South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1400-1600 Thursday 19 March 2026
(Teams meeting)

Co-Chairs: George Verghese and Ceri Jacob

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

Agenda

#	Area	Lead	Time
1	**Introduction and apologies for absence**	Chair	1400
2	**Declarations of interests relevant to the business on the agenda**	All	1402
3	**Minutes of the meeting held on 15 January 2026 (Enc 1)**	Chair	1405
4	**Actions and matters arising (Enc 2)**	Chair	1410
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**Strategic Forward Look (Enc 3)** **a. National guidance/expectations** **b. London programme and deliverables** **c. SEL Strategic Investment Fund and Requirements and the medium-term roadmap** **d. How this plays into ICB governance and system working at place**	H Eden	1415
6	**Digital Workstream Update (Enc 4)** **a. Digital Roadmap and EPR/Digital Solutions for INTs** **b. Specifics around clinical system integration (INT, EPR and PHM)**	N Wheeler/ M Higson	1455
7	**Proposed SEL outcome metrics for 26/27 (Enc 5)**	H Eden/ A Bray- PPL	1535
8	**Any other business.**	Chair	1555
9	**Date of next meeting** **1230-1430 Wednesday 22 April 2026**	Chair	1600

Enclosure 1

Neighbourhood Based Care Board
Draft Minutes of the meeting held on Thursday 15 January 2026 MS Teams

Present:

Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	**CJ**
George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	**GV**
Jessica Arnold	Greenwich LCP representative	**JA**
Diana Braithwaite	Bexley LCP representative (for part of the meeting)	**DB**
Sarah Burchill	Mental Health Provider representative	**SB**
Humphrey Couchman	AD Communication, Media and Campaigns (Non-voting)	**HC**
Oge Chesa	Lambeth LCP representative	**OC**
Gemma Dawson	Community Provider representative	**GD**
Lynn Demeda	Workforce Representative	**LD**
Holly Eden	Director of Delivery – Neighbourhoods and Population Health	**HE**
Toby Garrood	ICB Medical Director	**TG**
Laura Jenner	Lewisham LCP representative	**LJ**
Neil Kennett-Brown	ICB System Sustainability Team Representative (Non-Voting)	**NKB**
Raj Matharu	Community Pharmacy representative	**RM**
Joanne McCaffery	Acute Services representative	**JM**
Tal Rosenzweig	Voluntary Sector Representative (for part of the meeting)	**TR**
Finlay Royal	Medicines Management representative	**FR**
Geetika Singh	Southwark LCP representative	**GS**
Elliott Ward	Bromley LCP representative	**EW**
Nisha Wheeler	Digital representative	**NW**

In attendance:

Tim Borrie	Strategic and Operations Estates Director	**TB**
Ashish Dwivedi	Health Integration Partners (for item 009/2026)	**AD**
Chloe Harris	Head of People and Culture SEL ICS	**CH**
Nick Harris	Head of CESEL	**NH**
Brian Jopling	Health Integration Partners (for item 009/2026)	**BJ**
Bhumika Mittal	Clinical Lead CYP (for item 009/2026)	**BM**
Colin Nash	Governance Manager (Minutes)	**CN**
Alison Roberts	AD CYP Planning, SEL ICB (for item 009/2026)	**AR**
Imogen Setter	PPL	**IS**

Apologies for absence:

Andrew Bland	ICB CEO (non-voting member) (for part of the meeting)	**AB**
Gabi Darby	Greenwich LCP representative	**GD**
Neil Goulbourne	Acute Services Representative	**NG**

Denise Radley	Adult Social Services representative	**DR**

No	Item	Action
001/2026	**INTRODUCTIONS AND APOLOGIES**	
	CJ welcomed members to the meeting. Apologies were noted as above.	
002/2026	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
003/2026	**MINUTES OF THE MEETING HELD ON 20 NOVEMBER 2025**	
	The minutes were **APPROVED.**	
004/2026	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log for this meeting: - 30/25 – HE agreed to report to the March meeting. Action brought forward. 31/25 – Integrator representation on the NBCB and integrators workplan would be agreed in February 2026. Action brought forward. 37/25 –OG reported that an initial discussion about how PHM would contribute to neighbourhood-based care planning had taken place and a further meeting was planned. She agreed to report back to the March meeting. Action brought forward.	 **HE** **GV, CJ, HE** **OC**
	IMPLEMENTING NEIGHBOURHOOD CARE	
	INTEGRATOR DEVELOPMENT PLANS	
005/2026	**Greenwich**	
	JA took the Committee through the slide presentation, and the following points were highlighted. In November 2025, members from the Healthy Greenwich Partnership (HGP) Executive were sent an online questionnaire to consider maturity levels against each domain of integrated neighbourhood arrangements. The anonymised responses were reviewed and discussed at the HGP meeting on 26 Nov 2025 which identified key priorities and informed how the £250,000 grant was to be allocated. A summary of the survey results was set out on page 10 of the pack. Page 11 set out the Greenwich integrator development priorities and page 12 how the £250k would be allocated. In response to a question from LD, JA replied that Greenwich were looking to finalise their communications and engagement requirements and expenditure may exceed the £25k from the £250k allocation. In response to a question from TR, JA replied that Greenwich were looking to establish robust arrangements to ensure VCSE were involved in leading the development of integrated neighbourhood care and utilising funding, in addition to the £25k from the £250k allocation. TR replied that she was keen to support this work.	

	RM noted the challenge of ensuring all clinicians were able to contribute to the development of integrated neighbourhood care. CJ replied that she would be discussing this further with HE. She also agreed the need to be clear when references to primary care referred just to general practice and when it did not. JA added that Greenwich would he holding an event to discuss how best to involve community pharmacy in integrated neighbourhood care.	
006/2026	**Bexley**	
	DB took the Committee through the Bexley presentation, and the following points were highlighted. The Bexley integrator comprised LB Bexley, Oxleas NHS Foundation Trust, the local GP Federation and 4 primary care networks. It was known as Bexley Care *Plus* **Development of a Memorandum of Understanding (MoU) & Governance** Through a Task and Finish Group, established in early 2025, Bexley Care *Plus* developed a comprehensive MoU setting out the shared intention to work in partnership to further develop detailed plans for Bexley Care Plus, alongside a clear set of underpinning principles to support this work. The MoU had been widely socialised across the local health and care system and formally signed off by all appropriate parties. Shadow governance arrangements e.g. Delivery Board due for early 2026 were underway. **Assessing current maturity** In October 2025, the first in-person Bexley Care *Plus* workshop took place with all partners. This focused on developing a shared overarching vision and assessing current maturity against the agreed maturity matrix. This was followed by an online survey and three facilitated working sessions to confirm a collective view of maturity and to agree priorities for the use of the £250k funding allocation. This work supported, and was closely aligned with, the well-established transformation programmes for the three priority cohorts: Children and young people, People with multiple long-term conditions, and People living with frailty. **Roadmap** In parallel, we have developed a roadmap to support delivery of the MoU and achieve a legally binding Partnership Agreement was developed. Progress against this roadmap would be driven and assured through the establishment of shadow governance arrangements for Bexley Care *Plus*. The £250k funding will support delivery of key milestones set out in the roadmap. The results of the survey against the maturity matrix were set out on page 16, key integrator development priorities on page 17 and how the £250k allocation would be invested on page 18 of the pack. In response to a question from CJ, DB replied that difference in governance arrangements for integrated neighbourhood care was the need for a legally binding agreement over and above the MOU. *DB left the meeting.*	

007/2026	**Feedback from the 3 December event**	
	IS reported that the event had been well attended by SEL integrators. Shared challenges had been identified, as had the importance of consistency in the use of language when discussing integrated neighbourhood care and differences in maturity at Place level. In response to questions IS replied that the outputs from the session would be made available to NBCB members in due course. The meeting discussed the challenge of raising awareness and understanding of integrated neighbourhood care amongst those stakeholders not directly involved. CJ replied that it was intended to discuss this in more detail at the March meeting. HE added that in order to establish better links between the NBCB and front line providers it was planned to repurpose some of the NBCB meetings as sessions for integrator members. GV joined the meeting and took over the Chair.	
008/2026	**NEIGHBOURHOODS PMO REPORT**	
	IS referred to the third quarterly highlight report from the six Places and SEL workstream leads. The following points were highlighted. Areas of progress and key learning were set out on page 24 of the pack. **Integrators across all six places had now agreed what they will spend the £250,000 development fund on** with most having been approved, and upcoming approval pending for others. **Progress was being made on models of care for the three priority cohorts,** with some areas live across all neighbourhoods, others scaling their models, some with operational delivery groups set up, and further sites aiming to test cohort models before year-end. **Workforce mobilisation was underway** but uneven, with recruitment progressing in some Places and interim or blended models being used elsewhere to maintain momentum. **Population Health Management was increasingly supporting MDT working,** with interim risk stratification tools and dashboards being used to identify priority cohorts and inform delivery. **Digital limitations were no longer fully preventing action,** as teams agree what is “safe enough” to proceed while longer-term solutions were developed. **Estates discussions are now centred on operational feasibility** (who uses the space, when, and how), not just identification of potential sites. The key learnings and reflections this month were:- **There were shared challenges and priorities across SEL integrators,** creating a clear opportunity to join up approaches, share solutions and avoid unnecessary duplication.	

	Neighbourhood hub workshops in each borough were a critical enabler of delivery, particularly in ensuring neighbourhood teams have appropriate space to operate effectively with the resident at the centre; equal emphasis is needed on making hubs operationally workable, not just identifiable. **Early and meaningful co-design with the VCSE sector and residents was essential** and ultimately time-saving, reducing the need for later adaptation and strengthening ownership and buy-in. **Digital "workarounds" were unavoidable in the short term,** with shared recognition that full interoperability will not be achieved immediately and that pragmatic interim solutions were required to maintain momentum. **Delivery is advancing fastest where "good enough" definitions were accepted**, rather than waiting for perfect alignment across all partners. Risks and interdependences were described on page 25 of the pack. IS noted that Places were progressing at different speeds and care was necessary to ensure that this did not widen health inequalities. CJ added that the NBCB had a role in understanding the reasons for variation and where this was legitimate and ensuring momentum, in developing integrated neighbourhood care, was maintained. EW commended the inclusion of enabler reports, noting that resolving challenges here would increase the speed of progress towards integrated neighbourhood care.	
	The meeting discussed cohort selection for INTs and noted that NHS London were promoting the Health Navigation Limited model for Frailty and long-term conditions. In response to a question from OC, HE replied that she would consider if the Lewisham model could be shared more widely.	**HE**
	It was agreed that a future NBCB should have cohort selection as its main agenda item. HE to schedule this in the Forward Planner.	**HE**
009/2026	**CHILDREN AND YOUNG PEOPLE TASK AND FINISH BROUP - CYP FRAMEWORK**	
	AR introduced her colleagues who together would present the paper on the development of a framework for CYP integrated neighbourhood teams in SEL. The paper included a summary report (pages 62 to 80 of the pack) and the draft final report (pages 81 to 194 of the pack). The following points were highlighted. The framework set out a model for CYP INTs which can be used to develop CYP INTs based on local need and population requirements. It sets out functions and potential participants required to deliver a comprehensive CYP INT. The framework had been developed over the last 3 months engaging with clinicians, commissioners, CYP provider leads, VSCE, children and parents.	

	The framework advocates a population health approach to delivering care for CYP based on need, not on diagnosis. It suggests cohorts for initial focused work at this stage based on complexity rather than age or diagnosis. It was noted that complex CYP were agreed as a key cohort for INTs across SEL and the NBCB agreed that a SEL framework would be developed to support this work and enable local delivery. The guidance on neighbourhood MDT's for CYP set out requirements around CYP with complex health and social care needs which were to be a focus during 2025/2026. NBCB members are asked to note that the current Local Child Health teams (CHILDS, BCHIP) are a step towards achieving this but were not complete INTs. However, the LCHTs can be incorporated into and developed as part of a CYP INT. It is acknowledged that there was a lot of work happening through Joint Commissioning Teams around the Family First and Family Hubs requirements. The framework acknowledges this work and recognises that these partnerships may be a way to deliver the framework. The framework includes a roadmap to achieving implementation by 2029, in line with the NHS 10 Year Plan and Medium-Term Plan, whilst recognising that this will be an ambitious and challenging target to meet. The 10 key principles underpinning the framework were set out on page 70 of the pack. It was noted that the framework required a coordination of care role (see page 71 of the pack). To assess if the new framework was working for the SEL population 8 outcome domains with associated key performance indicators, were described on page 73 of the pack. In response to a question from CJ, AR replied that Family Hubs could be a point of access into the framework. In response to a question from RM, GV replied that the point of access to the framework would need to be widely known by all primary care providers such as community pharmacy.	
	AR and TG agreed to work together on developing mental health outcomes for the framework.	**AR/TG**
	Place representatives informed the Board of their plans to socialise the framework. HE and AR would agree the date when the final framework would return to the NBCB for endorsement.	**HE/AR**
010/2026	**ANY OTHER BUSINESS**	
	HE briefed the Board on outcomes from the following meetings: - **CEOs meeting** The meeting focused upon ensuring the INTs covered the whole population for each cohort. The Frailty cohort was expected to cover at	

	least 1.5% of the total population for a particular ICB. SEL and other ICBs were currently below this figure. Although integrated neighbourhood care was expected deliver a 10% reduction in hospital admissions in 2026-27, those attending the meeting stated that that was unlikely. The right size of virtual wards, as part of INTs, was discussed. Delegated medicines budgets were discussed, with ICBs interested in being early adopters likely to be sought. **NHSE Planning Webinar** Planning guidance would be delayed. The planning focus would be on high-risk cohorts.	
011/2026	**DATE OF NEXT MEETING**	
	1400-1600, Thursday 19 March 2026. *NB the 11 February meeting would be repurposed as an integrator workshop.*	

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Enclosure 2

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

Item Ref	Minute number	Item title	Action description	Owner responsible	Due Date	Comments	
ACTIONS BROUGHT FORWARD							
30/25	004/2026	Quarterly Highlight Reports	Work on a shared risk log between place and SEL	**H Eden**	For 19.3.26 meeting.		
31/25	0042026	Quarterly Highlight Reports	Agree integrator representation on the NBCB and a workplan for integrators	**H Eden/ C Jacob/ G Verghese**	February 2026.		
37/25	004/2026	PHM	Discuss how PMH would contribute to neighbourhood-based care planning	**O Chesa/ H Eden**	For 19.3.26 meeting.		
40/25	004/2026	Workforce Deep Dive	Bring a further paper on clinical governance to the March meeting.	**L Demeda**	For 19.3.26 meeting		
ACTIONS FROM THE 15 JANUARY 2026 MEETING							
1/26	008/2026	Neighbourhoods PMO Report	Consider if the Lewisham model for cohort selection could be shared with other LCPs	**H Eden**	As soon as possible		
2/26	008/2026	Neighbourhoods PMO Report	Schedule cohort selection as the main agenda item for a future NBCB meeting.	**H Eden**	As soon as possible		
3/26	009/2026	CYP Framework	Work together to develop mental health outcomes for the framework.	**A Roberts/ T Garrood**	As soon as possible		

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Neighbourhood Based Care Board

Title	**Strategic Neighbourhoods Forward Look**					
Meeting date	19th March 2026	Agenda item Number	**5**	Paper Enclosure Ref	**3**	
Author	**Holly Eden, Director of Delivery – Neighbourhoods and Population Health**					
Executive lead	**Holly Eden, Director of Delivery – Neighbourhoods and Population Health** **Ceri Jacobs, Place Executive Lead for Lewisham (SEL SRO for Neighbourhoods)**					
Paper is for:	Update		Discussion	**X**	Decision	
Purpose of paper	To provide the Board with a strategic overview of national, regional and SEL-wide policy and planning as it relates to neighbourhoods.					
Summary of main points	There is a considerable amount of national policy development underway which has the potential to influence and shape neighbourhood delivery. This shifting environment can make it challenging to ensure delivery aligns with expectations whilst retaining our local vision for neighbourhoods. Through this paper, we explore: • the key national policy developments that may impact on neighbourhood delivery • the key planning work underway at regional and SEL level; and • how this is translated into delivery requirements for the 26/27 financial year and over the medium term.					
Potential conflicts of Interest	None					
Sharing and confidentiality	Should be shared widely					
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**
Equalities Impact	N/A					
Financial Impact	Includes information on the 26/27 requirements for neighbourhood health and how this aligns to the Strategic Investment Fund					
Public Patient Engagement	N/A					
Committee engagement	N/A					
Recommendation	To discuss the paper and: • Provide comments on the SEL Medium-term Neighbourhoods Roadmap at Appendix A					

	• Endorse Appendix B which sets out 26/27 delivery requirements for Neighbourhood Health, aligned to the Strategic Investment Fund

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Strategic Neighbourhoods Forward Look

National guidance/expectations

1. National guidance relating to Neighbourhood Health has not yet been published. As an ICB, we continued to use "best knowledge" of what national requirements may be to inform planning.

2. As part of the development of the Five Year Strategic Commissioning Plan, place partnerships articulated their high-level neighbourhood development plans across 7 areas, aligned to our expectations of the requirements that will be set out in future national guidance. These areas are:

   - Develop **neighbourhood footprints** around natural communities
   - Ensure good access to **high quality general practice**
   - Continue to **improve the primary-secondary care interface** and implement the recommendations of the Red Tape Challenge (RTC) and 'Bridging the Gap'
   - Establish **Integrated Neighbourhood Teams** (INT) focused on people with complex needs at higher risk of hospital admissions (people living with frailty, care home residents, housebound and people at end of life).
   - Agree a **multi-neighbourhood urgent care plan** which includes ensuring the teams supporting urgent community response, hospital at home and home-based intermediate care have the right capacity and work seamlessly in partnership with ambulances, acute care and are linked to INTs
   - **Improving planned care** in the community (linked to work to redesign outpatient care)
   - **Improving care for children and young people** as part of neighbourhood working

3. Beyond the areas outlined above, we also expect that national guidance will require **INTs to initially focus on patients living with Frailty and End of Life Care** as well as the **top 1.5% of an ICB's population in terms of non-elective hospital activity**. We have worked with national policy colleagues to ensure that we shape out 26/27 requirements in a way that would meet future national requirements, but also reflect our local ambition to ensure INT models also support people living with multiple long term conditions and children and young people, as well as maintaining a focus on developing our preventative neighbourhood model.

GP Contract 26/27

4. On 24th February 2026, the Government published information on the proposed 2026/27 GP Contract. The key changes include:

   - **£485m uplift** to the core contract (3.6% cash / 1.4% real-terms)
   - **£292m repurposed** from PCN Capacity & Access Payment (CAP) into a **practice-level GP reimbursement scheme** to increase GP sessions or hire additional GPs.
   - Removal of restrictions on employing only newly-qualified GPs within **ARRS**, allowing recruitment of experienced GPs.

- Practices must deliver a **same-day response** for all clinically urgent requests.
- Expanded **data requirements**, including practice-level access and online consultation data.
- Updated **QOF**: 18 new points (c.£25m) focussed on vaccinations, obesity (including weight management prescribing), diabetes, HF; retirement of the Obesity Enhanced Service.
- Advice and Guidance ES retired and funding moved into baseline – noting that policy in 26/27 will be driving significant changes in Advice and Guidance that may increase GP workload further.
- PCN responsibilities clarified in vaccinations, cancer screening, continuity and **alignment with** The **British Medical Association (BMA)** has issued one of the **strongest critical responses** to the 2026/27 GP contract.

5. The BMA GP Committee (GPC England) **formally voted to reject** the contract changes. BMA has launched a **referendum of all GPs and GP registrars** (4–25 March) to decide whether to accept the contract or demand a return to direct negotiations. This is likely to lead to a return to collective action and potentially wider actions by parts of the sector during 2026/27.

6. Neighbourhood delivery will likely experience **both opportunities and risks** from the 2026/27 GP contract changes.
   - **Shift of Funding From PCNs to Individual Practices -** Repurposing £292m from PCN-level Capacity and Access Payments to practice-level GP reimbursement could reduce **shared resource pools** previously used for neighbourhood MDT roles,
   - **Increased Same-Day Urgent Access Requirements -** Same-day urgent care targets may **pull GP capacity inward**, prioritising reactive over proactive or preventive neighbourhood activity
   - **Clarification of PCN Responsibilities & Alignment With Neighbourhood Geographies -** The contract pushes **greater alignment of PCNs with neighbourhood geography** (although this does not come with new contracting levers)
   - **Data and Access Monitoring -** New practice-level access data requirements may enhance intelligence for neighbourhood planning and enable **more targeted interventions**. However, increased administrative load could further challenge capacity unless data infrastructure is streamlined at system level
   - **Workforce Flexibility -** Relaxed ARRS GP rules may allow PCNs/neighbourhoods to shape more balanced MDTs, particularly if experienced GPs can be employed in system-facing roles. However, there is a risk that ARRS resources increasingly get used to manage acute demand, weakening

Better Care Fund

7. The 2026–27 Better Care Fund (BCF) framework represents the first formal step in aligning BCF with the neighbourhood health service, as set out in the 10 Year Health Plan for England. While full integration is not expected this year, systems are explicitly asked to link BCF plans to priority areas of neighbourhood health, particularly for people with complex health and social care needs.

8. This is a **transition year**, focused on:

   - Strengthening integration without destabilising core services
   - Maintaining and increasing investment in adult social care
   - Laying the foundations for deeper neighbourhood-based reform from 2027–28 onwards

9. BCF is positioned as a **key enabler of neighbourhood health services**, setting out an initial focus on **people with frailty and those approaching the end of life**. The framework places particular emphasis on:

   - **Integrated neighbourhood teams**, bringing together primary care, community health, social care and other partners
   - **Intermediate care** (health and social care), including urgent community response, step-up and step-down services
   - **Reablement** and recovery-focused support to help people remain independent

10. The guidance also sets out a strong role for Health and Wellbeing Boards in leadership and assurance over the Better Care Fund

Other Local Authority Guidance

11. **Local Outcomes Framework -** In early 2026, the Government published the first edition of the “Local Outcomes Framework””) which will enable outcomes-based performance measurement against key national priorities delivered at the local level and driven by councils as local leaders of place. The framework will strengthen the way government supports and holds councils to account for improving outcomes for their areas. Within the framework, there are a range of outcome measures which align to our SEL Neighbourhoods Outcome Framework, providing solid foundational ground to continue to develop shared approaches to neighbourhood health and care.

12. **Best Start Family Hubs (BSFHs) and Healthy Babies – Aims to bring together** elements of Sure Start and the Family Hubs and Start for Life approaches to create a more integrated, accessible system of support for families across the country. BSFHs will be open to all families with children aged 0–19 (or up to 25 for young people with SEND). While universally accessible, they will prioritise support for families with babies and young children, and for families facing more complex challenges, BSFHs will help identify

emerging problems early and provide access to support BSFHs are expected to provide a physical space for health services to be delivered within the community, forming part of the 'Neighbourhood Health' architecture, and to strengthen the delivery and integration of health services within the local community, with a particular focus on the period from conception to age 2

13. **SEND Reform Consultation –** Sets out proposed reforms to the SEND support framework. In terms of specific health and neighbourhood impact, the proposals include:
    - a new national offer called 'Experts at Hand', wrapping professionals such as educational psychologists, speech and language therapists, and occupational therapists around mainstream settings, and
    - Specialist Provision Packages which will be nationally defined and will set out the interventions, resources and standards required to support children and young people with the most complex needs including statutory entitlements to health provision.

London programme and deliverables

14. The London Neighbourhood Health Delivery Board continues to meet monthly, the key task and finish groups, and their scopes are set out below. There are clear areas of alignment between London-wide sub-groups, SEL-wide enabling workstreams and then place-led delivery. Sub-groups are building on work that is already underway within ICBs, as well as considering where the scale of London could be useful in driving progress further and faster or in removing barriers to change.
    - **Estates Sub Group**
        - Shared understanding of utilisation, condition, accessibility, and alignment of current estates across London in line with neighbourhood footprints.
        - Mapping of gaps (underserved areas) and overlaps (duplication of provision) and options for future usage.
        - Development of a minimum specification for Neighbourhood Hubs in London.
        - Development of shared approach to co-location and development of Neighbourhood Health Centres.
    - **Digital Sub Group**
        - Articulation of the digital requirements from integrated neighbourhood teams, and where London-wide approaches will support neighbourhood working and where digital enablers can transform ways of working
        - An approach to support the development of a London wide approach to population segmentation and care record sharing
        - Identification of areas to spread and scale digital innovations, prioritising existing work and opportunities.
        - Translation of national digital policy, standards and learning into practical actions for London, aligned with wider NHS digital strategies and neighbourhood health priorities.
    - **Strategic Commissioning Sub-Group**
        - Modelling the impact of the shift to a Neighbourhood Health Service, accounting for the impact of cross-boundary flows.

- Providing clarity on the future contracting arrangements required to deliver the shift to a Neighbourhood Health Service.
- Identifying approaches to funding flows and pooled funding that enable the shifts in resources required.
- Work collaboratively with the relevant partners to understand how the Neighbourhood Health Service will contribute to the sustainability of Local Authorities, VCFSEs, and Independent Providers.
- Reviewing the current model of outpatient care in the context of the shift to a Neighbourhood Health Service.
- Guidance for the role of primary care, VCSEs, and independent providers in the Neighbourhood Health Service.

- **People Sub-Group**
  - Agree shared expectations for what most residents can rely on from their neighbourhood and what staff should be enabled and trusted to deliver across organisational boundaries
  - Improving the basic understanding of what neighbourhood health is and the London TOM across London
  - A consistent development offer across London, developing core competencies and building development capacity in the system for significant cultural change
  - Development of key governance levers, including approaches to risk sharing, delegation and indemnity
- **Community of Practice Sub-Group**
  - To ensure that clinicians, professionals and residents understand the purpose and direction of neighbourhood health, and what it will mean for them.
  - To act as the vehicle for participation across the region, enabling people to shape neighbourhood health through a range of inclusive and innovative formats.
  - To ensure that community insight is meaningfully embedded, shaping priorities and informing programme decision-making.
  - To enable shared learning and practical problem-solving across the system.
  - To amplify learnings and successes from across the system, creating a visible shared narrative of neighbourhood health in action.

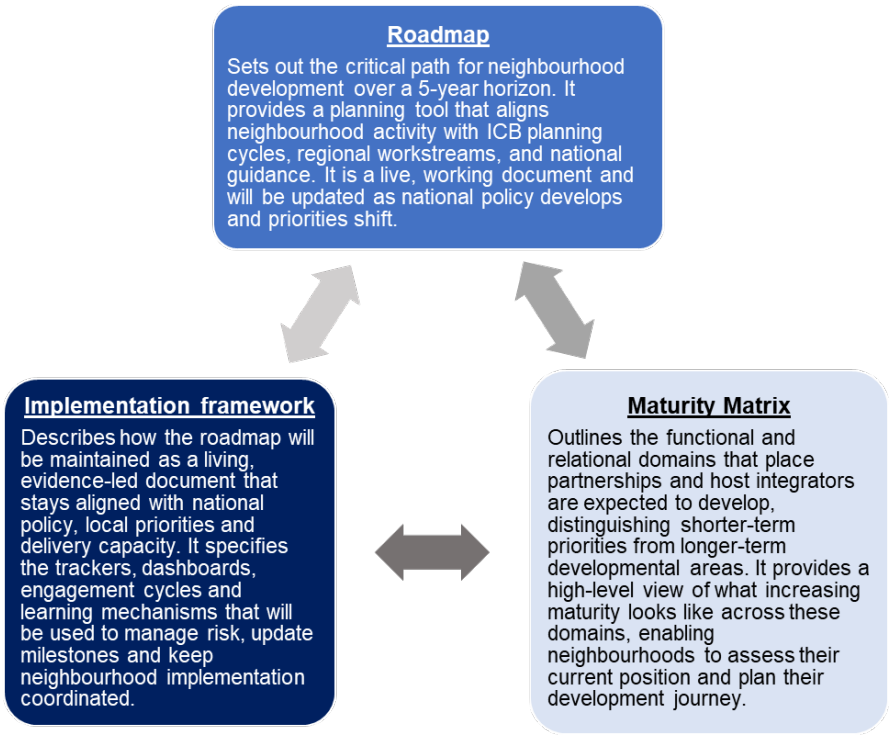
SEL Neighbourhoods Medium Term Roadmap

15. Work has been undertaken to develop a draft SEL Neighbourhoods Medium Term Roadmap. This is attached as Appendix A to this paper. The roadmap aims to articulate the critical path for neighbourhood development over a 5-year horizon, including clarifying ICB, place and provider milestones. The roadmap is intended to act as a strategic planning tool that aligns neighbourhood delivery with ICB (and eventually local authority) planning cycles, regional workstreams and national guidance. It is intended to be maintained as a live, working document that is updated as national policy develops and priorities shift.

16. The roadmap will sit alongside:

- the Maturity Matrix which outlines the functional and relational domains that place partnerships and host integrators are expected to develop over the medium term to enable neighbourhood health; and
- an implementation framework that will including the trackers, dashboards, engagement cycles and learning mechanisms that will be used to manage risk, updated milestones and keep neighbourhood implementation coordinated.

17. Each year, specific annual delivery requirements will be articulated, aligned with available investment.



26/27 Neighbourhood delivery requirements aligned to investment

18. The 2026/27 Neighbourhood delivery requirements aligned to available investment via the Strategic Investment Fund have been articulated. These are set out in the document attached as Appendix B to this paper.

19. The requirements will be shared with Integrator host organisations on 20th March 2026 who will then co-produce investment and delivery plans with acute, community, mental health, primary care and VCSFE parters and local place governance by 22nd May 2026 for approval through appropriate ICB governance.

South East London
Integrated Care System

SEL ICB Neighbourhood Development Roadmap

Version 6.0

January 2026

Our shared intention for an Integrated Neighbourhood Health and Care Service in SEL

South East London Integrated Care System

SEL ICB is **committed to delivering a neighbourhood health and care service that improves population health, reduces inequalities, and strengthens the sustainability of health and care services.**

To achieve this, **we will work in a deeply integrated way with Local Authorities, VCFSE partners, communities and residents, recognising that**:

- **Wider determinants and social drivers shape the majority of health and care outcomes**, inequalities and service utilisation.
- **Community organisations, local government and residents are essential partners** in addressing these drivers and improving wellbeing.
- A neighbourhood model only succeeds when **care, prevention, social support and community assets are aligned around people and place.**
- Our **focus on acute care impacts is balanced with a strong emphasis on prevention, early intervention, and community-based support.**
- **Much of this work must be led and owned at Place**, where relationships, local knowledge and community assets are strongest.

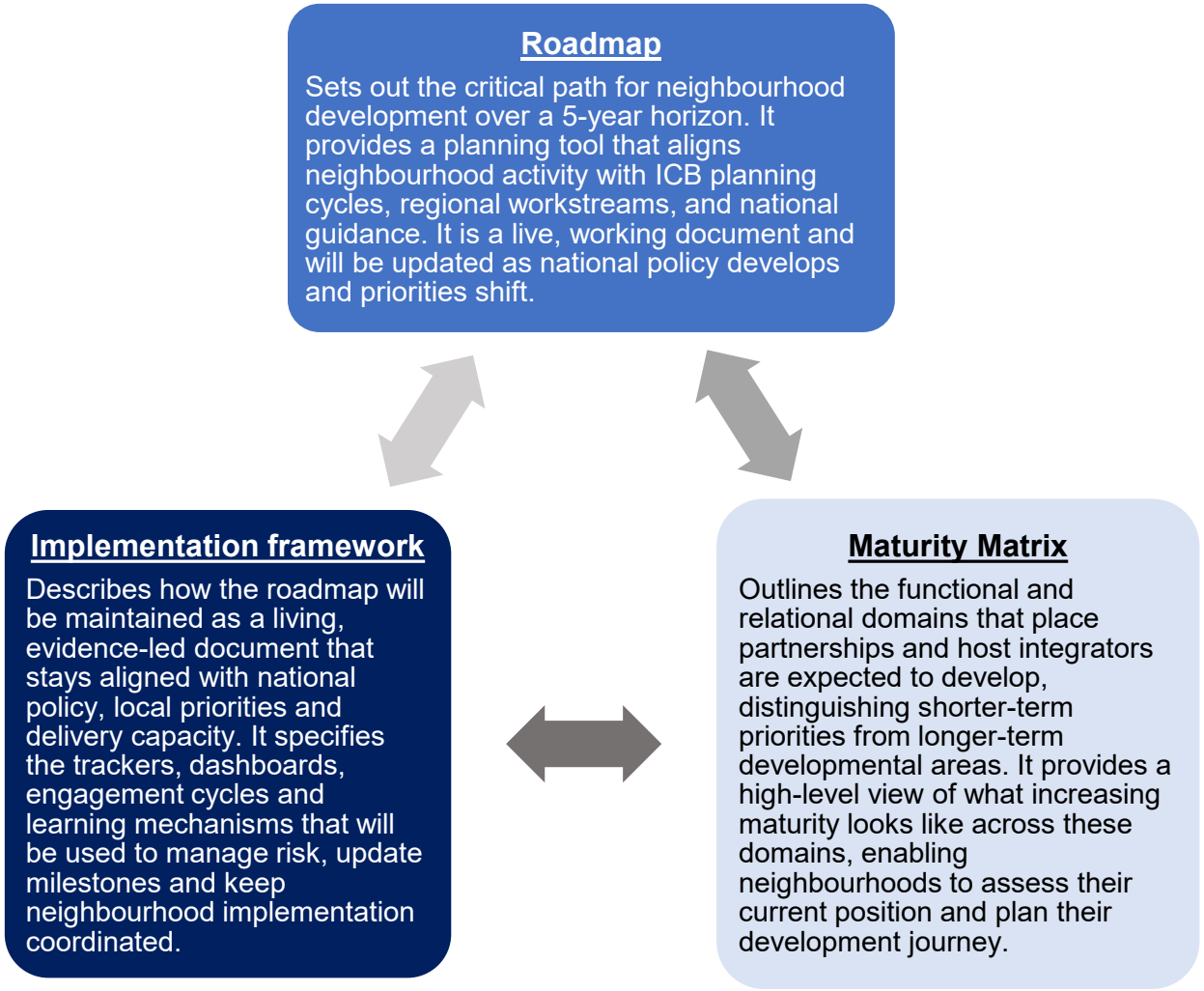
We intend to build a neighbourhood health and care service that:

- **Brings together health, social care, public health, housing, education, VCFSE partners and communities** as equal contributors.
- Addresses the causes of ill-health, not only the consequences, by **embedding prevention and population health approaches in every neighbourhood.**
- **Strengthens community participation**, ensuring residents shape priorities, design solutions and hold the system to account.
- Creates **consistent, high-quality, accessible local care**, while allowing **each Place to tailor delivery to local needs and inequalities.**
- **Supports integrated neighbourhood teams to work across organisational boundaries with shared goals, shared information and shared responsibility for outcomes**.

