but not necessarily reverse long-term conditions or address underlying healthy behaviours. It is therefore recommended that over the course of 2026/27, we pilot a new initiative scheme that provides peer support and stronger healthy lifestyle advice at either suspicion or diagnosis of SMI, ideally within an Early Intervention Service (EIP) which is part of the secondary care mental health services offer. The service would form part of an integrated care pathway and team, and could involve a wider range of professionals as well as the voluntary and community sector. Data collection could also be built into this model upfront to support future commissioning decisions.

2.14. Through the EIP service, there is an opportunity to emphasise early physical health assessment (including BMI, blood pressure, smoking status, metabolic markers, substance use, medication review, lifestyle factors, oral health, cancer screening and immunisation status) and support people in making informed decisions on their choice of medication which may have an impact on their physical health. The offer could also include identifying interventions to target modifiable risks which would run alongside the initiation of antipsychotic medication to mitigate rapid weight gain and metabolic disturbances.

2.15. It is recommended that this pilot run in addition to the phased roll out of the core prevention offer and funding has been identified separately via Planning and Commissioning budgets for this offer. The aim would be to have a pilot in each mental health trust, likely one borough in each geographical patch in the first instance. The pilot is supported by both mental health trusts. Should the pilot be successful in year 1, then there would be an opportunity to consider spread and scale via the SIF in 2027/28 and beyond.

C. Wider mental health services offer from secondary care within neighbourhoods

2.16. It is recognised that secondary care mental health services provide a range of mental health services that are community-based. This primarily includes community mental health services for adults and older adults, but also includes Talking Therapies, dementia care/memory services, eating disorder services and perinatal mental health services. It will therefore be important over the course of the next 2-3 years for these services to continue to expand and align to local neighbourhood footprints as part of the wider development of neighbourhood care.

2.17. There is already significant work underway across both mental health trusts to align their offers to neighbourhoods and ensure they are effectively addressing demand and capacity challenges. This has been supported by dedicated service development funding for community mental health services in previous years and through the mental health investment standard.

2.18. Furthermore, South London and Maudsley NHS Foundation Trust (SLaM) are one of the national 24/7 mental health community mental health services pilots with learning now becoming available on key service developments and roles that are benefiting patients in their care and recovery, and the wider system.

2.19. As we move into 2026/27, it will be important for the two mental health trusts to begin to understand and map their contribution to the broader neighbourhood-based care agenda, and to identify the services that will form part of a local community offer, including dock-ins and integration with other primary care and community services, and the voluntary and community sector.

2.20. In doing so, there will need to be a specific emphasis improving access to and the responsiveness of a localised and targeted support and service offer that will improve population health and outcomes. Furthermore, the mental health trusts will need to demonstrate that their plans to align existing community services to neighbourhoods and neighbourhood teams, facilitate improving integrated care and co-working with physical health and preventative services, as well as the neighbourhood health hub agenda.

2.21. It is recommended that the two mental health trusts work in collaboration to identify these services and work collectively to respond to national asks regarding neighbourhood mental health centres, providing leadership to the south east London system.

2.22. This may include defining core standards across both organisations for the services that will form part of the neighbourhood-based core offer and developing a local approach for the implementation of neighbourhood mental health centres which draws in the learning from the current SLaM pilot, whilst considering integration with other neighbourhood health centres that might emerge across the landscape.

2.23. Relationships with teams in boroughs leading the design and delivery of neighbourhood based care and the integrators will be key, and this work would continue to be supported by the mental health investment standard/mental health uplift (and potentially SIF) in future years.

3. Next Steps & Key Considerations

3.1. It is recognised that there is significant work described above and this may require multiple different funding streams to come together to support the development of mental health care as part of the wider neighbourhood-based care agenda.

3.2. When considering the SIF for mental health neighbourhoods for 2026/27 (allocated to the mental health trusts) it is recommended that this is prioritised for the following initiatives/areas described above:

- Embedding a mind and body approach to the existing INTs.

- Expanding the multi-morbidity INT to include SMI, and in particular the service users/residents on LAIs in the first instance as a clear patient cohort.
- Completion of annual health checks in primary care. However, this must be considered in conjunction to the SIF which has been identified for the roll-out of the core prevention, funding (currently with the integrators), but also considered as part of the wider funding available at a borough level for mental health (including any local incentive schemes that are in place for physical health checks for SMI).

3.3. As referenced above, there is a separate source of funding for the proposed new service offer via EIP services; should this demonstrate benefit, then this could be considered as part of the future SIF or mental health uplift in upcoming years.

3.4. Finally, the work on the development of wider mental health services offer, particularly via secondary care and our mental health trusts, in 2026/27 will be supported by the mental health uplift. It is unlikely that the mental health neighbourhood SIF will be able to cover further developments in these services in addition to what is laid out in section 3.2 above. However, there is considerable work that the two mental health trusts can collaborate on during 2026/27 to then inform planning for 2027/28 and 2028/29 and for inclusion in broader neighbourhood-care plans.

3.5. It is recognised that this paper doesn't fully recognise the breadth of the mental health services offer available in local communities and in particular the offer via the voluntary and community sector, nor does this consider the contribution local authority commissioned services make to the sector provision (including links to social care and substance misuse services). Feedback on how this is considered and built into future planning would be welcomed as part of the discussion at the Neighbourhood Based Care Board.

Appendix 1: Expanding the Multi-Morbidity INT to include people with SMI on antipsychotic long-acting injections (LAIs)

Aims/Ambitions

- Increase in parity for people with SMI in the multi-morbidity INT.
- Development of an integrated team working approach across physical health, mental health and primary/secondary care services.
- Increase in choice for people with SMI on how and where to access their care.
- Improved patient outcomes through a holistic mind and body approach.

Patient Cohort

Patients currently on a secondary care community mental health caseload in south east London who are:

- Clinically stable*;
- Have been attending appointments with their community mental health team regularly;
- Have one or more long term physical health condition(s); AND
- Are willing to step down from the community mental health team and receive their care via the INT model.

**Definition in the process of being finalised and will be confirmed by the end of April 2026*

What Service Offer Should be Available within the Multi-Morbidity INT

- Administration and management of anti-psychotic LAIs. This will include tracking and follow-up for patients who do not attend appointments and administering any overdue injections.
- Completion of a regular physical health check (at least annual) with relevant signposting and interventions available both within their INT and broader across the local community offer.
- Care, advice and guidance for their physical health long term condition as part of the existing Multi-Morbidity INT offer.
- General health and wellbeing check.

