South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1400-1600 Wednesday 18 September 2025
(Teams meeting)

Co-Chairs: George Verghese and Ceri Jacob

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

Agenda

#	Area	Lead	Time
1	**Introduction and apologies for absence**	Chair	1400
2	**Declarations of interests relevant to the business on the agenda**	All	1402
3	**Minutes of the meeting held on 20 August 2025 (Enc 1)**	Chair	1405
4	**Actions and matters arising (Enc 2)**	Chair	1410
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**INT Delivery: Implementation Stocktake from Each Place (Enc 3)**	Place Leads	1415
6	**SEL ICS Population Health Management Update (Enc 4)**	M Higson	1445
7	**2025/26 Planning Process and Neighbourhoods (Enc 5)**	H Eden	1510
8	**General Practice Sustainability (Enc 6)**	C Ross/O Chesa/L Jenner	1535
9	**Any other business.**	Chair	1550
10	**Date of next meeting** **1400-1600 Wednesday 22 October 2025**	Chair	1600

For information only

i. Sustainability (Green Plan) (**Enc 7**) – N Kuchemann/J Colley
ii. National Neighbourhood Health Improvement Programme (NHIP) Outcome (https://www.selondonics.org/pilot-site-national-neighbourhood-health-implementation/) – H Eden
iii. Updated Maturity Matrix (**Enc 8**) – H Eden

Enclosure 1

Neighbourhood Based Care Board
Draft Minutes of the meeting held on Wednesday 20 August 2025 MS Teams

Present:

Dr George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	**GV**
Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	**CJ**
Jessica Arnold	Greenwich LCP representative	**JA**
Vanessa Burgess	Medicines Management representative	**VB**
Diana Braithwaite	Bexley LCP representative (for part of the meeting)	**DB**
Lynn Demeda	Workforce Representative	**LD**
Iain Dimond	Mental Health Provider representative	**ID**
Holly Eden	ICB Director of Delivery Neighbourhood Planning & Commissioning	**HE**
Neil Goulbourne	Acute Services Representative (for part of the meeting)	**NG**
Kallie Hayburn	Bexley LCP representative (after D Braithwaite left)	**KH**
Anna Marcus	Lambeth LCP representative	**AM**
Raj Matharu	Community Pharmacy representative	**RM**
Kelly Scanlon	AD Communication and Engagement (Non-voting)	**KS**
Darren Summers	Southwark LCP representative	**DS**
Elliott Ward	Bromley LCP representative	**EW**
Nisha Wheeler	Digital representative	**NW**

In attendance:

Angela Bhan	Bromley PEL	**ABh**
Mark Edginton	Health Innovation Network	**ME**
Nick Harris	Head of CESEL	**NH**
Josh Lowe	PPL	
Colin Nash	Governance Manager (Minutes)	**CN**
Kate Simpson	PPL	**KS**
Dr Krishna Subbarayan	Strategic Clinical Lead for Community Based Care, SEL ICB	**KS**

Apologies for absence:

Andrew Bland	ICB CEO (non-voting)	**AB**
Andrew Eyres	Lambeth PEL	**AE**
Oge Chesa	Lambeth LCP representative	**OC**
Gabi Darby	Greenwich LCP Representative	**GD**
Gemma Dawson	Community Provider representative	**GD**
Toby Garrood	ICB Medical Director	**TG**
Laura Jenner	Lewisham LCP representative	**LJ**
Neil Kennett-Brown	ICB System Sustainability Team Representative (Non-Voting)	**NKB**
Tal Rosenzweig	Voluntary Sector Representative	**TR**

No	Item	Action
73/2025	**INTRODUCTIONS AND APOLOGIES**	
	GV welcomed members to the meeting. Apologies were noted as above.	
74/2025	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
75/2025	**MINUTES OF THE MEETING HELD ON 24 JULY 2025**	
	The minutes were **APPROVED.**	
76/2025	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log: - 2/25 – CJ noted this was to come back to the October meeting. 23/25 – After the meeting RM confirmed to CN that this action could be closed as the Modern Community Pharmacy document was still being drafted and not yet ready for circulation. 24/25 – On the agenda. Action closed. 26/25 – HE reported this action had been completed and could be closed. 29/25 – HE confirmed that the next quarterly highlights report would include a summary of emerging themes. Action closed. 30/25 – Brought forward. 31/25 – Brought forward. 32/25 – HE asked that this action be transferred to OG and brought forward for the September meeting.	**CJ** **HE** **HE/CJ/ GV** **OC**
	IMPLEMENTING NEIGHBOURHOOD CARE	
77/2025	**MATURITY MATRIX**	
	HE took the Committee through the paper setting out a draft maturity index for integrators. This had been developed though the Primary Care Plus Group and shared with TR and Sarah Cottingham. It had also been informally tested with another London ICB, to provide external challenge. In April 2025, the NBCB agreed a set of principles around the functions of integrators, following development by the Primary Care Plus Group. In June 2025, the NBCB agreed a set of maturity domains for integrators, that built on these functions and considered the relationships that integrators would need to develop to perform their role. The South East London Integrator Maturity Matrix, attached as Appendix A, provided a description, using the agreed domains, of how the integrator function *may* develop in maturity over time. As each place partnership and integrator arrangement was unique, flexibility was required in the adoption of the matrix locally. Some elements may not be relevant to all integrator arrangements (and instead may be	

	something the broader Local Care Partnership would lead on) or may only be relevant in the future. There were however some core domains which will be relevant to all integrator arrangements from the very beginning. The maturity approach was intended to be supportive but not exhaustive. It was not a blueprint or specification for integrators, but intended to: - • Provide prompts that promote open discussion, debate and deep reflection within and across integrator arrangements and with Local Care Partnerships on what the role of the integrator is in enabling neighbourhood health. • Enable local partners to reach a common view as to the current level of maturity of the integrator function; and • Jointly identify key developmental priorities. In the discussion the followed points were made. • All welcomed the document and its flexible, nonprescriptive, approach. Local discussion would be needed to determine the balance of responsibilities of between the integrator and the wider local care partnership. • The NBCB recognised that key enablers, such as use of data, would need to be in place before further progress with neighbourhood-based care could be made. A shared understanding of the integrator role would also be necessary. • Further discussion would be needed to understand how integrator maturity and system maturity both contribute to successful implementation of neighbourhood-based care. • The meeting agreed on the importance of the matrix identifying the priorities for integrators to focus on over the next six months. NW suggested early clarity from integrators on their digital requirements would be needed for digital services to offer the required support. • The maturity matrix document could be discussed more widely provided it was recognised as a draft that would be further refined.	
	It was **AGREED** that LCP representatives would let HE know their top 5 domains for the current financial year, by the middle of next week.	**LCP reps**
78/2025	**DEVELOPING OUR LEARNING APPROACH**	
	KS referred the Board to the paper proposing the development of a Neighbourhood Health Learning Environment. A system wide learning environment would help to create the conditions necessary to capture early progress and enable INTs to share learning and test solutions. This would strengthen the coordination of neighbourhood development and promote consistency in the outcomes being worked towards. KS took the Board through slides setting out the background and context and rationale for developing a system wide learning environment. The next slide explained how the environment would develop from tracking early progress and learning, to creating a cross-system learning environment to growing that environment. Page 43 of the pack set out how this development might proceed in practice, from co-design, though engagement and initial INT implementation to evaluation.	

	In the discussion the following points were made: - • Care would be needed to ensure that the learning environment work was not conflated with the maturity matrix. It was also essential that the approach encouraged enthusiasm for neighbourhood-based care. • Some consideration of where the learning will take place and aligning it with similar current structures, such as NHIP, would be helpful. • Consideration of the potential effects that the current ICB reorganisation on the learning environment would be useful. • The importance of fostering a supportive culture, that allowed people to be vulnerable, should also be included. • It was suggested that the learning environment should utilise existing QI methodologies where possible, rather than introduce a new one. Further work to understand who the learning environment was aimed to benefit, would strengthen the proposals. • It was recognised that learning also took place informally and in an unstructured way and this should be recognised in this work. • It was suggested that in the early stages of neighbourhood-based care there would be a need for learning hubs, where colleagues could benefit from expertise in this area, rather than just a community of practitioners.	
79/2025	**DIGITAL GOVERNANCE DISCUSSION FOT INTs/NEIGHBOURHOOD HEALTH**	
	NW referred to the paper highlighting the need for appropriate digital governance to be in place to support decision making and funding requests for digital tools and solutions for INTs and neighbourhood working. There was also a need to address fragmented decision making, encouraging standardisation where possible, so established and newly forming INTs dock into a set of systems and solutions that support collaboration through integration and interoperability. This would ensure that where movement and flow of patients between SEL boroughs occurred equilibrium of care was not interrupted. The paper proposed establishing a new Integrated Neighbourhood Health (INH) Digital Working Group, reporting into the Neighbourhood Based Care Board. It would provide relevant proposals and recommendations through SME input for the unification and standardisation of digital solutions for INT and neighbourhood working. Due to an error, the proposed terms of reference for the working group were circulated to NBCB members after the meeting, rather than as part of the paper. The following points were made in discussion: - • It was important the INH Digital Working Group was an enabler of neighbourhood working. It was also suggested that the proposal be discussed with Denis Lafitte, Chief Digital Information Officer GSTT/KCH. NW confirmed that she would be doing this. • In response to further questions NW confirmed the enabling role of the INH Digital Working Group and its remit would be confined to INT and neighbourhood IT proposals. As the NBCB was not a decision-making Committee the Digital Committee would consider NBCB recommendations, endorsed by the INH Digital Working Group and decide which proposals should be implemented. As the Working Group	

	would align with the objectives of the ICB Data Strategy, it was hoped it would also align with Place priorities. The NBCB **SUPPORTED IN PRINCIPLE** the establishment of an INH Digital Working Group that fed into the NBCB and supporting endorsement of decisions to be made by the Digital Committee for digital systems and solutions proposed for INTs and neighbourhood working.	
	It was noted that, following circulation of the draft terms of reference NW would discuss these with NBCB members who would be members of the INH Digital Working Group and agree a final version. She would ensure the final terms of reference were circulated to NBCB members.	**NW**
80/2025	**INTs AND ELECTRONIC PATIENT RECORD (EPR) SYSTEMS**	
	NW took the NBCB through the paper providing an overview of EPR system usage within SEL and discussed the need for a longer-term unified approach and decision making across the ICS. LCP representatives confirmed that none were planning on taking INT EPR decisions to use a system other than EMIS Community and would ensure this continued to be the case in their local areas. NBCB **AGREED** that the Digital Team will fully investigate and scope out INT requirements in respect of EPR solutions. The Team would work collaboratively with stakeholders, at pace, to develop the necessary specification that can then be used to evaluate the options available which provide the necessary integration and interoperability as a fundamental requirement to SEL. A further paper, setting out the options and putting forward recommendations for the NBCB to consider, would be presented in due course.	
81/2025	**CESEL INT SUPPORT**	
	NH took the Committee through the paper (pages 56 to 63 of the pack) updating the NBCB on the development of best practice resources along side examples of tailored support delivered at place. The NBCB were supportive of the direction of travel and suggested CESEL support might usefully link with the work to create a learning environment, discussed above. It was also suggested CESEL work should complement support already being offered in other neighbourhood areas, such as frailty. NH confirmed CESEL was linked into the Ageing Well Group. NBCB **NOTED** the update.	
82/2025	**ANY OTHER BUSINESS**	
	None.	
83/2025	**DATE OF NEXT MEETING**	
	1400-1600, Wednesday 18 September 2025.	

South East London Integrated Care System

NHS South East London

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Enclosure 2

Neighbourhood Based Care Board
Draft Action log from the meeting held on 20.08.25

Item Reference	Minute number	Item title	Action description	Owner responsible	Due Date	Comments	
ACTIONS BROUGHT FORWARD							
2/25	76/2025	Enabler- Estates Strategy	Present a timeline to the September meeting for the establishment of INT hubs in each Place.	**C Jacob**	For 22.10.25 meeting		
30/25	66/2025	Quarterly Highlight Reports	Work on a shared risk log between place and SEL	**H Eden**	No date set		
31/25	76/2025	Quarterly Highlight Reports	Agree integrator representation on the NBCB and a workplan for integrators	**H Eden/ C Jacob/ G Verghese**	No date set		
32/25	76/2025	Primary Care Sustainability	Include Nancy Kuchemann in membership of the group co-designing the general practice support offer.	**O Chesa**	No date set		
ACTIONS FROM THE 20 AUGUST 2025 MEETING							
33/25	77/2025	Maturity Matrix	Each LCP representative to let H Eden know their top 5 domains for the current financial year.	**LCP reps**	By 27.8.25		
34/25	79/2025	Digital Governance	Following agreement with NBCB members who will be members of the INH Digital Working Group circulate the final terms of reference to NBCB members	**NW**	No date set		

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**INT Delivery at Place Deep Dive**						
Meeting date	18 September 2025		Agenda item Number	***5***	Paper Enclosure Ref	***3***	
Author	**Place Neighbourhood Leads**						
Executive lead	**Place Executive Leads**						
Paper is for:	Update	**X**	Discussion		Decision	**X**	
Purpose of paper	This paper provides the Neighbourhood Based Care Board with an update on INT implementation within each place across South East London.						

Summary of main points	• The NBCB receives quarterly highlight reports on all neighbourhood workstreams on a quarterly basis. It also receives a deep dive item into an individual workstream on a monthly basis. In September the deep dive item is into the INT delivery workstream led at place level.
	• As part of the agreed Neighbourhoods Delivery Plan, all places set out their expectation to have INT implementation plans in place by September 2025 and a number had set out their expectation to have initiated INT implementation by this date
	• Each place has provided an update on their progress in INT delivery against the three priority population groups as well as specific responses to the following five key lines of enquiry:
	  • Please outline the dates that INTs are expected to be live in each neighbourhood for the three priority populations (noting that for CYP this will initially be the CHILD health model)
	  • If you are prioritising the population scope of INTs more narrowly than the initial broad definition of each priority population, please outline what your initial priority population is. For example within multiple LTC, if the INT is focusing on a sub-set of conditions please outline what these are and expected cohort size.
	  • Please outline if you are applying any risk stratification approaches within your INTs and if so what these are
	  • Please outline the anticipated workforce model for each INT by role and function.
	  • Please outline how places and INTs are planning and/or plan to engage their local populations in INT development and delivery
	• These key lines of enquiry were agreed by Neighbourhood SROs and reflect information that is deemed key for enabling workstreams to understand as part of the dependencies across the programme.						

Potential conflicts of Interest	None						
Sharing and confidentiality	Can be shared widely						
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x	
	Greenwich	x	Lambeth	x	Southwark	x	
Equalities Impact	The move to neighbourhood care has a strong focus on reducing health inequalities						

Financial Impact	The move to neighbourhood care is part of the ICS's system sustainability programme and is expected to drive medium to long term financial impact alongside improvements to care
Public Patient Engagement	There has been significant engagement undertaken to build the London Case for Change and Target Operating Model including through deliberative engagement across the capital.
Committee engagement	Local Care Partnership
Recommendation	The Committee are asked to discuss progress being made in implementing INTs at place level, the responses to KLOEs related to population health approaches, workforce models and engagement and identify any opportunities or risks that emerge.

Bexley INT Delivery/Implementation stock take

3+LTCs, Ageing Well/Frailty & ICHT

September 2025

V1.0

Bexley Wellbeing Partnership

bexleywellbeing.org

Context and Background

Bexley has been organised around three geographical neighbourhoods, or Local Care Networks since 2017. Adult mental health, physical health and social care services have been delivered by 'Bexley Care' – a partnership between Bexley Council and Oxleas NHS Foundation Trust – via integrated neighbourhood teams aligned to the Local Care Network footprints in North Bexley, Clocktower and Frognal since 2017.

More recently, Bexley has made significant progress in implementing neighbourhood health services, focusing on our 3 priority cohorts:

- **Multiple long-term conditions**
- **Integrated child health**
- **Ageing well/frailty**

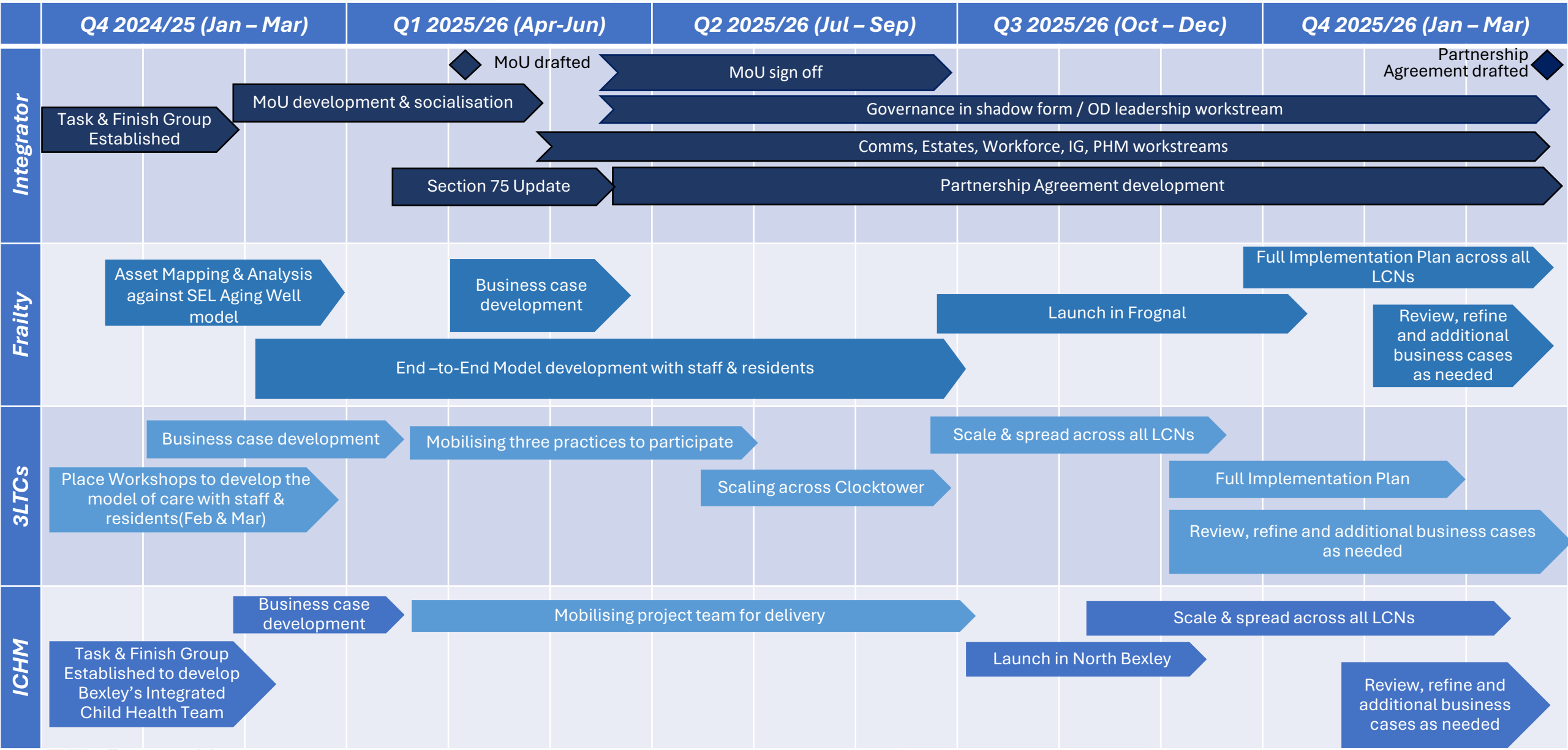
Bexley has adopted population health management methodology to develop and enhance our existing models of integration, enabling us to go 'further, faster'.

Stratifying risk and identifying unmet needs has enabled the delivery of proactive, upstream interventions ensuring the provision of earlier support to improve resident outcomes whilst reducing pressure on acute services.

BEXLEY CARE
We're here for you

Bexley Wellbeing Partnership

Bexley INT Roadmap



INT Development - Multiple Long-Term Conditions

Programme Leads: Michelle Barber/Dr Cheryl Leung | **Programme Status:**

Summary of programme:

The aim of this initiative is to make the shift from a disease-specific focus to a more holistic, person centered approach integrating primary care, community services, adult social care, VCSE, and secondary care to provide personalised proactive care. The Bexley model of care was developed following two workshops and form the basis of an integrated neighbourhood team pilot. Initially, this will be implemented in Clocktower LCN commencing in late May 2025. The focus is on people with 3+ LTCs who are in the CVD cluster and have COPD. New interventions will dovetail with the emerging frailty model to ensure broader integration, seamless delivery of care and avoid duplication.

Go live dates:

- Clocktower LCN went live in in May 2025
- Two remaining LCNs, North Bexley and Frognal, will go live by Quarter 3

Cohort details:

- Residents with 3+ LTCs, including CVD and COPD
- Expected cohort numbers: Clocktower (999), Frognal (655) and North Bexley (1032)

Risk stratification:

- Risk stratification is in place using GP clinical system (EMIS)
- RAG rating applied depending on level of medical optimisation and healthcare usage:
    - Green RAG rating applied where LTCs are medically optimised and in range with evidence of low healthcare usage
    - Amber RAG rating applied where some LTCs are uncontrolled, and resident has depression and/or pain
    - Red RAG rating applied Majority of LTCs are uncontrolled., resident has depression and/or pain and there is evidence of high healthcare utilisation or not engaging.

Workforce model:

- Health and wellbeing coaches – supporting residents to achieve their personal health goals
- GPs – stratifying patients and undertaking holistic/clinical assessment
- Pharmacists – medication reviews
- Social prescribing link workers- connect individuals with non-medical community services and activities

Engagement activities/plans:

- Two in-person workshops (14th Feb 2025 & 14th March 2025) to co-develop the new model of care with representation from health, social care, community services, the voluntary sector and residents
- Weekly task and finish groups focusing on developing the model, implementation and scaling
- Third engagement event to share progress to date, early learning and impact

Next steps:

- Finalise implementation plan details for North Bexley and Frognal LCNs
- Draft evaluation framework for 6-month review
- Revisit longer term transformation ideas generated at workshops

Additional information:

- Regular reporting is in place
- First performance meeting with practices held in July

INT Development – Ageing Well/Frailty 1

Programme Leads: Kallie Heyburn/Laura Williams/Dr Lesley Bull	**Programme Status:**	

Summary of programme:

The understanding demand workstream was completed at the end of November 2024. Bexley actively participated in the development of the SEL Ageing Well Framework which was endorsed by the Bexley Wellbeing Partnership Committee meeting in public on 22nd May 2025. Asset mapping work is complete with funding arrangements and service impact to be finalised. Gaps and opportunities analysis incorporates views from key stakeholders as well as capturing the voice of our residents. Engagement event took place on 4th June which attracted 60+ attendees including broad resident representation. Outputs of the event have informed: i) a pilot model of care focusing on the moderately frail population within Frognal LCN ii) the development of an end-to-end borough wide best practice model of care and iii) prioritisation of the end-to-end model of care enabling phased implementation.

Go live dates:	**Cohort details:**	
• Frognal LCN pilot (ageing well community hub and INT) go live scheduled for the end October 2025 • Two remaining LCNs (North Bexley and Clocktower) go live dates to be confirmed	**Hub:** Numbers of residents in this cohort are not yet defined as this is an early intervention and prevention initiative for people who are: • Aged 50+ • Living in the community (not in long-term residential care) • Mild frailty or at risk of frailty (e.g. loss of strength, confidence, or independence) • Interested in physical, mental, or creative activities to support wellbeing Access to the hub is via self-referral (walk-in) and referral	**INT:** There are 1089 moderately frail people in Frognal, however the application of criteria to this cohort identifies 262 people which ensures manageable cohort size for go live. The INT is: • Not age specific as based on frailty • Accessed via referral only • For people identified as moderately frail (Clinical Frailty Score 5-6) although lower CFS considered if declining • For Bexley residents (excluding those who are housebound and those in care homes)

Risk stratification: Hub (self-referral by individual or carer)	**Risk stratification: Hub (referral by GP, nurse, therapist, social prescriber, community worker)**
Criteria applicable for self-referrals are for people who: • Want to stay active and independent. • Are feeling less confident with memory, daily activities or with balance (for example have fallen over recently or are struggling getting out and about. • Have become less social or lost motivation. • Have experienced a life change (retirement, bereavement, moving). • Is a carer who wants to look after their own wellbeing	Access to the hub is based on the following criteria for people who: • Have fallen over recently, following a hospital discharge, or have reduced mobility. • Experience Increasing loneliness, isolation, or low mood. • Confidence or balance declining. • Long-term conditions (e.g. arthritis, COPD, diabetes, memory concerns). • Caring responsibilities affecting wellbeing. • Identified as pre-frail or mildly frail (Clinical Frailty Scale 3 & 4).

INT Development – Ageing Well/Frailty 2

Programme Leads: Kallie Heyburn/Laura Williams/Dr Lesley Bull | **Programme Status:**

Risk stratification: INT

Access to the INT is for people who have a clinical frailty score of 5 or 6 via referral through stratifying people on EMIS as well as through visual cues identified by the hub, community pharmacy, post reablement, following attendance at A&E and via trusted partners. Criteria comprises of mandatory 'core signs' plus two or more flags associated with healthcare utilisation and aspects affecting social and daily life.

Workforce model: Hub

- Bexley Age Well Navigator - central point of contact and support; undertake comprehensive assessments
- Social Care Worker – link to community resources, focusing on a person's broader social and emotional needs to support independence
- Co-Ordinator (Library employee)
- Others to be confirmed

Workforce model: INT

- Bexley Age Well Navigator (spans both hub and INT)
- Social Care Worker (spans both hub and INT)
- Administrator – all supporting administrative tasks
- Community Nurse (Frailty lead or Snr Matron) - comprehensive frailty assessments, clinical input to individual care plans and oversight of BAWN
- AHPs (OT/Physio) - assess and support people with frailty focusing on their ability to perform daily activities/assess and treat mobility and functional problems in older
- Pharmacist – medication review
- GP/Clinical Lead - manages complex care by leading the MDT; acts as a bridge to primary care
- Community Geriatrician – provides expert clinical advice; second line support
- VCSE - connect individuals with non-medical community services and activities (eg community hub)

Engagement activities/plans:

- An in-person workshop on 4th June 2025 with representation from health, social care, community services, the voluntary sector and residents (from sheltered accommodation, carers, members of a local South Asian women's group and a number of Community Champions)
- Second event planned for 26th September 2025
- Weekly task and finish group focusing on implementation
- Ongoing engagement with Community Champions

Next steps:

- Finalise roles and responsibilities
- Confirm staff for hub & INT and arrange engagement session
- Hub onsite visit to enable activity programming
- Map digital pathway

Additional information:

- Workstream links into the SEL Ageing well (frailty) framework implementation support group
- Model will dovetail with the Bexley Care SPC to avoid duplication

INT Development – Integrated Child Health Team

Programme Leads: Katie Farrar-Daniel/Dr Mohammed Rahmen | **Programme Status:**

Summary of programme:

The Integrated Child Health Team ICHT) model of care was developed following engagement with local partners and stakeholders and is based on models implemented in Bromley, Lambeth and Southwark. The overarching model is planned to be delivered via an integrated neighbourhood team comprising of health, social care, voluntary sector and broader partners. In the first instance, a scaled back model will be implemented starting in North Bexley and will initially focus on triage and delivery of an in-reach clinic. Anticipated go live date was initially June which was pushed out to September, however go live is now confirmed as week commencing 6th October 2025.

Go live dates:

- North Bexley LCN will go live w/c 6th October 2025
- Two remaining LCNs (Clocktower and Frognal) will go live by November 2025

Cohort details:

- Children aged 0-18 requiring a referral to General Paediatrics
- Expected cohort numbers: Clocktower (860), Frognal (539) and North Bexley (1,130) this is based on an average data, numbers could be slightly lower or higher in practice

Risk stratification:

- Risk stratification not required as all general paediatric referrals will be directed to triage in the first instance.
- Outputs of triage will be:
  - Redirection back to GP with advice and guidance, or
  - Appointment at the in-reach clinic, or
  - Referral to secondary care or community services
- Outputs of in-reach will be directed back to the GP or referred to community/acute care

Workforce model:

- Acute paediatrician – clinical expertise offering advice and guidance to ICHT team; oversees triage and joint in-reach clinic
- CYP GP Lead – triage and in-reach clinic
- CYP Community Nurse – triage and support smooth access to community services if required

Engagement activities/plans:

- Task and finish group meeting with representation from partner organisations
- 1:1 interviews with stakeholders and partners
- LCN meetings and PLT events

Next steps:

- Finalise dates and time of clinics for North Bexley LCN
- Secure estates for Clocktower and Frognal LCNs
- Finalise comms packs for practices

Additional information:

- MDT to be developed further and implemented following implementation of the proposed pilot

Bexley Wellbeing
Partnership

ONE BROMLEY

WORKING TOGETHER TO IMPROVE HEALTH AND CARE

INT Delivery Stocktake

September 2025

INT Delivery Stocktake - Bromley

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

SEL Pathway	Status	Target cohort	Comments
CYP CHILDS	Live	Reactive: Referrals to secondary physical healthcare	Now exploring beyond this to health, education and social care
mLTC	Live across borough by end 2025/26	Proactive: Residents with 3+ LTCs who have all three conditions from the CVD cluster AND from Core 20 Population OR experience chronic pain OR experience depression	Tactical delivery initially to drive true INT working (engaged in community, prevention focussed, more joined up and reducing burden on staff and residents)
Frailty (Aging Well)	Live	Reactive/Proactive: Residents aged 65+ living with serve frailty (7+ Rockwood)	Mapped broader pathway against Aging Well strategy to identify gaps and implement broader development

Risk stratification: Initially using proactive segmentation in mLTC and driving towards this in frailty. If can use the BI reidentification tools will explore ED attendances and admissions as cohort driver. Further clarity of (and overlap with) Ardens segmentation + risk stratification may support different approaches.

Workforce model:

- **Leadership and project management** approach in Executive discussion. Proposition: Leadership group of 4-5 senior leads (Director, Senior Manager, Senior Clinician) from One Bromley organisations for each INT. Chair as first among equals with delegation to act. Dedicated project manager (B7-8a) time per INT to support bringing the three pathways into a coherent INT.
- **Workforce models** are currently in pathways with GPs and practice nurses from primary care, community nurses and matrons from community health provider undertaking holistic reviews, administration staff from community health provider, physical and mental health consultants, third sector, social care for MDTs, represented. Social prescribers and health coaches key part of mLTC model development – currently reviewing funding options.
- **Currently exploring administration hub** models to support all 4 Bromley INTs and pathways. Requirements for practice EMIS level access to support the administrative burden of the proactive elements of the models.

Engagement: September 2025 online and in-person workshops with residents to test and improve approach, language and useability of tools for mLTC pathway. Further engagement likely throughout INT development, including hub working and expanding CYP and frailty pathways.

Our initial INT pathways – next 12 months

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

We are delivering and learning through 4 pathways, aligning to CYP and adults:

	Pathway	Target	Activities
CYP	CYP	Residents 0-18 with a more complex physical health and/or social need	• Community triage of physical secondary care referrals • Provide advice or link to relevant services*
Adult	mLTC	Residents with 3+ long term conditions	• Holistic assessment (CGA for frail) - reduce duplication in health appointments • Link with prevention activities and self care/management • Named clinician where appropriate to need • Take an MDT approach for those with highest need • Proactive end of life care planning
	Frailty	Residents aged 65+ living with serve (current) or moderate (planned) frailty	
	Hospital discharge pathway	People discharged from hospital admission	

** Exploring beyond this to health, education and social care*

Spectrum of INT delivery

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WORKING TOGETHER TO IMPROVE HEALTH AND CARE

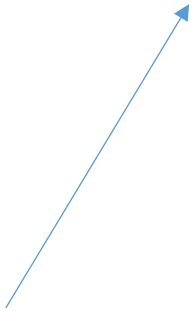
Experimental visual explanation:

Virtual

- Shared understanding of community partner offers
- Multiagency approach for highly complex cases

Physical and virtual

- INT Hub as base for teams of teams working in community together
- Operating as teams of teams working together for the population's proactive and reactive needs
- Voluntary and third sector, wider public services



Current frailty pathway
Current children's pathway

mLTC pathway at go live

Developing

Our vision for implementing neighbourhood health and care:

Thriving communities where people feel heard, supported, and empowered to live as independently as possible.

We will achieve this by:

- Building strong teams and networks of diverse professionals who collaborate across boundaries.
- Working side by side with communities, ensuring residents have a real voice in shaping what we do.
- Encouraging innovation through a culture where people are supported to try new things and learn together.
- Investing in prevention and early intervention, empowering people and communities to be independent and resilient.

HEALTHIER GREENWICH PARTNERSHIP

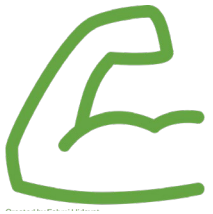
Enabling independence

Prevent

Taking proactive steps (e.g., promoting healthy lifestyles, early interventions, and risk reduction) to stop decline in physical, mental, or social abilities.

Maintain independence

Identifying people proactively to support their wellbeing and manage needs early, helping them stay well in the community and avoid unnecessary hospital admissions or stays in residential/nursing care homes.

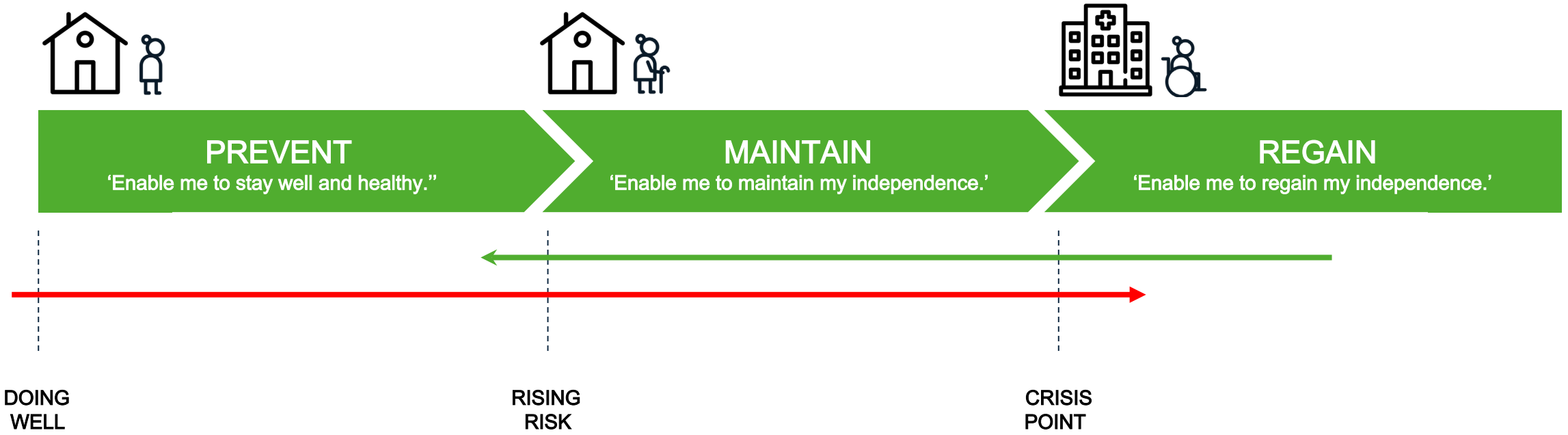


Regain independence

Supporting recovery and reablement after illness or hospital treatment, helping people avoid readmission and return to independent living within their communities.

HEALTHIER GREENWICH PARTNERSHIP

Enabling independence



Design challenges:

- *How might we enable people to stay well and healthy?*
- *How might we identify and support groups / people at risk?*
- *How might we involve the community to enable people?*

Design challenges:

- *How might we avoid unnecessary hospital admission?*
- *How might we avoid restrictive care options?*
- *How might we enable people in a holistic and sustainable way?*

Design challenges:

- *How might we avoid hospital readmission?*
- *How might we avoid restrictive care options?*
- *How might we enable people in a holistic and sustainable way?*

A whole person approach

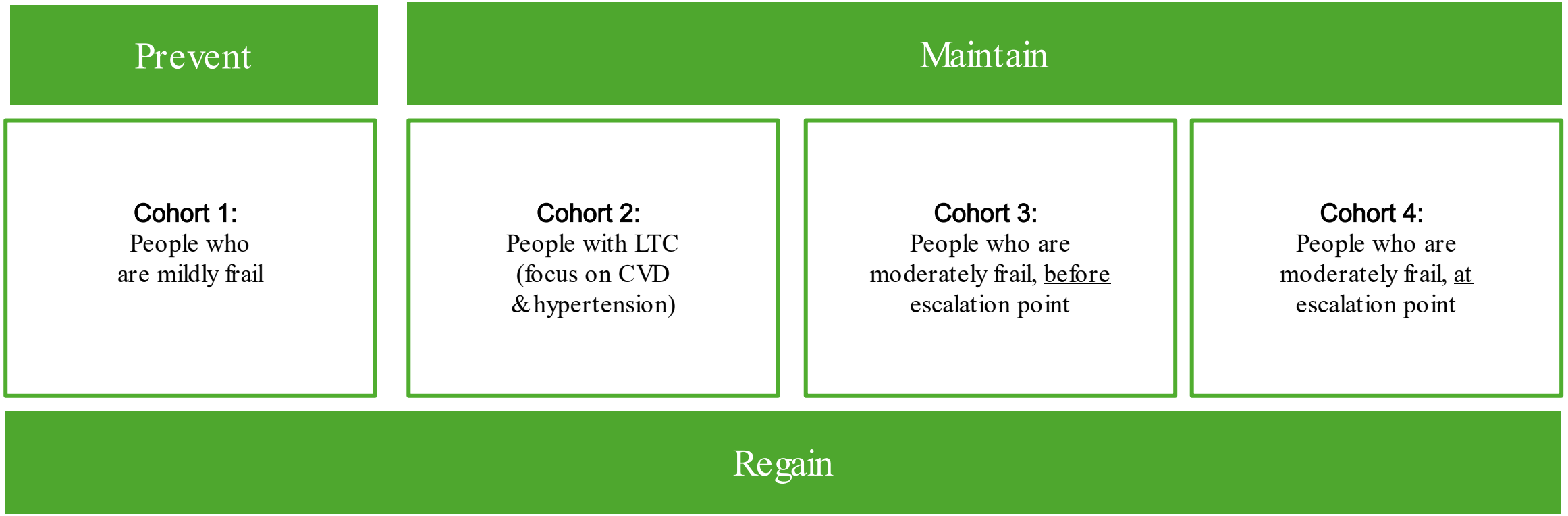
We believe that when people are **empowered** in every important part of their lives, they are more likely to **thrive** in their health and overall wellbeing.