Neighbourhood Delivery and Planning: Roadmap, Implementation Framework and Maturity Matrix

South East London Integrated Care System

Together, the roadmap, implementation framework and neighbourhood maturity matrix provide a single, system-wide approach to planning and delivering neighbourhood based care over the next decade.



How they enable delivery

- **Set a common direction:** The roadmap offers a single, unifying framework that aligns neighbourhood priorities with local, regional and national expectations, and connects day-to-day delivery to the ICB's statutory 3 - 5 year planning cycles.
- **Sequence change and investment:** It describes the critical path, phasing and dependencies between workstreams, so that neighbourhood activities, procurements, digital and workforce enablers are planned, timed and resourced coherently.
- **Define what 'good' looks like:** The neighbourhood maturity matrix translates the London Target Operating Model and SEL integrator functions into clear functional and relational domains, with shorter- and longer-term priorities that neighbourhoods can work towards.
- **Support local self-assessment, prioritisation and maturity:** Partnerships can use the maturity matrix and implementation framework to understand their current position, agree realistic next steps, and tailor their development focus to local circumstances, while remaining aligned to SEL expectations and strengthening their overall maturity.
- **Keep implementation coordinated and evidence-led:** The implementation framework sets out the trackers, dashboards and feedback loops needed to monitor progress, manage risk, and refresh the roadmap as policy, local priorities and delivery capacity evolve.
- **Create a living planning and delivery cycle:** Insights from delivery, engagement and evaluation feed back through the implementation framework into the roadmap and maturity matrix, ensuring neighbourhood-based work remains responsive, sustainable and joined-up.

The Roadmap Structure

The roadmap will act as a single source of truth, translating national policy into local delivery through a clear line of sight for every domain:

- **National:** 10 Year Health Plan and Medium Term Planning Framework requirements.
- **Regional (London):** London Region workstreams (Digital, Estates, People, Contracting and commissioning).
- **ICB (SEL):** System wide targets and initiatives.
- **Place (Boroughs):** Specific actions and milestones required locally.

**As we iterate the roadmap, we will ensure that mental health, children and young people, social care and VCFSE are fully and visibly captured.*

Core Delivery and Strategic Enabler Domains

The roadmap is organised by **delivery domain** and separates the work into what residents experience (clinical and neighbourhood delivery) and the cross-cutting enablers that make this possible. This gives a clear line of sight between operational delivery targets (e.g. INTs, access, UCR, PHM) and the system architecture, workforce, digital, estates and financial arrangements that support them.

Structure

- **Core Delivery Domains - "the What" (5 domains)**
  - *Integrated Neighbourhood Teams (INTs) & Targeted Care; Primary Care & Community Access; Acute-Community Interface (Urgent & Planned Care); Prevention & Health Inequalities; Population Health Management (PHM).*
- **Strategic Enabler Domains - "the How" (5 domains)**:
  - *Integrator & System Architecture; Workforce, Leadership & Culture; Digital, Data & Technology; Estates & Infrastructure; Finance, Productivity & Governance*.

Core Delivery Domains (the "What")

South East London

Domain	Scope & Key Topics (National, Regional & Local)	Rationale
1. Integrated Neighbourhood Teams (INTs) & Targeted Care	**Scope:** The operational delivery of multi-disciplinary teams for specific population cohorts. **Key Topics:** • SEL Priority Cohorts: Rollout of INTs for Children & Young People, Multiple Long-Term Conditions (mLTCs), and Frailty/End of Life. Adult MH, CYP, LD/ASD, community mental health transformation. • Care Planning: Personalised care plans for complex needs. • Maturity: Moving neighbourhoods from "launch" to "thriving" based on the Maturity Matrix.	Separating this ensures there is a focus specifically on the new multi-disciplinary working, distinct from "business as usual".
2. Primary Care & Community Access	**Scope:** The "front door" of the NHS ensuring sustainability and access. **Key Topics:** • General Practice: Improving access (National Target: 90% urgent same-day) , GP Sustainability support offer . • Community Pharmacy: Implementing "Modern Community Pharmacy" vision (preventative/acute/chronic care) and Pharmacy First. • Dentistry: Delivering the 700,000 additional urgent appointments target.	Primary Care has distinct national targets and contractual levers that require focused oversight separate from the wider INT work and is fundamental to the success of neighbourhoods.
3. The Acute-Community Interface (Urgent & Planned Care)	**Scope:** Managing flow between settings, keeping people out of hospital and getting them home faster. **Key Topics:** • Same day urgent Care: Urgent Community Response (UCR) targets, reducing avoidable admissions , and 12-hour community urgent care offer . • Planned Care: Outpatient transformation (digital follow-ups), Specialist advice to GPs to prevent referrals . • Discharge: Virtual Wards and intermediate care capacity.	This domain addresses the "Hospital to Community" shift directly. It reflects what needs to happen to relieve the acute pressure and increase community capacity.
4. Prevention & Health Inequalities	**Scope:** Upstream interventions to stop people becoming patients (The "Sickness to Prevention" shift). **Key Topics:** • Public Health: Vaccination uptake (flu, HPV) , Smoking cessation (opt-out models) . • Obesity: Weight loss medication rollout and digital weight management referrals. • Inequalities: Core20PLUS5, targeted outreach for "rising risk" groups.	Keeping this separate ensures prevention doesn't get deprioritised by urgent operational pressures in the other domains.
5. Population Health Management (PHM)	**Scope:** The intelligence function. Using data to decide who the INTs should target. **Key Topics:** • Risk Stratification: Deploying tools like Bridges to Health and a segmentation model . • Impact Modelling: Financial and demand modelling to prove the value of the neighbourhood model . • Outcomes: Monitoring outcomes delivery.	PHM allows data tracking maturity distinct from the clinical services.

Strategic Enabler Domains (the "How").

South East London Integrated Care System

Domain	Scope & Key Topics	Rationale
6. The Integrator & System Architecture	**Scope:** The governance and vehicle for delivery. How partners collaborate at Place and within the system. **Key Topics:** • Integrator Partnerships: Developing the host organisations in all 6 places. • Contracting: Implementing new forms of contract (e.g., Integrated Health Organisation contracts) . • Strategic Commissioning: Shifting to outcomes based commissioning.	To focus on the structure of the system (contracts, partnerships) and aligns with the London region workstream on contracting and commissioning.
7. Workforce, Leadership & Culture	**Scope:** The people and capacity building required to deliver the new model. **Key Topics:** • Staff Activation: From "Awareness" to "Embed" phases . • New Roles: Recruiting to INTs, ARRS roles, and leadership development. • Culture: Foster a "test and learn" culture. Social care, VCSE workforce and partnership working.	Maps directly to the London "People" workstream. Critical for tracking recruitment, transformation and cultural change.
8. Digital, Data & Technology	**Scope:** The tools (The "Analogue to Digital" shift). **Key Topics:** • Patient Facing: NHS App functionality (appointments, prescriptions). • Staff Facing: Interoperability, Single Patient Record, AI tools (scribes/triage) . • Infrastructure: Federated Data Platform (FDP) onboarding.	Maps directly to the London "Digital" workstream. Ensures the tech roadmap keeps pace with the clinical ambition.
9. Estates & Infrastructure	**Scope:** The physical locations and assets. **Key Topics:** • Neighbourhood Hubs: Identifying and prioritising hubs • Utilisation: Making better use of existing estate and capital investment.	Maps directly to the London "Estates" workstream.
10. Finance, Productivity & Governance	**Scope:** To ensure appropriate financial and governance structures to ensure sustainability. **Key Topics:** • Productivity: 2% year on year target. • Financial Flows: Moving to "Year of Care" payments or capitated budgets . • Assurance: Performance monitoring and risk management.	Ensures there is oversight of the "business" side: is the change being embedded unlocking value, and is it meeting statutory governance requirements?

Inclusions and Outstanding Gaps (1/2)

South East London Integrated Care System

The roadmap has been developed through a structured review of national, regional, and local planning frameworks, including the NHS 10-Year Plan, Fit for the Future, the 2025/26 NHS Planning Framework, the London Target Operating Model, and the South East London (SEL) Joint Forward Plan and JSNA. **Its purpose is to provide a clear and coherent view of how neighbourhood working in South East London** is expected to evolve over the next decade.

A light-touch review of existing work across population health, digital, workforce, estates, finance, and governance was undertaken to understand current progress, key dependencies, and areas requiring improved alignment or sequencing. In addition, stages of transformation were examined to ensure the roadmap aligns with the SEL ICB's statutory three- to five-year planning cycles.

However, further guidance, policy, and plans are anticipated at national, regional, and local levels. As a result, this will need to be a live document. The tables below highlight current inclusions and identified gaps, alongside areas where there is still uncertainty.

Paper	Level	Included?	Estimated Date
10 Year Health Plan for England: fit for the future	National	✓	N/A
Medium Term Planning Framework – delivering change together 2026/27 to 2028/29	National	✓	N/A
Changes to the GP Contract in 2025/26	National	✓	N/A
2025/26 priorities and operational planning guidance	National	✓	N/A
NHS Neighbourhood Health Guidelines 2025/26	National	✓	N/A
NHS Model Neighbourhood Framework	National	✕	January 26
System Archetypes Blueprint	National	✕	TBC
Future of GP contracts	National	✕	TBC
Future of PCNs	National	✕	TBC
Future direction of national platforms e.g. EPR	National	✕	TBC
SEND White Paper	National	✕	February 26
Local Government Outcomes Framework	National	✓	February 26

Inclusions and Outstanding Gaps (2/2)

South East London Integrated Care System

Paper	Level	Included?	Estimated Date
Better Care Fund Framework	National	✓	February 26
Casey Commission – Phase 1 report	National	✕	TBC
A neighbourhood health service for London: The Target Operating Model	Regional	✓	N/A
Outpatient Delivery and Commissioning Recommendations	Regional	✕	TBC
Strategic Commissioning Model for London	Regional	✕	TBC
Role Definitions and Commissioning Approaches	Regional	✕	TBC
Model for Workforce	Regional	✕	TBC
Model of Care	Regional	✕	TBC
London Neighbourhood Health Development Plan	Regional	✕	TBC
Digital Requirements Pack for Neighbourhood Delivery	Regional	✕	TBC
Population Segmentation Recommendation	Regional	✕	TBC
ICB Estates Implementation Plans	Regional	✕	TBC
Planning Principles for Future Estates Developments	Regional	✕	TBC
SEL Five Year Strategic Commissioning Plan	ICB	✕	March 26
Development of our South East London Neighbourhood Health Service Paper	ICB	✓	October 2025
Local Neighbourhood Health and Care Plan incl. Population Health Improvement Plan & Delivery Plan for neighbourhood care	Place	✕	March 26

1. Integrated Neighbourhood Teams (INTs) & Targeted Care: National Expectations

South East London Integrated Care System

Nationally, the expectations so far include:

- Deliver a Neighbourhood Health Service with neighbourhood health centres offering joined-up access in communities, open 12 hours a day, 6 days a week.
- By 2027, 95% of people with complex needs must have an agreed care plan
- Personal Health Budgets: double the number of people supported by 2028/29, reach 1 million by 2030, and move towards a universal offer by 2035.
- Introduce Modern Service Frameworks (for example cardiovascular disease, severe mental illness, frailty, dementia) to reduce unwarranted variation and standardise high-quality pathways.
- Implement a Single National Formulary within the next 2 years to support consistent prescribing and reduce unwarranted variation.
- Expand the National Contract Value Review into neighbourhood health services by 2026, and scale adoption through mechanisms such as the Innovator Passport.
- Reduce clinical trial set-up time to 150 days by March 2026 with transparent reporting.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Keeping people living independently, reducing escalation into long term care (rate of long term care home admissions for older people, community based long term support).
- Adult social care outcomes and experience (quality of life, satisfaction, feeling safe, social contact, control over daily life, carers' experience).
- Successful reablement and targeted support for frailty and complex needs (reablement success, remaining at home after reablement).
- Children and young people thriving (early years development at age 5, attainment at KS2 and KS4, attendance and persistent absence, NEET).
- Keeping children safe and stable (children in care rate, repeat child protection plans, placement stability, care leaver outcomes).
- Reducing outcome gaps between groups (disadvantage gaps, SEND gaps, inequities in outcomes for priority cohorts).

1. Integrated Neighbourhood Teams (INTs) & Targeted Care

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Publish a single SEL INT model that every Place can implement (what "good" looks like: team membership, leadership, care coordination roles, decision making, and link to neighbourhood health centres)	• Write and sign off the SEL **minimum INT specification** aligned to the London TOM (including what must be consistent vs what can vary locally). • Set up an ICB assurance approach (simple maturity measures and clear evidence required).	• Require each Place to submit an implementation plan against the SEL specification (with workforce, capacity, and delivery risks). • Fund and support Places to close the biggest gaps first (for example care coordination capacity).	• Confirm **full neighbourhood coverage** against the minimum model, then update the spec where evidence shows improvements are needed.	• Refresh the INT model based on evaluation, patient experience and workforce sustainability.	• Move the spec into routine commissioning and annual planning cycles, with a yearly refresh rather than "one-off" redesign.
Define SEL target cohorts and commission care models for each	• Agree SEL cohort set (for example frailty, 3+multimorbidity, CYP with complex needs, learning disability/autism). • For each cohort: define outcomes, access expectations, and escalation routes.	• Commission or re-commission cohort pathways so every Place is delivering against the same outcome intent (with local tailoring where needed).	• Expand to additional cohorts (e.g maternity) where data shows unmet need and high avoidable hospital use.	• Tighten specifications based on variation and outcomes (reduce postcode differences).	• Embed cohort-based commissioning as standard practice, with clear annual outcome review and updates.
Deliver care planning and coordination at scale so people with complex needs have an agreed plan (national expectation: 95% by 2027)	• Define the SEL standard for care plans (minimum content, who leads, where it is stored, how it is shared, how carers are involved). • Set requirements for proactive identification and review cycles.	• Scale delivery so Places can meet the national expectation by end of 2027: oversight of coverage, quality checks, and escalation when delivery slips.	• Improve plan quality and usability.	• Audit equity of care planning (who is missing out, and why) and address gaps.	• Maintain routine annual/biannual reviews for those who need them, and ensure plans remain meaningful and updated.
Grow personalised care offer (including personal health budgets) so people have real choice and control (national milestones through 2028/29, 2030, 2035)	• Establish SEL approach: who is eligible, what support brokerage looks like, how safeguarding and governance works, and how Places access support.	• Expand delivery so uptake increases across all boroughs fairly, not just where capacity already exists.	• Deliver the national growth milestone by 2028/29 through sustained commissioning and practical support for frontline teams.	• Move from "pilot groups" to wider offer where appropriate, with clear monitoring of outcomes and safety.	• Embed personalisation into the standard care offer, with routine reporting and learning.
Reduce avoidable admissions and long lengths of stay for priority cohorts by strengthening community alternatives	• Set SEL measures that matter (avoidable admissions, readmissions, length of stay drivers) and align Places on a single improvement focus for frailty and complex needs.	• Commission consistent SEL expectations for community alternatives (rapid response, proactive support, step-down) and require Places/providers to align.	• Strengthen cross-SEL escalation and mutual aid where one Place is under pressure.	• Use outcomes and variation analysis to direct resources to what is proven to reduce avoidable admissions.	• Maintain improvement as routine: quarterly review, rapid support where performance deteriorates, and sustained investment where it works.
Implement national quality and pathway standards locally (Modern Service Frameworks, Single National Formulary, SEND-related changes)	• Translate national standards into SEL commissioning requirements: what changes in pathways, referral routes, prescribing and reviews.	• Audit implementation: identify variation, require action plans, and support Places/providers to implement consistently.	• Expand to additional MSFs as they are published and ensure neighbourhood delivery reflects them.	• Tighten assurance: focus on outcomes and unwarranted variation.	• Keep standards current and embedded in routine commissioning cycles.
Build a strong evaluation and improvement loop	• Set expectations for real-time patient experience (including triangulating surveys with existing feedback routes) and define a simple evaluation template.	• Require evaluation as part of scale decisions (what improved, for whom, and at what cost).	• Use national research enablers (for example faster trial set-up expectations) to build a stronger evidence pipeline in neighbourhood models.	• Embed continuous improvement capability across Places and providers (support, training, shared learning).	• Maintain a yearly SEL learning cycle that refreshes the roadmap based on evidence and lived experience.

1. Integrated Neighbourhood Teams (INTs) & Targeted Care

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Every neighbourhood has an INT operating as a "team of teams"	• Mobilise neighbourhood leadership and delivery groups. • Agree INT footprint, named leads, and how health, social care and VCFSE work together day to day.	• Expand INT coverage so it is reliably available across all neighbourhoods, not just pilots. • Fix the operational blockers (referral routes, handovers, escalation).	• Improve consistency: reduce variation between neighbourhoods and strengthen cross-neighbourhood cover.	• Consolidate: make the INT the routine "way of working" for target cohorts.	• Keep INT delivery stable and safe through workforce churn: clear induction, shared practice standards, ongoing learning.
Priority cohorts are actively identified and supported (targeted care is proactive)	• Agree local cohort lists aligned to SEL definitions, and create practical case-finding workflows.	• Deliver cohort pathways at scale (including proactive reviews and rapid escalation routes).	• Add cohorts where data shows high unmet need or avoidable hospital use.	• Improve pathway experience and outcomes for underserved groups.	• Maintain proactive targeted care as routine neighbourhood practice.
People with complex needs have an agreed care plan (and carers are involved where appropriate)	• Start with highest-need people first: create case lists, confirm who is accountable for writing and updating plans, test plan templates.	• Scale to meet the national 2027 expectation locally: increase coverage, improve quality, ensure plans are accessible to those delivering care.	• Improve plan usefulness: ensure plans change real decisions (medication, escalation, crisis response).	• Focus on equity: identify communities missing out and redesign outreach and access.	• Keep plans updated through routine review cycles and clear responsibilities.
Personalised care is real and practical	• Identify where personal health budgets and personalisation are most helpful locally; build brokerage and support capacity.	• Expand access and ensure consistent offer across the borough (not postcode dependent).	• Grow uptake in line with national milestones through sustained delivery support.	• Strengthen safeguarding and quality while widening access where appropriate.	• Maintain an embedded personalisation offer with ongoing learning and outcome tracking.
Avoidable admissions and long stays reduce because community alternatives work	• Implement practical alternatives for frailty and complex needs (rapid response, proactive support, step-down working with social care).	• Strengthen interface with acute and community providers (shared escalation, predictable step-down pathways).	• Improve outcomes for people repeatedly attending hospital by providing coordinated neighbourhood support.	• Maintain improvements and respond quickly when performance deteriorates (winter pressures, workforce gaps).	• Embed as standard practice and keep improving year on year.
Resident's experience drives improvement (so they feel listened to and respected)	• Implement simple real-time feedback routes, and agree how feedback results in visible change.	• Use feedback to improve care coordination, communication and access.	• Target improvements where people report the poorest experience (including carers).	• Regularly publish "you said, we did" locally to build trust.	• Keep this as a permanent part of neighbourhood delivery.
CYP and SEND support is better joined up (fewer children and families bounce between services)	• Map the current pathways and bottlenecks; agree what "joined-up" means locally in practice (handoffs, shared plans).	• Implement practical improvements that reduce waits and reduce duplication (shared triage, clearer referral routes).	• Scale what works across neighbourhoods and reduce variation.	• Improve family experience and continuity.	• Maintain consistent joined-up support with routine review and improvement.

1. Integrated Neighbourhood Teams (INTs) & Targeted Care

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Providers participate in INTs as real clinical teams	• Agree which roles attend regularly, how advice is provided, and how decisions are documented and acted on.	• Make MDT participation routine and reliable (cover arrangements, agreed response times).	• Improve cross-provider working (reduce duplication, simplify handoffs).	• Keep continuity through workforce change (standard onboarding and shared working agreements).	• Maintain as core operating practice and keep improving.
Targeted cohort pathways are delivered in day-to-day practice	• Align clinical leadership around cohort pathways and test changes (for example frailty response, SMI support).	• Scale delivery so pathways work across the whole provider footprint, not a few sites.	• Improve outcome consistency across sites and teams.	• Reduce unwarranted variation with audit and improvement support.	• Maintain pathways as “how we work” and update when standards change.
Care planning is supported and acted on	• Enable staff to create and update plans, and ensure they are used at key points (admissions, discharge, crises).	• Increase reliability: plans are visible, updated, and used consistently.	• Improve integration so plans follow the person across settings.	• Audit quality and equity of delivery and address gaps.	• Maintain routine review and continuous improvement.
Personalised care is supported safely	• Train teams in personalisation conversations and ensure options are explained clearly.	• Expand delivery in partnership with Places and ICB framework.	• Improve consistency and safety through supervision and governance.	• Embed and widen where appropriate.	
Reduce admissions and long stays	• Implement practical changes that prevent avoidable admissions (rapid advice, proactive reviews, early senior decision making).	• Strengthen step-down and community interfaces to reduce length of stay.	• Improve flow for high-impact cohorts (frailty, LD/autism, SMI) through dedicated pathway leadership.	• Maintain performance through winter and demand spikes with agreed escalation approaches.	• Embed into standard operating practice.
National quality standards are implemented in clinical pathways	• Implement MSF-related changes in clinical practice and referral routes	• Audit delivery and improve where gaps persist.	• Extend to new MSFs and updated standards.	• Focus on outcomes and variation reduction.	
Evaluation and learning is routine	• Collect and use outcomes and experience data to guide pathway change.	• Use evaluation results to decide what to scale and what to stop.	• Build stronger evidence generation aligned to national direction (including research readiness expectations)	• Maintain shared learning across provider sites.	

2. Primary Care & Community Access

South East London Integrated Care System

Nationally, the expectations so far include:

- End the “8am scramble” and enable people who need it to get a same day GP appointment, supported by online advice in the NHS App.
- Introduce two new GP contracts, with roll out beginning “next year”, to help primary care work over larger geographies and lead new neighbourhood providers.
- Through the NHS App, enable people to book appointments, message professionals, get advice, and self refer to tests and services.

From the GP contract changes (2025/26)

- By 1 October 2025, practices must keep their online consultation tool open for the full duration of core hours (8:00 to 18:30) for non urgent appointment requests, medication queries and admin requests (with safeguards so urgent needs are directed safely).
- By no later than 1 October 2025, practices must enable GP Connect functionality that:
    - allows read only access to the GP record for other NHS commissioned providers for direct care (and private providers only with explicit patient permission), and
    - allows community pharmacy to send consultation summaries into the GP workflow (reducing admin burden).
- NHS England will publish a patient charter setting out the standards patients can expect, and it must be published on the practice website.
- In 2025/26, the Additional Roles Reimbursement Scheme (ARRS) becomes more flexible (a single pot for patient facing staff costs, including GPs and practice nurses).
- In 2025/26, the Capacity and Access Improvement Payment (CAIP) continues but focuses on:
    - modern general practice access, and
    - risk stratifying patients to identify those who would benefit most from continuity of care.
- In 2025/26, practices must “have regard” to the primary care patient safety strategy and register for an admin account with the Learn from Patient Safety Events service (LFPSE), enabling recording and learning from safety events across settings.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Access to timely primary care (ability to meet urgent demand quickly, same day access where applicable).
- Community based access points working well (community pharmacy contribution, dentistry urgent access, other community routes reducing pressure on general practice and urgent care).
- Access to services locally and ability to get to care (connectivity and transport access to key services, local bus usage and coverage where relevant).

2. Primary Care & Community Access

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
General practice access is reliably better	• Set SEL minimum expectations for access improvement aligned to the GP contract requirements (including core-hours online consultation)	• Assure improvement delivery across all boroughs and target support where access remains poorest.	• Strengthen cross-SEL consistency so access does not vary sharply by borough or practice group.	• Maintain performance through demand surges (winter, outbreaks) with agreed resilience actions.	• Keep access improvement embedded with annual review and continuous improvement.
Same-day consultation is available when clinically needed (and continuity is protected for people who benefit from it)	• Define SEL access principles: what "same-day" means in practice, how triage works safely, and how continuity is prioritised for complex need.	• Monitor delivery and equity: ensure people in deprived areas are not waiting longer.	• Improve how people move between same-day access and planned continuity, without being bounced.	• Keep improving quality and patient experience.	• Sustain balance between same-day access and continuity as routine practice.
Community access is joined up (people can be seen in neighbourhood services without unnecessary hospital referrals)	• Commission consistent neighbourhood community access expectations (including how people are navigated and how advice is obtained).	• Expand availability and simplify referral routes (fewer forms, clearer criteria).	• Improve integration with diagnostics and specialist advice so community settings are confident and supported.	• Reduce duplication and unnecessary follow-ups.	• Maintain a stable, understandable offer for residents and professionals.
Neighbourhood health centres work as practical access hubs (not just buildings)	• Agree SEL approach: what services are in-scope, how booking works, and how it links to INTs.	• Implement in a phased way across boroughs based on readiness and estate capacity.	• Expand functionality (more services booked and delivered through the centre).	• Improve experience and throughput without losing person-centred care.	• Maintain and refresh offer based on population need.
Diagnostics and "right test, right time" access improves (fewer delays and repeat visits)	• Set commissioning expectations for community diagnostics use and decision support where available.	• Increase consistency of access across boroughs and reduce variation in waiting times.	• Expand use for high-impact cohorts (frailty, LTC, suspected cancer pathways where appropriate).	• Improve turnaround times and reduce repeat testing due to missing information.	• Sustain high-quality, consistent diagnostic access across SEL.
Community waiting times reduce for key services (and people know what to expect)	• Set a single SEL approach to measuring and reporting community waits so the problem is visible and comparable.	• Implement improvement trajectories per service line and intervene where waits remain longest.	• Scale successful models across boroughs and providers.	• Maintain performance through demand growth and workforce gaps.	• Embed as routine performance management and improvement.
People can navigate the system more easily (clear routes, fewer handoffs, better information)	• Agree SEL public-facing "where to go" model aligned to neighbourhood delivery.	• Improve consistency of messaging and frontline navigation across services.	• Expand digital and non-digital navigation support so people are not excluded.	• Maintain and improve based on feedback.	• Keep navigation clear as services evolve.

2. Primary Care & Community Access

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Access to general practice feels easier locally	• Implement local access improvements aligned to GP contract requirements and borough needs.	• Spread improvements across all neighbourhoods.	• Reduce borough-level variation between neighbourhoods.	• Maintain reliability and patient experience.	• Access improvements embedded and sustained locally.
Same-day and continuity both work	• Agree local workflows that protect continuity for complex need while offering timely same-day support.	• Improve reliability and fairness including for underserved groups.	• Strengthen links to community services so same-day does not default to ED.	• Sustain consistent balance between urgent and continuity care.	• Same-day and continuity embedded in routine practice.
Neighbourhood access points are real and used	• Mobilise neighbourhood access hubs (including community venues where relevant) and make routes clear.	• Expand services available locally and reduce friction in referrals.	• Improve booking and service integration.	• Maintain clear, consistent access model.	• Neighbourhood access points embedded in local care model.
Neighbourhood health centres become usable hubs	• Identify sites and develop operational model.	• Implement phased delivery and make access routes clear.	• Expand functionality and integration.	• Improve based on experience.	• Hubs operating as stable access points.
Diagnostics access improves locally	• Increase use of community diagnostics and reduce avoidable referrals.	• Reduce variation in waiting times.	• Expand where most helpful for priority cohorts.	• Sustain reduced waits and improved criteria.	• Diagnostics embedded in neighbourhood pathways.
Community waits reduce and are transparent	• Make waits visible and agree improvement actions.	• Deliver reductions through redesigned pathways.	• Scale successful models.	• Maintain transparent reporting.	• Community waits consistently managed.
Navigation is clearer for residents and staff	• Implement simple, local “where to go” messaging and staff navigation guides.	• Improve consistency across services.	• Strengthen inclusion (language, digital exclusion).	• Maintain clarity and refresh materials.	• Navigation remains clear and trusted locally.

2. Primary Care & Community Access

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
General practice access improvement is delivered in practice	• Implement contract-aligned access processes (including core-hours, online consultation).	• Improve reliability and reduce queues and call failures.	• Sustain high reliability during peak demand.	• Maintain resilience and access standards.	• Access consistently reliable year-on-year.
Same-day consultation is safe and reliable	• Implement triage and same-day capacity models with clear clinical governance.	• Improve equity and continuity.	• Reduce unnecessary handoffs to urgent care/ED.	• Sustain safe same-day capacity.	• Same-day model stable and embedded.
Community providers support joined-up access	• Align referral routes, advice lines, and response expectations.	• Reduce duplication and delays.	• Improve integration with INTs.	• Sustain integrated access model.	• Joined-up access embedded across services.
Neighbourhood health centres operate as services	• Stand up staffing, booking, and operational processes.	• Expand service range.	• Improve experience and flow.	• Sustain quality and throughput.	• Centres functioning as core access hubs.
Diagnostics pathways improve	• Implement community diagnostic capacity and clearer criteria.	• Reduce waiting times and repeats.	• Expand for priority cohorts.	• Sustain consistent diagnostic turnaround.	• Diagnostics embedded in routine care pathways.
Community waits reduce through pathway redesign	• Redesign high-wait pathways.	• Deliver measurable reductions.	• Sustain reduced waiting times.	• Maintain stability through demand changes.	• Reduced waits embedded in routine performance.
Navigation and communication improve	• Provide consistent information and warm handovers.	• Improve based on feedback.	• Reduce avoidable re-direction and duplication.	• Sustain clear communication model.	• Navigation and communication embedded in daily practice.

3. The Acute-Community Interface (Urgent & Planned Care)

South East London Integrated Care System

Nationally, the expectations so far include:

- By 2028, support more people to book into the most appropriate urgent care service via NHS 111 or the NHS App before attending (optional, but intended to reduce long waits and enable earlier triage).
- By 2028, the NHS App will include “My NHS GP”, an AI enabled tool to help people navigate to the right service when they do not need emergency care.
- Invest up to £120m to develop more Mental Health Emergency Departments (MHEDs), with a national ambition (over the first half of the Plan) to reach around 85 MHEDs, co located (or very close to) 50% of type 1 A and E units, providing rapid assessment typically within 4 hours and same day access to specialist support.
- Expand Same Day Emergency Care (SDEC) and co located Urgent Treatment Centres (UTCs), and use digital tools to improve triage, flow and discharge.
- Systems are expected to set out how they will expand access to urgent and emergency care at home and in the community, including understanding virtual ward capacity and planning with ambulance services and NHS 111.
- Long term ambition: end hospital outpatients as we know it by 2035 by moving more urgent and planned care into community settings and neighbourhood health centres.
- Restore the elective constitutional standard of 92% of patients starting elective treatment within 18 weeks.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Avoiding avoidable hospital use (emergency admissions for older people, unplanned admission rates).
- Faster, safer discharge and reduced delays (average discharge delay, discharge on discharge ready date, days from discharge ready date to discharge).
- Strong intermediate care and reablement pathway (older people discharged into reablement who remain in the community at 12 weeks, reablement effectiveness).
- Reducing step up and step down friction (metrics and assurance focused on flow, delayed discharge, and preventing readmission driven escalation).

3. The Acute-Community Interface (Urgent & Planned Care)

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Eliminate very long emergency department waits (protect people from unsafe and undignified delays)	• Set SEL definition and measurement for "very long waits" and require a system plan that addresses flow end to end (ED, wards, discharge, community capacity).	• Hold Places and providers to a clear improvement trajectory and intervene where performance is persistently unsafe.	• Aim for sustained elimination of 12+ hour waits through stable capacity and flow processes, not short-term escalation only.	• Maintain resilience and rapid support during pressure.	• Long ED waits consistently avoided across SEL.
Create a single SEL urgent care access model that becomes bookable by 2028	• Align commissioning of 111, UTCs, SDEC and community urgent response so access routes are consistent and understandable.	• Scale consistent booking and redirection processes across SEL.	• Deliver the 2028 "book before you arrive" expectation across services.	• Improve equity and usability (language, digital inclusion).	• Urgent care access embedded system-wide.
Expand alternatives to admission so people get timely care without avoidable hospital stays	• Commission consistent expectations for SDEC, frailty response, crisis alternatives and urgent community support.	• Scale across all Places and providers with shared operating standards.	• Improve integration so people do not fall through gaps between services.	• Sustain integrated acute-community pathways.	• Admission avoidance embedded system-wide.
Virtual wards and hospital at home are safe, integrated and scaled	• Set SEL model: inclusion criteria, clinical governance, escalation, and how primary/community teams are involved.	• Expand capacity and consistency, focusing on step-up and step-down pathways.	• Move towards the national scale ambition through reliable staffing, pathways, and measurement.	• Improve quality and outcomes.	• Virtual wards routine part of pathway model.
Discharge and transfer of care are joined up (people leave hospital safely with support in place)	• Align discharge approach across SEL and remove predictable blockers (handovers, step-down commissioning, social care interfaces).	• Reduce delays through consistent multi-agency working and clear escalation.	• Improve outcomes (fewer readmissions, better experience).	Strengthen LA and VCSE integration.	Discharge consistently timely and coordinated.
Planned care pathways shift work out of hospital where appropriate (PIFU, community one-stop, fewer unnecessary follow-ups)	• Implement PIFU where appropriate and redesign pathways that drive high follow-up volumes.	• Expand redesigned pathways across specialties with greatest benefit.	• Improve productivity and reduce waits without compromising quality.	Sustain appropriate activity shift.	Planned care consistently delivered in most appropriate setting.
Learning and improvement is routine across the interface	• Establish SEL learning loop: what changed, what impact, what to scale.	• Use learning to target resources to what works.	• Maintain shared learning across all boroughs and providers.	Sustain shared improvement culture.	Continuous system learning embedded.