Roles for Testing to Support this Cohort as part of the Multi-Morbidity INT

It is recommended that the following roles could be tested as part of the core INT model:

- Practice nurses, specialist community mental health nurses (from secondary care), and pharmacists.
- Phlebotomy roles – could be used to complete physical health checks and support in accessing wider health and wellbeing support and interventions.

How Will Secondary Care Contribute to the Multi-Morbidity INT

The existing community mental health teams will need to contribute to the multi-morbidity INT to ensure we provide a team of teams based approach; this will include:

- In reach function which provides advice and guidance to practitioners working as part of the core INT on the administration and management of LAI doses.
- Offer of training and support for the core INT on the management of these patients.

- A clear and swift pathway back into core secondary care services if necessary.

It is expected that psychiatrists and pharmacy teams from the two mental health services will provide advice and guidance on medications and wider as part of the INT.

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**Workforce Workstream Deep Dive**						
Meeting date	22 April 2026		Agenda item Number	**7**	Paper Enclosure Ref	**5**	
Author	**Chloe Harris**						
Executive lead	**Lynn Demeda**						
Paper is for:	Update	**X**	Discussion	**X**	Decision		
Purpose of paper	It was requested to facilitate a workforce deep dive discussion at the April'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 (currently in draft and testing) ○ Please note the full draft document has been included as part of an appendix to this paper for your reference • High level thoughts on further work						
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 November 2025, which focused on Clinical Governance & Risk. Since our last update, we have made great progress in our areas of focus, which is covered as part of April's update. This includes: • Significant engagement with our Neighbourhood Care webinars, with the first webinar receiving 422 registrations to date • Completion of mapping exercise supporting Aging Well Frailty workstream – by identifying and education needs and offers for staff across pathway • Completion of risk & governance task & finish group meetings, and draft document currently in circulation for testing • Significant influence in shaping London PPL People Task and Finish Group outputs and chairing two subgroups on Risk and Behaviours, and use of SEL knowledge and expertise to develop London frameworks						
Potential conflicts of Interest	Nil						
Sharing and confidentiality	Open						

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	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 and discuss questions highlighted on slide 13.					

South East London
Integrated Care System

Workforce workstream deep dive

Neighbourhood Based Care Board – 22nd April 2026

Lynn Demeda – Director of SEL ICS People Programme

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

Introduction

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 November 2025, which focused on Clinical Governance & Risk.

Since our last update, we have made great progress in our areas of focus, which is covered as part of April's update.

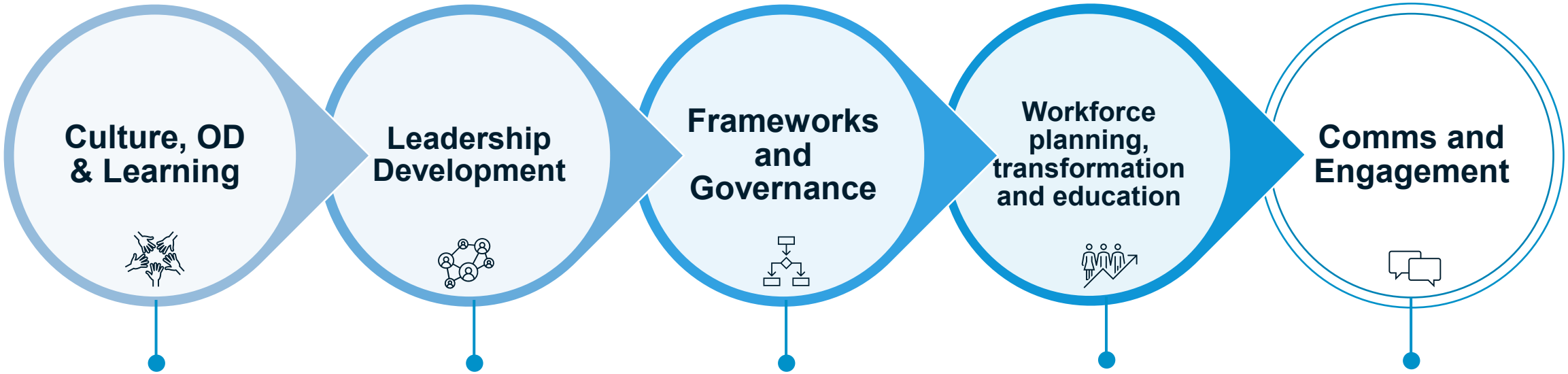
Purpose and contents of this paper

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 (currently in draft and testing)
  - Please note the full draft document has been included as part of an appendix to this paper for your reference
- ✓ High level thoughts on further work

RECAP: People Programme Workforce Plan for Neighbourhood Care

After significant engagement, an overarching workforce plan to enable neighbourhood health was agreed in Spring 2025, with four workstreams, including:



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

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

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

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

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

Overview: progress updates (1)

Comms & Engagement

Staff Activation Plan- *Complete*

- Design and development of a staff activation plan outline three phases: raising awareness; educate and empower; enable and embed.
- Support and endorsement for the plan by Neighbourhood Care Board in October 2025.
- Supporting comms toolkit shared with members and stakeholders.

Neighbourhood Care Webinars– *In progress*

- Educating and enabling staff to understand how it affects their role – through interactive webinars, to launch Spring this year.
- Speakers confirmed for four sessions currently, work happening to confirm more.
- Comms and promotion for first session via SEL People Programme network and channels – ***422 registrations to date***
- Further sessions planned for Digital Tools, AI and Prevention in train.

Topic	Month	Progress
Introduction Session What is neighbourhood care and what this means for SEL	30th Apr 26	Speakers confirmed , promotion in progress
Population Health Understanding population needs, inequalities, and using data at neighbourhood level	May 26	Speakers to be confirmed
Digital Tools & Apps Practical use of NHS digital tools to support care coordination and self-management	Jun 26	Speakers confirmed, dates being provided
Artificial Intelligence What AI means for health and care, ethics, governance, and real use cases	Jul 26	Speakers confirmed, dates being provided
****Summer break – Aug 26***		
Prevention Vital 5, public health - managing long term conditions, associated training/education available	10th Sept 26	Speaker and dates confirmed
Leadership in INTs Place-based and distributed leadership, psychological safety, and leading across boundaries	Oct 26	Planning to commence
Strategic Commissioning How commissioning works and how neighbourhood insight shapes decisions	Nov 26	Planning to commence
****Winter break – Dec 26***		

Overview: progress updates (2)

Culture, OD and Leadership Development

OD community of practice- *Ongoing*

Set up OD community of practice for OD leads supporting neighbourhoods in order to:

- Support sharing on INT/NH OD/Leadership work across Place/Boroughs
- Identify areas of common work that may benefit a system level approach

Group currently meets monthly.