Quadrant diagram based on work by Hilary Cottam

Principles of this work

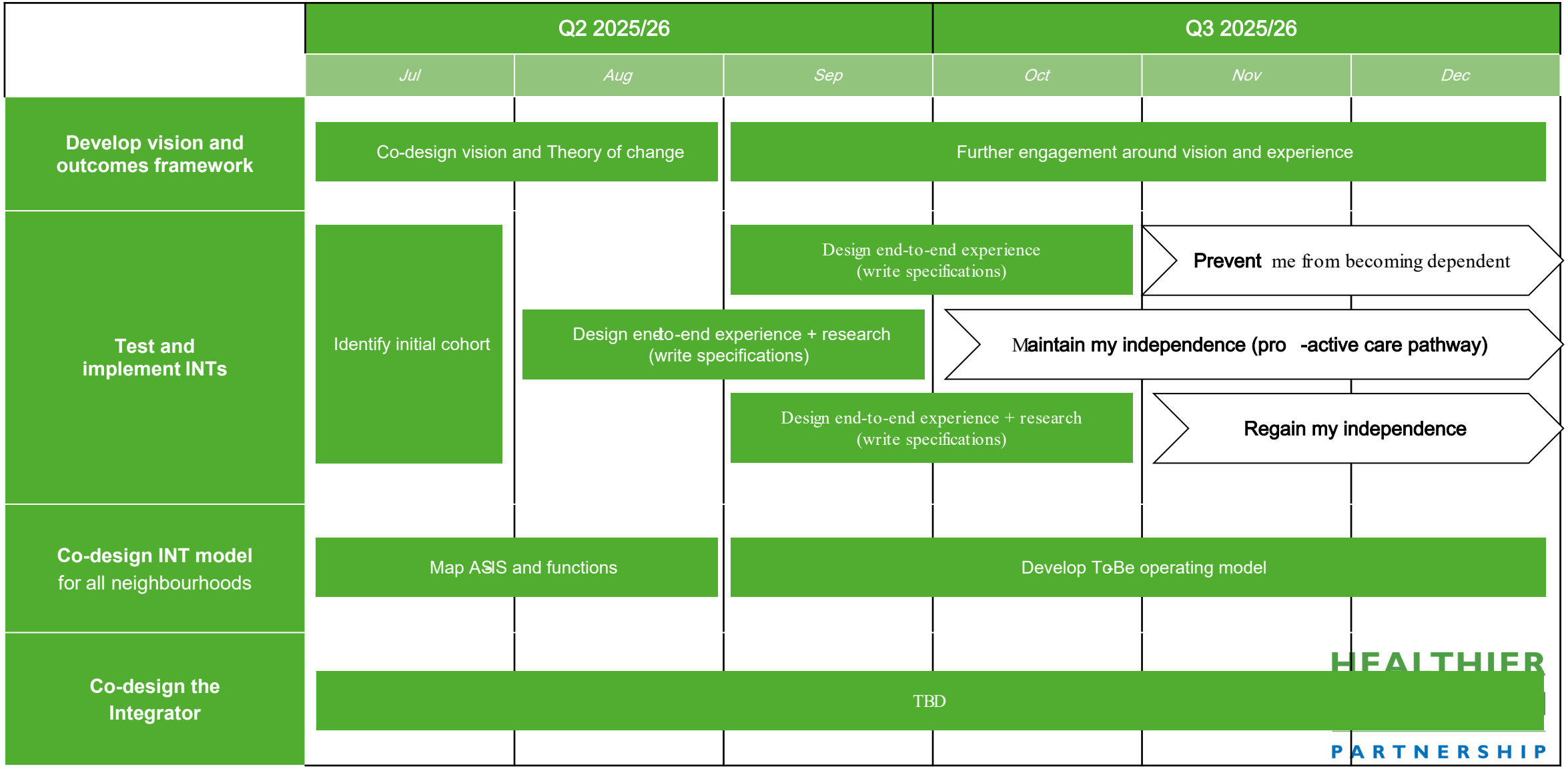
- Start with a strong sense of mission and purpose
- Build on what works in existing staff, management and partnership working
- Putting codesign with residents, colleagues & partners at the heart of everything we do
- Fix the structure the last, not first
- Develop practices and ways of working alongside operating model
- Test new ways of working and improve operations simultaneously
- Avoid arbitrary rules and ensure flexibility to respond to changing demand and complexity

Target cohorts



HEALTHIER GREENWICH PARTNERSHIP

Greenwich Neighbourhood Programme Operating Model Design 25/26



Neighbourhood Programme Dependent Milestones 25/26

	Q2 2025/26			Q3 2025/26		
	Jul	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*
Prevent				• Recommissioning of Live Well • Recruitment of Vital5 H&WB coaches		• Cabinet decision on redesign of RBG VCS grants scheme
Maintain				• PMS service specification implementation • Proactive care pathway implementation		
Regain				• ASC op model staff consultation • District nursing options paper • DHACT benefits review		
Integrator		• Health host integrator decision				

HEALTHIER GREENWICH PARTNERSHIP

Neighbourhood Programme Dependent Milestones Jan-Jun 27

	Q4 2025/26			Q12026/27		
	Jan	*Feb*	*March*	*Apr*	*May*	*June*
Prevent		• End of Greenwich Supports pilot & options review	• RBG VCS grants programme applications open	• New Live Well service go live		
Maintain						
Regain	• DHACT budget and direction setting for 26/27			• DHACT take on virtual wards		
Integrator						

HEALTHIER GREENWICH PARTNERSHIP

Neighbourhood Programme Dependent Milestones Jun-Dec 27

	Q2 2026/27			Q3 2026/27		
	Jul	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*
Prevent			• RBG VCS grants programme applications close			• RBG VCS grants programme awards decision
Maintain						
Regain				• LNCS contract extension starts		
Integrator						

HEALTHIER GREENWICH PARTNERSHIP

Risks and mitigations

Risk	Mitigation	Severity (1-5)	Likelihood (1-5)
We don't have a shared view on the bas for operational costs across ICB and RB	We need someone with financial expert to get to the baseline. First dedicated finance workstream booked for early October, with wider system oversight through HGP subgroup	3	4
Gaps around strategic estates and workforce development plans for INTs	We need dedicated estates and HR supp to drive this work across the system. W review the key people that may be able provide support & identify any gaps.	3	4
Our current timeline with going live in October might be optimistic considering potential recruitment	Need to get to estimations about additic staff for scaling frailty MDT and implementing LCT faster	2	4
Designing separate & more costly pathw that don't make best use of collective resources	Regular SRO checks on overall operatir model design spec	2	2

Lewisham Key achievements (1 of 2)

NHS South East London

Community

- Work with local community through Lived Experience Group completed and outputs informed how the LTC INTs were established
- Working with the Council and the Main Grants programme it has been agreed that each neighbourhood will have a lead VCSE organisation, providing:
  - Capacity-building support
  - Signposting to other VSCE groups
  - One VCSE Key Worker per Neighbourhood, to attend INT MDT meetings and offer support to patient cohort
- Health Equity Fellows linked with grass roots VCSE in each neighbourhood to strengthen involvement of the local community and in particular, groups for whom we do not feel accessible

INTs and the three priority population groups

- Staff for first multiple INTs across the 4 neighbourhoods have been recruited and inducted and have commenced work
  - Intitial focus in 3+LTCs with expansion to incorporated frailty planned for completion in March 2026, building on the existing Proactive Ageing Well service
- Plans for complex CYP confirmed
- Approach to measuring impact using Lewisham and Greenwich PHM team agreed

Key achievements (2 of 2)

NHS
South East London

Neighbourhood hubs

- Three identified with some services live
- Links to housing support via the hubs established. INT assessments include questions re employment.
- Links to “Lewisham Works” programme established. INT assessments include questions re employment.
- Links to local Family Hubs being established

Governance

- Integrator agreed
- MOU for first year ready for sign off
    - Allows time for full partnership agreement to be finalized
- Governance ready for sign off
- Regular meetings with local CEOs to maintain very senior commitment and progress updates provided to partner senior teams and Board etc. meetings
- Workstreams being led by executive SROs from across the system to secure system commitment and responsibility

Activity summary – *Sep 2025*

Key activity and decisions in reporting period LTC

- Governance for Integrator has been agreed MOU drafted
- Recruitment for new roles in the INT Community Link Worker, Health and Wellbeing Coach and Case Worker has all been completed 16 members of staff. (10 have started)
- Induction and training framework developed.
- Establishing INT Estates requirements.
- Mobilisation plans developed for each neighbourhood to support smooth roll-out.
- Digital pathway is in place. The DPIA has been developed, and we're now working to secure full EMIS access for prescriber roles. (working with SEL digital for better solution to support integration).
- INT Assessments co-designed (Getting to know you and Health Review) uploaded onto EMIS.
- Multidisciplinary Meeting – New proactive approach, Population Health reporting. Went live June
- INT dashboard is being built within HealtheIntent, This will be ready for team mobilisation.
- INT Business Case finalised.
- Standard Operating Procedure (SOP) competed
- Ongoing comms and engagement including patient facing leaflets and other communication
- INT Outcome Framework – Agreed
- Developing clinical governance
- Developing test and learn approach
- Resident leaflet completed
- Co-design the Preventative workstream with the VCS and wider council services
- Commission PPL to work with Gps on the INT partnership

Key proposed next steps

- INT reporting to INT Board
- Roll out Induction Programme
- Finalise INT Programme DPIA and Data Sharing Agreements.
- Mapping of Frailty services
- Recruit the project officer for Complex children INT
- Get the teams ready to see patients

Key partners engaged

Primary Care, Residents and Patients
LGT, Slam, Council, DWP,
Housing partners, ICB, Digital, Estates, IG
VCSE Organisations

Key learnings

Ongoing stakeholder communication is critical/ through various channels.
We carried out INT Co-design programme with people with lived experience. This has resulted in positive change to the model of care.

Risk	Action update	Current risk score
Inability to share data across partners. Secure INT DPIA and DSA.	Identified as a priority area and escalated locally to IG Leads meeting.	L6
Securing location for INT Operation	Working with ICB Estates and PCNs to secure desk space. Weekly mobilisation	L6

Lewisham PPL South East London Integrated Care System

Overall RAG Status	

For the board

Decision or action required	Note Progress of the INT development in Lewisham. Most actions relating to the LTC INT programme. work on Frailty and Children are moving forward
Supporting papers	PWLE Co-design Report

Milestone	Due date	Status
Estates	13/06	
INT Roles - confirming appointment	11/07/25	Completed
Implement Digital IT tools and equipment	01/08	On Track
Clinical Prescriber interviews	28/07	On Track
Complete SOP – Including clinical Management arrangements and clinical Protocols.	28/07	Completed
Population Health dashboard user acceptance testing	28/07	On Track
Population Health Dashboard Goes live	11/08	On Track
INT - start Staff Onboarding	01/09	On Track
Go Live	08/09	Go live Oct

Issue (change, problem, other)	Action update	Priority
Estates – Identifying	Working with ICB Estates and PCNs to secure desk space and consultation space.	6

INT Programme Roadmap

NHS South East London

Sep. '24 – Aug. '25

INTs – LTCs & Complex
- Pathway design
- Setup of new programme (estates, digital, governance, recruitment etc...)
- Preparation for go-live in September 2025

Sep. '25

INTs – LTCs & Complex
- Pathway goes live

Aug. '25 – Mar. '26

INTs – Frailty
- Building on LTC INT learning, and existing Frailty pathway, to develop integrated support offer for residents with Frailty
- Mapping, currently underway – will inform further recommendations

Aug. '25 – Mar. '26

INTs – Complex Children
- Building on LTC INT learning, and existing CYP pathway, to develop integrated support offer for Complex Children
- Mapping currently underway – will inform further recommendations

Sep. '25 – Mar. '26

QI Approach
- Logic model & KPIs for LTC INTs already established
- Next step is to adopt a test and learn approach once LTC INTs are operational

Sep. '25

Wider Prevention
- Options paper
- New Community Wellbeing Workers ('Brazilian Model') being designed
- No Front Door workshop
- Continue to develop Community Hubs

Sep. – Nov. '25

Primary Care Development
- Options paper – on developing a cohesive, representative, and influential primary care voice within wider partnership

Oct. – Nov. '25

Acute to Community
- Scope workstream between secondary care and primary care to facilitate transition from acute to community (aligned with 10 Year Plan)

Oct. '25

Integrated Neighbourhood Board
- New board set up and operational, with Terms of Reference agreed

Oct. '25

OD Approach
- Support cultural integration across professions & sectors
- Promote 'one team' mindset
- Address barriers related to professional identity, hierarchy, and siloed working

Dec. '25

VCSE
- Options paper on establishing VCSE partnership as being part of neighbourhood board
- Board-level VCS groups to support development of wider VCSE sector in Lewisham

Jan. '26

Neighbourhood Working
- Neighbourhood Partnership Board set-up

Mar. '26

Primary Care Development
- New way of working for Primary Care in place

Mar. '26

VCSE
- Support the development of the main grant council funding to enable neighbourhood working
- Establish new VCSE Key Worker role within each neighbourhood

lhcp Lewisham Health and Care Partnership

Integrated Neighbourhood Programme

Integrated Neighbourhood Teams (INTs)

INT Model designed to meet the holistic needs of the local population. By using our local population health data patients with 'rising risk' will be proactively identify and supported by the INT team.

Community Hubs

Waldron Community Centre
Goldsmiths Café Appletree Cafe
Lewisham Shopping Centre

Creating local community hubs that provide coordinated services all in one location.

Health Equity Teams (HETs)

HEFs work within a PCN, with their local community, GP practices and other partners to identify at risk population, identify local priority workstreams and work with the community to codesign initiatives to make an impact on health outcomes for Lewisham residents.

CESEL

PHM

Multi-Disciplinary Teams (MDMs)

A group of professionals from primary care (and other health and social sectors) discuss individual patients at practice level, to coordinate ongoing support for the most complex patients.

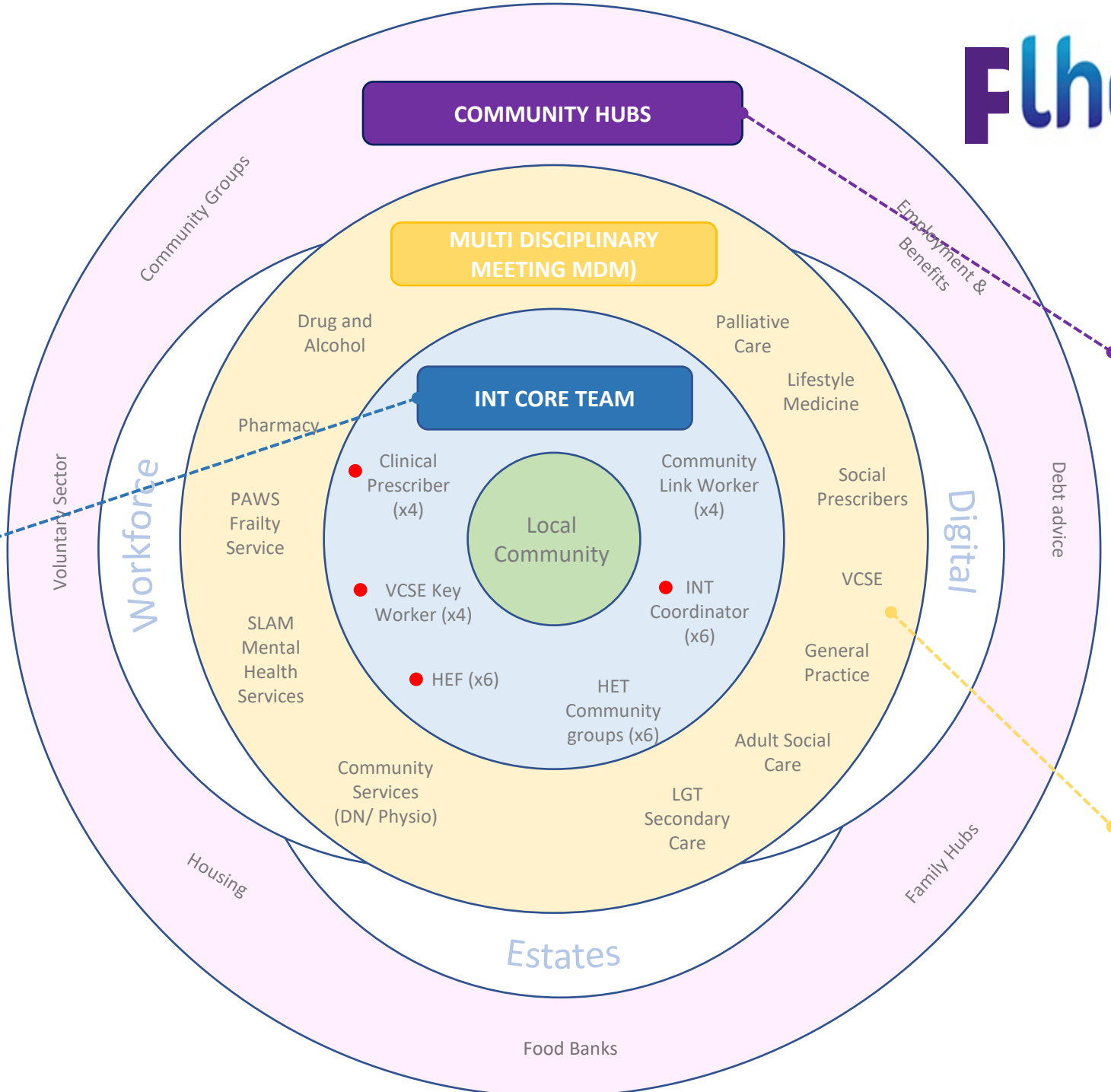
Integrated Neighbourhood Programme Comms and Engagement Plan

Key ● New Role Enablers

Lewisham Health and Care Partnership

INT Core Team:
The core team includes a variety of professionals working in integrated roles, such as Clinical Prescribers, and Community Link Workers, PCN Coordinators and lifestyle support

The team also includes a GP and community group that work together to design community-based support with residents



Wider Support Services:
This includes community groups, debt advice, adult education , employment support all contributing to a holistic approach to patient care.

Multi-Disciplinary Meetings (MDM):
Through the **(MDM)**, the core team will also be able to **support vulnerable populations** who may not fit into specific LTC cohorts but need comprehensive care due to a variety of health and social factors.

LDA Reasonable Adjustments

- Check if existing care plan in place
- Provide easy read and large font handouts/leaflets
- Initial contact should be a phone call anda reminder call prior to appointment
- Training to include Oliver McGowan and LD Safeguarding??

- Extended appointment length ~90 minutes
- Provide care plans in writing – easy read and no jargon
- LDA Friendly Assessment Template
- Create the right space for holistic assessment – neurodivergent friendly

- Special considerations for medical condition investigations e.g. blood tests and urine
- Extended appointments length ~90 minutes

- Allow LDA patients to observe group consultation before joining
- Link in with existing LDA services and understand adjustments in place e.g. Lewisham Speaking Up

- Extended appointment length ~90 minutes
- Provide care plans in writing – easy read and no jargon
- LDA Friendly Assessment Template
- Create the right space for holistic assessment – neurodivergent friendly

- Improve uptake of yearly Health Checks

INT Pathway

Within 2 weeks		*Support for up to 12 weeks*		*Within 2 weeks*	
Patient Contacted →	Getting to Know You Assessment →	Health Review Review →	Interventions →	Follow Up Getting to Know You Assessment →	Discharge (PFIU)
PCN	*PCN*	*Neighbourhood*	*PCN or Neighbourhood*	*PCN*	*PCN*

INT Role

INT Caseworker →	INT Caseworker →	Pharmacists →		INT Caseworker →	INT Caseworker

Clinical Supervision

PHM send list.
INT Core Team review list and sends to patient practice to ensure appropriate reaching out and risk management

Patients discussed in INT weekly meeting and raised with patient GP if concerns
Option for direct discussion at MDT
Clinical input or assessment from PAWS team where appropriate

Clinical supervision from LIMOS and patient GP

Community Diabetes team for monthly facilitation clinic for most complex patients

GP
Key Worker
Social Prescriber
Health Wellbeing Coach
Community Link Worker
Lifestyle Medicine
Secondary Care – Community Diabetes
Practice-based MDMs
Other Direct Referrals

Additional Clinical :
Agreed audits with INT core team
Appraisal for clinical staff
Agreed supervision within LIMOS and Community Diabetes Team
Education with Protected Learn Time (PLT)
Induction and Training
Secondary Care MDT
Practice-based MDMs

Lewisham INT Programme – Workstreams

NHS South East London

INT – Long-Term Conditions & Complex

SRO: Neil Goulbourne
Programme Lead: Laura Jenner
Operational Leads: Kath Howes, Camille Hirons, CDs
Scope: Integrated teams working within neighbourhood footprint, offering proactive health & wellbeing support to patients with multiple long-term conditions & Complex. This includes development of new VCS role

INT – Frailty

SRO: Denise Radley
Programme Lead: Corinne Moocarme
Operational Leads: Andrew Cook, Joan Hutton, Jessica Gossage
Scope: Implement the Frailty Framework through a joined-up approach across all partners. Strengthen and streamline community and voluntary sector teams within each neighbourhood to provide more coordinated care and support.

Complex Children

SRO: Pinaki Ghoshal
Programme Lead: Simon Whitlock, Paul Creech
Operational Leads: primary care, Dorett Davis,
Scope: implement the child the Local Child Health Teams and Integrated Neighborhood teams

Acute – community

SRO: Miranda Jenkins
Programme Lead: Naomi Sheeter
Operational Leads: Tom Hastings, primary care
support the move from acute to community starting with scoping LTC services- Diabetes, Cardio, respiratory

Wider Prevention

SRO: Ceri Jacob and Denise Radley
Programme Lead: Rachel Pierce/ Catherine Mbema/ Laura Jenner
Scope: Bring together the No wrong front door project, development of community hubs, link housing and Lewisham works to community hubs the INT team

Neighbourhood 2 Mental Health and CMHT Transformation

SRO: David Bradly / Kate Lilywhite
Programme Lead: Lesa Bartlett
Scope The Lewisham Neighbourhood 2 (N2) pilot is testing a new 24/7, open-access community mental health model

Enablers (Digital, Estates)

SRO: Neil Goulbourne
Programme Lead: Kerry Bourne, Jess Haines, Charles Malcolm Smith
Scope: Finding digital and estates solutions – and new ways of working – to better-support the INT programme. This also includes the identification of local Neighbourhood Hub sites for each N'hood reviewing community and primary care site to assess what options are available.

Population Health

SRO: Neil Goulbourne / Ceri Jacob
Programme Lead: Rachael Smith
Scope: Proactive casefinding of eligible INT patients and building dashboards and reports containing Pop. Health insights. Support the move to a SEL wide approach and new platform.

QI Approach

SRO: Tom Hastings
Programme Lead: Operational Leads: Beckie Burn
Scope: To build a culture of continuous learning and improvement within the INT, enabling the team to deliver safer, more effective, person-centred and integrated care to the local population.

OD Approach

SRO: Ceri Jacob
Programme Lead: Charles Malcolm Smith
Operational Leads: Joan Hutton, Andrew Cook, Lesa Bartlett, primary care
Scope: Support cultural integration across professions and sectors. Promote a 'one team' mindset. Address barriers related to professional identity, hierarchy, and siloed working

Partnership Development

NHS South East London

Governance

SRO: Jennifer, Ben Travis, David Bradley, Lead GP
Programme Lead: Laura Jenner
Operational Leads:
Scope: new governance arrangement, new INT Board, principles, joint accountability, MOU.

Primary Care Development

SRO: Helen Tattersfield, Simon Parton
Programme Lead: Ashley O'Shaughnessy
Operational Leads:
Scope: To develop a cohesive, representative, and influential voice for Primary Care within the wider health and care system, ensuring their perspectives shape decision-making, service design, and integrated care delivery at neighbourhood, place, and system levels.

VCSE

SRO: Gulen Petty
Programme Lead: Laura Jenner
Operational Leads:
Scope: To meaningfully involve the VCS as equal partners in the Integrated Neighbourhood Team, leveraging their community knowledge, trusted relationships, and preventative focus to improve health and wellbeing outcomes. Support the development of the main grant council to enable neighbourhood working.

Draft Principles for Working Together

The following were previously agreed with Lewisham Primary Care colleagues:

- Always act in the best interest of the resident/ patient
- Equal voting between partners
- Decisions made by unanimous voting
- Open book for the integrator budget
- Trust and being open
- Shift the balance of spend in Lewisham from acute/reactive to community/proactive care over time

Neighbourhood-Level Support – VCSE and Community

Community Hubs/ Family hubs

Included in the 10-Year Plan, neighbourhood health centres bring health, local authority, community and VCSE services under one roof. Services include:

- Health Checks
- DWP
- Housing advice
- Social support
- Information and advice
- Children and youth services
- Employment support

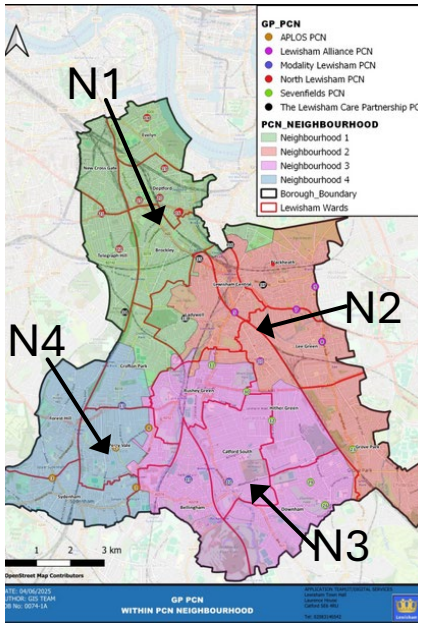
INT Teams (Adult and Children)

Bringing together health, social care, community services and the VCSE sector to offer proactive, holistic support for vulnerable cohorts.

Main Grants Programme

Each neighbourhood will have a lead VCSE organisation, providing:

- Capacity-building support
- Signposting to other VSCE groups
- One VCSE Key Worker per Neighbourhood, to attend INT MDT meetings and offer support to patient cohort



Lewisham INTs – *Lewisham Council Support Services*

Main Grants Programme: Jointly funded by Health and the Council, with a new commissioning round planned for 2026. The programme supports the Neighbourhood Model by designating a lead VCS organisation in each neighbourhood, providing one-to-one support for residents, and building capacity within smaller community groups

Addressing Housing Challenges: Through the Vital 5 programme, £150k has been allocated to recurit four community workers in each neighbourhood. Their focus will be on supporting households in deprived areas of the borough with employment and training

Opportunities for Adult Learning: Strengthening pathways between health, adult learning, and employment through community hub offers, with opportunities for further development.

Employment Support: Working in partnership with Lewisham Works and community hubs. INT team assessments will include employment needs, with referrals to Lewisham Works to help residents access training and return to work.

Public Health: Six partnerships commissioned, linking each of Lewisham's six Primary Care Networks (PCNs) with local voluntary and community sector organisations (VCSOs) and Health Equity Fellows. These teams are delivering local projects to address cardiovascular disease (e.g., heart attacks and strokes) and better serve Lewisham's diverse communities

Wider Lewisham Neighbourhood Workstreams

Mental Health and Primary Care: Bring together Community Mental Health teams to establish a mental health lead in every neighbourhood. The initiative also supports the Neighbourhood 2 Pilot, designed as a one-stop shop for mental health support.

Integrated Neighbourhood Teams (INTs): Created to support patients with multiple Long-Term Conditions; Frailty; and Children with Complex Needs – bringing together Primary Care, Health, Community Services, Social Care, and the Voluntary Sector.

Bridge to Family Hubs: Evaluating connections between adult and family services to ensure seamless support for families.

Four Community Hubs: Developed as 'one-stop shops' for information, advice, support, and health checks. These will be located at the Waldron, Downham Leisure Centre, Goldsmiths Centre, and Lewisham Shopping Centre – with potential for further sites.

Lambeth and Southwark – INT delivery

September 2025 – NBCB update

Partnership Southwark

Lambeth together

Lambeth context

- The Integrator in Lambeth is a partnership between GSTT and the Lambeth General Practice Provider Alliance (LGPPA). We have established our Integrator Delivery Board which is overseeing the design and delivery of INTs. The Board reports into the Neighbourhood and Wellbeing Delivery Alliance (NWDA).
- Lambeth Together has agreed that our first phase of INTs will be in place by April 2026. In order to manage capacity of local leads, each neighbourhood will focus on helping to design one INT initially. We will then expect the scaling of the models to happen throughout the 2026/27 financial year.
- The Integrator Delivery Board is supported by our established neighbourhood leadership meetings. This brings together agreed neighbourhood leads to codesign our INT models, including:
    - Clinical lead from general practice
    - Community services leads from GSTT
    - Acute consultant leads from GSTT and KCH
    - VCFSE representatives from Thriving Communities (also represented in the Lambeth Ecology Group)
    - Change management support
- Healthwatch Lambeth are delivering a programme of patient, public and community engagement to develop insights and feedback to inform the design and development of INTs and neighbourhood working. A final report summarising the feedback, including key themes, findings, and recommendations will be shared in December 2025.
- We are establishing our programme delivery architecture, drawing on existing partnership spaces to deliver the neighbourhood health service enablers that will be required to fully deliver on INTs. Examples include:
    - Lambeth Offer incentivisation – general practice funding has been repurposed for 25/26 to develop an integrated neighbourhood team locally commissioned service to support general practice participation in INTs.
    - Specific tariff for community-based INT activity. Participation, particularly in pilot phases, will rely on colleagues earmarking time and goodwill alongside existing commitments. Any tariff progressed would need to be consistent across all INTs, locally and nationally, and would unlock the potential for patient-facing teams able to deliver treatment and intervention. CHILDS in Lambeth is acting as a pilot site for a potential tariff, recognising that the evolution of this model to a patient-facing team enabling treatment or intervention, would only be made possible through the establishment of a tariff for community-based INT activity.
- Mental health remains a key enabler for all of our INT work as well as existing as an INT priority cohort within its own right. Work is being undertaken by SLaM and the Lambeth Living Well Network Alliance to develop a neighbourhood model of support in conjunction with partners and forms a core part of the neighbourhood model within Lambeth.

Lambeth INT overview

	Frailty	Multiple LTCs	Children & Young People
Expected go live date	April 2026 for first full neighbourhood April 2025 prototype started at Minet Green GP	April 2026	Child Health Integrated Learning and Delivery System (CHILDS) is already live with integrated pathways for constipation, eczema, and asthma.
Neighbourhood	Brixton & Herne Hill	North Lambeth & Stockwell, Clapham & Streatham	All have INT for children's physical health conditions. Norwood acting as testbed for further work.
Initial priority population & expected cohort size. State if any risk stratification.	**In-reach cohort:** 65 + housebound / dementia / Moderate or severe frailty coding on EMIS **Outreach model:** Likely focus initially in sheltered & extra-care sheltered accommodation sites **Cohort size:** Around 850 with moderate to severe frailty with an additional approximately 770 with mild frailty. Around 730 at risk of falls. ***Minet Green Practice: 114***	Build on the MMMOC pilot with broadened focus on residents with CVD. **Cohort size:** Across the three neighbourhoods, there are around 16,350 patients within the CVD cluster, approx two-thirds have hypertension, and more than one-third have a diagnosis of coronary heart disease, atrial fibrillation, heart failure, or stroke. Further work is required to refine cohort. Likely use same risk stratification from MMMoC pilot for those with CVD – 4 cohorts: urgent review for abnormal results or multiple conditions / further investigations or repeat tests / stable with recent engagement / patients lacking engagement	Scoping underway for INTs for children and young people with complex needs. Cohorts could include: CYP with emotional wellbeing and mental health needs (c500-1000), frequent paediatric emergency department attendances (c350 children), transitions for children with SEND (c500-1000), transition of children with cerebral palsy and complex learning disability (37 children), CYP on the waiting lists for autism and ADHD diagnoses (c1,500). Linking with Families First, multi-agency team to manage safeguarding concerns, based in social care.
Workforce model – note that this is still under development	MDT will use existing services. Current model is geriatrician (GSTT), frailty practitioner (GSTT) and social prescriber (Age UK Lambeth). Weekly MDM in primary care attended by all members of prototype team, Minet Green general manager and primary GP.	GP – review of patient, direct care Specialist from acute – specialist advice Care coordinator & HCA – review of patients Community groups – help with identifying and engaging with those who are underserved	Virtual multi-agency/multi-disciplinary team meetings with a focus on triage and meeting the CYP's bio-psycho-social needs. Relevant partners (health, education, social care, voluntary and community sector) meet to agree actions and function as a triage point to escalate or redirect as needed.
Resident engagement	Outreach is a core part of the model – Thriving Fiveways are supporting outreach. Insights from outreach informing future development of model. VCSFE engagement in neighbourhood group. Healthwatch Lambeth undertaking resident engagement with a frailty focus group.	Community outreach days incl. MSK Community Days Working closely with grassroots VCS Co-design workshops with the voices of those with lived experience represented. Healthwatch Lambeth undertaking resident engagement with a mLTC focus group.	Early engagement undertaken with Healthwatch Lambeth. Further engagement with families and young people will be coordinated through the Children and Young People Alliance during the pilot phase of INTs.
RAG rating & rationale	Amber – frailty prototype underway & neighbourhood leadership group established to design scaling across neighbourhood. Risks include capacity and capturing impact.	Amber – existing model developed through MMMOC gives baseline for building on. Consideration needed for embedding this without dedicated additional funding.	Green – there is existing integrated work already and an agreed model to develop offers in this area. Early identified priority areas area underpinned by good data, and they are being worked-up to further assess viability.
Any other areas to raise	Funding identified to support prototype development from Live Longer Better community funding at GSTT.	Rolling our PEACS chronic pain programme in 2026/2027. Linked to delivery of NNHIP programme – see later slide	Expansion being worked through. Linking into development of integrated tariff.

Note that prevention and mental health are cross-cutting across all of our neighbourhoods and will support our INT delivery models

Southwark context

Phase 1: **COMPLETE June 2025**

- Five neighbourhood geographies agreed
- Integrator appointed (Collaboration between GSTT, Improving Health Limited (IHL), and Quay Health Solutions (QHS))
- Programme governance established

Phase 2: July 2025-April 2026

INT development

- INT models to be tested and developed in Southwark by April 2026
- Each neighbourhood will co-design at least one INT initially
- Wider rollout expected across the 2026/27 financial year

Governance & Partnerships:

- Integrator Delivery Board (IDB) established to oversee INT delivery of integrator responsibilities
- Southwark INT Programme Executive under review to ensure appropriateness for phase 2 delivery
- Joint venture between GP federations to be finalised in Q3

Engagement & Collaboration

- VCSE Engagement: Working with Community Southwark to co-design INTs with VCSE organisations
- Resident Engagement: Align with Southwark Council community engagement programme for neighbourhood development
- General practice: Engagement underway. Further engagement events being scheduled for the Autumn

Contractual levers

- Population Health Management (PHM) and GP premium contracts redesigned to support neighbourhood working
- Developing new specification for the Southwark Wellbeing Hub (mental health) to deliver on neighbourhood footprints

Southwark INT overview

	Frailty	Multiple LTCs	Children & Young People
Expected go live date	Camberwell & Walworth neighbourhood pilot live currently	April 2026 The MMMOC pilot is underway in both North and South PCNs, testing varied models and approaches for delivering care to individuals with multimorbidity, specifically those with cardio-renal-metabolic conditions. By Quarter 4, we aim to: ○ Finalise the neighbourhood geographies for INT implementation ○ Clearly define the specific mLTC cohort who will benefit from the INT approach ○ Prepare for handover to integrators.	Live CHILDS is already live with integrated pathways for constipation, eczema, and asthma. While this model is primarily health focused, we will expand to address complexities that encompass social determinants in a more integrated way. By Quarter 4, we aim to: ○ Finalise neighbourhood geography. ○ Define the specific cohort of CYP with complex needs who would benefit from an INT approach. ○ Prepare for handover to integrators.
Neighbourhood	Frailty INT model to be developed in all five neighbourhoods	First workshop is scheduled for Nov, bringing together partners—including Public Health—to determine first neighbourhood to test & refine the 3+LTC INT model and also, to review & expand our scalable model for our wider cohort.	A workshop scheduled for 18 September to determine neighbourhood boundaries and review the triangulation of data to define our cohort
Priority population	Frailty, housebound or mod / severe frailty	CVD cluster. Through the aligned structures of the care coordination contract specifications in Population health management contracts with the GP federations and the care coordination specification in local GP premium contract we have a base service offer. This approach will be further locally tested in one neighbourhood to enable prioritisation and wider interactions with the integrated neighbourhood team and assets and strengths in the services locally available. Expansion across the full Southwark footprint will be based on the test and learn models from one neighbourhood across the borough. Particularly wider connections to place assets and the VCSFE strengths locally supporting the populations.	• Priority population to be identified by triangulating data from multiple existing datasets (e.g primary care, hospital, education, social care). • Currently, exploring different cohorts of CYP with complex needs, & how an INT can support them.
Cohort size	Dementia register: 1367 Housebound: 2156 Mod/severe frailty: 6652 2 elements and >65: 1872 2 elements and >75: 1593	7,107	Initial cohort sizes will be small, reflecting targeted and complex needs.
Risk stratification approach	Initial subset - people living with dementia (1367)	Initial subset - less than 65 years (overlap with frailty>65)	Children identified through: ○ Existing data sources (primary care, hospital, education, social care). ○ Professional referral into INT discussions.
Workforce model	Integrated PCN team + geriatrician, Admiral nurse, Dementia UK, Alz Soc	Integrated PCN team + relevant CVD expertise + patient groups (DUK etc)	CHILDS team & utilise existing services e.g. family hubs & triage meetings.
Resident engagement	Initial conversations underway to commission Healthwatch Southwark to undertake resident engagement	• Plan to have early engagement with social prescribers & their network within the local comminutes (VCSE sector and faith). • Further engagement with residents will be coordinated through the SP & VCSE group during the pilot phase. • Ongoing feedback will inform INT development and delivery.	• Early engagement with VCSE sector and social prescribers. • Further engagement with families and young people will be coordinated through the VCSE group during the pilot phase. • Ongoing feedback will inform INT development and delivery.
RAG rating & rationale	Amber – Frailty prototype development underway	Amber: Although the existing model developed through MMMOC provides a baseline for further development, this work remains in its early phase & contributing components of the system needs to be mapped.	Green: Existing integrated work. Early priority areas are underpinned by good data and being further assessed for viability
Any other areas to raise	Implementation aligned to PHMS contract review	Implementation aligned to GPP review, CKD pilot implemented in 3 neighbourhoods in 24/25	Expansion to children with complex needs.

National Neighbourhood Health Implementation Programme

- Lambeth and Southwark have been chosen to be part of the first wave of the NNHIP, along with 25 other places across England
- This focuses on developing neighbourhood models to support people with multiple long term conditions, looking at the structural enablers that will support innovation to deliver on the three shifts within the NHS 10 Year Plan
- Expecting initial conversations with the national team to commence w/c 15th September
- The NNHIP programme will influence our approach for our MLTC INT
- We will also share learning across our INTs and across SEL, as well as continuing to work with other boroughs to understand examples of good practice in other places
- Place leadership will be provided through:
  - Integrator Delivery Board (covering Lambeth & Southwark)
  - Lambeth Together's Neighbourhood and Wellbeing Delivery Alliance
  - Partnership Southwark's Wells Transformation Board

NNHIP offer

- A national coach to work with your Place and neighbourhood teams
- Access to subject experts
- 3 face-to-face regional learning workshops
- Online support (practical tools, case studies and real-time learning)
- A knowledge hub with themed areas for peer-to-peer learning (currently in development)
- Data and evaluation workshops to support baseline development and outcome tracking
- A knowledge management centre to share and access insights from across the country
- Capability-building training for your local coach and team members
- Opportunity to help shape enablers (such as funding flows)

Partnership Southwark

Lambeth together

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Neighbourhood Based Care Board

Title	**SEL ICS PHM Programme Update**					
Meeting date	18 September 2025	Agenda item Number	***6***	Paper Enclosure Ref	***4***	
Author	**Maria Higson, ICB Director of Transformation**					
Executive lead	**Toby Garrood, ICB Medical Director and Holly Eden, Director of Delivery, Neighbourhoods and Population Health Management**					
Paper is for:	Update	**x**	Discussion		Decision	
Purpose of paper	To provide an update on the SEL ICS PHM Programme and the development of options assessments for a SEL PHM approach and supporting function(s).					

Summary of main points	• PHM is a core enabler of the shift towards neighbourhood-based proactive care. The SEL PHM Programme has been working with stakeholders from across the system to set out the options for a shared SEL approach to PHM, supported by the appropriate function(s).
	• The process has worked from first principles under a function-before-form approach.
	  • Through stakeholder interviews and workshops the PHM approach was broken down into constituent functions
	  • Functions were then grouped together based on the whether they were 'do once for SEL', 'agree once for SEL', or local, and the type of expertise required. This provided a set of structural components.
	  • In parallel, conversations are ongoing regarding the technical components of PHM (access to the correct data in a useable form and supporting analytics tools/ platforms). Options for both technical components are presented.
	  • Finally, the 'agree once for SEL' components require the system to consider where and how our approach can be standardised. A list of standards and common frameworks has been set out, with recognition where these already exist for SEL.					

Potential conflicts of Interest	None					
Sharing and confidentiality	No risks					
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**
Equalities Impact	Population Health Management is a key enabler to addressing health inequalities.					
Financial Impact	A Population Health Management approach will support a shift towards Value Based Care, a key enabler of long-term system sustainability.					
Public Patient Engagement	None					

Committee engagement	none
Recommendation	The Neighbourhood Based Care Board is asked to consider the attached update on the SEL ICS PHM Programme and the options assessment under development, for comment.