3. The Acute-Community Interface (Urgent & Planned Care)

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Very long ED waits reduce because the whole system works better	• Implement local flow and discharge improvement with borough partners and providers.	• Scale improvements and remove recurring blockers.	• Maintain elimination of unsafe waits through stable processes.	• Sustain stable performance through joint review.	• Long ED waits remain eliminated.
Urgent care access is clearer locally	• Align local comms and navigation; strengthen alternatives to ED.	• Improve booking and redirection processes.	• Deliver bookable access model locally.	• Sustain clarity and consistency.	• Urgent care access embedded in routine practice.
Alternatives to admission work in practice	• Stand up local urgent community support pathways and crisis alternatives.	• Improve integration with ED, UTC, ambulance and primary care.	• Demonstrate reduction in avoidable admissions.	• Sustain and optimise alternatives.	• Admission avoidance routine and reliable.
Virtual ward pathways are integrated locally	• Mobilise local pathways and roles to support step-up/step-down.	• Improve quality and experience.	• Expand coverage and eligibility.	• Sustain safe delivery at scale.	• Virtual wards embedded in routine pathway.
Discharge is joined up with local authority and VCSE	• Strengthen discharge planning and step-down support.	• Reduce delays and improve experience.	• Sustain timely discharge.	• Improve continuity post-discharge.	• Discharge consistently joined up.
Planned care shifts appropriately	• Implement pathway changes locally.	• Expand community-based planned care.	• Reduce unnecessary acute follow-ups.	• Sustain appropriate activity shift.	• Planned care appropriately located long term.
Learning is shared locally	• Run regular learning sessions and “what we changed” reviews.	• Share learning across neighbourhoods.	• Embed improvement cycles.	• Sustain collaborative learning culture.	• Continuous improvement routine locally.

3. The Acute-Community Interface (Urgent & Planned Care)

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
ED flow improves and long waits reduce	• Implement internal flow improvements and escalation processes.	• Reduce long waits and improve 4-hour performance.	• Sustain improved flow and eliminate unsafe waits.	• Maintain stable processes year-round.	• Long waits consistently avoided.
Alternatives to admission reduce bed use	• Embed admission avoidance pathways in clinical practice.	• Expand alternatives to additional cohorts.	• Reduce non-elective bed days for priority groups.	• Sustain reduced admission rates.	• Admission avoidance embedded in routine care.
Virtual wards integrated into acute pathways	• Implement virtual ward eligibility and referral processes.	• Expand appropriate patient cohorts.	• Integrate monitoring and escalation.	• Sustain quality and safety.	• Virtual ward embedded in routine discharge model.
Discharge improves and delays reduce	• Improve discharge planning and coordination.	• Reduce length of stay and discharge delays.	• Sustain reduced delays.	• Improve post-discharge continuity.	• Discharge stable and timely.
Planned care redesign reduces unnecessary acute activity	• Expand straight-to-test and one-stop pathways.	• Reduce follow-up burden where clinically safe.	• Shift appropriate activity into community settings.	• Sustain planned care transformation.	• Planned care model optimised.
Learning drives pathway improvement	• Use pathway audits and feedback to refine models.	• Share learning across services.	• Embed improvement cycles in governance.	• Sustain continuous pathway improvement.	• Data-driven improvement routine.

4. Prevention & Health Inequalities

South East London Integrated Care System

Nationally, the expectations so far include:

- Shift from treating sickness to preventing ill health and slowing exacerbation.
- Planning expectations to identify underserved communities and surface inequalities.
- Halve the gap in healthy life expectancy between richest and poorest regions.
- Increase healthy life expectancy for everyone and raise the healthiest generation of children ever.
- Improve vaccination, screening and early diagnosis uptake.
- Deliver the Tobacco and Vapes Bill and reduce youth vaping.
- Take stronger action on obesity, including junk food advertising restrictions and industry measures.
- Tackle harmful alcohol consumption.
- Publish and implement an HIV action plan, including tackling inequalities in testing and access to prevention.
- Scale an NHS Health Check online offer.
- Join up support across work, health and skills systems.
- Introduce incentives and campaigns to support healthier behaviours.
- Evaluate and implement breakthrough early detection technologies where proven.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Healthier lives and narrowing gaps (healthy life expectancy, disability free life expectancy, inequality in healthy life expectancy).
- Tackling key preventable risk factors (smoking, maternal smoking at delivery, obesity in adults and children, physical inactivity).
- Preventable illness and early intervention (cardiovascular prevention measures, health checks activity where included, preventable mortality).
- Alcohol and substance related harm (alcohol related hospital admissions, drug treatment outcomes such as successful completion).
- Multiple disadvantage drivers of poor outcomes (rough sleeping persistence, homelessness duties and temporary accommodation measures, continuity of care for prison leavers, and placeholders for domestic abuse and mental ill health where metrics are still being developed).
- Prevention in wider determinants of health (housing insecurity and rough sleeping as prevention priorities, not just housing system measures).

4. Prevention & Health Inequalities

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention priorities are agreed across SEL and aligned to HWB plans	• Set SEL-wide prevention priorities and minimum expectations aligned to JSNAs and HWB strategies.	• Require Place plans to demonstrate delivery against shared priorities.	• Strengthen consistency and reduce variation in outcomes between boroughs.	• Refine priorities based on outcome data and emerging need.	• Prevention priorities embedded and reviewed as part of routine system planning.
Vaccination and screening uptake improves for underserved groups	• Align commissioning levers and reporting to focus on underserved populations.	• Support Places/providers to scale targeted outreach.	• Maintain improved uptake and reduce gaps.	• Narrow variation across boroughs.	• Sustained high uptake with reduced inequality gap.
Tobacco, obesity and alcohol harm reduction is embedded in health and care pathways	• Set SEL expectations for prevention conversations, referrals and consistent support offers.	• Expand delivery through neighbourhood teams and community partners.	• Improve outcomes and reduce inequity in smoking, obesity and alcohol harm.	• Sustain behaviour change support at scale.	• Harm reduction embedded in routine care pathways.
Falls and frailty prevention reduces avoidable harm and admissions	• Set a SEL model for proactive frailty and falls prevention.	• Scale across boroughs with consistent measurement.	• Reduce avoidable admissions and improve quality of life.	• Sustain and optimise proactive identification.	• Frailty prevention embedded across system.
Maternal and child health and early help improve outcomes	• Align commissioning to reduce inequalities in early years outcomes.	• Scale targeted support where outcomes are poorest.	• Demonstrate narrowing of early years inequality gaps.	• Embed early help model across boroughs.	• Improved maternal and child health outcomes sustained.
Inclusion health is addressed through joined-up services	• Commission consistent expectations for integrated support pathways (e.g. homelessness, asylum seekers, severe mental illness).	• Scale and improve access to inclusion health services.	• Monitor reduction in inequities for inclusion groups.	• Sustain integrated delivery.	• Inclusion health embedded within neighbourhood model.

4. Prevention & Health Inequalities

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
HWB-led neighbourhood health plans drive prevention delivery	• Refresh JSNA insights into practical neighbourhood priorities and delivery plans.	• Implement and scale prevention actions.	• Reduce variation across neighbourhoods.	• Strengthen consistency of delivery.	• Prevention delivery embedded in neighbourhood model.
Vaccination and screening gaps narrow	• Target outreach with communities least served.	• Expand community-based vaccination and screening access.	• Demonstrate improved uptake in priority groups.	• Reduce inequalities in coverage.	• High, equitable uptake sustained.
Tobacco, obesity, alcohol harms reduce through practical support	• Implement local prevention pathways and community offers.	• Increase referrals and uptake of support services.	• Demonstrate reduction in smoking prevalence and harmful drinking in target groups.	• Sustain behaviour change support.	• Harm reduction embedded in routine neighbourhood practice.
Falls and frailty prevention becomes routine	• Implement proactive identification and interventions locally.	• Expand reach of frailty reviews.	• Reduce avoidable falls and crisis admissions.	• Sustain proactive case-finding model.	• Frailty prevention routine across borough.
Maternal/child health and SEND early help improve	• Align local partners and pathways.	• Target early help support where outcomes are poorest.	• Reduce variation in early years outcomes.	• Sustain improved pathways.	• Improved early years outcomes embedded.
Inclusion health pathways work better	• Build integrated offers with partners (LA, VCSE).	• Improve access for inclusion groups.	• Monitor and reduce inequity in service access.	• Sustain integrated model.	• Inclusion health embedded locally.

4. Prevention & Health Inequalities

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention is embedded in routine care	• Train and support staff to deliver consistent prevention conversations and referrals.	• Increase referral and follow-through rates.	• Embed prevention prompts in pathways.	• Sustain prevention delivery in routine care.	• Prevention conversations standard across services.
Vaccination/screening outreach improves	• Deliver targeted approaches with Places.	• Expand outreach clinics and flexible access.	• Improve uptake in underserved groups.	• Sustain high uptake.	• Equitable coverage embedded.
Falls and frailty prevention reduces harm	• Implement proactive interventions in pathways.	• Expand proactive reviews and multidisciplinary input.	• Reduce avoidable admissions.	• Sustain proactive frailty model.	• Frailty prevention embedded in provider pathways.
Maternal/child and early help support improves	• Implement pathway improvements.	• Strengthen partnership with community services.	• Improve early intervention coverage.	• Sustain improvements.	• Early help integrated in routine care.
Inclusion health delivery improves	• Implement integrated pathways for inclusion groups.	• Increase engagement and access.	• Reduce inequity in outcomes.	• Sustain inclusive practice.	• Inclusion health embedded.

5. Population Health Management (PHM)

South East London Integrated Care System

- The 10 Year Health Plan explicitly links neighbourhood health services with a genomics population health service to enable more predictive and preventative care (anticipating need, not only reacting).
- National expectation that population health data is used to identify groups who need proactive support (eg frequent A&E attenders) and intervene earlier.
- The planning framework requires plans to be underpinned by robust analytics, including:
    - population health needs assessment identifying underserved communities and inequalities
    - demand and capacity analysis
    - workforce analytics and financial forecasts
- Primary care contract incentives require risk stratification (via CAIP) to identify those who would benefit most from continuity of care.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Understanding need and targeting the right cohorts (population segmentation, risk stratification, identifying rising risk groups).
- Tracking neighbourhood level wellbeing and cohesion (belonging, trust, ability to influence decisions, loneliness, perceptions of safety).
- Neighbourhood safety and harm indicators (neighbourhood crime, anti social behaviour, serious violence where included).
- Place based protective factors (access to green and blue space, civic participation and volunteering).
- System level insight development (development of system level measures for complex issues such as multiple disadvantage, including data improvement ambitions).

5. Population Health Management (PHM)

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Single Segmentation Framework	• Agree a single SEL segmentation model for neighbourhood use.	• Ensure all boroughs applying segmentation in planning and reporting.	• Refine segmentation using outcome and utilisation data.	• Align segmentation directly to contracting and investment decisions.	• Segmentation routinely drives system resource allocation.
PHM Embedded in Commissioning	• Require PHM evidence in business cases and service redesign proposals.	• Link investment decisions to identified high-risk cohorts.	• Increase proportion of spend explicitly linked to segmented cohorts.	• Demonstrate measurable shift in resource to priority populations.	• Commissioning fully population-led and prevention-focused.
System-Level Dashboards & Oversight	• Publish standardised neighbourhood PHM dashboard metrics.	• Use dashboards in system performance reviews.	• Intervene where borough performance against cohorts lags.	• Reduce unwarranted system-level variation.	• PHM metrics embedded in routine oversight.
Proactive Care Model Framework	• Define system expectation for proactive case finding and review cycles.	• Monitor borough expansion beyond highest-risk cohort.	• Require measurable proactive coverage across priority cohorts.	• Optimise model based on outcomes and learning.	• Proactive population management embedded system-wide.
Variation Reduction at Neighbourhood Level	• Define common variation indicators.	• Publish comparative neighbourhood data.	• Require action plans where unwarranted variation persists.	• Demonstrate narrowing of variation across system.	• Variation management routine and sustained.
Safe Information Sharing Standards	• Confirm system information-sharing principles and participation requirements.	• Assure cross-provider participation.	• Address gaps in data completeness and participation.	• Maintain high compliance.	• Trusted, routine data sharing embedded.

5. Population Health Management (PHM)

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Segmentation Used to Target Neighbourhood Action	• Implement common segmentation in neighbourhood planning.	• Use segmentation to define local priority cohorts.	• Update segmentation annually using outcome data.	• Embed segmentation in commissioning cycles.	• Segmentation drives routine planning and delivery.
Neighbourhood Dashboards Used in Practice	• Stand up local reporting and review cycles.	• Embed dashboards in MDT and neighbourhood meetings.	• Use dashboards to track proactive cohort outcomes.	• Refine metrics and escalate gaps.	• Dashboard use routine and embedded.
PHM Informs Local Commissioning & Investment	• Use PHM insights to shape local priorities and investments.	• Align contracts and incentives to priority cohorts.	• Track spend and outcomes for targeted populations.	• Adjust investment based on measured impact.	• Commissioning consistently PHM-led.
Proactive Case Finding Becomes Routine	• Start with proactive groups. (e.g. frailty, LTC)	• Expand to additional cohorts.	• Embed proactive reviews into routine workflow.	• Sustain coverage and reduce avoidable deterioration.	• Proactive model fully embedded.
Variation Reduction is Active Work	• Identify neighbourhood gaps and implement action plans.	• Monitor variation across practices and teams.	• Demonstrate measurable reduction in unwarranted variation.	• Sustain reduced variation.	• Variation management routine and expected.
Safe Information Sharing is Routine	• Implement practical information-sharing workflows.	• Embed shared data use in MDTs.	• Resolve workflow barriers to safe sharing.	• Maintain compliance and confidence.	• Cross-provider sharing fully routine.

5. Population Health Management (PHM)

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Segmentation & Targeting Used Clinically	• Train teams and implement segmentation workflows.	• Apply segmentation routinely in care reviews.	• Expand segmentation use across key pathways.	• Refine cohorts using outcome data.	• Segmentation embedded in routine clinical decision-making.
Dashboards Inform Care & Improvement	• Use dashboards in MDTs and service reviews.	• Track cohort outcomes and escalate deterioration.	• Embed dashboard review in governance cycles.	• Use data to redesign pathways.	• Data-driven improvement routine.
Proactive Care Reduces Deterioration	• Implement proactive reviews and early intervention.	• Expand proactive coverage to additional cohorts.	• Reduce avoidable admissions and crises.	• Sustain proactive approach across services.	• Proactive care model embedded.
Variation Reduction is Active	• Audit pathways and address unwarranted variation.	• Monitor improvement and close gaps.	• Demonstrate measurable improvement.	• Sustain reduced variation.	• Continuous variation management embedded.
Information Sharing Works Safely	• Use agreed shared data processes in care delivery.	• Integrate shared record into proactive workflows.	• Remove operational barriers to safe sharing.	• Maintain consistent compliance.	• Safe information sharing routine.

6. The Integrator & System Architecture

Nationally, the expectations so far include:

- Introduce a revised foundation trust framework based on system archetypes.
- Establish Integrated Health Organisation (IHO) contracts as contract-based delivery models.
- IHO contracts to hold end-to-end responsibility for defined populations.
- Shift resources from hospital-based care toward integrated, preventative, neighbourhood-aligned models.
- ICBs to take on greater leadership responsibility for commissioning.
- ICBs to assume commissioning responsibility for screening services.
- ICBs to assume commissioning responsibility for vaccination services.
- ICBs to assume commissioning responsibility for health and justice services (subject to legislation).
- Oversight to focus on improvement, including peer support and tailored interventions.
- Move away from creating new statutory bodies in favour of contractual system models.
- Develop cross-sector capability frameworks.
- Develop advanced practice models for nurses, midwives and allied health professionals with appropriate accreditation and regulation.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Joint planning and delivery requirements (joint plan agreement, delivery against objectives, compliance with funding conditions).
- Assurance and oversight (plan approval outcomes, escalation where performance concerns arise, step down once improvements are embedded).
- Reporting and governance cadence (quarterly progress reporting and monitoring expectations).
- Partnership effectiveness (shared accountability, leadership and governance across partners, and practical multi agency ways of working).
- Outcomes based commissioning direction of travel (moving towards outcomes focused arrangements where referenced).

6. The Integrator & System Architecture

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Define System Architecture Model	• Confirm SEL system archetype and contract-based delivery model.	• Clarify where integrator functions sit within governance.	• Align system oversight to architecture model.	• Review architecture effectiveness.	• Mature, stable contract-based system architecture embedded.
Define Integrator Role & Scope	• Specify integrator functions (data, workforce, estates, back-office, planning).	• Formalise integrator responsibilities through governance.	• Embed integrator role across neighbourhood model.	• Refine scope based on performance.	• Integrator model stable and clearly understood.
Transfer of Commissioning Functions	• Confirm commissioning functions transferring to ICB (screening, vaccination, health & justice).	• Establish governance for transferred functions.	• Embed accountability and reporting lines.	• Optimise commissioning performance.	• Full commissioning accountability embedded.
IHO / Contract-Based Population Responsibility	• Define approach to end-to-end population responsibility via contracts.	• Implement contract mechanisms reflecting defined populations.	• Monitor resource shift toward neighbourhood delivery.	• Refine contracts to strengthen prevention focus.	• Population-based accountability embedded in contract model.
Risk & Performance Flow	• Define risk-sharing and performance oversight framework for integrators.	• Ensure clear reporting and escalation mechanisms.	• Embed risk and performance flow across neighbourhoods.	• Refine based on system learning.	• Stable risk governance across system architecture.
Maturity Framework & Development	• Define integrator maturity matrix.	• Assess readiness across SEL.	• Provide central support to address gaps.	• Review maturity progress.	• High maturity integrator model across system.
Hosting Enabling Functions	• Confirm which enabling functions sit at integrator level.	• Transition agreed functions to integrator hosting.	• Embed shared services operating model.	• Optimise shared service efficiency.	• Shared enabling model operating at scale.

6. The Integrator & System Architecture

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Neighbourhood Architecture Alignment	• Align borough governance to agreed system architecture.	• Embed integrator role within neighbourhood model.	• Strengthen borough-level accountability for defined populations.	• Review local architecture effectiveness.	• Stable neighbourhood architecture embedded.
Population Accountability	• Define borough-level population cohorts aligned to contracts.	• Monitor resource flow toward neighbourhood delivery.	• Demonstrate shift from hospital to integrated model.	• Optimise population-based delivery.	• Population accountability routine at borough level.
Shared Enabling Functions	• Identify borough functions transitioning to integrator hosting.	• Implement shared service arrangements.	• Embed shared back-office and support functions.	• Optimise efficiency locally.	• Shared enabling model stable and efficient.
Governance & Risk Alignment	• Align borough governance with integrator reporting structure.	• Embed performance and risk reporting flows.	• Refine based on system oversight feedback.	• Sustain governance maturity.	• Borough governance aligned to system architecture.
Maturity Development	• Complete maturity self-assessment.	• Address priority capability gaps.	• Improve readiness and equity of voice across partners.	• Sustain maturity growth.	• High maturity neighbourhood model embedded.

6. The Integrator & System Architecture

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Contract-Based Delivery Model	• Operate under agreed contract-based system archetype.	• Embed population responsibility within service design.	• Align internal planning to neighbourhood contract requirements.	• Refine services to support prevention model.	• Fully embedded population-based delivery.
Participation in IHO / Population Model	• Align service delivery to defined population cohorts.	• Monitor activity and resource shift toward integrated care.	• Adjust internal resource allocation accordingly.	• Sustain integrated model of care.	• Provider model aligned to neighbourhood-first architecture.
Shared Services Participation	• Transition agreed enabling functions to integrator hosting.	• Embed shared service arrangements.	• Optimise operational interfaces.	• Maintain efficiency and accountability.	• Stable participation in shared enabling model.
Risk & Performance Accountability	• Comply with integrator performance and reporting requirements.	• Align internal governance to system risk flows.	• Demonstrate performance against population outcomes.	• Sustain performance transparency.	• Routine accountability within system architecture.
Prevention & Resource Shift	• Begin shifting resource emphasis from acute to integrated pathways.	• Increase neighbourhood-based service delivery.	• Demonstrate measurable shift in service mix.	• Sustain prevention-oriented delivery.	• Provider operating within prevention-led architecture.

7. Workforce, Leadership & Culture: National Expectations

South East London Integrated Care System

Nationally, the expectations so far include:

- Implement the 10 Point Plan for resident doctors.
- Workforce plans must triangulate with finance and activity plans.
- Deliver integrated multi-year workforce planning aligned to service demand.
- Reform statutory and mandatory training frameworks to reduce burden and duplication.
- Embed service-level and multi-professional job planning linked to demand and capacity.
- Achieve full annual sign-off of consultant and multi-professional job plans.
- Track job-planned activity against delivered activity.
- Reduce reliance on agency staffing and deliver a clear reduction trajectory.
- Develop and implement cross-sector capability frameworks.
- Expand advanced practice roles for nurses, midwives and allied health professionals.
- Improve supervision, training experience and rota stability for doctors in training.
- Shift workforce capacity upstream into prevention and neighbourhood models of care.
- Optimise skill mix to maximise productivity and professional scope of practice.
- Strengthen system and regional leadership accountability through named SRO roles.
- Implement leadership development programmes aligned to system transformation.
- Address racism, discrimination and misconduct through measurable action plans.
- Improve staff experience, engagement and retention metrics.
- Reduce sickness absence and improve workforce wellbeing.
- Strengthen organisational development to support cross-sector collaboration
- Establish transparent workforce data and reporting to support planning and oversight.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Workforce stability in adult social care and children's social care (turnover and vacancy rates).
- Capacity to deliver integrated neighbourhood models (ability to staff multidisciplinary teams and key roles).
- Leadership and culture for change (test and learn, shared practice across partners, culture that supports integration and continuous improvement).

7. Workforce, Leadership & Culture

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Workforce Plans Aligned to Finance & Activity	• Publish integrated workforce plan aligned to financial and activity plans.	• Embed triangulated workforce planning across providers.	• Assure job-planned activity matches demand trajectory.	• Use workforce model to support service redesign.	• Workforce planning fully integrated into system planning cycles.
Consultant & Multi-Professional Job Planning Reform	• Agree system expectations for transparent job planning.	• 95% of job plans signed off annually.	• Full tracking of job-planned vs delivered activity.	• Optimise job planning to support neighbourhood model.	• Mature, transparent job planning embedded across system.
Reduction in Agency Use	• Establish baseline agency spend and reduction trajectory.	• Deliver measurable agency reduction.	• Agency use materially reduced across system.	• Continue reduction trajectory.	• Agency reliance eliminated or minimal by 2029/30.
Statutory & Mandatory Training Reform	• Reform local S&M training delivery to reduce duplication and burden.	• Align training to service-level workforce needs.	• Embed streamlined training model across organisations.	• Monitor compliance and impact on productivity.	• Efficient, demand-aligned training model routine.
10 Point Plan for Resident Doctors	• Implement system-level actions from 10 Point Plan.	• Monitor rota gaps and supervision standards.	• Improve training experience metrics.	• Maintain compliance and quality standards.	• Stable, high-quality training environment.
Cross-Sector Capability Framework	• Define system skills and capability requirements (including PHM, MDT working).	• Align training and recruitment to capability gaps.	• Embed cross-sector working expectations in role design.	• Monitor capability maturity across services.	• Cross-sector workforce capability embedded.
Leadership Model Reform	• Establish clear system SRO roles for major change programmes.	• Implement leadership development programmes across system.	• Align leadership accountability to delivery outcomes.	• Review leadership effectiveness.	• Stable, accountable system leadership culture.
Workforce Shift to Proactive & Community Care	• Define target workforce shift toward neighbourhood and prevention model.	• Begin reallocating roles to upstream care.	• Increase proportion of workforce in community settings.	• Optimise workforce distribution.	• Workforce model aligned to neighbourhood-first delivery.
Culture & Inclusion	• Use staff survey data to address priority cultural issues.	• Demonstrate improvement in staff experience metrics.	• Embed anti-racism and inclusion programmes.	• Sustain culture improvement trajectory.	• Positive, inclusive culture evidenced in survey trends.

7. Workforce, Leadership & Culture

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Neighbourhood Workforce Model	• Map local workforce baseline across neighbourhood services.	• Implement INT/MDT staffing model aligned to demand.	• Increase workforce operating in neighbourhood teams.	• Optimise skill mix locally.	• Stable neighbourhood workforce embedded.
Job Planning & Workforce Efficiency	• Ensure local compliance with job planning standards.	• Monitor job-planned vs delivered activity.	• Improve workforce productivity locally.	• Sustain workforce performance.	• Mature, transparent workforce management locally.
Agency Reduction	• Set borough-level agency reduction plan.	• Deliver measurable reduction.	• Continue downward trajectory.	• Sustain reduced reliance.	• Agency use minimal locally.
Training & Skills Development	• Identify local skills gaps (PHM, MDT working).	• Expand training beyond trust boundaries where needed.	• Embed new skills in neighbourhood roles.	• Maintain training aligned to demand.	• Skills profile aligned to neighbourhood model.
Leadership & OD	• Clarify borough leadership roles for transformation.	• Implement local leadership development support.	• Strengthen cross-organisational collaboration.	• Review leadership effectiveness.	• Stable collaborative leadership culture.
Culture & Staff Experience	• Address key local staff survey issues.	• Demonstrate improvement in sickness and engagement metrics.	• Sustain culture improvement.	• Embed inclusive working practices.	• Positive staff experience sustained locally.

7. Workforce, Leadership & Culture

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Consultant & Multi-Professional Job Planning	• Ensure annual job plan sign-off.	• Track job-planned vs delivered activity.	• Align job planning to productivity expectations.	• Optimise job plan flexibility.	• Mature, transparent job planning model embedded.
Workforce Productivity (≥2%)	• Deliver workforce productivity improvement aligned to system plan.	• Reduce variation in productivity across teams.	• Embed productivity in workforce governance.	• Sustain productivity gains.	• Workforce productivity embedded in routine practice.
Agency Reduction	• Reduce agency usage against agreed trajectory.	• Continue reduction plan.	• Maintain lower reliance levels.	• Optimise workforce stability.	• Agency use minimal.
Training Reform & Compliance	• Implement streamlined statutory training.	• Align training delivery to workforce demand.	• Improve training completion and quality metrics.	• Sustain efficient training model.	• Training fully embedded and proportionate.
Resident Doctor 10 Point Plan	• Implement required local changes.	• Improve training environment and supervision.	• Maintain rota stability and quality standards.	• Sustain training quality.	• High-quality training environment stable.
Advanced Practice & Skill Mix Reform	• Expand advanced practice roles in line with national direction.	• Optimise skill mix within teams.	• Embed advanced roles into pathway design.	• Sustain advanced practice model.	• Mature advanced practice workforce in place.
Leadership Accountability	• Clarify executive and clinical leadership accountability.	• Align leadership roles to delivery metrics.	• Strengthen leadership visibility and engagement.	• Review leadership effectiveness.	• Stable, accountable leadership culture.
Culture & Inclusion	• Address staff survey themes and misconduct concerns.	• Demonstrate improved staff experience scores.	• Embed inclusive working culture.	• Sustain improvement trajectory.	• Positive, inclusive workforce culture embedded.

8. Digital, Data & Technology: National Expectations

South East London Integrated Care System

Nationally, the expectations so far include:

- NHS App to function as the primary digital front door for non-urgent care.
- Majority of routine appointments to be digitally bookable post-triage.
- Digital triage and access models to be implemented across primary and neighbourhood services.
- 100% provider coverage of Electronic Patient Records meeting minimum national capability standards.
- Structured clinical data capture to replace reliance on unstructured records.
- Interoperability between acute, community and primary care systems using national standards.
- All providers to connect to and use a Shared Care Record.
- Data Platform to be adopted for elective, urgent and emergency, and population health use cases.
- System operational planning to use analytics outputs.
- Required national datasets (including AACC updates) to be implemented in full.
- Data completeness and coding quality to meet national reporting standards.
- Remote monitoring to be expanded for long-term conditions.
- Majority of long-term condition patients to have a digital care plan.
- Virtual and remote care models to be embedded within neighbourhood delivery.
- Nationally supported AI diagnostic and administrative tools to be deployed.
- AI tools to be embedded into routine clinical and operational workflows where proven safe and effective.
- Digital communication (results, reminders, follow-up messaging) to be routinely delivered via digital channels.
- Population health management analytics to inform resource allocation and planning.
- Real-time data to support demand, capacity and performance management.
- Systems to operate within a nationally defined digital capability and interoperability framework.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Shared data and measurement infrastructure (development and rollout of a national or local outcomes data tool, and local capacity to use it).
- Data quality and linkage (governance for better data, shared data feeds where possible, improved use of multiple sources such as JSNAs).
- Digital inclusion and connectivity (gigabit capable broadband coverage, full fibre and 5G coverage where included).
- Metric pipeline milestones (some measures are explicitly placeholders pending stronger datasets, and some are expected to come in later).

8. Digital, Data & Technology

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Digital Access Standard (NHS App & Digital Front Door)	• Agree single SEL digital access standard aligned to NHS App.	• Assure majority routine appointments are made digitally bookable across providers.	• Monitor digital uptake and address variation.	• Digital-first access consistent across neighbourhood services.	• NHS App established as default non-urgent access route system-wide.
EPR Interoperability Across System	• Confirm all providers meet national EPR minimum capability.	• Require structured data exchange across providers.	• Assure interoperability across priority pathways.	• Close remaining interoperability gaps.	• Fully interoperable system-wide record exchange assured.
Shared Care Record Adoption	• Ensure all providers connected to Shared Care Record.	• Assure routine use in neighbourhood MDTs.	• Monitor completeness and usage across system.	• Address gaps in participation or usage.	• Shared Care Record embedded across system.
Federated Data Platform (FDP)	• Onboard SEL to priority national FDP use cases.	• Use FDP analytics in system performance meetings.	• Embed FDP outputs in demand and capacity planning.	• Expand use into neighbourhood performance review.	• FDP routinely supports system optimisation decisions.
Remote Monitoring & Digital Care Plan Coverage	• Set expectation for remote monitoring expansion and digital care plans for LTC.	• Assure scaling across priority pathways.	• Majority LTC patients supported by digital care plans (system-wide).	• Monitor coverage and quality.	• Digital care and monitoring routine across neighbourhood model.
AI Adoption (Nationally Supported Tools)	• Approve priority AI pilots aligned to national programme.	• Assure deployment in agreed services.	• Expand use where proven safe and effective.	• Monitor impact on productivity and outcomes.	• High maturity AI adoption across applicable pathways.
Structured Data & National Dataset Compliance	• Confirm implementation of required national datasets.	• Assure structured recording compliance.	• Use structured data in system reporting.	• Maintain high completeness and accuracy.	• Structured data embedded in planning and oversight.

8. Digital, Data & Technology

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Neighbourhood Digital Access Model	• Implement consistent triage and digital booking routes into neighbourhood teams.	• Increase digital booking uptake locally.	• Majority neighbourhood appointments digitally bookable post-triage.	• Digital-first access embedded across sites.	• Virtual-first neighbourhood model routine.
Shared Care Records Use in MDTs	• Ensure neighbourhood teams actively use Shared Care Record.	• Embed shared record in discharge and MDT processes.	• Majority cross-provider activity supported by shared record.	• Improve completeness locally.	• Shared record standard practice in borough.
Use of Federated Analytics for Planning	• Use FDP outputs in borough elective and UEC discussions.	• Embed analytics into borough demand planning.	• Routine data-driven performance reviews.	• Refine neighbourhood performance using data insights.	• Data-led planning embedded locally.
Remote Monitoring Delivery	• Deliver remote monitoring in selected borough pathways.	• Scale monitoring across neighbourhood teams.	• Integrate monitoring data into care plans.	• Monitoring embedded in pathway design.	• Monitoring routine in borough services.
Digital Care Plan Implementation	• Begin structured digital care plan rollout.	• Expand LTC digital care plan coverage.	• Majority LTC patients supported digitally.	• Maintain coverage and quality.	• Digital care plans embedded in borough delivery.
Local NHS App Adoption	• Ensure borough services publish appointments to NHS App.	• Promote digital booking and messaging.	• Routine use of App for reminders and follow-up.	• Stable digital uptake locally.	• App dominant patient interaction channel locally.

8. Digital, Data & Technology

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
EPR Minimum Capability & Structured Recording	• Meet national EPR capability standards.	• Enable structured referrals and results exchange.	• Structured workflows routine across services.	• Resolve remaining pathway data gaps.	• Fully interoperable provider systems.
NHS App Integration	• Enable appointment publishing and messaging via NHS App.	• Expand booking and communication functionality.	• Deliver results and follow-up messaging digitally.	• Optimise App-enabled workflows.	• App embedded in routine patient interaction.
Shared Care Record Participation	• Connect to Shared Care Record and contribute required data.	• Embed use in clinical workflows.	• Routine cross-provider usage.	• Maintain completeness and accuracy.	• Shared record fully embedded in care delivery.
Federated Data Contribution & Use	• Provide required datasets to FDP.	• Use FDP analytics in operational management.	• Embed analytics into service planning.	• Maintain high-quality data contribution.	• Routine data-driven service management.
Remote Monitoring Capability	• Implement remote monitoring in defined pathways.	• Scale across relevant specialties.	• Use monitoring to reduce unnecessary face-to-face activity.	• Embed in pathway design.	• Remote monitoring routine across relevant services.
Digital Care Plans	• Implement structured digital care plans in LTC pathways.	• Expand coverage.	• Majority LTC patients supported digitally.	• Sustain and optimise quality.	• Digital care plans embedded in routine care.
AI Tools Where Nationally Supported	• Deploy nationally approved AI pilots.	• Expand AI where proven effective.	• Embed AI-supported workflows.	• Optimise AI-supported processes.	• Mature AI adoption embedded in operations.

9. Estates & Infrastructure

South East London Integrated Care System

Nationally, the expectations so far include:

- Define Neighbourhood Health Centre archetypes, including what they should contain and how infrastructure will be delivered.
- Direct capital funding toward areas with low healthy life expectancy.
- Develop ringfenced CYP (children and young people) surgical capacity within existing NHS estate.
- Ensure alignment between estates, workforce and digital infrastructure.
- Support the establishment of functional neighbourhood hubs.
- Link public sector estate and capital investment to integrated neighbourhood working.
- Address physical infrastructure challenges to ensure service continuity during transitions.
- Confirm place opportunity assessment timescales and use outputs to shape estate planning.
- Develop unified estate portfolio strategies over time.
- Co-locate mental health emergency departments with approximately 50% of Type 1 EDs by 2029.
- Enable delivery of neighbourhood-based models through appropriate estate configuration.
- Use capital investment as a catalyst for transformation and performance improvement.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Housing supply ambition and delivery (net additional dwellings, planning timeliness, national home building ambition where stated).
- Housing quality and safety (decent homes, EPC C and above, damp or hazards, cladding remediation, deaths in home fires).
- Homelessness system pressure (temporary accommodation levels and duration, prevention and relief performance).
- Environmental sustainability and climate resilience (emissions per head, recycling and residual waste, flood risk, air quality, tree canopy).
- Local infrastructure supporting daily life (road condition, road safety casualties, EV charging infrastructure where included, public transport measures).

