South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1415-1600 Wednesday 20 November 2025
(Teams meeting)

Co-Chairs: George Verghese and Ceri Jacob

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

Agenda

#	Area	Lead	Time
1	**Introduction and apologies for absence**	Chair	1415
2	**Declarations of interests relevant to the business on the agenda**	All	1417
3	**Minutes of the meeting held on 22 October 2025 (Enc 1)**	Chair	1420
4	**Actions and matters arising (Enc 2)**	Chair	1425
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**Benefits Realisation Modelling Task and Finish Group – Modelling output for discussion (Enc 3)**	A Wall	1430
6	**Workforce Workstream Deep Dive – Clinical Governance (Enc 4)**	C Harris	1435
7	**Integrated Urgent Care Update (Enc 5)**	Paper A Bhan	1515
8	**Integrator Development Plans** • **Priorities for development especially where there is cross over with enabling workstream plans (Enc 6i and 6ii Excel attachment)**	Place Reps	1530
9	**Any other business.**	Chair	1555
10	**Date of next meeting** **1400-1600 Wednesday 12 December 2025**	Chair	1600

Enclosure 1

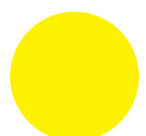
Neighbourhood Based Care Board
Draft Minutes of the meeting held on Wednesday 22 October 2025 MS Teams

Present:

Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	CJ
Jessica Arnold	Director of Primary Carte and Neighbourhoods (Greenwich)	JA
Angela Bhan	Bromley PEL (for part of the meeting)	ABh
Andrew Bland	ICB CEO (non-voting member) (for part of the meeting)	AB
Vanessa Burgess	Medicines Management representative	VB
Mark Cheung	Bromley LCP representative (sharing with EW)	MC
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
Neil Goulbourne	Acute Services Representative (for part of the meeting)	NG
Kallie Hayburn	Bexley LCP representative	KH
Rebecca Jarvis	Southwark LCP representative	RJ
Laura Jenner	Lewisham LCP representative	LJ
Neil Kennett-Brown	ICB System Sustainability Team Representative (Non-Voting)	NKB
Raj Matharu	Community Pharmacy representative	RM
Denise Radley	Adult Social Services representative	DR
Tal Rosenzweig	Voluntary Sector Representative	TR
Kelly Scanlon	AD Communication and Engagement (non-voting)	KS
Dr George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	GV
Elliott Ward	Bromley LCP representative (sharing with MC) (for part of the meeting)	EW
Nisha Wheeler	Digital representative	NW

In attendance:

Kerry Bourne	Interim ICS Programme Director Estates (for item 107/2025)	KB
Chloe Harris	GSTT	CH
Nick Harris	Head of CESEL	NH
Sian Howell	Clinical Lead for Clinical Effectiveness Southwark	SH
Colin Nash	Governance Manager (Minutes)	CN
Tony Rackstraw	Interim ICS Programme Director Estates (for item 107/2025)	TR
Imogen Setter	PPL	IS



Apologies for absence:

Diane Braithwaite	Bexley PEL	**DB**
Gabi Darby	Greenwich LCP representative	**GD**
Darren Summers	Southwark PEL	**DS**

No	Item	Action
103/2025	**INTRODUCTIONS AND APOLOGIES**	
	CJ welcomed members to the meeting. Apologies were noted as above.	
104/2025	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
105/2025	**MINUTES OF THE MEETING HELD ON 18 SEPTEMBER 2025**	
	The minutes were **APPROVED SUBJECT TO** i. 94/2025 v. amended to read "KH agreed to share the output from the first 6 months of the Bexley multiple long term conditions INT with TG".	**CN**
106/2025	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log for this meeting: - 2/25 – Agenda. Closed. 34/25 – NW reported that the INT Digital Working Group terms of reference had been circulated to NBCD members. Closed.	
	IMPLEMENTING NEIGHBOURHOOD CARE	
107/2025	**ESTATES DEEP DIVE: DEVELOPING NEIGHBOURHOOD HEALTH CENTRES**	
	TR took the Board through the paper providing an overview of the outputs from the national Neighbourhood Health Estates Working Group and a summary of the Archetypes for a neighbourhood Health Centre being discussed at a national level. It also updated the Board on the work that had been undertaken to identify Neighbourhood Hub locations in SEL. Neighbourhood health centres were a central part of delivering integrated neighbourhood care as set out in the NHS 10 Year Health Plan. They were designed to bring together multi-disciplinary teams into local hubs that provide joined-up, person-centred support. A national working group had developed five models, ranging from refurbishing existing buildings to fully virtual centres. These were not simply enhanced GP practices, but hubs that co-locate diagnostics, community services, VCFSE organisations, and other public services. In south east London (SEL), mapping of potential hub sites is underway across all six boroughs, with Greenwich used as an example of how boroughs can assess and prioritise locations. The Greenwich approach	

	included evaluation criteria aligned with the London Target Operating Model and SEL estates strategy and was being used to guide borough-level workshops. JA took the Board through the Greenwich slides on pages 28 to 37 of the pack. A SEL-wide approach will be undertaken, using the Greenwich evaluation criteria, to ensure consistency and support decision-making around prospective neighbourhood hubs. This process will provide a clear picture of the status of hub identification across SEL, highlight areas of alignment and variation between places, and offer a system-wide understanding of what is needed to progress the development of functional neighbourhood hubs. The followed points were made in discussion. A sense of the scale of community hubs envisaged would be helpful and also a view on whether or not surplus space in hospitals could be used as a neighbourhood hub. It was noted that if hubs would be providing hands on care that would tend to rule out a fully virtual hub (Archetype 5). TR emphasised that the process of identifying hubs should be Place, rather than Estates led, and meet the needs of the local population. Estates would present options, focusing on existing estate where possible. JA emphasised that hubs should allow for voluntary organisations to engage with their communities. She also noted that the co-location of teams did not necessarily lead to joint working. Hub space needed to be genuinely flexible and be served by excellent public transport. NW stressed that the digital requirements of neighbourhood hubs should be clear from the outset to avoid reverse engineering later. She asked that a Digital representative be included in the forthcoming hub workshops. RM noted that, because of the perceived risks involved, community pharmacy would not be in a position to subsidized hubs if they locating within them. Community pharmacies were currently considering whether or not to invest in neighbourhood hubs. GV noted the need for some body to “hold the ring” as Place based hubs were developed to avoid the risk that health inequalities may increase. A core set of SEL standards would assist here. VB commended a hub and spoke model of neighbourhood hubs as being best able to allow full contribution of community pharmacy to be realised. CJ thanked the Estates Team for their presentation, and they left the meeting.	

<table>
<tr><td>108/2025</td><td>STAFF ACTIVATION: TESTING PLANS AND APPROACH</td><td></td></tr>
<tr><td></td><td>LD took the Board through the paper outlining the proposed approach to engaging and empowering staff across SEL to support neighbourhood working, and to seek the Board's feedback and support for local testing and implementation. The following points were highlighted.