Leadership development for middle managers – *In progress*

- HIN actively progressing two pieces of leadership development work within Bromley and Lewisham.
- Mapping exercise across NHS management and leadership framework, Leadership Qualities Framework (Social Care) and SEL Leadership characteristics to identify core leadership behaviours for middle managers in INTs
- Discussions with Workforce Development Hub about future offers for neighbourhood teams.

Bespoke work by care pathway – ageing well and frailty workstream

Mapping of education offers – *Complete*

Supporting Aging Well Frailty workstream – by identifying and education needs and offers for staff across pathway

Worked with education colleagues across SEL to understand training offers available which can be offered at Place for frailty, in particular:

- Comprehensive geriatric assessment (CGA),
- Holistic Care assessment
- End of life training

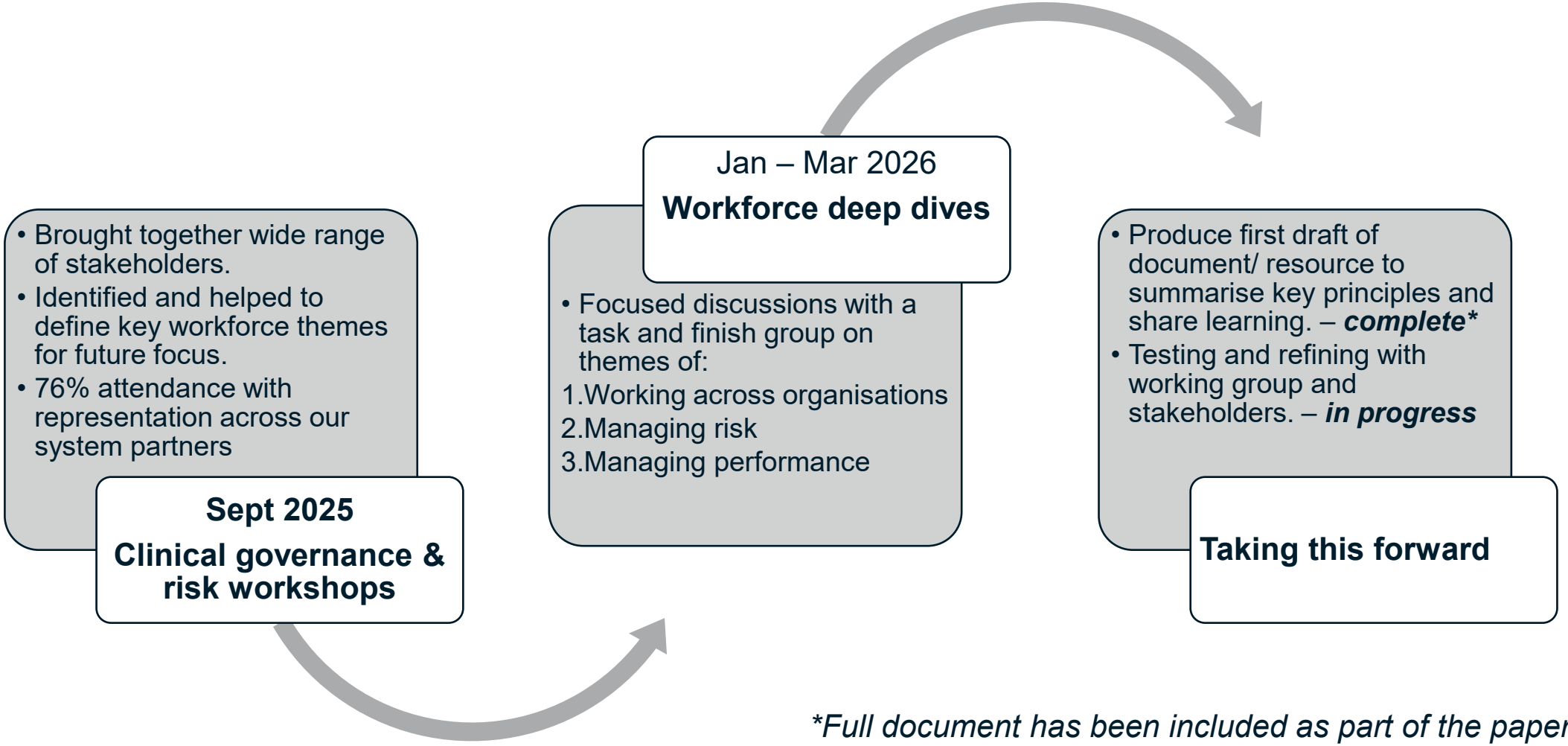
Work completed and presented to ageing well workstream meeting 9th March 2026

Stakeholder engagement

- Continual engagement with reps at Place and workforce colleagues leaning into neighbourhood health
- Influencing work with national/London team – escalation of challenges that can be looked at 'once for London'
- Part of London People workstream for Neighbourhoods, active role and sharing with other ICS CPOs

Focused update: Clinical Governance & Risk workshops and working group

Our approach



*Full document has been included as part of the papers.

Focused update: Clinical Governance & Risk workshops and working group

Key insights

Workshop themes

- Ambiguity in accountability and governance structures
- Digital, data sharing and information governance
- Workforce complexity and staff movement
- Culture change and communications
- Standards, regulation and risk

Risk specific

Consistency is essential: Need a shared approach to serious risk that complements existing statutory responsibilities.

Culture and clarity drive safety: Ambiguity in roles and communication is a direct driver of serious risk.

Frontline practicality matters: Any principles or framework must be usable in real-world, multi-agency neighbourhood settings.

Leadership must enable learning: Creating psychological safety, supporting experimentation, and reinforcing system learning are critical enablers.

Integration must be intentional: Existing good practice can be scaled, but requires governance alignment and sustained cross-organisational collaboration.