9. Estates & Infrastructure

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
System Estates Strategy	• Publish SEL Estates Strategy aligned to national requirements • Define neighbourhood hub estate specification	• Review and update strategy based on capital approvals and delivery progress	• Embed unified estate portfolio management approach across SEL	• Refresh long-term capital pipeline	• Fully operational unified estate portfolio in place
Capital Prioritisation (Low HLE Focus)	• Produce prioritised capital list focused on low healthy life expectancy areas	• Secure and allocate capital to first wave of projects	• Monitor delivery of funded schemes • Re-prioritise if required	• Continue targeted capital allocation	• Evidence majority of new investment directed to priority geographies
Neighbourhood Health Centre Estate Rollout	• Approve first wave of hub sites • Agree delivery phasing	• Oversee build/refurbishment of wave 1 • Approve wave 2 sites	• Ensure multiple hubs operational across SEL	• Complete build of remaining priority hubs	• Full planned network of neighbourhood hubs physically operational
Estate Consolidation & Disposal Programme	• Identify surplus/underutilised estate • Approve disposal list	• Commence disposals and reinvest receipts	• Continue phased consolidation programme	• Complete majority of planned disposals	• Optimised estate footprint aligned to hub model
Mental Health ED Co-location (Estate Component)	• Agree SEL site list and phasing plan for ED co-location	• Approve capital business cases • Commence builds	• Deliver first tranche of co-located facilities	• Continue rollout toward national trajectory	• Required proportion of Type 1 EDs physically co-located
CYP Surgical Estate Provision	• Identify and designate estate for ringfenced paediatric surgical capacity	• Upgrade/refurbish estate where required	• Review sufficiency of estate capacity	• Expand or optimise estate if required	• Sustained dedicated estate provision for CYP surgery

9. Estates & Infrastructure

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Define Local Neighbourhood Hub Estate Requirements	• Translate SEL hub specification into borough-level options. • Define required services, room numbers, diagnostics, shared space; confirm population catchment	• Refine requirements based on confirmed capital and delivery sequencing	• Update requirements if additional hubs required	• Maintain standardised configuration across borough sites	• Requirements embedded as borough estate standard
Site Identification & Securing Premises	• Identify preferred site(s); assess feasibility • Secure lease/freehold or agree use of NHS-owned estate	• Finalise site acquisition/lease arrangements	• Identify additional site(s) if expansion required	• Secure any further premises for expansion	• Stable site portfolio supporting hub model
Hub Build / Refurbishment Delivery	• Complete outline business case • Commence refurbishment or enabling works	• Complete construction/refurbishment; open first hub	• Deliver additional hub(s) if required	• Complete any remaining capital works	• All planned borough hub estate fully operational
Local Estate Rationalisation	• Map all NHS and partner estate in borough • Identify underutilised buildings	• Develop consolidation plan aligned to hub opening	• Implement closures or repurposing of redundant premises	• Continue phased consolidation	• Borough estate footprint streamlined and aligned to hub model
Primary & Community Service Relocation (Estate Enabling)	• Confirm which services will relocate into hub • Plan decant	• Execute service moves into new hub premises	• Reconfigure or release vacated space	• Complete remaining relocations	• Consolidated primary/community estate footprint embedded
Mental Health ED Co-location (Local Estate Support)	• Work with acute provider to define spatial requirements • Support planning approvals	• Support construction phase (planning, local authority approvals, infrastructure coordination)	• Complete build and enable occupation	• Optimise space utilisation locally	• Co-located estate fully embedded in borough infrastructure
Planning & Local Authority Alignment	• Secure planning permission where required • Align with borough regeneration plans	• Manage planning conditions and compliance	• Ensure estate supports wider civic infrastructure plans	• Maintain compliance and alignment	• Estate integrated into long-term borough development strategy

9. Estates & Infrastructure

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Acute Estate Review	• Conduct internal estate utilisation review	• Identify space for release or reconfiguration	• Implement agreed reconfiguration works	• Align acute footprint to reduced estate need	• Optimised acute estate footprint
CYP Surgical Estate Delivery	• Allocate dedicated theatre/session space • Identify upgrade needs	• Complete minor capital upgrades	• Review capacity utilisation	• Adjust estate allocation if required	• Sustained ringfenced CYP surgical estate provision
Mental Health ED Co-location Build	• Develop detailed estate design	• Commence construction works	• Complete build and commission facility	• Optimise operational use of space	• Embedded co-located emergency estate model
Service Relocation into Hubs (Estate Enabling)	• Identify clinical space suitable for relocation	• Vacate and transfer agreed services	• Reconfigure vacated space for alternative use or disposal	• Continue relocation programme	• Acute estate right-sized following relocations
Estate Compliance & Readiness	• Ensure estates meet regulatory and safety standards for new models	• Upgrade infrastructure where required	• Maintain compliance during consolidation	• Continue lifecycle investment	• Estate fully compliant and maintained

10. Finance, Productivity & Governance: National Expectations

South East London Integrated Care System

Nationally, the expectations so far include:

- Set out a new multi-year financial regime with fair shares allocations, dismantling of block contracts, new UEC payment model, and best-practice tariffs.
- Mandate a simplified “rules-based” operating model that sets outcomes, standards and shared platforms.
- Expand NHS Oversight Framework to include access, quality, finance, people, productivity and “left shift”.
- Development of new payment models that encourage a shift in urgent and emergency cares activity into the community – to be tested, refined and rolled out
- New planning framework embedded
- Prevention funds allocated by need.

Better Care Fund policy framework 2025 to 2026 and Local Outcomes Framework

- Better Care Fund financial requirements (NHS minimum contribution, grant allocations including Disabled Facilities Grant).
- Local financial rules and thresholds (minimum growth requirement in NHS contribution to adult social care, Disabled Facilities Grant maximum per application where stated).
- Wider economic and prosperity context (employment, unemployment, inactivity, earnings, business births, deaths and survival).
- Deprivation and inequality context (indices of multiple deprivation and income deprivation measures).
- Time horizon and refresh cycle (framework period and when it is expected to be refreshed).

10. Finance, Productivity & Governance: National Expectations

South East London Integrated Care System

SEL ICB milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Multi-Year Financial Regime	• Build & agree a multi-year (3–5 yr) financial plan aligned to national multi-year regime	• Embed 3-year plan in organisational budgets; set controls aligned to MTFF	• Refresh plan based on Year 1/2 performance; align future years	• Maintain multi-year control totals	• System delivers integrated multi-year financial plan routinely
Balanced Position & Break-Even	• Set balanced position targets; define productivity challenge based on national >2% expectation	• Deliver first year of ≥2% productivity; reduce deficit reliance	• System on track to break-even; adjust trajectories	• Maintain balanced position with minimal risk	• System delivering break-even without deficit support
Productivity & Granular Costing	• Implement granular costing & productivity dashboards across system	• Use dashboards to drive clinical & operational redesign	• Embed bottom-up cost management in decision making	• Continuous improvement culture with >2% gains	• Productivity routines embedded across organisations
Shift to Prevention & Community Spend	• Agree proportion of investment shift to community & prevention aligned to neighbourhood framework	• Monitor spend shift; refine allocations based on impact measurement	• Increase share of spend in community delivery	• Sustain prevention-oriented allocations	• Prevention spend embedded in routine plans
Neighbourhood Contracting & Risk/Gain Share	• Define neighbourhood contracting principles; test draft risk/gain share models	• Pilot risk/gain share contracting in early neighbourhood contracts	• Expand contracting complexity (lead provider / alliance mechanisms)	• Refine models based on performance data	• Stable population & outcome-based contracting commonplace
Governance & Oversight Alignment	• Align SEL governance with national oversight framework; integrated finance/workforce/quality reporting	• Streamline governance structure; reduce duplicate reporting	• Embed integrated board reporting across boroughs/providers	• Governance review & refinement	• Mature governance routines meeting national oversight expectations
Resource Allocation by Risk/Need	• Develop resource allocation model using PHM & risk indices	• Implement initial allocations by risk & need	• Refine model based on tracing outcomes	• Sustain risk-adjusted allocations	• Routine use of need/risk allocation in planning

10. Finance, Productivity & Governance: National Expectations

South East London Integrated Care System

Place milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Place-Based Financial Framework	• Align borough financial plans to SEL multi-year plan & neighbourhood commissioning principles	• Implement place budgets that reflect prevention and community priorities	• Mature place budget oversight & financial control	• Routine place budgeting tied to outcomes	• Place budgets fully operational, risk-adjusted
Local Productivity Gains (≥2%)	• Deliver ≥2% productivity locally; use cost & activity data	• Consolidate productivity gains; adjust pathways accordingly	• Embed productivity expectations into business plans	• Sustain productivity impact	• Productivity embedded in neighbourhood governance
Neighbourhood Contracting Participation	• Agree to participate in neighbourhood contract pilots	• Engage in risk/gain share arrangements locally	• Evaluate and expand contract participation	• Standard neighbourhood contracts in place	• Fully mature neighbourhood contracting model at place
Outcomes & Transparency Reporting	• Implement local outcomes measurement aligned to SEL framework	• Regular reporting of finance & performance (quarterly)	• Align local reporting to neighbourhood contracts	• Transparent outcomes tied to budgets	• Outcomes performance embedded in local governance
Local Resource Mapping & Shift	• Map local spend & resources; identify opportunities to shift to prevention	• Begin reallocating resources to community/PHM interventions	• Track impact of resource shifts; adjust local allocations	• Continue reallocation based on performance	• Routine PHM-driven budgeting

10. Finance, Productivity & Governance: National Expectations

South East London Integrated Care System

Provider milestones	Year 1	Year 2	Year 3	Year 4	Year 5
Productivity Delivery (≥2%)	• Deliver ≥2% productivity; baseline granular costing	• Sustain ≥2% productivity gains; address variances	• Embed routine productivity measurement	• Continue productivity gains and benchmarking	• Productivity improvement part of organisational culture
Financial Recovery & Break-Even	• Define provider financial recovery plans tied to system control totals	• Reduce reliance on non-recurrent support	• Break-even without additional support	• Maintain financial balance	• Demonstrate sustained financial stability
Cost Transparency & Activity Data	• Deploy granular costing tools; implement activity & cost reporting	• Use data to drive clinical pathway efficiency	• Cost per case improvement embedded in practice	• Routine cost/quality monitoring	• Internal cost management routines well-embedded
Neighbourhood & Risk/Gain Contract Participation	• Engage in early neighbourhood contract test arrangements	• Operate under revised contracting models	• Refine contracting participation (lead/alliances)	• Expand contracting complexity as needed	• Fully engaged in outcome-based contracting models
Governance & Reporting Compliance	• Align governance/reporting to SEL integrated requirements	• Streamline internal reporting systems	• Demonstrate quality, finance & productivity integration	• Ongoing compliance and refinement	• Stable governance aligned with national oversight

CORE REQUIREMENTS FOR INTEGRATORS AND NEIGHBOURHOOD HEALTH AND CARE IN 2026/27

CONTENTS TABLE

Version Control

Version	Shared with	Changes
1	Population ICB leads	Initial draft
2	Planning Directors leading on SIF	Feedback from population groups and digital requirements
3	Shared with PELs	Feedback from SIF leads
4	Shared with NBCB	Feedback from PELs Addition of prevention requirements

1. PURPOSE

This document sets out the minimum standards and requirements for neighbourhood health and care delivery across South East London, to be achieved by the end of the 2026/27 financial year utilizing investment being made available through the NHS South East London ICB Strategic Investment Fund.

The document draws on already agreed South East London-wide (SEL) frameworks, principles and plans and is intended to act as a practical, delivery facing reference for Integrator and Place partnerships on the minimum standards to be achieved with the investment being made available

The document does not reflect the full ambition of neighbourhood care across South East London, and some places will choose to go beyond the minimum standards set here. Equally, additional funds may be invested through place budgets or through shared investment across Integrator and Place partners, which sits outside the scope of this document.

Please refer this section for detail on the process and timescales for integrator hosts to work with their Integrator and Place partnership teams in developing and agreeing the investment and delivery plan aligned to this document.

2. THE INTEGRATOR FUNCTION

In 2025/26, an “integrator” function was developed working along with acute, community, mental health, primary care, VCSFE and local authority partners in each place.

The integrator function, working in partnership, is expected to provide the place-based infrastructure, coordination and leadership required to help enable neighbourhood health and care to function effectively.

Within each integrator function, an “integrator host” organization has been identified in each partnership delivering the integrator function. This host works on behalf of the whole partnership

A. Maturing the function of the integration during 2026/27

The functions of the integrator were defined in 2025/26 and a Maturity Matrix to support integrators to consider the maturity of their local neighbourhood approach and their functional and relational responsibilities. The Maturity Matrix can be found here

From within the maturity matrix, an initial set of priority domains were established for focused work in 2025/26.

During 2026/27 integrators are expected to continue to utilize the maturity matrix to review and assess their maturity against prioritized domains in 2026/27. We would expect this to happen during September 2026 and March 2027. Once maturity has been reviewed and assessed by Integrator and Place partnerships, the updated maturity assessment should be shared with the Director of Delivery of Neighbourhoods and Population Health.

Alongside the domains prioritized in 2025/26, integrators are asked to include focus on the following additional maturity domains during 2026/27:

- Integrated and shared workforce planning
- Supporting segmentation and stratification (in line with SEL-wide approaches)
- Integrated intermediate care with a “Home First” approach
- Collaborative Leadership Development

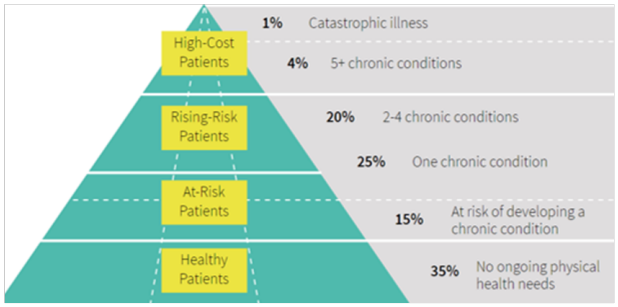
3. NEIGHBOURHOOD HEALTH AND CARE CORE DELIVERY MODEL

A. Neighbourhood Health and Care

Neighbourhood health and care is a population-based approach organised around defined neighbourhood geographies. It aims to meet a greater proportion of health and care needs locally through services that are closely connected to the communities they serve.

This approach emphasises outreach and place-based delivery, making greater use of community settings where people naturally gather and integrating health and care services with wider neighbourhood provision. This includes partnership with VCSFE organisations and other statutory and non-statutory services such as social care, housing, employment, advice and leisure.

Neighbourhood models are tailored to reflect different life stages and levels of health need ensuring care is responsive to the diverse needs of the local population.



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

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

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

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

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

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

B. Integrated Neighbourhood Teams

A key component of neighbourhood health and care are “Integrated Neighbourhood Teams” (INTs), these are multidisciplinary, multi-agency teams delivering proactive, holistic and coordinated care for defined population groups within a defined neighbourhood footprint.

In the main, INTs will consist of existing health, care and VCSFE workforce. The key difference is that instead of care being organized and delivered in a fragmented way across the different organisations in silo, care delivery will be remodeled to:

- Support and enable individual health and care professionals to work as unified and integrated teams to plan and deploy their collective time in alignment with need – leading to a more efficient care model; and
- Ensure that care is proactive and holistic supported by effective digital tools that enable us to better predict need before it arises, and to ensure that our delivery reflects wider wellbeing alongside clinical needs.

C. Core INT Characteristics

At their core and regardless of the population being served, Integrated Neighbourhood Teams must:

a.) **Serve a defined neighbourhood footprint –** Neighbourhood footprints have already been agreed at place level and include both a resident footprint based on geographical boundaries and a "registered patient" footprint based on practice list. Any mutually agreed changes to neighbourhood boundaries, determined via appropriate Place partnership governance, must be communicated to the SEL ICB to ensure that they can be reflected in South East London wide dashboards and reporting.

b.) **Use population health management tools and techniques** to provide proactive and targeted support that meets the needs of defined cohorts. INTs must deliver care to priority populations as set out within each of the following sections, using agreed SEL segmentation definitions and risk stratification approaches.

c.) Deliver the shared SEL Models of Care - This includes delivery of the core functions set out overleaf (and with reference to all three model of care frameworks that can be found here). Places and Integrators may expand beyond these functions as locally determined.

d.) **Consist of a multidisciplinary team spanning primary care, community services, social care and VCSE**. - Teams may consist of some newly recruited roles but will primarily consist of existing staff from across relevant local organisations working in new ways. INTs will also need dedicated input for specialists (i.e. defined levels of consultant, specialist nurse or care professional time) in line with population need. Again, whilst this input may initially be pump-primed, integrators will be expected to support providers to align workforce plans across key services and specialties to reflect neighbourhood models of care and shifting settings of care. Mental health support will be integrated with INTs as a core part of the INT model during 2026/27 (with expectations around this defined by the end of April and shared with integrator hosts and mental health providers)

e.) Develop standard operating procedures that enable the integrated teams to proactively reach identified cohorts rather than maintaining reliance on referral-based mechanisms - This will be supported through the development of population health management capacity, capability and tools. Initially, INTs can and should access Ardens (available across SEL) and other locally developed tools as appropriate to support proactive identification. Guidance on how to enable patient-level data access within Ardens for active case finding can be found here. We will aim to share additional SEL-wide tools to support the proactive

identification of need based on our shared segmentation and stratification approaches during 2026/27 as our system level population health management architecture develops.

f.) **Ensure that a holistic approach is taken to assessing, planning and managing patient needs to enable improved quality of life and experience.** This means investing in the capacity and capability of the INT to undertake holistic assessment aligned to the needs of the patient, co-produce care plans with patients, carers and families as well as utilizing the shared resource and expertise of the MDT, and consider the broader social, economic and wellbeing needs of people under the care of the INT – alongside health and care needs.

D. Our Priority Populations

In 2024/25, we agreed as a system to prioritise the implementation of integrated neighbourhood teams for three population cohorts:

1. Frailty / Ageing Well
2. People living with Multiple Long-Term Conditions (LTCs)
3. Children and Young People with complex care needs

The following sections will set out the minimum requirements for each population cohort in relation to Integrated Neighbourhood Teams. However, operationally these requirements may be delivered through a unified INT in each neighbourhood with a team of teams approach that enables that INT to meet the needs of different population cohorts. The delivery structure is down to integrator partnerships to decide.

4. INT REQUIREMENTS: FRAILTY & AGEING WELL

Frailty / Ageing Well INTs are entering Phase Two across SEL during 2026/27, so the focus will be to refine and standardize the model, expanding the scale of the cohort and the number of neighbourhoods with INTs established.

The minimum consistent model for Frailty / Ageing Well INTs across SEL in 2026/27. Local delivery may add to this model but should not fall below these requirements.

A. Population segment definition

- Registered patients aged 65 years or older across the frailty continuum
- Inclusive of those who are:
    - living in care homes, extra care and supporting housing
    - housebound
    - approaching the end of life or in receipt of palliative care

INTs will utilize risk stratification tools to target available capacity on risk-groups within this overall segment

B. Risk stratification approach

INTs will look after a growing share of the specified population segment as they embed. Initially the focus is on those living with moderate and severe frailty, or those approaching the end of life.

Within the definition above, individuals should be prioritized (in-line with available INT capacity) based on their relative admission risk. In the initial stage, the existing Ardens sQ-Admission Risk Score embedded within EMIS is being used as an interim risk stratification solution across South East London. This tool is based on primary care data only, with the sQ-Admission Risk Score applied to estimate each person's likelihood of unplanned admission. Results are presented through the standard Ardens dashboards.

During 2026/27, we will continue to develop the Population Health Management capacity and capability across the South East London system. As a result, we expect more advanced tools to become available during the year, which will be made available to all INTs and the approach to proactive case finding will evolve over time.

C. Minimum functional requirements of the INT

The minimum functional requirements of Ageing Well / Frailty Integrated Neighbourhood Teams are:

a) **Proactive identification and case finding** – INTs use available tools to seek out people within the neighbourhood geography who fall into the agreement cohort and stratification definitions. Initially, INTs may also choose to use referral routes to maximise throughput, but as PHM tools improve in sophistication and availability the expectation will be for a case finding model to become the norm

b) **Coding of Clinical Frailty scale –** INTs will increase the coding of frailty using the Clinical Frailty Scale in EMIS for all those age 65+ to become more aware of the frailty cohort & to improve validation of case-finding models. CFS must be completed/validated by an appropriately trained clinician. We are not setting expectations on how much coding should increase by during 26/27 but will monitor coding to guide delivery expectations in future years.

c) **Holistic Assessment** – People being supported through the INT will be offered a holistic assessment (with INT capacity prioritized in line with the risk stratification approach outlined above). Initially INTs may use existing assessment approaches (i.e. an established Comprehensive Geriatric Assessment). For clarity, holistic assessments such as CGA should include all parts of the CGA processing including screening, assessment, interventions (which are coordinated & pulled together by an appropriately skilled lead clinician) and follow through. Holistic assessment should not be considered as a simple completion of data around CGA needs, nor be completion of disjointed elements of CGA. The London NHS England Proactive Community Frailty Service Standards should be used to guide this. During 26/27 clinical and care professionals working within INTs across SEL will work together to improve the use of CGAs across South East London.

d) **Care Planning (via the UCP)** - All people who meet the cohort and stratification definitions will be offered a care plan. Care plans must be undertaken using the Universal Care Plan template. INTs should ensure full completion of all relevant sections of the care plan; this includes advanced care planning discussions (where appropriate) and completion of the personalized care sections. Care plans should be co-produced with the individual, and their family and/or carers as appropriate. Through the care planning process, the INT will agree how they will meet the needs of the patients through MDT-led care delivery.

e) **Named Coordinator and Lead Clinician** - Each person being cared for within the Integrated Neighbourhood Team will have a named coordinator and/or case manager for their care. They will also have a lead clinician who is responsible for pulling together the elements of care with the support of the MDT. The lead clinician may be a named GP, a named geriatrician or another clinician trained to lead patient frailty care.

f) **Integrated case management** – The INT will ensure that there are standard operating procedures in place that enable integrated case management, with regular discussions across the team and clarity on the input and expectations required from team members across individual cases. The INT will ensure this includes consideration of comorbidity management, polypharmacy falls, nutrition, dementia, mental health, social isolation / loneliness and carer support as a minimum part of the integrated case management approach delivered through the MDT.

g) **Ongoing monitoring and review of health needs** - INTs will use available tools and approaches to monitor the health and wellbeing of their population cohort and regularly review individual care needs. This may include remote monitoring technology and use of population health management tools based on real-time data. The initial minimum expectation is that care needs are reviewed following hospital admission or a self-reported change in circumstances.

h) **Multi-disciplinary case review** - INTs will ensure that regular (at least monthly) MDT discussions are in place with wider health and care professionals to ensure broader MDT input into care delivery. These discussions will support patients with the most complex health, care and wellbeing need. The INT will decide on which cases are to be reviewed through the broader MDT meetings.

i) **Consistent access to Geriatrician, Specialist Palliative Care and nursing/AHP Input** – INTs will ensure that they have arrangements in place to secure suitable access to Geriatrician and Specialist Palliative Care input within the assessment, care planning and case management functions. INTs will also ensure suitable access to AHPs & nursing input (to include physiotherapy, OT, nursing and dietetic support at a minimum) to support preventative strategies that avoid deterioration and the subsequent need for onward referral.

j) **Effective pathways for draw-down support to meet escalating need** – INTs will have effective and efficient pathways in place to draw-down additional input and capacity from Urgent Community Response, Virtual Ward and other hospital@home services as required to support escalating need within the

community and avoid admission to hospital. Pathways will ensure supported de-escalation of care back to INTs following urgent care support/admission to avoid "cliff-edge" transitions of care.

D. Training

Clinical staff will be expected to complete Frailty training as required including Clinical Frailty Scale training:

- NHS England e-learning for health Frailty e-learning module, relevant to their roles. Frailty - elearning for healthcare
- More CFS training available at NHS Specialty Frailty Network CFS Training — Specialised Clinical Frailty Network

Non-clinical staff should be signposted towards short locally agreed frailty awareness training. SEL ICB will work with the SEL Training Academy and other partners to ensure training material and resources are available to support staff.

5. INT REQUIREMENTS – MULTIPLE LONG TERM CONDITIONS

Multiple Long Term Condition INTs are entering Phase Three across SEL during 2026/27, so the focus will be to ensure full neighbourhood coverage of the INT model across SEL and increasingly embed the model as business as usual.

Currently people living with Serious Mental Illness are excluded from the cohort. However, during 2026/27 we will be providing additional funding through our mental health investment to enable widening of both capacity and capability within neighbourhood models to support people living with Serious Mental Illness through INTs. As such this exclusion will be removed from 1st July 2026, with those with SMI included within the cohort definition. Mental Health expectations aligned to the Strategic Investment Funding will be defined by the end of April and shared with integrator hosts and mental health providers.

A. Population segment definition

- Registered patients aged 18-64 years old living with three or more long term conditions
- Inclusive of residents who are housebound

INTs will utilize risk stratification to target available capacity on risk-groups within this overall segment

B. Initial risk stratified cohort

Whilst INTs will look after a growing share of the specified population segment as they embed, it is recognized that this population segment is particularly large and INTs will need to continue to prioritise available capacity. In 2026/27, the focus is on people with three or four cardiovascular-related long-term conditions—diabetes, hypertension, atrial fibrillation, and chronic kidney disease—counting only conditions that are undiagnosed or clinically unoptimised (diagnosed and optimised conditions are not included). Individuals should then be segmented by need:

- **Red**: all three or four undiagnosed or unoptimised conditions
- **Amber:** two undiagnosed or unoptimised conditions
- **Green**: one undiagnosed or unoptimized condition

Within the definition above, individuals should be prioritised based on their relative admission risk. In the initial stage, the existing Ardens sQ-Admission Risk Score embedded within EMIS is being used as an interim risk stratification solution across South East London. This tool is based on primary care data only, with the sQ-Admission Risk Score applied to estimate each person's likelihood of unplanned admission. Results are presented through the standard Ardens dashboards.

This is the cohort that INTs are expected to prioritise in 26/27 as a result of the Strategic Investment Fund. Integrator partnerships and places may invest further funds to expand the INT cohort in-line with local priorities (i.e. including patients living with COPD)

During 2026/27, we will continue to develop the Population Health Management capacity and capability across the South East London system. As a result, we expect more advanced tools to become available during the year, which will be made available to all Integrated Neighbourhood Teams and the approach to proactive case finding will evolve over time.

C. Minimum functional requirements of the INT

The minimum functional requirements of multiple long term condition INTs within 2026/27 are:

a) **Proactive identification and case finding** – INTs must use available tools to seek out people within the neighbourhood geography who fall into the agreement cohort and stratification definitions. Initially, INTs may also choose to use referral routes to maximise throughput, but as PHM tools improve in sophistication and availability the expectation will be for a case finding model to become the norm.

b) **Outreach to identify people with undiagnosed disease** - As part of the multiple LTC model, integrators must work with local pharmacy representatives to embed community pharmacy into the model of care, particularly in supporting identification of people with undiagnosed disease. Integrators must also use other routes, including point of care testing within neighbourhood settings, to improve identification

c) **Holistic Assessment** - People being supported through the INT will be offered a holistic assessment (with INT capacity prioritized in line with the risk stratification approach outlined above). Initially INTs may use existing assessment approaches. However, during 26/27 clinical and care professionals working within INTs across SEL will work together to agree elements that should constitute a minimal holistic assessment. This will then be built into a SEL-wide assessment tool to support minimum standards.

d) **Care Planning (via the UCP)** – People being supported through the INT will be offered a Care Plan. Care plans must be undertaken using the Universal Care Plan template. INTs should ensure full completion of all relevant sections of the care

plan; this includes completion of the personalized care sections. Care plans should be co-produced with the patient, and their family and/or carers as appropriate. Through the care planning process, the INT will agree how they will meet the needs of the patients through MDT-led care delivery.

e) **Named Coordinator** - Each person being cared for within the Integrated Neighbourhood Team will have a named coordinator and/or case manager for their care. Whilst all people must have a named coordinate, the INT will deliver care through an MDT approach which ensures shared accountability for meeting the individual's health and wellbeing needs.

f) **Integrated case management** – The INT will ensure that there are standard operating procedures in place that enable integrated case management, with regular discussions across the team and clarity on the input and expectations required from team members across individual cases. The INT will ensure this includes consideration of mental well-being needs, pain management and lifestyle support as a minimum.

g) **Ongoing monitoring and review of health needs** - INTs will use available tools and approaches to monitor the health and wellbeing of their population cohort and regularly review individual care needs. This may include remote monitoring technology and use of population health management tools based on real-time data. The initial minimum expectation is that care needs are reviewed following hospital admission or a self-reported change in circumstances.

h) **Multi-disciplinary case review** - INTs will ensure that regular MDT discussions (minimum monthly) are in place with wider health and care professionals to ensure broader MDT input into care delivery. These discussions will support patients with the most complex health, care and wellbeing needs. The INT will decide on which cases are to be reviewed through the broader MDT meetings.

i) **Consistent access to specialist input** – INTs will ensure that they have arrangements in place to secure suitable access to consultant or specialist nursing input within the assessment, care planning and case management functions. The key initial specialties are cardiology, diabetology and nephrology.

j) **Effective pathways for draw-down support to meet escalating need** – INTs will have effective and efficient pathways in place to draw-down additional input and capacity from Urgent Community Response, Virtual Ward and other hospital@home services as required to support escalating need within the community and avoid admission to hospital.

6. INT DELIVERY REQUIREMENTS: CHILDREN AND YOUNG PEOPLE

A. The CYP INT Framework

The CYP INT Framework [Insert Link] was agreed across SEL during 2025/26 and describes a **population health led, holistic and multiagency model** focused on neighbourhood delivery. It is underpinned by shared principles including early intervention, proactive case finding, family centred care, tackling inequalities (with a focus on the Core

20 population), partnership with VCSE organisations, effective information sharing and meaningful coproduction with CYP and families.

B. Phase of delivery in 2026/27

Most places have established the Child Health Model across their places to some degree. Whilst these models deliver excellent specialist care in the community for children with physical needs and are a strong foundation to build from, they are not a neighbourhood health model, nor an Integrated Neighbourhood Team for Children and Young People as set out in the CYP INT Framework.

As such, we are entering Phase One for Children and Young People INTs across SEL during 2026/27. The focus will be to establish at least one INT in each of the six Places, testing the model on priority cohorts, supported by demand and capacity modelling, agreed outcomes and quality improvement methods and working collaboratively to define key outcomes for INTs.

C. Risk Stratification

CYP INTs will look after a growing share of the segmented CYP population as they embed. The initial cohort will be CYP who fall into the Core 20 population and/or with complex needs.

Existing population health management tools should be used to identify those patients within this cohort who are at increased risk of poorer outcomes. It is recognised that Population Health Management capacity and capability currently vary from place to place.

Currently, all places have access to a minimum set of tools driven by primary care data via Ardens Manager dashboards. These should be used to identify the children who should be prioritised for care under this INT in 2026/27. This will require a case management approach.

During 2026/27, we will continue to develop the Population Health Management capacity and capability across the South East London system. As a result, we expect more advanced tools to become available during the year, which will be made available to all Integrated Neighbourhood Teams and the approach to proactive case finding will evolve over time.

D. Core Functions and Model of Care

CYP INTs will deliver a defined set of core functions, scaled to the needs of identified cohorts, including:

- Population Health Management and risk stratification to identify priority cohorts.
- Universal health and care offers alongside targeted prevention.
- Proactive identification and early intervention using data, outreach and simplified access.
- Multi-agency coordination through MDT working and named key workers.
- Community-based, integrated direct care (e.g. joint clinics, group interventions).
- Clear escalation pathways to prevent crisis and avoidable A&E attendance.

- Longitudinal support, including transition to adult services.
- “Waiting well” support during periods of delay.
- Enabling CYP to flourish through self-management, skills and wellbeing support.

E. Expected Outcomes

As with all INTs, success will be measured through the Neighbourhood outcomes framework with a set of 26/27 metrics that track early signs of delivery. Initial year one focus is on:

- Earlier identification of CYP with the greatest need.
- Reduced health inequalities.
- Improved access to proactive and preventative support.
- Better experience for CYP and families through coordinated care.

Alongside the outcomes framework and 26/27 metrics, Integrators and INTs will be asked to use a shared readiness assessment to assess their delivery readiness for the CYP model.

F. Delivery expectations during 2026/27

During 2026/27, Integrators will be expected to meet the following requirements in relation to the delivery of CYP INTs:

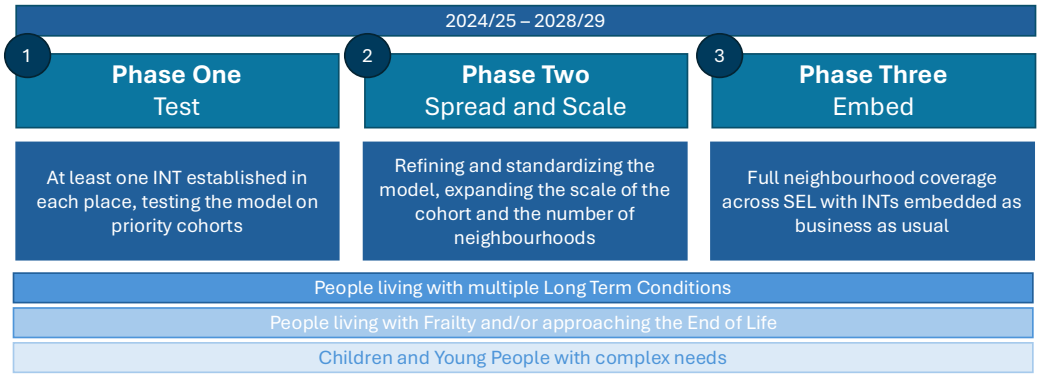
- Completing the readiness assessment in April and September of year 1
- Identifying a lead for CYP INT development to lead the work and attend the CYP INT oversight group – to be confirmed to Alison.Roberts@selondonics.nhs.uk
- Developing a CYP INT proposal and implementation plan – with the aim of starting the first INT in July 2026
- Embedding the CYP INT principles and population health approach.
- Delivering the agreed core functions.
- Using data and intelligence to identify and prioritise cohorts (initially focusing on the Core 20 population).
- Defining and delivering local operating models that build on existing assets (e.g. Family Hubs, child health teams) and integrate VCSE partners.
- Ensuring robust governance, information sharing and continuous improvement.

