South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

1415-1600 Thursday 15 January 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	1415
2	**Declarations of interests relevant to the business on the agenda**	All	1420
3	**Minutes of the meeting held on 10 December 2025 (Enc 1)**	Chair	1425
4	**Actions and matters arising (Enc 2)**	Chair	1430
	IMPLEMENTING NEIGHBOURHOOD CARE		
5	**Integrator Development Plans** • **Priorities for development especially where there is cross over with enabling workstream plans from Bexley and Greenwich (Enc 3i & 3ii)** • **Feedback from 3 December event**	Bexley, and Greenwich Place Reps J Sanderson	1435
6	**Neighbourhoods PMO Report (Enc 4)**	C Jacob/ H Eden	1450
7	**Children and Young People Task and Finish Group – Endorsement of CYP Framework (Enc 5)**	Alison Roberts, Bhumika Mittal, Ashish Dwivedi, Brian Jopling	1510
8	**Any other business.**	Chair	1550
9	**Date of next meeting** **1400-1600 Wednesday 11 February 2026**	Chair	1600

Enclosure 1

Neighbourhood Based Care Board
Draft Minutes of the meeting held on Wednesday 10 December 2025 MS Teams

Present:

George Verghese	ICB Partner Member (Primary Care) (Joint Chair)	**GV**
Angela Bhan	Bromley PEL (for part of the meeting)	**ABh**
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**
Toby Garrood	ICB Medical Director	**TG**
Kallie Hayburn	Bexley LCP representative	**KH**
Ceri Jacob	ICB Place Executive Lead Lewisham (Joint Chair)	**CJ**
Rebecca Jarvis	Southwark LCP representative	**RJ**
Neil Kennett-Brown	ICB System Sustainability Team Representative (Non-Voting)	**NKB**
Raj Matharu	Community Pharmacy representative	**RM**
Tal Rosenzweig	Voluntary Sector Representative (for part of the meeting)	**TR**
Nisha Wheeler	Digital representative	**NW**

In attendance:

Tim Borrie	Strategic and Operations Estates Director	**TB**
Mark Cheung	Bromley LCP representative	**MC**
Chloe Harris	Head of People and Culture SEL ICS (for item 118/2025)	**CH**
Nick Harris	Head of CESEL	**NH**
Nancy Kuchemann	Deputy ICB Medical Director	**NK**
Colin Nash	Governance Manager (Minutes)	**CN**
Jenny Sanderson	PPL	**JS**

Apologies for absence:

Andrew Bland	ICB CEO (non-voting member) (for part of the meeting)	**AB**
Diane Braithwaite	Bexley PEL	**DB**
Gabi Darby	Greenwich LCP representative	**GD**
Holly Eden	Director of Delivery – Neighbourhoods and Population Health	**HE**
Neil Goulbourne	Acute Services Representative	**NG**
Laura Jenner	Lewisham LCP representative	**LJ**
Denise Radley	Adult Social Services representative	**DR**

No	Item	Action
123/2025	**INTRODUCTIONS AND APOLOGIES**	
	GV welcomed members to the meeting.	

	Apologies were noted as above.	
124/2025	**DECLARATIONS OF INTEREST RELEVANT TO THE BUSINESS ON THE AGENDA**	
	None.	
125/2025	**MINUTES OF THE MEETING HELD ON 20 NOVEMBER 2025**	
	The minutes were **APPROVED.**	
126/2025	**ACTIONS AND MATTERS ARISING**	
	The Board considered the open actions on the log for this meeting: - 30/25 – Brought forward to the January meeting. 31/25 – GV reported that work continued on integrator representation on the NBCB. Action brought forward. 38/25 – Action closed. 39/25 – CH thanked members for forwarding names of subject experts who could assist in developing the workforce approach to the 5 governance challenges. Action closed.	**HE** **GV,** **CJ, HE**
	IMPLEMENTING NEIGHBOURHOOD CARE	
127/2025	**PHARMACY AND NEIGHBOURHOODS**	
	JS made a presentation, using slides that were circulated to members by email after the meeting (10/12/25 16:35). The following points were highlighted. London's health system was under pressure. Demand was increasing by more than 10% year on year, whilst the workforce was reducing. Core 20 Plus 5 inequalities persisted across SEL. Patient journeys were often fragmented and access to health care was variable. Unplanned hospital admissions, linked to medicines and chronic disease were increasing. The NHS 10 Year Plan and system plans emphasise the need for three shifts; hospital to neighbourhood, analogue to digital and reactive to preventative care. At neighbourhood level conversations still default to GPs when talking about primary care. Community pharmacy was an untapped asset that could help address these challenges. It offered 5 strategic advantages: - • Access – immediate walk-in care, known to residents • Continuity – as a medicine's safety anchor • Prevention – a local health hub giving visibility to common heath challenges • Digital – connected to the NHS App and Shared Record • Productivity – offers a high return on investment by reducing GP attendances and A&E demand. The 10 year Health Plan and Medium-Term Planning Guidance envisages pharmacy transitioning from a focus on dispensing to becoming integral to neighbourhood health by taking on an expanded role, supporting prevention and public health and integrating digitally. This was described in more detail on slide 4. Slide 5 set out some of the ways pharmacy could contribute to meeting the health challenges.	