Staff were central to making neighbourhood working real and sustainable. The proposed staff activation approach aimed to build understanding, ownership, and confidence amongst those delivering care in neighbourhoods.

It was proposed to adopt a three phased approach:
i. Raise awareness – Share key messages and stories to explain neighbourhood working.
ii. Educate and empower – Provide training, leadership development, and forums for learning.
iii. Enable and embed – Establish feedback loops, staff champions, and recognition activities.

A communications toolkit had been developed to help with the first phase. This included:
• Core messages, FAQs, slide pack etc.
• Templates for local use in staff briefings and communications.

The Toolkit had been tested in Greenwich and the feedback incorporated. A Place-level stocktake on INT development had been undertaken.

NKB and TG felt a powerful motivator to engage staff would be stories illustrating how having the patient at the centre of their care made a positive difference to outcomes.

RJ emphasised the importance of making Phase 1 material available to staff as quickly as possible to build engagement.

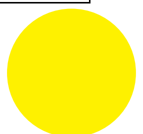
TG queried if the term Staff activation was a helpful title to cover work to engage staff in neighbourhood care.

EW left the meeting.

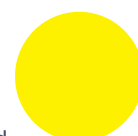
Given that little extra investment would be available, VB felt an emphasise on how this work would enable creative approaches to provide better patient care would help engage staff. It would also be important to identify which staff needed to be engaged in the process to ensure messages were targeted.

OC suggested that, if staff were to be engaged at scale, neighbourhood care could be added to the mandatory training schedule for all staff. LD replied that the plan was to engage at scale during the first 6 months via a series of webinars.

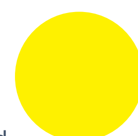
NW queried if there was a plan to inform the wider public about what to expect from neighbourhood care.</td><td></td></tr>
</table>



	MC noted that the larger providers would be serving patients across borough boundaries and messaging would need a level of consistency.	
	HE thanked members for their comments and asked that those with messaging suggestions make these directly to LD so they could be considered.	**ALL**
109/2025	**NEIGHBOURHOODS QUARTERLY PMO REPORT**	
	HE referred to the second cycle of quarterly reports aimed at strengthening programme management, governance and accountability, and increasing visibility across the highly complex web of interdependent workstreams that form our approach to Neighbourhood working. She took the Board through the Shared issues slides on pages 95 to 96 of the pack. These covered: - i. Capacity constraints, ii. Data sharing, clinical system integration and data governence iii. Estates availability iv. Infrastructure funding v. Clinical risk management In response to a question from RJ, CJ confirmed the NBCB's role was peer oversight of variations in neighbourhood care at Place level. Variation was allowable provided it did not compromise the ability to deliver neighbourhood care across SEL. NG noted that metrics showing the impact of neighbourhood care on the designated cohorts should be included when available. He suggested this might be explored further in a seminar on Place variations. In response to a question from VB, HE confirmed that a core set of SEL wide metrics was envisaged, supplemented by Place metrics where applicable. NBCB **NOTED** the report.	
110/2025	**QUICK UPDATE ON PROPOSED APPROACH TO DEVELOPING A LEARNING SYSTEM FOR NEIGHBOURHOOD HEALTH**	
	In the absence of JS, IS took the Board through the paper discussing the evolving test and learn approach for neighbourhood health. The SEL Neighbourhood Framework recognised that Integrated Neighbourhood Teams (INTs) are a radical change to existing ways of working and will therefore require experimentation through the early implementation phases to understand what is and is not working and explore ways of overcoming challenges. A test and learn approach and creation of a learning environment will help ensure INTs are delivering impact in the right places; create space for failure and ensure understanding of the impact each new iteration of the INT model. Beginning with a focus on INT working SEL may look to expand over time to incorporate other elements of the neighbourhood health service A 'test and learn' approach provides the space to experiment, adapt, and improve - ensuring we understand what works, for whom, and in what	



	context to support scaling of effective neighbourhood working across SEL. The proposed next steps were: • Bring together Integrators across Places through an initial session on how they are developing and how to share learning. • Work with the PC+ Group to explore how Places can collaborate more effectively to share learning, align improvement priorities. • Develop a clear 'Test and Learn' framework that sets out the principles, roles, required infrastructure and expectations for how learning is captured, shared, and acted upon across spatial levels. The six principles of the proposed framework were set out on page 132 of the pack. In the discussion that followed there was recognition that the proposed approach would not be perfect, but it was important to move forward with the proposal so learning could proceed. The importance of a "safe space" for staff to be able to discuss failure and learn from it was emphasised.	
111/2025	**ANY OTHER BUSINESS**	
	This was taken before item 110/2025. HE briefed the meeting on the outcome of the first London Neighbourhood Health Delivery Board meeting on 22 October. Key points were: - • Although some planning guidance was expected imminently, other guidance would take longer. • Given the complex agenda NHSE were keen to focus on the basics of neighbourhood care. This included the definition of neighbourhood, GP access and the primary secondary care interface. • There was discussion about the subgroups that will support the London board. • PHM was recognised as a difficult issue. • Social care were concerned about changes to the BCF.	
112/2025	**DATE OF NEXT MEETING**	
	1400-1600, Wednesday 20 November 2025.	



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Enclosure 2

Neighbourhood Based Care Board

Draft Action log from the meeting held on 22.10.25

Item Ref	Minute number	Item title	Action description	Owner responsible	Due Date	Comments
ACTIONS BROUGHT FORWARD						
30/25	87/2025	Quarterly Highlight Reports	Work on a shared risk log between place and SEL	**H Eden**	For 10.12.25 meeting.	
31/25	872025	Quarterly Highlight Reports	Agree integrator representation on the NBCB and a workplan for integrators	**H Eden/ C Jacob/ G Verghese**	For 11.2.26 meeting.	
36/25	94/2025	Implementation Stocktake	Circulate the output from the first 6 months of the Bexley multiple long term conditions INT with T Garrood.	**K Hayburn**	When available	
37/25	99/2025	PHM	Discuss how PMH would contribute to neighbourhood-based care planning	**M Higson/O Chesa/ H Eden**	No date set	
ACTIONS FROM THE 22 OCTOBER 2025 MEETING						
38/25	108/2025	Staff Activation	Provide suggested text to L Demeda to enhance staff engagement messages about neighbourhood-based care if necessary.	**All**	No date set.	