7. POPULATION COVERAGE OF INTS DURING 2026/27

Implementation of INTS across South East London is following a three-year test and learn cycle.

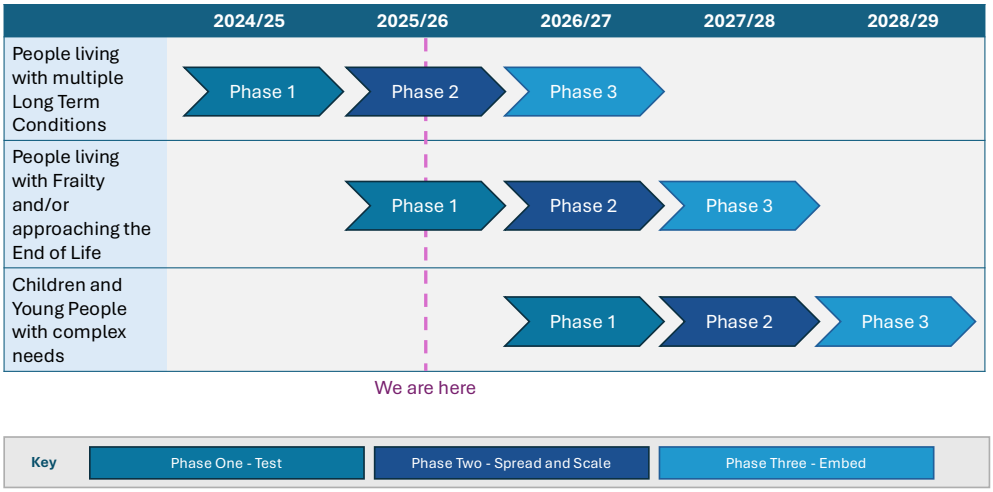
Phased Approach to INT Roll-Out

We will take a **staggered** and **phased** approach to INT roll-out. Different **population models** will be expected to **scale at different times**. The three phases will be delivered over a three-year period:



Each population cohort is at a different stage of this cycle across South East London, with some additional variation at place.

Priority population INT phased roll-out plan



2026/27 will mark a step change in the spread of Integrated Neighbourhood Team working, with all neighbourhoods expected to benefit from at least one INT by the end of this financial year. This is supported by the recurrent investment we are making through the Strategic Investment Fund.

This level of spread is significant, and new INTs will take time to embed and optimise. To ensure this spread is deliverable, we would anticipate that the capacity of each INT may scale more slowly. By the end of 26/27, each place will be expected to ensure a minimum of 1.5% of the borough registered population are being supported through INT models.

We are not setting any expectation on how these minimum patient numbers should be split across neighbourhoods or cohorts, recognizing that there is significant local variation. Integrator partnerships will want to consider the relative readiness of neighbourhoods, population need and potential impacts on system activity when determining the scale across their neighbourhoods and the individual INT models. Integrators will be asked to confirm their minimum expected cohort numbers by INT cohort and neighbourhood as part of their submitted plans, as well as their expected phasing of this over 2026/27.

During 2027/28, we will focus increasingly on scaling models for a larger percentage of our overall population, as well as considering opportunities to support other cohorts with higher risk of poorer health outcomes. If integrator partnerships feel ready and able to help push the boundaries around INT models during 2026/26 on a test and learn basis, then they can submit proposals for action in-year for the ICB to consider. [Please see this section for more information]

8. DIGITAL AND DATA

A. SEL digital principles and expectations

The shared digital vision for neighbourhood health across SEL partners is "*to enable integrated neighbourhood teams to work as one, around the resident, supported by digital tools that provide a single, trusted view of information, minimise administrative burden, and enable proactive, coordinated care across organisational boundaries".*

A system-wide digital workstream is in place to delivery key improvements to the digital architecture that supports integrated working.

To deliver this digital vision, there are a set of guiding principles and expectations as to the use of digital within integrated neighbourhood teams that we would expect integrator functions to follow during 2026/27. These are to:

- Maximise the value of existing investments such as existing electronic patient record (EPR) systems across SEL, London Care Record (LCR), Universal Care Plan (UCP), NHS App, Population health management (PHM) tools before commissioning or procuring new systems.
- Not to commission any new EPR solutions outside of what is already within the SEL landscape.
- Expand integration and utilisation of UCP and LCR to provide a minimum level of visibility across core INT partners. There is currently variation in how UCP and LCR are used across SEL and consistent utilisation across health and care is critical to successful neighbourhood working
- Help to improve the usability of UCP and LCR, ensuring all key information fields are completed when delivering care within an INT.
- Develop policies and procedures that drive inclusivity for all partners, including expanding access through role-based access (underpinned by honorary contracts

where necessary) to share digital systems and data for wider partners (including VCSE, Housing, and Employment Support)

- Supporting staff, particularly those working within Integrated Neighbourhood Teams, to engage in SEL-wide digital and population health training programmes as these are established to support the digital literacy and skills of all INT professional
- Taking part in agreed proof of concepts and/or pilots to support evaluation of transformative integrative digital tools including AI and supporting the scaling of solutions across other neighbourhoods if the POC/pilot is successful.
- Ensuring that digital governance arrangements and data-sharing arrangements put in place locally make full use of the existing data-sharing arrangements in place across South East London (further detail on how existing data sharing arrangements in place can already enable and support INT working will be shared)

B. Data and Coding

To enable us to track agreed system wide metrics, understand the impact of neighbourhood care against modelling and/or business case assumptions and support the evaluation of neighbourhood care we need to be able to effectively identify patients who are being cared for through integrated neighbourhood team models.

To do this, we need INT activity to be coded within the EMIS EPR system using a shared set of codes across South East London. We are reviewing the existing coding approaches for INT activity already in place across South East London and applicable national coding guidance shared through the National Neighbourhood Health Implementation Programme. We will develop coding guidance for integrator partnerships during April 2026 that should then be used to code activity that has been undertaken within the INT.

Across SEL we will use these codes to identify relevant INT-related activity across shared data reports and dashboards on the outcomes and impacts of our collective efforts to deliver Neighbourhood Health and Care across SEL. We will also use these codes to underpin modelling and impact data on activity shift across our system. Precise coding is key to enabling us to differentiate between the changes to outcomes, activity and cost for patients cared for within an INT model against our current models of care, supporting our learn and evolve approach as well as future commissioning and contract models.

9. PREVENTION

As outlined in the SEL Prevention Framework (add hyperlink), the SEL ICS prevention offer will support residents in the healthy, at-risk and rising-risk groups, helping to prevent escalation into more complex needs. It adopts a life-course perspective, using adult prevention as a lever to improve outcomes for maternal health, children, and young people through a ‘think family’ approach.

Following a review of evidence, insights and data, we have prioritised a SEL-wide prevention focus on the **‘Vital 5 Plus’ -** hypertension, unhealthy weight and associated

lifestyle factors (e.g. physical activity and nutrition), poor mental health and wellbeing, tobacco dependency, alcohol harm **plus** financial security, employment, social connectivity and housing. This is underpinned by a making every prevention count approach (e.g. targeted efforts to increase uptake in vaccinations and screening or small actions to encourage healthier lifestyles and wellbeing).

The SEL Prevention Framework includes a set of high-level population health outcome statements, which map to our long-term population health and prevention ambitions:

- Extending healthy life expectancy of residents by delaying the onset of preventable long-term conditions and proactively addressing health issues and illness.
- Reducing health inequalities for residents by targeting those at greatest risk of poor health (including those in Core20Plus5 groups).
- Ensuring every mother, baby and family enjoys a safe and healthy pregnancy and the very best start in life.
- Adults live healthier for longer; avoiding premature heart disease, stroke & diabetes and other long-term conditions.
- Older people are safe and independent, living in their own homes for longer.
- Building trust and confidence in preventative healthcare services in our communities.
- Reducing the gap between mental and physical health outcomes.
- All residents possess the capability and confidence to sustain healthy lifestyles and manage their own health and wellbeing at every stage of life.

The Strategic Investment Fund includes two areas of focus in 26/27 for neighbourhood-based prevention:

- **Targeted Neighbourhood Prevention Core Offer** – rolling-out the core neighbourhood offer within the SEL Prevention Framework to specific neighbourhoods aligned to health inequalities (see here).

- **Proactive identification and optimization of cardio-vascular renal metabolic (CVRM) risk factors** – reducing variation in and improving early detection and optimization of key CVRM risk factors (see here).

Funding will be made available over 2026-27 – 2028/29 subject to annual review of impact and SIF funding parameters/allocations.

A. Targeted neighbourhood prevention core offer

£3m of investment via the Strategic Investment Fund is being made available to support the delivery of the core prevention offer within specific neighbourhoods. £300k per neighbourhood is available, with prioritization as follows:

- 1 neighbourhood within each of Bexley and Bromley
- 2 neighbourhoods within each of Greenwich, Lambeth, Lewisham and Southwark.

Through this investment, Integrator and Place Partnerships will be expected to target neighbourhoods characterized by high proportion of Core 20 population.

Planning expectations

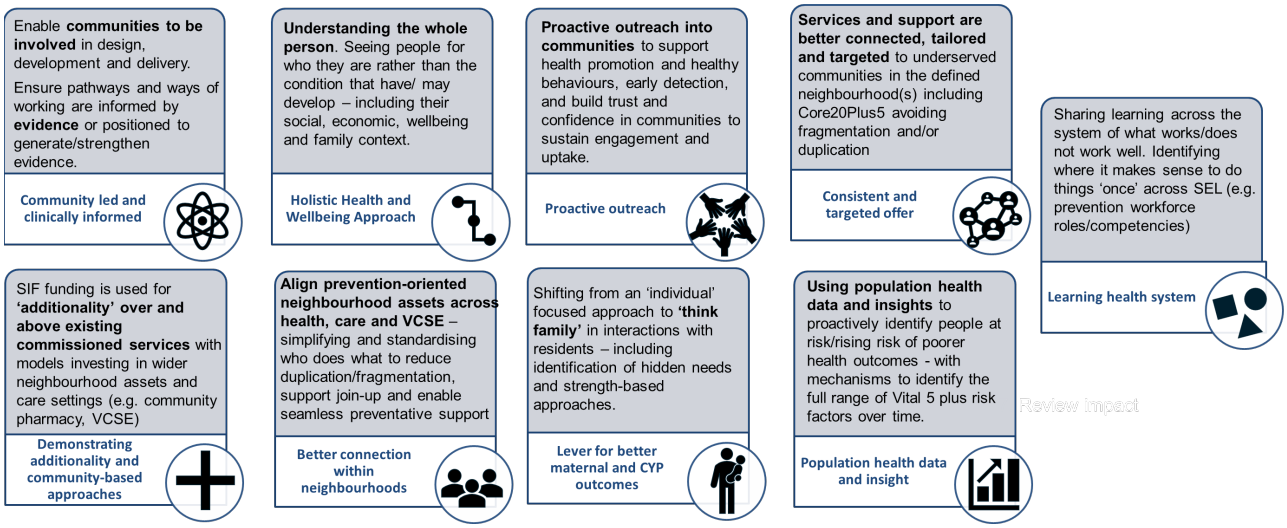
The prevention neighbourhood offer seeks to deliver a connected '**prevention focused pathway of care**' which reduces fragmentation and proactively seeks to identify and support residents' holistic needs aligned to Vital 5+ (incl. financial security, employment, housing and social connectivity). This will be targeted at a neighbourhood level for people at risk/rising risk of poorer health outcomes – using Core20Plus5 as a proxy for this.

There are a set of **shared standards** and **minimum expectations** for the prevention neighbourhood offer which will ensure consistency while enabling local flexibility. These have been informed by cross-system Prevention Framework workshops including a SEL implementation planning workshop on 9 March 2026.

Integrators, with their Place-based partnerships, are expected to develop local plans that:

- Demonstrate alignment to the Prevention Framework and minimum expectations.
- Target neighbourhoods based on health inequalities (Core20Plus).
- Include a logic model setting out realistic and measurable metrics and outcomes – aligned to outcomes statements set out in the Prevention Framework.
- Include a financial breakdown of use of allocation. Leveraging and demonstrating additionality/value add over and above existing NHS and local authority commissioned services.
- Facilitate investment to be directed to wider neighbourhood assets and care settings, including community pharmacy and VCSE – meeting communities where they are and supporting health creation as part of our approach to prevention.
- Have had input and expertise from Public Health to ensure proposals are either aligned to evidence base or positioned to generate or strengthen evidence-base.

Shared standards



Minimum expectations for inclusion within neighbourhood prevention offer plan

1. **Proactive identification**
   - Demonstrate capability to proactively identify people at risk/rising risk of poorer health outcomes associated with Vital 5 plus risk factors – using a mix of case finding, insight and outreach.
   - Ensure approach links to Vital 5 plus incl. social connectivity, housing, employment and financial security – acknowledging limitations of current PHM tools which will improve in sophistication as they evolve.
2. **Follow up and proactive support**
   - Ensure there are tailored and connected services and support that can be targeted to Core20Plus populations in the neighbourhood for each of the building blocks that make up the core offer.
   - Establish and maintain mechanisms that enable timely, appropriate follow-up (with consent) for identified risks, improving understanding of need and ensuring the most suitable preventative support is provided.
   - Utilise the wider workforce strategically — including health ambassadors/champions, health coaches, and community health workers — by establishing clearly defined roles and standardised responsibilities to ensure clarity, consistency, and effective delivery across teams.
   - Identify and remove systemic barriers to engagement by proactively understanding and supporting at-risk groups, reducing DNAs and improving access to services.
3. **Outreach**
   - Enable proactive outreach within communities — ensuring teams can meet people where they are, deliver tailored health promotion, and build trusted, long-term relationships.
   - Ensure communications use accessible written and visual materials, recognising that not everyone has basic literacy skills. Provide appropriate translation and disability-friendly formats, aligned to the needs and demographics of each neighbourhood.
   - Enable peer-led interventions (e.g. peer support).
4. **Monitoring and evaluation**
   - Define clear measurement criteria — specifying what will be measured, how it will be measured, and by when — to enable consistent tracking and demonstration of both return on investment (ROI) and social return on investment (SROI) over time.
   - Reorientate resources where interventions are demonstrating little or low impact to those that are/can.
   - Share learning across the system of what works/does not work well and find opportunities to share learning and insights.

B. Risk factor identification and management

Planning expectations

All integrators are expected to set a neighbourhood-specific improvement trajectory based on their local baseline position.

For each expected outcome (see table below), integrators should:

- translate outcomes into clear, measurable KPIs.
- set a realistic three-year improvement trajectory specifying delivery in Year 1 Year 2 and Year 3 individually.

Progress will be assessed against locally appropriate improvement, rather than absolute performance, with a clear line of sight from baseline to Year 2-3 impact.

#	Outcome
1	Improvement in condition-specific management indicators across AF, BP, lipids, HF, CKD and diabetes, including improvement trajectories for specific populations most at risk of health inequalities [populations/ cohorts tbc]
2	Reduction in variation between lowest and highest-performing practices across CVRM indicators
3	More people with CVRM conditions or risk factors are appropriately identified, coded and recorded within primary care systems
4	Increased proportion of patients in active CVRM management
5	Modifiable cardiovascular and metabolic risk factors are systematically identified and addressed for people at risk
6	Eligible patients are appropriately referred to evidence-based preventative interventions aligned to CVRM pathways
7	Improved uptake and completion of preventative interventions
8	Reduction in inequality gaps in CVRM identification and optimisation across deprived and underserved populations in South East London

Minimum expectations for inclusion within CVRM plan

1. **Use population health management to identify and stratify the at-risk population**
   - Use practice and neighbourhood-level data to identify patients and cohorts at highest risk across CVRM, heart failure, lipid management, diabetes and CKD
   - Segment the population to identify: unmet need, unwarranted variation, practices with poorer outcomes or lower achievement, underserved groups and health inequalities
   - Produce a prioritised list of practices and patient cohorts requiring enhanced support

2. **Understand your neighbourhood baseline and set realistic improvement trajectories**
    - Set manageable improvement trajectories for Year 1 and Year 2 based on your local starting position, including improvement trajectories for specific populations most at risk of health inequalities
    - Consider the following key indicators when setting trajectories: obesity, hypertension prevalence, diabetes management (HbA1c), lipid control, smoking prevalence [future indicators TBC]
3. **Proactive detection and improved clinical coding**
    - Deliver proactive case-finding activity to improve identification of undiagnosed or under-coded patients across priority conditions
    - Review and improve SNOMED coding accuracy at practice level to ensure populations are correctly identified for recall and management
    - Establish regular searches
4. **Medicines optimisation**
    - Deliver structured medication optimisation for priority cohorts, ensuring patients are on optimal evidence-based therapies
    - Identify patients not on guideline-recommended treatments and implement structured review processes to address gaps
    - Work with community pharmacy where appropriate to support medicines adherence and optimisation at scale
5. **Address health inequalities – ensure the offer reaches underserved populations**
    - Articulate clearly how the core offer identifies, targets and supports high-risk or underserved populations, including those underserved SEL populations specifically identified [tbc]
    - Develop an active outreach approach to reach patients less likely to engage with services, including those in deprived neighbourhoods or with language and cultural barriers
    - Demonstrate how investment additionality will reduce inequalities in access and outcomes
6. **Design the offer for delivery across multiple care settings**
    - Show how primary care, community services, community pharmacy and digital approaches contribute to a single, coherent model of care
    - Avoid siloed delivery — proposals should demonstrate integration and clear patient pathways across settings
    - Outline the role of each provider type and how they will coordinate to deliver a seamless experience for patients
7. **Suggest innovative ways to operationalise early intervention and CVRM principles**
    - Propose how CVRM and early intervention principles can be practically operationalised at neighbourhood level

- Where relevant, reference existing models or exemplars (e.g. Healthy Heart Clinic) and how they can be adapted or scaled
- Translate outcomes into KPIs, and report impact and progress at a quarterly basis against agreed indicators and trajectories.

8. **Embed lifestyle and behaviour change as a core component of CVRM delivery**
   - Consider and propose how lifestyle and behaviour change (e.g. healthy eating, mental wellbeing, physical activity, sleep, minimizing harmful substances) can be incorporated in your delivery model.
   - To inform local plans, consider existing examples of effective lifestyle and behaviour change practice that are demonstrating positive outcomes (e.g. North Lewisham Lifestyle Medicine Service)

10. DEVELOPING AND AGREEING INVESTMENT AND DELIVERY PLANS

Investment

The table below outlines the investment available per integrator (and per place) for each area of the Strategic Investment Fund that integrators need to submit plans for.

	Oxleas		**KCH**	**LGT**	**GSTT**	
	Bexley	**Greenwich**	**Bromley**	**Lewisham**	**Lambeth**	**Southwark**
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Integrator Development	*£250*	*£250*	*£250*	*£250*	*£250*	*£250*
Frailty INT	*£264*	*£162*	*£283*	*£155*	*£131*	*£133*
Multiple LTC INT	*£271*	*£359*	*£326*	*£390*	*£424*	*£386*
CYP INT Model	*£220*	*£219*	*£311*	*£249*	*£271*	*£230*
TOTAL	*£1,005*	*£990*	*£1,170*	*£1,045*	*£1,076*	*£999*

	Oxleas		**KCH**	**LGT**	**GSTT**	
	Bexley	**Greenwich**	**Bromley**	**Lewisham**	**Lambeth**	**Southwark**
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Core Offer	*£300*	*£600*	*£300*	*£600*	*£600*	*£600*
Risk Factor Identification and Management	*£440*	*£438*	*£622*	*£498*	*£541*	*£460*
TOTAL	*£740*	*£1,038*	*£92*	*£1,098*	*£1,141*	*£1,060*

Process

Cohesive investment and delivery plans need to be developed that set out how investment will be utilized to deliver the minimum requirements set out in this document for neighbourhood care, and the minimum requirements set out here for prevention. A single template has been developed covering all the requirements within this document.

Where integrator hosts are receiving money directly, to hold on behalf of the Integrator and Place Partnership, the host must co-produce the investment and delivery plan with the full local integrator partnership, including explicit sign-up from the acute, community, mental health, primary care and VCSFE partners and the Place Executive Lead. Host Integrator leads must work with the Place Partnership team within the ICB to agree the local governance process for the agreement of the investment and delivery plan. It is fully expected that a robust investment and delivery plan for neighbourhood health and care, including prevention, that has been co-produced with partners at place, will set out and require investment in other partners from the funds held by the host Integrator.

Plans should reflect that this investment is recurrent and therefore enables sustainable investment in the workforce, underpinning structures and services that will enable delivery of neighbourhood care. It is recognized that in 2026/27 some funding, particularly in Q1 and Q2, may be used to pump prime change on a transitionary basis, but the aim should be to achieve sustainable change and a recurrent investment profile by the end of this financial year.

Where trusts are holding funds on behalf of their Integrator/Place partnerships (either as an integrator host or mental health provider), it will be imperative that the Trust can report on the use of those funds separately from other funds into the Integrator/Place partnership in a transparent and open way. Appropriate mechanisms should be agreed between Place ICB teams and integrator partnerships to ensure that the correct processes are in place to ensure partnership stewardship and oversight of the delivery of plans and associated budgets.

Timeline

Stage	By When
Confirmation of expectations for neighbourhood and prevention SIF to be shared with Integrators	Friday 20 March 2026
Integrators to coordinate the development of proposals. Proposals should be developed using the "2026/27 Neighbourhoods and Prevention Investment and Delivery Plan template" that has been shared alongside this document. Proposals must secure Integrator and Place Partnership endorsement through appropriate governance channels. This should include sign-off from the lead representative or CEO of the key health partners working with the integrator host (acute, community, mental health, primary care, VCSFE) plus the Place Executive Lead.	Friday 22 May 2026
Proposals shared with SEL Planning Directorate for collation and final endorsement through appropriate ICB governance – Please send to Annabel.Appleby@selondonics.nhs.uk	Friday 22 May 2026
Sign-off via appropriate ICB governance of all proposals	Friday 12 June 2026
Proposal to be mobilised/implementation	June 2026 onwards

11. OTHER SIF INVESTMENT SUPPORTING NEIGHBOURHOOD HEALTH IN 2026/27 OUTSIDE OF THIS PROCESS

A. Pushing the boundaries of current neighbourhood and INT models

A further £1.5m is available for investment in 2026/27 for integrators to test or push the boundaries of Neighbourhood Care and Integrated Neighbourhood Team models. This funding can support the piloting of proactive, preventative INT population support for rising risk populations aligned to local population need.

Integrators are asked to submit any proposals for the use of this funding by the end of June 2026, using the template set out here (include link). These proposals will be assessed at a SEL level with prioritization given to those that are able to demonstrate:

- Strong confidence in delivery
- Consideration of the full Integrator / Place partnership, with a particular focus on the role of VCSFE partners, local authority partners and primary care partners (particularly general practice and pharmacy providers).
- Impact on outcomes for residents who are at rising risk of ill health
- Commitment to learning, evaluation and sharing across INTs within the integrator, and with other integrators across SEL.

The final decision on which proposals are prioritized for investment in 2026/27 will be taken through appropriate SEL governance and communicated in July 2026.

B. Integration of Mental Health into INT and Neighbourhood models

£3.5m is being made available to support mental health neighbourhood development. This will be led/coordinated by Mental Health Trusts partners along with Integrator and Place partners.

The investment will be split by Mental Health weighted population and is expected to support:

- Dedicated mental health support into existing adult INTs, specifically psychological support (Talking Therapies) and dementia/memory care.
- Expansion of INTs for people with multiple long-term conditions to include SMI (with a particular focus on the people who receive long-acting injectables) aligned to any agreed SEL framework.
- Realignment of existing Community Mental Health Team provision to secure a neighbourhood aligned and focused model targeted to high areas of need, and inclusive of enhanced capacity/resource including VCSE investment.

Guidance will be shared with Mental Health Providers by the end of April on the core requirements expected through this investment, with plans expected by 5th June 2026 (following a similar process to the one set out in this document)

C. Leveling up primary care provision

£4m FYE (in 2026/27 £2m for PYE) will be invested recurrently to support enhanced, wrap-around primary care provision to secure and stabilise the base level of access / provision within primary care across neighbourhoods. In 2026/27, the investment will have part year effect beginning in October 2026.

The ICB will invest on a targeted basis to address imbalance in existing provision, with work beginning in March on the approach for this. The ICB will work across SEL and place teams to develop shared standards, expectations and outcomes for enhanced provision

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**SEL INT Digital Roadmap and EPR / Digital Solutions Paper**					
Meeting date	19 March 2026	Agenda item Number	**6**	Paper Enclosure Ref	**4**	
Authors	**Nisha Wheeler** **Ananya Datta** **Vish Valivety** **Will Clayton** **Maria Higson**					
Executive lead	**Denis Lafitte**					
Paper is for:	Update		Discussion	**X**	Decision	**X**
Purpose of paper	This paper is to update the NBCB on the digital and enablement and data and PHM workstreams and associated activities that have taken place since we last met in October 2025. To set out the approach for the delivery of optimisation of digital solutions already within the SEL estate alongside outlining key transformational digital programmes identified that will promote the advancement of SEL neighbourhoods to a higher degree of maturity than that of the present day. These optimisation and transformation workstreams have been brought together in a single digital roadmap for integrated neighbourhood teams. To also set out the context, challenges and digital principles for neighbourhood health within its operationalised space, and to set out a small number of credible options for digitally enabling neighbourhood health in SEL in the realm of operationalisation. To provide an update on the population health management workstream, including the proposed approach to SEL's data architecture and proposed approach to networked analytics capacity.					
Summary of main points	In November 2025, in recognition of the significant digital and data agenda for neighbourhood health services / integrated neighbourhood teams (INTs), the NBCB agreed that a separate Digital Neighbourhood Working Group (DNWG) should be established to provide a framework and appropriate governance to enable digital and data requirements to be scoped and developed. Since this time, the DNWG has convened monthly with INT stakeholders across the wider SEL system including integrators to bring together collective harmonisation of digital and data projects and programmes aligned with neighbourhood working. Baselining the digital landscape and understanding the challenges and aspirations faced by INTs was just one of the first key requirements of this systemwide group and through an intensive discovery process – a three-year digital roadmap spanning 2025 - 2028 was developed and endorsed through the DNWG members. This digital roadmap sets out the approach for the delivery of optimisation of digital solutions (both national assets and locally commissioned solutions) already within the SEL					

estate whilst also outlining key transformational digital programmes identified that will promote the advancement of SEL neighbourhoods to a higher degree of maturity than that of the present day. These optimisation and transformation workstreams have been brought together in a single digital roadmap for integrated neighbourhood teams.

Key optimisation and transformation programmes can be seen as follows:

Optimisation Programmes:

- **London Care Record (LCR):** A shared care record providing a secure, single view of health and social care information across London. Efforts are underway to enable additional practices, PCNs, and federations to access LCR data.
- **Universal Care Plan (UCP):** A digital personalised care and support plan, with ongoing work to expand access to all primary care settings and care homes.
- **ICE Order Comms:** Radiology and pathology ordering is being optimised, with the expansion of ICE access and transition from legacy systems like T-quest.
- **NHS App Integration:** All SEL GP practices are integrated with the NHS App for records, messaging, and appointments. Major trusts are progressing towards integration of patient portal solutions within the NHS App.
- **Primary and Secondary Care Clinical System Integration:** The Dovetail project has been established to improve information visibility and workflow between Primary and secondary care EPR (EPIC – Optum – Medicus), with plans for shared workflows and secure messaging. In addition to this, a project to enable EPIC-MESH integration has also recently been established and will enhance document quality and reduce workload in primary care for GP letters
- **Lower Limb Wound Management:** Ongoing evaluation and rationalisation of digital tools (Healthy.io and Isla Health) to support improved wound care pathways across SEL.

Transformation Programmes:

- **Defining the direction of travel for INT EPR(s) to support at scale work efficiently aligned to the NHSE 10-year plan**

  A task and finish group was established to investigate digital challenges and define future options for digital solutions/EPR interoperability within the SEL INT space. The group aims to enable seamless care across services, addressing the limitations posed by multiple EPR solutions and supporting

at-scale working aligned with the NHSE 10-year plan. A collaboration of stakeholders across SEL supported the development of a digital solutions paper providing recommendations to the NBCB on the future direction for integrated digital care.

- **Population Health Management and Data Architecture**

  The SEL ICB has launched the Ardens Manager tool for population segmentation, enabling proactive and coordinated care planning. Collaboration with the London Data Service (LDS) is underway, alongside local ambitions to develop the necessary data infrastructure for Patient Identifiable Data to support INTs and other direct use cases. Discussions are also ongoing regarding the need to better align the network of analytics capacity and capability.

- **Virtual Wards and Remote Monitoring**

  Virtual ward services are managed at borough level, with significant variation in provider arrangements. There is a clear need for seamless patient care across step-up and step-down pathways, and for the integration of wearables and remote monitoring into core care processes. Engagement with borough Virtual Ward teams is planned to align strategies and ensure digital solutions meet INT needs. This work is being led through GSTT teams.

- **Directory of Services and Referral Management**

  Multiple, fragmented directories of services (DOS) currently exist, creating administrative burdens and inefficiencies. The roadmap prioritises developing a centralised, unified DOS integrated with INT EPR solutions, supporting both referral and self-referral pathways. Detailed scoping work is planned to streamline these processes across SEL.

Alongside the Digital Roadmap, the DNWG was also tasked with the responsibility to form a Task & Finish (T&F) Group to explore digital operational requirements for neighbourhood health in South East London (SEL), originally focusing on Electronic Patient Records (EPRs). The scope later expanded to wider digital enablers needed for Integrated Neighbourhood Teams (INTs).

The T&F Group brought together integrator organisation leads, IT and digital colleagues, and clinical representatives from across the system, including GPs, community pharmacists, acute specialists, mental health clinicians and palliative care consultants.

The T&F Group identified five consistent challenges which must be addressed to enable integrated neighbourhood working:

1. **Poor interoperability**
   - Multiple EPR systems do not talk to each other consistently. Key gaps include GP EMIS instances, community pharmacy, social care, and

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variable integration with tools like the London Care Record (LCR) and Universal Care Plan (UCP).
2. Uncertain information governance
• Lack of clarity on roles, responsibilities, and what can be shared across INTs — especially with VCSE and local authority partners.
3. No simple communication mechanism
• No shared tool for quick, secure communication between INT partners, causing accountability issues and residents falling through gaps.
4. Fragmented and inconsistent data
• Variation in data entry and coding leads to gaps and reduces trust in shared records. Some teams have only partial access to needed information.
5. Limited resident visibility
• Difficulty tracking people across settings due to no “live” record and limited linkage of episodes and outcomes.

The group also identified three core areas where digital enablers could support neighbourhood health through better use of data, data investigation leading to case finding, operationalising neighbourhood teams through data entry and access, and outcomes and impact tracking at a population health level.

For this initial phase, the group agreed operationalising neighbourhood teams was the immediate priority, so the paper focuses on context, challenges, digital principles and a small number of credible options in that area.

Through the collaboration and collective work of the T&F Group, it has concluded that the long-term aim must be to ensure fully digital, integrated neighbourhood working which features the following:
• A complete longitudinal care record (with read/write access)
• Seamless, paperless referrals
• Unified workflows and activity visibility
• Shared definitions for population health
• Tracking across pathways to measure impact
• Strong, shared IG enabling multi-sector working
• Instant, secure communication across partners
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Public Patient Engagement	N/A
Committee engagement	The options paper been shared with the SEL EPR Task & Finish Group, and the SEL Neighbourhood Digital Working Group.
Recommendation	The Committee are asked to: • Reflect on the contents of the digital and data papers presented • Approve the digital roadmap for INTs supporting these as key digital priorities for the system to take forward and in so doing enabling INTs to mature in their digital footprint. • Endorse the case for change set out in this paper in respect of the digital operationalising of INTs, recognising that the current digital and EPR landscape in SEL is not sufficient to fully support integrated neighbourhood working at scale. • Agree the proposed key priorities, digital vision and guiding principles set out for digitally enabling neighbourhood health in SEL and to act as system-wide guardrails for future decisions. • Endorse a phased, system-led approach to digitally enabling neighbourhood health, using the options set out in this paper to prioritise near-term improvements that support INT delivery and reduce friction for staff and residents; and set a clear long-term direction that avoids further fragmentation and aligns with national policy and planning expectations. • Endorse the next phase of work, including more detailed appraisal of the preferred option(s), implementation sequencing, affordability, risks and dependencies, to be brought back to NBCB and the Digital Committee as appropriate. Agreeing a clear direction at this stage does not require committing to a single technical solution or immediate large-scale procurement but it is essential in adopting a coherent, system-wide approach to future digital development.

Context and scope of paper

Context and scope

- The Task and Finish Group was originally set up by the Digital Working Group to define the EPR requirements for neighbourhood health, and what SEL would need to do to implement them, then agreed to broaden scope to the wider digital enablement needed for neighbourhood health.
- The group brought together integrator organisation leads, IT and digital colleagues, and clinical representatives from across the system, including GPs, community pharmacists, acute specialists, mental health clinicians and palliative care consultants.
- The work was delivered through three to four focused sessions covering problem definition, principles, requirements and credible digital options, plus an additional short workshop focused on the digital needs of different clinical and care roles within INTs in SEL.
- The group identified three core areas where digital enablers could support neighbourhood health through better use of data, data investigation leading to case finding, operationalising neighbourhood teams through data entry and access, and outcomes and impact tracking at a population health level.
- For this initial phase, the group agreed operationalising neighbourhood teams was the immediate priority, so the paper focuses on context, challenges, digital principles and a small number of credible options in that area.
- The paper is intended to support discussion and endorsement by the Neighbourhood Based Care Board and to inform later detailed appraisal and decision making, with scope covering EPRs and shared capabilities across health, social care and VCSE interfaces, and alignment with existing SEL strategies and governance, while excluding business cases, procurement, population health tools, resident empowerment tools and funding.

Paper aims and inputs

Main elements of the paper

- An articulation of the current challenges faced within the digital landscape of SEL to support neighbourhood health
- An outline of available tools and programmes currently in train
- A set of co-designed principles to guide the digital vision for neighbourhood health in SEL
- A set of personas and use cases to identify how individuals across services would interact with digital platforms required to support neighbourhood working
- An outlined future vision for digital enablement of INTs and neighbourhood health
- Options appraisal and recommended approach to focus resources over the immediate period
- A high-level timeline of activities required to move SEL into a more permanent state for INTs and Neighbourhoods

Membership

- We had a core Task & Finish Group made up of a strong cross sector mix to support delivery e.g. Frontline clinical and primary care voices, community pharmacy leadership, borough local authority digital leadership, voluntary sector representation, and innovation and partnership organisations
- This Group was supplemented a wider set of stakeholders from across the system, bringing c.50 voices to this paper.