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Under continued development

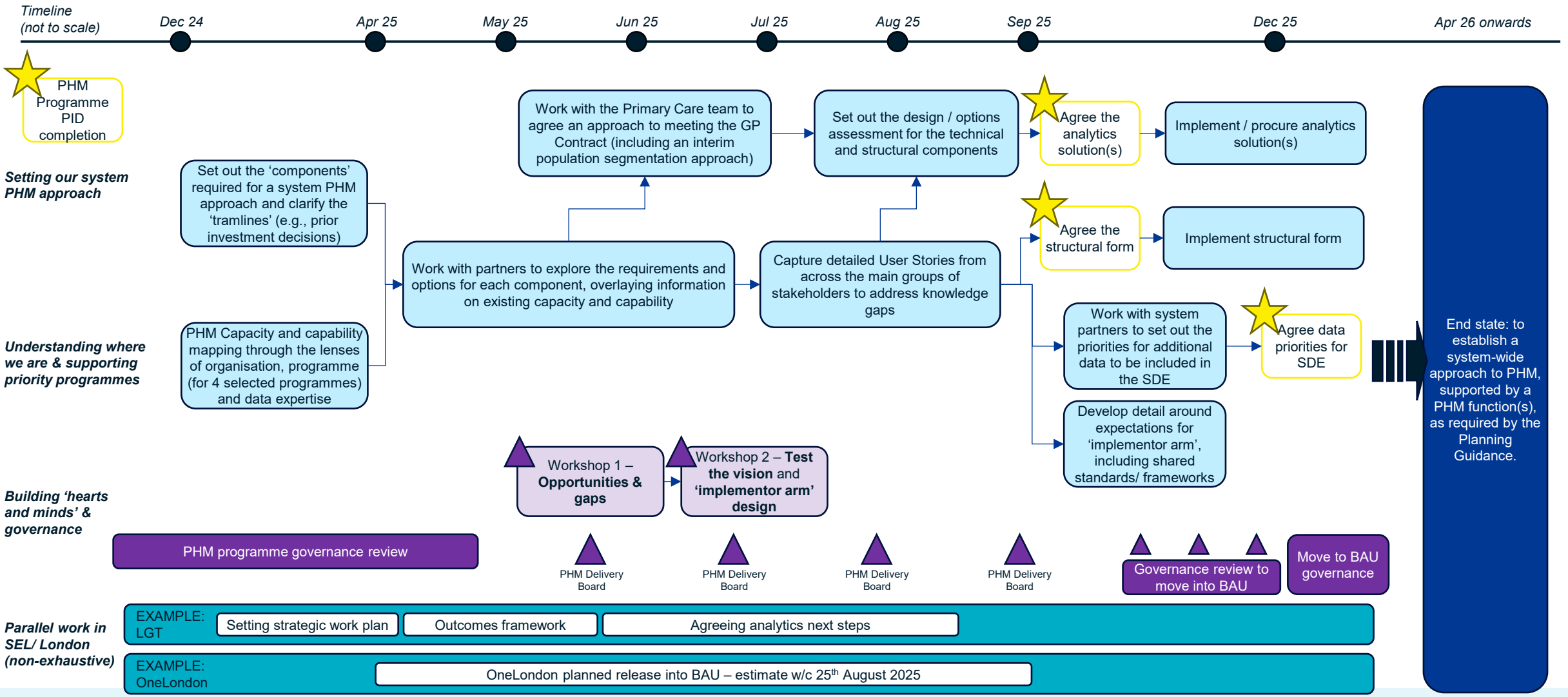
SEL approach to PHM

Options assessment: update for the September Neighbourhood Based Care Board

Context

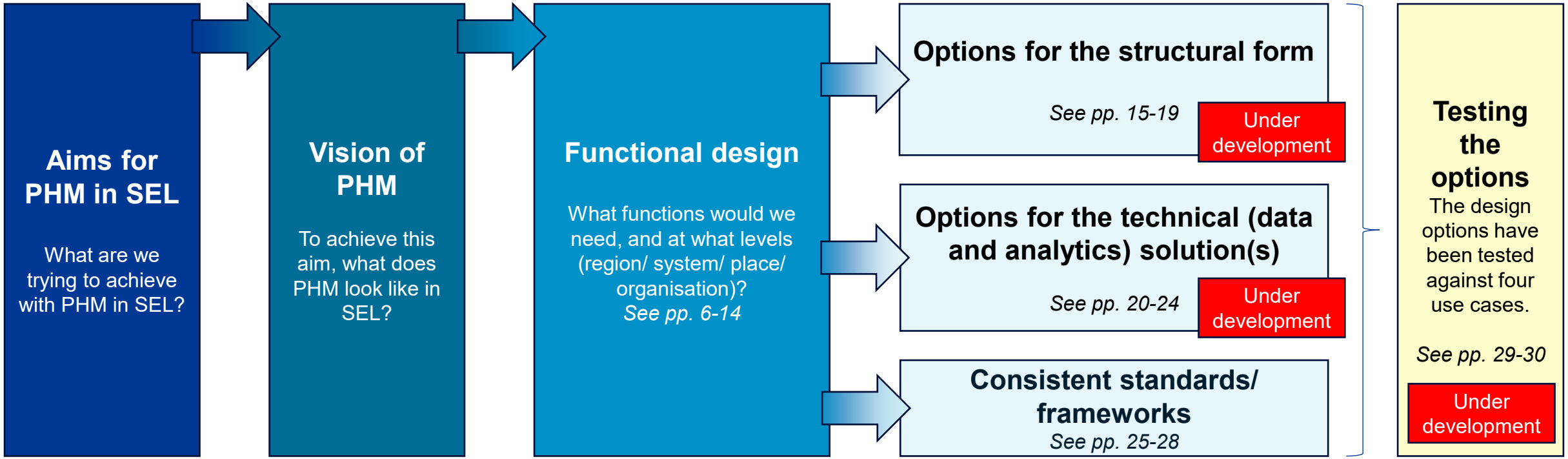
- PHM is a core enabler to achieving a shift to pro-active care, supporting the neighbourhood model and addressing health inequalities. In addition, it is a requirement of the Model ICB.
- We have a plethora of existing population health work across the system, with pockets of good practice on which we can and should build. A mapping of this work has been completed (see Appendix B).
- **However, despite the significant work in PHM over the past c. 5 years, feedback from across the system is that we need to find coherence based on a shared aim and vision.**
- Since December 2024, the PHM Programme has attempted to engage with colleagues from across the Trusts, including all Boroughs and Trusts. The programme has been led by a 'core team' of enthusiasts who bring together expertise across data and digital alongside colleagues from Trusts (GSTT and LGT) and a Borough (Bromley).
- Together we have been seeking to cover the breadth of the ask:
  - Bringing together the technical requirements (data, analytics) with the need for implementation and learning
  - Understanding the different user groups including analysts and other data specialists, strategic commissioners, Integrators and Neighbourhood Teams, Trusts, enthusiasts in the system, and front-line clinicians for direct care delivery
- Recognising the number of voices in this space, and that different interpretations of 'PHM' had led to confusion, we chose to undertake this from first principles, using engagement (see appendix C). The programme plan is set out on p. 3.
- We need to recognise that this is a journey. We are building on a myriad of existing projects, but we are still a long way from comprehensive and equitable access to PHM capacity and capability. This won't be 'fixed' immediately; this is a long-term shift in how we plan and deliver pro-active care.
- *N.B. To support this document, Appendix A sets out key definitions.*

The design is a milestone in our PHM Programme Plan



Developing the design options

- In December 2024, the PHM Programme was refreshed, with a new focus on PHM as an approach to how we plan and deliver care, and not just a data / digital tool.
- Since then, we have used cross-system engagement to work from first principles, using the 'function over form' principle to work towards design options for the structural form and technical solution.
- This process has also identified a range of standards or frameworks which need to be in place to support new ways of working. Some of these already exist, and many are being addressed in other programmes of work.



Aims and vision for PHM in SEL

Based on discussions with SEL stakeholders and national guidelines, we have broadly four aims:

1. Front line clinical and care professionals will have easy-to-use access to the right data, by which they can deliver targeted and pro-active services which reduce health inequalities.
2. Our Integrators will be supported to effectively plan, deliver and evaluate integrated neighbourhood-based health services.
3. We will have the data and evidence to become a learning system, embedding continuous learning, sustainable QI, evaluation and research into our way of operating.
4. As we plan, deliver and evaluate our services, we will have the information required to drive towards financial, environmental and service sustainability.

Our vision is for a common SEL PHM approach, supported by a shared PHM function, which will deliver these aims and meet the requirements set out in the Model ICB document

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Functional design

Functional design: Setting out and grouping the functions and standards

Through cross-system engagement, including two workshops, a view on the functions and standards required to deliver our vision has been developed. These functions/ standards can broadly be mapped into four groups.

Agree once for SEL

- System population segmentation approach and risk stratification model
- A shared approach to setting outcomes frameworks
- System-wide incentives and funding/ ROI models for PHM, including GPs
- Framework for VBC / ROI calcs (including financial, environmental and service sustainability)
- Framework for data standards and coding
- Framework for community engagement
- Framework for health needs analysis
- Framework for co-design with the community and VCSE partners
- Framework for project delivery incl. monitoring, governance and continuous learning – how to do a project within a PHM structure
- Framework for evaluation (incl. Value Based Care, co-design and care co-ordination)

National and/or regional offers

- London Data Service (LDS) will provide the data
- The London Research Platform is agreed. Other analytics platforms may be available.
- National training offers e.g., Making Data Count
- Collating the evidence base for national priorities

Do once for SEL[1]

- Clear system priorities with a problem definition and outcomes frameworks for all parts of the system, which shows how this will benefit everyone
- Manage relationship with key partners including the LDS (to expand the data set), the AI Centre and KCL.
- SEL-side technical support for the SEL Snowflake Environment and expansion of the SDE data
- Provide / procure an SEL shared analytics platform and real-time risk stratification tools which meet the needs of all user groups.
- System IG framework and managing IG arrangements for the LDS and shared analytics platform
- Commissioning for pro-active care (incl. incentives), and movement to population health budgets
- Support for service design around system priorities, including collating the evidence base for system priorities and developing shared ROI models
- Signpost to education and training offers, including sustainable QI

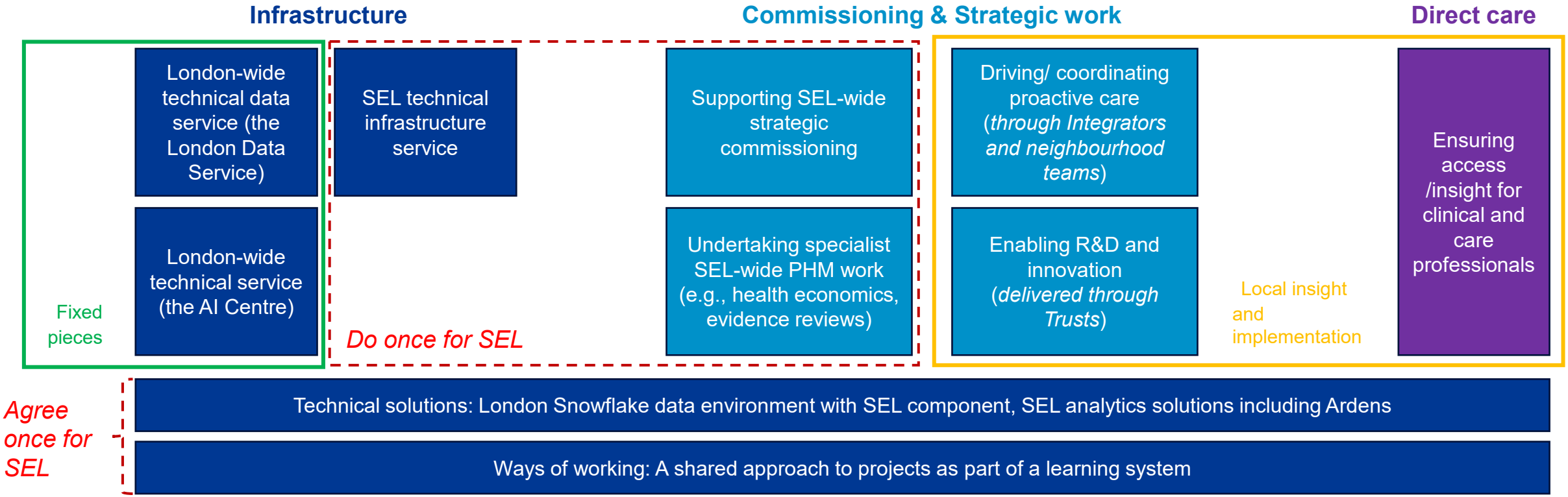
'Local' functions[2]

- Clear local priorities with outcomes frameworks
- Local interpretation of the analysis
- Design and implementation of interventions, including ROI calculations
- Engagement with clinical and care professionals to implement and expand the use of PHM
- Use of population segmentation and real-time risk stratification tools to enable proactive care
- Supporting the shift to more care in the community (e.g., by exploring new funding models based around patient cohorts (as opposed to specialties/ services)
- Embed PHM into leadership structures and expectations
- Cultural shift throughout the system, supported by OD, to break down organisational boundaries and move PHM into business-as-usual
- Support for PHM-based R&D
- Delivery of education and training offers

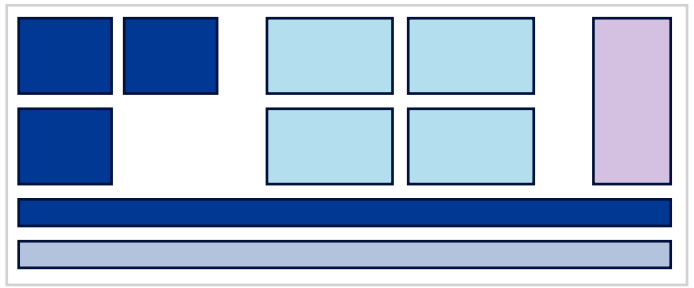
1. This makes no assumption as to the organisational host of these functions. 2. Includes functions to support Integrators, Neighbourhood Teams, Trusts and other specific organisations

Functional design: Mapping the functions into design areas

- Working from first principles, we have engaged stakeholders from across the system to establish the functions required to deliver our SEL vision for PHM.
- To translate these functions into practical design options, we have divided them into interconnected areas based on:
  1. The capability/ capacity/ infrastructure required to complete each function (e.g., managing technical infrastructure vs. strategic analysis vs. delivering front-line care)
  2. Whether functions are 'do once for SEL', 'agree once for SEL', or require local insight and implementation
  3. A recognition of the 'fixed pieces' on the board (e.g., the London Data Service, the Ardens contract).



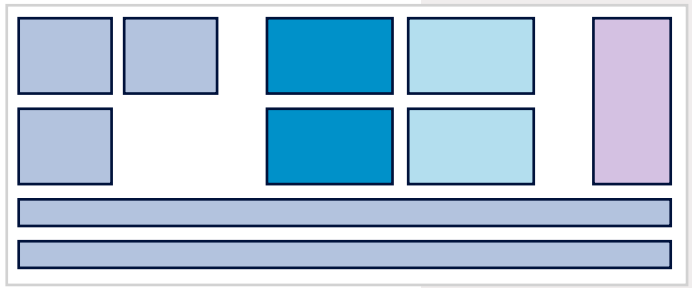
Mapping the functions
London and SEL infrastructure



London-wide technical functions (*including London Data Service & AI Centre proposals*)	Functions required in SEL technical service
• Provision of a single data set which grows to include all relevant qualitative and quantitative data sets (see p. 19 for more information) The AI Centre has been commissioned to: • Create a central library of code, tooling and predictive analytics models which can be applied (with local adaptation) across London. • Specifically in 25/26, develop tools that will support the design, delivery, and evaluation of new care models, by developing tools for Segmentation / Stratification / Needs identification which can be applied across London. N.B. Funding for AIC team is available from OneLondon until April 2026, to cover the work outlined above across London ICBs including SEL. Funding for 26/27 is being sought.	• Holding relationships with the London Data Service and AI Centre regarding technical developments • SEL-side support for the integration of additional data sets • Provide an SEL shared analytics platform and real-time risk stratification tools which meet the needs of all user groups.

A separate options assessment for the SEL analytics solution(s) is considered on pp. 23-24

Mapping the functions
SEL strategic commissioning & insights



ICB Insight Function

1. These functions are necessary, but not sufficient, to support strategic commissioning, and would need to align to broader insight and other functions.

PHM functions required to support strategic commissioning[1]

- Clear system priorities with a problem definition and outcomes frameworks for all parts of the system, which shows how this will benefit everyone
- Strategic health assessments at a system level
- Clarity on payments and incentives for PHM work, including commission for pro-active care and movement towards population health budgets
- Embed PHM into leadership structures and expectations, and work with ICB leadership to support the cultural shift throughout the system, supported by OD, to break down organisational boundaries and move PHM into business-as-usual

Specialist PHM functions required at a system level

- Develop SEL risk stratification models, work with public health specialists and health economist to undertake whole-system AI/ machine learning analyses, and build appropriate user-friendly tools for priority cohorts, including in partnership with the AI Centre.
- Evidence reviews for cross-system priorities, including and working with KCL and the AI Centre
- Analysis of Return on Investment for major cross-system initiatives
- Set out the education and training offer, signposting to local offers where available and upskilling the workforce where required.

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Mapping the functions
Integrator/ Neighbourhood functions

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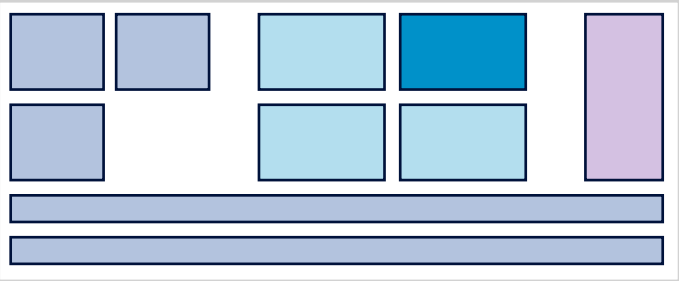

Functions required to support Integrators / Neighbourhood teams
• Use of population segmentation and real-time risk stratification tools to enable proactive care through neighbourhood teams • Clear local priorities with outcomes frameworks, with a drive towards service, environmental and financial sustainability. • Local interpretation of analysis (as completed by either system-level analysts and/or specialists, or through a shared analytics platform). This includes overlaying local data (where it is not yet included in the London Data Service) and qualitative intelligence. • Local input into and interpretation of evidence reviews and return on investment analyses (using the shared framework for VBC / ROI calcs, including financial, environmental and service sustainability). • Embed PHM into Integrator and Neighbourhood Team leadership structures and expectations, with sufficient engagement with and empowerment of leaders, front-line clinicians / care providers and other colleagues

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Mapping the functions
Trust functions

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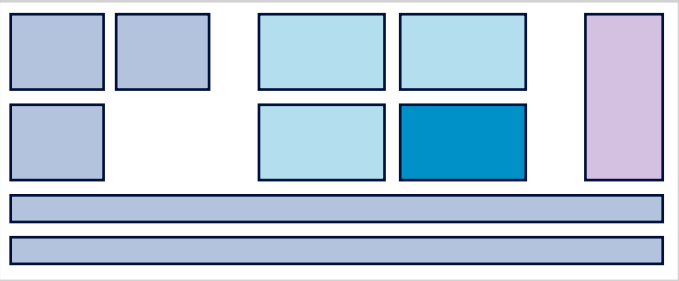

Functions required to support Trusts (*where applicable, this is in parallel to functions related to hosting Integrator arrangements*)

- Use of population segmentation and real-time risk stratification tools to enable proactive care within the context of acute services, working in partnership with Neighbourhood Teams (including through the Integrators)
- Clear organisational priorities with outcomes frameworks, , with a drive towards service, environmental and financial sustainability.
- Supporting the shift to more care in the community (e.g., by exploring new funding models based around patient cohorts (as opposed to specialties/ services)
- Enabling research and innovation within the trust (supporting the R&D agenda)
- Delivery of education and training offers (as existing offers – ask to consider opportunities to share with the broader system)

South East London Integrated Care System

Mapping the functions
Supporting direct care

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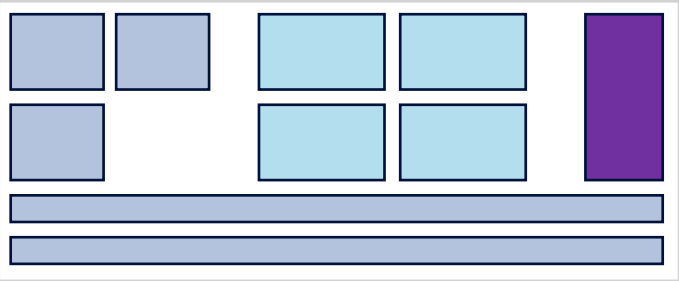
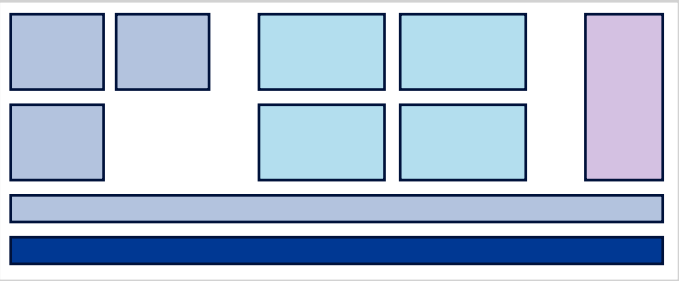


Functions required to support direct care and the shift towards PHM as an embedded way of working
• Use of real-time AI-driven predictive risk tools to support individual patient care • Use of holistic shared-assessment care planning tools. • Use of PHM tools to support capacity and demand management • As set out in the NHS 10 Year Plan, direct care providers will need to move to integrate the use of wearables and additional opportunities for remote monitoring into their clinical practice. • Support to improve data quality through improved coding practices. • Inclusion of patient wellbeing and patient experience data.

Mapping the functions
Shifting ways of working (*working with teams across the system*)



Standards and frameworks (*N.B. many of these are held outside of the PHM programme and will be drawn on to support the shift to PHM – see p. 24*)

- A shared approach to setting outcomes frameworks
- System IG framework
- Agreed system population segmentation approach and risk stratification model
- Framework for data standards and coding
- Framework for community engagement
- Framework for co-design with the community and VCSE partners
- Framework for health needs analysis
- Agreed approach to assessing the environmental impact of interventions/ services, and the inclusion of environmental sustainability within decision making
- Framework for project delivery incl. monitoring, governance and continuous learning – how to do a project within a PHM structure
- Framework for evaluation (incl. Value Based Care, co-design and care co-ordination)

A separate review of the consistent standards/ frameworks to be agreed is provided on pp. 25-28

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Options for the structural form

Structural form: considerations

Translating the functions into a proposed form requires us to recognise several design principles and contextual realities:

- Given the system's financial position, the structural form must deliver the maximum value for the minimum investment, whilst still meeting our core aims for PHM. Duplication of function should be avoided where possible, and expensive specialist resource should be shared across the system.
- However, balanced against this is the recognition that delivery will need to align to the Integrators and the Trusts. Learning from the LGT PHM team tells us that local-facing resource with the ability to overlay local insight and undertake engagement with front-line colleagues is critical to success.
- It is also recognised that the ICB as an organisation is undergoing a major change programme which must result in a substantial reduction of staff costs. Whilst the future structure must meet the functions set out in the Model ICB document – most notably to support strategic commissioning – there is a drive to combine functions within a provider where it is efficient to do so.
- The balance between resourcing and reach will also require us to be smart as a system as to what can be achieved through providing access to a shared analytics platform, versus what work should be supported by the time of analysts and/ or PHM specialists (including the AI Centre). For this design, we have assumed that the system reserves the use of analysts/ specialists for strategic priority projects, as is currently the case.

Straw man for discussion

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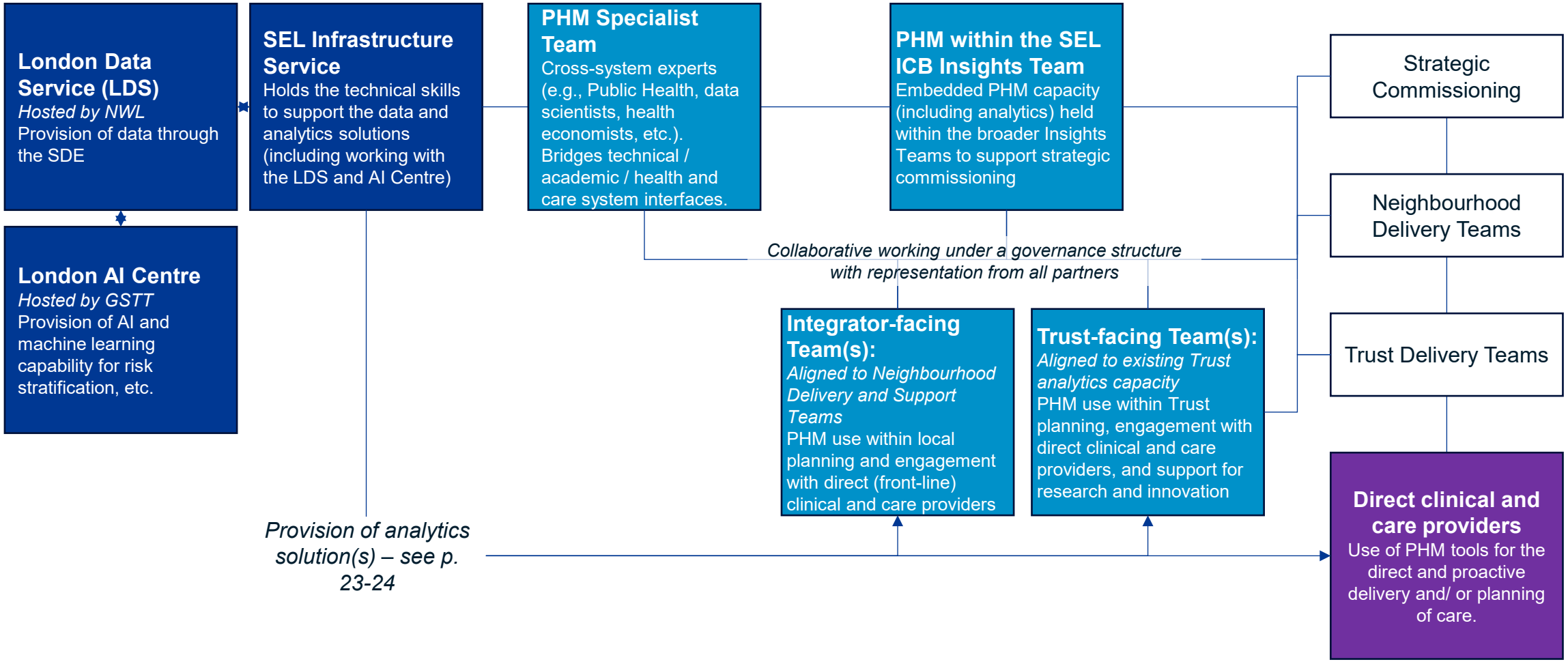
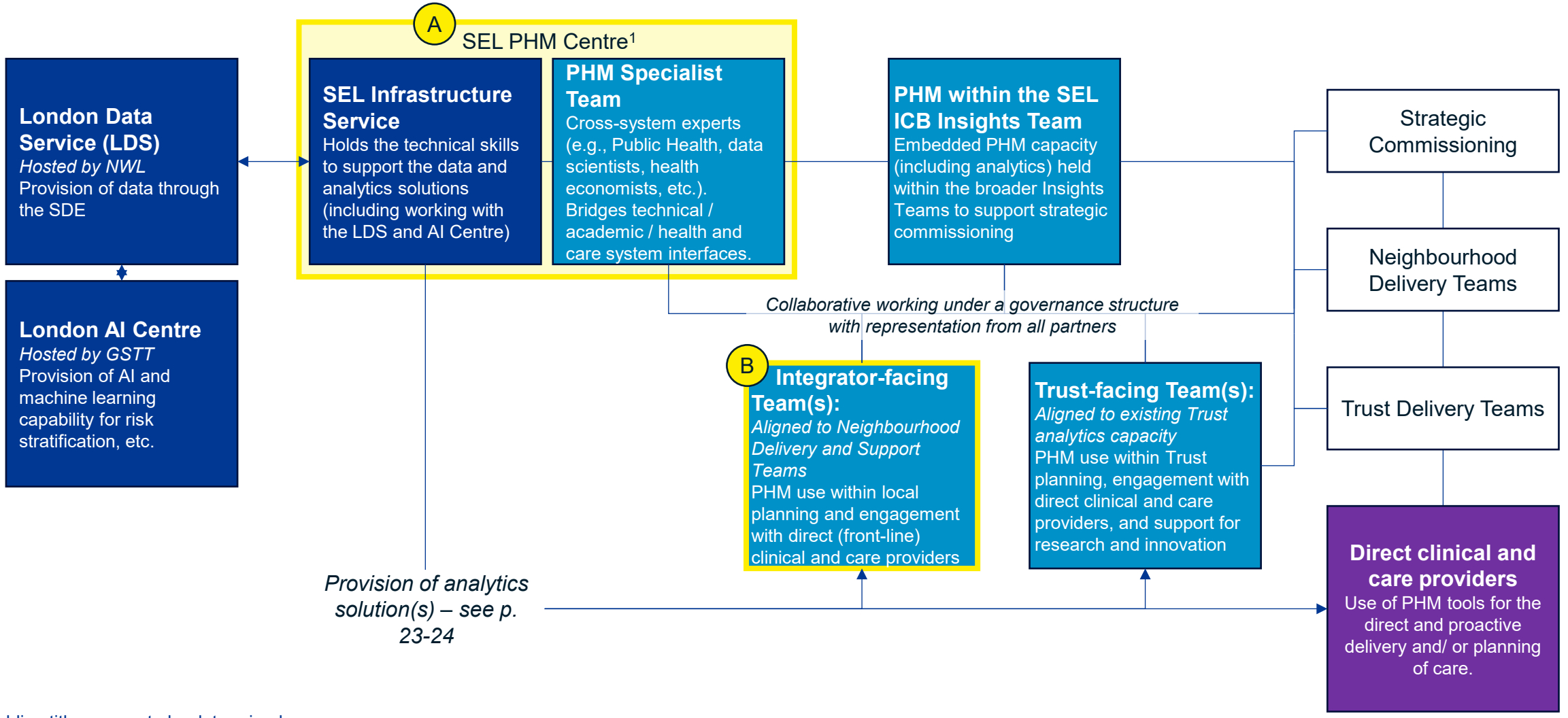
Structural form: the key components



Straw man for discussion

Structural form: components without a clear 'home'



1. Holding title – name to be determined

Straw man for discussion

South East London Integrated Care System

Governance, leadership and ways of working

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Governance

- PHM would require a business-as-usual cross-system board with responsibility for agreeing priorities and ensuring a coherent work programme. This could evolve from the existing SEL PHM Delivery Board (which has been created as a time-limited programme board).
- In addition, if PHM functions are delivered on behalf of the system through a provider or provider network, that would need to be structured as a contracted service with clear deliverables. The ICB would maintain a role in the management of that contract, under the strategic leadership of the cross-system board.

Leadership

- One of the reasons PHM is difficult to embed is that it spans between technical requirements (needing data and digital expertise), population and public health, clinicians, planners and operational colleagues. Leadership would need to bind these components together, drawing on the strengths of the different expert groups.
- It should be noted that visible clinical leadership will be key; within SEL CESEL has demonstrated the power of clinician-to-clinician engagement. Borough and pathway clinical leaders will need to maintain a link to the PHM functions.

Ways of working

- Embedding PHM will require cross-organisation and multi-disciplinary working. Learning from the Lewisham and Greenwich team shows that building relationships between clinicians, planners and analysts is key to delivery.
- Thought will need to be put into how to build a networked team which genuinely works together. For example, the team should spend time together on a regular basis, and understand each others work programmes.

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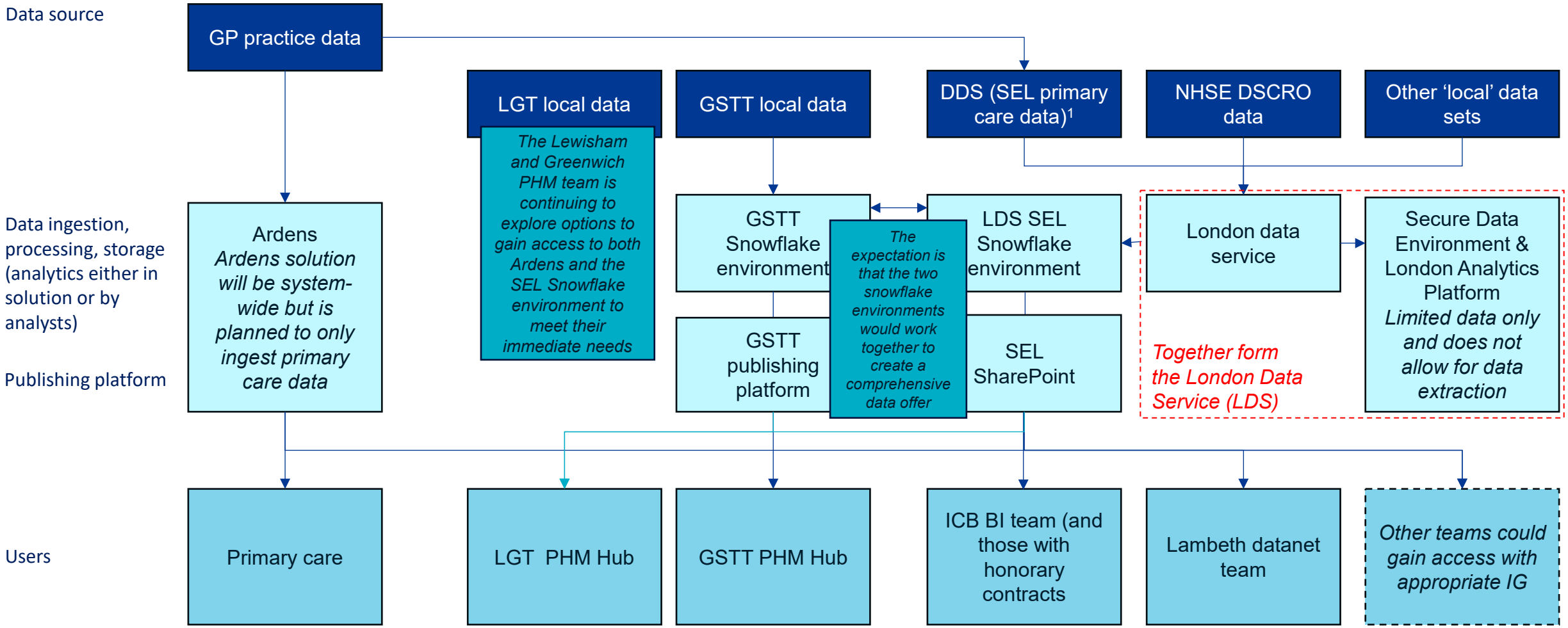
Options for the technical (data and analytics) solution(s)

Data: A simplified view of the current/ near-term SEL data flows



1. DDS will be replaced with the London data service

Data: The SEL Snowflake (fed from the London Data Service) provides near-term and future opportunities

London Data Service

The SEL Snowflake environment currently receives primary care data, NHSE DSCRO data and some other local data sets from the London Data Service (LDS).

Opportunities with the current SEL Snowflake:

There may be an opportunity to grow the data within the LDS (see right).

The SEL Snowflake does not hold patient identifiable data. However, work is ongoing regarding potential re-ID tools for direct patient care use cases, subject to appropriate IG.

The SEL Snowflake should be able to 'speak to' the (currently under procurement) GSTT Snowflake environment; strategically this is critical.

Built for research, the Secure Data Environment also receives a subset of the LDS data. This data is 'locked down' in that SEL cannot extract the data for local dashboards, etc. However, there may be an opportunity at a London level to use the SDE for some pan-London tools.

Potential to expand the LDS

By December 25 we have committed to setting out a prioritisation for the inclusion of additional data sets, building on the priorities already established between the ICB and LDS (and recognising that LDS has limited capacity).

We will need to consider the various use cases and system priorities, as well as the cost and technical barriers to including the data.

Further data could be included in the SDE either through:

1. Direct integration of the data set. This has an associated cost and would need to be agreed with the London Data Service.
2. Coding the data into a data set which is integrated (e.g., initially EMIS). This would require an engagement and/ or training programme to ensure clinician buy-in.

Additional data sets requested (in no particular order) include:

- Acorn
- EMIS Community
- Trust EPR data
- Patient wellbeing and experience data

Analytics: User group requirements mapped against possible solution types

User group	Requirements	Suggested solution (s)	Mapping against possible solution types: Direct access to data / back end	Front end curated dataset with ability to query ('analytics platform' – see next page)	Front end curated dataset in standardised and consistent dashboards	EPR linked alerts and flags	Delivery options
Direct and Proactive Care Delivery	An ability to view structured information quickly and easily, while delivering or planning care - Individual and population views of insights, consistent (cohort agnostic) and simple user interface, insights are easily obtained and viewed (no work required), specific tools for priority cohorts, ideally push alerts to EPR systems, from population views, for individual people's care (identifiable data needed)	Information pushed into EPR systems. Purpose built dashboards for population groups, ability to drill down to patient lists and to individual people's care records and insights for onward action.	*Not required*	*Not required*			• Procure a commercial analytics solution • Collaboration with AI Centre to build a solution for SEL / London. • **<u>If not linking to EPR</u>:** Use of SEL Snowflake dashboards or dashboards from the London Analytics Service (extended from WSIC)
Planning	An ability to view structured information quickly and easily with population views of insights, consistent (cohort agnostic) and simple user interface, insights are easily obtained and viewed, specific tools for priority cohorts. Pseudonymised data needed.	Availability of population dataset within an "analytical" platform, which allows skilled planning users to run their own queries and generate their own outputs.	*Not required*				• Use of SEL Snowflake dashboards • Procure a commercial analytics solution • Collaboration with AI Centre to build a solution for SEL / London.
Clinical and Care Leads with interest in data and analytics, Place teams and or BI Teams supporting PHM	An ability to look at curated and normalised information, generate queries and investigate problems (a degree of skilled self-service access to curated data). Pseudonymised data needed.	Availability of a curated dataset within an "analytical" platform, which allows skilled clinical data users to run their own queries and generate their own outputs. Where applicable, access as for Direct and Proactive Care Delivery (above).	*Not required*				• Use the London Analytics Platform (NWL WSIC) • Create an appropriate SEL Snowflake area and curated dataset for a group of authorised clinical analysts, with a sharepoint space to publish reports and outputs.
Skilled analytical specialists	Regular reporting tasks such as national returns or requested information for local commissioned schemes. An ability to analyse information and generate a range of analytical outputs and queries, including building reports and dashboards were requested (bespoke work). Pseudonymised data needed.	Availability of an "analytical" platform and appropriate datasets, which allows skilled BI and Analytics staff in the ICB to run their own queries and generate their own outputs, incluing bespoke requests.				*Not required*	• (Already in place for SEL ICB BI users) SEL Snowflake environment containing agreed national and local datasets accessible by an agreed set of users, with a sharepoint space to publish reports and outputs.
Research and Innovation	An ability to undertake research generate queries and investigate problems centred on agreed, authorised (SEL DUC and Ethics cttees) research. Anonymised data requirement	Availability of an anonymised dataset, in an open analytical environment, which supports skilled researchers to develop complex queries.	*Not required*		*Not required*	*Not required*	• Use the London Research Platform (part of the London SDE)

Analytics: platform options

N.B.: **solutions are <u>not</u> mutually exclusive ad be layered, save for the desire to avoid duplication**. For example, SEL access to the London Research Platform is agreed regardless of other platforms.