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Neighbourhood Based Care Board

<table>
<tr><td>Title</td><td colspan="6">Update on INT Benefits Realisation Modelling</td></tr>
<tr><td>Meeting date</td><td colspan="2">20 November 2025</td><td>Agenda item Number</td><td>5</td><td>Paper Enclosure Ref</td><td>3</td></tr>
<tr><td>Author</td><td colspan="6">Neil Kennett-Brown, Director of System Sustainability
Adam Wall, Head of Data & Analytics, PPL</td></tr>
<tr><td>Executive lead</td><td colspan="6">Holly Eden</td></tr>
<tr><td>Paper is for:</td><td>Update</td><td>Yes</td><td>Discussion</td><td></td><td>Decision</td><td></td></tr>
<tr><td>Purpose of paper</td><td colspan="6">To provide a progress update on the Benefits Realisation Modelling Exercise being delivered by the ICB BI team in partnership with PPL.</td></tr>
<tr><td>Summary of main points</td><td colspan="6">
BI team colleagues have extracted episodic primary, secondary, and community datasets for Frailty & MLTC cohorts with patient identifiers to allow links across those datasets.
PPL team have completed the processing and cleaning of requested data, including automated SNOMED code matching and an assessment of data completeness for fields drawn from General Practice data.
Place leads have responded to our ‘information capture’ request to provide inputs for modelling, including cohorts definitions, neighbourhood footprints, and workforce plans.
PPL team are producing initial descriptive visualisations to validate data quality and completeness.
A first draft set of benefits realisation results are due to be shared before the end of November
An interim report was circulated to NBCB members in October
The attached slide deck is current position, as the analytical work is currently underway, an updated version will be presented in the meeting, showing initial results
Final report due in December 25
</td></tr>
<tr><td>Potential conflicts of Interest</td><td colspan="6">N/A</td></tr>
<tr><td>Sharing and confidentiality</td><td colspan="6">N/A</td></tr>
<tr><td rowspan="2">Relevant to these boroughs</td><td>Bexley</td><td>x</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr>
<tr><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr>
</table>

Equalities Impact	INT modelling, linked to cohort identification should help each borough to improve how they provide and target proactive INT interventions.
Financial Impact	The impact of implementing Integrated Neighbourhood Teams is expected to have a significant impact on activity and financial flows across the ICS, with the left shifts from acute to community, and from treatment to prevention. This modelling work will provide evidence and logic to these shifts, which will support financial strategic allocations and planning.
Public Patient Engagement	N/A
Committee engagement	NBCB have had the interim report on the INT modelling exercise (October 25) and agreed the overall approach (May 25)
Recommendation	The Committee approve the timeline and approach set out in the update.

South East London
Integrated Care System

SEL ICS INT Benefits Realisation Modelling

NBCB Paper – November 2025

FINAL

PPL

Modelling INT benefits to support strategic resource planning

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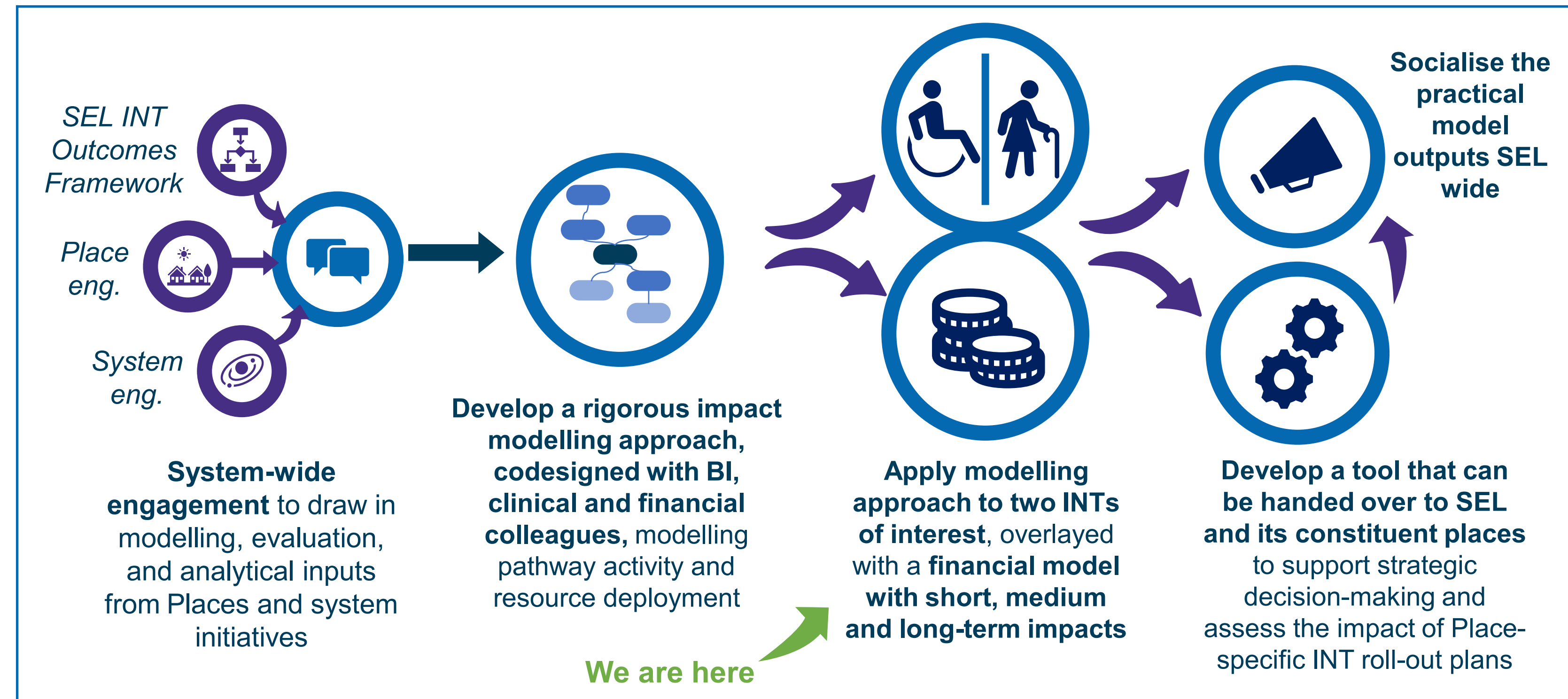
There is a need to develop a shared, robust understanding of the impact the shift to neighbourhood working will have on system sustainability. This is critical to making strategic decisions about future investment as a system, shifting activity from acute to community settings, and ensuring our model of care is sustainable and effective.

To support this, SEL ICS have partnered with PPL to develop a robust approach to modelling the benefits of Integrated Neighbourhood Teams (INTs). This work is being delivered through a **blended team** including SEL ICB BI, LGT PHM, and PPL drawing on SEL's existing capabilities while adding capacity and technical expertise.

The work aims to:

- **Quantify and forecast the impact of INTs on health & care demand and system sustainability.** This initial modelling exercise will focus on:
  1. Frail elderly and palliative and end of life care (PELOC) INTs, and
  2. Multiple long-term conditions (MLTC) INTs.
- **Support strategic planning**, investment decisions, and resource allocation.
- **Serve as a credible shared tool** that provides partners across organisations and geographies a shared view of past, current, and potential future benefits realised through the shift to neighbourhood.



Status update and forward plan for this phase of work

This project is intended as a first phase of work to establish a functional core model based on our initial data request. This phase of work is scheduled to be **completed by December 2025**, as set out in the below plan.

Following phases will look to **build on the modelling approach**, particularly by engaging with provider finance teams to turn the model's 'theoretical' financial outputs into an analysis that accounts for the on-the-ground reality of costs faced by providers over the short, medium, and long run. We also intend to turn the analysis developed in this phase of work into an **interactive tool which can be used by colleagues across SEL** for planning and analysis purposes.