How we sought input and feedback

- We ran three structured Task & Finish Group sessions, each designed to address specific areas of the paper
- Outside of these sessions, we set up a shared Mural board for members to complete “homework”, feeding in additional insights to address gaps
- We also drew on PPL’s learning and expertise of INT development across London and nationally
- Following the initial draft of the paper, we undertook an extensive feedback loop to ensure that the recommendations and findings were accurate and useful.

High level session overviews

Session 1 – December 2nd

Aims

- Confirm principles
- Allow the group to define and agree on the problem
- Prioritise current challenges
- Agree a set of “red lines” and mitigations against risks

Key Questions

- What issues does a lack of integrated digital records create for patients, staff, and the system currently?
- What issues are most pressing?
- What does the digital solution need to avoid doing?
- What works well currently and should be retained?

Session 2 – December 16th

Aims

- Develop a set of “core requirements” to address our key challenges
- Understand what existing tools we have to address challenges
- Agree initial preferred approach

Key Questions

- What do we need a digital solution to do to address our key challenges?
- What are our red lines’?
- Which approach (e.g an overlay, a new EPR etc.) would best suit SEL currently?
- How are we going to break up the process into manageable chunks?

Session 3 – January 7th

Aims

- Develop and refine use cases for an array of stakeholders involved in neighbourhood health
- Identifying challenges to address and ideal solutions for their needs

Key Questions

- What specific challenges are we looking to solve?
- What existing capability allows the user to do this?
- What potential improvements do we need to implement?

T&F group members also updated interactive mural board as “homework” to provide additional details

Outputs: Current Challenges

Clinical Challenges

- Care planning is a major challenge currently – we need a system that allows partners to view and input into shared records and plans
- Both residents and clinicians have to log in to multiple platforms and systems, adding unnecessary delays and friction
- Lack of visibility across platforms means residents have to tell their story multiple times and impacts communication and coordination between partners
- There is more than one version of the truth, driven by the need to double enter data into multiple systems
- Clinical coding training for clinicians outside of primary care will be necessary to enable “read write” capabilities across system partners

Technical Challenges

- There are challenges around the ability to improve the level of interoperability between systems, both within health (e.g. EMIS integration across different levels of the system (PCN vs Practice etc.) and with UCPs and the LCR), and beyond health e.g. integrating health systems with local authority records and platforms
- Currently minimal interoperability with Community Pharmacy systems
- Identifying residents under care of INTs as they move across and between different settings - although there's been some positive initial work in this space within the current digital landscape
- We need clear agreement on who is responsible and accountable for information with INTs

Initial Outputs: Principles

The shared digital vision for neighbourhood health in SEL is:

To enable integrated neighbourhood teams to work as one, around the resident, supported by digital tools that provide a single, trusted view of information, minimise administrative burden, and enable proactive, coordinated care across organisational boundaries.

- **Neighbourhood-first, function-led:** Digital solutions should be designed around the functions neighbourhood teams need (e.g. care planning, tasking, referrals), not organisational silos.
- **Optimise first:** Maximise the value of existing investments (such as LCR, UCP, NHS App, PHM tools) before procuring new systems.
- **Interoperability by default:** Prioritise solutions that reduce interfaces, support data-once-use-many-times, and integrate with national and London-wide platforms.
- **Single version of the truth:** Residents and staff should be able to rely on a consistent, shared record, reducing duplication and variation.
- **Inclusive of all partners:** Digital enablement must work for primary care contractors, community services, acute providers, social care and the voluntary sector.
- **Proportionate, pragmatic and scalable:** Solutions should be deliverable in the short to medium term, while aligning to a longer-term strategic direction.
- **Safe and governed:** Strong information governance, role-based access and clinical safety must underpin all options.

Mini specification built on user needs

The Group supported the development of a ‘mini-specification’ for a digital environment that would allow multi-organisational teams to effectively view relevant information about a resident’s needs and support the update of their care plan.

Area	Core Requirement

Improving existing systems	• Expanded access to core shared platforms (LCR, UCP) for all partners
	• Optimisation of LCR and UCP information:
	  ○ Addition of key information (e.g GP notes, tests, medication)
	  ○ Streamlining to ensure key information is easy to find
	  ○ Automated data entry and autofill where possible to reduce repetitive, manual data entry tasks
	• Streamlining the referrals system and moving towards fully digitally enabled referrals without the need for manual print outs

Communication	• A medium for instant, secure and auditable communication between clinical and administrative staff working together as part of an INT (e.g shared Teams channels)
Information Governance	• Clear information governance which allows teams to share data appropriately and safely
Learning	• Training support for digital tools, ensuring existing capabilities are being maximised and platforms are being used appropriately and consistently across the system

South East London Integrated Care System

Options reviewed

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Option	Description	Benefits	Risks / Limitations
Do nothing beyond existing plans	Continue with current optimisation activity (e.g. LCR, UCP, NHS App, PHM) with no specific neighbourhood EPR strategy	No additional cost or disruption; allows focus on delivery of existing programmes	Does not resolve core neighbourhood challenges; continued duplication and poor visibility; high risk of local divergence
Optimise and standardise current landscape	System-led optimisation of existing EPRs and shared tools with agreed SEL-wide standards for neighbourhood working	Builds on existing investment; faster to implement; lower risk and cost; improves consistency	Structural limitations of multiple EPRs remain; limited read/write interoperability; benefits may plateau
Pilot new digital approaches locally	Developing and testing new digital approaches (e.g a digital overlay and shared longitudinal care record) within a specific locality	Test long-term solutions within a more manageable context; opportunity to test and learn; informs future system development	Dependent on interoperability maturity; requires new resource to implement, test and learn
Neighbourhood digital layer / overlay	Implement a shared neighbourhood platform sitting across existing EPRs, providing common workflows (care planning, tasking, referrals)	Supports INT workflows; reduces duplication; inclusive of health, social care and VCSE; avoids immediate EPR replacement	Additional system to manage; dependent on interoperability maturity; requires strong adoption and governance
Single neighbourhood EPR (long-term)	Converge towards a single EPR for neighbourhood services across SEL	Strongest potential for single version of the truth; simplified architecture; future-proofed	High cost and complexity; long delivery timescales; significant change needed; potentially disruptive to borough- and organisation-specific systems

South East London Integrated Care System

Our recommendation for taking this forwards

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Recommended approach	Prioritise optimising and expanding existing systems and platforms to meet the minimum digital requirements for INT delivery in the short term, whilst undertaking a thorough assessment of the digital health market to understand the extent to which more transformative approaches may be viable in the medium to longer term.
Phased delivery	Progress iteratively through three stages: establishing information visibility; enabling information transfer; and realising collaborative working, with the long-term ambition to move from Stage 1 in the short term towards Stage 3 over time. This will be linked to the wider digital roadmap produced for SEL, which also includes elements such as NHS app integration, virtual wards and remote monitoring, and shared care platform development (linked to the LCR and UCP programmes).
Investment approach	Deliver core requirements through ongoing development and integration of current solutions, recognising that major digital transformation while the contours of neighbourhood working are still taking shape may be counterproductive.
Test and iteration	Use areas with stronger digital maturity to pilot more advanced digital enablement, generating evidence before scaling, and align SEL ICB activity to the London Neighbourhood Health Delivery Board Digital Task and Finish workplan, leveraging wider resource and feeding in SEL specific recommendations.

Our ask for the Board

- **Endorse the case for change** set out in this paper, recognising that the current digital and EPR landscape in SEL is not sufficient to fully support integrated neighbourhood working at scale.
- **Agree the proposed digital vision and guiding principles** for digitally enabling neighbourhood health in SEL, to act as system-wide guardrails for future decisions.
- **Endorse a phased, system-led approach** to digitally enabling neighbourhood health, using the options set out in this paper to prioritise near-term improvements that support INT delivery and reduce friction for staff and residents; and set a clear long-term direction that avoids further fragmentation and aligns with national policy and planning expectations.
- **Endorse the next phase of work**, including more detailed appraisal of the preferred option(s), implementation sequencing, affordability, risks and dependencies, to be brought back to NBCB and the Digital Committee as appropriate.

This endorsement does not commit the system to immediate procurement or a single technical solution, but provides clarity of direction, pace and coherence as neighbourhood health moves into full operational delivery.

South East London Integrated Care System

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SEL INT Digital Enablement and Roadmap

SEL Digital Committee - March 2026

Introduction and Context - SEL Digital enablement

- **Strategic Alignment**: The SEL digital enablement plan is closely aligned with the digital ambitions set out in the NHSE neighbourhood health guidance 2025/26, the SEL ICS digital and data strategy and the NHS10-year plan with key drivers being population health management, modern general practice, and integrated pathways of care.

- **Our goal**: To harness digital solutions, optimising existing solutions wherever possible, delivering standardised digital pathways to improve patient outcomes, streamline care delivery, and foster collaboration across primary, secondary, community, and voluntary sectors.

- The following slides set out key digital optimisation and transformation workstreams identified through the discovery phase undertaken with SEL stakeholders* who are involved in developing or enhancing existing INT models and/or already working within them.

**SEL stakeholders involved in discovery phase: including Practice leads, PCN Clinical Directors, Trust colleagues and community stakeholders involved in existing MDTs and Place based INT leads and colleagues, which identified a range of digital issues and concerns that need to be addressed.*

SEL ICB Priorities

- The SEL Executive has identified three priority population groups for INTs to initially focus on where the opportunity for improvement is greatest, for addressing health inequalities and improving health and care outcomes for our population.

1. 3+ Long Term conditions
2. Frailty and approaching end of life
3. Children and complex needs

SEL ICB Place Level INTs

The following map shows the current SEL landscape and the number of INTs across the SEL boroughs. All Places have now agreed their INT footprints and there will be **25 INTs** across SEL. The SEL framework for neighbourhood working and INTs is undergoing final sign-off via the 6 place Local Health and Wellbeing Boards.

Neighbourhoods in each Place will adhere to SEL's geography principles. It is anticipated that some PCNs will have to work across neighbourhood boundaries to provide wrap-around support to all residents.

SEL Places have started to identify potential sites for integration to support INTs as their physical place for collaboration. As part of taking an asset-based approach, these sites already have some level of multi-disciplinary working and integrated services being delivered and will be different in each Place.

Key Digital Priorities for INTs

Optimisation Required

LCR and UCP are not accessible from all EPRs e.g. EMIS PCN/ community instances and not used adequately which is a key area to improve

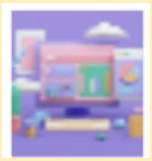
Consider options to integrate ICE for order comms into PCNs and INT instances of EPR

Not all patient-facing apps are integrated with NHS app e.g. Remote monitoring app, MyChart etc. which is still in progress also Enable self referral via the NHS app

Improving Primary and Secondary Care Integration. **Dovetail project –** this project has recently started between Optum (EMIS) and EPIC to improve information Visibility – in primary care and secondary care. **EPIC MESH integration project** - This will potentially improve clinical safety and reduce workload in primary care as the content will be richer and the trust will have direct control on what information they are sharing.

Lower Limb Wound Management, Digital Consolidation and Collaboration - Move all Places that share a tool, onto a single procured solution, to gain synergies and better value for money through scale.

Digital Transformation Requirements to support INTs



Majority of INTs have some form of remote monitoring in place - however challenges being seen in visibility of handoff between virtual ward and remote monitoring activities and having this integrated with relevant clinical management system and for it to available via NHS App

INT stakeholders have raised the need for significant improvements in the interoperability space between existing SEL EPRs where there is a need to increase visibility of cross organisational data and reduce data duplication

Improvements needed around referral management and self-referral pathways together with a centralised DOS/ catalogue of services would be beneficial. Looking to achieve a unified managed referral platform integrated with the INT EPR(s).

Boroughs need a single PHM dashboard to replace current multiple reports and searches and dashboards for different EPRs. Utilising AI to support the holistic assessment of patients and identify core risk groups.

Digital Transformation Requirements

Defining the direction of travel for INT EPR(s) to support at scale work efficiently aligned to the NHSE 10-year plan

- INT stakeholders have raised the need for significant improvements in the interoperability space between existing SEL EPRs where there is a need to increase visibility of cross organisational data and reduce data duplication
- A task and finish group has been established to further explore and develop a deeper understanding of the digital challenges INTs are faced with.
- Multiple EPR solutions offer reduced visibility of the resident's holistic journey of care based on their host organisation EPR.
- The T&F group will seek to define the options available to INTs in the existing SEL landscape in order to enable seamless care within their services and will develop recommendations for the NBCB to define the future direction of travel to address interoperability within the EPRs used across different care settings in SEL.

Population Health management and risk stratification

Ardens Manager:

- SEL ICB has launched the AM population segmentation tools to deliver proactive, consistent care using data to group patients with similar health needs so care can be planned, prioritised, and coordinated more effectively across practices and Integrated Neighbourhood Teams (INTs)
- LGT Population health team is working with Ardens to develop INT reports to go live prior to April 2026

London Data service (LDS) development update:

- The London Data Service (LDS) is a secure, region-wide data infrastructure for health and care in London. Essentially, it collects and links patient data from general practices (GPs), hospitals, community care, mental health services, social care, and other health-care providers across London.
- The SEL PHM team is working with the data/ digital colleagues and the SEL PHM programme to establish the future SEL data architecture, which should capitalise on the opportunities of the London Data Service amongst others.
- The longer term strategic plan is to align the PHM requirements of INTs with the LDS work.

Digital Transformation Requirements

Virtual ward & Remote monitoring

- Currently across SEL, VW falls within the responsibility of the 6 SEL Places with a variation of providers managing the VW contracts.
- There's a need to enable seamless patient care across all settings for step up and step-down pathways. This doesn't exist currently and is a challenging landscape for INTs.
- This workstream addresses the digital requirements raised by INT stakeholders who would like to see the challenges they face mitigated through system collaboration and coordination.
- In addition, the NHSE 10-year plan articulates that wearables should be a standard part in preventative, chronic, and post acute treatment.
- This requirement needs to be further scoped and assessed with key integrators and care providers to determine feasibility of delivery across SEL.
- We would like to invite the VW teams from 6 boroughs to present their strategies for upcoming years and discuss alignment with INT digital strategy across SEL.

Directory of Services, and referral management including self-referral

- Providers have identified several key challenges with existing referral and self referral pathways. Notably the key issue being that there are multiple directories of services (DOS) that exist at national, regional and local level – with even further sub-division of service directories happening at local level.
- Maintaining up-to-date information (e.g. availability, capacity, hours, referral routes) across many services is a heavy administrative burden for providers.
- Often basic contact details for service pathways are not routinely maintained and updated leading to delays in care continuity, patient safety and administrative inefficiency.
- Improvements are therefore needed around referral management and self-referral pathways together with a centralised DOS/ catalogue of services.
- Ideally looking to achieve a unified managed referral platform integrated with the INT EPR solutions.
- Detailed scoping work is needed for improving and streamlining directory of services within SEL to support both INTs and wider system referral and self referral pathways.

Digital Solutions for Optimisation (1/3)

London Care Record (LCR)

- LCR is a digital shared care record across London (and some neighboring areas). It gives authorised health and social-care professionals a single, secure view of a person's health and social-care information — combining data from GPs, hospitals, community services, mental-health services, social care, etc.
- It is a key enabler for INT staff to work at scale as it includes key information such as diagnoses/conditions, medications, allergies, test or scan results, referral letters or discharge summaries, care plans, contact details, and recent appointments or hospital visits
- Digital team will be working with London LCR service desk team hosted by LGT trust to enable the key providers that are yet to be enabled e.g. 2 practices, 26 PCNs, 5 Federations that are yet to have their practice able to view London Care Record data for their patients

Universal Care Plan (UCP)

- The Universal Care Plan (UCP) is a digital personalised care and support plan that enables every Londoner to share 'what matters to them' with all professionals involved in their care. In January 2025, the Universal Care Plan (UCP) underwent a significant evolution.
- A UCP can be created following a conversation between a healthcare professional (such as a doctor or nurse) and the person they care for. It is important that INT team like any other care settings, embed UCP as part of their care delivery as it relates to residents' preferences
- Currently all SEL trusts, almost all practices (3 pending), 4 PCNs, 1 Federation and 51 Care homes have access to UCP. We aim to enable access to all primary care settings in the coming months and enable additional care homes and home cares to have UCP access by actively reaching out to them and showcasing the benefits

Digital Solutions for Optimisation (2/3)

ICE Order Comms – Radiology and Pathology

Radiology

- All practices in SEL have access to ICE, 31 PCNs and all federation have access
- 2 PCNs in Lambeth yet to get access to ICE – a contract variation has been raised to include these two PCN instances to enable them in upcoming months
- Initial evaluation show various usage in different PCN and Federation instances providing an opportunity to optimize and improve. PCIT facilitator team is reaching out to those organisations with low or no usage to understand the challenges they may be facing

Pathology

- ICE project team have started working on implementation of ICE as a solution for pathology which will enable ordering organisation to use ICE in future instead of T-quest (current solution).
- Target time to go-live is current set for 1st quarter of next financial year

NHS App Integration

- All GP practices across SEL are integrated with the NHS app for GP record view, GP registration, messaging and appointment booking.
- LGT's integration with the NHS App is continuing to perform strongly and patients receiving services from LGT can now see their appointments, patient letters and any pre-operative questionnaires. The impact has been positive with reduced DNA rates and operational efficiencies.
- GSTT and Kings College Hospitals, Oxleas Mental Health Trust and Bromley Healthcare CIC have all received funding from NHS England to integrate their existing patient portal solutions within the NHS app, with delivery dates expected by the end of March 2026.
- The South London and Maudsley Mental Health Trust is in the process of procuring a new electronic patient record system and will look to integrate with the NHS app post completion of this work. At this stage, their planned integration into the NHS App is expected to be post April 2027.

Digital Solutions for Optimisation (3/3)

Improving Primary and Secondary Care Integration

- **Dovetail project –** this project has recently started between Optum (EMIS) and EPIC to improve information Visibility – in primary care and secondary care.

  In later phases, it will also plan to include Shared workflows to get instant discharge updates, check and update medications from Epic to EMIS with one click, receive safety alerts and eventually enabling quick, secure messaging via Epic InBasket and EMIS Task Workflows

- **EPIC – MESH integration for GP letters** – another project has started to improve the documents / letter sent from EPIC to come via National API Message Exchange for Social Care and Health (MESH) which provides the ability to share data directly between health and care organisations) which will come to the practices using EMIS document management workflow. This will potentially improve clinical safety and reduce workload in primary care as the content will be richer and the trust will have direct control on what information they are sharing. Current process of sending data via Docman Connect reduces data quality and content

Lower Limb Wound Management – Digital Consolidation and Collaboration

An overview was provided at the December Neighbourhood Digital Working Group on wider improvement work that is underway across the six Places to maximise benefits of improved pathway for patients with lower limb wound problems. The approach delivers savings (dressings and staffing) by enabling remote digital would management platforms.

Two tools are in use with a range of functionality, and both are being developed further by the supplier to meet the need of NHS

- **Healthy.io:** Used by Bromley for the past few years through Bromley Healthcare, Greenwich and Bexley are piloting in limited District Nursing areas until Aug 26 through Oxleas. Lewisham is to be supported by Bromley CIC to mobilise Helathy.io
- **Isla Health** (through GSTT): Within Lambeth and Southwark. Proposal is to keep both tools until evaluation in summer 2026:

Move all Places that share a tool, onto a single procured solution, to gain synergies and better value for money through scale. Oxleas and Bromley Healthcare to work together on this, with support from ICB Digital.

South East London

2025 – 2028 Digital Roadmap Timeline

NHS South East London

Workstream	Project Name	FY 25/26 (Apr 2025 – Mar 2026)				FY 26/27 (Apr 2026– Mar 2027)				FY 27/28(Apr 2027– Mar 2028)			
		Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27	Q1 27/28	Q2 27/28	Q3 27/28	Q4 27/28
Connected Care	Development of INT digital roadmap by establishing digital and infrastructure support required for INTs	Apr 25 – Mar 26											
Data Driven insight & Care	Establish Ardens manager, Population health management and risk stratification platform (short to mid-term i.e. 1 – 2 years)		Jul 25 – Mar 27										
Data Driven insight & Care	Development of London data service to establish SEL ICS wide PHM and risk stratification platform	Apr 25 – Mar 27											
Connected Care	Enable London Care Record access for primary care (Practices, PCNs, Community Pharmacy), INT teams, Care Homes			Oct 25- Mar 27									
Connected Care	Enable Universal Care Plan access primary care (Practices, PCNs, Community Pharmacy), INT teams, Care Homes			Jul 26 –Mar 27									
Empowering people	Support developing a consistent approach to remote monitoring and virtual wards in 6 boroughs					Apr 26 –Mar 27							
Connected Care	Prepare specification with the necessary integration and interoperability for EPR options and put forward recommendations to the NBCB to consider at Mar meeting			Dec 25 – Mar 26									
Connected Care	Investigate options to develop a DOS to improve referrals / self-referral pathways and Option to embed AI to support referral and self referral if one DOS is established						Jul 26 – Mar 27						
Empowering people	Continue working with NHS app team on digital front door and to enable key features in 10-year plan relevant to INTs		Jun 25 – Mar 28										
Connected Care	Dovetail Project – Enable better integration to view patient record between primary and secondary care (EPIC- Optum – Medicus)				Jan 26 - Mar 27								
Connected Care	EPIC - MESH Integration for GP Letters			Nov 25 - Mar 27									

South East London Integrated Care System

NHS South East London

Defining the direction of travel for INT EPR(s) to support at scale work efficiently aligned to the NHSE 10-year plan

Mar 2026

Context and scope of paper

Context and scope

- The Task and Finish Group was originally set up by the Digital Working Group to define the EPR requirements for neighbourhood health, and what SEL would need to do to implement them, then agreed to broaden scope to the wider digital enablement needed for neighbourhood health.
- The group brought together integrator organisation leads, IT and digital colleagues, and clinical representatives from across the system, including GPs, community pharmacists, acute specialists, mental health clinicians and palliative care consultants.
- The work was delivered through three to four focused sessions covering problem definition, principles, requirements and credible digital options, plus an additional short workshop focused on the digital needs of different clinical and care roles within INTs in SEL.
- The group identified three core areas where digital enablers could support neighbourhood health through better use of data, data investigation leading to case finding, operationalising neighbourhood teams through data entry and access, and outcomes and impact tracking at a population health level.
- For this initial phase, the group agreed operationalising neighbourhood teams was the immediate priority, so the paper focuses on context, challenges, digital principles and a small number of credible options in that area.
- The paper is intended to support discussion and endorsement by the Neighbourhood Based Care Board and to inform later detailed appraisal and decision making, with scope covering EPRs and shared capabilities across health, social care and VCSE interfaces, and alignment with existing SEL strategies and governance, while excluding business cases, procurement, population health tools, resident empowerment tools and funding.

High level session overviews

Session 1 – December 2nd

Aims

- Confirm principles
- Allow the group to define and agree on the problem
- Prioritise current challenges
- Agree a set of “red lines” and mitigations against risks

Key Questions

- What issues does a lack of integrated digital records create for patients, staff, and the system currently?
- What issues are most pressing?
- What does the digital solution need to avoid doing?
- What works well currently and should be retained?

Session 2 – December 16th

Aims

- Develop a set of “core requirements” to address our key challenges
- Understand what existing tools we have to address challenges
- Agree initial preferred approach

Key Questions

- What do we need a digital solution to do to address our key challenges?
- What are our red lines’?
- Which approach (e.g an overlay, a new EPR etc.) would best suit SEL currently?
- How are we going to break up the process into manageable chunks?

Session 3 – January 7th

Aims

- Develop and refine use cases for an array of stakeholders involved in neighbourhood health
- Identifying challenges to address and ideal solutions for their needs

Key Questions

- What specific challenges are we looking to solve?
- What existing capability allows the user to do this?
- What potential improvements do we need to implement?

T&F group members also updated interactive mural board as “homework” to provide additional details

Outputs: Current Challenges

Clinical Challenges

- Care planning is a major challenge currently – we need a system that allows partners to view and input into shared records and plans
- Both residents and clinicians have to log in to multiple platforms and systems, adding unnecessary delays and friction
- Lack of visibility across platforms means residents have to tell their story multiple times and impacts communication and coordination between partners
- There is more than one version of the truth, driven by the need to double enter data into multiple systems
- Clinical coding training for clinicians outside of primary care will be necessary to enable “read write” capabilities across system partners

Technical Challenges

- There are challenges around the ability to improve the level of interoperability between systems, both within health (e.g. EMIS integration across different levels of the system (PCN vs Practice etc.) and with UCPs and the LCR), and beyond health e.g. integrating health systems with local authority records and platforms
- Currently minimal interoperability with Community Pharmacy systems
- Identifying residents under care of INTs as they move across and between different settings - although there's been some positive initial work in this space within the current digital landscape
- We need clear agreement on who is responsible and accountable for information with INTs

South East London Integrated Care System

Options reviewed

NHS South East London

Option	Description	Benefits	Risks / Limitations
Do nothing beyond existing plans	Continue with current optimisation activity (e.g. LCR, UCP, NHS App, PHM) with no specific neighbourhood EPR strategy	No additional cost or disruption; allows focus on delivery of existing programmes	Does not resolve core neighbourhood challenges; continued duplication and poor visibility; high risk of local divergence
Optimise and standardise current landscape	System-led optimisation of existing EPRs and shared tools with agreed SEL-wide standards for neighbourhood working	Builds on existing investment; faster to implement; lower risk and cost; improves consistency	Structural limitations of multiple EPRs remain; limited read/write interoperability; benefits may plateau
Pilot new digital approaches locally	Developing and testing new digital approaches (e.g a digital overlay and shared longitudinal care record) within a specific locality	Test long-term solutions within a more manageable context; opportunity to test and learn; informs future system development	Dependent on interoperability maturity; requires new resource to implement, test and learn
Neighbourhood digital layer / overlay	Implement a shared neighbourhood platform sitting across existing EPRs, providing common workflows (care planning, tasking, referrals)	Supports INT workflows; reduces duplication; inclusive of health, social care and VCSE; avoids immediate EPR replacement	Additional system to manage; dependent on interoperability maturity; requires strong adoption and governance
Single neighbourhood EPR (long-term)	Converge towards a single EPR for neighbourhood services across SEL	Strongest potential for single version of the truth; simplified architecture; future-proofed	High cost and complexity; long delivery timescales; significant change needed; potentially disruptive to borough- and organisation-specific systems

South East London Integrated Care System

Recommendation for taking this forwards

NHS South East London

Recommended approach	Prioritise optimising and expanding existing systems and platforms to meet the minimum digital requirements for INT delivery in the short term, whilst undertaking a thorough assessment of the digital health market to understand the extent to which more transformative approaches may be viable in the medium to longer term.
Phased delivery	Progress iteratively through three stages: establishing information visibility; enabling information transfer; and realising collaborative working, with the long-term ambition to move from Stage 1 in the short term towards Stage 3 over time.
Investment approach	Deliver core requirements through ongoing development and integration of current solutions, recognising that major digital transformation while the contours of neighbourhood working are still taking shape may be counterproductive.
Test and iteration	Use areas with stronger digital maturity to pilot more advanced digital enablement, generating evidence before scaling, and align SEL ICB activity to the London Neighbourhood Health Delivery Board Digital Task and Finish workplan, leveraging wider resource and feeding in SEL specific recommendations.

South East London Integrated Care System

NHS South East London

Digital Neighbourhood Working Group Overview

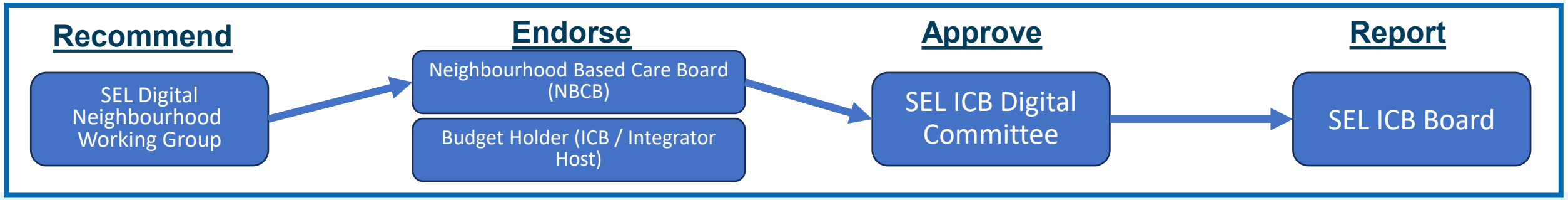
Mar 2026

Governance for Neighbourhood Working

- Digital is seen as one of the key enablers for neighbourhood health service delivery and as such reports into the SEL Neighbourhood Based Care Board (NBCB) alongside other enabler teams including estates, population health management, people and OD, Comms and Engagement, Frailty, LTC and Children and Young People teams.

- Recognising the complexity of challenges and priorities within the digital space, the NBCB has agreed a separate Neighbourhood Digital Working Group (NDWG) is established that focuses specifically on digital neighbourhood requirements providing the necessary system leadership on proposals and recommendations through relevant SME expertise.

- The NDWG provides guardrails and shared capabilities so Places and providers can plan and implement local solutions that still connect system-wide. To support delivery, the group will oversee a neighbourhood digital delivery plan, monitor progress, risks and benefits, and provide high-level oversight to ensure value for money across all system partners, reflecting how digital budgets sit across multiple organisations.



Digitally Enabling Neighbourhood Health in South East London

The Neighbourhood Based Care Board is asked to:

- Endorse the case for change set out in this paper, recognising that the current digital and EPR landscape in SEL is not sufficient to fully support integrated neighbourhood working at scale.
- Agree the proposed digital vision and guiding principles for digitally enabling neighbourhood health in SEL, to act as system-wide guardrails for future decisions.
- Endorse a phased, system-led approach to digitally enabling neighbourhood health, using the options set out in this paper to prioritise near-term improvements that support INT delivery and reduce friction for staff and residents; and set a clear long-term direction that avoids further fragmentation and aligns with national policy and planning expectations.
- Endorse the next phase of work, including more detailed appraisal of the preferred option(s), implementation sequencing, affordability, risks and dependencies, to be brought back to NBCB and the Digital Committee as appropriate.

This endorsement does not commit the system to immediate procurement or a single technical solution, but provides clarity of direction, pace and coherence as neighbourhood health moves into full operational delivery.

Contents

1 Context

The NHS 10-Year Health Plan and national neighbourhood health guidance set a clear direction for the health and care system: a shift towards proactive, preventative and coordinated care delivered closer to home, enabled by digital transformation. In South East London (SEL), this ambition is being in part operationalised through the development of 25 Integrated Neighbourhood Teams (INTs) across six Places. These "teams of teams" bring together staff employed by different organisations and sectors, working across traditional boundaries. Digital enablement is therefore critical to making neighbourhood models work in practice, allowing professionals to work as one around residents, regardless of organisational boundaries.

Over time, SEL has invested in a range of system-wide and place-based digital solutions, both locally (e.g. multiple Electronic Patient Record (EPR) systems) and for London wide solutions (e.g. London Care Record (LCR) and Universal Care Plan (UCP)). While these provide a strong foundation, there is system-wide recognition that the current digital landscape remains fragmented. This fragmentation leads to duplication, limited visibility of residents' holistic journeys, and friction for both staff and residents. In response, a Digital Task & Finish Group, reporting into the Neighbourhood Digital Working Group, was convened to assess whether the current digital landscape can adequately support neighbourhood working and to set out options for the future.

This work forms part of the SEL Digital Enablement Plan for Integrated Neighbourhood Teams and aligns with the six core digital priority areas set out in the SEL ICS Digital and Data Strategy:

1. Data-driven insight and care
2. Connected care
3. Empowering people
4. Supporting our workforce
5. System resilience, data integrity and cyber security
6. Continuous improvement and innovation.

1.1 Scope of this paper

The Task & Finish Group (T&F) was initially stood up to focus on the EPR requirements for neighbourhood health, and what would need to be done within SEL to implement them. However, as the T&F group met, there was an agreement that the scope of the work should move wider. As such, the group, which brought together leads from our integrator organisations, IT and digital colleagues, and clinical representatives across the wider system (including GPs, community pharmacists, acute care led specialists, mental health clinicians and palliative care consultants), was structured over three to four focused sessions to address the problem definition, principles, requirements and options for digitally enabling neighbourhood health. This work went on to include a further short workshop, focused on the digital needs of different clinical and care roles within INTs in SEL.

The Group initially identified three core areas where digital enablers could support neighbourhood health, particularly as it relates to the utilisation of data:

1) Data investigation, leading to case finding
2) **Operationalisation of neighbourhood teams, particularly around data entry and reading**
3) Outcomes and impact tracking at a population health level

For this initial T&F process, the membership agreed that operationalisation of neighbourhood teams was an area of immediate focus. As such, this paper summarises the context, challenges and digital principles for neighbourhood health, and sets out a small number of credible options for digitally enabling neighbourhood health in SEL in the realm of operationalisation. It is intended to support discussion and endorsement by the Neighbourhood Based Care Board, and to inform subsequent detailed appraisal and decision-making.

In scope for this paper:

- The digital enablement required to support integrated neighbourhood health, with particular emphasis on EPRs and shared digital capabilities.
- Health, social care and VCSE interfaces insofar as they are required to support neighbourhood working.
- Implications of existing SEL digital strategies, governance and optimisation programmes.

Out of scope for this paper:

- Detailed business cases, affordability assessments or procurement decisions for specific products.
- Stand-alone digital programmes not directly related to neighbourhood working (e.g. invoicing systems) and organisation- or role-specific solutions.
- Population health management-related tools and solutions.
- Wider digital tools related to resident empowerment (e.g NHS app).
- Funding for digital investment and transformation.

The SEL Digital Roadmap for Integrated Neighbourhood Teams provides a clear, system-wide approach to some of the key areas that fall outside of the scope of this paper. The Digital Roadmap has been presented to the Neighbourhood Digital Working Group and is now being finalised for approval and publication in the February meeting.