Potential platform/ platform provider	Relevant user groups	Strengths	Weaknesses	Timescale to implement	Addiitonal cost	Likely part of the near-term / long-term solution?
Ardens	GPs, Neighbourhood Teams and Integrators	Integration with the broader Ardens solution, with a RAG risk flag being pushed directly into the patient record.	Ardens will only access GP data on EMIS. The RAG risk tool, whilst meeting the GP contract, is a simple segmentation we would seek to replace.	Implementation is due to take place by September 2025	None Ardens has been procured for the next three years for the broader 'Modern General Practice' requirements	Yes. Ardens has been agreed with a three-year contract.
SEL SharePoint-hosted dashboards linked to SEL Snowflake	All (developed by analysts)	Continuation of existing dashboards, including those developed by the ICB BI team, with the opportunity to add LGT and other dashboards	Continuation of the current resource requirements to build dashboards (does not move towards greater automation)	In place. LGT access timescale in the order of months	Initial cost for migration, followed by low additional ongoing costs	Yes.
GSTT-hosted dashboards linked to GSTT Snowflake	GSTT, potential for LGT	Supports GSTT's PHM ambitions and works with the GSTT Snowflake environment	Continuation of the current resource requirements to build dashboards (does not move towards greater automation)	Snowflake environment under procurement; data integration would need to happen post-April 26	Initial cost for migration, followed by low additional ongoing costs	Yes
London Analytics Platform (building on NWL WSIC)	All	Low risk around deliverability	The platform would not be tailored to SEL. We have yet to explore the functionality of WSIC.	TBC – likely to be deliverable within months as it would leverage the existing WSIC platform (which pulls from the SDE)	London-level costs are currently covered via existing capital and ICB agreed payments. However, the cost of a new / expanded SEL/ London solution has yet to be determined.	Yes – there is a clear direction of travel towards a London-wide analytics platform, with ongoing conversations
A different London-wide analytics solution (e.g., a solution built in partnership with the AI Centre)	All	Bespoke solution for London or SEL with the ability to build out into new functionality (e.g., Natural Language Processing)	High risk around deliverability. A London-wide solution would not be tailored to SEL.	TBC – expected to be significant, into 2026/27 and beyond		
Commercial solutions (e.g., Optum, HealtheIntent)	All	Low risk around deliverability with a rapid implementation timeline	High cost, either through an upfront implementation or as a gain-share agreement. The platform would not be tailored to SEL.	TBC – initial conversations with Optum suggested a timescale in weeks/ months	Very high (based on Oracle cost for LGT)	Unlikely due to cost
London Research Platform	Researchers	The SDE/ London Analytics Platform is already established for research.	Platform is limited to research use cases.	In place	Current London-level costs are agreed, as above.	Yes

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Consistent standards/ frameworks

Required standards/ frameworks

Standard/ framework	Progress
System population segmentation approach and risk stratification model	See pp. 27-28
A shared approach to setting outcomes frameworks	Outcomes frameworks have been/ are being developed for the three INT priority cohorts, and for the development of INTs.
System-wide incentives and funding/ ROI models for PHM, including GPs	To be developed over time through strategic commissioning, in partnership with Integrators and Neighbourhood Teams
Framework for Value Based Care / Return on Investment calculations	The Prevention Programme has been leading work to agree a Return on Investment approach for SEL.
Framework for data standards and coding	Various programmes (e.g., CESEL) are working on improvement data standards and coding. However, this is an area flagged as requiring a concerted programme of work.
Framework for community engagement and for co-design with the community and VCSE partners	The SEL Engagement toolkit (Engagement toolkit - South East London ICS) is in place.
Framework for health needs analysis	There is no single SEL approach to either completing health needs analyses or project delivery. Across the system various approaches exist; these should be considered to understand (1) areas of best practice, (2) existing areas of overlap/ consistency, and (3) areas which require consistency.
Framework for project delivery incl. monitoring, governance and continuous learning – how to do a project within a PHM structure	
Framework for evaluation (incl. Value Based Care, co-design and care co-ordination)	A partnership between the HIN, KCL and KHP has piloted evaluation clinics; following positive feedback these are being continued. The discussion is now broadening out to consider a framework for evaluation that leverages existing available resources.

Population segmentation model and risk stratification approach: our roadmap to maturity

Summer 2025 – primary care (see p.x)

Primary care requires a model to meet the GP contract, to be integrated into Ardens. The proposal is:

- As an interim solution, a basic population segment approach is applied to split out the priority cohorts (CYP, MLTC, frailty). A broader free model (e.g., Bridges to Health) could be used as an interim model. This would be replaced with the agreed national / regional model.
- A second segmentation is applied based on Ardens 'RAG' model. In the future, this would be replaced by an agreed SEL risk stratification approach.

By end of 2025/26

- A full population segmentation model is agreed for SEL. This may be a national or regional approach if procured. If no national/ regional model is agreed SEL should agree a consistent model locally.
- Working with the AI Centre a risk stratification approach is modelled for the three priority cohorts.

- Growing sophistication in risk stratification as the system moves towards a shared and validated approach.

End state

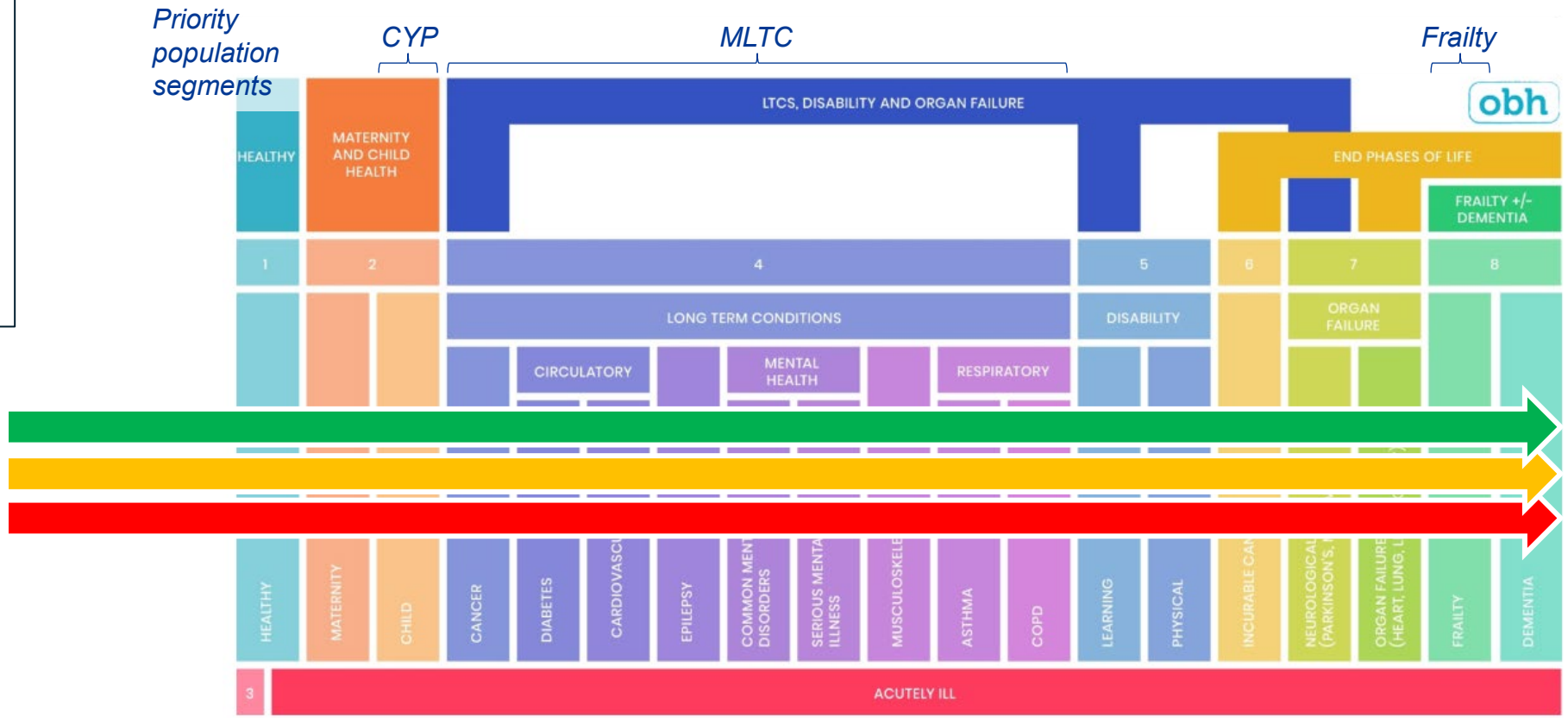
In the end state, the population segmentation model and risk stratification approach are defined for SEL:

- The population segmentation model is likely to be defined and procured at a national or regional level. This must define the top-level segments and ensure a common starting point but still allow for local sub-segmentation / nuanced analysis.
- The risk stratification approach is expected to draw on the expertise of nationally procured solutions, the AI Centre and existing SEL experts to define how we segment. This approach can then be applied to relevant segments.

Population segmentation model: our starting point for primary care

Ardens allows us to meet the PCN DES requirements through its PHM tool which applies two approaches to segmentation. GPs can pull out 'Red' for each segment (e.g., patients in the Frailty segment who are 'Red'). The tool is live at a practice, place, PCN and ICB levels, and work is ongoing to expand access to INTs as they come online.

1. A consistent (interim) segmentation approach is applied to include the three priority cohorts of CYP/ frailty/ MLTC. [For simplicity, the current proposal is to base our approach on the Bridges to Health model; this would be replaced by a London/ national segmentation approach when available.]



2. The Ardens RAG model (an interim model, see Appendix A) is applied across the entire population. In time this would be replaced by a modelled risk stratification approach.

1. Source: Outcomes Based Healthcare at Part 2: Whole Population Segmentation Models – Outcomes Based Healthcare

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Testing the options

How would this work in practice?

Example: A data-enthusiastic Trust CD considering service redesign (not within a system priority area)

Continuous learning cycle

Project overview:

- The CD would use the system frameworks for project delivery and evaluation (see p. 24) as the basis to set up the project.
- They would need to define the problem, theory of change, and implementation plan. If needed additional support would be given through the HIN/ KHP/ KCL Evaluation Clinics.
- The project should be put through the PHM governance [/ system forum] to note the project and ensure that the frameworks have been followed.

Needs assessment:

- A needs assessment would need to be completed using the system framework (see p. 26).
- Data would be accessed through the analytics platform (see pp. 20-22). If a Trust PHM team exists, they may provide support, although the intention of the platform is to minimise the need for analyst resource.
- The CD would speak to the ICB Insights Team and their Integrator-facing function to draw on existing analysis.

Gap mapping services and systems

- Based on the needs assessment, the CD / service team would consider the gap within their local context to build a hypothesis on the problem and potential solutions.
- At this stage either the Trust or the Integrator-facing PHM team would need to provide support/ a critical friend for the building of a logic model. [There could be a system network for the testing of these logic models, and to identify any similar projects happening elsewhere.]

Evidence review

- As this is not in a system priority area, the CD would need to conduct their own evidence review to support a business case for the change. The approvals process would be within the Trust, although the established connections with the ICB Insights Team and their Integrator-facing function should ensure that the recommendation is supported.

Create solutions

- The service would use the system community engagement and co-design frameworks (see p.24) and may draw on Trust engagement resource.
- The CD would be responsible for driving the project. However, assuming the redesign is towards neighbourhood care the Integrator and Neighbourhood Delivery and Support Teams would provide support for the project creating a (pseudo) project delivery team.

Implementation and Evaluation

- The implementation and governance should align to the project delivery framework and meet any Trust requirements.
- Continuous learning and evaluation should be completed as defined at the project outset. Outputs should be shared back through the PHM governance [/ system forum].

Decision to stop / continue would be taken at a Trust level

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Appendix A: Definitions

Population Health Management (PHM)

Population Health Management (PHM) involves using data we hold about our patients and communities and their health requirements to plan how we deliver the best, tailored care for our local population. As an approach, it uses data to design new ways of proactively offering patients care before they need to go the NHS with a problem – and helping them to improve their health and wellbeing.[1]

Components of PHM[2]

Infrastructure

Leadership, population definitions, data infrastructure, information governance, digital maturity, capacity and capability (including analytics)

Intelligence

Understanding population need, opportunity analysis, tools to target those in need, impact assessments

Interventions

Implementation of effective interventions, workforce, patient empowerment and activation, care integration, evaluation

For more information see Population Health Management - South East London ICS

1. From SEL ICS website 2. NHS England PowerPoint Presentation.

Population segmentation vs. Risk stratification

Population Segmentation

Dividing the population into more manageable chunks or segments. At every point in their life, every person should fit into one of these categories, and there should be no individuals who do not fit into a segment. This is not based on a predicted risk, but on known factors which impact on need e.g., age, known conditions. Examples of population segmentation models include Bridges to Health and Johns Hopkins.

Care can be planned to support a particular segment. For example, within the Outcomes Based Healthcare segmentation model, adapted from the Bridges to Health model, four segments are included within the red 'severe' groups: acute conditions, incurable cancer, organ failure, and frailty and/or dementia[1]. However, this is the use of population segmentation as opposed to the application of a risk stratification.

Risk stratification

Risk stratification looks for individuals who are most at risk of deterioration or at risk of a significant care event (e.g., hospital admission). For risk stratification, first a single risk to be avoided must be agreed (e.g., non-elective admission). A risk stratification approach identifies the factors (preferably by a regression analysis on your whole population data) that determine whether a certain event, like a non-elective admission, will occur. This allows for specific patients or patient cohorts to be prioritised for proactive preventative care. As the approach is implemented a feedback loop should allow for the factors to be updated.

1. OBH-Part-2-Segmentation-for-Outcomes-Updated-Oct-2018.pdf

The Ardens RAG model

The definitions below are used nationally by Ardens to define their Red, Amber and Green populations.

Red
- Latest Risk Group (Done Here) = Chronic long-term disease management required: complex needs (416357003) without more recent diagnosis of eligible triggers
- Frailty - Severe
- End of Life
- >=5 LTCs (as defined by NICE)

Amber
- Not in Red
- Latest Risk Group (Done Here) = Chronic long term disease management required (416239002) without more recent diagnosis of eligible triggers
- Frailty - Moderate
- >=2 LTCs (as defined by NICE)
- New Cancer Diagnosis in last 1y

Green
- Not in Red
- Not in Amber
- Latest Risk Group (Done Here) = General health good (135815002) without more recent diagnosis of eligible triggers

Supporting Resources
- Patient cohorts for continuity review (e.g., housebound, care home, LD, MND, MS, PD, SMI, Dementia)
- Where a continuity need has not been reviewed in more than X months
- Where a continuity need was previously recorded but has since been overridden by a new diagnosis
- Patients in Green/Amber/Red with disproportionate appointment use (e.g., Red with low, Green with high)

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Appendix B: Mapping of existing PHM capacity and capability

Capacity and capability mapping

Scoping & approach

- Defined scope based on the PHM approach (including data, analytics, insight, delivery and evaluation)
- Agreed semi-structured interview questions
- Set approach based on clinical and non-clinical interviews across two lens: organisational and programme (with additional interviews as required)

Programme lens

Clinical and non-clinical representatives of the priority programmes were invited for interview. Discussions have also been held with CESEL, the CPN and SLOSS

Discussions were allowed to follow the maturity of the programme (questions from the semi-structured interviews were used when appropriate).

Overarching themes from across the interviews have been pulled out

Organisational lens

Representatives from all Boroughs and Trusts were invited for interview. Where multiple local stakeholders exist, all were invited to participate

Semi-structured discussions were completed with detailed information recorded

Overarching themes from across the interviews have been pulled out

Gaps & opportunities

- The themes from both lenses are presented here; there is significant overlap in the key messages.
- Based on the themes drawn out, major gaps/ opportunities are proposed, for discussion in this workshop

Organisational lens: questions and summary

Clear vision for PHM

Population Health Management is articulated in different ways / It is not always clear who is responsible for supporting organizations with PHM approaches and / or data

PHM projects

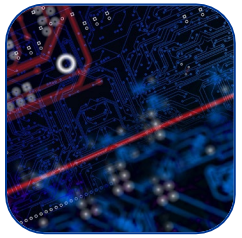
Ad hoc pockets of work are underway / Success typically depends on having a delivery vehicle in place to take action / Best practice sharing is limited / Support welcomed on PHM ways of working and project pre-requisites

Capacity

Capacity, including analysts, is limited across the system and varies between organisations / Dedicated PHM roles less common, often on top of core role / Specialist skills needed e.g Data scientists.

Data

Inconsistency in the data available across SEL / Gaps in data means making the best of what we have / this hinders the work and being able to mature / want to know what data is available when so decisions can be made locally on what to do.



Technical advances

Opportunities (e.g., longitudinal patient linked data sets, natural language processing) are recognised/ Though not yet systematically implemented if at all.

Population segmentation

There is uncertainty about the approach to population segmentation / An openness to a single system approach / But there are trade-offs in terms of quick implementation vs usefulness vs cost.

Evaluation framework

Almost all interviewees would like an agreed project evaluation and tracking framework.

Barriers to PHM maturity

Hard to do the work we want to due to data restrictions / And without the data less point in having a dedicated PHM team / technical skills varied / Unsure about PHM approaches

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Programme lens

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	Priority Area	Capacity	Capacity Status	Capability	Capability Status
1	**CYP (Children & young people)**	• Clinical lead new in role. • Key priorities have remained consistent for the past decade. Significant inequalities persist. • Bromley, Lambeth, Southwark, have established integrated child health teams, Bexley, Greenwich and Lewisham still in the process of developing those. • Identified bundles of care and mapped what is available across southeast London for different areas. Reliance on process measures as outcomes e.g.wait times. • Lack capacity to proactively reach patients despite availability of data	Minimal	• Bromley Child Health Integrated Partnership is working to reduce wait times and improve services available making it possible to proactively identify unmet need • Lack an effector arm e.g. Bromley lacks a children's asthma service to refer into • BCHIP focuses on deprived areas like Penge and the Crays • Existing EMIS data is used to support predetermined priorities which are set nationally. This is supplemented by local clinical knowledge, but data is not used to provide local insights	Some
2	**MLTC (Multiple Long-Term Conditions)**	• In the MLTC workstream, 6 Integrated Neighbourhood Teams (INTs) have been identified for cardiorenal metabolic pilots. • £2 million was allocated (originally CKD-focused) but broadened to cover multi-morbidity, cardio-renal, and metabolic conditions. • There is an effort to compare and align approaches across PHM, care coordination, case management, and establishing universal care plans . • The frailty pathway is being closely integrated into this work — recognising that not all frail individuals have 3+ LTCs, and some people with a single severe condition (e.g., heart failure) may be highly frail.	Some	• Integrated data from acute care, primary care, local authority, and mental health providers; • Multiple dashboards exist for data analysis. • Established information governance facilitates data sharing in Lewisham but no current patient involvement; PHM strategy not developed yet. • Focus areas include musculoskeletal review, hypertension, moderate frailty, and atrial fibrillation data.	Some
3	**Frailty**	• Analytics tools are available, but often they are not used effectively by clinicians. • Tools are not necessarily user-friendly and don't cater for data enthusiasts & those who want simple descriptive analytics • Able to generate interactive dashboard ,but not always necessary • Clinical engagement with data identified as a significant barrier	Some	• Strong focus on embedding community engagement in PHM projects. • Focus area: Vital 5 (current focus is on planning next steps and defining governance), Research group that focuses on increasing participation from communities, improving dashboards, improving data recording by making fields in Epic mandatory/hard stop (eg demographics).	Minimal
4	**Prevention**	• No financial or human resources available in primary care to undertake improvement projects. • Lack of financial incentives e.g. QOF payments to incentivise preventative care • Difficulty in measuring long term outcomes to justify pathway redesign • No strategic PHM approach in primary care; confusion among PHM, Public Health, and Health Inequalities exists; PHM viewed as an additional demand in primary care without the capacity to implement it.	Minimal	• GPs typically do not review data or engage in improvement activities relating to prevention. • Access to EMIS exists, but there's a lack of support, such as analysts or project management in primary care.	Minimal

Gaps and opportunities identified in the mapping

	Gaps	Opportunities
Infrastructure	• SEL has a single definition of PHM (Population Health Management - South East London ICS) and a shared programme to develop a system approach to PHM and PHM function. However, the vision for the approach/ function is under development and there are gaps in engagement with this process. • Data requirements vary by user; often requirements are unknown/ difficult to map. • Data gaps exist, particularly around our most vulnerable population groups. • Lack of integrated clinical and socioeconomic and social care data available to clinicians.	• Through the SEL PHM Programme, establish a shared vision for PHM. • Utilise EPIC for enhanced data recording and analytical capabilities in PHM efforts. • The move to the London Data Service will maintain the existing data access (primary care and national returns from acute care including mental health). This will require completion of necessary IG agreements. • Further opportunities will exist to integrate additional quantitative and qualitative data sources in the future, subject to data sharing and IG agreements.
Intelligence	• Whilst population segmentation is done to some extent across the boroughs, methodology differs by project, and is sense checked by clinical knowledge and local experience. • Often difficult to demonstrate the financial benefits or clinical impact of PHM implementation beyond some simple process measures • Clinicians require a balance of interactive dashboards, simple descriptive analytics and (once available) predictive analytic tools depending on intended purpose. • Training is limited, if in place at all within each organization. This includes for front line clinical and other colleagues.	• Create shared tools which cater for clinical end-users with differing levels of proficiency, ranging from simple descriptive to predictive analytics. • Embed the London-standardised PHM segmentation model. • To scale good practice e.g., Bromley Healthcare's model for showcasing financial impact of PHM projects • Explore barriers to access experienced by clinicians (note data might be accessible but not used due to capacity/availability of effector arm). • Strengthen the partnership between the ICS and the KCL Population Health Institute to share expert guidance and support. • Develop a system-wide training and development platform for clinicians and other colleagues.

Intervention	• Lack of understanding of PHM/ a sense that PHM is purely the remit of data and analytics functions
	• There is a lack of evaluation/ impact assessment. Reasons include:
	  • The lack of an established evaluation framework
	  • The protracted time frame required to evidence clinical improvement, especially related to prevention.
	• PHM practices are fragmented, time limited, often small local projects and vary significantly by local context.
		• Standardise the PHM approach, including clinical leadership, to convert insight into action. Appropriate clinical expertise should be included within each programme.
		• Using this approach, develop integrated and anticipatory care models which also utilises cost data to ensure system sustainability.
		• There is widespread interest and motivation for collectively tackling health inequalities and shifting towards prevention, with a recognition that PHM will enable this; we have an opportunity to tap into this within a culture shift towards PHM.

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Appendix C: Outputs from cross-system workshops

Two workshops used a project cycle to explore the required functions

Continuous learning cycle

Project overview:
- **Define**: problem, population, intervention, outcomes
- **Theory of change**: what, who, when, how
- **Implementation plan**: health and care system
- **Evaluation plan**: comparator, design, measures

Needs assessment:
- Trends and patterns of need
- Data requirements and analysis
- Engagement with communities

Gap mapping services and systems
- What is missing? Is it a capacity or capability or connectivity problem?
- Do we know what is needed?

Evidence review
- What solutions are effective and cost-effective?
- What is our acceptable standard of evidence?

Create solutions

Working with communities to adopt or adapt effective interventions or co-designing new interventions

Implementation and Evaluation
- Programme monitoring and governance
- Rapid learning cycles for continuous improvement
- Evaluation for impact (effectiveness, cost-effectiveness)

Decision to stop / continue

What functions will we need to deliver our vision?[1]

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Project overview:

- *Clear system priorities with a problem definition and outcomes frameworks for all parts of the system, which shows how this will benefit everyone*
- *Clarity on payments for PHM work*
- *A shared approach to setting outcomes frameworks*
- *System-wide incentives and funding/ ROI models for PHM, including GPs*
- *Clear local priorities with outcomes frameworks*

Needs assessment:

- Trends and pattern
- Data requirements
- Engagement with c

- *Single data set which grows to include all relevant qualitative and quantitative data sets (incl. cost and local data (e.g., residents' surveys))*
- *A single needs assessment for SEL – a system-level understanding of where the big issues are*
- *System IG framework*
- *Shared user-friendly analytics platform*
- *System population segmentation approach and risk stratification model*
- *Framework for data standards and coding*
- *Framework for community engagement*
- *Framework for health needs analysis*
- *Local interpretation of the analysis*

Gap mapping services and systems

- *System-wide offer for education and training (drawing on local offers), incl. understanding data and evidence, improving data quality, needs assessments, gap analysis, etc., for clinicians and non-clinicians*
- *Delivery of education and training (which may be for internal colleagues or colleagues across the system)*

Evidence review

What solutions
What is our acc

- *Collating the evidence base*
- *Commissioning for pro-active care (incl. incentives)*
- *Movement to population health budgets*
- *Framework for VBC / ROI calcs.*
- *Intervention ROI models*

Create solutions

- *Central support for services design*
- *Framework for co-design with the community and VCSE partners*
- *Implementation of interventions*

Implementation and Evaluation

- Programme m
- Rapid learning
- Evaluation for

- *Framework for project delivery incl. monitoring, governance and continuous learning – how to do a project within a PHM structure*
- *Framework for evaluation (incl. Value Based Care, co-design and care co-ordination)*
- *Project delivery*

Decision to stop / continue

- *Embed PHM into leadership structures and expectations*
- *Cultural shift throughout the system, supported by OD, to break down organisational boundaries and move PHM into business-as-usual*

Key

- *Delivered at a system (or higher) level*
- *Consistent system standards/ framework*
- *Determined and/ or delivered locally*

1. Based on inputs from the two PHM Programme workshops

What functions should we prioritise for near-term delivery?[1]

Project overview:
- **Define**: problem, population, intervention, outcomes
- **Theory of change**
- **Implementation plan**
- **Evaluation plan**: core metrics and measures

- *Clear system priorities / priority cohorts of CYP, MLTC and frailty, plus prevention, to be delivered through INTs, each with a (limited) outcomes framework*
- *Clarity on payments for PHM work*
- *System-wide incentives and funding/ ROI models for PHM in the priority areas*
- *Local priorities set at a Borough/ Trust level*

Needs assessment:
- Trends and patterns of
- Data requirements and
- Engagement with communities

- *Implementing the London Data Platform*
- *Agreeing an easy-to-use system-level analytics platforms (building on Ardens, EMIS, etc.), tested with one specific challenge aligned to INTs*
- *System IG framework and data sharing agreements for all organisations*
- *System population segmentation approach and risk stratification model*
- *Framework for data standards and coding*
- *Framework for community engagement*
- *Local analysis to support INT implementation*

Gap mapping services and systems
- What
- Broaden

- *Map out the existing offer for education and training and identify any key gaps (for clinicians and non-clinicians incl. training for BI teams, commissioners and Integrators)*
- *Broadening access to local education and training (which may be for internal colleagues or colleagues across the system)*

Evidence review

What solutions are effective and cost-effective?

What is our accepted standard of evidence?

- *Collating the evidence base for INT priorities*

Create solutions

Working with communities to adopt interventions

Designing new interventions

- *Framework for co-design with the community and VCSE partners*
- *Implementation of INTs*

Implementation and Evaluation
- **Programme** monitoring and governance
- **Rapid learning** cycles for continuous improvement
- **Evaluation** formative (effectiveness, cost-effectiveness)

- *Framework for evaluation (incl. Value Based Care, co-design and care co-ordination)*
- *A 'how to' guide for a project within a PHM structure*
- *Project delivery*

Decision to stop / continue

- *Ensure named leaders in each place (within existing resources)*
- *OD programme to support the necessary cultural shift. Relationships will be the key to implementation. Immediate priorities are:*
  - *Building relationships with VCSE sector partners to understand their needs and what data they can give*
  - *Bringing in public health expertise*

Key
- *Delivered at a system (or higher) level*
- *Consistent system standards/ framework*
- *Determined and/ or delivered locally*

1. Based on inputs from the two PHM Programme workshops

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Neighbourhood Based Care Board

Title	**2025/26 Planning Process and Neighbourhoods**						
Meeting date	18 September 2025		Agenda item Number	**7**	Paper Enclosure Ref		***5***
Author	**Holly Eden, Director of Delivery – Neighbourhoods and Population Health**						
Executive lead	**Ceri Jacobs, Place Executive (Lewisham)** **Holly Eden, Director of Delivery – Neighbourhoods and Population Health**						
Paper is for:	Update	**X**	Discussion		Decision		**X**
Purpose of paper	This paper provides an update for the Neighbourhood Based Care Board on the draft planning guidance shared in August 2025 and the requirements within this linked to neighbourhood development						
Summary of main points	• National colleagues issued draft planning guidance in August 2025. • The guidance makes explicit the shift to strategic, multi-year planning to support the effective delivery of the 10 Year Health Plan (TYHP), but frames expectations in terms of five year planning milestones/outcomes as expressed through the ICB's strategic commissioning plan and an annual planning process that will include the details of associated finance, activity, workforce and performance assumptions and deliverables. • Final planning guidance, alongside more detailed supporting information on both planning outputs and enabling guidance such as the strategic commissioning framework is expected to be available in October 2025. • The final planning guidance is also expected to include a National Framework for neighbourhood health plans. Further neighbourhood specific national guidance is expected around the "model neighbourhood", "model system architypes" and "model neighbourhood centre architypes" • There is a lot of existing planning documents within and across SEL and place around neighbourhoods and health improvement as well as shared work on outcomes, system development and maturity. • There is an ongoing need to work collaboratively between and across SEL teams and place teams to ensure alignment and linkages between local health improvement plans and local neighbourhood delivery plans and a SEL Five Year Strategic Commissioning Plan. Equally there will need to be strong partnership working at place to ensure alignment and linkages to provider five-year strategic plans. • Our initial neighbourhood planning process was predominantly focussed on the shorter term and on two immediate priorities – initiating integrated neighbourhood team working and securing our integrator arrangements. Having a longer-term view of our shared vision for neighbourhood health and a roadmap/critical path for how we plan to get there will enable us to be on the front foot when responding to national policy announcements or maximising future opportunities that may be launched relating to neighbourhood health.						
Potential conflicts of Interest	None						
Sharing and confidentiality	Can be shared widely						

Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	The move to neighbourhood care has a strong focus on reducing health inequalities					
Financial Impact	The move to neighbourhood care is part of the ICS's system sustainability programme and is expected to drive medium to long term financial impact alongside improvements to care					
Public Patient Engagement	There has been significant engagement undertaken to build the London Case for Change and Target Operating Model including through deliberative engagement across the capital.					
Committee engagement	ICB Executive Committee. Local Care Partnerships (and HWBB)					
Recommendation	The Committee are asked to review and note the current understanding of ICB, and place planning requirements related to neighbourhood health, associated timescales and endorse the approach to ensure linkages between the two.					

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System Planning – Neighbourhood Health

September 2025

Background

- There are **a range of existing strategies, frameworks and plans which articulate a shared vision for the Neighbourhood Health Service** across South East London:
- The 6 Places, who are accountable for the development of community-based care, have worked through the Neighbourhood Based Care Board (NBCB) to develop the **overarching SEL Integrated Neighbourhood Team (INT) framework** which guides the development of neighbourhood ways of working and INTs across SEL
- In May 2025, the **London region published their Case for Change and Target Operating Model for a Neighbourhood Health Service** which aligns closely to the work already underway across South East London. This was developed in partnership with local authority leaders across London alongside NHS leaders and patient and public representatives.
- On 3rd July 2025, the Government published "**Fit for the Future: A 10 year health plan for England**". This sets out a transformative vision for the National Health Service (NHS), with a focus on shifting from a reactive, hospital-centric model to a preventative, community-based, and digitally driven healthcare system. The shift to the Neighbourhood Health Service is a key plank of this vision, and the 10 year plan provides more detail on how this is expected to develop over time.

As part of the NHS Planning guidance:

- ICB's will develop a five year strategic commissioning plan that includes details on the overarching population health and commissioning strategy, new models of care and investment programmes aligned to the 10 YP.
- Local systems will develop a population health improvement plan which includes social care, public health, the VCSE and BCF, co-ordinated by Health and Wellbeing Boards as well as a delivery plan for neighbourhood health services.

The pack provides an overview of the SEL-wide planning process, recognising the need for aligned and joined up planning outputs across neighbourhood, place and SEL. This pack sets out the overall planning approach, the work we will need to undertake to secure the neighbourhood related elements of our plans and the linkages across local plans and the SEL Five Year Strategic Commissioning Plan.

SEL Planning Approach (1/2)

Phase	Output	Lead(s)*	Input Required
Phase 1 (Due end of Sep 2025)	Assessment of our delivery/progress against the foundation elements	Annabel and Rupi	• Finance (Ben) • Performance (Harriet/Sarah O) • Public Health (Angela with DPHs, additional support from Ethica) • Quality (Annette) • Community Insights (Rosemary) • BI (Nic) • Care Pathways (ADs)
Phase 2 (Due end of Dec 2025)	Five-year strategic commissioning plan • Integrated plan that cover service plans, workforce, finance, quality improvement and digital. • Will bring together local neighbourhood plans into a population health improvement plan (PHIP). • Plan will include details on overarching population health and commissioning strategy, new models of care and investment programmes aligned to the 10 YP, how funding will be used to meet need/maximise value/deliver priorities, and how the ICB core capabilities will be delivered.	Annabel and Rupi	• Finance • Care pathways • Boroughs
	Local Neighbourhood Plan(s) • Part A: Population health improvement plan which includes social care, public health and BCF, co-ordinated by Health and Wellbeing Boards. • Part B: Delivery plan for neighbourhood health services.	Annabel, Rupi and Holly (with Place Leads)	• Local authorities – public health and social care • VCSEs • Borough integrator
	National return (annual) • Single ICB numerical return expected across finance, workforce, activity and performance (with triangulation with providers as required).	Harriet and Sarah O	• Finance • Performance • Workforce • BI • Care pathway teams (as required)

SEL Planning Approach (2/2)

It should be noted that we are expecting further planning guidance in the Autumn both for ICBs as well as a specific national framework for neighbourhood health plans. Given ICBs have been informed that planning outputs will be required for December 2025, we will have to start our planning work based on the best information we have to date and then iterate our approach as further guidance is made available

Neighbourhood Health Planning– Maximising existing plans

What do we already have to draw from?

- Places have worked through their Health and Wellbeing Board to set out **local population need via Joint Strategic Needs Assessments** and have articulated **local strategic priorities via their existing Joint Health and Wellbeing Strategies**. The ICB has an **existing Joint Forward Plan** and we have developed ways of working which ensure **alignment between local and system level plans.**
- Our 6 places across South East London have also worked together to co-develop a set of **strategic, long-term outcomes** for the Neighbourhood Health Service across South East London. These were developed with input across primary and secondary care, local authority partners, VCSE partners and residents with a cross-section of our clinical and care professional workforce. These outcomes are in the process of being applied to our initial priority population segments to ensure underpinning population-level metrics are described for each population group.
- We have an **established delivery programme** in place across South East London. Our 6 places are currently in the process of implementing new models of care for the initial priority population groups, with **delivery plans for 25/26** in place, and future years being developed. We have **established integrator arrangements** and have set out initial thinking for how the maturity of these arrangements would develop over time. **Enabling workstreams** have been developed, or are developing detailed implementation plans including Population Health Management, Digital, Workforce and Comms and Engagement.
- At a London level, there is description of key deliverables required across London as part of the **Target Operating Model**, and development of **London-wide workstreams** where a regional focus would be helpful.
- A **SEL Population Health Needs Assessment** is being completed (drawing up from place-based Joint Strategic Needs Assessments) that will along with local HWBB Plans provide insight into medium and longer term system-level population health priorities which need to be reflected in our planning process.

Bringing together local and system planning (1/2)

Local and SEL plans will need to interlink to ensure a cohesive approach across strategic commissioning and delivery.

The SEL Five Year Strategic Commissioning Plan will need to articulate:

- Our system-level population health improvement outcomes over the medium to longer term;
- An overarching population health and commissioning strategy, new models of care and investment aligned to the 10 YP including articulating how funding will be used to meet need, maximise value and deliver priority outcomes,
- How service plans, workforce, finance, quality improvement and digital will coalesce to drive our overall priorities
- Set out how the ICB core capabilities will be delivered; and
- Articulate how local neighbourhood plans will contribute to system-level population health improvement outcomes.

Local plans, coordinated via Health and Wellbeing Boards, will need to articulate:

- Local population health improvement priorities
- How local resources will be aligned to the delivery of both system and local population health improvement priorities; and
- A multi-year neighbourhood delivery plan for their place

Bringing together local and system planning (2/2)

Place ICB and SEL ICB teams will need to work together to agree:

- The contribution local plans are expected to make to strategic population health improvement priorities is reflected in a consistent way within the five-year strategic commissioning plan
- The enabling infrastructure places need to support delivery is reflected within the five-year strategic commissioning plan.

This is similar to the approach taken in previous years to link between place Health and Wellbeing Strategies and the SEL Joint Forward Plan

To support the interlink between system and local plans it is proposed that we undertake the following key steps as part of the overall planning process

1. Use our existing neighbourhood care priority population groups in place for multiple LTC, frailty and CYP to r**eview the phase 1 work on population need across our system and align this to our initial INT models**. The output of this would be to:
    a) **ensure our key population health priorities and outcomes for these groups align to population need** – this can be built into the next stages of work on our neighbourhood outcomes framework that is already underway.
    b) **identify any gaps in our developing INT models** that we would need to address as part of our medium-term planning.
2. **Set out the SEL-wide population health priorities and outcomes** across the system as identified in Phase 1, and **work with local teams to articulate how local population health improvement plans and neighbourhood delivery plans will contribute to their improvement**. These would then be included in the five-year strategic commissioning plan, in the same way the HWBB/JFP interfaces and alignment works now.
3. **Work with local teams to capture initial enabling or infrastructure support required** and ensure these are reflected in our wider service planning, workforce, finance, quality and digital plans within the five–year strategic commissioning plan
4. Use the **phase 1 work and outputs above to inform our Neighbourhood Roadmap** (see slides 10 and 11) particularly to inform how we would widen PHM approaches and INT working across new population groups over the medium term.
5. **Further iteration** of approach once the further ICB planning guidance and the National Framework for Neighbourhood Health Plans has been published

Building a Neighbourhoods Health Service Roadmap

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Our initial neighbourhood planning process was predominantly focussed on the short term and on two immediate priorities – initiating integrated neighbourhood team working and securing our integrator arrangements. This recognised both our desire to start small and build up the Neighbourhood Health Service as well as the fact that the national policy was still be formed. With the 10 year plan in place, we will see an increasing range of opportunities for, and requirements of, systems coming from our national partners at pace. Having a longer-term view of our shared vision for neighbourhood health and a roadmap for how we plan to get there will enable us to be on the front foot when responding to national policy announcements or maximising future opportunities that may be launched relating to neighbourhood health. It will also help our broader partners across the system understand the longer-term journey we are on, prepare for change and understand how we are staging our work.

The purpose of the roadmap would not be necessarily to create new workstreams but to align and stage activity across our teams against expectations outlined in the 10 Year Plan – **providing a clear, high-level view of what is needed and when.**

The roadmap would be owned by the Neighbourhood Based Care Board to help guide our work across place and system workstreams. Whilst it will inform and help iterate our five-year strategic commissioning plan and local neighbourhood delivery plans (particularly during annual refreshes), it is not intended to duplicate those plans.

The roadmap will:

- Set out a **critical path for our Neighbourhood model** over the next decade, making explicit the **dependencies between different pieces** of work.
- Provide a structure that allows us to **signal priorities clearly**, while also showing how enthusiasm for **emerging areas** (e.g. children's, mental health, urgent care) will be **sequenced into the plan** over the short and medium term.
- Frame neighbourhoods not just as INTs for three population groups, but as a **broader paradigm shift in how and where care is delivered**, supported by community assets, prevention, and targeted interventions.
- Act as a **template for workstream leads, offering visibility of the medium-term planning timeframe** and enabling consistency in how plans are developed. This will enable future planning to sit alongside current implementation and reduce the risk of a stop/start approach to implementation.
- Make it **easier to connect neighbourhood activity into the ICB's operating and financial planning cycles**, against the backdrop of significant change.
- Provide a view of **what may be required to instigate work that hasn't 'come online' yet** e.g. new contract forms or genomics.

What should the SEL roadmap include?

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Key content necessary to make the roadmap both comprehensive and useful:

- Building out the detail of the core components of neighbourhood care (influenced by the 8 key areas identified in the 10 Year Plan).
- Overlaid with:
  - Longer term view of the enabling infrastructure required to support the full shift to neighbourhood health and stage implementation plans
  - An understanding of our population segments beyond mLTCs, Frailty, CYP (i.e mental health, healthy adults etc) – aligned to work underway across the ICB's Population Health programme and strategic commissioning priorities
- Working assumptions as to national policy development and how we would maximise these in the strategic commissioning approaches that enable neighbourhood care and the left shift, inclusive of funding flows, workforce, contractual form, risks and incentives .
- Key milestones, outcomes and metrics needed to measure progress against and inform planning
- Underpinned by principles inc. coproduction
- Risks and contingencies inc capacity, finance and contracting, procurement timelines etc

Areas of alignment

One of the challenges of developing the road map, but also key to its value, is providing a clear view of the various areas of national, regional and local policy and work/implementation development. We include some examples here:

- National: NHS 10 Year Plan, National Planning Guidance,
- Regional: London Target Operating Model
- Work across SEL ICB:
  - Neighbourhoods Outcomes Framework
  - SEL Primary Care Sustainability
  - POCT work with System Sustainability Group

SEL ICB Neighbourhood Based Care Board

Item 8
Enclosure 6

Title:	**General Practice Sustainability**
Meeting Date:	**18th September 2024**
Author:	Clare Ross, Oge Chesa, Laura Jenner
Executive Lead:	Holly Eden

Purpose of paper:	**To provide the Board with details of the General Practice Support offer and to seek endorsement of the offer**	Update / Information	*X*
		Discussion	*X*
		Decision	*X*

Summary of main points:

The Primary Care Plus group are undertaking work to bolster primary care resilience and sustainability to ensure it is able to firstly deliver its core contract and secondly take on a central role within neighbourhoods. SEL is facing significant challenges in primary care including recruitment and retention, access, distribution of resource and CQC ratings which need addressing. The Group is focussing on three keys areas to:-

(i) develop a partnership approach with General Practice in line with neighbourhood working
(ii) Ensure equity of offer, access, experience and outcomes across general practice
(iii) Develop a practical, support offer for general practice resilience and sustainability

The overarching support offer at point (iii) has now been developed following a series of co-design meetings involving GPs, general practice staff, commissioners and stakeholders from all six boroughs. The support will be based on a tiered approach according to practice need, which will either be identified by practices themselves, or through the use of agreed data metrics by Commissioners. Following endorsement from this group the work now needs to move to the next stage which will result in the commissioning of a consistent offer across South East London for all practices.