Timeline and status update for this phase of work

Milestone	Date
Finalise patient-level data request for acute, primary, and community care with SEL BI team	Sept 25
Agree approach and assumptions for financial model (acute, primary, community cost implications)	Sept 25
Interim report summarising finalised approach, available data, and key assumptions	Oct 25
Start modelling using patient level data	Oct 25
Analyse and integrate Place data return information	Oct 25
First run data analysis complete	Nov 25
First draft set of results shared for feedback with key stakeholders	Nov 25
Share final report including next steps to develop modelling approach, toolkit, and engagement with providers	Dec 25

Full specification of data received as of October 2025

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Based on our logic modelling exercise we identified key datasets that would be required to deliver a rigorous model and worked with SEL BI Team colleagues to specify a **patient / contact-level data request** that accounted for current data availability at ICB level:

Community Services	*General Practice*	*Emergency Acute*	*Non-elective inpatient*	*Outpatient*
Contact-level dataset: • Pseudo patient ID • Financial year & month of referral request • Organisation that initiated the referral • Borough of registration • PCN of registration • Registered GP practice • Patient's age at referral • Gender of the patient • Ethnic group • The reason for referral • The type of service • LSOA of residence • IMD decile number of residence • Whether the referral request was rejected	Patient-level dataset: • Pseudo patient ID • Flag for 'mLTC cohort' defined as 3+ MLTCs • Flag for 'Frailty cohort' defined as 65+ with 1 or more LTCs • Practice ID & name • Demographics • LSOA • LTCs • Count of primary care contacts (F2F & total) • Count of screenings & latest readings • Number of medications • Fields indicating whether this patient has been through INT or MDM for Lewisham only	Contact-level dataset: • Pseudo patient ID • Accommodation Status • Organisation Site ED, • Urgent, SDEC • F2F, telephone, remote • Planned/unplanned/initial/follow-up • Referred by GP, referred by NHS telephone, Inpatient ward… • Date • HRG Code • Diagnosis • Referred to Service • Discharge	Contact-level dataset: • Pseudo patient ID • Referral to treatment • Carer support indicator • Patient classification code • Method of admisison (hospital provider spell) • Discharge Start Date (Episode) • Length of stay • HRG Code • Primary Diagnosis (ICD) • Organisation • Site Identifier (At start of care episode) • Activity Location Type Code • Ward	Contact-level dataset: • Pseudo patient ID • Referral to treatment • Carer support indicator • Primary Diagnosis (ICD) • Attendance Status • HRG Code • Attendance Status • Organisation Site Identifier (Of Treatment) • Activity Location Type Code • Clinical Code • Priority Type Code

In addition to this data, the SEL BI team has a **patient-level understanding of who has received care from an INT in Lewisham** via SNOMED-CT coding in primary care data. This will enable retrospective matched-cohort analysis of the impact of INT care on service usage.

Assumptions feeding into the model will be informed by a structured **Place 'information capture' form** shared with INT leads in all six SEL Places.

Summary of information requested from Places to inform model assumptions

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Generating a useful output for this initial phase of modelling work, based on a static dataset, means collating a **set of inputs that accurately reflect the current and future on-the-ground realities of INT delivery** in each of SEL's six Places to serve as inputs and assumptions.

The outputs of this information capture as set out in this document should also serve as a **stocktake and means of identifying variation** for the broader SEL INT Implementation Programme.

Section	Content
Basic Information & Implementation Status	• Basic information on neighbourhood configuration, boundaries,, and size. • Implementation status of both MLTC and Frailty & PELOC INTs
Cohort Definition	• Current / potential future definition of cohorts for both INTs • Current / expected maximum caseload capacity for both INTs
Delivery Models	• Series of questions on how each INT is expected to deliver care, balance between reactive and proactive care, PHM infrastructure, VCSE involvement, barriers to access, discharge, and patient activation
Data Availability	• Specification of data that is / will be captured by the MLTC and Frailty & PELOC INTs
Partner Orgs	• Lists of partners involved in the delivery of each of the MLTC and Frailty & PELOC INTs
Budget & Workforce	• Source of any resources allocated to both INTs, including repurposed funding, and estimate of funding gap • Estimated current and future workforce of composition for both INTs
Pilots & Evaluations	• Information on any pilots delivered, in progress, or planned, seeking to evaluate the impact of either INT

Detailed status update on data structuring and first run analysis (1/2)

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To prepare the linked datasets provided by the SEL BI team to be used in analysis, a significant amount of **processing, data cleaning, and restructuring** is required. Our team have focused on the following activities to ensure our analysis is built on one structured, linked, and quality assured dataset:

1. **SNOMED code matching** – To make use of fields that use SNOMED coding, including a range of critical indicators from General Practice data (e.g. screening, MDM contacts, medication reviews), we have set up an API to automate the conversion of codes to useable data. This will be critical for tracking INT activity over the coming months and years as Places establish coding principles for tracking INT activity.

2. **Tariff matching** – Our initial approach to estimating theoretical shifts in resource deployment depends on linking acute HRG codes to tariff costs and grouping these into useful categories. We have built an automated process for drawing on the latest available tariff data.

3. **Linking across datasets to create patient journeys** – The data provided by the SEL BI team has unique patient identifiers which can be used to link across primary, secondary, and community care datasets. To carry out an analysis of service usage dynamics, these datasets have been consolidated into a single table.

4. **Data cleaning and alignment** – Many of the datasets extracted by the SEL BI team contain fields that describe similar data (e.g. fields on age, LSOA of residence, ethnicity, gender, etc.) which can vary across those datasets. We have set up an automated cleaning process to remove duplicate fields and ensure the most recent and complete data are used in analysis

5. **Data completeness analysis** – Some of the fields provided by the SEL BI team draw on data, particularly from General Practice, that has not been assessed for completeness. We have carried out a comprehensive review of the fields provided to ensure that conclusions are not drawn from skewed data.