2 The Digital Landscape in SEL Today

2.1 Digital challenges currently faced by the system

The Task & Finish Group and the wider Neighbourhood Digital Working Group identified a consistent set of clinical, technical and system challenges which must be addressed to enable integrated neighbourhood working:

:

1. **Limited system interoperability:**
    - Staff working in neighbourhoods routinely need to access multiple EPRs and system instances, which remains a key barrier to seamless working. For example, whilst almost all GP practices use EMIS (with one exception in Bexley), EMIS practice, PCN and federation instances do not consistently “talk” to each other, nor with community, mental health or acute systems.
    - Interoperability with shared assets such as UCP and LCR is variable across places and partners, and integration with local authority systems remains very limited.

- Limited or no interoperability with community pharmacy systems; community pharmacy operates under a provider funded IT model, with varying systems in use – interoperability is often chargeable, inconsistently supported by suppliers, and in some cases actively resisted, limiting effective integration into neighbourhood pathways.
- Platform providers can themselves present barriers (both financial and technical) to future interoperability.

2. **Uncertain information governance landscape:**
    - There is a lack of clarity around the roles and responsibilities for information governance within INTs, with partners uncertain what information can and should be shared between teams and organisations.
    - There are concerns that the information governance risk falls upon Data Controllers within the INT landscape, especially in the context where the shared care record can be written into by wider partners.
    - There are significant concerns about the extent to which information can be shared with INT partners beyond health, specifically VCSE and local authority partners.
3. **Lack of simple communication within INTs and between partners:**
    - There is no mechanism for facilitating quick, simple and secure communication between INT partners about the people being cared for.
    - Lack of communication can also contribute to unclear clinical accountability, leading to residents falling through the gaps particularly during transition points in care.
4. **Fragmented and inconsistent data sources:**
    - Inconsistent approaches to data entry, and coding, particularly around medication for example, lead to key information gaps and undermine trust in the data in shared records (e.g LCR).
    - Some partners have partial access to the data required to support clinical delivery (e.g some District Nursing teams) or assess risk (e.g for mental health teams)
    - At the same time, shared tools like LCR can often present large amounts of information at a time, leading staff to struggle to quickly identify the pertinent information they require and spend additional time on data retrieval.
5. **Limited Resident Visibility**
    - Teams face challenges tracking residents under the care of INTs as they move between different care settings.
    - Some partners have limited visibility of different episodes of care (instead seeing an aggregate view), compounded by the lack of a true “live” patient record.
    - This also limits teams’ ability to link episodes of care and outcomes, and therefore effectively measure and assess the impact of interventions.

2.2 Areas of Uncertainty

In addition to the current challenges faced by the system, there are areas of uncertainty that can only be clarified as time goes on and as the neighbourhood model evolves in SEL, but also at a national level:

- The realistic level of interoperability achievable between existing EPRs from various providers that is possible within acceptable timeframes and cost.
- National policy and regulatory changes that may affect data controllership, consent and information governance, particularly for general practice and social care.
- The future direction of national and London-wide platforms, including how the London Data Service, OneLondon and national EPR strategies will evolve.
- The long-term sustainability and affordability of maintaining multiple EPRs alongside additional overlay solutions.
- The pace at which neighbourhood models will standardise across SEL, and the degree of variation that will persist.
- Supplier behaviour and market maturity, particularly around openness, interoperability and pricing models.

2.3 Existing tools and capabilities

SEL is not starting from a blank sheet. There are strong digital foundations that can be built upon to enable neighbourhood health. This includes the current usage of local, London-wide and national platforms that affect various elements and functions that will relate back to neighbourhood health:

- **Strong system alignment in secondary care** with two major trusts and system integrators, Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH) having implemented Epic in the last two years; a third, Lewisham and Greenwich NHS Trust has also recently announced that they will be procuring Epic.
- **London Care Record (LCR)** providing shared, read-only access to health and care information across London, with further rollout and optimisation underway.
- **Universal Care Plan (UCP)** offering a shared personalised care and support plan aligned to 'what matters to me', already available across most SEL providers.
- **High primary care EPR coverage with near-universal use of EMIS in general practice,** creating opportunities for consistency and scale.
- **Population Health Management (PHM)** capability including Ardens Manager tools and emerging alignment with the London Data Service.
- **NHS App integration** across all GP practices and increasing coverage across acute, community and mental health providers.
- **Established digital governance** structures including the Neighbourhood Digital Working Group and Digital Committee.
- **Improving integration between primary and secondary care,** with a programme underway to provide a strong level of integration between GSTT and KCH's Epic systems and EMIS; and similarly integration planned with LGT's Epic system.
- **Robust information governance** across SEL between system partners to facilitate the data-sharing required to support neighbourhood working (including the SEL Data

Sharing Framework, for example). Further information will be shared at the Digital Working Group in future to help improve understanding of the information governance landscape in SEL and clarify roles and responsibilities within it.

These assets provide a strong base but are not yet configured or consistently used in ways that fully support neighbourhood working. The engagement with the T&F group highlighted specific challenges and areas for improvement within two core tools that the Group felt would be key to supporting further work, and that should remain central to any digital usage approach SEL takes.

Existing Digital Tools	Limitations / Challenges
London Care Record	• Not fully integrated with the majority of PCNs, GP Federations, Community Pharmacy, Care Homes, and social care • Information not always presented intuitively – can be challenging for staff to find what they are looking for • Inconsistent approaches to data entry across that feeds the LCR
Universal Care Plan	• Limited integration with some partners • Utilisation varies across partners

2.4 SEL's digital guiding principles

The shared digital vision for neighbourhood health in SEL is:

> To enable integrated neighbourhood teams to work as one, around the resident, supported by digital tools that provide a single, trusted view of information, minimise administrative burden, and enable proactive, coordinated care across organisational boundaries.

In response to this vision, the Task & Finish Group and the Neighbourhood Digital Working Group articulated a further set of guiding principles to shape future digital decision-making:

- **Neighbourhood-first, function-led:** Digital solutions should be designed around the functions neighbourhood teams need (e.g. care planning, tasking, referrals), not organisational silos.
- **Optimise first:** Maximise the value of existing investments (such as LCR, UCP, NHS App, PHM tools) before procuring new systems.
- **Interoperability by default:** Prioritise solutions that reduce interfaces, support data-once-use-many-times, and integrate with national and London-wide platforms.
- **Single version of the truth:** Residents and staff should be able to rely on a consistent, shared record, reducing duplication and variation.
- **Inclusive of all partners:** Digital enablement must work for primary care contractors, community services, acute providers, social care and the voluntary sector.
- **Proportionate, pragmatic and scalable:** Solutions should be deliverable in the short to medium term, while aligning to a longer-term strategic direction.
- **Safe and governed:** Strong information governance, role-based access and clinical safety must underpin all options.

2.5 INT Core Digital Requirements

As the focus of the Task and Finish Group evolved from identifying EPR solutions to understanding the digital needs of INTs to effectively work together to support residents, one of the first exercises was to articulate the real needs of stakeholders involved in neighbourhood health. This took the form of User Profiles, with members of the T&F group outlining the core digital requirements within INTs i.e what teams and individuals would need today to enable effective neighbourhood working. **While the personas do not represent an exhaustive list of those who may be involved in neighbourhood health, they do represent the main archetypes that will inform a fuller foundation for a digital environment:**

- Residents
- VCSE workers
- GPs
- Children and Young People Nurses
- District Nurses
- Acute Consultants
- Social workers
- Community Pharmacists
- Population Health Analysts
- Mental Health professionals

Persona and use cases developed

Elena, Resident

Key Challenges
- Limited digital literacy
- No joined-up communication – receiving information from different providers

Support Needs
- Training on end-user technology
- Support / training on how to use the NHS app
- Easy to use digital interface but still able to use a non-digital route

Potential Improvements
- Improved NHS app
- UCP and LCR with improved access for health and social care providers
- Improved access and integration between clinical systems to support data sharing

Future State
- Access to shared digital tools and data
- Confidence and knowledge to use digital and data systems and resources
- Good integration with wider health and care services

Charles, Voluntary Sector Worker

Key Challenges
- Unable to access good quality data about patients
- Lack of awareness of, and access to, digital tools

Core Requirements
- Role-based access to suitable digital tools
- Suitable and secure digital connectivity to support remote working
- Digital training and support to use tools

Potential Improvements
- Digital upskilling programme
- Better integration and role-based access to the data needed to do their job
- Suitable offering and support to voluntary (non-salaried) workers, recognising limits

Future State
- Access to shared digital tools and data
- Confidence and knowledge to use digital and data systems and resources
- Good integration with wider health and care services

Dr Evans, GP

Key Challenges
- Social care records not accessible via LCR
- Poor visibility of shared care
- No communication platform for MDTs
- No shared live patient record

Core Requirements
- Shared access to longitudinal care record
- Data governance and shared risk
- Ability to view active teams for a patient; and waiting lists, referrals etc to avoid duplication

Potential Improvements
- LCR funded as the main platform for all services to feed into
- Digital referrals
- Messaging platform between teams
- Improved EMIS interoperability

Future State
- Communication between INT teams
- A single integrated patient view
- Seamless workflows with trusted data
- Patients are able to access and understand data

Oli, CYP Nurse

Key Challenges
- Interoperability – LCHT currently uses 2 EPRs, aligned to PCN not neighbourhoods
- Lack of visibility for episodes of care
- Inability to assess long-term impact of care

Core Requirements
- One shared plan live and accessible to INT team (inc. non-health)
- Ability to refer directly from the EPR into all services (inc. non-health)

Potential Improvements
- Streamlined access for INT teams
- Care record compliance
- Data overlay and linkage
- Ability to evidence ROI outside of health

Future State
- A single view of general practice-based and community paediatrics/LCHTs
- Tracking of all touchpoints on individual pathways
- Easy sharing of data across EPRs

Alice, District Nurse

Key Challenges
- Lack of information to support clinical delivery (inc. tests, real time medication, GP records, care packages etc.)
- Fragmented patient information

Core Requirements
- A single record, or ability to access shared records, of all INT partners
- Access to key patient information
- Trust in the data

Potential Improvements
- Optimising UCP/LCR/GP Connect
- Using Smart Notes

Future State
- Full holistic understanding of the patient - including social care and acute information
- Intelligent integration: layered patient data in a single platform
- No duplicate assessment forms required

Fiona, Consultant Geriatrician

Key Challenges
- Unclear information governance
- Communication barriers
- Lack of visibility of primary care data
- Inconsistent processes around data entry

Core Requirements
- More organisations in LCR and UCP access in short term
- Automatically update of medication from GP record

Potential Improvements
- UCP (universal care plan) to have more automated features
- Chat options between INT partners
- Tools to ensure governance and assurance across different care settings

Future State
- Updated live data
- Communication platform for all INT partners including clinical and admin staff
- One system across different care settings giving

Sofia, Population Health Analyst

Key Challenges
- Lack of trust in the data
- Lack of connection between digital tools and clinical tools
- Lack of flexibility in the tools available

Core Requirements
- Single longitudinal patient-level data set
- Protected time for analytics
- Information governance which allows us to share data appropriately and safely

Potential Improvements
- Need to build trust in the data – this is a virtuous cycle
- Ability to use the same data set to evaluate interventions (e.g., code the intervention, pull the full cohort and compare outcomes)

Future State
- One version of the truth
- One set of definitions shared across partners
- Easy to use and flexible tools
- Using Ardens so that clinicians can directly see the cohort within their system

Sarah, Community Pharmacist

Key Challenges
- Lack of clear information governance
- Time lag and accuracy of patient information
- Lack of system interoperability

Core Requirements
- Shared Teams channels for INT staff
- Consistent, accessible referrals
- Full access to patient care record with read/write capability

Potential Improvements
- Data sharing agreements across providers
- CP prescribing via EMIS not CLEO
- Full utilisation of current products (e.g EMIS Local Services button)

Future State
- Funded support to improve interoperability and access to other systems (e.g LCR)
- Centralised referral system
- Digital tools to support risk stratification and consultation

Adil, Social Worker

Key Challenges
- Day-to-day connectivity challenges with existing hardware
- Lack of interoperability and access to some other systems and information sources

Core Requirements
- Access to shared records and tools
- Improved communication with INT partners (e.g teams)
- Better connectivity on site and on-the-go

Potential Improvements
- Improving connectivity on site and tools to support remote working
- Improving data sharing to reduce duplication and manual data entry where possible

Future State
- Using shared tools and information daily
- Contact via teams with system partners
- Drawing on AI to support working (e.g Magic Notes)
- Digital tools to work interactively with residents

Erika, Mental Health Nurse

Key Challenges
- Staff can't easily see up-to-date data across systems, driving duplication
- Limited visibility of risk, making transitions of care potentially unsafe

Core Requirements
- One clear source of risk information
- Care coordination capacity, with the ability assign and track actions across organisations

Potential Improvements
- An agreed core dataset for risk, crisis plans and safeguarding
- Shared, editable care plans with role-based access
- Patient summaries, not just raw data

Future State
- One shared mental health record giving a view of the whole patient journey not isolated episodes
- Pathway-based digital design with digital handovers embedded into workflows

In addition to what individuals/teams may need to see and have access to, the Group also developed a 'mini-specification' for a digital environment that would allow multi-organisational teams to effectively view relevant information about a resident's needs and support the update of their care plan.

Area	Core Requirement

Improving existing systems	• Expanded access to core shared platforms (LCR, UCP) for all partners
	• Optimisation of LCR and UCP information:
	  ○ Addition of key information (e.g GP notes, tests, medication)
	  ○ Streamlining to ensure key information is easy to find
	  ○ Automated data entry and autofill where possible to reduce repetitive, manual data entry tasks
	• Streamlining the referrals system and moving towards fully digitally enabled referrals without the need for manual print outs

Communication	• A medium for instant, secure and auditable communication between clinical and administrative staff working together as part of an INT (e.g shared Teams channels)
Information Governance	• Clear information governance which allows teams to share data appropriately and safely
Learning	• Training support for digital tools, ensuring existing capabilities are being maximised and platforms are being used appropriately and consistently across the system

Developing and implementing solutions to address these core requirements should be priority areas of focus for the system over the next 12 months.

2.6 Future Vision

Fully digital-enabled neighbourhood working will take time, and needs may change as ways of working, workflows, and the scope of INTs evolve. Nonetheless, the group recognised that we should be working towards a collective future vision. The key building blocks of that future ideal state include:

- Complete access to a holistic and longitudinal care record, encompassing health, care and wider determinants, with appropriate read/write access functionality.
- Fully digital, centralised referral system that reduces duplication and need for paper forms.
- Seamless workflows with trusted data allowing clear visibility of INT activity.
- Set of shared definitions across partners to support population health analysis.
- The ability to track touchpoints within and across pathways to be able to effectively assess impact and outcomes over time.
- Information governance, data-sharing agreements and technology in place to enable information to be safely and securely shared between systems, organisations and partners; and thorough understanding of existing information governance and how it affects information sharing across the system.
- System to enable instant, auditable and secure communication between INT partners.

Above all, there was a recognition that this vision should be inclusive of all system partners involved in neighbourhood working – social care, mental health, housing, the VCS – and not solely health-focused. Future digital optimisation, enablement and transformation must take place within this inclusive framework.

3 Options Appraisal

3.1 Why a decision is needed now on the future of SEL's digital integration

There is a clear and time-critical need for the system to agree a direction of travel for digitally enabling neighbourhood health in SEL. Neighbourhood models are moving from design into delivery, with INTs increasingly operating across all six Places. At the same time, national expectations set out in the NHS 10-Year Health Plan and the Medium Term Planning Guidance require ICBs to demonstrate progress towards neighbourhood-based, digitally enabled models of care within a three-year planning horizon. It is imperative, therefore, that we adopt a shared SEL-wide digital approach: an approach which synthesises the digital needs of Places and Neighbourhoods to support emergent models of neighbourhood working with a thorough understanding of what is being offered at regional and national level in terms of infrastructure and capacity.

While some "once for London" thinking and decision-making can be made at a London-wide level, the onus is on SEL as a region to articulate a coherent digital strategy that meets its own specific needs and unique circumstances and helps to shape the London-wide approach. Without doing so, there are material risks that:

- Local, place-based or pathway-specific decisions are made independently to address immediate operational pressures, further fragmenting the digital landscape and driving variation in the medium- to longer-term.

- The London region develops a set of minimum criteria and/or a digital strategy that does not align to SEL's needs.

Setting our own digital direction now is about taking agency and proactively shaping the digital systems, platforms and processes we need to enable effective neighbourhood working in SEL.

Agreeing a clear direction at this stage does not require committing to a single technical solution or immediate large-scale procurement. Rather, it enables the system to:

- Establish a shared set of principles and guardrails for neighbourhood digital enablement;
- Avoid further uncoordinated investment that undermines interoperability and value for money;
- Prioritise near-term improvements that deliver tangible benefits for staff and residents;
- Set a credible long-term trajectory that aligns local decisions with system and national strategy.

Endorsement of a preferred direction of travel will therefore provide clarity, pace and coherence as neighbourhood health moves into full operational delivery.

3.2 Potential options for digitally enabling neighbourhood health in SEL

Option	Description	Benefits	Risks / Limitations	Timescale	Strategic fit
A. Do nothing beyond existing plans	Continue with current optimisation activity (e.g. LCR, UCP, NHS App, PHM) with no specific neighbourhood EPR strategy	No additional cost or disruption; allows focus on delivery of existing programmes	Does not resolve core neighbourhood challenges; continued duplication and poor visibility; high risk of local divergence	Short term (0–2 years)	Low – unlikely to deliver neighbourhood ambition
B. Optimise and standardise current landscape	System-led optimisation of existing EPRs and shared tools with agreed SEL-wide standards for neighbourhood working	Builds on existing investment; faster to implement; lower risk and cost; improves consistency	Structural limitations of multiple EPRs remain; limited read/write interoperability; benefits may plateau	Short–medium term (1–3 years)	Medium – pragmatic improvement but not transformative
C. Pilot new digital approaches locally	Developing and testing new digital approaches (e.g a digital overlay and shared longitudinal care record) within a specific locality	Test long-term solutions within a more manageable context; opportunity to test and learn; informs future system development	Dependent on interoperability maturity; requires new resource to implement, test and learn	Short-medium term (1-3 years)	Medium – tests transformative approach, but limited scope
D. Neighbourhood digital layer / overlay	Implement a shared neighbourhood platform sitting across existing EPRs, providing common workflows (care planning, tasking, referrals)	Supports INT workflows; reduces duplication; inclusive of health, social care and VCSE; avoids immediate EPR replacement	Additional system to manage; dependent on interoperability maturity; requires strong adoption and governance	Medium term (2–5 years)	High – balances deliverability with ambition
E. Single neighbourhood EPR (long-term)	Converge towards a single EPR for neighbourhood services across SEL	Strongest potential for single version of the truth; simplified architecture; future-proofed	High cost and complexity; long delivery timescales; significant change needed; potentially disruptive to borough- and organisation-specific systems	Long term (5–10 years)	High (long term) – but not immediately deliverable

3.3 Recommended Approach

Our recommended approach is to take forward a combination of Options B and C in the short term, whilst undertaking a thorough assessment of the digital health market to understand the extent to which more transformative approaches (Options D and E) may be viable in the medium to longer term. This recommendation recognises that the shift towards fully digitally-enabled INTs will necessarily be a phased, iterative process broadly progressing through three key stages:

1. **Establishing information visibility:** building the capabilities for all partners to access the information they need when they need it
2. **Enabling information transfer:** facilitating partners to easily share and transfer information quickly and easily
3. **Realising collaborative working:** putting the tools in place to enable INT partners to work as one team with full read/write capability where appropriate

This recommendation is further rooted in the understanding that:

- Some of the key core requirements for digitally-enabled INT working can be achieved to some degree through ongoing development, optimisation, and expansion of existing systems and platforms
- Undertaking major digital transformation when the contours of neighbourhood working are still taking shape at both a local, regional and national level may be counterproductive
- There is an appetite in some local areas with strong levels of digital maturity to test more transformative digital enablement, presenting an opportunity to test, learn and optimise complex digital solutions before expanding to a larger scale implementation
- There is a lack of clarity on what is possible within the current digital market offer

There is also currently a London Neighbourhood Health Delivery Board that is overseeing the London-wide implementation of INTs across the London ICBs. As part of this work, a Digital Task and Finish Group has been stood up to support the 4 ICBs, along with regional partners, to agree and secure the infrastructure to support a once for London approach to the digital focused of the London Neighbourhood Health Target Operating Model (TOM), in line with agreed plans and priorities set by the London Neighbourhood Health Delivery Board.

The Task and Finish Group is responsible for driving delivery against agreed workplans, ensuring that the necessary inputs, dependencies and priorities are in place to enable implementation at regional, system and neighbourhood levels. The current workplan of the Task and Finish Group aligns with many of the considerations and approaches that are recommended within this paper. This includes:

- The development of a London-wide specification for digital enablers, outlining what would provide value-add as a once for London approach and where ICB flexibility would allow for a more tailored approach
- The development of an agreed population segmentation approach, building upon the London Shared Data Environment and understanding what tools are available and appropriate for use
- Identification of where the UCP and LCR can be utilised more effectively to support the development of a Shared Care Record that can be accessed and used by multiple partners and residents
- Articulation of the Information Governance gaps that currently exist that may restrict Neighbourhood working and how they can be resolved

SEL ICB is represented on this T&F group, and so the workplan within the ICB should align to the development plan at a regional level to make use of wider resource to answer relevant questions but to also feed in specific recommendations that may support the wider digital agenda.

Some of the initial opportunities that can support this evidence gathering include:

- Work to integrate Epic and Emis between GSTT, KCH, and LGT and primary care practices
- A potential pilot within Bromley to test neighbourhood EMIS as an INT EPR option
- Continued insight from the Primary and Secondary Group to align Digital thinking between groups focused on SEL system-wide challenges and those focused INT delivery

In short, this recommendation focuses on maximising existing investment to meet the minimum digital requirements of INTs whilst developing a greater understanding of emerging longer term digital needs and the ability of the market to meet those needs, utilising the London-wide working group where possible. The long-term ambition should be to move from Stage 1 (establishing information visibility) in the short term towards Stage 3 (realising collaborative working) in the long term.

3.4 Future Planning

The table below provides an outline for the potential direction of digital enablement over a 5-year timeline, as well as the underlying reasons for the suggest actions:

12 Month Horizon	
Area	**Action/s**

Maximising existing systems	• Expanding integration and utilisation of UCP and LCR to provide a minimum level of visibility across core INT partners
	  ○ There is currently inconsistent in how UCP and LCR are used across social care. Consistent utilisation across health and care is critical to successful neighbourhood working
	  ○ Lack of integration with community pharmacy and between different levels of primary care further hinders INT working
	• Improving usability of UCP and LCR, including streamlining information
	  ○ Information is not always presented in an intuitive way; staff reported challenges in quickly and easily finding key information, and that some key information fields were missing
	• Continuing existing integration efforts across the system (e.g Dovetail integration between EPIC and EMIS), focusing on:
	  ○ Establishing visibility of patient records across primary and secondary care
	  ○ Building smart communication between primary and secondary care
	  ○ Building, accessing and sharing workflows

Clarifying the information governance landscape	• Sharing clear information about current information governance arrangements, including data-sharing agreements, and improving understanding of roles and responsibilities at an organisational and system-wide level, including: • What can be shared and with which partners • Responsibilities and risk-sharing in an INT context • Working at local, regional and national level to develop clear processes where gaps exist in the current information governance landscape, including:

	• How data sharing should extend beyond traditional "health" boundaries • Clearly defined role-based access for different data sources • Engagement with residents to understand their views and concerns around data sharing to support their care ○
Facilitating Communication	• Investing in a short-term solution (e.g Teams) to enable quick, easy and auditable communication between partners within INTs ○ Communication currently relies on informal channels (emails, calls etc.) and is not always possible when required, leading to miscommunication, poorer care, a lack of accountability, and the risk of residents "falling through gaps"
Learning	• Investing in the digital literacy and skills of all INT staff; implementing training to ensure all INT partners are comfortable with using existing tools and are utilising them consistently to accurately capture and share information within an appropriate timeframe ○ There is a recognised inconsistency across partners in what information is inputted into shared systems and how

Planning for the future	• Market engagement to scope viability and options for transformative digital enablement technology
	  ○ We need a strong understanding of the state of the market in order to effectively and strategically plan for future digital transformation
	  ○ Engagement should focus on exploring the market offer around:
	  ▪ Digital EPR overlays that can integrate across multiple systems
	  ▪ Longitudinal patient care records with read/write capabilities
	  ▪ A shared platform to facilitate easy communication and information-sharing between partners
	  ▪ Digital referrals systems with the capability to integrate with different systems

Years 2 – 3	
Expanding access	• Implement suitable role-based access to shared digital systems and data for wider partners (including VCSE, Housing, and Employment Support)

Testing	• Pilot a more transformative integrative digital tool (e.g a single digital overlay) within a specific locality
Improving connectivity	• Digitising, streamlining, and centralising referrals, reducing the need for manual print outs, repeated requests for information, and improving connectivity between system partners
Embedding Change	• Developing a SEL-wide digital training programme, with curriculum and training resources linked to roles to help successfully upskill staff and embed digital transformation within INTs
Years 4 – 5	
Frictionless Communication	• Establishing a simple and intuitive platform that facilitates frictionless communication and information sharing between partners in an auditable and secure environment

Shared Records	• Establishing an integrated system (e.g a digital overlay) that feeds a shared record, providing:
	  ○ Complete visibility of necessary information within a longitudinal patient record
	  ○ Real-time updates
	  ○ A minimum level of visibility for wider system partners

3.5 What we need from you

The transition towards a Neighbourhood Health Service will require significant shifts in ways of working, workflows, and – fundamentally – how we conceptualise care delivery. From acute to community and from separate services to integrated care, our health and care services will have to work together more closely than ever before, reach people in the communities in which they live, and provide joined-up, holistic support.

Our digital systems need to reflect that model and will be central in enabling true integrated working. In this paper we have outlined what the conditions for digital enablement are, the barriers we will have to overcome, and recommended the steps we must take to deliver a digital landscape that is ready to support neighbourhood working in SEL.

To summarise, we have:

- Highlighted the current challenges and strengths within the digital landscape in SEL
- Outlined a set of core principles to guide future digital development in support of neighbourhood working
- Synthesised the digital requirements for enabling the operationalisation of neighbourhood teams
- Assessed the different options for realising those requirements and long-term digital enablement in SEL
- Recommended an approach and developed a high level plan to take forward that approach as a system

What we need from you as key system leaders and decision-makers is to:

- Reflect on the contents of this paper
- Endorse the case for change set out in this paper, recognising that the current digital and EPR landscape in SEL is not sufficient to fully support integrated neighbourhood working at scale.
- Agree the proposed digital vision and guiding principles for digitally enabling neighbourhood health in SEL, to act as system-wide guardrails for future decisions.
- Endorse a phased, system-led approach to digitally enabling neighbourhood health, using the options set out in this paper to prioritise near-term improvements that support INT delivery and reduce friction for staff and residents; and set a clear long-term direction that avoids further fragmentation and aligns with national policy and planning expectations.

- Endorse the next phase of work, including more detailed appraisal of the preferred option(s), implementation sequencing, affordability, risks and dependencies, to be brought back to NBCB and the Digital Committee as appropriate

Agreeing a clear direction at this stage does not require committing to a single technical solution or immediate large-scale procurement but it is essential in adopting a coherent, system-wide approach to future digital development.

4 Appendices

4.1 INT Role-Based Requirements

The table below summarises the outputs from a session in January where staff, representing their roles (or assigned roles) within INTs, were asked to consider the challenges they face today, their digital needs – now and in future – and where they saw opportunities for potential improvements to existing systems.

Role	Challenges	Core Requirements (now)	Ideal state (future)	Potential Improvements
VCSE Support Worker	• Unable to access good quality data about patients, adding to potential for misinformation and confusion • Time-consuming to double check data • Lack of awareness / access to existing digital capabilities • Lack of HSCN connectivity to access EPR and wider infrastructure • Lack of digital resources and maturity	• Role-based access to suitable digital tools • Suitable and secure digital connectivity wherever Charles is working • Digital training and support to use tools	• Access to shared digital tools and data • Confidence and knowledge to use digital and data systems and resources • Good integration with wider health and care services	• Digital upskilling programme • Better integration and role-based access to the data needed to do their job • Suitable offering and support to voluntary (non-salaried) workers, but with recognition of security needs and limitations
CYP Nurse	• LCHTs often use 2 EPRs: primary and secondary care • LCHT EPR currently aligned to PCN not neighbourhood footprint	• Ability to have one shared plan live and accessible to the MA team (inc. non-health) • Track referrals/triage outcomes to understand activity supported by INT	• A single view of general practice-based and community paediatrics/LCHTs • Single point of access	• Streamlined processes for access to all MA professionals • Care record compliance • Data overlay and linkage

	• Inability to link records to understand long-term impact of care given • Lack of visibility for episodes of care records	• Report generation and automatic flagging of breaches/performance • Ability to refer directly from the EPR into all services (inc. non-health)	• Tracking of all touchpoints on individual pathways • Easy sharing of data across EPRs	• Ability to evidence ROI outside of health to support funding flow • Ability to track wider details
District Nurse	• Lack of information to support clinical delivery (inc. tests, real time medication, GP records, care packages etc.) • Fragmented patient information • Issues with mobile working, hardware, connections	• A single record, or ability to access shared records, of all INT partners • Access to key patient information - test results, care packages etc • Trust in the data • Active referrals / outcomes • Training support for digital tools	• Full holistic understanding of the patient - including social care and acute information • Intelligent integration: layered patient data in a single platform • No duplicate assessment forms required • Consistent connections whilst remote working	• Optimising best practice for UCP/LCR/GP Connect • Smart notes
Community Pharmacist	• Cost of digital connectivity with CP PMR systems, which are funded by pharmacy • Access to patient records is dependent on who the data controller is - lack of clear information governance • Time lag and accuracy of patient information	• All systems should have read/write capability and full access to patient record • All data stored according to GDPR standards • Appropriate access to shared teams channels for INT staff • A referral system which is consistent and can be used by all providers within/out	• CPs have read/write capability to enter into shared records • CP IT PMRs are funded by ICB for improvements in the quality of CP IT PMRs and better connectivity with other ICB IT systems. This must include training to be able to access all systems • A central referral system	• Funding to improve CP systems (e.g ability to store patient discharge summaries etc.) • Full license access to Microsoft products • Data sharing agreements across all providers • CP Prescribing via EMIS not CLEO Solo

	• Lack of system interoperability - CPs have to access 2-3 IT systems to provide a service	the INT-a universal referral system	• Digital tools to assist with consultation and risk stratification • CPs will be assisted and funded to access other systems, e.g LCR	• Full utilisation of current commissioned products, e.g EMIS Local Services button
PHM Analyst	• Lack of trust in data • Lack of connection between digital tools and clinical tools • Lack of flexibility in the tools available	• A single patient-level longitudinal data set (with patient identifiable data and appropriate controls). • Protected time to do the analytics and to engage with clinicians and carers on the outputs (can't just be an afterthought or something that doesn't get used) • IG which allows us to share data appropriately and safely • Continue to use the pop health analyst network to share best practice and keep us informed	• One version of the truth • One set of definitions shared across partners • Easy to use and flexible tools • Using Ardens so that clinicians can directly see the cohort within their system (rather than having to look at a separate report., etc.)	• Access to data sources other than NHS and social care e.g. school attendance data • Ability to use the same data set to evaluate interventions (e.g., code the intervention, pull the full cohort and compare outcomes pre / post intervention) • Need to build trust in the data - there is a virtuous cycle in which trust increases so people use the data more, so people see the value of the data, so coding improves, so trust improves
GP	• Fragmented patient data • Referrals sitting outside of GP software	• Shared access to a longitudinal care record	• One system to manage all aspects e.g. patient notes, documents, referral forms	• LCR - funded as the main platform for all services to feed into

	• Poor visibility of shared care leading to lack of clear accountability / governance for shared care • Communication platform to discuss MDT queries • No autopopulation of referrals • Social care records not accessible via LCR • LCR search functionality is poor • Duplication of information requests - no shared live record	• Data governance and shared risk at a system level • Reliable and secure HER • Ability to view active teams for a patient and current inpatient status • Ability to view waiting lists, referrals, radiology requests etc for patients to avoid duplication •	- single integrated patient view • More contemporaneous and easy communication between all teams involved in patient care • Seamless workflows with trusted data allowing clear visibility of INT activity • opportunity for intelligent analysis allowing need for support to be recognised: relies on high quality data • Patients are able to access and understand data •	• data governance/risk management around shared platforms - assurances • MDT - discussion platforms • Referrals - be more e-smart / digital • Messaging platforms between teams • EMIS interoperability - poor integration between practice, PCN, and neighbourhoods; EMIS Enterprise not offering true integration
Consultant Geriatrician	• What could and should be shared between partners is unclear • Primary care see more data from secondary care but not vice versa. Chat options across different clinical teams are not available (communication barrier) • Inconsistent processes for entering data - e.g medication can become very complicated,	• More organisations in LCR and UCP access in short term • More visibility in secondary care EPR to have for PC data - can LCR have additional data field e.g. GP notes and other missing data • Automated update of medicines from GP record e.g. GP system to trust	• Updated live data • Communication platform for all INT partners including clinical and admin staff • One system across different care settings giving them rule based on setting based access e.g. one EPR used by trusts based on their need and role based access for SC, same EPR can be used by INT based on their roles and Primary	• Updated live data - for INT team to work and chat options for staff across different INT organisations; preferably in future between primary, secondary and tertiary care • One system across different care settings giving them rule based on setting based access e.g. one EPR used by

	depending on who is entering the data	system write back for medications or other details • Sharing virtual ward capability with remote monitoring team of INT for frailty and Multiple LTC	care too - aligned with assurances and roles for different organisations • AI capabilities on INT cohort - prioritisation as well as risk stratification (preferably across different settings either collecting data from all EPRs e.g. AI on London Data Service or having one EPR and run AI capabilities	trusts based on their need and role based access for SC, same EPR can be used by INT based on their roles and Primary care too; aligned with assurances and roles for different organisations • Tools to ensure the governance and assurances across different care settings • UCP (universal care plan) to have more automated features and manually entered the data already available in primary and secondary care • AI capabilities on INT cohort

4.2 Appendix B: Stakeholders

The table below lists the stakeholders from organisations across the system whose experiences and expertise have led the development of this paper:

Name	Organisation
Adeline Hagan	Digital Transformation Project Manager, SEL ICB
Aimee Hesp	Bexley Voluntary Service Council
Alison Furzer	Chief Digital Information Officer, Oxleas
Alison Pryor	Business Support and Compliance Manager, SEL ICB & Resident
Ambra Caruso	Head of Digital Transformation, Community Pharmacy
Ananya Datta	Associate Director of Primary Care Digital Delivery, SEL ICB
Anna Marcus	Associate Director of Primary and Community Care, SEL ICB
Ashfaq Khan	LPC Support Consultant, Community Pharmacy
Caroline Bowring	Director of Clinical Systems, GSTT & KCH
Ciara Doherty	Frailty representative, Lewisham and Greenwich NHS Trust (LGT)
Claire Angell	District Specialist Nurse, Oxleas NHS Foundation Trust (Oxleas)
David Blows	Local Care Network Delivery Manager, SEL ICB
Dean Holliday	Associate Director Digital Solutions - Data and Analytics, SEL ICB
Debbie Joyce	Programme Manager, LGT
Divanka Wijendra	GP, Lambeth
Emily Ridley-Fink	Clinical Lead in Digital Transformation, SEL ICB
Emma Lane	Senior Optimisation Co-ordinator, Oxleas

Harprit Lally	Programme Manager, South Southwark GP Federation
Holly Eden	Director of Delivery for Neighbourhoods and Population Health Management, SEL ICB
Isabel Rodrigues de Abreu	Senior Project Manager, Health Innovation Network (HIN)
Jack Barker	Chief Clinical Information Officer, King's College Hospital NHS Foundation Trust (KCH)
Jessica Freedman	Head of Digital Innovation, GSTT
Liam Doyle	Digital Lead, Guy's and St Thomas' NHS Foundation Trust (GSTT)
Lucy Hindell	Associate Director of Business Development – One Bromley, SEL ICB
Maria Higson	Director of Transformation and Delivery, SEL ICB
Mark Cheung	Programme Director, One Bromley
Nicky Skeats	Primary Care Commissioning Manager, SEL ICB
Nisha Wheeler	Deputy Chief Digital Information Officer, SEL ICB
Oge Chesa	Director of Primary Care and Transformation, SEL ICB
Patricia Ojo	LPC Vice Chair, Community Pharmacy
Patrick Montgomery	Chief Technology Officer, One Bromley
Pearl Okeke	Senior Project Manager, Health Innovation Network
Rachael Smith	Population Health Associate Director, SEL ICB
Raj Matharu	Chief Executive Officer, Community Pharmacy
Reena Patel	Chief Operating Officer, Pharmacy Alliance
Ros Keeler	Senior Primary Care Enabler Development Manager, Lambeth Together
Ryszard Stepaniuk	Development and Information Manager, Quay Health Solutions
Sam Bassett	Head of Digital Health & Care, Royal Borough of Greenwich (RBG)

Sarah Birch	Head of Community Based Care Development, SEL ICB
Shaheen Khan	Deputy Medical Director for Integrated and Specialist Medicine, GSTT
Sian Knight	GP Partner, Modality Lewisham
Simon Boote	Programme Director, Children & Young People Alliance, Lambeth Together
Steven Thorndyke	Director of IT, LGT
Sue Horbury	Head of Digital Transformation, Oxleas
Teresa Hocking	Associate Director of Operations, Bromley Healthcare
Vijay Sivapalan	Primary Care Chief Clinical Information Officer, SEL ICB
Warren Beresford	Associate Director Health and Care Planning and Intelligence, SEL ICB

PHM programme update

11th March 2026, for inclusion within the Digital Workstream Update

Context (recap)

Population Health Management is a core enabler of INT-delivered proactive care and the broader strategic ambitions of the SEL ICS. We have a plethora of existing population health work across the system, with pockets of good practice on which we can and should build. 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. 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

Appendix A sets out a high-level overview of the requirements identified through this engagement process.