	Slide 6 set out what the system would need to do differently if the pharmacy contribution was to be realised. This included: - • Embedding pharmacy within every INT • Building the capacity to commission community pharmacy services effectively • Strengthening digital interoperability and NHS APP integration • A shift to blended, outcome-based funding models • Investing in workforce development and independent prescribing capability This would take time, so slide 7 proposed four steps, to be taken over the next 6-12 months, to move things forward. If undertaken, it was expected that by 2028-29 improved integration with community pharmacy could deliver: - • A significant proportion of same-day demand managed in pharmacy • Reduction in medicines-related readmissions • Increased screening & vaccination in underserved groups • Significant numbers of GP appointments avoided annually • Improved equity and consistent access across boroughs • Better patient and staff experience In the discussion, the following points were made. In order to make a difference at a population level it would be necessary to have commitment from *all* community pharmacies. It was agreed that the pharmacy needs assessments undertaken by public health, needed to be more ambitious in the role envisaged for pharmacy. With regard to next steps over the next 6-12 months, to ensure as more even spread of pilot investment, it was suggested the proposed demonstrator site be considered for boroughs other than Southwark and Lambeth. To make progress with practical improvements the importance of strong relationships between community pharmacy leads and Places was emphasised. NW noted that at present the ICB's digital function was not required or resourced to support community pharmacy. Greater integration would be needed to address this. RM agreed that in order to tackle London's primary and community care challenges all community pharmacies need to be working together. This would require a cultural change needing ICB support. GV thanked JS and RM for their presentation.	

128/2025	**INTEGRATOR DEVELOPMENT PLANS**	
	Bromley MC spoke to a presentation with additional slides to those included within the pack. These were circulated to NBCB members by email after the meeting (10/12/25 16:35). The following points were highlighted. The One Bromley Integrator would be hosted by King's College NHS FT. Kings would be formally responsible for hosting integrator functions and providing the infrastructure, governance and operational support needed for INTs to function effectively Their key responsibilities will be:- • to enable integration, by bringing together primary care, community services, mental health, local authority and VCSE partners. • support the development and functioning of Bromley INTs • to co-lead the local governance forum and provide accountability to the Bromley Place Partnership. • facilitate the shift of resources from acute to community settings. • mobilise teams, support digital and estates planning and ensure workforce readiness. • use population health data to target interventions and reduce inequalities. Bromley's integrator development plan was set out in slide 6. Bromley planned to use its £250k to appoint INT Development Leads for each INT and fund an organisational development programme to build the organisational capacity, leadership, culture and infrastructure to deliver person centred care through INTs (slide 7). In response to a question from CJ, MC replied that the £250k was expected to last for the first year, during which the continuing leadership for neighbourhood-based care would be developed at INT level. ABh noted that, the ongoing leadership requirements for neighbourhood-based care had yet to be determined. LD commented that discrete areas of OD expertise did exist within the ICS and the challenge was ensuring this could be accessed across SEL, by those that would benefit.	
	GV thanked MC for his presentation. As Bexley and Greenwich were unable to be represented at the meeting today, their updates would be brought forward to the January meeting.	**DB/GD**
	Feedback from the 3 December event Deferred to the January meeting.	**JS**
129/2025	**ANY OTHER BUSINESS**	
	None.	

130/2025	**DATE OF NEXT MEETING**	
	1400-1600, Thursday 15 January 2026.	

South East London Integrated Care System

NHS South East London

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Enclosure 2

Neighbourhood Based Care Board
Draft Action log from the meeting held on 20.11.25

Item Ref	Minute number	Item title	Action description	Owner responsible	Due Date	Comments	
ACTIONS BROUGHT FORWARD							
30/25	116/2025	Quarterly Highlight Reports	Work on a shared risk log between place and SEL	**H Eden**	For 15.1.26 meeting.		
31/25	1262025	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.		
37/25	126/2025	PHM	Discuss how PMH would contribute to neighbourhood-based care planning	**M Higson/ O Chesa/ H Eden**	January 2026		
40/25	118/2025	Workforce Deep Dive	Bring a further paper on clinical governance to the March meeting.	**L Demeda**	19.3.26		
ACTIONS FROM THE 10 DECEMBER 2025 MEETING							
41/25	128/2025	Integrator Development Plans	Update the January meeting on Bexley and Greenwich Plans	**D Braithwaite/ G Darby**	For 15.1.26 meeting.	Completed. On the agenda	
42/25	128/2025	Integrator Development Plans	Update the January meeting on outputs from the 3 December event	**J Sanderson**	For 15.1.26 meeting.		

Enclosure 3i

Greenwich

Integrator Development Update

Neighbourhood Based Care Board

15th January 2026

HEALTHIER GREENWICH PARTNERSHIP

Greenwich Integrator

The Greenwich Integrator
The Healthier Greenwich Partnership, brings together a wide range of partners in the borough including the council, local Trusts and Community Hospice, will be supported by Oxleas NHS Foundation Trust as the Health Host.