Wider reflections from those working to build neighbourhood teams:

- **Very busy space** - with multiple groups at national, regional, ICB, organisational, integrator, Place and Neighbourhood level.
- **Significant activity being generated –** lots of organisations and groups grappling with the same issues and challenges
- **Heavy burden of documentation –** national policies and guidance, organisational processes and meeting slides and documentation require significant ‘head space’ to process

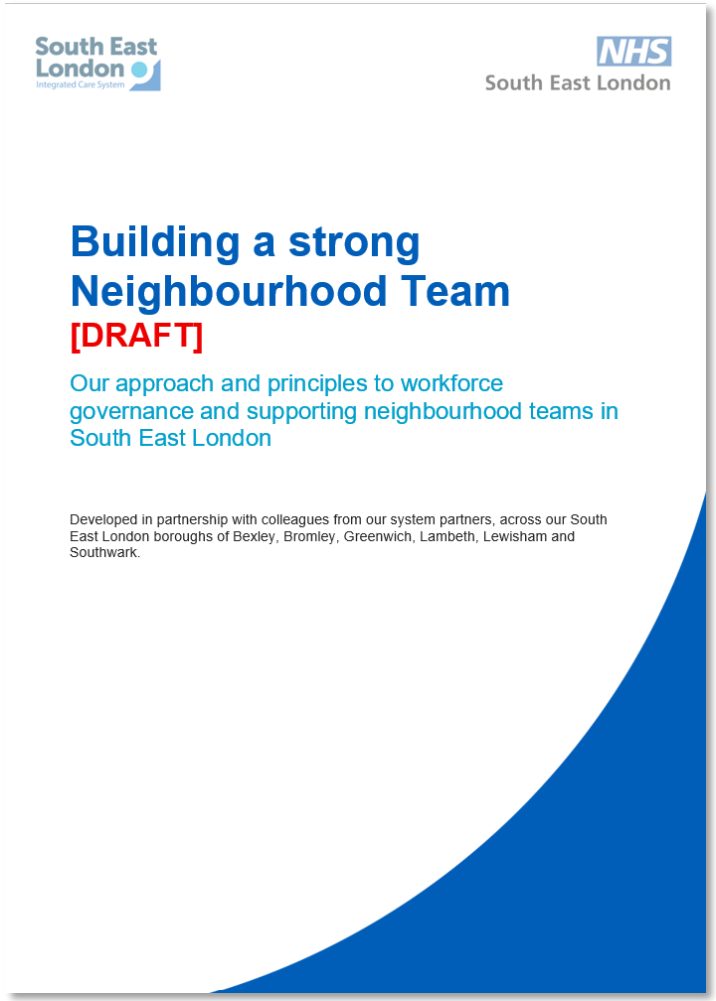
Focused update: Clinical Governance & Risk Draft document

Aim

- Establish a set of people specific principles for all those in SEL involved in neighbourhood teams.
- Provide practical information - aiming to encourage consistency and use of best practice.
- Take an iterative approach in developing document – commit to review in 6 months time.

Contents and format

- Set out principles, and then for each theme:
  - Provide context
  - Key considerations
  - Provide practical tips, share good practice and tools.
  - Scenario/case studies to bring to life
- Collate relevant guidance and information.



South East London Integrated Care System

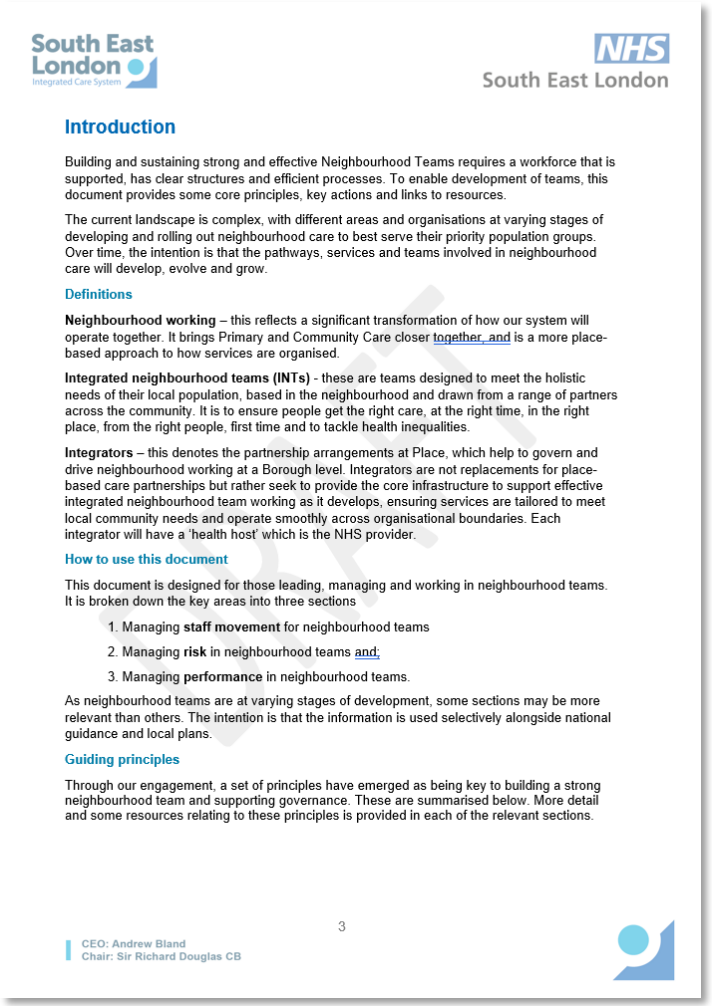
NHS South East London

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.



South East London Integrated Care System

NHS South East London

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

Focused update: Clinical Governance & Risk Draft document (points of note)

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.