Our approach to embedding PHM

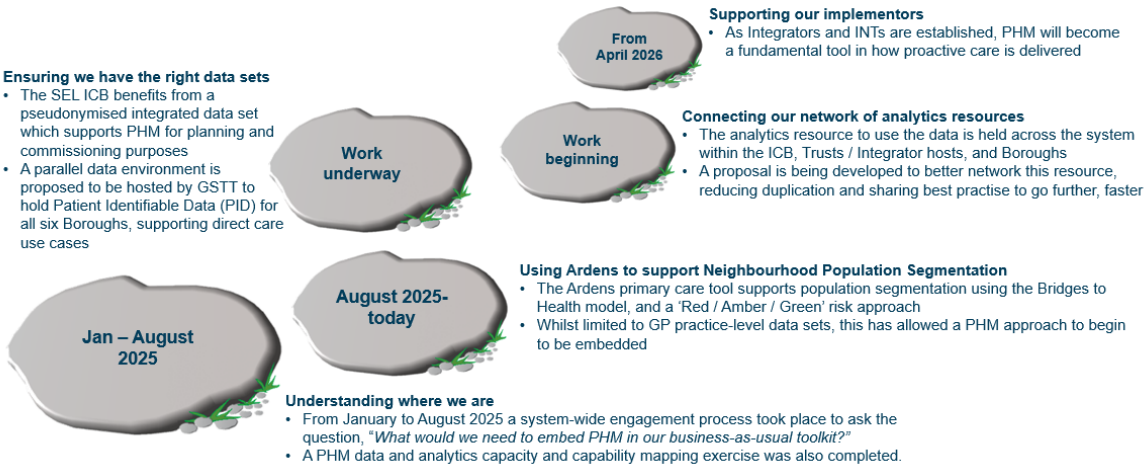
The system requires three things to embed an effective, shared approach to PHM:

1. To have a linked data set (including primary and secondary care data, with the ambition to expand to include mental health, community, social care and other data sets) of patient identifiable data, alongside the existing pseudonymised data set used for strategic commissioning purposes.
2. To ensure sufficient analytical capacity and capability across the SEL system to make best use of the available identifiable and pseudonymised data sets.
3. To have routes by which the insight can be translated into real-world action, working with colleagues from across the system, including (but not limited to) Place teams, INTs, and integrator organisations to deliver change management.

Embedding PHM as an approach is a long-term vision; on this journey we will need to take a ‘stepping stone’ approach, making best use of available tools and resources

whilst we build our long-term system capability and capacity. This is outlined in Figure 1 below.

Figure 1: Our 'stepping stones' approach to embedding PHM



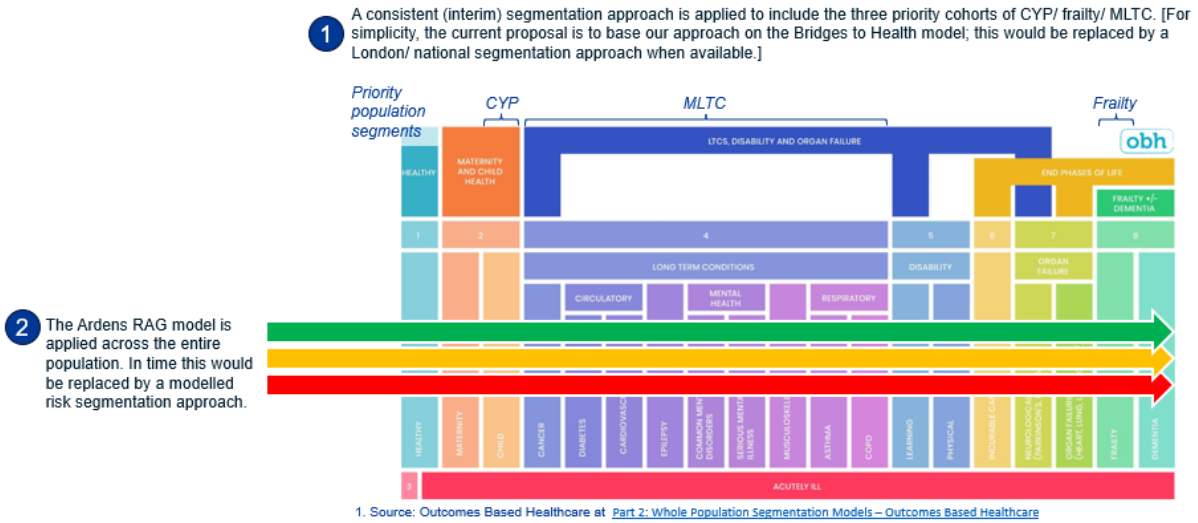
Ardens population segmentation functionality (recap)

Ardens allows us to meet the PCN DES requirements through its PHM tool which will apply two approaches to segmentation, as shown in Figure 2 below. These are:

- The Bridges to Health segmentation tool, which separates the population (in this case those within the GP practice's records) into eight segments, three of which match the priority populations of: children and young people, those with multiple long term conditions, and those with frailty.
- An overlaid 'Red / Amber / Green' model.

As both models run across the whole population, GPs can pull out 'Red' for each segment (e.g., patients in the Frailty segment who are 'Red').

Figure 2: Population segmentation approaches within Ardens



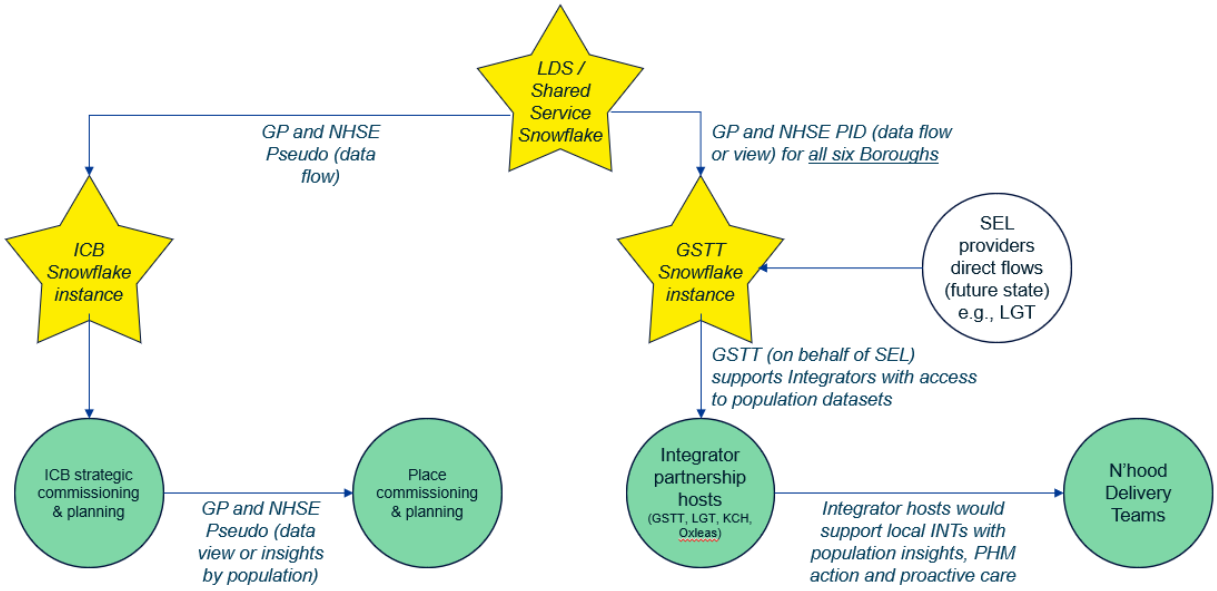
The proposed approach to data architecture

As set out in the stepping stones approach, the proposal is that SEL will have access to two Snowflake instances:

- The ICB's Snowflake environment will continue to host a pseudonymised linked data set for the purposes of strategic commissioning and planning.
- GSTT's new Snowflake environment will be expanded to create a SEL Secure Data Environment for Patient Identifiable Data, which will support direct care use cases across all Boroughs / Integrators.

Figure 3 sets out the proposed data architecture. This has received approval from the Data Usage Committee. Funding to support this architecture has yet to be agreed.

Figure 3: Proposed SEL data architecture



The proposed approach to analytics

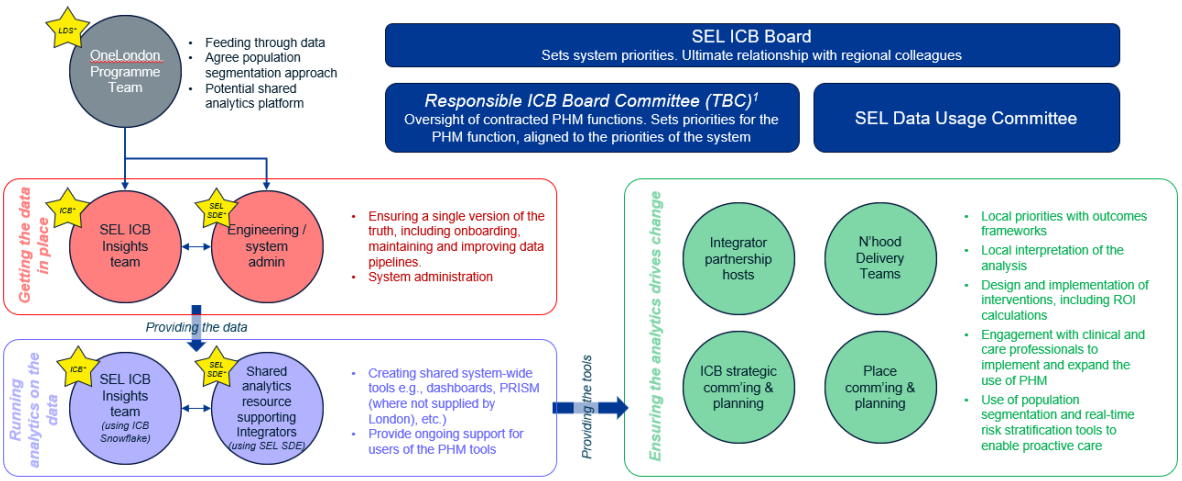
Creating the right analytics support is more complicated, as there is a need to balance the benefits of standardisation (including eliminating duplication of work) against the need to align to local implementation and overlay local insight.

It is expected that most analytics capacity will be held within a cross-system network, including resource within the ICB, each of the Trusts, Integrator host arrangements, and Boroughs. A small level of ICB-funded resource is also under discussion, with the purposes of:

1. **Convening:** Being the overarching 'glue' across general PHM, helping to ensure alignment across the Integrators, Trusts, ICB, local authorities and other partners.
2. **Delivery:** Specific agreed components of delivery (e.g., agreeing definitions, developing tools) on behalf of the Integrator functions.

Figure 4 provides an overview of the thinking thus far. However, this network approach requires further work with system partners to agree the ways of working, responsibilities and practical systems. A series of workshops is being arranged to work up the proposal.

Figure 4: Proposed approach to analytics



1. PHM will sit within the remit of an ICB Board Committee within the new ICB governance structure; the details will be confirmed after the governance re-design

Next steps

- A paper setting out the costs for these proposals is currently under discussion, with potential to access the ICB Strategic Investment Fund (this is yet to be confirmed).
- The GSTT-hosted Snowflake Environment is due to go live in April 2026. If the funding is agreed, this will then be expanded over 2026/27, initially to include PID primary care data and LGT's acute data. The ambition is to continue this expansion, subject to further funding.
- Regarding the analytics resource, regardless of ICB funding there will be a need to bring together the various pockets of capacity and capability to better align and reduce duplication. This will be done through a series of workshops, currently being organised.
- A joint governance forum will be required; this will be agreed once the new ICB governance structure is in place to support the embedding of PHM as part of the business-as-usual approach of the system.

Appendix A: Requirements identified through cross-system engagement

User group	Resource / delivery (non-technical) support required	Technical requirements (data and analytics)
Direct and Proactive Care Delivery	• Clear local priorities with outcomes frameworks • Engagement with clinical and care professionals to implement and expand the use of PHM • Leadership and education support for the ese of population segmentation and real-time risk stratification tools to enable proactive care (e.g., signposting to education and training offers, including sustainable QI) • (Note: expectation is that direct care delivery will be supported through tools, alleviating the needs for analytics resource at this level)	• Ability to view structured information quickly and easily, while delivering or planning care. • Ability to push into EPR systems as well as extract patient lists. • 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 (developed by technical experts) • Patient identifiable data needed
Planning (at system, Borough, Trust and Neighbourhood levels)	• Clear local priorities with outcomes frameworks • Support for local interpretation of PHM analyses, including overlaying local insight • PHM support to design and implementation of interventions, including ROI calculations • Technical management of local Snowflake / data environments with data sharing to the SEL Snowflake • PHM 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	• 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 and support consistent health needs analysis approach • Specific tools for priority cohorts (developed by technical experts) • Tools to assess/ compare ROI calculations/ models for different interventions • Pseudonymized data needed

Strategic commissioning	• Analytics support to enable the commissioning of pro-active care (incl. incentives), including changes to funding flows (e.g., ROI calculations, potential to explore population health budgets) • 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) • Technical management of the SEL Snowflake environment with data sharing to Trust data environments. This includes working with the LDS to expand the data held.	• Ability to look at curated and normalised information, generate queries and investigate problems (a degree of skilled self-service access to curated data). • Support consistent health needs analysis approach • Tools to create system-wide incentives and funding/ ROI models for PHM • Pseudonymised data needed.
Research and Innovation	• Strong relationships across the research and innovation ecosystem with clear priorities and lines of governance/ decision making • Leadership / organizational support for PHM-based R&D (e.g., during business case processes)	• An ability to undertake research generate queries and investigate problems centred on agreed, authorised (SEL DUC and Ethics committees) research. • Anonymised data requirement via a secure data environment • Data required over as large a population as possible (e.g., consistent data across London).

Common requirements across user groups include:

- Clear system priorities with a problem definition and outcomes frameworks for all parts of the system, which shows how this will benefit everyone
- 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
- One version of the truth / consistent data sources which can be drawn together
- Consistent population segmentation approach and risk stratification model
- Shared approach to setting outcomes frameworks
- Framework for VBC / ROI calcs (including financial, environmental and service sustainability)

- Framework for data standards and coding
- Framework for community engagement
- 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)
- System IG framework and managing IG arrangements for the LDS and shared analytics platform

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**Proposed SEL Outcome Metrics for 26/27**					
Meeting date	19 March 2026	Agenda item Number	**7**	Paper Enclosure Ref	**5**	
Author	Holly Eden, Delivery Director PPL					
Executive lead	Ceri Jacobs, Place Executive Lead for Lewisham Holly Eden, Director of Delivery Neighbourhoods and Population Health					
Paper is for:	Update	**x**	Discussion	**x**	Decision	**x**
Purpose of paper	**This paper sets out the proposed priority metrics for monitoring activity (Long Term Conditions and Frailty) across SEL during the 2026-27 transition and implementation period.**					
Summary of main points	The performance indicators set out in the attached paper incorporate National measures applicable to all Neighbourhoods, alongside priority indicators for Long Term Conditions and Frailty. Together, it is proposed that these priority measures will be used in the first instance to provide assurance about Neighbourhood progress and performance during the transitional period 2026-27. We have chosen metrics which are currently measurable across SEL and will be working to identify where new measurement processes could be put in place. Only those metrics that are measured quarterly or more and could potentially show change in-year have been included. Integrators will need to code activity in-line with coding guidance so that we can identify relevant activity. To aid ongoing performance management, the metrics will be incorporated into a dedicated dashboard. In parallel, a comprehensive Evaluation Framework with a broader set of metrics will be developed.					
Potential conflicts of Interest	N/A					
Sharing and confidentiality	N/A					
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**
Equalities Impact	N/A					
Financial Impact	Dashboard development costs may need to be factored in to support the SEL BI team with capacity during the period 2026-27.					
Public Patient Engagement	N/A					
Committee engagement	Ceri Jacobs, Place Executive Lead for Lewisham Holly Eden, Director of Delivery Neighbourhoods and Population Health					

Recommendation	To review, discuss and agree the proposed priority metrics for Long Term Conditions and Frailty, for onward incorporation into a performance dashboard. Once developed, this dashboard will be received by the SEL ICB on a quarterly basis for information and to inform assurance.

South East London Integrated Care System

Proposed Priority SEL INT Metrics 2026-27

19 March 2026

Purpose, Background and Context

- This paper sets out the **proposed priority metrics** for monitoring Integrated Neighbourhood Team (INT) activity relating **to Long Term Conditions and Frailty** across South East London (SEL) **during the 2026–27 transition and implementation period.**
- The performance indicators outlined in the attached paper **incorporate national measures used within the national programme**, which are expected to apply to all places and neighbourhoods, **alongside priority indicators specific to Long Term Conditions and Frailty.**
- It is proposed that these priority measures will initially be used to provide assurance on neighbourhood progress and performance during the 2026–27 transitional period.
- **The proposed metrics have been selected on the basis that they can be measured from 1st April 2026,** while further work is undertaken to develop and incorporate a broader set of health and wellbeing metrics in future years. This **does not preclude places from monitoring additional local measures** that are appropriate to the populations they are working with.
- To support ongoing performance management, these metrics will be incorporated into **a dedicated dashboard.** In parallel, a comprehensive Evaluation Framework, including a wider set of measures, will be developed for implementation in subsequent years.

Rationale and Engagement

- In addition to national metrics, the following have been identified as priority indicators, based on factors including:
  - Focus on patient outcomes
  - Additional focus on service utilization where applicable
  - Alignment with Cardiac, Renal and Metabolic
  - Combination/balance of generic cohort-focus (frailty) and specific dimension (e.g. eyes, weight, mental health) related metrics.
- We have chosen metrics which are currently measurable across SEL and will be working to identify where new measurement processes could be put in place.
- Only those metrics that are measured quarterly or more and could potentially show change in-year have been included.
- Where applicable, data for some indicators will be gathered and reported for each cohort.
- Feedback has been sought from a range of stakeholders including the LTCs and frailty programmes of work and proposed priority metrics have been subsequently iterated.

South East London Integrated Care System

Proposed Metrics

NHS South East London

Reference	Indicator
Frailty & LTC- 1	Hypertension detection gap closed
Frailty & LTC - 2	NDPP referrals and completions (eligible cohort)
Frailty - 3	BP control in diagnosed hypertension
Frailty & LTC- 4	Lipids optimisation in secondary prevention
Frailty & LTC - 10	Weight management control
Frailty - 11	Early detection of frailty
Frailty - 14	Median length of stay for cohort
Frailty - 15	Quality of life - Proportion of people who use services who report having control over their daily life
Frailty - 16	EOLC - Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'
Frailty - 17	EOLC - Avoidable admissions
Frailty - 18	Lipids optimisation in primary prevention
LTCs - 1	% of cohort recorded in EMIS with BMI >30
LTCs - 2	Lipids optimisation in primary prevention
LTCs - 3	BP control in diagnosed hypertension
LTCs - 4	% of cohort with EOT2D treated to target
LTCs - 5	% of cohort that have had a PHQ9 recorded in their notres in the last 12mnths
LTCs - 6	% of cohort that have had a GAD7 recorded in their notres in the last 12mnths
LTCs - 7	Inequalities gap on key indicators (Core20PLUS5)
LTCs - 8	GP Access & timely appointment proxy (GPAD)
LTCs - 9	Right care first time (resident-reported)

Next Steps

- **Dashboard Development & Reporting** - To aid ongoing performance management, the metrics will be incorporated into a dedicated dashboard.
- **Evaluation Framework** - In parallel, a comprehensive Evaluation Framework with a broader set of metrics will be developed.
- **Consistent Activity Coding** - Integrators will need to code activity in-line with coding guidance so that we can identify relevant activity.

	A	B	C	D	E	F
1	**Proposed Priority SEL Metrics (Incorporating Frailty and LTCs)**					
2	**NBCB Meeting Discussion 19/03/2026**					
3						
4	**Cohort**	**Domain**	**Outcome**	**Metric**	**Definition**	**Existing Metric**
5	Frailty & LTC- 1	Population health, prevention & inequalities	Improved prevention coverage and earlier detection for high risk conditions	Hypertension detection gap closed	(Expected prevalence – rec+G2+H2:H16	CVDPREVENT (national), QOF
6	Frailty & LTC - 2	Population health, prevention & inequalities	Improved prevention coverage and earlier detection for high risk conditions	NDPP referrals and completions (eligible cohort)	Rate of referrals/1,000 eligible; % completing programme.	—
7	Frailty - 3	Population health, prevention & inequalities	Better control of risk factors in priority cohorts (e.g., mLTCs, frailty)	BP control in diagnosed hypertension	% of hypertensive adults with BP at target per QOF/CVDPREVENT definition.	QOF / CVDPREVENT (national)
8	Frailty & LTC- 4	Population health, prevention & inequalities	Better control of risk factors in priority cohorts (e.g., mLTCs, frailty)	Lipids optimisation in secondary prevention	% of ASCVD patients at LDL C target or on high intensity statin/ezetimibe per audit.	CVDPREVENT (national)
9	Frailty & LTC - 10	Population health, prevention & inequalities	Improved prevention coverage and earlier detection for high risk conditions	Weight management control	% of population identified as obese	
10	Frailty - 11	Population health, prevention & inequalities	Improved prevention coverage and earlier detection for high risk conditions	Early detection of frailty	% of 65yrs+ with coded frailty (via CFS coding)	
11	Frailty - 14	Population health, prevention & inequalities	Supporting people to age well	Median length of stay for cohort	Median number of days spent in hospital per admission for patients in the cohort (e.g. frailty cohort), from admission to discharge. Used to assess efficiency of care, discharge planning, and impact of integrated care interventions.	NHSE Hospital Episode Statistics (HES) / SUS / Model Health System
12	Frailty - 15	Resident experience & community impact	Supporting people to age well / Improved resident / carer experience	Quality of life - Proportion of people who use services who report having control over their daily life	Social Isolation: Percentage of adults who feel lonely often or always. At an individual / cohort level/ Care Act Ax - ASC. Qualitative survey (person feedback): List of 5 questions - could include aspects like 'ability to self manage', 'improved connectivity' and 'feeling trusted, heard and respected'. Real life stories through deep dive semi-structured interviews (for learning and CQI).	ASCOF
13	Frailty - 16	Resident experience & community impact	Positive dying	EOLC - Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'	PPoC and PPOD from UCP correlated against actual place of care and death	From UCP?
14	Frailty - 17	Resident experience & community impact	Supporting people to age well	EOLC - Avoidable admissions	Admissions due to ACSC / avoidable admissions	ACSC / avoidable admissions & A&E attendances - BCF
15	Frailty - 18 (& LTCs - 2)	Population health, prevention & inequalities	Better control of risk factors in priority cohorts (e.g., mLTCs, frailty) : Lipids	Lipids optimisation in primary prevention	% of pts on EMIS with CVD risk score >10 on statin + treated to target	CVDPREVENT baseline; audit if needed.
16	LTCs - 1	Population health, prevention & inequalities	Improved prevention coverage and earlier detection for high risk conditions : Obesity	% of cohort recorded in EMIS with BMI >30	% of adults with BMI >30	ICB
17	LTCs - 2	Population health, prevention & inequalities	Better control of risk factors in priority cohorts (e.g., mLTCs, frailty) : Lipids	Lipids optimisation in primary prevention	% of pts on EMIS with CVD risk score >10 on statin + treated to target	CVDPREVENT (national)
18	LTCs - 3	Population health, prevention & inequalities	Better control of risk factors in priority cohorts (e.g., mLTCs, frailty) :BP	BP control in diagnosed hypertension	% of hypertensive adults within cohort with BP at target per QOF/CVDPREVENT definition.	QOF / CVDPREVENT (national)
19	LTCs - 4	Population health, prevention & inequalities	Improved treatment control : DM	% of cohort with EOT2D treated to target	% of EOT2D adults with Hba1c at target per QOF	QOF
20	LTCs - 5	Population health, prevention & inequalities	% of population that has PHQ 9 : MH	% of cohort that have had a PHQ9 recorded in their notes in the last 12mnths	No of patient recorded in emis who have had a PHQ9 recorded in their notes in the last 12 months	ICB
21	LTCs - 6	Population health, prevention & inequalities	% of population that have had a GAD7 :MH	% of cohort that have had a GAD7 recorded in their notes in the last 12mnths	No of patients recorded in emis who had have had a GAD7 recorded in their notes in the last 12 months	ICB
22	LTCs - 7	Population health, prevention & inequalities	Reduced avoidable admissions and unwarranted variation (equity narrows)	Inequalities gap on key indicators (Core20PLUS5)	Difference between most and least deprived quintiles for BP control, smoking prevalence, ACSC admissions and UEC usage.	Core20PLUS5 HI Dashboard (national)
23	LTCs - 8	Resident experience and community impact	Residents get the right care, first time, closer to home	GP Access & timely appointment proxy (GPAD)	% appointments within ≤2 weeks; mode mix; continuity proxy (same clinician) where available.	GPAD (national)
24	LTCs - 9	Resident experience and community impact	Residents get the right care, first time, closer to home	Right care first time (resident reported)	Rate of residents reporting their issue was resolved in the right place first time; proxy via GPPS items on receiving needed advice/treatment and clarity on next steps.	GPPS / FFT (national)

	A	B	C	D	E
1	**For Reference: National Metrics**				
2	**NBCB Meeting Discussion 19/03/2026**				
3	**National**	**Metric**	**Definition & Source**	**Denominator**	
4	National - 1	Number of new consultant-led outpatient appointments per 1,000 patients in the cohort	**Definition**: Count of outpatient appointments in the month with a MAIN SPECIALTY CODE is a consultant specific code, FIRST ATTENDANCE CODE = 1 OR 3 and ATTENDED OR DID NOT ATTEND CODE equal to 5 OR 6 and PRIMARY PROCEDURE (OPCS) IS NULL for patients in the cohort **Source**: SUS Outpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
5	National - 2	Number of follow up consultant-led outpatient appointments per 1,000 patients in the cohort	**Definition**: Count of outpatient appointments in the month with a MAIN SPECIALTY CODE is a consultant specific code, FIRST ATTENDANCE CODE = 2 OR 4 and ATTENDED OR DID NOT ATTEND CODE equal to 5 OR 6 and PRIMARY PROCEDURE (OPCS) IS NULL for patients in the cohort **Source**: SUS Outpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
6	National - 3	Number of consultant-led outpatient procedures per 1,000 patients in the cohort	**Definition**: Count of outpatient appointments in the month with a MAIN SPECIALTY CODE is a consultant specific code, ATTENDED OR DID NOT ATTEND CODE equal to 5 OR 6 and PRIMARY PROCEDURE (OPCS) IS NOT NULL for patients in the cohort **Source**: SUS Outpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
7	National - 4	Number of specific acute non-elective spells in the period with a length of stay of zero days per 1,000 patients in the cohort	**Definition:** Count of completed inpatient spells where length of stay (Discharge Date - Admission Date) = 0 and Admission Method Code and Treatment Function Code meet the national definition set out in the AcuteNonElectiveDefs worksheet is in list for patients in the cohort **Source:** SUS Inpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
8	National - 5	Number of specific acute non-elective spells in the period with a length of stay of one or more days	**Definition:** Count of completed inpatient spells where length of stay (Discharge Date - Admission Date) >= 1 and Admission Method Code and Treatment Function Code meet the national definition set out in the AcuteNonElectiveDefs worksheet is in list for patients in the cohort **Source:** SUS Inpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:**Local cohort data	

	A	B	C	D	E
9	National - 6	Number of inpatient bed days per 1,000 patients in the cohort	**Definition:** Sum of inpatient bed days completed inpatient spells where Admission Method Code and Treatment Function Code meet the national definition set out in the AcuteNonElectiveDefs worksheet is in list for patients in the cohort **Source:** SUS Inpatients	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
10	National - 7	Number of category 1 ambulance conveyances per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE ARRIVAL MODE IN (1048051000000107, 1048031000000100, 1048041000000109) and EMERGENCY CARE ACUITY = '1064891000000107' for patients in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
11	National - 8	Number of category 2 ambulance conveyances per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE ARRIVAL MODE IN (1048051000000107, 1048031000000100, 1048041000000109) and EMERGENCY CARE ACUITY = '1064911000000105' for patients in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
12	National - 9	Number of category 3 ambulance conveyances per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE ARRIVAL MODE IN (1048051000000107, 1048031000000100, 1048041000000109) and EMERGENCY CARE ACUITY = '1064901000000108' for patients in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
13	National - 10	Number of category 4 ambulance conveyances per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE ARRIVAL MODE IN (1048051000000107, 1048031000000100, 1048041000000109) and EMERGENCY CARE ACUITY = '1077241000000103' for patients in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
14	National - 11	Number of A&E attendances at a type 1 department per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE DEPARTMENT TYPE = 01 for patients in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
15	National - 12	Number of A&E attendances at an other type department per 1,000 patients in the cohort	**Definition:** Count of A&E attendances in the month where EMERGENCY CARE DEPARTMENT TYPE <> 01 for patients is in the cohort **Source:** ECDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	

	A	B	C	D	E
16	National - 13	Number of appointments in general practice and Primary Care Networks per 1,000 patients in the cohort	**Definition:** Count of general practice and PCN appointments where Appointment Status = 'Attended', SDS Role Group = 'GP' and Service Setting in ('General Practice', 'Primary Care Network') **Source:** Local primary care systems for patients in the cohort	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
17	National - 14	Number of Community Care Contacts attended per 1,000 patients in the cohort	**Definition:** Count of care contacts where cyp201carecontact.Unique_MonthID = 'Unique_MonthID' and cyp201carecontact.Contact_Date between 'ReportingStartDate' and 'ReportingEndDate' for patients in the cohort **Source:** CSDS	**Definition:** Number of patients in the cohort (defined locally) **Source:** Local cohort data	
18	National - 15	Number of patients on the NNHIP caseload	Count of active cases the Place is actively working with during the month. This should not be the whole cohort. **Source:** Local data collection		
19	All INTs 1	Care coordination (resident and workforce experience)	% of residents and staff reporting that services involved in supporting people work well together	GPPS / NHS Staff Survey / Local ICS survey	
20	All INTs 2	Patient Reported Outcome Measure (EQ-5D)	EQ-5D health-related quality of life score measuring mobility, self-care, usual activities, pain/discomfort and anxiety/depression; reported as utility index and/or EQ-VAS.	EQ-5D-5L (PROM standard, used in NHS and HTA)	
21	All INTs 3	Patient activation (PAM)	Mean PAM score or % of residents in activation levels 3–4 (indicating confidence to manage health and care)	PAM-13 survey	
22	All INTs 4	Staff burnout / stress score (NSS: We are safe & healthy)	NHS Staff Survey People Promise theme scores relevant to wellbeing and burnout (e.g., 'We are safe and healthy').	NSS People Promise themes (NHSE)	
23	All INTs 5	Turnover a+F30:O30nd stability rate (ESR)	Annual turnover %, stability index, vacancy rate for community & PCN-aligned staff.	ESR metrics (NHSE)	
24	All INTs 6	Cross org MDT participation breadth	% of MDTs in neighbourhood including primary care, community, MH, LA/ASC, VCSE.	—	