Maturity Matrix
In November 2025, to inform our assessment of the maturity of our system to deliver neighbourhood-based care in Greenwich, members from the Healthy Greenwich Partnership Executive were sent an online questionnaire to consider the maturity levels criteria against each domain asking them to highlight Greenwich's stage of development for each of the priority domains. 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 allocated. **Summary of survey results on next slide**.

Investment
The £250,000 that has been made available to support Integrator arrangements will be spent on five priority areas, which include securing operational, clinical and programme expertise to further INT pathways/systems in each of the four Neighbourhoods, as well as borough-wide support for VCSE development and comms and engagement.
The key risk is that £250k does not stretch far enough to deliver the desired outcomes within the wider Greenwich plans for integrated Neighbourhood development. However, it is important to note that these are not the only funds available, and we will seek to maximise both existing resource and other new sources of investment.

Governance
Development of Memorandum of Understanding.
Planned workforce development efforts across the Partnership including establishing a Workforce Board for Neighbourhoods, and outlines the roles, responsibilities and governance for the programme overall.
Clarifying responsibility between ICB and Integrator on enabler functions.
Build on the mature interface group's successes by sharing best practices and lessons learned across neighbourhoods.

Maturity Matrix: Summary of Survey Results

The survey identified that most areas of maturity of integrated neighbourhood arrangements in Greenwich are mainly at the 'emerging' stage with a few domains at the 'developing' stage.

Functional Domains: These reflect the potential functions of place partnership arrangements supported by host integrator organisations based on the London Target Operating Model and the South-East London Integrator Functions.

Domain	Subdomain	Emerging	Developing	Maturing	Thriving
Supporting Operational Co-ordination	Operating Integrated Functions	93%	7%	0%	0%
	Shared Clinical Risk	93%	7%	0%	0%
Facilitating Population Health Management	Facilitating Data Sharing	73%	27%	0%	0%
	Promoting Use of Data	53%	47%	0%	0%
Improving the Interface	Process and Pathway Mapping	67%	33%	0%	0%
Driving Equity	Understanding Variation	47%	47%	6%	0%
Leading Delivery	Integrated Neighbourhood Teams	100%	0%	0%	0%
Essential Infrastructure	Digital Optimisation	93%	0%	7%	0%

Relational Domains: These reflect the potential relationships that the place partnerships and host integrator organisations will need to nurture both within their partnership's arrangement and with residents, staff and the ICB.

Domain	Subdomain	Emerging	Developing	Maturing	Thriving
Building Relationships & Trust	Codesign ways of working	53.3%	33.3%	13.3%	0%
	Parity of Voice	67%	20%	13%	0%
	Shared Accountability	67%	33%	0%	0%
Organisational Development and Culture	Embedding Holistic & Personalised Care	60%	40%	0%	0%
Residents & Neighbourhoods	Supporting Neighbourhood Infrastructure (community assets, VCSE services, etc.)	73%	20%	7%	0%

Greenwich Integrator Development Key Priorities

Operating integrated functions
- Complete the development of the MOU to support a shared approach between partners.
- Develop operational deliverables and assign accountability and leadership for neighbourhood teams.
- Agree additional programme delivery resources.

Developing our Core INTs
- Design and agree on the new operating model for INTs with clear alignment of neighbourhood teams, particularly Homecare, Reablement, Frailty, District Nursing and ASC services.

Shared Clinical Risk
- Develop a shared approach to clinical risk management.
- Establish a working group to map current approaches to clinical risk management and governance structures.

Promoting use of data, based on understanding need and unwarranted variation
- Review and update historic data sharing agreements to ensure they support neighbourhood working and comprehensive data integration.
- Build on current collaborative data use in services like JET and DHACT to expand joint data working across Public Health, Adult Social Care, health, housing, and other services.
- Understand which outcomes and services show the greatest unwarranted variation.
- Explore opportunities to link Adult Social Care data with health data.
- Continue to develop partnership structures (e.g., S75 agreements, HGP initiatives) that facilitate integrated working and data sharing to anticipate and address community needs.

Pathway mapping and Embedding holistic & personalised care
- Redesign care pathways with front-line teams that better enable holistic and personalised care.

Using enablers to realise plans in each INT
- Maximise use of estates, community relationships, digital and community assets and relationships in each INT.
- Programme and Quality Improvement methodology to deliver initial core INT and continuously improve processes and pathways.