Initial visualisations produced as part of this data cleaning and validation process are set out on the next slide

Detailed status update on data structuring and first run analysis (2/2)

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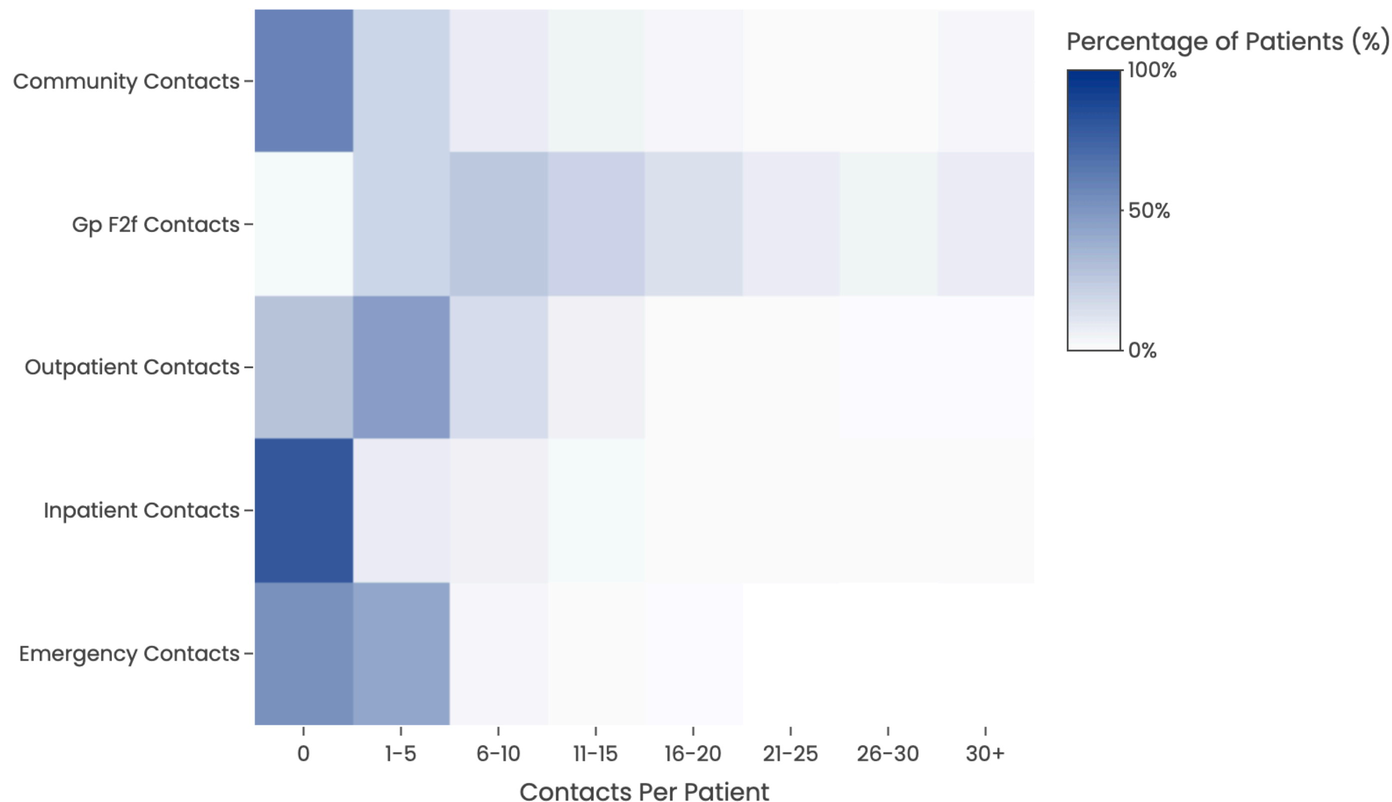
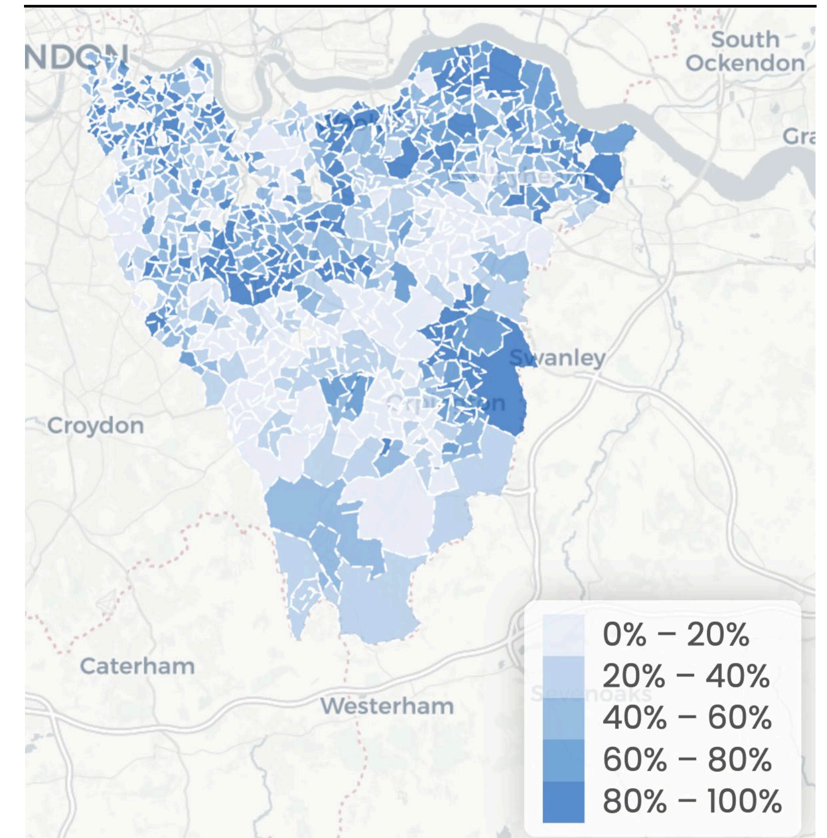
As part of our work to understand the linked dataset provided by the BI team, we are **generating data visualisations as we consolidate datasets** to explore key descriptors and sense-check the data, in particular the relationships between different kinds of 'contact' across the system and the distribution of our target cohorts across the SEL footprint.

'Intensity of use' distribution for each contact type within our Frailty cohort *– darker colours to the right indicate more patients receiving multiple contacts*



Spatial distribution of our Frailty cohort



Neighbourhood Based Care Board

<table>
<tr><td>Title</td><td colspan="6">Workforce Workstream Deep Dive – Clinical Governance</td></tr>
<tr><td>Meeting date</td><td>20 November 2025</td><td>Agenda item Number</td><td>6</td><td>Paper Enclosure Ref</td><td colspan="2">4</td></tr>
<tr><td>Author</td><td colspan="6">Chloe Harris</td></tr>
<tr><td>Executive lead</td><td colspan="6">Lynn Demeda</td></tr>
<tr><td>Paper is for:</td><td>Update</td><td>X</td><td>Discussion</td><td>X</td><td>Decision</td><td></td></tr>
<tr><td>Purpose of paper</td><td colspan="6">It was requested to facilitate a deep dive discussion at the November Neighbourhood Based Care Board, sharing outputs from Clinical Governance and Risk workshops and potential next steps. The purpose of this update is to:
• Share findings from workshops regarding key challenges and examples raised
• Share potential solutions suggested to address challenges, themes for escalation and areas a working group can take forward
• Discuss reflections on the above, and seek agreement on next steps</td></tr>
<tr><td>Summary of main points</td><td colspan="6">SEL boroughs are working through their models for Neighbourhood Health and alongside this a workforce plan has been developed and agreed to support this work.

Since approval of this workforce plan, conversations at Place and London level have consistently highlighted clinical governance and risk as a key challenge to integrated working and implementation of neighbourhood models.

Considering this, the SEL People Programme team hosted two workshops with interested stakeholders, to identify and discuss the challenges & solutions associated with this new way of working.