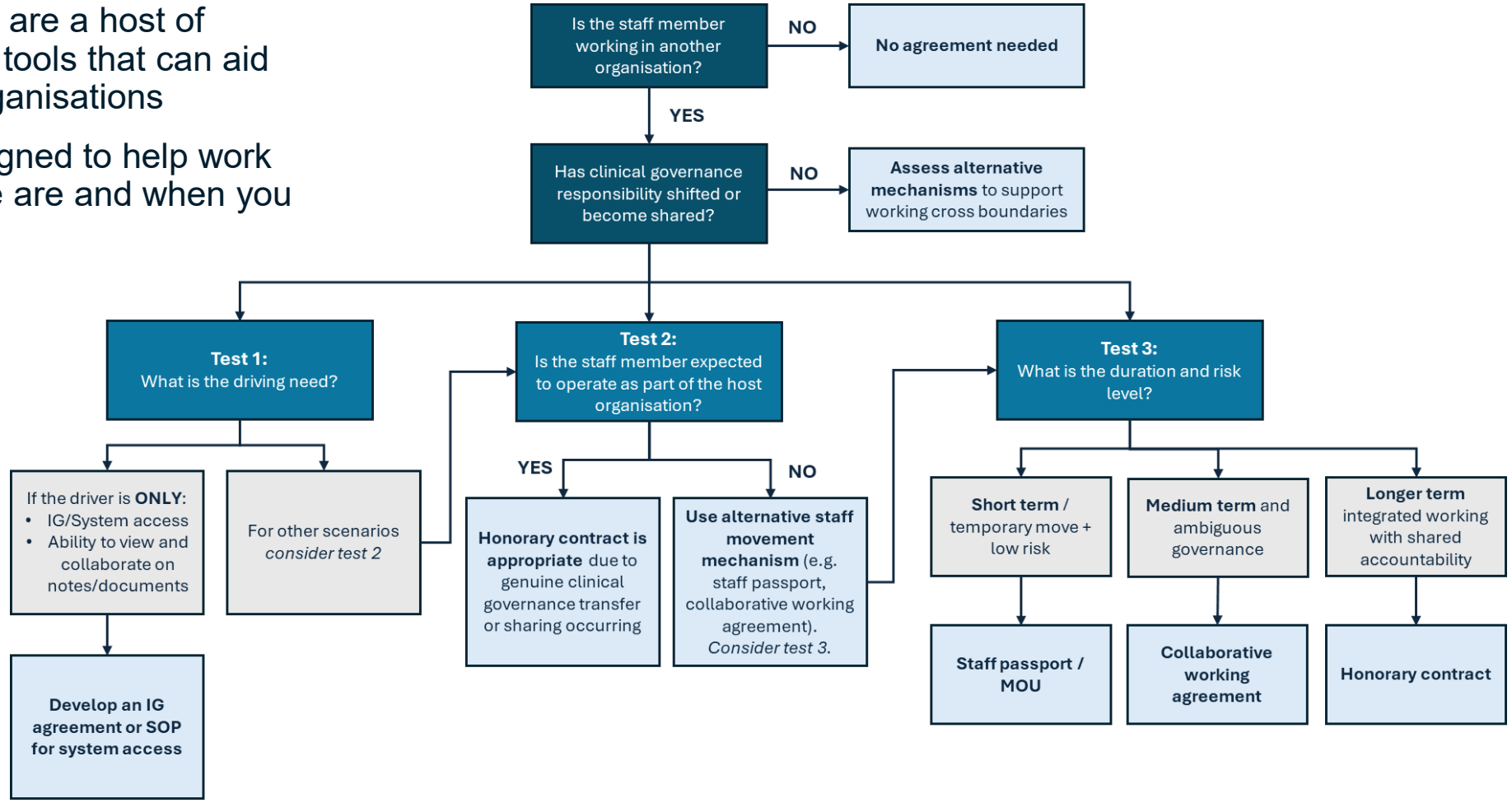
Managing performance in neighbourhood teams

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

Focused update: Clinical Governance & Risk Draft document (points of note)

Page 6 – Staff movement flowchart

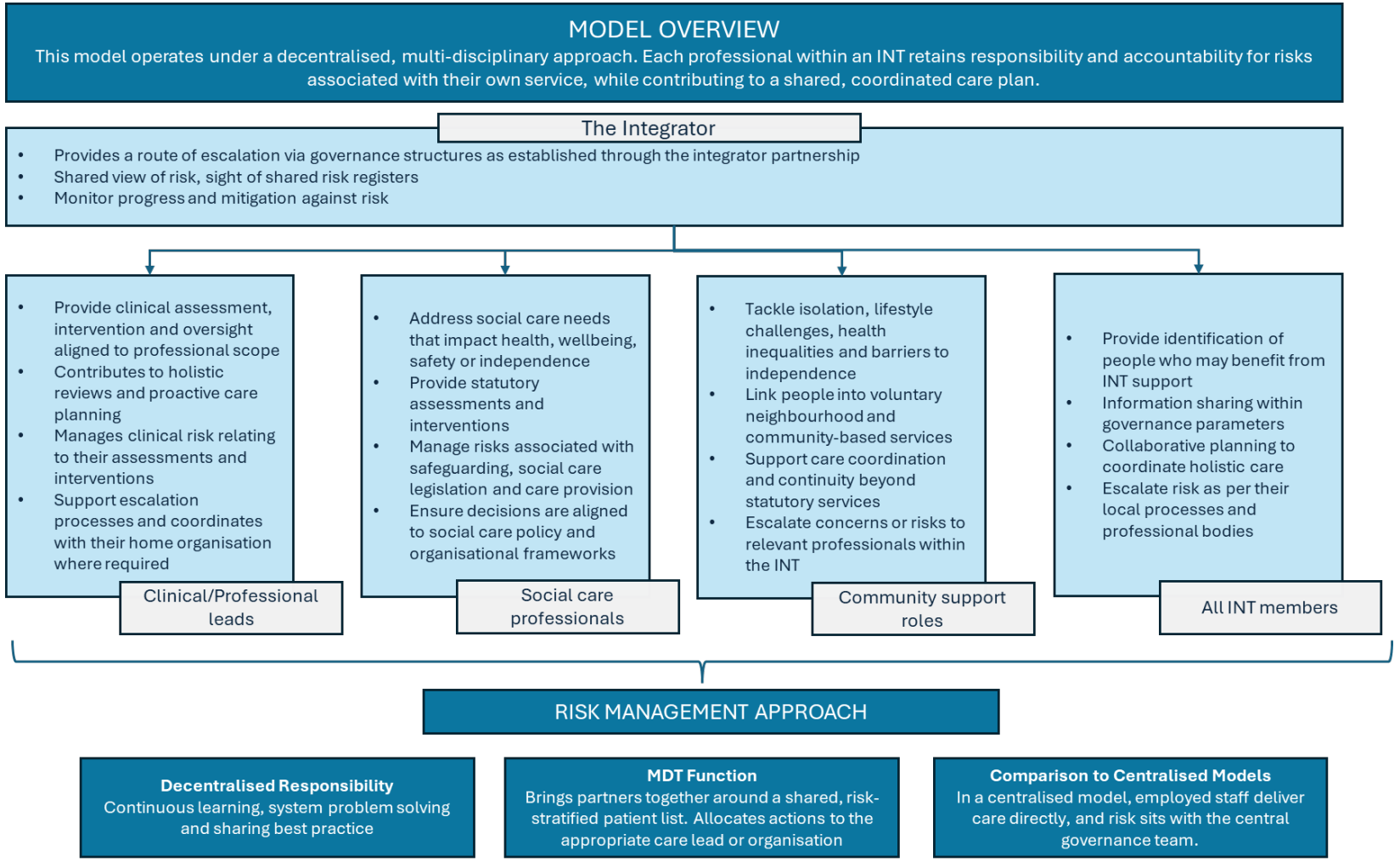
- Engagement showed there are a host of arrangements and existing tools that can aid the movement between organisations
- The decision tree was designed to help work through what each of these are and when you may want to use them
- **To be further tested and refined using live scenarios**