Greenwich £250k Investment Allocations

Key Priorities of this investment	Funding Allocated
Neighbourhood (executive) leadership resource Oxleas will work with RBG ASC and primary care to establish a management structure for INTs.	£ 75,000.00
Programme/ delivery team capacity – to manage programme pilot and embed change including supporting coordination of health & wellbeing, estates and pathway implementation.	£ 100,000.00
Neighbourhood clinical leadership resource to ensure robust PCN, primary care and provider clinical input, complementary to the clinical leadership already in the system and particularly focusing around areas of clinical / population priority such as LTCs.	£ 25,000.00
Expanding and securing a strong VCSE sector role within integrated Neighbourhood working	£ 25,000.00
Additional comms and workforce OD/ engagement capacity. Workforce Lead has been seconded from SEL ICB into Oxleas (0.4 FTE) to support progress.	£ 25,000.00
Total	£ 250,000.00

Greenwich Priorities outside of the £250k

Areas of focus	Funding stream
As part of establishing the operational co-ordination of Neighbourhoods, we will look at different models of clinical risks management. This is likely to include separating a team management role from a professional leadership role - as has been done in the existing integrated JET service.	**Not funded separately**
Greenwich has established a data workstream, which will utilise the Accelerated Reform Fund (ARF) on behalf of SEL to help build upon the existing data work that has been undertaken as part of Healthy Intent and across SEL. Critically, this will include establishing options for shared data sets across health and care that also help predict, and prevent, use of residential care as well as hospital admissions. The recommended system is the Greenwich and Lewisham Snowflake enclave within the GSTT Snowflake platform which will securely hold identifiable data for LGT and Greenwich & Lewisham EMIS data to support effective PHM. ***Existing Healthy Intent platform ends 01 Apr 2026**	**Funded via existing programmes**
We will map existing care pathways against the Frailty and long-term condition frameworks in order to identify gaps and areas for development. Continue mapping and aligning individual staff to appropriate teams, particularly within DN and ASC services. We will also utilise the existing Interface group to smooth and reduce transitions across organisational interfaces in the pathway	**This will be covered under the programme team funding allocation.**
The public health team have developed detailed population profiles for each Neighbourhood which have been shared with Neighbourhood teams at a recent launch conference. We will develop mechanisms for sharing data with Health and Wellbeing teams, and leadership, to help drive continuous innovation and improvement to address variation across population groups. Close work with communities will help understand how differences can be addressed.	**Existing resource**
We will expand the frailty service to cover an increasing proportion of the moderately frail cohort in Greenwich and support more consistent collaboration with this service by practices through a new PMS premium. We will implement holistic appointment for patient with multiple LTCs and a more proactive approach with Health & Wellbeing coaches piloted in 2 networks with highest LTC rates (central and east)	**Service funding required**
We will participate in the SEL wide work to find robust solutions to staff record sharing across organisations, with reduced reliance on multiple log-ons.	**To flow from SEL solution works**
Map the estates available across the partnership and the current care delivered within this estate. Identify opportunities to optimise our estates supporting shared use of estates from across the public, private and VCSE sector to enable co-location of services	**Programme capacity as costed above to supplement existing resource**
Working with StoneKing, to develop the HGP to form a Partnership in Collaborative in Greenwich that incorporates VCSE expertise and ultimately gives a legal form capable of holding and delivering on future contracts or population budgets in an innovative way. This is a structured 12-month work programme.	**Funded separately**

Enclosure 3ii

Bexley Care *Plus*: Integrator Development Update

January 2026
V2.0

SEL Neighbourhood Based Care Board, Thursday 15th January 2026

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Bexley Care *Plus*

Bexley Care *Plus* (integrator) brings to together the **London Borough of Bexley, Oxleas NHS Foundation Trust, the local GP Federation and the 4 Primary Care Networks**. Oxleas NHS Foundation Trust is the 'host' NHS organisation.

Development of a Memorandum of Understanding & Governance

Through the Task and Finish Group, established in early 2025, Bexley Care *Plus* developed a comprehensive Memorandum of Understanding (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 has 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 is underway.

Assessing current maturity

In October 2025, the first in-person Bexley Care *Plus* workshop took place with all partners, which focused on developing a shared overarching vision and assessing our current maturity against the agreed maturity matrix. This was followed by an online survey and three facilitated working sessions to confirm our collective view of maturity and to agree priorities for the use of the £250,000 funding allocation. This work directly supports, and is 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.

Our Roadmap

In parallel, we have developed a clear roadmap to support delivery of the MoU and to guide us towards a legally binding Partnership Agreement. Progress against this roadmap will be driven and assured through the establishment of shadow governance arrangements for Bexley Care *Plus*. The £250,000 funding will support delivery of key milestones set out in the roadmap.

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Maturity Matrix: Summary of Survey Results

The survey identified that most areas of maturity of integrated neighbourhood arrangements in Bexley are **mainly at the 'emerging' stage with a few domains at the 'developing' stage** which were then discussed over a couple of working sessions to identify development areas.