Potential Conflicts of Interest	Practices of GP members of this Board may benefit from the work being undertaken			
	Bexley	**x**	**Bromley**	**x**

Relevant to the following Boroughs	**Greenwich**	**x**	**Lambeth**	**x**
	Lewisham	**x**	**Southwark**	**x**
	Equality Impact	Support reduction in health inequalities		
	Financial Impact	Support funding identified from existing sources		
Other Engagement	Public Engagement	None as yet		
	Other Committee Discussion/ Engagement	Discussion and endorsement at Primary Care Executive and sign off by the Primary Care Plus group Engagement with GPs and practice staff, LMC, South East London Workforce Development Hub and pan-SEL ICB teams		
Recommendation:	To endorse the GP support offer To discuss what integrators might provide as support and how places are considering this locally To discuss what training and support other partners such as public health and provider partners, for example, could offer			

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General Practice Sustainability: Developing a Support Offer for Modernising General Practice

NBCB Update

September 2025

Paper purpose

- **Purpose:** This paper outlines the proposed GP support offer developed through the Co-design Sprint held in August, with representation from all Places and frontline general practice staff, as well as a high-level view of the existing support available across SEL for general practices.
- **Background:** The GP support offer has been endorsed by the Primary Care Executive (PC Exec) and formally signed off by the PC+ Group. It reflects a shared commitment to ensuring all GPs across South East London have access to a consistent support offer, while retaining commissioning at Place level.
- **Ask of the NBCB:** To approve and sign off the GP support offer.
- **Next steps:** Places to work through the detail of the offer in practice, including specific learning outcomes for each identified support area and delivery methods, to then commission the support - ensuring the final offer provides consistent, equitable support for all GPs across South East London.

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Proposed GP Support Offer

Enabling consistency and resilience across SEL

Aim

South East London wanted to co-develop a practical support offer for general practice resilience that builds off the sectors views on what is needed now and in the future. A shared SEL-wide support offer is vital both for the system - to deliver resilience, equity, and better patient outcomes - and for practices themselves, who need practical, flexible help to manage pressures and plan for the future.

What this is:

- Clarify what cross-SEL consistent support should be available to all practices across South East London
- How SEL will engage with general practices to identify support needs
- How support will be offered and directed based on these needs, supporting practices who are not engaging and those who need additional support

What this isn't:

- Performance managing general practice in South East London. This is about being able to provide the right support to general practice *now* and *invest up front* based on local need with the aim to avoid performance management altogether if possible.

This will support equity of offer, access, experience and outcomes across general practice taking into account the two main drivers of this:

1. Historical funding and commissioning variation in relation to support
2. Provider variation and challenges in truly exposing this and improving it

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Context

The 10 Year Health Plan and the London Neighbourhood Health Target Operating Model (TOM) highlight how neighbourhood health cannot succeed without strong and sustainable primary care; and equally, the impact on primary care of not having effective multi-disciplinary and cross-sectoral neighbourhood working. Both documents highlight how shifting from reactive treatment to proactive and preventative care, from acute delivery to community-based support, and to harnessing new digital capabilities, will need to be underpinned by a shift from organisational silos to population-centred collaboration.

Primary care has been described as "the first point of contact", "front door", "gateway" and also the "gatekeeper" for NHS services. Situated within neighbourhoods and communities, it is often the part of the health service which has also had the most significant degree of interaction with local government, officers and elected members, and the voluntary & community sector, including increasingly through social prescribing. As such, general practice is uniquely placed to provide early intervention, prevention, and personalised ongoing care, forming a core foundation of neighbourhood health.

However, the ability of general practice to engage in future Neighbourhood Health Services is far from guaranteed. Practices are already under intense operational pressure. Success depends on primary care being properly supported, sustainably resourced, and structurally enabled to contribute to neighbourhood delivery. **This support offer is about being proactive** in prioritising what is most needed.

Our support offer

South East London wants to create a system-led, data-informed, equitable model for supporting general practice sustainably. This is in line with the NHS Confederations' six proposed shifts to achieve strategic commissioning that will help drive a sustainable health and care system. Key proposals outlined in this support offer include:

- **Peer-first and supportive:** engagement and support will start with peer-based conversations, recognising that it can be difficult for practices to be open about challenges. This ensures the offer feels safe, collaborative and focused on improvement, not performance management.
- **Proactive and equitable support:** moving beyond self-referral and relationship-driven access to allocate support strategically. SEL want to commission and deliver support proactively, using local intelligence to reach practices that would benefit the most.
- **Tiered support:** all practices will have access to a consistent, universal offer. Where practices face common challenges, programmes will bring them together to share solutions. Where local, specific issues arise, bespoke support will be co-designed to meet those needs. This tiered approach ensures that all practices are supported to build resilience, while additional help is available when and where it is most needed.
- **Flexible commissioning:** enabling rapid access to bespoke support based on real-time intelligence and practice need, rather than one-size-fits-all offers.
- **Clear central access:** ensuring practices know where and how to find support. This includes maximising existing central functions such as SELNet, but will also require clear and consistent communications so practices can easily see what is available.
- **Outcomes-based monitoring:** tying support delivery to clear, measurable outcomes so that support can be scaled and tailored as needed. This ensures SEL and practices can be confident that the support on offer is beneficial, impactful and tailored to their needs.

Our methodology

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We took a co-designed, evidence-based approach to developing the proposed SEL general practice support offer. By combining national best practice with local data and workforce insights, and through a focused Sprint process with wide representation, we have created a consolidated support package that reflects both system priorities and the lived realities of general practice. This offer will continue to be tested and iterated with partners across SEL. Our work to date has included:

1. **Reviewing best practice and existing support:** drew on national evidence and regional examples of what works; mapped SEL-wide and borough-level offers (training hubs, PC sustainability groups, workforce programmes); and learned from other systems to highlight transferable approaches.
2. **Understanding general practice challenges in SEL:** developed a dashboard combining multiple data sources for cross-borough comparison and practice-level insight; mapped data trends with soft intelligence and thematic analysis; and worked with the PC+ Group to surface borough/practice-specific risks, variations, and gaps in the current offer.
3. **Focused Sprint (Aug–Sept 2025):** Applied the 4D process with representatives from all six boroughs, training hubs, CESEL, Peer Ambassadors, PC Exec, PC+ Group, and frontline GPs, PMs, and nurses to co-develop and synthesise findings into a consolidated SEL support offer, aligned with INT readiness and system priorities.

High-level view of support offer

SEL's refreshed general practice support offer sets out a clear, systematic approach so every practice knows what is available and how to access it. The support will be available to every practice, that includes universal and bespoke packages co-designed where deeper needs exist delivered in a proactive, equitable, and collaborative way.

Engage practices to identify needs

Consistent, predictable and relationship-based engagement with local practices to:

- **Hold trusted conversations via peer and network engagement** where practices feel safe to raise concerns, and where they can be supported to identify support needs.
- **Communicate support offer at every opportunity** so that practices are aware of what is on offer.
- **Use data and insight** to proactively identify and open conversation about emerging and potential needs.
- **Targeted outreach** via direct contact, 1-2-1 visits and protected discussion time where needs might be emerging.

Identify appropriate support

- **Central resource** (SELNet) holds a clear, accessible menu of all available support offers that all practices can draw down from.
- **Needs are triaged** through borough leads based on local intelligence from practices, borough teams, training hub, CESEL, LMC and networks.
- **Support is matched collaboratively with practices,** ensuring the right mix of universal, or bespoke input is agreed together and that the support provided is proportionate to need and delivered before practices reach crisis point.

Tailor and deliver support

Support is delivered through a mix of "one-to-many" and practice-specific approaches:

- **Universal offers:** open access to online training, QI collaboratives, toolkits, dashboards and peer forums.
- **Shared challenge programmes:** bringing practices together around common needs (e.g. neighbourhood working, workforce morale).
- **Bespoke packages co-designed with practices around specific needs** such as specific CQC / performance improvement.

Delivery is designed to be flexible, proactive, and not punitive, focused on improvement and resilience.

Measure outcomes and adapt

- **Practices receive ongoing engagement** to ensure changes embed and support has delivered expected outcomes.
- **All support is linked to clear outcome metrics monitored via feedback loops** providing real-time insights both during and after support so support can be flexed accordingly.
- **Where improvement is on track, practices move to lighter-touch support**; where risks persist, escalation to more intensive or bespoke input is triggered.
- **Impact and delivery of support is reported openly** through SEL dashboards and borough leads to enable the "core" support offer to evolve as needed over time, and build transparency and trust.

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Identifying practice needs

Our principles for general practice engagement

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Engagement with practices needs to happen locally, led by those who know and understand their communities but with robust feedback mechanisms to Places and the ICB. Because this will involve different people and approaches in each borough, SEL have set out common principles to ensure consistency, fairness, and trust. These principles are designed to support meaningful relationships, promote equity of reach, and make engagement with general practice supportive so practices feel comfortable sharing their concerns wherever they are in SEL.

- **Use the right messenger** – match the communicator to the audience (GP to GP, nurse to nurse, PM to PM).
- **Everyone has a voice** – everyone hears the same message at the same time; all contributions are valued.
- **Build and maintain trust** – through consistent, genuine relationships at all levels.
- **Empower local champions** – identify and support credible individuals to lead conversations within their community.
- **Be supportive, not punitive** – frame engagement around help and improvement, not performance management.
- **Timely and proactive** – engage early and anticipate needs, avoiding high-pressure periods where possible (March, August, December, Mondays, school holidays) and linking engagement to natural planning and reporting cycles.
- **Clarity of purpose** – be transparent about why you're engaging and the intended outcomes; needs to be inclusive for the whole of the practice.
- **Consistency** – maintain predictable, reliable contact and messaging; aim for long-term relationship building, not just one-off interactions.
- **Flexibility** – adapt style, content, and tone to the context of each practice.
- **Mutual benefit** – design engagement to create value for both the system and the practice.
- **Equity of reach** – make deliberate effort to connect with practices that are under-represented or hard to reach.
- **Evidence-informed** – base priorities on reliable data and lived experience.
- **Be opportunistic** - "Make every contact count" asking about emerging needs in any meeting or informal interaction with practices.

How we will identify practice needs

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Data & insight

- Use benchmarking and comparative data to highlight potential needs.
- Review SEL dashboards and ICB performance data regularly.
- Use data to open conversations, not just to monitor performance.
- Use a consistent checklist and standard templates to guide conversations and ensure consistent capture for monitoring and identifying areas of shared challenge across practices.

Strategic outreach

- Monitor engagement signals (e.g., meeting attendance) and follow up where needed.
- Direct contact with practices that are less engaged or flagged through data.
- One-to-one visits or calls from trusted messengers (PCN leads, Training Hub).
- Use PLTs, academic half days, and protected learning events for focused discussions on priority topics.

Peer & network engagement

- Leverage existing forums and networks (PM forums, nurse forums, clinical forums, accreditation programmes) for structured “needs conversations.”
- Enable peer-to-peer contact via buddy systems and local champions.
- Capture insights from PCN leads and other trusted intermediaries.
- Hold multi-level engagement including both peer-to-peer and leadership-level.
- Use personal, relationship-based approaches (e.g., individual calls, informal chats).

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What support will be provided

What practices need support on

The below outlines the core areas of support that every practice should be able to access to build resilience and deliver high-quality care. While individual practices may need bespoke help with concerns specific to their local context, these domains represent the essentials that must be available consistently across SEL to ensure equity, stability, and a strong foundation for neighbourhood working.

Understanding and responding to patient need	Helping practices listen to and engage patients, manage expectations, and communicate effectively about service changes and roles.
Change management and quality improvement	Practical help for change management, process mapping, identify inefficiencies, and make sustainable improvements using QI methods.
Strengthening non-clinical workforce and entry-level roles	Support with structured pathways and induction support for non-clinical and entry-level staff - especially for roles like newly qualified nurses.
Understanding and using data (including PHM)	Building confidence and skills in interpreting and acting on data, including population health insights, to inform service planning and improvement.
Business operations	Strengthening core operational skills such as finance, HR, contract management, succession planning, and running the practice as a resilient organisation. This should also include any clinical updates; and support to think through the most efficient scale for care delivery, and back-office functions to maximise financial resilience.
System and partnership working (e.g., navigating interfaces with secondary care and VCSEs)	Helping practices work effectively across organisational boundaries, improve referral/escalation pathways, and strengthen links with VCSE partners.
Digital transformation	Supporting practices to adopt, optimise, and embed digital health / AI tools in a way that improves patient care and efficiency while reducing workload.
Workforce and team development (including retention, team culture, leadership and OD)	Building strong, inclusive teams including integrated workforce planning and succession planning; supporting retention, preventing burnout, improving wellbeing and morale, and leadership skills; and fostering a culture of shared ownership and improvement.
Clarifying and supporting neighbourhood working	Defining the purpose, benefits, and practical steps for neighbourhood/PCN collaboration, and supporting practices to engage meaningfully.
Specific CQC / performance improvement	Providing bespoke help for practices at risk.
Infrastructure (e.g., estates)	Helping practices assess, improve, and plan and implement their premises and infrastructure to meet patient and staff needs.

Tiered approach

SEL's general practice support offer is designed to be fair, systematic, and proportionate. Where practices face common challenges, programmes will bring them together to share solutions. And where local, specific issues arise, bespoke support will be co-designed to meet those needs. This tiered approach ensures that all practices are supported to build resilience, while additional help is available when and where it is most needed.

All three "tiers" of support will be available to all practices; it will depend on their need for what, and when they access this. SEL will also signpost and link into complementary national and regional offers, such that SEL does not duplicate and makes best use of existing support.

Shared challenges

Informed by data, practices that share challenges will be brought together and targeted support will be provided to address and share common challenges. This will likely include:

- System and partnership working – improving referral pathways, links with VCSEs.
- Clarifying and supporting neighbourhood working – enabling PCN/neighbourhood collaboration.
- Strengthening non-clinical workforce and entry-level roles – structured pathways, induction support.
- Workforce and team development – workforce planning, recruitment, retention, morale, leadership, OD.
- Understanding and responding to patient need – engaging patients, managing expectations, communication.

Bespoke support

Practices that have specific, local challenges will be offered and support will be tailored. This should be proactive and help avoid the need for performance management in future. This is likely to include:

- Specific CQC / performance improvement – intensive support for at-risk practices.
- Infrastructure (e.g., estates) – premises assessment and planning.

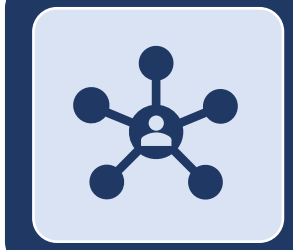
Universal support

Every practice will have access to this support on an ongoing, regular basis. Information about the offer, and resources will be centrally held on SELNet. This will include:

- Business operations – finance, HR, contracts, resilience, clinical updates
- Change management and quality improvement – process mapping, workflow efficiency, QI methods.
- Understanding and using data (including PHM) – data confidence and skills.
- Digital transformation – adoption and optimisation of digital tools.

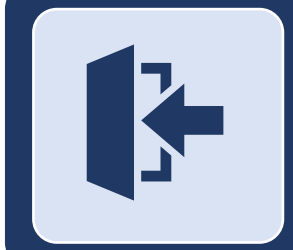
How will practices access this support

Practices will be able to access support in clear and consistent ways; however, ultimately each practice is responsible for their own development needs and accessing support in line with this*. Support needs can be surfaced proactively through forums, data and leadership, or requested directly by practices through simple referral routes and peer networks that is escalated appropriately. A central function showing what is on offer, consistent branding, and clear communication will ensure the offer feels supportive and easy to navigate.



Proactive engagement routes

- **Through established forums** (CD forums, nurse/PM networks, PC+ group), using routine conversations to surface needs.
- **Via dashboards and data feedback** collating and providing practice-level insights to Place/general practices that spark dialogue and signpost to relevant offers.
- **Neighbourhood/PCN leadership** where INT/neighbourhood leads and PCN CDs act as a channel into the system offer.



Responsive, practice-initiated routes

- **Direct requests** where practices can contact the support delivery partners, borough support teams, or ICB primary care leaders for bespoke support.
- **Clear referral processes** and pathways into specialist offers e.g., clear criteria for when and how bespoke support is accessed.
- **Peer ambassadors/mentors** - practices can access support by linking into peer schemes (PM mentoring, clinical fellows, nurse networks).

Effective branding and communication

- **Branding as supportive not punitive** such that the support offer is positioned as “helping to improve and thrive” rather than performance management.
- **Single front door / support portal** using SELNet or similar as a central access point, with clear signposting to relevant programmes.
- **Coherent, impactful communications**, pulling disparate offers together into one visible “SEL Support Package” that is clearly communicated - rather than fragmented schemes with a myriad of accompanying emails that can be lost.

**While this is the case, we recognise that if a practice has severe difficulties (e.g., financial) that are preventing them from engaging in support, there are support mechanisms that can be enacted (e.g., potential section 96 applications).*

Delivery mechanisms

SEL recognises that there is no single way support should be offered. Different areas and practices require different approaches, and the format will need to evolve through frequent feedback and iteration dependent on need and the support being offered. The below outlines suggested delivery formats and areas where practices and the system is likely to benefit from delivering support collectively and on an individual practice-level basis.

Collectively delivered support

Purpose: supporting practices to build baseline capability, share common learning, and show what "good" looks like where it makes sense for support to be delivered collectively rather than individually.

Suggested formats:

- Webinars / online training (recorded for flexibility)
- Mandatory modules (e.g., safeguarding, core compliance)
- Large group workshops and QI collaboratives
- Intranet / SELNet resources hub (central repository of information)
- Practice manager or nurse forums for shared discussions
- Online toolkits, case studies, and exemplars

Example support areas suited to one-to-many:

- **Understanding and using data (PHM):** shared dashboards, tutorials, group QI sessions.
- **Digital transformation:** demos, shared best practice, drop-in webinars.
- **Business operations basics:** finance, HR, contract management training.
- **Clarifying neighbourhood working:** explainer sessions, FAQs, case studies.
- **Workforce and team development (general leadership/OD principles):** leadership webinars, peer networks.

Individual practice support

Purpose: specifically tailoring support for practices with higher support needs, sensitive or practice-specific issues.

Suggested formats:

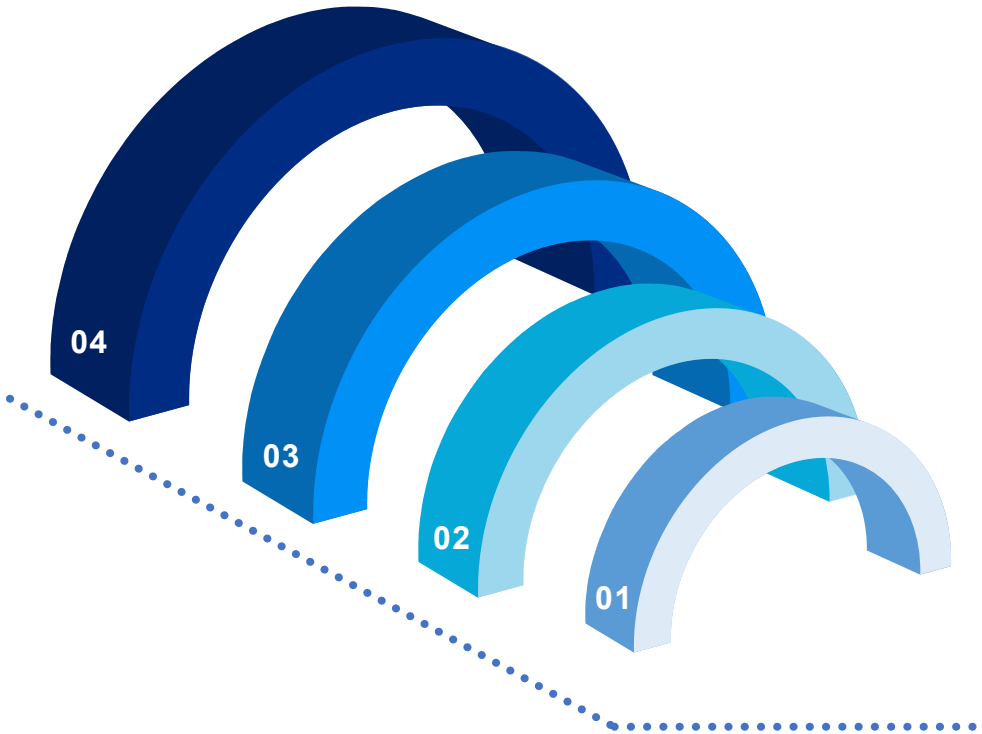
- Baseline needs assessments (SLF / PCST visits)
- Drop-in support sessions with targeted coaching
- Peer mentoring (PM mentors, GP mentors, nurse forums)
- Bespoke OD / QI facilitation with individual practices or PCNs
- Direct "buddying" with a high-performing practice

Example support areas suited to individual practice support:

- **Specific CQC / performance improvement:** intensive practice-level input.
- **Infrastructure / estates planning:** practice-by-practice needs.
- **Workforce retention and culture issues:** coaching, mediation, mentoring.
- **Complex business operations (succession planning, partnership disputes):** bespoke consultancy-style input.
- **Responding to patient need (esp. comms with local populations):** tailored messaging approaches.

How will we know the support is working

To know whether the support offer is making a real difference, we need more than activity counts. Success must be measured through continuous feedback, clear outcome metrics, and visible impact on workforce resilience, patient care, and system performance. This will support SEL to quality assure and measure the impact of the providers and support on offer, so that the support can be delivered and flexed dependent on practice needs.



01. Feedback

Quick, routine mechanisms such as informatl conversations, surveys, forums, and peer ambassador insights will provide real-time intelligence on whether support is landing well and highlight where changes are needed.

02. Measure

Each element of the offer will be linked to clear outcomes (for example, retention rates or patient experience) so we can evidence tangible improvements resulting from support, rather than just activity.

03. Adapt

Support will be regularly reviewed and refined, scaling approaches that work well and redesigning or stopping those that do not, ensuring the offer stays relevant and effective for practices.

04. Report

Progress will be reported openly through NBCB*, with transparent SEL-wide dashboards that show impact to practices and reinforce trust and shared ownership across SEL.

**This might change in the future based on any potential future re-structuring.*

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Integrated Care System

High-level existing support offer for GPs in SEL

What are partners already delivering

Across SEL, a range of partners provide programmes, training, and support to strengthen primary care. We will harness what partners are well placed to deliver to shape future commissioning. By building on what works well, we will reduce duplication, increase value for money, and ensure support is more effective and tailored to the needs of practices across SEL. The four key delivery partners outlined here supplement wider regional and national GP support offers (see Appendix).

CESEL	LMC	Training Hub	SEL ICB
• CESEL is a data driven support programme, providing an evidence-based approach to quality improvement, to help improve health outcomes and reduce inequalities. • As a SE London programme, CESEL has economy of scale to develop a range of resources (e.g. guides, training) that can support consistency across the ICS. • Place-based multi-professional CESEL teams can tailor and implement support, to meet the needs of local teams and population.	• Host Learning, Education and Development (LEAD) programme of events for all practice team members. • Deliver Practice Manager/GPN/HCSW training programmes, Registered Nursing Associate training, professional forums. • Londonwide LMCs' GP Professional Support Network provides a single point of online access to match GPs with the most appropriate form of professional support for them. The service is open to all GPs who work within the areas of London covered by Londonwide LMCs, providing confidential, expert and impartial one-to-one advice and support to any individual GP. • This includes group coaching circles (interactive zoom sessions: focused on real-time coaching, discussions, with reflective exercises and Q&A) and Wellbeing Webinars (offering a tailored approach to addressing the unique challenges faced by healthcare professionals). These GP could be tailored with providers if there were specific offers required.	• SELWDH delivers a wide-ranging programme of support and training. • This includes structured practice support through SLF visits, bespoke 1:1 Primary Care Support Team (PCST) input, mentoring programmes (1-2-1 mentoring for all clinical staff and PMs) and strong peer networks/forums (e.g., GP, Nurse, HCA). • They deliver training programmes including leadership programmes, Practice Manager development programmes, care navigation training, weekly webinars (clinical and non-clinical), monthly induction programme for new primary care staff (Foundations of Primary Care), GPA accredited programme, partnership with University of Greenwich to deliver the primary care training for new to practice nurses in SEL, Learning Environment Accreditation. • SELWDH also supports career progression through NtP Fellowships (final year of NHSE funded scheme), placement support for pre-reg nurses and CPD offer to all clinical and non-clinical staff (based on annual needs assessment and other inputs) • SELWDH supports digital and AI readiness through digital maturity reviews, safe AI adoption training pilots underway. • They also support quality improvement & change through QI coaching, workflow/docman redesign, thematic projects on workload efficiency.	• SEL ICB provides a range of in-house support to general practice, delivered through its specialist teams. This includes: • Estates: advice, planning, and investment in primary care premises and facilities. • Commissioning: oversight of GP contracts, enhanced services, and service redesign to meet local population need. • Communications and Engagement: support for practice and PCN engagement with patients, communities, and system partners. • Workforce: coordination with Training Hubs and national programmes to strengthen recruitment, retention, and workforce planning. • Clinical Leadership & Groups: borough-based and system-wide GP clinical leads shaping pathways, quality improvement, and integration with wider providers.

Who could deliver what?

Not providing support in this area
Providing some relevant support in this area
Providing very relevant support in this area

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	Potential SEL delivery partner			
Practice support needs	**CESEL**	**LMC**	**Training Hub**	**SEL ICB**
Understanding and responding to patient need	CESEL takes a PHM approach, gaining insights from data and staff engagement, including VCS.	Learning Disability Training in Primary Care; End of Life Training for HSCPs.	SLF diagnostics (>100 practices) surface patient priorities, access pressures, high-frequency users. Care navigation training strengthens first-contact response and inclusion. Patient survey data built into SLF Plus.	Possibly comms and patient engagement team could offer support
Change management and quality improvement	Provide data packs, QI tools, templates and in-person visits to support PCN and practice teams keep sight of how they are getting on compared to peers and using insights to inform and implement proactive care and quality improvement.	GP Support Team providing 1:1 support within this area.	PCST QI coaches embedded in SLF/SLF Plus and bespoke 1:1 work; workflow and document management redesign (e.g. automated HRT templates, AccuRx); OD facilitation includes culture change, workload management, team redesign.	N/A
Strengthening non-clinical workforce and entry-level roles	CESEL delivers teaching and tailored support, for diverse multi-disciplinary teams – this includes the Vital 5 guide which has informed training for non-clinical primary care professionals.	Registered Nursing Associate Training Programme; Initial Training Cervical Sample Taker Course.	LOWD (Leadership, Organisational and Workforce Development) Programme. PM development programmes (Essentials, Advanced, Aspiring to PM). Care navigation training strengthens first-contact response and inclusion. Admin team coaching, induction tools, buddying support. Apprenticeship and career development pathways via CPD team. Foundations of Primary Care programme for new starters. Non-clinical essentials CPD offer.	See 'Workforce Development'
Understanding and using data (including PHM)	As described above, CESEL takes a PHM approach, including analysis of data insights, to shape and drive support to front line staff.	LEAD programme has previously covered data related topics (incl. clinical coding).	BI team analytics, CATS dashboard used in SLF and borough reports. Support for PCNs on LTC metrics and year-of-care models. Coaching practices to use demand/capacity data for access planning. Could pull together a team from different areas.	Clinical group working on developing support to practices around using the Ardens RAG tool and total triage. The PHM Board are overseeing options for the SELPHM function which would include support for neighbourhoods around PHM

Who could deliver what?

Not providing support in this area
Providing some relevant support in this area
Providing very relevant support in this area

South East London Integrated Care System

	Potential SEL delivery partner			
Practice support needs	**CESEL**	**LMC**	**Training Hub**	**SEL ICB**
Business operations	CESEL resources and support including local guides and workforce training, can contribute to operational resilience	Introduction to Practice Finance (recommended); GP Management Training Programme; GP Nurse Training Programme; Aspiring to Partnership Programme (covers GP regulation, practice finance, development, premises, due diligence, HR and leadership); Managing People in GP and Primary Care Module.	PCST bespoke 1:1 on finance optimisation, contracts, mergers, crisis. Risk management, governance, HR advice; contract webinars	Contracting teams provide training sessions on various contractual matters and could expand this to how to make claims.
System and partnership working	CESEL increasingly works across a multi provider landscape, including links into VCS to support community outreach.		PCN SLF visits include assessment of PCN collaboration. PCN Plus builds leadership capacity across networks. Support for emerging Integrated Neighbourhood Teams.	Borough teams are best placed to facilitate this but need to reach out wider than just to CDs. All members of practice team need to be included
Digital transformation	As a clinician led team, CESEL understands the benefits of digital resources and able to embed utilisation of QI innovation	LEAD programme has previously covered data related topics (incl. telephone triage).	Recently ran 2x3 sessions on getting ready for the digital switch. Practice digital maturity reviews and EMIS configuration support. Safe AI pilots (scribes, triage automation, demand modelling). CPD training on safe data/AI adoption.	SEL digital team is supporting development of neighbourhood-level dashboards for INTs and PCNs; support to use EMIS, Apex, Ardens, and NHS Dashboards more effectively; and digital Pathways Framework driving move towards 'modern general practice'. SEL IT support team provide IT Training for use of EMIS and non clinical IT. Training available for practice staff via HALO portal.
Infrastructure (e.g., estates)		GP Support Team providing 1:1 support.	Light-touch support on lease issues, landlord negotiations, premises challenges.	Estates team set up to deliver support.

Who could deliver what?

Not providing support in this area
Providing some relevant support in this area
Providing very relevant support in this area

South East London Integrated Care System

	Potential SEL delivery partner			
Practice support needs	**CESEL**	**LMC**	**Training Hub**	**SEL ICB**
Workforce and team development (including retention, team culture, leadership and OD)	See 'Business Operations' - support and workforce development for all staff would help 'resilience'.	GP Management Training Programme; GP Nurse Training Programme; Aspiring to Partnership Programme; Managing a Multi-Located Team Programme; Peer to Peer Support service (no cost to GPs); GP support services; Peer to peer professional advice and support; Educational support and supervision; Professional coaching; Talking therapy support	LOWD webinar programme for non-clinical staff (e.g. leadership across cultures; coaching skills for leaders; building resilient teams). GP & GPN Fellowships (national) plus mentoring (>100 mentees, 27 mentors). Career coaching and personalised development plans (new in 25/26). Leadership: PCN Plus, Nurse Facilitators, ILM-accredited PM coaching. OD interventions for high-turnover practices via SLF Plus.	SEL workforce team host: • Wellbeing support: dedicated EAP, MSK, menopause and physiotherapy support for primary care. • Rise line manager development programme: 8 modules, incl. e-learning and masterclasses (non-recurrent so will end soon). Looking to evolve this to have neighbourhood lens. • Culture support: EDI programme incl. tools and resources for practices (micro-site available). • Day to day support for leaders: speaking with the HIN to develop support offer • System leadership support: Working with regional team to see what they can offer
Clarifying and supporting neighbourhood working	CESEL is expanding and developing support to reach beyond primary care. Shared learning across multi-disciplinary INTs can reduce silo-working and enhance preventative proactive care.		PCN SLF tool to assess cross-practice functioning. Facilitation of difficult conversations; leadership development via PCN Plus. Linking access and workforce support to local VCSE/community pathways.	Comms and engagement team, Place-based Leads and commissioning teams supporting health and care reform, so would expect SEL to take a role in increasing practice knowledge on neighbourhoods, and what it means for them. Workforce team holding workshop on clinical governance to help clarify roles.
Specific CQC / performance improvement	CESEL is an offer of support to practices that require bespoke help in proactively identifying and managing patients, especially those with long-term conditions.	GP Support Team: CQC prep, mock inspections, compliance advice, contracts and performance troubleshooting. LEAD programme on CQC fundamentals.	CQC baseline compliance in SLF. Bespoke 1:1 CQC support (e.g. practices preparing for visits, complaints handling). Governance and policy packs shared.	Quality team may be able to provide support.

At what level?

Not appropriate format

Currently delivering on small scale, or could transform to deliver in this format with relative ease

Currently delivery at scale required

South East London Integrated Care System

	Potential SEL delivery partner			
Delivery formats	**CESEL**	**LMC**	**Training Hub**	**SEL ICB**
Intensive 1:1 practice support	Currently delivering some 1:1 support, however, there is a recognition that capacity may hinder being able to do this on a SEL-wide basis as part of the core offer. CESEL can take a PHM approach to prioritise where need is greatest, whilst help to facilitate peer support and shared learning (see below).	Currently delivering some 1:1 support e.g., through GP Support Network, however, there is a recognition that capacity may hinder being able to do this on a SEL-wide basis to all practices as part of the core offer.	Currently delivering 1:1 support at Practice and PCN level including via PCST Specialists (Ops & Clinical), QI Coaches, and Career Coaches (CPD team).	Teams not set up in a way that supports intensive 1:1 practice support, although support has been provided by SEL teams/individuals in the past on a case-by-case basis.
One-to-many	Trusted peer support programme, connecting and sharing best practice.	Existing strong relationships with practices through GP Support Network, providing 1:1 support.	Delivering workshops, practice manager development cohorts, leadership programmes (PCN Plus, 2x 40p cohorts), forums (regular, borough-based).	Primary care leads and SEL teams such as estates could deliver at borough level.
SEL-wide combined delivery	CESEL produces SEL best-practice guidance and resources, in addition to delivering education across SEL	Already providing London wide resources and training including London wide LEAD events.	Delivering certain SEL-wide elements (e.g., SELWDH CPD cohorts and large-scale events with CESEL). Capacity to expand.	Already providing SEL-wide resources, comms and support.

Time has been raised as a key barrier for practices to engage in support. In response, there has been suggestions of short, bite-sized videos of around 15 minutes on specific topics, offering an accessible format that allows practice managers to dip in and out as needed rather than committing to full-day courses. Alongside this, suggestions have included downloadable toolkits and templates for immediate use, on-demand webinars and interactive e-learning modules, short live drop-in sessions with experts, and opportunities for peer learning through small networks or forums. Alternative formats such as podcast-style audio content were also noted as a way to make resources more flexible and engaging, while the use of talking heads, media team support, and expert input was seen as important to ensure credibility and impact.

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Next steps

Next steps (1/2)

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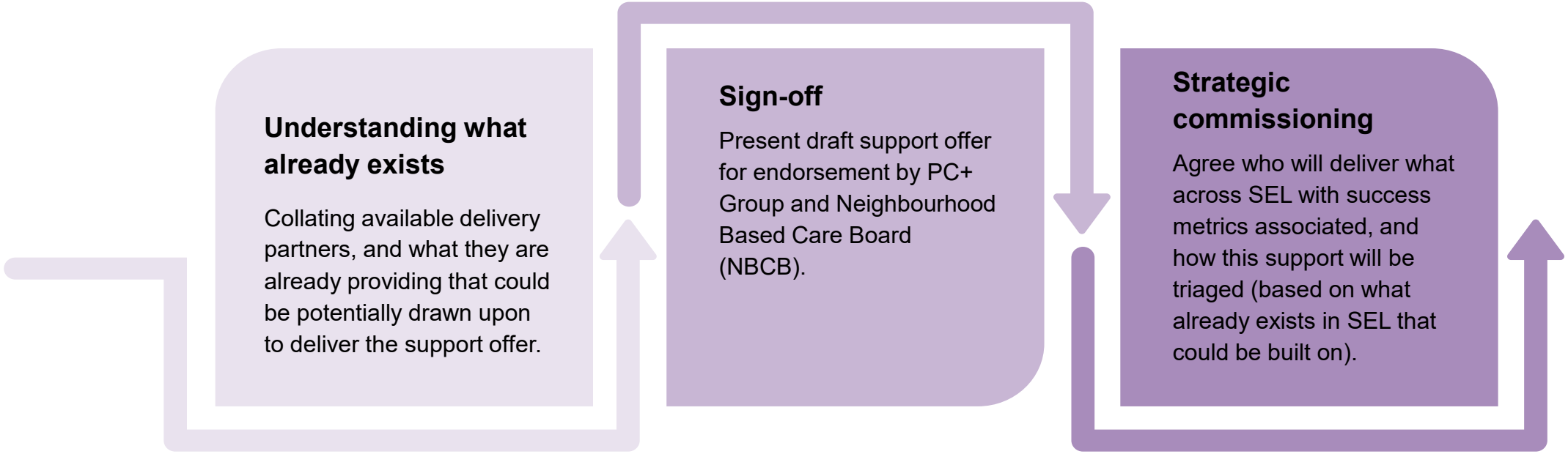
The proposed offer sets out a more strategic approach that SEL aims to adopt to better meet and tailor support to practice needs, strengthening resilience. The next step will focus on clarifying roles and responsibilities - identifying who will deliver which aspects of the offer, how, and in what format.

From there, attention will turn to implementation planning and clear, targeted communication to ensure that general practices recognise the benefits of engaging with the support available. It will be essential to establish reliable routes for sharing and escalating support needs, supported by clear thresholds for when and how requests are managed. A potential soft launch could provide an opportunity to test and refine the approach. Alongside this, SEL will prioritise effective coordination across delivery partners, the appointment of suitably qualified providers, the development of an accessible and well-maintained resource repository and – crucially – the review and use of outcome data to ensure the support offer adapts dependent on practice need. Together, these elements will help ensure that access to support is straightforward, consistent, and responsive to practices' needs.



Next steps (2/2)

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As an immediate next step, we propose a second Sprint to develop an implementation plan and work through the detail of what the support offer looks like in practice. This will build on existing support within SEL, drawing on what is working well, identifying opportunities for collaboration between delivery partners, and commission additional elements where needed.

The Sprint will include:

- Collation of the existing support offer across potential delivery partners.
- Developing a set of commissioning principles to guide the work.
- PC Exec group to complete/fill in the detail beneath each support area for what they want to commission (incl. learning outcomes and proposed delivery methods).
- Convening a wider PC Exec meeting with Peer Ambassadors c.2/3rd October to discuss and confirm the proposed support.
- Using this as the basis for commissioning via the PC+ group.
- Weekly meetings for 4-5 weeks from c. w/c 29th Sept onwards (providing the NBCB has signed off the support offer) to progress implementation planning and work through details e.g., how the escalation route will look / feel like (predominantly owned by PC Exec).

South East London Integrated Care System

NHS South East London

Appendix

The benefit of support to system and practices

A shared SEL-wide support offer is vital both for the system - to deliver resilience, equity, and better patient outcomes - and for practices themselves, who need practical, flexible help to manage pressures and plan for the future.

System case for a support offer

- **Support resilience:** General practice is under sustained pressure. Without structured support, practices risk burnout, workforce loss, and service instability.
- **Improve patient care:** Enables practices to focus on what matters most - timely, safe, and equitable care.
- **Tackle variation and inequalities:** A system-wide offer helps level the playing field so patients across SEL receive consistent standards of access and quality.
- **Shift from reactive to proactive:** Prevents issues escalating into crisis by identifying and addressing challenges earlier.
- **Strengthen neighbourhoods and INTs:** Ensures general practice is confident and equipped to play its part in integrated models of care.
- **Show value and recognition:** Signals that the system values general practice, listens to its challenges, and invests in future sustainability.

Practice case for a support offer

- **Relieve day-to-day pressure:** Practical help with demand, data, and workforce issues, freeing up time for patient care.
- **Tailored to their reality:** Flexible support shaped by feedback and adapted to individual practice needs, not one-size-fits-all.
- **Invest in their teams:** Training and development that helps staff feel valued and retained.
- **Strengthen the business:** Support with finance, HR, estates, and succession to ensure resilience and reduce risk of performance management.
- **Shared learning:** Opportunities to connect with peers, share good practice, and be part of a wider improvement effort.
- **Improve patient care and relationships:** Tools and models that improve patient experience, outcomes, and safety.
- **Influence wider change:** Ensures practice voices shape how neighbourhoods and INTs develop.