There were 71 attendees in total (76% attendance rate) across both sessions, covering representation from primary care, SEL ICB and larger NHS providers.

Challenges raised in 5 areas including:
• Ambiguity in accountability and governance structures
• Digital, data sharing and information governance
• Workforce complexity and staff movement
• Culture change and communications
• Standards, regulation and risk

Recommendations and next steps have been sorted into the following categories:
• Points of escalation to national/London team
• Points for clarification at SEL level
• Suggested next steps for working group - a small working group is being established to support this</td></tr>
</table>

Potential conflicts of Interest	Nil					
Sharing and confidentiality	Open					
Relevant to these boroughs	Bexley	x	Bromley	x	Lewisham	x
	Greenwich	x	Lambeth	x	Southwark	x
Equalities Impact	N/A					
Financial Impact	N/A					
Public Patient Engagement	N/A					
Committee engagement	Some Committee members may have engaged in original workshops held 29th and 30th September.					
Recommendation	The Committee is asked to discuss points as outlined in page 8 of the paper. In summary these are to share overall reflections on findings from workshops and thoughts on recommendations shared.					

South East London Integrated Care System

Workforce workstream deep dive – Clinical Governance

Neighbourhood Based Care Board – 20th November 2025

South East London Integrated Care System

Introduction

- SEL boroughs are working through their models for Neighbourhood Health and alongside this a workforce plan has been developed and agreed to support this work. Since approval of this workforce plan, conversations at Place and London level have consistently highlighted **clinical governance and risk** as a key challenge to integrated working and implementation of neighbourhood models.
- Considering this, the SEL People Programme team hosted two workshops with interested stakeholders, to identify and discuss the challenges & solutions associated with this new way of working. We understood this to only be the start of the conversation, to help unpick this topic in more detail.
- It was requested to facilitate a deep dive discussion at the November Neighbourhood Based Care Board, sharing outputs from workshops and potential next steps.

The purpose of this update is to:

- Share findings from workshops regarding key challenges and examples raised
- Share potential solutions suggested to address challenges, themes for escalation and areas a working group can take forward
- Discuss reflections on the above, and seek agreement on next steps

South East London Integrated Care System

Clinical Risk & Governance Workshops

Workshop aims

The aims of the workshop were as follows:

- To be able to clearly articulate the challenges associated with clinical risk and governance in a neighbourhood health context
- Better understand the 'how' and 'what' needs to happen to resolve these challenges
- Have a view on immediate next steps and actions to take

Attendance

There were 71 attendees in total (76% attendance rate) across both sessions, covering representation from primary care, SEL ICB and larger NHS providers.

Date	No. of registered	No. of attendees	Attendance rate
29th September	49	41	84%
30th September	44	30	68%

Session format

Following introductions, participants were placed into one of four breakout rooms, with a facilitator from the SEL ICS People Programme team. Participants discussed the following:

1. What are the **challenges** associated with clinical governance and risk when delivering services provided by multiple organisations (across health, care and VCSEs)?
2. What needs to happen to **resolve** some of the challenges shared? How can we go about addressing these?
3. What are some of the **immediate next steps** we need to take?

A nominated scribe took notes and share this centrally with the SEL People Programme team. The following sections capture summary of themes discussed and next steps.

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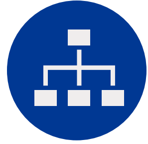
Session outputs – defining the challenge (1)



Ambiguity in accountability and governance structures

- **Accountability in integrated teams is complex**. Governance varies across organisations (NHS, local authorities, VCSEs), creating blurred lines in areas like incident reporting, supervision, and medicines safety.
- **Cross-organisation working raises liability concerns**. Staff often work in settings different from their employer, creating gaps in indemnity, oversight, and legal responsibility. Current frameworks (e.g., London MOU) don't support long-term arrangements. (beyond temporary moves).
- **Delegated healthcare roles (e.g. ARRS, VCSE staff) can add further complexity**. The lack of a unified framework means that risk can go unaddressed, and learning from incidents can be fragmented or lost.

Digital, data sharing and information governance

- **Digital infrastructure across health and care remains siloed and technologies vary.** There is no single patient record or interoperable system being used across SEL ICS. This means information could be duplicated, missed or inaccessible at times.
- **It is recognised that IG is crucial in safeguarding data but has significant implications for working in INTs**. IG presents a further challenge when considering access rights, permissions and information sharing. The volume of data is difficult to sort through and identify what is relevant.
- **The lack of shared digital tools** hinders continuity of care and makes coordinated decision making harder.

***Medicines safety** – how do we transfer information regarding medicines and who is responsible for medicines safety?*

***Incident reporting** – different systems are being used across organisations, making it difficult to track and learn from events. Who has responsibility for incident reporting overall?*

EMIS was mentioned as a central record system in some areas, but gaining access to it – especially for non-NHS partners – was described as "painful" due to IG restrictions and technical barriers.

***The lack of formal data sharing agreements between organisations** – especially between NHS and non-NHS is a major barrier can lead to further legal and procedural uncertainty.*

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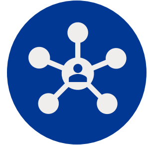
Session outputs – defining the challenge (2)



Workforce complexity and staff movement

- This model relies heavily on a flexible workforce that can **operate across organisational boundaries**. However, this introduces significant challenges as staff may have inconsistent experiences and expectations around supervision and training.
- Responsibility for **supervision, induction, preceptorship, mandatory training compliance** must also be considered. Staff need to receive the consistent induction and onboarding so that information shared is consistent to all.

Culture change and communications

- **Building shared language and understanding around this is essential** in efforts to work more collaboratively. Terminology and practices can often be weighted towards NHS and may not translate across social care providers or VCSE organisations.
- **Finding common ground and building a shared set of principles is key.** Organisations often have different organisational values, strategies, priorities and ways of working. Leadership also needs to support in championing the ethos to 'think system' rather than organisation.
- **Communications and awareness raising of neighbourhood working** and its benefits provides a good basis to aid staff engagement and involvement with embedding this at a local level.

***Indemnity and insurance** may fall short if staff work for an organisation other than their employer*

***Pre-employment checks** may not be consistent across our organisations*

*One of the groups raised that a **multi partners workshop** was held in their Place and terminology was a real issue for gaining a consistent understanding*

*Some Places have already begun to explore/scope an **OD/culture change plan** via their integrator arrangements – to support with building trust of workforce*

South East London Integrated Care System

Session outputs – defining the challenge (3)

Standards, regulation and risk

- **Formal definitions on safety and quality across organisations can vary.** There can be inconsistencies also in approaches towards training standards, processes and risk management.
- **Services are regulated to varying degrees, which can present challenges in establishing common expectations.** Without shared clinical guidance or SOPs (standard operating procedures), teams may struggle to coordinate effectively, and patients may experience variable are depending on where/how they access services. This can lead to fragmented service delivery.