Focused update: Clinical Governance & Risk Draft document (points of note)

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
- **To be further tested and refined using live scenarios**



Focused update: updates to draft document and key themes from testing and feedback

- **Feedback is consistently positive and this document was welcomed**. The document is viewed as helpful, timely, and in the right direction, providing a framework for future INT working
- **There was overall endorsement of core principles**. These are seen as appropriate, clear, and aligned with neighbourhood and integrated working.
- **There was repeated emphasis on making clinical accountability and decision-making being more explicit**, particularly in situations of clinical disagreement and where professionals receive conflicting advice across organisations.
- **There is a need to test this with practical application in mind**. Flowcharts, decision trees, and scenarios are welcomed and seen as useful, however we need to test these tools against real-world, complex scenarios
- **There is clear appetite to use existing arrangements** to enable staff movement where we can. Anything developed should not replace, but compliment and account for local nuance.
- **Scenarios section was viewed as a key strength of the document**. Suggestions made to add scenarios on clinical disagreement and safeguarding.

Where to next?

Influence and steering London PPL work

- SEL People Programme playing an active role in London Neighbourhood Delivery People Task & Finish Group People
- Chairing of two sub-groups on Risk and Behaviours, working towards
  - Scaling of SEL document for London
  - Behaviours and competency framework for neighbourhood working
  - Future focus on enhancing London MOU

Further testing and refinement of risk document

- Running roundtable discussions to actively test flowcharts, decision trees against live scenarios
- Formal review of document in six-months time to reflect learning and experience

Continued work on staff activation

- Planning and promoting all staff webinars

Other work on the radar

- Developing a workforce survey for neighbourhood teams
- Developing values-based recruitment bank of assessment/interview questions
- Mapping of role profiles across neighbourhood teams to understand similarities/differences in job titles, competencies, etc.
- SEL leadership development offer for INT middle managers

Questions for you

- Where should our next areas of focus be?
- What is the role of integrators in next steps and what areas are worth doing once for SEL?

South East London Integrated Care System

NHS South East London

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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.

Guiding principles

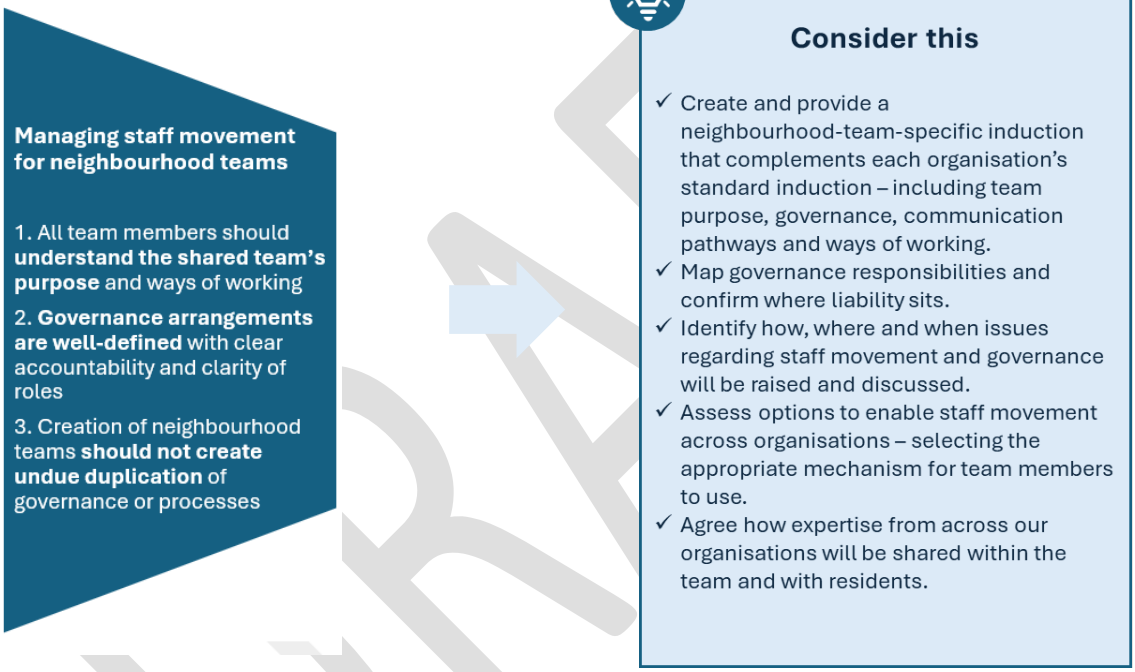
Through our engagement, a set of principles have emerged as being key to building a strong neighbourhood team and supporting governance. This isn't an exhaustive list but is sharing a consensus opinion in the SEL system. It is not professional, legal or mandatory guidance. More detail and some resources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