The case for change

South East London Integrated Care System

- **South East London's general practice is under strain.** Despite deep commitment from our workforce, a combination of rising demand, systemic inequities, and workforce attrition has left general practice stretched and vulnerable.
- **The general practice workforce has also flatlined in recent years**, in the face of a growing population and high burnout and retention challenges.
- **And with nearly 25% of staff indicating they intend to leave***, action is required to create a more sustainable, equitable, and attractive environment for primary care.
- **There is high variation in performance between practices** and lack of appetite for taking on the risk of partnerships from younger GPs. In South East London, the most deprived populations have a lower number of GPs per capita than the least deprived.
- **This echoes wider qualitative concerns of a sector in distress.** Indications from the Fuller Report suggest that South East London will experience a further acceleration of these trends over the next ten years unless there is significant change in how primary care is delivered.

Why does this matter for neighbourhoods?

General practice is unique as a place where we register a population and provide preventative and proactive care, with continuity for those who need it. Thus, general practice is well-placed to serve as a strong foundation for neighbourhood working.

Neighbourhoods need to wrap around GPs and support care for their registered population. The GP role needs to evolve as they become part of neighbourhood multi-disciplinary teams (MDTs).

The interface between general practice and social care needs to improve and acute clinicians will also need to be involved more in the health of the populations they serve rather than just being involved in reactive care.

In some cases, practices may need even more hands-on support. Integrators and PCNs/GP Feds could be a source of that support providing e.g., more shared back-office functions or operational support.

**SEL Workforce Development Hub Report May 2025*

Overview of challenges in general practice in SEL

South East London Integrated Care System

- **Workforce attrition:** High numbers of GPs, nurses, and practice managers across boroughs are planning to leave, primarily due to burnout, lack of recognition, poor work-life balance, and retirement. For instance, 38% of GPs in Lewisham intend to leave, while 43% of Bexley's practice managers cite retirement from the Workforce Development Hub May 2025 Report.
- **Uneven access and resources:** There is significant variation in GPs per capita, and in workforce distribution, digital maturity, and access to development opportunities. There is also variation in how engaged practices are, particularly around the neighbourhood agenda and accessing available support.
- **Practice closures:** A 23% reduction in practices over a decade reflects both consolidation and systemic failure. The accompanying administration is also taking away from strategic thinking and transformation.
- **Estates:** The PC+ Group reflected there is additional opportunity to take more advantage of underutilisation across *all* estates beyond primary care.
- **CQC & support ratings:** 7.4% of practices are rated as "Requires Improvement" overall; over 15% have at least one underperforming domain. Practices report needing most help with high-frequency users, demand and capacity data, and developing a shared vision.

We must move from reactive, fragmented care to a proactive, neighbourhood-based model built around primary care. Practices need to be able to deliver their core contract, whilst also being able to work in neighbourhoods. We cannot do this without ensuring primary care is sustainable and can serve as a strong foundation, which will require South East London to use the available intelligence and allocate resources strategically to enable the modernisation of general practice.

Why is it so important to have consistency of general practice support offer?

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A consistent general practice support offer is essential for equity, sustainability, and neighbourhood success. Without it, access to support becomes patchy, variation deepens, and neighbourhood working risks fragmentation. Consistency doesn't mean uniformity, but it does mean clarity on expectations, equitable support, and aligned system delivery.

- **Equity of opportunity:** Every GP and practice deserves access to the same level of support (e.g., training, guidance, system development offers) regardless of borough or historic engagement. Variation can undermine trust and demoralises staff.
- **A resilient foundation for neighbourhoods:** Neighbourhoods rely on functional practices. If primary care is under-supported in some areas, neighbourhood models may fragment. A failing practice won't just affect its patients, it could destabilise local systems and affect funding flows within and between neighbourhoods.
- **Preventing widening gaps:** Inconsistent engagement and support will likely lead to widening variation in access, outcomes and sustainability. SEL-level coordination prevents postcode lotteries in GP support, workforce development, and operational help.
- **Making change possible in a resource-constrained system:** In the context of workforce and financial pressures, we can't afford duplication or gaps. Standardisation (not uniformity allowing for local delivery) ensures efficiency.
- **Engagement is everyone's business:** We know there are pockets in SEL where there is weaker strong primary care engagement. Practices that understand the direction of travel towards neighbourhoods and modern general practice are more likely to engage. Consistency helps all practices see where they fit, why it matters and what support is available and essentially be in a position to recognise the importance of engagement and make the required changes to be involved in neighbourhood working.
- **Delivery partners must align:** It doesn't necessarily matter *by who* or *how* support is delivered whether that be through integrators, training hubs, PC support teams, LMCs but they should work to the same offer, language and expectations.

What SEL practices are saying they are struggling with now

South East London Integrated Care System

While each practice faces its own unique challenges, looking holistically across South East London is starting to reveal a set of common themes where support may be most needed and could be delivered as part of a “core” offer for general practices.

Key theme	Potential support area
Workforce resilience and role optimisation	High levels of **staff turnover, sickness absence**, and **succession gaps** are placing significant pressure on practices. The repurposing of ARRS roles, now considered business-as-usual in practices, combined with rising list sizes, is intensifying this strain.
Estates and access infrastructure	**Growing list sizes, more complex care needs**, and **physical space constraints** are limiting service delivery and patient experience.
Health inequality reduction & community engagement	Several practices face persistent challenges in **engaging underserved populations,** particularly around: • Blood pressure monitoring (notably among Black men) • Immunisation uptake (especially in African families) • Diabetes and maternal health engagement • Language and communication barriers for patients with limited English proficiency
Integrated care access & navigation	Some GPs report a **lack of integration with key services** - especially mental health and hospital care - as well as limited engagement with VCSE and community pathways. These gaps create inefficiencies and missed opportunities for holistic care.
High frequency users & continuity of care	**Rising patient complexity, growing practice sizes, and staff turnover** are making it harder to maintain continuity of care. Practices also need more tools and support to manage high-frequency attenders and promote better patient **self-management.**
Quality improvement	There is a clear need for tailored support to help practices with **lower CQC ratings, declining patient satisfaction, or low self-assessed confidence.**
Data, intelligence and digital integration	Practices want to strengthen their use of data for proactive care. This includes **embedding risk stratification and population health tools, adopting AI safely, making better use of demand and capacity data,** and ensuring **robust data governance and interoperability across systems.**

What we said was working well / not so well

South East London Integrated Care System

What's working well

- **Having the right people** leading engagement is key.
- **Established, consistent relationships** build credibility, trust and rapport.
- **Peer-to-peer links** and networking help open conversations and deepen engagement. E.g., Greenwich Nurse Leads contact Nurses that do not attend forums to encourage them and find out if any blockers and work together to overcome.
- **Informal, relationship-building approaches** (e.g., in-person visits, softer introductions) work.
- **Support that delivers tangible benefits** (efficiencies, increased income) is valued so it is clear "what's in it for them."
- **Responsive, evidence-based insights** are appreciated.
- **Effective links at Place level** with key people and organisations.
- **Shared forums and internal newsletters** (e.g., PM forums, PLTs) to enable information exchange with GP colleagues, and for practices to know others can provide support and alliance.
- **Use of SEL Net** as a central source of information is helpful.
- **Resources allocated to protected time** and backfill e.g., for mentoring.
- **Staff dedicated to support programmes** add value (e.g., at the Training Hub).

What could be improved

- **Often too many communications**; and important offers are lost in the volume. Difficult for practices to sift through 500+ daily emails to find relevant information.
- **Practices most in need are often the hardest to engage** ("inverse care law").
- **Some programmes do not lead to longer-term impact** (no follow-on opportunities).
- **No single, central point for all engagement** and support. Many organisations involved, making navigation difficult.
- **Sustained engagement is hard** due to workforce patterns and limited capacity.
- **Over-reliance on existing engaged practices** and individuals.
- **Concern from practices that offers are about performance management** rather than support.
- **Risk of reactive engagement rather than proactive**, needs-led approaches.

Codesign group members

We want to ensure we take a co-designed approach to developing the support offer with representatives from across the six boroughs, as well as representatives from key groups including the Training Hub, Peer Ambassadors, PC Exec and PC+ Group; and GPs and nurses themselves. We have also included the chair from the Bromley Sustainability Group to draw on learnings from their similar work. There is an expectation that once the support offer has been developed this will be tested and iterated with a wider group across SEL.

- Clare Ross (SEL ICB)
- Matthew Shimwell (Training Hub)
- Nancy Kucheman (Deputy Medical Director)
- Sarah Riley (LMC)
- Dr Clive Anggiansah (Peer Ambassador)
- Dr Divanka Wijendra (Peer Ambassador)
- Dr Bridget Hopkins (Chair, Bromley Sustainability Group)
- Dr Claire Riley (Chair, Bromley Sustainability Group)
- Joseph Mayhew (CESEL)
- Nick Harris (CESEL)
- Sian Howell (CESEL)
- Julie Archer (SEL ICB)
- Steven Hunt (Nexus Health Group, Director of Operations)
- Anna Marcus (Lambeth, PC Exec)
- Oge Chesa (Lambeth, PC+ rep)
- Laura Jenner (Lewisham, PC+ rep)
- Graham Tanner (Bexley, PC Exec & PC+ rep)
- Maria Howden (Greenwich, PC Exec & SEL Workforce Group rep)
- Claire O'Connor (Greenwich, Practice Nurse, Training Hub)
- Laura Davies (Greenwich, Practice Nurse, Training Hub)
- Helen Oakley (Greenwich, Practice Manager)
- Roksana Kalizsz-Kaya (Southwark, Practice Manager)
- Debbie Brown (Lewisham Nurse, SELWDH)
- Rebecca Whitnall (GP, SELWDH)
- Nick Langford (SEL ICB, Contracting)
- Angela Ezimora-West (SEL ICB, Contracting)

South East London
Integrated Care System

Additional national / regional support

Other national / SEL resource

South East London Integrated Care System

Support area	Organisation	Training or support available	Link
Business operations	GMC	National registration and register of Doctors providing professional standards, guidance	Home - GMC
	NHS Resolution	Clinical Negligence Scheme for GPs - national programme for claims on/after 1.4.2019.	Clinical Negligence Scheme for General Practice (CNSGP) - NHS Resolution
	BMA	Medical indemnity guidance	Medical indemnity
	GMC	Insurance, indemnity and medico-legal support guidance	Insurance, indemnity and medico-legal support for doctors
	MDU, RCN but others available	Professional Practice Insurance which tops up NHS Resolution service for individuals or practices. These providers provide training to members to reduce risk in clinical practice.	https://www.themdu.com/ https://www.rcn.org.uk/
	NHSE	Toolkit for primary care online consultations	Using online consultations in primary care: implementation toolkit
	GMC	Guidance on professional standards	
	GMC	Ethical hub - applying professional standards in practice	
	GMC	Fitness to practice process	
	RCGP	Essential knowledge updates, programmes and hot topics	Home | RCGP Learning
	RCGP	Clinical toolkits	Home | RCGP Learning
	NMC	Standards of Professional Practice	
	NMC	Links to registered training providers including for Nurse prescribing	https://www.nmc.org.uk/education/information-for-students/
	NHS England	Primary Care Support England - resources to manage claims and registrations	https://pcse.england.nhs.uk/

Other national / SEL resource

South East London Integrated Care System

Support area	Organisation	Training or support available	Link
Business operations	Practice Index	Independent Practice Support Service- training on a wide range including mandatory training support, practice development and CQC	https://practiceindex.co.uk/gp/solutions/training/
	NHS Resolutions	Claims management (clinical negligence scheme for GP practices), practitioner performance advice, Primary care appeals, safety and learning (claim risk profiles, safety activity)	Services - NHS Resolution
Change management & quality improvement	Deep end work	1:1 / small group of practices that Deep end - work in dperived areas - in pulling practices together - single handed and struggling with patients and they gel together quite quickly	https://www.gcph.co.uk/latest/publications/193-gps-at-the-deep-end
	GMC	Learning materials with some tools to support decision making	
Understanding and responding to patient need	NHS England Oliver McGowan	Training for staff working with those who have a learning disability	https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism
	RNIB	Provide Training and support for those working with site impaired	https://www.rnib.org.uk/living-with-sight-loss/education-and-learning/
	RNID	Provide Training and support for those working with hearing impaired	https://rnid.org.uk/information-and-support/support-for-health-and-social-care-professionals/?_gl=1*nt3zz6*_up*MQ..*_gs*MQ..&gclid=EAIaIQobChMI1f3W-dzmjgMVd45QBh1gMSoLEAAYASAAEgLihfD_BwE
	Zero Suicide Alliance	Training to have conversations and prevent suicide	https://www.zerosuicidealliance.com/training

Other national / SEL resource

South East London Integrated Care System

Support area	Organisation	Training or support available	Link
Specific CQC / performance improvement	National Training Centre for smoking cessation	Training to support stop smoking	https://elearning.ncsct.co.uk/england
	Warwick Diabetes Course	Diabetes Diploma	https://warwick.ac.uk/fac/sci/med/study/cpd/diabetes/
	Diabetes UK	Diabetes awareness and management	https://www.diabetes.org.uk/for-professionals/learning-and-development/training-courses/courses-hcps
	Respiratory Matters	Training in COPD management	https://www.respiratorymatters.com/copd-diploma
	Asthma and Lung UK	Asthma and COPD training	https://www.asthmaandlung.org.uk/healthcare-professionals/training-development
	The Faculty Od Sexual and reproductive Health	Training in contraception and HRT	https://www.fsrh.org/Public/Public/education-training.aspx
Workforce development	Immunisation & Vaccination Training	Online training and in person training provision	https://www.e-lfh.org.uk/programmes/immunisation/ https://www.mkupdate.co.uk/course/immunisation-training-for-nurses-and-ahps
	NHSE	Return to General Practice programme - includes support for returners including form completion support/career/education development, financial support	Return to Practice | Medical Hub

Other national / SEL resource

South East London Integrated Care System

Support area	Organisation	Training or support available	Link
Workforce development	E - Learning for Health	Online training resources covering a wide ranger of courses relevant to health and staff working in health care	https://www.e-lfh.org.uk/programmes/
	Thrive London	Well Being Training Resources	https://thriveldn.co.uk/hyo-categories/training/
	University Providers	Undergraduate and Postgraduate training and provision of professional courses or support career development . London has more than 25 universities as well as online university provision and provision in Kent	https://www.topuniversities.com/where-to-study/europe/united-kingdom/top-10-universities-london https://www.open.ac.uk/ https://www.canterbury.ac.uk/
	RCGP	Leadership pathways e-learning, podcasts, support and peer support networks	Home | RCGP Learning
	RCGP	First 5 pathway to support revalidation - flexible CPD framework	Home | RCGP Learning
	RCGP	Online members forum	Home | RCGP Learning
	NHSE	Practical toolkit to improve GP retention	: NHS England » Making general practice a great place to work – a practical toolkit to improve the retention of GPs
	RCGP	Online clinical and non clinical e-learning, linked to CPD points	Home | RCGP Learning
	BMA Doctor support service	Confidential support line for Doctors	Sources of support for your wellbeing
	Blue Stream Academy	Providers of courses for practice staff	https://www.bluestreamacademy.com/
	Primary Care CPD	Training for Primary Care staff	https://primarycarecpdtraining.co.uk/
	Practitioner Health	MH, stress, depression	Practitioner Health

Other national / SEL resource

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Support area	Organisation	Training or support available	Link
Workforce development	Sick Doctors Trust	Addictions	Sick Doctors Trust
	DocHealth	Psychological consulation for practicing doctors, exploring professional or personal difficulties	What we offer | DocHealth
	Doctors in Distress	Support for any healthcare worker includes webinars, weekly support groups, MH/burnout support	Programmes - Doctors in Distress
	Royal Medical Foundation	Financial hardship assistance	Royal Medical Foundation -
	Royal Medical Benevolent Fund	Financial hardship assistance	Royal Medical Benevolent Fund - Help for Doctors in Need
	The Cameron Fund	Financial hardship assistance	The Cameron Fund
	BMA Doctor support service	Free confidential helpline 24/7, resources/links to support wellbeing, emotional support for those undergoing GMC investigation	Sources of support for your wellbeing
		List of regional resources to support wellbeing	20250125-wellbeing-services-directory-update.pdf
	Frontline 19	Psychological support for NHS/front line service staff in UK	Home | Frontline19
	The Doctors support network	Peer support for Doctors and medical students with MH concerns	The Doctors' Support Network - Home page
	RCGP	New ways to stay involved for retiring GPs	Home | RCGP Learning

Other national / SEL resource

Support area	Organisation	Training or support available	Link
Workforce development	BMA	Advice & guidance and e-learning including around career development, wellbeing, communication skills, clinical guidance and practice management.	
	RCGP	Range of guidance, support and training for GPs, those aiming to qualify as GPs to practice in England	Royal College of General Practitioners (RCGP) - Home
	GMC	E-learning resource including e-learning podcasts, guides	
	RCGP	Range of courses/events	Home | RCGP Learning
	NHSE	Futures platform: Primary care hub - range of resources/links to resources	FutureNHS Collaboration Platform - FutureNHS Collaboration Platform
	GMC	Consultancy/advisory/tailored training	

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**ICS Green Plan refresh – sharing the current working draft for the information of Neighbourhood Based Care Board members**					
Meeting date	18 September 2025		Agenda item Number	_	Paper Enclosure Ref	**7**
Author	**James Colley, Programme Manager Corporate Operations**					
Executive lead	**Tosca Fairchild, Chief of Staff and ICS SRO for Sustainability**					
Paper is for:	Update	**X**	Discussion		Decision	
Purpose of paper	This paper is the current working draft (v6.4) of the SEL ICS Green Plan refresh for 2025-2028. It is shared for information/awareness of Neighbourhood Based Care Board members (and, **optionally, to allow members to give feedback/input prior to moving to a final version in October**)					
Summary of main points	• The NHS in England is to be carbon net zero by 2040 (for emissions in our control) and 2045 (for emissions in our influence). • The first iteration of the SEL ICS Green Plan (2022-2025) was our system-wide sustainability strategy that addresses the above requirements. System Green Plans are written and owned by respective ICBs. • Guidance from Greener NHS (a function of NHS England) requires the ICS and each of our Trusts to refresh their Green Plans for the period 2025-2028. The current working draft (v6.4) of the SEL ICS Green Plan is attached. • The ICB Executive Committee approved a draft of the refreshed plan (with comments) in July, so that it could be submitted to Greener NHS (NHSE) for an interim deadline. • We are now required to move the refreshed Green Plan to a final version by the end of October. It will go back to ExCo on 1 October and to the ICB Board on 15 October. • As part of the finalisation process, the draft plan is being shared with other interested groups and committees, for awareness and 'socialisation'. The Neighbourhood Based Care Board is one such group. **The group is not required to contribute or give feedback [to the plan] but may choose to do so, optionally.** Any feedback should be sent to james.colley@selondonics.nhs.uk. • It should be noted that there is a small pipeline of work that remains to get the plan to a final version. The version shared with the group is therefore not the final draft.					
Potential conflicts of Interest	None foreseen.					
Sharing and confidentiality	Can be shared more widely, if/as required **but** with the caveat that it is a working draft and therefore subject to change by its final iteration in October.					

Relevant to these boroughs	Bexley	X	Bromley	X	Lewisham	X
	Greenwich	X	Lambeth	X	Southwark	X
Equalities Impact	Environmental sustainabilty is an enabler to equality.					
Financial Impact	None arising directly from the plan as presented.					
Public Patient Engagement	None undertaken specifically for this draft, but PPE and stakeholder engagement will have informed SEL Trusts' individual Green Plans.					
Committee engagement	The ICB Executive Committee reviewed and approved a draft of the refreshed plan (with comments) in July, so that it could be submitted to Greener NHS (NHSE) for an interim deadline.					
Recommendation	The group is asked to: • Note the attached draft Green Plan, for information • **Optionally** provide feedback (if members of the group choose to) – which should be sent to james.colley@selondonics.nhs.uk asap, so that it may inform the final draft being submitted to ExCo 1 October.					

South East London Integrated Care System

NHS

Healthier Planet Healthier People

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South East London ICS

Foreword

Tosca Fairchild, ICS Sustainability Senior Responsible Officer

The NHS in England is undergoing a transition, but the need to address the world's environment and climate challenges remain as urgent as ever. We must continue to accept our responsibility to be good stewards of the environment while we deliver safe, effective and high-quality NHS services.

I joined South East London Integrated Care Board (SEL ICB) as Chief of Staff in the summer of 2022, just after the first SEL Integrated Care System (ICS) Green Plan was published. In my capacity as Sustainability Senior Responsible Officer (SRO) I have provided executive leadership to the ICS sustainability programme for the three-year duration of the first plan.

It has been an honour and a privilege to work with committed colleagues across the system and seeing them rise to the challenge of reducing carbon emissions against a backdrop of system change, financial challenge and evolving priorities. I have seen incredible progress against our net zero objectives, knowledge and expertise flourishing across the system, networks being formed, learning being shared and the acceleration of partnership working. In many ways, sustainability is still a challenging area of NHS work, but we are learning and working together and consequently, we are stronger in our delivery. It is important that we maintain this, because the challenge of improving our environment is not going away any time soon and we know that it is linked to the health of our population.

2025 will see the beginning of a period of significant change for the NHS, with the 10 Year Health Plan setting new directions of travel for our health service. SEL ICB will restructure in support of this new vision and in doing so, will shift to align with the new ICB Blueprint.

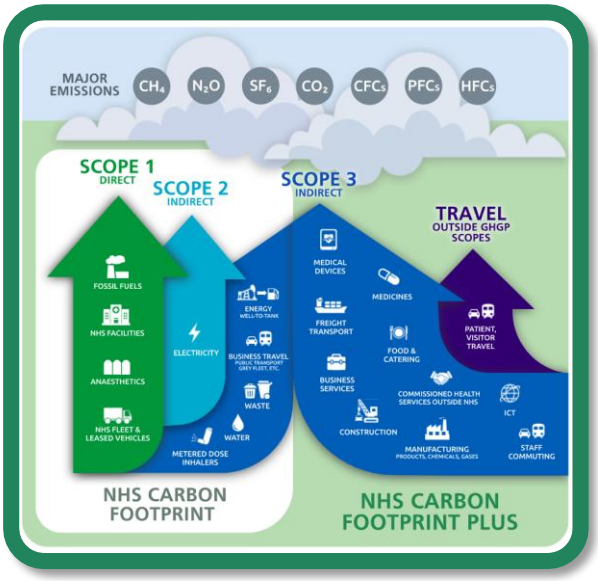
We must embrace and support this change, because it is about improving our health service and enabling every member of our population to be - and stay - healthier. This Green Plan does the same, because we recognise that a healthier planet is key to keeping our people healthier, and when our people are healthy, the NHS in south east London uses less resources and creates less waste that causes harm to our environment.

Thank you for reading.

Delivering a net zero NHS

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS.

The NHS was founded to provide high-quality care for all, now, and for future generations. Understanding that climate change and human health are inextricably linked, in October 2020, it became the first in the world to commit to delivering a net zero national health system. This means improving healthcare while reducing harmful carbon emissions and investing in efforts that remove greenhouse gases from the atmosphere.



With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act. The *Delivering a Net Zero Health Service* report sets out a clear ambition and two evidence-based targets:

1. **For the emissions we control directly (which we call the NHS Carbon Footprint – *see diagram above*) we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032**
2. **For the emissions we can influence (our NHS Carbon Footprint Plus - *see diagram above*), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.**

In 2022, the NHS became the first health system to embed net zero in legislation, through the Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to consider statutory emissions and environmental targets in their decisions. Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans.

The NHS's commitment to net zero was reinforced by Lord Darzi in his independent investigation of the NHS in England (September 2024).

Delivering a net zero south east London

The London boroughs of Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley are home to two million people, supported by the following net zero contributors:

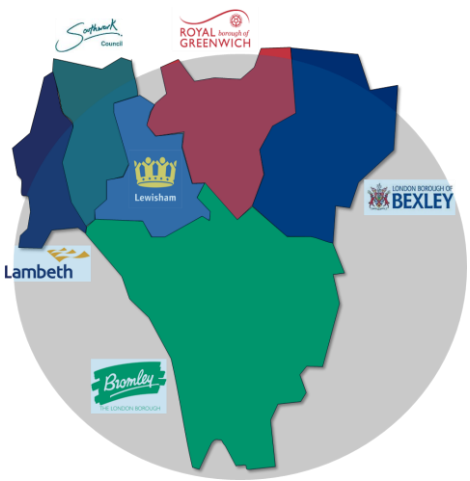
- **Five NHS hospital trusts - Guy's and St Thomas', King's College Hospital, Lewisham and Greenwich, Oxleas and South London and Maudsley NHS Foundation Trusts** – all of which are members of the South East London Sustainability Network.
- **Bromley Healthcare CIC** – a member of the South East London Sustainability Network.
- **194 GP practices organised within 35 Primary Care Networks (PCNs) alongside community pharmacies, dentistry and optometry.** Primary care input to green planning is via the ICB-facilitated *Primary Care Green Group.*
- **The six south east London local authorities** – with whom the ICB is a longstanding partner across health and care services.

The care provided by these contributors to our population is organised around 25 neighbourhood health services, each of which has a shared plan for coordinated, local care that meets people's needs earlier and more effectively.

Using net zero to improve health inequalities

Our borough populations in south east London share some commonalities, but also have their own characteristics, complexities and needs.

Some of our boroughs experience high levels of deprivation, social and health inequality and inequity – which are all key determinants of health. The health (physical and mental) and social impacts of poor environment and climate change tend to fall disproportionately on those who are disadvantaged and most vulnerable.



By taking actions to bring carbon emissions down, the whole of the south east London population benefits, but our most deprived communities stand to benefit most.

Delivering a net zero south east London will also enable our 2025/2026 Joint Forward Plan. This five-year plan ensures the work we do improves population health, reduces health inequalities and ensures the sustainability of health provision.

The 2022-2025 Green Plan: Achievements from the last three years

Overview

Contributors to the ICS Sustainability Programme have learned, grown and achieved together throughout the duration of the first ICS Green Plan.

The 2022-2025 Green Plan set 122 objectives for delivery by system partners. The efforts of partners working to their own Green Plans and working in system-wide collaboration saw delivery against 90 of the planned objectives. This delivery positioned was supported notably by consistent delivery by expert colleagues working in hospital trusts and by colleagues leading system-wide workstreams, such as in Estates, Medicines and Digital Transformation.

A selection of our achievements across the 2022-2025 Green Plan include:

Workforce & System Leadership

We established a net zero learning catalogue for our workforce and leaders with the Centre for Sustainable Healthcare, provided net zero education and training through development sessions with ICB leaders, and through external sources, such as *NHS Collaborate*

Workforce & System Leadership

We have built networks of Green/ Sustainability Champions across the south east London system

Workforce & System Leadership

We hosted a Chief Sustainability Officer's Clinical Fellow, within the ICB Medicines Team *(see photo, right)*

SEL's Clinical Fellow Minna Eii (second from right) graduating with the CSO Clinical Fellow cohort of 2023-2024

Workforce & System Leadership

We co-designed and co-ran the London Green Celebration event with Greener NHS (London) in 2024 and 2025

Achievements from the last three years

Air Quality

We installed air quality monitoring nodes and used the data to drive improvements in air quality

Travel and Transport

We ran travel surveys and used the findings to help our people use sustainable travel to get to NHS sites

Travel and Transport

We commenced electrification of NHS fleet and supported this by installing electric vehicle charging infrastructure

Travel and Transport

We implemented a number and wide range of active travel initiatives

High security *Cyclepods* were installed in at GP practices to encourage active travel

Estates and Facilities

We switched to low energy LED lighting across our estates

Estates and Facilities

We made multiple successful bids for funding to support estates decarbonisation, incl. installation of solar panels

Estates and Facilities

We reviewed waste being disposed of through different waste streams and reduced the amount going to landfill; moving towards more recycling and exploring *energy-from-waste* solutions

Estates and Facilities

We reduced the use of single-use items, including medical instruments, theatre hats, cubicle curtains – and noting particular success in reduced use of vinyl gloves through *Gloves Off* campaigns

Green Space

We created green spaces at hospital sites to improve biodiversity and to allow patients' healing to be supported by nature

Achievements from the last three years

Medicines

We made significant progress on switching respiratory patients to low-carbon inhalers and we launched the first nationally-funded inhaler recycling pilot scheme across King's College Hospital sites and 20 south east London community pharmacies

SEL Pharmacy Leads launching the SEL inhaler recycling pilot scheme, July 2024

Medicines

We reduced the use of high-emission anaesthetic gases and reduced nitrous oxide waste

Medicines

We engaged with patients to understand how we can work together to reduce overprescribing

Digital transformation

We provided the technical support for staff to work from home, where appropriate – reducing staff journeys

Digital transformation

We moved towards higher energy efficiency IT equipment and cloud solutions

Digital transformation

We developed the *London Care Record;* an electronic health record which can be shared across care sectors. This integrates services across south east London; making our services more efficient and less wasteful by removing unnecessary patient contacts and travel.

Digital transformation

We have recycled c.400 items of IT equipment, of which 94 have been redistributed to digitally excluded communities in SEL

A volunteer at Community Tech Aid restoring laptops for donation to members of our community

Supply Chain

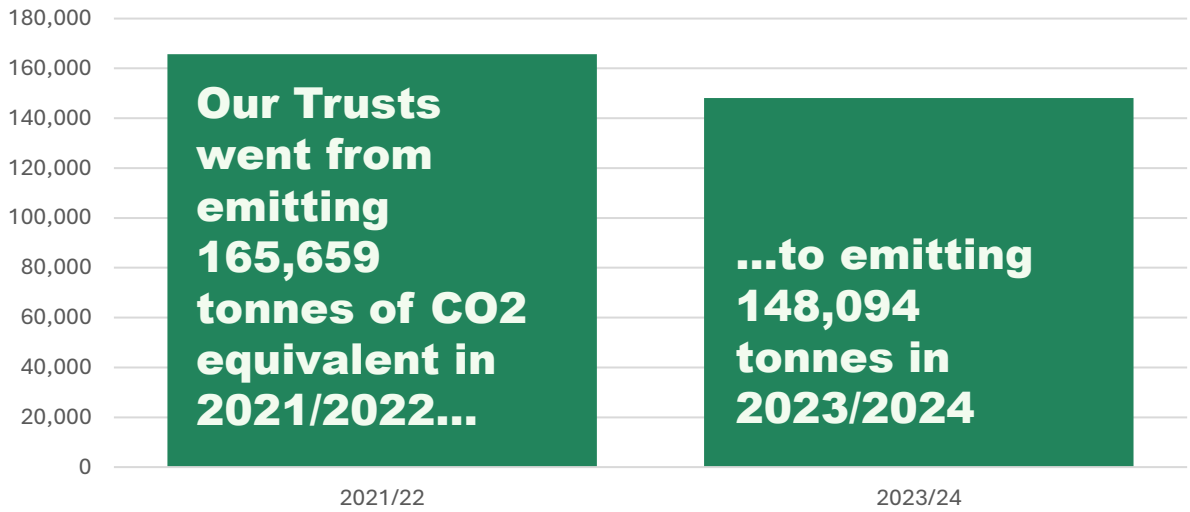
We started evaluating social value for the award of contracts, and suppliers must now have carbon reduction plans

Spotlight

Tracking progress in

Trust carbon emissions

In the two-year period since the first Green Plans were published (2022) to the latest available data (2024), NHS Trusts in south east London have lowered their NHS Carbon Footprints by 10.6%



The NHS Carbon Footprint are the emissions we control *directly* – emissions from building energy, waste, water, business travel and fleet. It also includes emissions from anaesthetic gases and the carbon-intense inhalers that are prescribed in secondary care. The table below shows how emissions in each of these categories have changed between 2022 and 2024.

Emissions from	2021/2022 (tonnes of CO2 equivalent)	2023/2024 (tonnes of CO2 equivalent)	% reduction
Anaesthetic gases	9,713	7,001	27.9
Building energy	129,179	119,192	7.7
Business travel and fleet	21,815	17,886	18
Metered dose inhalers	927	536	42.2
Waste	3,627	2,942	18.9
Water	398	537	35% *increase*

Data source: NHS England Green Plan Support Tool

Our 2025-2028 Green Plan

This Green Plan:

- Provides a system-level view of the net zero mission and objectives for south east London's NHS.
- Operates across the three-year period 2025-2028.
- Continues the work outlined in the 2022-2025 ICS Green Plan, whilst applying additional dimensions and/or outcomes.
- Invites contributions from every member of the NHS workforce and from our wider system partners in south east London
- Represents organisational objectives, whist recognising that we cannot deliver them without action at individual and collaborative levels.

Our mission

We will protect and improve our population's health and reduce health inequalities by mitigating our environmental impact and improving the quality of the environment in south east London.

We will achieve this by building awareness of net zero across our workforce - embedding sustainability into our 'business as usual' and supporting our colleagues and partners to minimise environmental harm in the design and delivery of our services.

To fulfil our mission, the objectives of this plan are designed to:

- **Recognise prevention as a key driver of sustainability, and sustainability as an enabler of prevention.** The single most effective way for the NHS to preserve resources and eliminate waste is to contribute to good public health and reduce the need for patients to attend our services for treatment. If we improve the environment around us, our population can enjoy healthier, happier, active lives that will help them stay in good physical and mental health.
- **Align with existing ICS priorities and the South East London Joint Forward Plan.** In our Joint Forward Plan, environmental sustainability is recognised as an enabler to population wellbeing, mental health and long-term conditions. The sustainability programme is also committed to developing leadership and our workforce; a key condition for change to deliver ICS priorities. The objectives of this Green Plan will raise the profile of sustainability and highlight the potential for further contribution to achievement of system objectives.

To fulfil our mission, the objectives of this plan are designed to:

- **Recognise the concept of the *sustainable value equation*** (also known as the '*triple aim*')

$$\text{Sustainable value} = \frac{\text{Outcomes for patient and populations}}{\text{Environmental + social + financial impacts}}$$

(the *'triple aim'*)

This concept describes how sustainable value is achieved when better outcomes for patients and population are achieved without detriment to environmental, social or financial impacts. We will work towards assessing the environmental impacts of every significant discussion or decision in the same way that we currently consider financial and people impacts.

- **'Design out' emissions, waste, inefficiency and harm.** By undertaking environmental impact assessments of services, pathways and projects we can identify potential negative impacts and take opportunities to maximise efficiencies. Where there is inefficiency, there is inevitably waste and a negative impact for our environment. We must eliminate this.

  We must also recognise the additional resources required in exploring and using artificial intelligence (AI) to meet the *10 Year Health Plan for England's* aim of moving from an analogue to a digital health service and balance this with the benefits it can create for patients and staff.

- **Give greater support to clinician-led sustainability projects.** Previous Green Plan objectives have focused on lowering the carbon emissions from daily operations; buildings, waste, energy and water usage (the *NHS Carbon Footprint).* Over the next three years the system will be encouraged to place a greater focus on clinician-lead projects around sustainable models of care.
- **Embed net zero as an enabler and output of strategic commissioning.** The *10 Year Health Plan for England* requires ICBs to transform into strategic commissioners; strategically redistributing resource out of hospital and integrating care. Achievement of net zero should be both an enabler and an output of strategic commissioning, and this plan will seek to influence realisation of this.
- **Encourage full use of contracting levers in the delivery of net zero.** Delivery of net zero objectives and targets by hospital trusts is included in the Service Conditions of the NHS Standard Contract. Where oversight of Green Plan delivery will transition away from the ICB, enforcement of contracting levers will be an essential mechanism for holding trusts to account on delivery.
- **Require and enhance collaboration** – within the existing South East London NHS sustainability network and with an increased breadth of system partners.

This plan is created with consideration of a number of contributors and influences, which include:

- **South East London NHS Hospital Trusts and their Green Plans.** Each Trust has refreshed its Green Plan for 2025, which sets out their strategy for sustainability and carbon reduction.
- **Bromley Healthcare CIC,** which is not held to Greener NHS guidance but works to its own Environmental, Social and Governance plan and actively participates in the ICS sustainability programme at multiple levels.
- **South East London ICB and Primary Care** – the ICB acting both in its capacity as commissioner and system convener in delivery of objectives.
- **Greener NHS;** the regional team of which convenes the London system and facilitates shared learning and the national team of which provides guidance, frameworks, tools and learning resources.
- **Collaboration and shared learning with/from wider system partners,** including (but not limited to) London Councils, the London Procurement Partnership, the Greater London Authority (GLA), and other ICBs across London.
- The **10 Year Health Plan for England**, which will promote three big shifts to address the changing needs of the UK population (from hospital to community care, from analogue to digital services, and from sickness to prevention) and direct changes to the purpose of ICBs.

With regards to these influences, this plan:

- **Serves as an overarching system-wide sustainability plan** encompassing and aligning with the green plans and inputs of the contributors listed above.
- **Is a continuation of the 2022-2025 SEL ICS Green Plan**, in that it recognises the work done over the last three years and requires the same work to continue, with adjustments for where we are now and what we have learned since 2022.
- **Recognises that responsibility for system-level oversight of net zero work will transition between NHS organisations.** To support this movement of responsibility, this plan confirms the system-wide sustainability themes and high-level delivery objectives but does not dictate the method of delivery or set delivery targets. This allows flexibility to be applied to delivery of this plan.
- **Is an enabling factor to the 10 Year Health Plan for England's focus on preventing sickness by keeping the SEL population healthy.** Keeping our environment in good health contributes to good public health – and the best way to increase sustainability and minimise waste is to promote good public health and to reduce the call on NHS services.

Spotlight

Delivering sustainability and net zero through

Neighbourhood working

The South East London system's move towards a neighbourhood health service connects directly with the system's resource and environmental sustainability programmes, acting to improve efficiency, design out waste and to implement effective and sustainable models of care.

The 10 Year Health Plan for England sets out a bold and ambitious vision to transform the NHS, ensuring it remains there for everyone who needs it, now and for generations to come. Neighbourhood care is central to this transformation, shifting care closer to home, strengthening prevention, and supporting more joined-up, personalised care for our diverse communities.

Neighbourhood working will transform how services work together at a local level, improving health outcomes and reducing inequalities by making care more personalised for the communities we serve and strengthening the role of communities in health and wellbeing through community-led approaches.

To ensure our transition remains on-track, and that we realise the benefits we expect from our transition to neighbourhood working, we have developed an outcomes framework. The framework sets a clear and succinct set of outcomes, inputs, outputs, and activities across four key outcome domains.

Population Health, Prevention and Inequalities

Resident experience and community impact

Workforce impact and staff experience

System resource and sustainability

Interwoven across the domains is an emphasis on environmental sustainability. Framework entries which relate explicitly to the environment are outlined on the next page. ***Note:*** *at the time of publication, the neighbourhood outcomes framework is in development and is subject to change as we continue to engage and refine the vision for neighbourhood working.*

South East London Neighbourhood outcomes framework entries which relate explicitly to the environment:

Resident experience and community impact

- *Activity:* active travel schemes are in place to support residents to access services
- *Activity:* population Health Management analytics and modelling are applied by neighbourhoods and Places to both planning and care delivery: to tailor resourcing and interventions, and to systematically and proactively flag and identify individuals vulnerable to health and social inequalities, rising risk, or the effects of climate change

Resident experience and community impact

- *Outcome:* communities are supported to thrive as local services are improved, more residents are supported to become or remain economically active and in employment, and environmental quality is improved
- *Output:* community and town centers are invigorated, with improved spaces for community collaboration, connection, and action
- *Activity:* there is greater grassroots action and community activation around the intersection of the environment and health and wellbeing outcomes
- *Input:* a cultural commitment to fostering healthy environments

System resource and sustainability

- *Outcome:* the system achieves environmental sustainability over the long term
- *Output:* reduced wastage and duplication of activity between individuals and within/between organisations
- *Output*: environmental sustainability and conscientiousness is embedded in our system-wide culture
- *Activity:* staff take up environmental training opportunities in sustainability in social care
- *Activity:* services are designed, commissioned and effectively evaluated on an outcomes basis, with an emphasis on reducing wastage.

Delivering our plan: governance, networks and assurance

Leadership, governance and strong assurance processes are needed to ensure that the net zero objectives in this green plan are delivered. This section focuses on oversight at an ICS level.

Leadership oversight

- NHS South East London Integrated Care Board's Chief of Staff is appointed as ICS Sustainability Senior Responsible Officer (SRO) and oversees Green Plan delivery.
- The ICB's Deputy Medical Director provides and promotes clinical leadership to Green Plan delivery. They also chair the Primary Care Green Group *(see below).*
- Each NHS Hospital Trust has appointed a designated board-level net zero lead (generally an existing executive director) to oversee delivery of its own Green Plan.
- Designated leads are responsible for ensuring that each contributor organisation has clearly identified operational support.