*Team of teams can mean that sometimes there may be **regulated and non-regulated services/ providers working together** and boundaries of responsibility unclear*

Next steps following the workshops…

- ✓ Collation and write up of notes. These were then analysed for key themes and shared with attendees as part of follow up
- ✓ Invitation was extended to attendees to join a small working group which meets monthly to progress tangible actions
- ✓ Inaugural meeting was held to discuss findings from workshops; solutions suggested and prioritise next steps

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Recommendations - taking this forward

Inaugural working group meeting discussed workshop findings, in which the group agreed summary reflected what was discussed and outputs regarding suggestions raised. The remainder of the conversation focused on tangible details regarding what a working group could look at and what needs to be escalated for further clarification.

Points of escalation to national/London team

- Staff movement MOUs/framework in the context of neighbourhood working (e.g. updates/strengthened London MOU or staff passporting)
- Legal advice/support – on review of indemnity frameworks
- Further guidance on principles published - NHS England — London » Governance: working together safely and efficiently and what this means in practice. Tool/template would be helpful

Points for clarification at SEL level

- Models of neighbourhood care and governance and leadership structures being established for neighbourhood working at Place level
- Funding arrangements – ensuring that strategic commissioning and funding flows (across partners VCSE/health/social care)

Suggested steps for working group

1. **Host working group meetings to devise recommendations/principles in the following areas:**
   - Use of honorary contracts
   - IG clearance
   - Escalation of serious risk
   - Escalation of performance issues
   - OH requirements and immunisation

   **Noting that we will need to invite subject matter experts into each of these sessions alongside core working group members.*
   ***Membership to be reviewed to ensure reflect representation of Place.*

2. Present complete list of recommendations/principles with Neighbourhood Care Board for sign off

South East London Integrated Care System

Neighbourhood Based Care Board Discussion

We invite Neighbourhood Based Care Board to reflect and discuss the following points:

1. **Overall reflections on findings from Clinical Governance and Risk Workshops**
    - Does they reflect your understanding of the challenges?
    - Is there anything missed that needs to be considered?

2. **Reflections on recommendations**
    - Do you agree with points of clarification and escalation at regional and SEL level?
        - Is there anything missed that needs to be considered?
    - Agree with suggested next steps for working group and topics of discussion?
        - Please share any thoughts on individuals who you believe should be represented on working group

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

<table>
<tr><td>Title</td><td colspan="6">Integrated Urgent Care update</td></tr>
<tr><td>Meeting date</td><td>20 November 2025</td><td colspan="2">Agenda item Number</td><td>7</td><td>Paper Enclosure Ref</td><td>5</td></tr>
<tr><td>Author</td><td colspan="6">Jodie Adkin, SEL ICB (Bromley) for workstream 1
Kerry Lipsitz and Claire Goody for workstream 2</td></tr>
<tr><td>Executive lead</td><td colspan="6">Angela Bhan</td></tr>
<tr><td>Paper is for:</td><td>Update</td><td>X</td><td>Discussion</td><td></td><td>Decision</td><td></td></tr>
<tr><td>Purpose of paper</td><td colspan="6">To update the Neighbourhood Based Care Board on the Integrated Urgent Care (IUC) work happening across SEL. This is through two main workstreams

1. Right Place, Right Time - Reducing Avoidable Use of 111 Working Group – as part of ensuring Same Day Urgent Care in the community
2. 111 Procurement</td></tr>
<tr><td>Summary of main points</td><td colspan="6">See paper.</td></tr>
<tr><td>Potential conflicts of Interest</td><td colspan="6">None.</td></tr>
<tr><td>Sharing and confidentiality</td><td colspan="6">With permission of authors or Executive Lead</td></tr>
<tr><td rowspan="2">Relevant to these boroughs</td><td>Bexley</td><td>x</td><td>Bromley</td><td>x</td><td>Lewisham</td><td>x</td></tr>
<tr><td>Greenwich</td><td>x</td><td>Lambeth</td><td>x</td><td>Southwark</td><td>x</td></tr>
<tr><td>Equalities Impact</td><td colspan="6">N/A</td></tr>
<tr><td>Financial Impact</td><td colspan="6">N/A</td></tr>
<tr><td>Public Patient Engagement</td><td colspan="6">N/A</td></tr>
<tr><td>Committee engagement</td><td colspan="6">N/a</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Committee are asked to NOTE the update.</td></tr>
</table>

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South East London

Neighbourhood Board Update on Integrated Urgent Care (IUC)

November 2025

The following provides an update to the Neighbourhood Based Care Board on the Integrated Urgent Care (IUC) work happening across SEL. This is through two main workstreams

1. Right Place, Right Time - Reducing Avoidable Use of 111 Working Group – as part of ensuring Same Day Urgent Care in the community
2. 111 Procurement

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1. Workstream briefing: Right Place, Right Time - Reducing Avoidable Use of 111

Work continues across South-East London (SEL) to reduce avoidable use of NHS 111, minimising duplication, ensuring patients access the right care in the right place to improve system efficiency and patient confidence. Since the last presentation to the Neighbourhood Care Board the working group has have been ensuring the work of the group is aligned with and informed by neighbourhood-based care model developments.

1.1 Primary Care

Borough-led discussions continue with practices showing higher-than-expected 111 use (based on weighted list size), supporting targeted improvement actions. With Total Triage now fully adopted across SEL, the interface between 111 call handling and in-hours primary care is being revisited, including how the current worklist approach (where patients are added to the duty doctor triage list rather than booked directly into GP appointments) can be refined to create consistency in access to primary care. Getting this interface right is a key element of neighbourhood development, ensuring 111 operates as an integrated part of local access and care coordination. Engagement with primary care and the LMC will support this work. Requests to improve the functionality of GP Connect are also being pursued with NHS England's GP Connect leads.

1.2 Communications and Engagement

Existing SEL and borough-level communications have been strengthened to focus on key reasons of 111 calls, particularly around repeat prescriptions and MSK presentations, rather than introducing new standalone campaigns. Defining the purpose of 111 to create a clear message for patients is also being explored by the group taking into account new national messaging, whilst balancing local neighbourhood developments.

1.3 Medicines Optimisation

Following a visit to the 111 call centre, several opportunities were identified to improve call handling and referral processes for pharmacy first utilisation and redirection of patients requiring a repeat prescription. The London Ambulance Service (LAS) is supportive, and an invest-to-save proposal is being processed to deliver these improvements, with significant potential for both financial savings and better patient experience.

1.4 Care Homes

A high proportion of 111 calls from care homes result in ambulance dispatches but with lower-than-average conveyance rates, supporting the view that strong neighbourhood pathways enhance clinical decision-making and reduce unnecessary ambulance use. Analysis of 111 usage by care homes has informed targeted work to:

- Reinforce awareness of local GP out-of-hours (OOH) access routes.
- Strengthen in-hours processes in boroughs where unnecessary 111 calls occur.

1.5 Self-referral pathways

Work is underway to ensure consistency of 111 with the rest of SEL in the use of self-referral services. The Southwark, Lambeth, and Bexley MSK service is now live, for back pain. Patients with MSK back pain symptoms are now directed to self-refer to the Get You Better app rather than being booked in to a GP appointment, who will then provide self-referral information. This pathway also featuring the first-in-country use of natural language processing to direct patients to self-refer at the initial point of the call, preventing unnecessary triage by 111.