Functional Domain	Subdomain	Emerging	Developing	Maturing	Thriving
Supporting Operational Co-ordination	Operating Integrated Functions	**50%**	33%	17%	0%
	Shared Clinical Risk	**83%**	17%	0%	0%
Facilitating Population health management	Facilitating Data Sharing	**50%**	**50%**	0%	0%
	Promoting Use of Data	**67%**	17%	17%	0%
Improving the Interface	Process and Pathway Mapping	**50%**	17%	33%	0%
Driving Equity	Understanding Variation	**83%**	0%	17%	0%
Leading Delivery	Integrated Neighbourhood Teams	17%	**50%**	33%	0%
Essential Infrastructure	Digital Optimisation	**83%**	17%	0%	0%
Relational Domain	**Subdomain**	**Emerging**	**Developing**	**Maturing**	**Thriving**
Building Relationships and Trust	Co-design ways of working	**50%**	33%	0%	17%
	Parity of Voice	**67%**	17%	0%	17%
	Shared Accountability	**67%**	17%	17%	0%
Organisational Development and Culture	Embedding Holistic and Personalised Care	33%	**50%**	17%	0%
Residents and Neighbourhoods	Supporting Neighbourhood Infrastructure (community assets, VCSE services, etc.)	17%	**83%**	0%	0%

Bexley Care *Plus* Development Key Priorities

1. Resident Engagement & Patient Support

- Develop a comprehensive vision and program for integrated care (INT).
- Provide education and digital tools to help patients manage long-term conditions.

2. Project & Digital Management

- Strengthen leadership, governance, and data flows to improve proactive care planning.
- Develop baseline mapping and business cases for shared care records accessible across providers.
- Focus on governance, strategy, data standards, security, consent, technical infrastructure, and partnerships.

3.Leadership & Organisational Development

A. Governance & Collaboration

- Develop joint governance framework and legal agreements across partners.
- Facilitate cross-sector leadership forums and team-building.
- Set shared objectives, performance metrics, and success measures.
- Embed shared goals into organisational strategies and performance reviews.
- Ensure transparent decision-making and risk-sharing models.
- Define roles, responsibilities, and escalation processes clearly.
- Develop risk-sharing models to support collective responsibility.

B. Workforce & Skills Development

- Provide cross-organisational training and development.
- Standardise risk management and clinical governance.
- Encourage joint problem-solving, peer learning, and interdisciplinary understanding.
- Develop mentoring, wellbeing, and supervision programs.
- Create shared job roles for cross-sector positions and coordinate workforce planning.
- Promote mutual understanding through interdisciplinary shadowing.

C. Innovation & Quality Improvement

- Establish a system-wide quality improvement (QI) programme.
- Train leaders and staff in improvement methodologies (e.g., PDSA, Lean).
- Encourage experimentation and safe failure through small-scale pilots.
- Partner with academic institutions and digital innovators.
- Celebrate and share successful innovations system-wide.
- Create learning networks and communities of practice.
- Use data to identify emerging needs and opportunities for innovation.

Bexley Care *Plus* £250k Investment Allocations

Key Priorities of this investment	Funding Allocated
Dedicated resident engagement resource to develop a comprehensive neighbourhood vision, approach and comprehensive programme, assets and products to include 3 key components: (i) Patient Engagement & Co-production; (ii) Health Literacy & Self-Management Support; and (iii) Community Engagement & Development	**£58,227**
Dedicated Bexley Care *Plus* Transformation Project Manager to support the acceleration of the delivery of INTs across the remaining Local Care Networks.	**£55, 690**
Digital Project Manager to develop baseline/mapping and business case for shared care records/information accessible across Bexley Care *Plus* providers.	**£55, 690**
Leadership Organisational Development capacity to establish and lead a shared, system-wide leadership and organisational development approach that aligns vision, governance, goals, resources, decision-making, and accountability across all partner organisations.	**£40,000**
INT Organisational Development expertise to deliver integrated organisational development that builds a skilled, supported, and collaborative workforce across the partners through shared training, governance, workforce planning, and cross-sector learning.	**£40,393**
TOTAL	**£250,000**

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Bexley priorities outside of the £250k

There are a few areas we will also work on, outside of the £250k allocation:

Area of focus	Funding Stream
Enablers – Estates: Development of the Queen Mary's Estates Utilisation Programme and potential neighbourhood centre/hub.	**Oxleas NHS Foundation Trust & Place Funding**
Enablers – Estates: Development of a **local health and care system** estates strategy and plan that supports identification of potential neighbourhood centres/hubs and to enable Neighbourhood working and teams.	**Funded Separately**
Enablers – Population Health Management: Population Health Analytics expertise to provide to drive continuous innovation and improvement to address variation across population groups working with Bexley Public Health.	**Place Funding**
Efficient Use of System Resources: Development of a financial framework and resource sustainability, working with the System Sustainability Programme and Health Economic Modelling.	**Existing**

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South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**SEL Neighbourhoods programme: Quarterly Highlight Reports**					
Meeting date	15 January 2026	Agenda item Number	**6**	Paper Enclosure Ref	**4**	
Author	Workstream leads & place neighbourhood leads					
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	
Purpose of paper	**This paper sets out the quarterly highlight reports from our six places and our SEL workstreams leads.**					
Summary of main points	This is our third of quarterly highlight reports as part of our engine room function for neighbourhoods, which seeks to strengthen programme management, governance and accountability, and increase visibility across the highly complex web of interdependent workstreams that form our approach to Neighbourhood working.					
Potential conflicts of Interest	None					
Sharing and confidentiality						
Relevant to these boroughs	Bexley	**x**	Bromley	**x**	Lewisham	**x**
	Greenwich	**x**	Lambeth	**x**	Southwark	**x**
Equalities Impact	N/A					
Financial Impact	Financial capacity continues to be raised as a risk to delivery and will need ongoing consideration across the NBCB.					
Public Patient Engagement	N/A					
Committee engagement	Local Care Partnership Committees Other ICB Committees in-line with programme governance structure					
Recommendation	To review and discuss the highlight report, particularly the common risks and interdependencies highlighted.					