Key governance groups and networks

- The **Greener SEL Oversight Committee** provides system-level leadership, oversight and reviews the assurance submissions made to Greener NHS bi-annually. It is attended by board-level executive leads from the ICB, each of the Trusts and Primary Care. The committee meets bi-annually.
- The **Primary Care Green Group** is a forum through which primary care colleagues can contribute to and receive support from the ICB Sustainability Programme and its partners. It is attended by representatives from each of the six boroughs and leads for ICB workstreams relevant to primary care. The group meets quarterly.
- The **SEL Sustainability Network** takes updates on delivery of Green Plans, whilst also providing a forum to share best practice. It is attended by the operational sustainability leads from SEL provider Trusts. The network meets quarterly.

Assurance reporting requirements

- A full review of delivery against Green Plan objectives is undertaken bi-annually, in March and September. It is reported to the Greener SEL Oversight Committee and copied to the Primary Care Green Group and Sustainability Network.
- The system makes a bi-annual assurance submission to Greener NHS (NHS England). This is signed off by the Greener SEL Oversight Committee.
- SEL ICB and Trusts are required to make quarterly submissions on Greener NHS priority measures to Greener NHS. Sign-off of submissions is per organisation.
- Progress reports on actions in the green plan are included in the ICS Annual Report.

Workforce and System Leadership

Our opportunity:

If we can create and nurture a shift in culture where our people understand and consider the relationship between planetary health and population health, where system leaders visibly show their commitment to delivery of net zero by role-modelling positive action and enabling our workforce to participate, we can:

- **Drive effective change from the top of our organisations**
- **Integrate sustainability into our core business by showing our people how and where it can be effective in driving local health improvement**
- **Strengthen relationships for sustainable change with our system partners**
- **Create a 'movement', harnessing the collective power of staff, enabling and encouraging them to implement change on the ground and/or to become Green Champions**

Net zero cannot be achieved if we do not visibly lead, support and enable our workforce to participate.

Across our system, we will:

1. Continue to offer system-level opportunities for board-level sustainability leads to engage on net zero delivery; including via the Greener SEL Oversight Committee (see *Governance, networks and assurance, page 13*) and by making sustainability leadership training available and accessible.
2. Continue to promote our core training offer to the whole workforce and assess the skills requirements of staff groups who underpin the delivery of our Green Plan, to promote training offers that align with specialist requirements.
3. Review green plan delivery oversight arrangements to ensure the correct functions are represented and aligned to green plan delivery and emerging connected requirements; for example, finance leads/colleagues to support the requirement to make annual climate-related finance disclosures (TCFD).
4. Continue to activate and grow our groups of Green Champions; providing members of our workforce with forums that they can connect with.
5. Champion our work, using communications channels to share case studies and successes, and to recognise key sustainability dates and events.
6. Continue to explore opportunities to offer sustainability-related apprenticeships and host clinical fellows; investing in leaders of the future.

Spotlight

Leading sustainable working in

Primary Care

Engaging primary care in the ICS Sustainability Programme provides a wide range of opportunities to unlock the mechanisms that can take us towards net zero. As small businesses and local community organisations, GP practices, dental and optometry clinics and community pharmacies can all have a direct influence on the actions and behaviours of their patients as well as the emissions produced by their own activity.

Over the last three years, primary care clinicians and colleagues have demonstrated a distinct will to make a difference. Whether by collaborating with the ICB Sustainability Team, by being active in the ICB Primary Care Green Group or by signing up to be an ICS Green Champion, the desire to move towards net zero is consistently shown.

"The concept of a healthier planet meaning healthier people resonates well with me and many primary care clinicians. Practices can also experience tangible benefits such as cheaper running costs and improved staff wellbeing from being greener'.

Over the last three years, we have established networks and created a movement towards greener practice. This means expertise and support are available to help embed sustainable practice into business as usual which is not just good for primary care organisations, but also for the patients they serve."

- Dr Nancy Kuchemann
GP, SEL ICB Deputy Medical Director and Primary Care Sustainability Lead

Primary care business obligations relating to the environment:

1. Working with ICB Digital, Medicines Optimisation and Primary Care estate teams to steer, develop and implement carbon reduction measures
2. Care Quality commission assessments – where leadership is required to support reducing our impact on the environment and supporting others to do the same
3. Business continuity planning – which must now include climate resilience, and an awareness of how extreme temperatures affect the health of vulnerable patients
4. Improving efficiency and reducing waste, leading to more cost-effective operations
5. Personalisation of care for patients – where providing more personalised and holistic care also supports improved efficiency

Opportunities to further promote sustainable practice in primary care:

- By raising awareness of the links between environment, climate, health and inequalities – and the benefits of adopting the sustainable value approach to neighbourhood care *(see the 'sustainable value equation' on page 11)*
- By growing sustainability leadership in primary care; and with it, growing the net zero knowledge base of leaders
- By putting primary care at the heart of, and to promote net-zero clinical transformation within neighbourhood development, and to play a key part in developing sustainable models of care
- By promoting primary care as key partners in the development of neighbourhoods as safe and healthy places, encouraging active travel and nature-based activity to influence patient health outcomes
- By promoting training opportunities, educational resources and good practice toolkits provided by external bodies, such as (but not limited to) the Centre for Sustainable Healthcare and the Royal College of General Practitioners through the Greener Practice
- By using the emergence of GP at-scale organisations to establish greater influence on green strategy and delivery; working collaboratively with the ICB (as commissioners of primary care) and providers
- By curating digital transformation to incorporate emissions reductions, recognising that primary care digital systems are some of the fastest changing and most innovative

Primary care priority objectives, 2025-2028

1. Support the decarbonisation of primary care estate
2. Reduce waste and emissions via use of existing systems to optimise medicines prescribing
3. Apply digital solutions to reduce emissions from travel and premises use
4. Support prevention and thereby avoid use of high carbon pathways. This can be realised through the neighbourhood approach to long term condition care
5. Educate leaders, colleagues and patients and develop networks that allow us to embed NHS net zero in everyday business
6. Recognise the impacts of climate change on patients and staff, and the emerging importance of climate adaptation and resilience

Air Quality

Our opportunity:

London has the highest percentage of deaths attributable to particulate air pollution of all English regions – 6.2% in 2023 compared to the national average of 5.2% If we can understand what puts pollution in the air and what causes air pollution levels and patterns to fluctuate – whether those pollutants come from NHS sites and services or from elsewhere – we can:

- **Take action to minimise the pollution the NHS puts into the air**
- **Actively communicate changes in air quality and pollution to our people, to help manage health conditions which are affected by changes in air quality**
- **Identify areas for collaborative work that spans health, social care and public health and determine which delivery partnerships will deliver it**
- **Provide appropriate training for NHS staff on the health impacts of air pollution, to support their treatment and management of our patients**

Objectives to address air quality fall mostly under the Areas of Focus concerning travel and transport, but additional actions in direct response to air quality monitoring data further support our efforts to improve air quality.

Across our system, we will:

1. Continue to use air quality data from the monitoring nodes we have installed across south east London and we will supplement it with live data and on-site observations to drive our action to reduce air pollutants.
2. Recognise the air quality improvements arising from initiatives across the other areas of focus in this Green Plan e.g. travel and transport
3. Seek points of entry into delivery partnerships with our councils to identify areas where we can work collaboratively on improvements to air quality.
4. Embed and consider local action to enhance the impact of the Air Quality alerts for healthcare professionals, which are circulated to GPs and EDs at times of high and very high air pollution.
5. Consider how key messages can be conveyed to healthcare professionals and patients on an ongoing basis.
6. Advocate for and champion action on air pollution; supporting key air quality events such as the annual Clean Air Day.
7. Continue motor vehicle anti-idling initiatives and zones across NHS sites.
8. Support patients with management of their respiratory conditions (see *Delivering Net Zero by Medicines Optimisation* on page 30)

Travel and Transport

Our opportunity:

If we can understand how, where and why our people need to travel, and how they would like to travel, we can:

- **Promote and influence shifts to sustainable modes of transport**
- **Work to decarbonise our business fleet, moving towards an electric fleet supported by appropriate electric vehicle charging infrastructures**
- **Support staff to decarbonise their personal travel, through staff transport schemes, enhanced active travel facilities and staff benefits schemes, such as salary sacrifice lease car scheme or bicycle purchase schemes**
- **Can support our patients to travel more sustainably and actively; whether it is to reach NHS sites for treatment, or for their general health and wellbeing**

Net zero and cleaner air cannot be achieved if we do not minimise unnecessary and/or high emissions travel.

Across our system, we will:

1. Implement travel surveys to understand travel patterns and barriers to active travel and use the results of these to develop sustainable travel plans.
2. Work towards offering only zero-emissions vehicles through salary sacrifice lease car schemes from December 2026 and purchasing/leasing only zero-emissions vehicles for business use from December 2027.
3. Continue to promote and incentivise active travel for staff and patients; with the provision of facilities, information on safe and clean walking and cycling routes, confidence training and promotion of cycle hire schemes. We will also explore incentivisation of business travel by bicycle by increasing mileage reimbursement rates for cycling.
4. Continue our work to decarbonise (and ultimately electrify) the NHS business fleet. This will be supported by continued trials of e-bikes and cargo bikes and the rollout of innovative approaches (such as drone delivery) where shared learning and best practice signals value in these approaches.
5. Recognise and promote the travel reduction benefits of hybrid and flexible working.
6. Form and strengthen partnerships with our local authorities and local transport authorities to drive modal shifts.

Estates and Facilities

Our opportunity:

If we optimise resource use in the construction and running of our buildings and the services housed in them – either by design or by retro-fitting solutions - we can:

- **Futureproof our estate by ensuring construction, facilities and maintenance are sustainable, efficient and adapted to our changing and volatile climate**
- **Ensure our buildings are fit-for-purpose and comfortable places to visit, work and receive NHS services**
- **Minimise carbon emissions from our running of buildings, including via decarbonisation and use of alternative and renewable energy sources**
- **Minimise waste and the environmental damage it does; including its emissions. This supports our legal duty to dispose of waste appropriately.**
- **Promote and increase re-use, recycling and energy recovery of/from waste as an alternative to disposal**

A considerable proportion of emissions within our direct control come from our estate (see *Tracking progress in Trust carbon emissions,* page 9) so there must be demonstrable reductions in resource consumption and emissions to deliver net zero.

Across our system, we will:

1. Continue to develop heat decarbonisation plans and develop roadmaps for decarbonisation of heating and hot water systems.
2. Ensure that all applicable new building and major refurbishment projects are compliant with sustainability standards and the NHS Net Zero Building Standard.
3. Continue our direction to zero-to-landfill and NHS targets for offensive waste. This will be supported by additional training, introduction of waste manager roles across the system (differential by organisation) and campaigns on recycling and reuse/circularity to further decrease waste disposal.
4. Develop an understanding of net zero opportunities and benefits from net zero adaptations within our general practice estate (see *Delivering net zero in Primary Care Estates*, page 18)
5. Actively explore the opportunities for generation of electricity via installation of solar panels, with procurement support for Trusts who have successfully secured Great British Energy funding and support from the GLA's London Estates Delivery Unit (LEDU) for general practice.

Spotlight

Delivering net zero in

Primary Care Estates

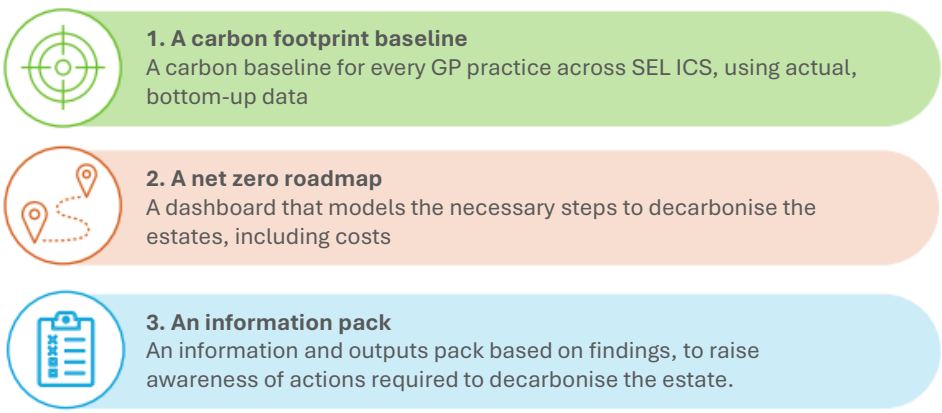
The SEL ICS Estates Strategy acknowledges the significant carbon emissions generated by NHS estates and approaches sustainability as a system-wide ambition, combining green design, digital innovation, resource efficiency, and place-based planning. It positions our estate as a key enabler in delivering environmentally sustainable, high-quality healthcare aligned with broader social and economic goals.

SEL ICS pledges to:

- Construct and maintain buildings to high environmental standards; adopting and exceeding the **NHS Net Zero Building Standard** for all new developments and major refurbishments.
- Use estate rationalisation and redesign to **reduce operational carbon emissions and improve efficiency.**
- Ensure estates are adapted for **climate risks** and incorporate **green space** and **biodiversity** into sites.

To meet these pledges, net zero is integrated into Integrated Care Systems (ICSs) governance and estate investment strategies.

South East London ICS includes 253 general practice sites. It is estimated that primary care accounts for c.25% of the NHS Carbon Footprint, with NHS estate accounting for similar. Through a programme led by the GLA London Estates Delivery Unit, in 2024 South East London ICB partnered with Turner & Townsend to develop three products/outputs:



The calculated footprint for the SEL primary care estate is an annual 7,184 tCO2e, with an annual energy bill of £4.04m. This demonstrates that energy efficiency and decarbonisation installations can reduce energy usage and costs. Reducing energy consumption can reduce energy costs, but it is important that energy demand is managed before installing more sustainable heating systems.

General Practice pilot study

Our work with Turner and Townsend – including the net zero roadmap and the recommendations from the information pack – has led SEL ICB to commission a detailed study of two GP Practices in South East London (Villa Street Medical Centre and Blackfriars Medical Practice) to understand current energy use and environmental performance and assess decarbonisation options.

Villa Street Medical Centre (top) and Blackfriars Medical Practice (bottom)

The study has recommended a package of interventions to decarbonise general Practice and lift energy performance:

1. **Comprehensive fabric upgrades** – roof and wall insulation and window replacement
2. **Heating System Replacement** – moving towards air source heat pumps
3. **Upgrades to high-efficiency LED lighting**
4. **Monitoring & Controls** – including sub-metering, thermographic surveys and air-tightness testing to verify performance.

The outcome of our case study/pilot work has confirmed a plan for supporting improvements to insulation and boiler replacement - as the main contribution to decarbonising general practice.

The ICB is now considering funding options to implement the improvements to our two pilot practices. This work means we are now in phase two of our 10-year implementation plan (see page 20) to achieve a 60–70% reduction in carbon emissions and EPC ratings of B across our GP estate.

Our 10-year implementation plan to achieve a 60-70% reduction in carbon emissions and EPC ratings of B across the south east London general practice estate (summarised for this plan)

Years 1-2: **Mobilise and prioritise**	
Key activities: • Baseline audits • Rank sites by scope • Secure funding	**Targets and outcomes:** • Site-specific roadmaps • Selection of pilot sites
Years 2-3: **Pilot and validate**	
Key activities: • Apply interventions at pilot sites • Implement metering and tests	**Targets and outcomes:** • Validate carbon reductions and energy improvements at pilots • Refine specifications
Years 4-7: **Scale-up and roll out**	
Key activities: • Bulk procure materials • Phase installations in waves • Delivery training to installers • Monitor performance [of roll out]	**Targets and outcomes:** • Energy use cuts evidenced • EPC ratings improvements across sites
Years 8-9: **Optimise and integrate**	
Key activities: • Investigate on-site renewables (solar panels, EV charging etc.) • Apply bespoke measures at high-energy sites	**Targets and outcomes:** • Additional carbon savings through optimisation • EPC ratings maintained or improved
Year 10: **Embed and report**	
Key activities: • Conduct final audits and EPC re-assessments • Publish a decarbonisation report • Develop a further net zero and technology refresh roadmap	**Targets and outcomes:** • Full GP estate at EPC rating B+ • Lessons learned reviewed and shared

Sustainable Models of Care

Our opportunity:

If we consider net zero principles in the design/re-design of patient services and pathways, we can:

- **Minimise emissions across patient pathways whilst improving quality of care, outcomes and patient satisfaction**
- **Engage with service users and local populations on how their health is linked to and influenced by the environment and invite service co-design – thereby improving social value**
- **Harness the benefits of organising the south east London system into neighbourhood health services, which will reduce duplication and inefficiency by bring joined-up care closer to patient's homes.**
- **Allow for tailored health services that support the reduction of health inequalities whilst reducing the financial impact of inefficient pathways**
- **Challenge ourselves to look at, evaluate and adopt modern, innovative approaches which may already incorporate net zero benefits**

Establishing strong clinical leadership for review of patient pathways will support the development of lean, low-carbon pathways where patients are empowered and prevention becomes a key objective.

Across our system, we will:

1. Identify clinical leads for oversight for net zero clinical transformation, who will be formally linked to board-level leadership and the Greener SEL Oversight Committee (see *Governance, networks and assurance, page 12).*
2. Continue to offer training in Sustainable Quality Improvement approaches to support staff to embed sustainability in service design.
3. Identify and adopt areas of good practice arising from clinical transformation work and frameworks developed elsewhere (e.g. *Greener ED).*
4. Undertake environmental impact assessments for ten pathways being considered for re-design under the South East London System Sustainability programme. This will allow us to identify development opportunities for emissions reduction as these pathways are re-developed.
5. Evaluate opportunities to switch to reusable and lower-carbon clinical instruments, personal protective equipment (PPE), textiles and consumables.
6. Engage the voluntary and community sector in the development of models of care and in the expansion of social prescribing services.

South East London ICS

Digital Transformation

Our opportunity:

If we fully harness the benefits of digitally enabled care (for patients) and digital innovations and options for the NHS digital estate (for staff) we can:

- **Minimise our digital and energy-related carbon footprint**
- **Support clinical care and efficiency by offering remote attendance and monitoring to patients**
- **Improve co-ordination between care sectors by digitally joining them up**
- **Empower patients by giving them digital tools, apps and access to records**
- **Support healthcare staff by offering remote and hybrid working options, saving time and reducing the carbon footprint from business travel**
- **Enable a move away from paper correspondence and printed documents**

Digital improvements to the sustainability of healthcare must not come at a cost to the quality of care or by creating digital exclusion, as this exacerbates inequalities in access to care. We must also be mindful that increased use of Artificial Intelligence (AI), whilst essential to our digital development, can contribute to our carbon footprint.

Across our system, we will:

1. Continue to support and develop digital options to deliver NHS services flexibly, including evaluation of digital self-care and self-referral options for patients.
2. Continue to work with suppliers of IT equipment to identify high energy efficiency, low carbon hardware, software and services – including data centres, cloud computing solutions and the shipping packaging of hardware.
3. Work with suppliers and resellers to recycle obsolete and out-of-warranty equipment, for redistribution to our digitally excluded communities.
4. Continue to digitise patient records in general practice.
5. Undertake digital maturity assessments and use outputs to inform how we can further embed sustainability in digital services.
6. Continue to roll-out and promote the London Care Record across care settings within the six south east London boroughs.

Spotlight

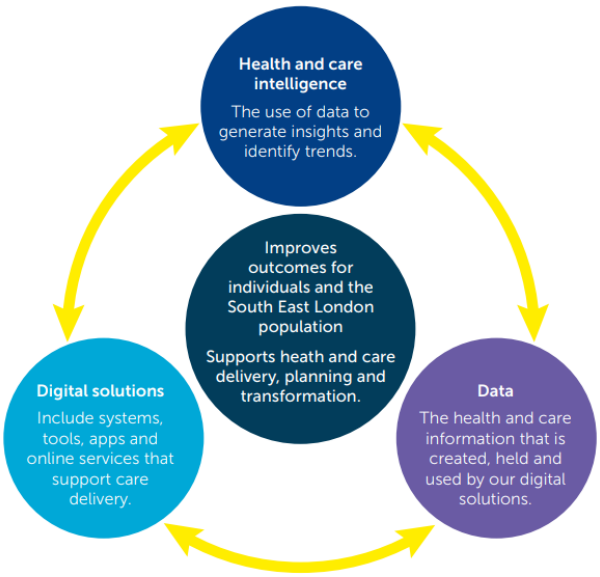
Delivering net zero through

Digital transformation

The South East London ICS Digital, Data and System Intelligence Strategy sets out our vision for how digital and data will enable the delivery of high quality, person-centred care in south east London.

Digital transformation is a key enabler in the delivery of safe and high-quality care as:

- **It unlocks access to data,** enabling generation of insights that can support the management of a person, as well as management of the health and care system
- **It supports collaboration** by making data needed for decision-making available at the point of care
- **It empowers people in our community** by allowing them to access health and care services from their own homes



Though these, digital transformation directly supports the Green Plan principles of **designing out emissions, waste, inefficiency and harm.**

Our digital programmes are designed to align closely with our Green Plan. By changing how we work with people and communities there are several ways in which the Strategy will help to make the NHS in south east London more environmentally sustainable:

1. Supporting care at home and remote monitoring (where appropriate) to reduce patient travel
2. Delivering digital transformation including digitisation of patient records to reduce the use of paper
3. Minimising duplication of testing, which can reduce patient travel time, consumable usage and logistics
4. Reusing and recycling IT hardware
5. Ensuring our suppliers consider sustainability by including net zero and social value measures in supplier contracts

How the digital transformation workstreams categorised in the SEL ICS Joint Forward Plan support good stewardship of our environment:

Joint Forward Plan category: **Digital solutions for connected care**	
Activity/aim: • We will use our digital platforms to support a shift from in-person contacts e.g. Accurx Web for messaging and remote consultation in Community Pharmacy	**Environmental benefit:** • Reduced carbon footprint associated with patient travel
Joint Forward Plan category: **Empowering people**	
Activity/aim: • We will support digital inclusion by expanding the Community TechAid donation/refurbishment scheme and through the Good Things Foundation hubs laptop donation programme.	**Environmental benefits:** • Reduction of waste through circular economy • Increased digital inclusion enhances access to care closer to home, further reducing carbon emissions from travel and resource use
Joint Forward Plan category: **Driving improvement and innovation**	
Activity/aim: • We will reduce paper consumption through changes to printing and Lloyd George digitisation • We will ensure our suppliers consider sustainability by including net zero and social value weightings • We will minimise duplication of testing via roll-out/use of the London Care Record; an electronic health record which can be shared across care sectors • We will mitigate the environmental impact of AI, as it's use grows, by undertaking environmental impact and ethical analyses	**Environmental benefits:** • Reduced consumption of paper/ natural resources • Reduced carbon footprint associated to the supply chain • Reduced patient travel, consumable usage and logistics • Mitigation of carbon footprint impact of AI usage

Medicines

Our opportunity:

If we optimise medicines prescribing and stock-keeping across our system, work with our patients to move to lower-carbon alternatives (where available) and educate our people on medicines disposal and recycling we can:

- **Minimise the carbon footprint of medicine use whilst providing high quality care where lower-carbon alternatives still support people to stay well and lead fulfilling lives**
- **Reduce the waste and potential harm of overprescribing/oversupply of medicines and in doing so, reduce spend**
- **Improve treatment adherence and effectiveness**
- **Move medicines waste away from landfill by providing (or signposting to) recycling options**

Medicines are a significant contributor to the NHS carbon footprint and an area where reduction of overprescribing and waste are within our direct influence. There is consensus on the work required with our patient populations and continued, concerted efforts are required to continue towards net zero.

Across our system, we will:

1. Minimise nitrous oxide waste by progressing the actions outlined in the NHS England nitrous oxide mitigation toolkit, supported by improvements to pipeline systems in trusts and switches to cylinders.
2. Continue our system-wide focus on the management of respiratory conditions (see *Delivering net zero in respiratory medicines*, page 26), promoting the uptake of short acting beta agonist (SABA) free pathways and improving care of chronic obstructive pulmonary disease (COPD) by reviewing local formulary recommendations and associated guidelines.
3. Use data from patient surveys, studies and pilots to inform a programme of work on reducing overprescribing.
4. Evaluate the success and cost-effectiveness of the SEL inhaler recycling scheme and seek to keep offering inhaler recycling across SEL trusts and community pharmacy.
5. Review options for switches between intravenous and oral medicines to increase efficacy with a secondary benefit of reducing use of consumables, where evidence indicates that it is safe, beneficial and effective to do so.

Spotlight

Delivering net zero by

Medicines Optimisation

Medicines account for approximately 25% of total NHS carbon emissions. It is estimated that for every £1 spent on medicines, 0.16kg of CO_2 equivalent emissions is generated. Medicines waste from overprescribing and usage non-adherence contributes to unnecessary environmental harm and resource use.

Reducing unnecessary prescribing and supporting adherence are therefore key enablers for improving clinical outcomes, reducing waste, and helping the NHS reach its Net Zero target.

The South East London Responsible Respiratory Prescribing Group (RRPG) provides a forum for healthcare professionals from across acute, community and primary care to work together to develop consistent, sustainable and cost-effective prescribing guidelines and strategies in respiratory disease for both adults and children. The RRPG supports moves to sustainable inhaler options, as outlined in the group's pledge to reduce the carbon footprint of inhalers:

1. Better patient education to support adherence with preventer use
2. Use combination inhalers where appropriate and where one is available
3. Improve asthma and chronic obstructive pulmonary disease (COPD) control and reduce short-acting beta agonist (SABA) use
4. "Make every puff count" – optimising inhaler technique
5. Increased utilisation of reusable inhaler device or their components
6. Choosing the most environmentally friendly inhalers where suitable
7. Monitor inhaler prescription requests and over-ordering
8. Used inhalers should not be placed in general waste

Additionally, the South East London ICB Overprescribing Groups has, in line with national medicines optimisation opportunities, identified two aims:

1. To better understand the sources of medicines waste and support the safe disposal of unused medicines
2. To improve medicines sustainability by embedding best practice around prescribing into local guidance and formularies

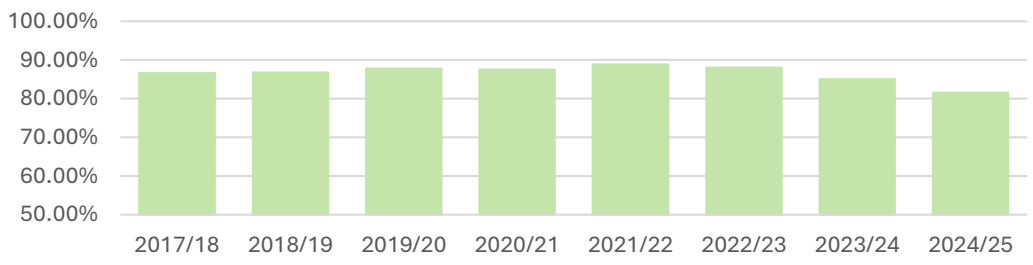
Progress on short-acting beta-agonist (SABA) free pathway uptake:

Although south east London is a high prescriber of SABA inhalers, significant progress has been made in promoting the uptake of SABA-free pathways:

- **A sustained and significant decrease in prescriptions for SABA**. The proportion of patients prescribed six or more SABA has decreased by 9% over the last three years. We have reduced carbon emissions from this category of inhaler by 5.76 kg CO2e per salbutamol item (a 25% reduction) - equivalent to travelling the circumference of the equator 69 times with an average sized car!
- **Improved adherence to preventer medications.** Adherence (number of preventer inhalers prescribed per person) has improved by 10% across both our asthma and COPD population, following patient education initiatives.
- **Improved uptake of SABA-free treatment.** Since the launch of the SEL asthma guide, prescribing of SABA-free treatments in the asthma population has increased from 8.5% to 15%.
- **Uptake of Dry Powder Inhalers (DPI).** Dry powder inhalers have several advantages over metered dose aerosol inhalers, including easier inhalation techniques, significantly lower carbon emissions, dose counters and other technologies to improve patient adherence and safety. The percentage of patient prescribed a higher-carbon metered dose inhaler (MDI) is consistently decreasing; evidencing gradual but sustained switches to DPI.
- **Training and support:** Working in partnership with our training hubs, healthcare professionals have received training on the benefits of SABA-free pathways and how to effectively communicate these to patients.
- **Monitoring and evaluation** – via development of the South East London respiratory dashboard, which provides useful insights and understanding of where to target our focus to improve prescribing and quality improvement.

Data insight

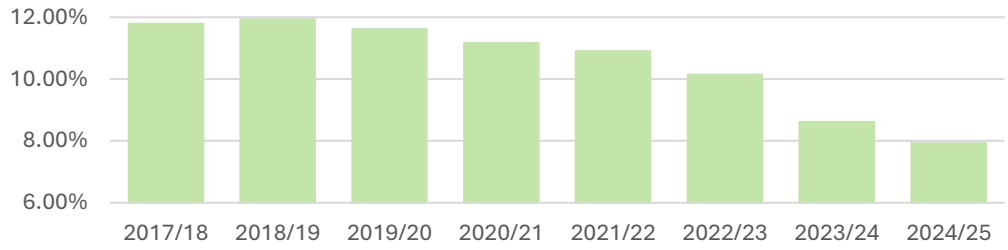
Trend #1: the percentage of patients prescribed a metered dose inhaler (MDI) peaked at 88.9% in in 2021/22 and has since fallen to 81.6% (graph below)



% of patients prescribed a metered dose inhaler, April 2017 - March 2025

Data insight

Trend #2: the percentage of patients prescribed a very high carbon MDI has fallen consistently since 2018/19, and is now less than 8%



% of patients prescribed a very high carbon metered dose inhaler, April 2017 - March 2025

Other medicines optimisation initiatives include:

- Implementation of the **Repeat PrescribingSelf-Assessment Toolkit,** developed by the Royal Pharmaceutical Society and the Royal College of General Practitioners, to review and improve repeat prescribing processes. This helps align medicines supply with patient needs, reduce waste and improve patient safety within workflows.
- Increasing the uptake of **structured medications reviews** with a focus on high-need or high-risk patients. Reviewing medicines use alongside patients empowers them in shared decision-making to reduce avoidable prescribing and support safe deprescribing to reduce medicines waste.
- Development and roll-out of the **Only Order What You Need** public engagement campaign in London region. This campaign encourages patients to avoid medicines stockpiling, reduce unnecessary ordering on repeat, return unused medicines and understand the environmental cost of waste.
- Development of **targeted waste medicines pilot projects**. Pilot projects include *SEL Waste Medicines with Public Engagement* and *Care Home Medicines Waste*. These pilot projects and being developed to identify scalable models that can deliver measurable environmental benefits.

Spotlight

An example of net zero

Patient participation

Joanna, a Greenwich resident and patient participation group (PPG) member at the Eltham Medical Practice, contacted the SEL ICB sustainability team in June of 2023 offering to work with the ICB on exploring opportunities and options for medicines blister pack recycling in south east London. Joanna facilitated an introduction to the Circularity in Primary Pharmaceutical Packaging Accelerator (CiPPPA) - an initiative developing and deploying solutions for recycling medicines packaging. Below, Joanna describes why blister pack recycling is important to her, and how she has contributed to building networks in south east London.

"Finding sustainable solutions for everyday living is embedded in my DNA. My husband and I are both in our sixties and between us we collect c.500 medicine blister packs every six months. If you multiply that up across the UK, that equates to *billions* of blister packs!

Blister packs are formed of two main elements, the clear plastic coating on the front and the printed metal film at the back. This means they can't be recycled in normal plastic waste. I'd collect our empty packs and every six months I'd make the five-mile trip to the local collection point in a high street chemist. The collection box was always overflowing and often had carrier bags of empty blister packs piled around the base.

It was clear people were interested and happy to recycle their empty blister packs. I contacted the ICB in 2023 to see if a recycling point could be set up locally and since then I've been working with James to explore the options. My work has included writing, on behalf of my practice, to 35 pharmaceutical companies to enquire about sponsorship of a collection box. Whilst we haven't secured sponsorship, one respondent pointed me to the Circularity in Primary Pharmaceutical Packaging Accelerator (CiPPPA). At last, I had found an organisation not only interested in the issues but taking an active and positive step in finding solutions.

I've had discussions and correspondence with the CiPPPA team and have facilitated a meeting between CiPPPA and James, who has since introduced them to the wider London ICB network to explore what can be done.

I am a firm believer in doing my bit, and if we all do that, we can make a difference and enhance sustainability."

Supply Chain and Procurement

Our opportunity:

If we use our supplies more efficiently, consider low-carbon alternatives, embed circularity and work with our suppliers to decarbonise their processes, we:

- **Reduce emissions from the supply chain, which are mostly out of our direct control** (referred to as the *NHS Carbon Footprint Plus* – see page 4)
- **Create additional social value for our people in south east London and for our suppliers and their workforce – contributing to healthier, happier communities and helping tackle health inequalities**
- **Embed principles of circularity in our purchasing decisions, using refurbished equipment and engaging providers who re-use and recycle materials in the production and delivery of their goods and services**
- **Support suppliers to plan and demonstrate their own carbon reductions**
- **Create financial savings though sustainable and efficient solutions**

Our supply chain accounts for the majority of emissions not within our direct control, so we must make conscientious and measured decisions and work closely with our suppliers to deliver net zero.

Across our system, we will:

1. Adhere to procurement guidance requiring us to take account of social value and suppliers' carbon reduction in the award of contracts, developing processes to embed social value commitments in contract management, to ensure that they are delivered throughout the term of supplier contracts.
2. Embed NHS Net Zero Supplier Roadmap requirements into all relevant procurements and ensure they are monitored via key performance indicators (KPIs) across the term of supplier contracts.
3. Encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment.
4. Explore the development of a sustainable procurement policy, in collaboration with the London Procurement Partnership (LPP).
5. Develop guidance and recommendations on appropriate consideration of the circular economy and reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects.
6. Seek 'once for London' opportunities that will allow us to unlock the purchasing power of London to support decarbonisation of the supply chain.

Food and Nutrition

Our opportunity:

If we can support our people and service users to maintain a balanced diet and receive good nutrition via food that is appealing, seasonal, locally sourced and sustainably produced, we can:

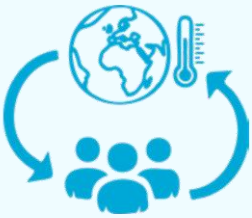
- **Reduce emissions related to transport and agriculture**
- **Minimise food waste, and the emissions resulting from it**
- **Consider moves towards a greater range of lower carbon plant-based menu options for inpatient meals and staff canteens**
- **Support the recovery of patients with healthy meals offering good nutrition**
- **Increase the affordability of food at our sites, and in doing so, contributing to the reduction of food insecurity**

Achieving net zero in this area of focus relies on sourcing high quality, healthy, appealing food from sustainable suppliers, so that as much as possible is consumed and not sent to landfill.

Across our system, we will:

1. Continue to implement innovative food ordering systems to minimise the oversupply and preparation of food.
2. Measure and monitor food waste and use the data we collect to determine how we can go further with our net zero actions. Where food waste is unavoidable, we will use options that divert food waste from landfill, such as energy recovery, anaerobic digestion or to fertiliser.
3. Continue - with our catering suppliers - to explore a greater range of plant-based meals and menu options which use unprocessed foods.
4. Use procurement and contract levers to place greater weight on healthier, lower carbon, and locally sourced options when renewing catering contracts.
5. Move away from single use cutlery, cups and carry-out packaging at catering outlets and explore reusable, recyclable or compostable options.

Explainer: what do we mean by ‘climate adaptation’?



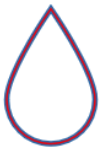
The climate is changing, and this has wide implications for health and care services. Adaptation is the process of adjusting our systems and infrastructure to continue to operate effectively whilst the climate changes and we experience a greater frequency of extreme weather events.

Climate adaptation is different to climate mitigation. Mitigation reduces the causes of climate change be cutting carbon emissions – which we must also do – but **climate adaptation** is about maintaining continuity of NHS services and ensuring a safe environment for patients and staff in even the most challenging times.

The risks of immediate concern for London, and examples of adaptation:

Heatwaves and overheating

We can adapt for this by installing efficient, passive cooling systems in our buildings, or by creating green spaces where trees create shade to protect our buildings from the heat of the sun. We provide our patients with advice on how to minimise the impact of heat.



Surface water flooding

We can adapt for this by making changes to our physical infrastructure; installing permeable property surfaces to manage water run-off or by creating green spaces which promote water drainage. We can also put water management strategies in place.

Thunderstorm asthma

Thunderstorm asthma is when wind and rain break up concentrations of airborne allergens into smaller particles which can trigger asthma symptoms. We can adapt for this by issuing health alerts and educating asthma patients on how to use their preventer inhalers before and during thunderstorms,

Adaptation measures are built into the business continuity and resilience plans of each NHS organisation in south east London. As the impacts of our changing climate become greater, our focus on climate risk grows and we move towards creating dedicated climate adaptation plans. NHS adaptation plans in London will respond to the recommendations raised by the London Climate Resilience Review – an independent review commissioned by the Mayor of London in 2023.

Climate Adaptation

Our opportunity:

If we can identify the full range of risks and impacts from climate change and climate events on our services, infrastructure and population and mitigate them via everyday discussions, decision-making and in our planning, we can:

- **Support our services to adapt to the changing climate and keep them running no matter what the weather or climatic conditions; reducing reliance on NHS business resilience processes**
- **Make our estates and services climate-resilient with financially viable long-term adaptations; moving away from costly reactive fixes and retrofit solutions**
- **Alert and educate our population to the impacts of our changing climate and use education and information to keep our people safe and well**
- **Deliver the recommendations from the London Climate Resilience Review**
- **Mainstream climate risk identification, so that the details and impacts of it are well understood and considered with equality to other corporate risks**

Without adapting to our changing climate, we can only be reactive to climate events, which risks the safety, security and wellbeing of our people, services and finances.

Across our system, we will:

1. Establish climate risk registers; first by organisation and then develop these into a system-wide register. This will allow us to recognise common risks and how we can collaboratively mitigate them.
2. Develop and publish climate adaptation plans.
3. Find as-yet-unrealised points of collaboration with wider system partners, including Local Authorities /Public Health and the Greater London Authority (GLA) and enter into delivery partnerships.
4. Facilitate the cascade of weather health alerts and relevant messaging
5. Continue to comply with the adverse weather standards within the Emergency preparedness, resilience and response (EPRR) core standards, and we will identify where action is required beyond the remit of EPRR teams. This will allow a greater focus on proactive, pre-emptive action
6. Identify actions (facilitated by London Region Greener NHS) to fulfil the recommendations of the London Climate Resilience Review, and in doing so, will identify which are best delivered ‘once for London’ and at-scale.

Green/Blue Space and Biodiversity

Our opportunity:

If we can expand green spaces (such as parks and gardens) and blue spaces (such as lakes and around rivers) at NHS sites and in our communities, we can:

- **Harness the healing power of nature in these spaces to improve physical and mental health and wellbeing**
- **Help reverse the loss of biodiversity**
- **Mitigate air pollution, noise and excessive heat**
- **Offer our workforce spaces to unwind to refresh and re-energise**
- **Offer our communities spaces for physical exercise and relaxation**

The loss of biodiversity is intrinsically linked to climate change. To mitigate climate change and contribute to the recovery of biodiversity we need to address them both, not just for planetary but also for human health.

Across the NHS estate in south east London, we have developed a number of innovative green spaces. Sharing our experiences and learning in creating natural healing spaces is key to continued innovation and biodiversification on our estate.

Across our system, we will:

1. Promote use of green spaces via social prescribing (also known as green prescribing).
2. Develop more green and biodiverse urban spaces at NHS sites, including incorporating them into new-build plans, to meet biodiversity requirements as per the Environment Act 2021.
3. Continue to partner with horticulture experts and NHS Forest in the creation of our green spaces, to access free trees for planting and to take expert advice on planting methods for longevity and diversity of species and spaces.
4. Work with councils and find opportunities to partner with local voluntary and community sector organisations to develop healthier neighbourhoods where access to green space is easy and safe.