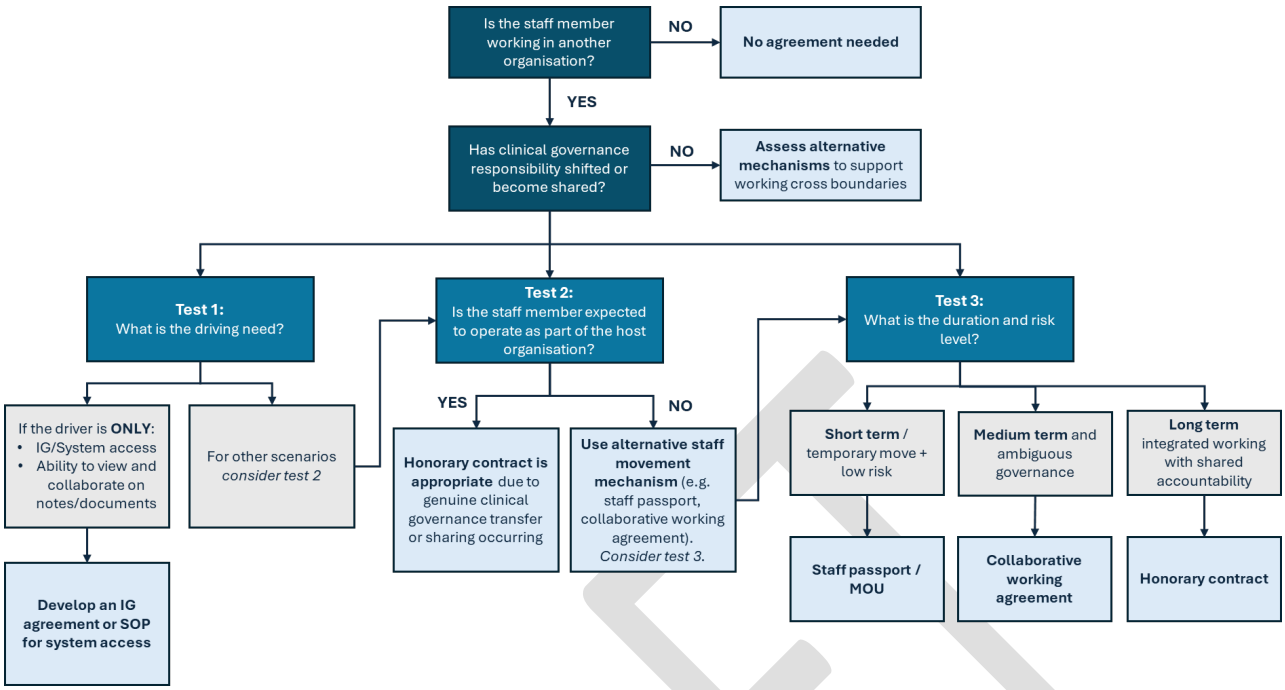
Working across organisational boundaries

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.



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.

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.

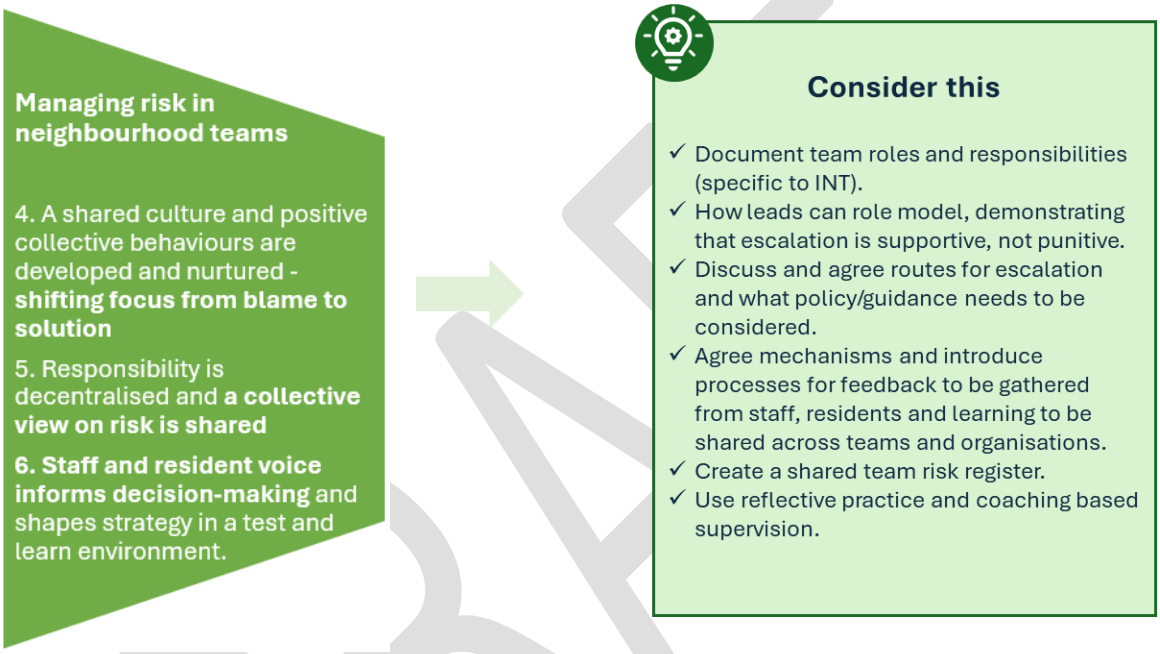
- Existing staff movement agreements - here
- National guidance on contractual mechanisms – here
- NHSE 'enabling staff movement' toolkit - here

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



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,

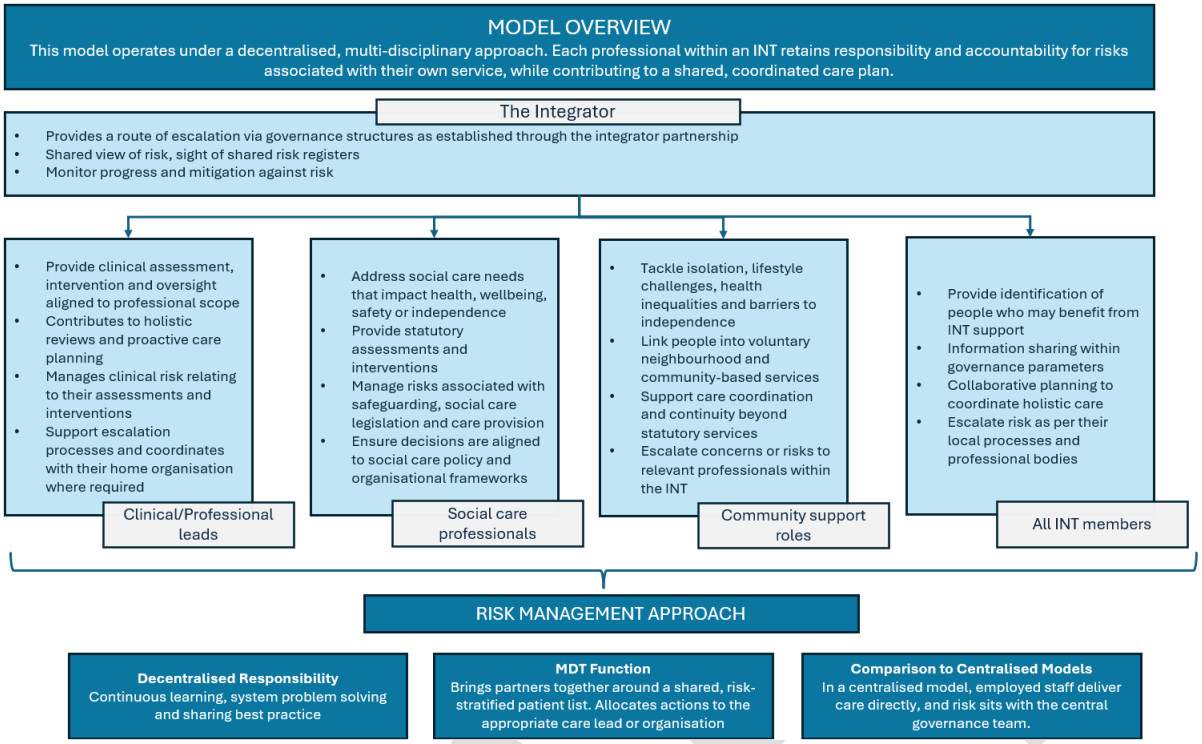
		learning mindset, and commitment to integrated working.
Delivering a Good Induction	→	• Provide a clear narrative of the INT's purpose and model, including local priorities, partner organisations, and how each role contributes. • Introduce team culture intentionally, e.g. shared norms, communication 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.