South East London Integrated Care System

SEL Neighbourhoods programme

NBCB reporting summary

15th January 2026

PPL

Workstreams: an overview

Place
Greenwich Gabi Darby
Bexley Diana Braithwaite
Southwark Darren Summers
Bromley Angela Bhan
Lewisham Ceri Jacob
Lambeth Andrew Eyres

	Workstream (sub-workstream)		System Leads/ Coordinators	Reports into…
1	**Delivery of INTs, Neighbourhoods and 3 priority areas at Place**	**INT delivery**	Primary Care + Group	NBCB, Place Governance Structures
		Models of care for priority areas (x3)	**mLTCs:** Rob McCarthy & Lauren Blum **Place:** Bexley – Kallie Heyburn, Bromley – Mark Cheung, Greenwich – Jessica Arnold, Lambeth – Josepha Reynolds, Southwark – Geetika Singh, Lewisham – Johnathan McInerny **CYP:** Bhumika Mittal, Alison Roberts **Frailty:** Julie Archer	
2	**Population Health Management approach & data**		Toby Garrood, Maria Higson, Holly Eden	NBCB; PHM Delivery Board; SEL ICS Digital Board
3	**Flexible workforce models and culture change**		Lynn Demeda, Trivedi Seema, Chloe Harris, Rebekah Middleton	NBCB; SEL ICS People Committee
4	**Comms and engagement**		Kelly Scanlon, Humphrey Couchman, Rosemary Watts	NBCB; Exec Committee
5	**Strategic planning and resource allocation***	**Strategic commissioning**	TBC	SEL Sustainability Committee; PHM Delivery Board; Finance Committee; NBCB
		Estates	Tim Borrie, Tony Rackstraw	
		Modelling and impact	Neil Kennett Brown, Holly Eden	
6	**Digital**		Nisha Wheeler, Ananya Datta	Digital Governance Group

South East London
Integrated Care System

High level summary

PPL

Areas of progress, key learning

Progress this month:

Integrators across all six places have now agreed what they will spend the £250,000 development fund on with most having been approved, and upcoming approval pending for others.

Progress is 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 is underway but uneven, with recruitment progressing in some Places and interim or blended models being used elsewhere to maintain momentum.

Population Health Management is increasingly supporting MDT working, with interim risk stratification tools and dashboards being used to identify priority cohorts and inform delivery.

Digital limitations are no longer fully preventing action, as teams agree what is “safe enough” to proceed while longer-term solutions are developed.

Estates discussions are now centred on operational feasibility (who uses the space, when, and how), not just identification of potential sites.

Content has been highlighted for Board review by: Bromley Place

Key Learnings/Reflections this month include:

- **There are 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 are 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 is essential** and ultimately time-saving, reducing the need for later adaptation and strengthening ownership and buy-in.
- **Digital “workarounds” are unavoidable in the short term,** with shared recognition that full interoperability will not be achieved immediately and that pragmatic interim solutions are required to maintain momentum.
- **Delivery is advancing fastest where “good enough” definitions are accepted**, rather than waiting for perfect alignment across all partners.

Risks and Interdependencies

Delivery of neighbourhood working continues to face a number of cross-cutting risks across both Place and workstream highlight reports.

- **Uneven pace of delivery across Places:** There is a risk that differing levels of readiness and capacity across Places lead to widening variation in progress and neighbourhood maturity. This is being mitigated through clearer highlight reporting, more honest use of RAG ratings, and increasing reuse of approaches and learning from Places that are further ahead, alongside a sharper focus on critical path activity. There are also shared SEL frameworks being developed for priority cohorts to support this.
- **Workforce and leadership capacity constraints:** Limited leadership and delivery capacity, often alongside substantive roles, continues to constrain pace and sustainability, and this is being exacerbated by winter pressures drawing clinical and managerial capacity back into operational response. Mitigation includes the use of interim and blended leadership arrangements to maintain momentum, commencement of recruitment to key roles in some Places, and clearer articulation of leadership roles and expectations to protect delivery focus where possible.
- **Digital interoperability and data limitations:** Ongoing lack of interoperability across systems continues to constrain MDT working, reporting and VCSE participation. Mitigation includes strengthened SEL-level digital governance, agreed interim access solutions and data flows, and the use of pragmatic, time-limited workarounds to enable safe progress while longer-term solutions are developed.
- **Estates and neighbourhood hub feasibility:** The absence of operationally workable neighbourhood space risks MDT working remaining fragmented or unsustainable. This is being mitigated through borough workshops focused on practical operational requirements, active scoping of specific sites, and earlier recognition of estates as a critical delivery dependency rather than a later enabler.
- **Risk of over-ambition relative to capacity and time:** There is a risk that attempting to implement full neighbourhood models too quickly could dilute impact or delay embedding. Places are mitigating this by narrowing focus to priority cohorts, accepting “good enough” definitions to allow testing, and prioritising incremental delivery over wholesale implementation.
- **Sustainability of interim arrangements:** Extended reliance on interim staffing, processes and digital solutions risks creating fragility if not transitioned. This is being mitigated by using interim arrangements deliberately and transparently, running longer-term workforce, digital and estates planning in parallel with delivery, and explicitly recording associated risks rather than assuming they will resolve.