South East London Integrated Care System

NHS South East London

Enclosure 8

The SEL Neighbourhood Maturity Matrix

August 2025

Context and application

South East London Integrated Care System

- This document outlines how cross-organisation partnerships at place, supported by integrator host organisations may need to mature over time to enable neighbourhood care.
- Neighbourhood implementation at place is being led by a **cross-organisational partnership** (typically covering primary care, community care, the local authority, acute services and the VCSE**), supported by an integrator host organisation**. Each place have developed their own arrangements meaning there will be **natural variation** in how these partnerships and their host integrator organisation(s) choose to structure their approach.
- We are also in a **period of significant change in roles and responsibilities across the NHS system**. Initially, Local Care Partnerships (as committees of the ICB) will continue to play a key coordinating role at place to drive change and delivery of neighbourhood care. However, it is anticipated that **we will increasingly move towards more provider-led partnership leadership** as referenced within the 10 year plan and the model ICB blueprint. The **pace of change at place may be differential** and as such all partners should be involved in assessing maturity of the relational and operational functions required across the place to deliver neighbourhood-based care as well as agreeing who is best placed to lead on different functions (recognising that this may shift over time and should be continually under review).
- **National policy related to neighbourhood care is emerging**, with significant policy decisions expected over the period of the current Parliament. In South East London **we want to move towards neighbourhood care at pace**, to deliver the benefits for our population, our workforce and our system. This requires us to be **building our maturity and readiness for what may come, even whilst there may be a level of ambiguity about future policy direction.**
- This maturity matrix outlines both **short-term priorities areas for maturity** which are based on what we already know, and **longer-term areas for maturity development** which are based on the expected policy direction. **Initially places are only expected to address the shorter-term priorities for maturity**, but some may wish to consider longer-term maturity priorities where this is agreed locally. The matrix will iterate overtime, and we will grow the expected scope of maturity of place-based arrangements in-line with national policy development

Integrator Principles: Functions

The functions listed below were developed across places and were signed off by the Neighbourhood Based Care Board in April 2025. It is expected that functions will evolve over time as Neighbourhood working evolves. The list includes short and longer term developmental functions.

Support operational coordination between sectors and partners across the borough and between INTs, bridging the gap across the current reality of fragmented pathways and services by addressing the practicalities of collaboration (e.g., building interfaces and relationships and supporting workforce planning.

Integration operational: operate dedicated integrated functions of neighbourhoods (e.g. the core INT) and support transformation initiatives, working with the Local Care Partnership teams.

Facilitate population health management (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes. Integrators will need to support ICB work to ensure the provision of real-time population health data, drawing down on regional and place capacity and skills, to enable INTs to target interventions proactively and preventatively addressing health inequalities and needs.

Address interface issues and share learning through coordinating discussions at Place level (e.g., sharing resources and managing care transitions) and escalating issues affecting multiple neighbourhoods to ensure system-wide alignment. They will need to facilitate cross-borough collaboration, spread and scaling of successful practice, ensuring continuous improvement and increasing alignment to the most efficient and effective models of local care.

Drive equity in access and outcomes across system, Neighbourhood and Place levels using PHM data and working closely with partners (including VCSFEs) to identify and address disparities in access and care delivery, supporting INTs to meet local needs and reduce inequalities.

Lead the delivery of INTs, driving the test and learn approach: The integrator will work within system and place leadership structures, including with primary care and local government, and in partnership with all local providers to ensure that agreed local and SEL ICB/S strategies and priorities for improving health and wellbeing are being translated into day-to-day delivery of services and care, and that the integrators are supporting the continuous improvement approach.

Support system sustainability and resilience supporting to identify and strategically manage where there might be issues and risks (e.g., alignment with Caretaker Arrangement)

Provide essential infrastructure for INTs, supporting people, finance, governance and risk management in a way which is consistent and cost-effective so that neighbourhood delivery becomes business-as-usual. This will include:

- Enabling shared use of estates from across the public, private and VCSE sector to enable co-location of services and public access where applicable
- Maintaining an up to date view of local assets, including the VCFSE sector, to ensure continual seamless delivery of Neighbourhood Health Services

Functional Maturity Domains

Functional Domain	Sub domains (initial priorities)
Operational Coordination	Operating integrated functions (e.g. the Core INT)**
	Shared clinical risk
	Integrated and shared workforce planning
Facilitating population health management	Facilitating data sharing
	Promoting use of data
	Supporting segmentation and stratification (inline with SEL wide approaches)
Improving the interface	Process and pathway mapping
	Scaling best practice
	Reducing transfers of care
	Cross boundary collaboration
Driving Equity	Understanding variation
	Building structures that tackle variation
Leading delivery	Integrated Neighbourhood Teams (beginning with frailty, multiple LTC and CYP)
	Integrated intermediate care with a 'Home First' approach
	Urgent neighbourhood services
	Modern General Practice (not yet developed)
	Prevention (not yet developed)
Supporting system sustainability	Encouraging mutual support
	Sustainability offer
	Driving efficiency
Essential Infrastructure	Digital optimisation
	Integrated estates optimisation
	Education, training and workforce development

The functional maturity domains are **aligned to the scope of the integrator function** shared with integrators earlier in 2025 (see previous slide).

These reflect the key role that integrator arrangements are expected to play within the delivery of neighbourhood care.

Initial priority domains are highlighted in green, and are the first focus of maturity development for integrator arrangements

Relational Maturity Domains

South East London Integrated Care System

The relational maturity domains **reflect the relationships that will need to be developed and matured between and across the partnership of organisations supporting neighbourhoods implementation**, the integrator host organisation and wider partners at place.

Given the different arrangements in place and the shifting roles and responsibilities across the NHS, **local places will need to decide how best to manage development across these domains**. This may not be via the integrator host initially.

Initial priority domains are highlighted in green, and are the first focus of maturity development

Relational Domains	Sub-Domains (green are the initial priorities)
Building relationships and trust	Co-design of ways of working
	Parity of voice
	Shared Accountability
	Aligned resources
Organisation development and culture	Embedding holistic and personalised care
	"One team" approach
	Sharing risk
Resident and neighbourhoods*	Supporting neighbourhood infrastructure
	Aligned communication and engagement around INTs
	Co-production and participative models
People, staff and teams	Integrated staff communication and engagement
	Staff activation
	Collaborative leadership development
	Wellbeing

Our Neighbourhood Maturity Matrix

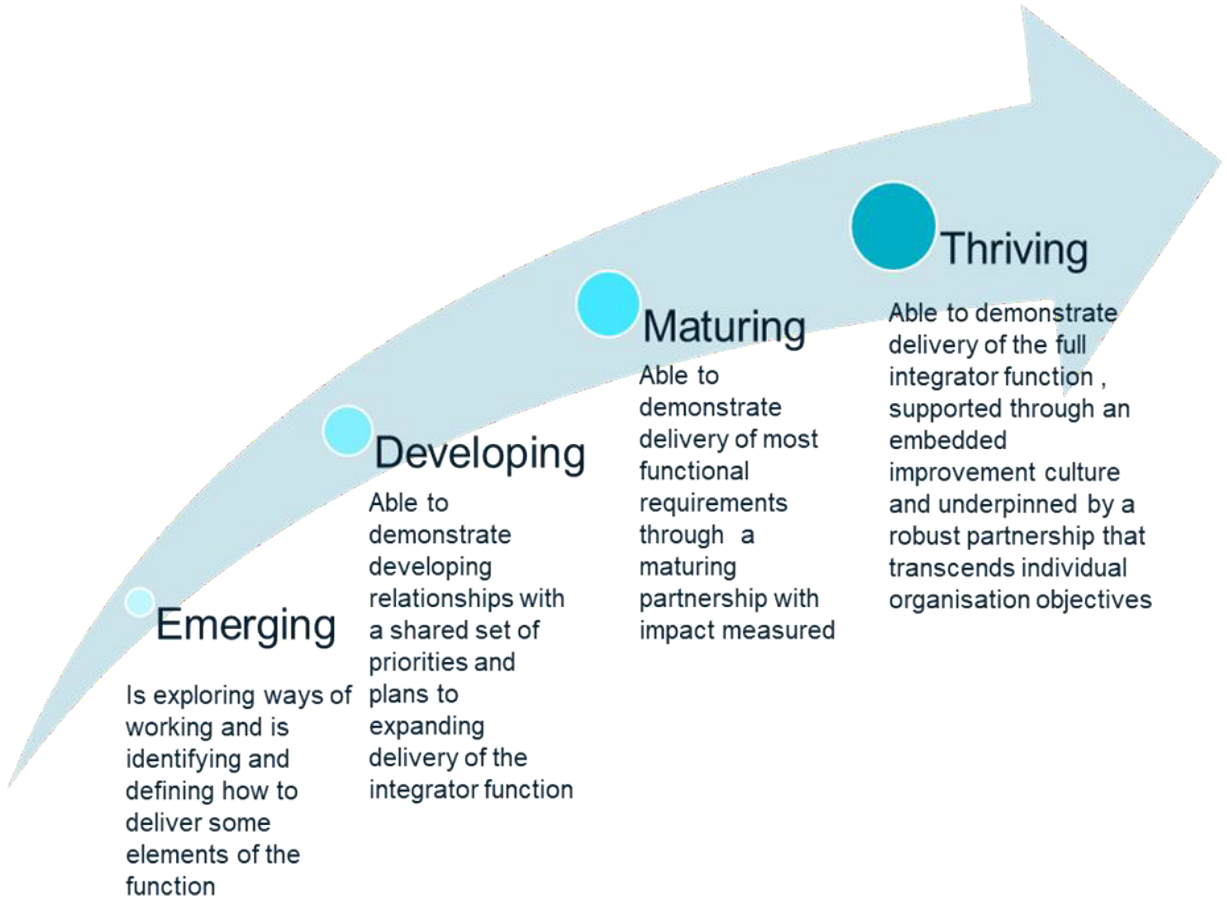
The South East London Neighbourhood Maturity Matrix outlines the broad developmental functions that and partnerships and host integrators may be expected to develop overtime. The matrix is split into core domains that all integrators will be expected to develop, and enhanced domains that may be developed depending on local circumstances. The domains reflect both functional requirements and also the relationships that an integrator may need to develop and mature. The matrix sets out what these domains may look like at various levels of maturity at a high-level.

Shorter term priorities	Shorter term priorities are the agreed areas that all place partnership arrangements supported by host integrator organisations are expected to initially priorities
Longer term domains	Longer term domains outline maturity domains that are likely to be required across place partnership arrangements, supported by host integrator organisations over the next 2-5 years (dependent on national policy decisions)
Functional Domains	These reflect the potential functions of place partnership arrangements supported by host integrator organisations based on the London Target Operating Model and the South East London Integrator Functions (see previous slide)
Relational Domains	These reflect the potential relationships that the place partnerships and host integrator organisations will need to nurture both within their partnerships arrangement and with residents, staff and the ICB.

What the Maturity Matrix is (and what it isn't)

South East London Integrated Care System

- The maturity matrix provides a description of **how the maturity of neighbourhood care may develop** over time, considering both **functions** and **relationships.**
- It is also intended to **ready local systems to respond to the strategic commissioning of neighbourhoods in the future** through a **coordinated provider system** and the provision of **underpinning infrastructure support** via an integrator host.
- As each place partnership and integrator arrangement is unique, **flexibility is required in the adoption of the matrix locally**. Some elements may not be relevant to all place arrangements or may only be relevant in the future.
- There are however an agreed set of **short-term priority domains** which will be relevant to all places from the very beginning.
- The maturity approach is intended to be **supportive but not exhaustive**. This is **not a blueprint or specification**. The intention is to:
  - **Provide prompts that promote open discussion, debate and deep reflection** within and across place partnership arrangements supported by host integrator organisations on **what the role of local partners and the integrator host is in enabling neighbourhood health**.
  - Enables local partners to reach a **common view as to the current level of maturity** of local functions; and
  - Jointly identify key **developmental priorities**.



How to use the Maturity Matrix

South East London Integrated Care System

- **All shorter term priority domains should be addressed,** but any longer term domains will be down to local determination at this stage.
- The integrator host organisation(s) may be best placed to coordinate the **completion the maturity matrix assessment**, working with their partnership to **ensure that the position reached is reflective of all partners views**.
- This could be achieved by ensuring each partner is able to submit their views on maturity domains independently (and potentially anonymously). It is highly **likely that partners will have different views, and an approach which registers and reflects those differences may help build relationship and trust**, as well as provide deeper insight into the current maturity of the relationship between partners supported by the host integrator
- Once a baseline understanding of partner views has been reached, place partnerships, supported by the integrator host organisations should **review the baseline assessment collectively** through a process of open discussion and debate**.** Places may want to consider bringing in a cross-section of place leadership, subject matter expertise and public/patient representatives to **provide reflection and challenge** where this is appropriate.
- This process should also ensure that there is clarity about the next steps needed to improve maturity and who is responsible for putting plans into action (initially within the shorter term priority domains).
- The integrator should **use the matrix to inform initial developmental priorities** and ensure these are reflected in local plans agreed for the use of the £250k non-recurrent development funding provided. This will also be reported into the ICB Board for their continued oversight.
- The maturity matrix tool should also be **used to monitor and track the development** of maturity over time. Equally, there should be continued discussion between the place partnership, integrator organisations and ICB on what domains across the matrix should be assessed, which is expected to mean that **new domains are likely to need additional assessment over tim**e.

South East London Integrated Care System

NHS South East London

Initial Maturity Domains

Supporting Operational Coordination

Sub-Domain	Emerging	Developing	Maturing	Thriving
Operating integrated functions (e.g. the Core INT)	• We have produced our functional operating model for INTs • We have agreed the key functions that need to be performed within the INT and the core staff roles required to deliver those functions • We have mapped the tools and support INTs will require to provide care	• We have aligned names staff from all our member organisations to neighbourhood footprints, including operation, clinical and senior management roles • We understand the skills required across our INT and have identified where there are current skills gaps • Work is underway to develop operating models for INTs, including pathways into, through and out of integrated neighbourhood teams • We have a plan in place to secure the necessary tools to operationalise the team • We have defined how we are going to measure patient and staff experience across INTs	• We have secured the tools needed to support INT working and are developing the skills and knowledge of our team • We are clear on how we will code information on clinical systems so that we can track the impact of our INT • We have co-produced ways of working across the team that support integrated working and holistic care • We have put in place the processes necessary to measure patient and staff experience	• All INTs are operating effectively and can deliver neighbourhood health to their target population • INTs report having access to the necessary tools, infrastructure and support they required • We can demonstrate qualitative and quantitative improvements for patients and staff across our INTs
Shared clinical risk	• We are committed to developing a shared approach to the management of clinical risk • We have established a working group to look at our current approaches to clinical risk management across the partnership	• We have mapped the current clinical risk management processes and governance structures of our member organisations • We understand the level of risk appetite of member organisations and have understood what this means for the management of shared care, including identifying key pain points • We are developing shared clinical risk management approaches for integrated neighbourhood teams	• We have approved our shared clinical risk management approach to support delivery of integrated neighbourhood teams, and there is clarity about how these relate back to individual organisational accountabilities. • We are testing our new processes and governance in shadow arrangements, and can demonstrate a strong, learning environment that promotes quality and safety. • We have set out how we will oversee the use of shared clinical risk management as a partnership and have the tools in place to do so	• We have shared clinical risk management in place within our integrated neighbourhood teams • We have shared governance as a partnership that enables us to oversee shared clinical risk and act where needed to improve the safety and effectiveness of these arrangements.

Facilitating Population Health Management

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Facilitating data sharing (noting that there are regional data sharing arrangements in place but that some places and integrators may have additional local arrangements)	• Our partnership has data sharing agreements in place between health partners that allow for the sharing of data for direct care and secondary uses • We offer support to partners who need further information on the benefits of sharing data	• Our partnership has data sharing agreements in place between health partners, adult/children social care and commissioned VCSE providers that allow for the sharing of data for direct care and secondary care uses • We meet regularly with organisations that do not currently share data to build a shared understanding of where this would benefit direct patient care	• Our partnership is exploring whether additional data should be shared between health partners, wider local authority teams, wider VCSE organisations and other system partners to support broader support population health management across neighbourhoods • Consideration is being given to the purpose of sharing data and therefore the type of data that should be shared. • We are investing in developing relationships with organisations that do not currently share data and are proactively addressing concerns that are inhibiting data sharing where this would benefit direct patient care.	• Our partnership has access to the data it needs to facilitate population health management. • We have processes in place to manage requests from new organisations to access or share data (these processes may be shared with other integrators or statutory partners) • We continue to provide support to individual partners to facilitate data sharing where this is required
Promoting use of data	• We have reviewed the data that is available to us across the partnership and have considered how we can best use this data to support population health	• We have the necessary analytical support in place to ensure that we can use data as planned • We are using data to drive discussions about our INT model of care • We have considered how we might best use the data available to us to understand impact • We are clear on how we will code information on clinical systems so that we can track the impact of our INT	• We have consistent and effective coding practices across our INTs • Our INTs are using data consistently to support the provision of direct care • As a partnership, we have the tools and processes in place to understand the impact out INTs are having	• Our partnership uses available data to plan how resources will be used across the partnership

Improving the interface

Sub-Domain	Emerging	Developing	Maturing	Thriving
Process and pathway mapping	• As a partnership we have identified the key pain points in processes and pathways between different organisations and sectors and have agreed initial areas for improvements	• We have undertaken process mapping of these priority areas and understand what is driving challenges across the interface within these areas • We have agreed high-impact improvements and have defined roles and responsibilities across the partnership	• We are implementing improvements to our processes and pathways • We have the tools, processes and governance in place to identify challenges across the interfaces within the partnership. • We regularly review interface issues within our partnership and identify solutions for implementation	• All partners feel that they can raise concerns about the processes and pathways across the partnership and that these concerns will be responded to • All member organisations within the partnership have leadership roles who are responsible for implementing changes where these are agreed by the partnership • Our data demonstrates that we are improving patient care and staff experience as a result of the changes we are making to processes and pathways

Driving Equity

Sub-Domain	Emerging	Developing	Maturing	Thriving
Understanding variation	• We have co-developed as a partnerships the key areas of variation that we want to more fully understand • We are developing data-sets that enable our partnership to understand unwarranted variation	• We understand the outcomes with most significant unwarranted variation across our partnership • We have agreed our priorities to reduce unwarranted variation and have set up cross-partnership groups to explore these	• We understand the impact of unwarranted variation on health inequalities across our partnership • We are delivering plans to reduce unwarranted variation within our priority areas	• We have highly effective tools, process and governance in place to identify and manage unwarranted variation • We have delivered demonstrable improvements in unwarranted variation in our priority areas • All partners feel supported and able to improve the quality and effectiveness of care • We have a long-term plan to drive improved health equity across our partnership

Leading Delivery

Sub-Domain	Emerging	Developing	Maturing	Thriving
Integrated Neighbourhood Teams (beginning with frailty, multiple long term conditions and children and young people)	• We understand the size of our priority populations in each neighbourhood and have an agreed approach to scaling up our INTs	• Integrated neighbourhood teams are established and delivering on our shared commitments for our three priority populations • We have a shared approach to holistic and personalised assessment of an individual's need. • We are working to joint care plans for our priority populations.	• Our INTs are reaching into neighbourhoods to deliver care, aligned to areas of greatest health inequalities • Frontline teams are routinely accessing help and support for their patients and service users from across the partnership • In-reach and out-reach pathways between INTs and aligned functions are in place • We are working to expand INTs to support additional population cohorts	• Our whole population is supported via a neighbourhood working model • We are working to joint care plans for all who need them, across age groups, mental and physical health and care services. • We are building direct support for the wider determinants of health into our neighbourhood model through our relationships with the local authority, skills and education providers and housing providers

Essential Infrastructure

Sub-Domain	Emerging	Developing	Maturing	Thriving
Digital optimisation	• We have identified the digital challenges that prevent information sharing, joint working across teams and that drive inefficiency • We have identified the digital opportunities across individual organisations which could support greater partnership working	• We have agreed our shared priorities for digital optimisation and have put in place shared programmes of work to achieve these objectives • We have identified members who needs more support to optimise digital tools and undertake digital change	• We are implementing shared digital tools • We are providing change management support to members across the partnership	• As a partnership, we use joint digital solutions to support the planning and delivery of care, including population health management, shared care records and plans, collaborative working and shared case management etc. • We regularly evaluate the effectiveness of our digital solutions and put in place new programmes of work as required to support efficiency and integration

Building Relationships and Trusts

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Co-design of ways of working	• We have an agreed shared purpose and a vision	• We understand the roles and responsibilities of partners in contributing to our shared purpose. • We have agreed mechanisms for all partners to collaborate on shared issues and solutions	• We have established open communication across partners • All partners feel they can influence integrator priorities and implementation programmes	• We have effective relationships with strong trust in place that support challenging discussions about how shared resources should be utilised to delivery optimum benefit for the population
Parity of voice	• We have equal representation from all key local sectors and partners (primary care, NHS Trusts, Social Care, VCSE, patients) on decision-making structures.	• Our representatives understand the benefit of the partnership and are developing an understanding of the strengths and challenging being faced by other partners. • All partners understand the shared decision-making processes in place.	• There are appropriate mechanisms and support in place to enable the partnership to make evidence-based shared decisions. • Our representatives have developed strong and deep mechanisms for engaging with front-line staff within the sector they represent.	• All members of the partnership are confident that the decisions being taken are best for the population and individual representatives take responsibility for leading challenging discussions within their sector or organisation
Shared Accountability	• Our integrator partnership has set out what we aim to achieve (starting initially with short-term objectives) - We understand how we can achieve these and are clear on how we will measure success	• We have clear lines of accountability in place between each member of the partnership, the partnership bodies they represent and any decision-making structures within constituent organisations • Integrator partnership objectives are understood by all individual member organisations. • We have established shared programmes to deliver our objectives • We are regularly reviewing information in our integrator partnership on how well we are achieving our shared objectives	• All members of the integrator take responsibility for engaging the integrator partnership in decisions that may be taken by their member organisation where these could impact on the delivery of the integrator objectives. • Open, transparent and bi-lateral communication enables our partnership to engage in discussions about conflicted priorities in a constructive manner. • We are sharing information on how well we are achieving our shared objectives with our population.	• Our member organisations do not make unilateral decisions which may impact on the integrator partnership objectives. • Our member organisations specifically address how well individual organisations decisions align to the integrator objectives as part of their decision-making process. • All partners feel able to hold each other to account for their individual and organisations roles in supporting the shared objectives of the integrator. • We are transparent with our population on the decisions we are taking and our progress in delivering shared objectives

Organisational development and Culture

Sub-Domain	Emerging	Developing	Maturing	Thriving
Embedding holistic and personalised care	• We are working with our population to define what holistic and personalised care would mean in practice	• We have an agreed definition of holistic and personalised care and a set of shared standards • We are working with our front-line teams to re-design care pathways that better enable holistic and personalised care • We have co-produced guidance for staff and patients on undertaking holistic assessments and competing shared care plans	• We are supporting staff through the provision of tools and support, peer review and training and development to deliver improved holistic and personalised care • We have measures in place to track improvements in the delivery of holistic and personalised care (which may include patient experience and activation measures)	• We can identify where care is falling below our shared standards and can provide rapid support to improve this across the partnership • We can demonstrate that our population feel involved in decisions about their care • We can demonstrate that our staff consider the broader health and wellbeing of our residents when planning and delivering care

Residents and Neighbourhood

Sub-Domain	Emerging	Developing	Maturing	Thriving
Supporting neighbourhood infrastructure (community assets, VCSE services etc.)	• We have mapped all the assets our member organisations have within our neighbourhoods • We are working with our VCSE representatives to map broader neighbourhood groups and assets	• We have developed a deep understanding of our population need within each neighbourhood (starting initially with the three priority populations) • We are reviewing population need against our neighbourhood assets to identify opportunities and gaps, including relative resource distribution against inequalities	• We have produced and agreed a plan to maximise the use of our existing neighbourhood assets to improve population health • We understand the gaps in our existing neighbourhood infrastructure and are considering the options available across the shared resources of the integrator to address those gaps • We have considered whether we need to shift resources across neighbourhoods to better address inequalities	• We have an agreed plan in place to address gaps in neighbourhood infrastructure over the medium term using our shared resources

South East London Integrated Care System

NHS South East London

Appendix: Longer Term / Future Domains

Supporting Operational Coordination

Sub-Domain	Emerging	Developing	Maturing	Thriving
Integrated and shared workforce planning	• We share information on the workforce structures within our member organisations across the partnership • We have mapped our workforce against staff groups and functions - beginning with core INTs	• We share information on our grading, pay rates and JDs of staff across shared staff groups and functions. • We utilise demand and capacity tools to understand organisational and partnership capacity and demand. • We have joint assumptions on demand growth (linked to broader system assumptions) and understand the impact these would have on organisational and partnership capacity • We understand where we have areas of duplication and inefficiency across our shared workforce, and where there are gaps in capacity across the partnership	• We have identified differences across grading, pay rates and the responsibilities of staff within shared staff groups delivering the same function. We are considering opportunities to align. • We are exploring opportunities to improve the efficiency of staffing models in areas where we have duplication and how we could jointly invest in our staffing gaps. • We have put in place staff passporting approaches and/or lead employment models • We are considering where new roles may be required and are creating career pathways for these roles	• We have a shared long-term workforce plan that aligns to predicted demand increases within neighbourhood models • We are considering shared HR and employment models where this would improve our ability to mobilise shared capacity more easily

Facilitating Population Health Management

Sub-Domain	Emerging	Developing	Maturing	Thriving
Supporting segmentation and stratification (inline with SEL wide approaches)	• We are building our understanding of population segmentation and risk stratification approaches.	• We have completed segmentation of our whole population utilising SEL-wide approaches. • We are considering the needs of different population segments and are exploring what this means for service models and resource (staff, clinical capacity etc.) allocation. • We are using risk stratification in certain projects on an experimental basis, i.e. identifying those who are at risk of becoming frequent service users.	• All partners use the same language when describing population segmentation. • We have implemented new pathways aligned to the needs of specific population segments. • We are taking steps to align our resources to the needs of different population segments and are using this to determine patient flow. • A population risk approach is applied to integrated neighbourhood teams but not yet systematically across the partnership or to the full population.	• Whole population segmentation and risk stratification deployed and fully implemented across the full partnership

Improving the Interface

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Scaling best practice	• All members agree to support the partnership through the sharing of best practice between organisations and sectors within the partnership, within South East London and with other partnerships nationally,	• We identify potential best practice from across member organisations or more widely when we develop programmes and approaches • We have established informal mechanisms with some other integrator partnerships in South East London	• We embed best practice within all programmes and develop our own case studies to share across the partnership, across South East London and nationally • We have established formal and informal mechanisms to share best practice with other integrator partnerships within South East London	• We share best practice regularly with other partnerships nationally through a variety of channels • We have strong connections with other partnerships in South East London and have developed shared priorities that can be taken forward together • We continuously learn from peers and adapt insights to local need
Reducing transfers of care	• Starting with INTs for our three priority populations, we understand the services that make up the care of those populations	• We have mapped current transfers of care across the services making up INTs for our three priority populations	• We have designed ways of working within our INTs that reduce the number of transfers of care between and across services supporting INTs	• We are using the learning from INTs to explore how we can reduce transfers of care for our broader population through new ways of working
Cross boundary collaboration	• We have used data available to use via our partnership to understand the current cross-border flow of the population our partnership services	• We have worked with other integrators within South East London to agree cross-boundary arrangements that most effectively supports integrated care for our population	• We have worked with other integrator partnerships in London to agree cross-boundary arrangements that most effectively support integrated care for our population • We have worked with priority partnerships outside of London (where applicable) to agree cross-boundary arrangements that most effectively support integrated care for our population	• We are confident that the our resident and patient populations receive integrated neighbourhood care within our area

Driving Equity

Sub-Domain	Emerging	Developing	Maturing	Thriving
Building structures that tackle variation	• We are having open and honest discussion about the drivers for unwarranted variation in access, experience and outcomes across our partnership	• We fully understand the drivers for unwarranted variation across our partnership (e.g. resource allocation, workforce, quality, processes) • We are developing plans as a partnership for how we can tackle these drivers of unwarranted variation	• We have built trust across our partnership that enables cross-member support to be offered to address variation in access, experience and outcomes across the partnership • We have a long term plan to address the drivers of variation across our partnership	• We take accountability as a partnership for any unwarranted variation in access, experience and outcomes and we address variation using our collective resources as a partnership

Leading Delivery

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Integrated intermediate care with a 'Home First' approach	• We have mapped all intermediate care services in place across our partnership, including understanding variation in eligibility, access and operating model • We have used the data available to us in our partnership to identify the populations most in-need of intermediate care • We have committed as a partnership to develop an integrated intermediate care offer that can in-reach into neighbourhood teams	• We have defined the capacity of all our existing intermediate care services and the demand anticipated for intermediate care within our partnership • We have co-produced an operating model for an integrated intermediate care offer working with existing services and established neighbourhood teams. • We have co-defined the ways of working required to offer swift and effective draw down support into neighbourhoods to support patients outside of hospital, and into hospitals to enable early discharge.	• We have defined the remote monitoring technology required and have agreed how we will secure this as a partnership • We have defined other support required such as rapid access diagnostics and point of care testing and have agreed how we will secure this as a partnership • We are testing the new operating model for integrated intermediate care as part of a test, learn and evolve approach • We can demonstrate that our approach will improve timeliness of intermediate care and will work hand in glove with neighbourhood teams	• Our integrated intermediate care approach is embedded across the partnership and is fully enabled with appropriate staffing capacity, digital capacity and other support (e.g diagnostics) • Our INTs can draw down support from intermediate care seamlessly to management exacerbations or increased complexity and reduce the need for hospital admissions • Our integrated intermediate care offer is fully embedded in discharge planning from admission and is supporting our hospitals to discharge patients at the earliest, effective point
Same Day Urgent Care	• We understand the demand for same day, urgent care within each of our neighbourhoods and how this is proportioned across primary care (pharmacy, GP practice, enhanced access), NHS 111, UTCs and A&E • We understand how demand changes seasonally, daily and hourly within each neighbourhood	• We have reviewed and understand inequalities in access, experience and outcome for same day urgent care within our neighbourhoods. • We have identified the drivers of variation where it exists • We have identified our assets and opportunities within each neighbourhoods that could improve same day, urgent care.	• We have developed as a partnership a functional model for how urgent care will be responded to within a neighbourhood using the full resources of the partnership • We have tested this model within a neighbourhood	• Our partnership delivers integrated same day, urgent care within and across a neighbourhood that is effective at meeting need outside of hospital Patients know the best route to access same day, urgent care and are supported to reach the right place for care regardless of their entry route.

Supporting System Sustainability

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Encouraging mutual support	Commit to share resources and capacity to deliver population benefits, increase productivity, reduce inefficiency and delivery savings	Develop programmes or systems to identify and begin to implement opportunities to share resources and capacity	Implement programmes or systems to manage shared resources and capacity, to create efficiencies and delivery population benefit	Share resources and capacity of partners with members flexibly to support wider system and population need
Sustainability offer	• We understand the drivers of cost over the short, medium and long term for all member organisations • We have identified areas where we could reduce costs in the short and medium term through different ways of working across our partnership	• As a partnership, we are committed to mitigating cost-drivers across our partnership, even if that means that our member organisations need to make decisions that increase their individual organisational costs • We understand our total partnership allocation and costs and are operating shadow budgets	• Our partnership understands its medium and long term financial context and has developed a plan to maximise sustainability across the partnership. • As a partnership, we have established risk and gain structures and associated processes that support individual organisations to change ways of working where this benefits the broader sustainability of the partnership • Member organisations feel confident that where there overall cost increases, resources will flow through the partnership to compensate	• Our partnerships increasingly plans, monitor and utilises resources at a partnership level. Resource allocation decisions are made in line with population need, rather than historical allocations
Driving efficiency	• Our partnership has identified where joint or hosted delivery in clinical care or corporate functions could drive efficiencies e.g., clinical/operational/managerial leadership, procurement, HR, digital	• Our partnership is developing programmes to deliver joint clinical care and corporate functions where we believe efficiencies can be created • We have put in place the appropriate governance to ensure collaborative ownership of any shared functions.	• Our partnership is delivering joint clinical care and is sharing some corporate functions All members have confidence and trust in shared functions and feel an active part of decision-making around those functions	• Our partnership is share and/or utilise savings from efficiencies effectively to support delivery of our collaborative priorities and objectives. • We regularly review the operations of our member organisations and our partnership to identify new priorities for the sharing of services • Our members are confidence that shared functions have delivered improvements for staff and patients, and that decisions on reinvestment of savings are being taken collaboratively

Essential Infrastructure

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Integrated estates optimisation	• We have mapped the estate available across our partnership and the current care delivered within this estate	• We understand the ownership, cost, lease conditions of our estate now and over time and have identified key estates challenges across our partnership; • We understand current utilisation of existing state, void areas and have identified opportunities to optimise our current estate	• We have developed a short and medium term estates plan to optimise our current estate through the shifting of settings of care (in-line with neighbourhood health) • We are developing a longer-term estates strategy that will full enable neighbourhood health and that will manage estates risk across our partnership. This strategy is aligned with our delivery plan for neighbourhood health, our sustainability plan and our workforce plan. • We understand our green plan responsibilities as a partnership and are building these into our estates optimisation work.	• Our partnership operates a unified estate that is fit for purpose, provides sufficient capacity for neighbourhood care reflective of health inequalities and is financially and environmentally sustainable
Education, training and workforce development	• We are working with staff and teams involved in the delivery of integrated neighbourhood teams to identify skills and training gaps	• We have agreed an initial shared education, training and workforce development programme for staff working within Integrated Neighbourhood teams • We have developed an implementation plan for this programme via our partnership resources	• We have implemented an education, training and workforce development offer for staff working within Integrated Neighbourhood Teams. We understand the impact that his has had for staff • We are working across our partnership to align education, training and workforce programmes	• Our partnership has a shared education, training and workforce development programme for neigbourhood health. • We review regular information on the needs of our collective workforce and their experience of our development programmes • We are proactive in responding to feedback for staff

Building Partnerships

Sub-Domain	Emerging	Developing	Maturing	Thriving
Aligned resources	• We have committed to share resources and capacity to delivery the objectives of the integrator partnership • We are actively working to identify the resources and capacity required to deliver the objectives of the integrator partnership	• We have agreed the resources and capacity required to delivery initial integrator objectives and have agreed the contribution of each member partner • We have established mechanisms which enable the pooling of resources and capacity against agreed objectives • We are developing approaches to enable more flexible and agile ways sharing of resources and capacity on a needs basis	• We are designing shared finance and workforce plans as an integrator partnership in tandem with organisational planning processes • We are using these shared processes to identify opportunities for greater efficiency across our partnership within our shared resources and capacity • We can quickly and effectively operationalise shared resource when opportunities are identified • We are actively considering the establishment of pooled budgets to support our neighbourhood teams	• We have pooled budgets in place that support neighbourhood teams • We have a shared medium term financial and workforce plan that all organisations have agreed and that is being implemented

Organisational Development and Culture

Sub-Domain	Emerging	Developing	Maturing	Thriving
Sharing risk	• We have identified delivery, quality, clinical and financial risks that impact on our shared objectives and programmes	• We have mechanisms in place to track and manage shared risks	• We take shared responsibility for the active identification and management of shared risk, including clarity on our respective roles and responsibilities	• We regularly reflect on how well these arrangements are working for all partners and how they need to be further improved
"One team" approach	• We are committed to developing an open culture of sharing and trust at all staff levels • We have aligned staff from all of our member organisations to neighbourhood footprints (where this is applicable to the staff function), including operation, clinical and senior management roles	• We have established approaches that support effective communication across staff at neighbourhood level • We are support staff at neighbourhood level to develop their team identity and their standard operating procedures • We are enabling staff to share ideas and opportunities to work better together at neighbourhood level • We are reflecting the emergence of neighbourhood development within the organisation development programmes of our member organisations	• We are measuring ways of working for effectiveness • We are developing a culture where staff feel able to speak openly about the challenges being experienced and are being encouraged to develop shared solutions • Work planning, annual reviews and personal development approaches within member organisations are changed to reflect neighbourhood teams	• Our staff identify themselves as working for a neighbourhood geography, population and team rather than an organisation • Our staff feel able to change their ways of working to align to the needs of the neighbourhood team (within specific competencies) • Staff are held to account for their contribution to population health within a neighbourhood

Residents and neighbourhoods

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Aligned communications for INTs with residents	• We are co-producing a shared vision for our integrated neighbourhood teams and defining the benefit for our population, staff and member organisations	• We have agreed shared communications materials for our residents and staff about integrated neighbourhood teams	• We have shared nomenclature for our integrated neighbourhood teams and the services working within those teams and are developing shared identity	• All member organisations are committed to the shared identify of our integrated neighbourhood teams • We have established single and shared communication routes with our patients who are supported by integrated neighbourhood teams, and no-longer use our organisation specific routes. • These routes include all digital, phone and written communication routes.
Co-production and participative models	• We have mapped all of the current ways we have to engage with residents across our partnerships, identifying the opportunities and gaps within our current infrastructure • We have discussed our commitment to co-production with residents as a partnerships and have agreed shared principles and values to support this	• We have worked with residents to develop integrated neighbourhood team approaches. We have made efforts to ensure that we have engaged with a representative group of residents aligned to the population demographics of our priority populations • We have developed our relationships across the VCSFE sector and are building a shared understanding of co-production and participative models	• We have agreed a model for co-production and participation with the VCSFE and a representative resident group. • We have identified how this model can be implemented and how resources will be shared across the partnership to support the mode	• Patients, service users, carers and residents consistently feedback that their priorities and objectives are fully incorporated into the planning, delivery and assurance of their care.

People, staff and teams

Sub-Domain	Emerging	Developing	Maturing	Thriving
Collaborative leadership development	• Our partnership is discussing the leadership functions that will be needed to support neighbourhood working of the short to medium term	• Our partnership has identified senior leadership within each neighbourhood and within each member organisation with responsibility for leading staff change • Our partnership has agreed shared values for our people that reflect neighbourhood working • We are designing mentoring, coaching and/or peer support approaches that will develop leadership around neighbourhood working • Our partner organisations are engaging the broader senior leadership team off member organisations on collaborative leadership	• Our partnership has agreed our shared values and are holding each other to account for living these values • Our partnership is implementing a leadership development programme within member organisations and within neighbourhoods aligned to our shared values • The senior leadership teams of our member organisations understand our shared collaborative leadership values	• There is strong senior, clinical and operational leadership within all neighbourhoods • Our partnership is investing in collaborative leadership develop and capability across all member organisations • The senior leadership teams within our member organisations are committed to the collective delivery of neighbourhoods
Wellbeing	• Our partnership is committed to improving the wellbeing of our staff and is undertaking engagement with staff to understand needs • We are sharing data via the staff survey and other opportunities across our partnership	• We have identified where we have common wellbeing challenges as a partnership and have put in place programmes of work to develop shared solutions to these challenges • We have identified areas of best practice across the partnership and are using these to inform our work	• We have implemented shared programmes of work to improve staff wellbeing • As a partnership, we are confidence that we have the right processes in place to gather the data we need regarding staff wellbeing • We continued to build our awareness of best practice from within the partnership and beyond. • As a partnership, we have set out our commitments to staff wellbeing publicly and have the processes in place to measure our delivery against these	• Our partnership can demonstrate improvement in staff wellbeing through both qualitative and quantitative data • We have the mechanisms we need in place as a partnership to track wellbeing across our organisations • We have the trust required as a partnership to hold each other to account for the wellbeing of our collective people and provider support to each other to improve wellbeing where required.

People, Staff and Teams

South East London Integrated Care System

Sub-Domain	Emerging	Developing	Maturing	Thriving
Integrated staff communication and engagement	• We have mapped and understood how we communicate with staff within our member organisations and, where relevant, their broader sectors	• We have developed and agreed a shared communication and engagement plan for all staff within our member organisations about neighbourhood care • We have agreed a shared communication approach for broader sectors and have aligned resources to support member representatives from those sectors	• - We have put in place the structures required to ensure all member organisations and broader sectors are using our shared communication materials when communicating with staff.	• We have established single and shared communication routes with staff who are involved in integrated neighbourhood teams to ensure that our communications are aligned
Staff activation	• Our partnership has agreed which staff groups will be most impacted by the implementation of integrated neighbourhood teams • Our partnership has committed to supporting engagement with those key staff groups	• Our key staff groups are aware of the concept of neighbourhood teams and can engage in discussions about what this means for them as individuals • Our partner organisations have identified potential change agents/activists within the key staff group.	• Our key staff groups have been bought together to develop a shared understanding of integrated neighbourhood teams • Some staff are confident in championing the change and are being supported to lead discussions across their peer groups • Our partner organisations are utilising internal resources to support staff leading change	• Our key staff groups can articulate what integrated neighbourhood teams means for them as individuals and for our population • Some staff have taken ownership for leading the change and there are effective staff networks that will enable integrated neighbourhood team working • Our partner organisations are rewarding staff for leadership around integrated neighbourhood team working