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.

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).

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.

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

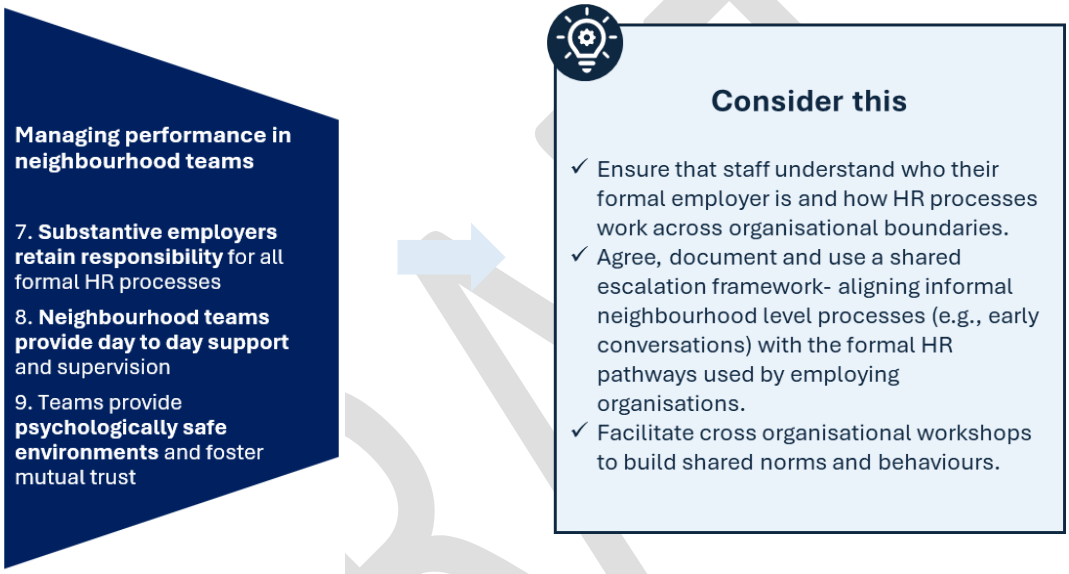
- NHSE assessing and managing risks across ICS - here
- NHSE RACI model template - here
- NHSE introduction to system workforce planning – here

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.

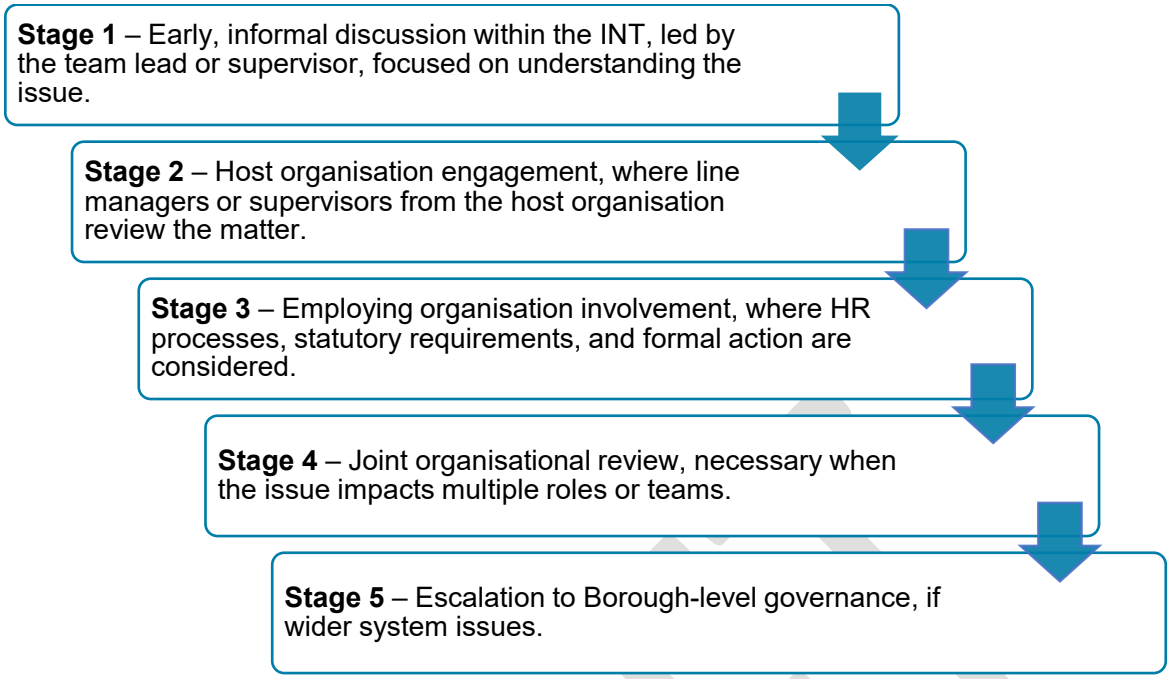
The below sets out the principles and actions that support early, constructive conversations; maintain organisational responsibilities; and enable safe, confident escalation where needed.

Core principles



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:



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

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.

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.