Bromley is finalising its interface between 111 and the local MSK service, with Bexley and Greenwich to follow. This will ensure 111 is aligned with local pathways and enables equitable, efficient access for patients.

2. Workstream: 111 Procurement

We have agreed an urgent modification for a 12-month extension with our current provider, the London Ambulance Service. Our current 111 contract will now expire on the 31st of March 2027.

Current timelines for the procurement:

December 2025 – SEL ICB Board approval to go out to market

January 2026 – Issue Invitation to Tender

July 2026 – Award contract

CEO: Andrew Bland
Chair: Sir Richard Douglas CB

August 2026 – March 2027 – Mobilise the service

April 2027 – New 111 service to start

Update provided by:
Jodie Adkin, SEL ICB (Bromley) for workstream 1
Kerry Lipsitz and Claire Goody for workstream 2

South East London
Integrated Care System

Enclosure 6i

Integrated Neighbourhoods Programme – Gaps in Support & Funding Update

Laura Jenner **– Director of System Development**

SEL-Wide INT and Integrator Development Funding

- Alongside funding for the integrator, additional funding has been made available in 2025/26 to pump-prime the implementation of INTs within our priority population groups.

	Frailty INTs	Multiple LTC INTs		Integrator Development	TOTAL
BOROUGH	Recurrent Funding *(£'000s)*	Recurrent Funding *(£'000s)*	Non-Recurrent Funding *(£'000s)*	Non-Recurrent Funding *(£'000s)*	
Bexley	£264.00	£141.65	£129.33	£250.00	**£784.98**
Bromley	£283.00	£170.23	£155.42	£250.00	**£858.65**
Greenwich	£162.00	£187.53	£171.23	£250.00	**£770.76**
Lambeth	£131.00	£221.74	£202.46	£250.00	**£805.21**
Lewisham	£155.00	£204.12	£186.37	£250.00	**£795.49**
Southwark	£133.00	£201.73	£184.19	£250.00	**£768.92**
TOTAL	**£1,128.00**	**£1,127.00**	**£1,029.00**	**£1,500.00**	**£4,784.00**

Gaps in Support for Integrated Neighbourhood Partnership & Model of Care Rollout

£250k funding has been allocated for partnership development and (yellow highlight for the £250k)

Domain	Current Position	Gap Identified	Impact on INP / Programme Rollout	Support Required	Resource Required	Priorities
Primary Care Development	Lewisham has 27 GP practices operating across 35 sites, all of which are aligned to one of the borough's seven Primary Care Networks	General Practice doesn't have unified voice that is consistently represented at the Partnership Board level	Delivery risk and lack of ownership from primary care	• To help general practice define its future in neighbourhood working — building a unified voice • Dedicated support for improving the interface between GPs and community & secondary care (improvement plan, governance etc...)	• £30,000 – GP Lead for 6 months • £56,680 – PPL engagement on primary care partnership model	Work started
Child Health team development	Service taking place in Lambeth and Bromley. SEL leading on rolling out across Lewisham, Bexley, & Greenwich	• No dedicated programme support locally • No engagement taking place with primary care to co-design the service	Delivery risks and poor coordination	• Dedicated programme manager for children's workstreams, **or**; • Commission engagement with general practices to co-design the local model	• 8a Programme Manager – currently being recruited via LGT • £60,000 – Engagement with GPs to co-design the offer. Funded via the child health project	Not started – funded via the child health development programme
Community Engagement	Strong VCS presence in Lewisham	Engagement often ad-hoc and project-specific	Risk of low trust; communities feel initiatives are "top-down"	Structured engagement framework; funding for VCS partners to co-produce services	£10k – Budget to fund expenses for people with lived experiences to take part in the co-design work	
Financial Resources	Funding aligned at ICS/borough level; limited pooling at INP level	Budgets not devolved to neighbourhood partnerships	Reduced flexibility to address hyper-local needs	Piloting pooled budgets at INP level; financial governance support – in the future		

Domain	Current Position	Gap Identified	Impact on INP / Programme Rollout	Support Required	Resource Required	Priority
Contract/legal support	Agreed governance and partnership MOU	No formal partnership contract in place	Limited opportunity to hold partners to account	Moving into a legal partnership agreement		
Organisational Development	Limited OD support across the partnership	No joint OD approach for leaders, middle managers to further design the INT model. To successfully embed this model, frontline staff need opportunities to engage, shape, and align around shared vision	• Partners lack shared understanding of integrated working and opportunity • Lack of ownership from frontline staff	• Implement an OD approach with middle mangers to co-design next stage of the INT model • Co-design vision and objectives for INT partnership with SRO group	• £37,440 – 48 days' work *(Lisa – see proposal)* • £55,000 – Commission external support; currently seeking proposals	Priority
INT – Projects/ Delivery Manager – to support both PM sort delivery the service as the models transitions into BAU over next 12 months	ICB project leads for some individual workstreams. No dedicated programme manager embedded at INP level	Limited support to implement the Prevention work (outer circle) Limited support to support the enablement workstreams	Delivery risks and poor coordination Test and learn not in place.	• Dedicated INP programme manager to oversee all INT workstreams, support partnership development, and manage risk & issues • Dedicated support to work with projects across the council, VCS and health – implementing the No Wrong Front Door, hubs, and wider prevention workstreams	ban 7 support for 12 months£74,385 + £27% £97,901	Priority
Communication & Engagement (Internal)	Internal comms strong within LGT and borough councils	Cross-partner comms inconsistent; staff not fully aware of the INT work	Lack of visibility and engagement with frontline teams	INP comms strategy – shared newsletters, intranet space, and joint events	Work with comms teams across the system to support	

Domain	Current Position	Gap Identified	Impact on INP / Programme Rollout	Support Required	Resource Required	Priority
Monitoring & Evaluation	Outcomes measured at ICS and borough scale	Neighbourhood-level evaluation limited (only LTC)	Hard to demonstrate impact of INP locally	INP-specific KPIs, real-time dashboards, evaluation framework co-designed with partners	Use the Pop Health team and BI team to develop the full evaluation framework.	
Estates opportunity for INT teams and hubs	LGT undertaking a review of community estates. ICB have recently completed a review of primary care estates	Current review doesn't include scoping and defining the options for community health hubs.	Unaware of the full opportunity to use Lewisham estates to enable integration move services out of acute and into the community	Increase the ICB community estate review to include community hubs or commission separately	This is being funded via the IVB estate team	
GP engagement/ clinical lead Mental Health		No dedicated GP support available to help co-design the new primary care mental health CMHT	Inefficient pathway Implementation delays Fragmented care	GP Lead 1 day per week around mental health	Funding identified via the ICB (SDF)	Advert out for recruitment
Total Non-Recurrent Funding Amount:	**£250,000**					
Total Spend	**££249,581**					