South East London Integrated Care System

Place reports

PPL

Bexley

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- **ICHT:** Went live in **North Bexley** w/c 8th December 2025 and first in-reach clinic scheduled for 16th January 2026; GPs and premises identified for Clocktower and Frognal with revised go live date of Q4.
- **Ageing Well/Frailty: Frognal hub & INT pilot** now scheduled for **w/c 12th January 2026**; **INT staff members** identified and attended an **INT development session** on 18th December. Hub programme finalised and promotional material has been drafted.
- **3+ LTCs: Clocktower** went live in **May 2025** (status context),; mobilising **North Bexley and Frognal** with the aim of going live during Q4, workforce evaluation underway and enhancement of model is being explored to support with complex case management.

Key proposed next steps

- **ICHT: Finalise mobilisation** actions for Clocktower/Frognal; joint health and care **transformation workshop** scheduled for February 2026 which will draw on the emerging SEL CYP Framework.
- **Ageing Well/Frailty: Finalise essential readiness checklist** ahead of go live**;** draft **end to end model** with phased implementation timeline and set out **frailty hub options** for consideration and discussion at CBC Delivery Board
- **3+ LTCs: Finalise implementation plans** for North Bexley and Frognal; **complete 6-month evaluation**; revisit longer-term transformation ideas generated in earlier workshops.

Variance from plan

- **ICHT scaling:** Planned for **November 2025**, now **planned for Q4 to allow winter pressures to ease**
- **Ageing well/frailty pilot go live October**: Planned for **January 2026**

Dependencies

- Interoperable IT systems
- Collaborative workforce and governance structures
- Agreed clinical and information governance arrangements

PPL South East London Integrated Care System

Overall RAG Status	

For the board	
Decision or action required	• Note the progress to date
Supporting papers	N/A

Milestone	Due date	Status
Implement ICHT pilot	December 2025	Complete
Scale 3+LTC model	From Q4	On track
Implement ageing well/frailty pilot	January 2026	On track
Finalise frailty end-to-end pathway and timeline for implementation	January 2025	On track
Scale 3+LTC model	December 2025	On track
Hold system wide estates workshop	January 2026	On track
Commence the Neighbourhood Health & INT Community of Practice programme	From January 2026	On track

Bexley

Risk	Action update	Current risk score
Lack of available appropriate estates	Explore shared-use of space; estates workshop planned for January	3x3 = 9
Funding pilots outside of Provider Selection Regime (PSR) rules	Consistent framework for fund transfers to enable progress of pilots (aligned with PSR where possible). Plan for future commissioning/contracting model beyond pilot period	4x3 = 12
Data sharing limitations across INTs	Completion of DSA/DPIA and development of interim datasets for pilots	3x4 = 12

Issue (change, problem, other)	Action update	Priority
Ageing well/frailty pilot go live date rescheduled from October/November to January 2026 due to finalizing data sharing agreements, confirming INT members and engagement with commercial provider	Implementation plan on track to enable go live w/c 12th January 2026	4
Primary care engagement with scaling the 3+ LTC model due to time limited funding, limited capacity and competing operational priorities	Working with PCN/LCN leads and BHNC to sup	6
Clinical governance and risk arrangements for pilot INTs	Working with ICB workforce leads; developing decentralised model for pilots based on existing national models	6

Key partners engaged

- All partners within the Bexley Wellbeing Partnership (NHS, local council, social care, libraries and the VCSE)
- GP leads, practices / LCNs: LCN meetings
- Primary Care PLT events.
- **Wider workforce & residents**:
  - Task-and-finish groups
  - Face to face workshops and on-line shared learning event
  - Ongoing engagement via Community Champions
  - INT development session and ‘meet the team’ day

Key learning

- Recognising the overlap between 3+LTCs cohort and frailty and ensuring pathways are aligned to enable smooth movement between services/models
- Understanding the potential opportunities to enhance our integrated models of care that are available from the voluntary sector
- Allowing more time than anticipated to work through complexities associated with bringing multiple professionals from multiple organisations together
- Continued engagement and communication with partners and stakeholders is critical for buy-in and ownership. Our ongoing conversations with those involved in designing the models of care has generated tangible enthusiasm and excitement about the forthcoming changes.

Bromley

Activity summary *December 2025*

Key activity and decisions in reporting period

- Successful application to Newton-supported sector-led INT community of practice.
- Operational delivery group for South West INT (mLTC focus) live & making progress.
- Agreed model for initial leadership, management and project support per INT.
- Agreed integrator development action plan, focussed on INT deliver and governance.

Key proposed next steps

- Integrator work with GSTT colleagues in understanding approach and input required to PID and non-PID population health management and analytics.
- Use SEL-wide CYP model to agree local phased BCHIP expansion: cohort and areas.
- SW INT go-live mLTC pathway, including integration w/ frailty colleagues as 'adult' INT, agreeing EPR, clinical governance, staffing and patient identification decisions.
- Commence neighbourhood delivery plan workshops – reviewing embedding prevention and wellbeing approach across our health and care system and beyond.

Variance from plan

- Go-live of mLTC pilot model in SW INT delayed pending further development on team structure, scale and processes for initial pilot. All being actively worked on.
- Clarity on clinical governance for INT model – using existing Place approach developed through Hospital at Home, but await further SEL/London input.

Dependencies

- SEL Programmes looking 'once for all' at key issues: Digital – EPR (overlay) system for viewing and visualising patient holistically, clear visibility of services for those working in and referring to neighbourhood teams; Workforce – sharing between organisations, workforce development / training planning, clinical governance for INTs.
- SEL mLTC Support: Coding of patients in mLTC pathway.

Overall RAG Status	

For the board	
Decision or action required	• Ask for SEL programmes prioritise immediate deliverables items (see Dependencies section) • Clarifying responsibility between ICB and Integrator on enabler functions. • Driving pace on 1) immediate deliverables from ICB-led enabler functions and 2) sharing clear timeline for when future deliverables are planned. • Agreeing approaches for reducing duplication of action across these matrixes of programmes
Supporting papers	Nil

Milestone	Due date	Status
CYP CHILDS Pathway live across Place w/ services aligned to neighbourhood footprints	March 2026	Complete
Frailty MDT Pathway live across Place w/ services aligned to neighbourhood footprints	March 2026	Complete
Full mLTC Pathway live across Place w/ services aligned to neighbourhood footprints	March 2026	At risk
Integrator fully operational	March 2026	On track
Clinical governance to support INT model	March 2026	At Risk
Agreed commissioning models, new funding flows and contractual mechanisms	March 2026	At risk

Bromley

Risk	Action update	Current risk score
Decision on EPR system aligned to clinical governance	Place task and finish-group	High
Clinical governance for INT working	Opportunities identified locally, SEL support through workforce group	High
Incentives / contracts misaligned to INT development	Work with Place and SEL Partners	High
All relevant patients lack access to information for direct patient care	DSA development approval	Moderate

Issue (change, problem, other)	Action update	Priority
Issue: Approach required on recruiting INT leadership and administration	INT Development Group decision made – to implement and close issue.	High
Issue: Understanding of current state mLTC service utilisation to support flow change analysis	DSA development approval	High
Issue: Capacity / resourcing across integrator (and strategic commissioner) – further clarity required on ICB staffing model / functions, and recurrent integrator investment.	INT Dev Group requested phased development plan	Medium

Key partners engaged

- Engagement with Integrators and SEL/PPL integrators session and continued ad hoc engagement between Integrator partners in SEL.
- Bromley Integrator development protected time to explore progress against maturity matrix, development plan and practical walk-throughs of working together to deliver new pathways.
- Engagement with SEL Clinical Lead for Informatics on population health management tools regarding Snowflake opportunities and role of Place. Commenced engagement across Integrator on input into the analytical team
- Continued engagement with One Bromley partners through South West Bromley INT Development Group and Executive INT Development Group.
- Digital partners across Bromley now formed digital working group to support aligned delivery of neighbourhood health across partners, aligning national plans and SEL developments.

Key learning

- Common challenge across integrators and Places in terms of risks of duplication and resource availability to service workload – initial thinking around utilising communities of practice.
- Key opportunity for working with other integrators in a Snowflake PID environment, with interest in expanding data sets available in the partition (e.g. community, mental health, adult social care). Need to understand how this may interact with non-PID environment and analytical resource.
- Increased communications required to support wider workforce knowledge of INT working, agreed models and levers.

Greenwich

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- Maturity Matrix Assessment complete
- Recommendations approved for allocation of £250k integrator development funding
- Frailty expansion plan developed
- Recommendation on testing 3+ LTCs cohorts approved
- Further developed plans for set up of INTs (i.e. operational and leadership composition)

Key proposed next steps

- Implementation of frailty expansion plan
- Development of a prevention framework to sit alongside neighbourhood working, including a preventative, community-based approach targeted at people with mild frailty
- Adult social care service reorganisation to align to neighbourhoods (consultation starting January 2026)
- Develop funding and evaluation plan for 3+ LTC approach
- Present options paper to confirm strategic leadership structure for INTs

Variance from plan

- None at this stage

Dependencies

- Developing a new MOU to underpin Healthier Greenwich Partnership & integrator duties
- Development and implementation of INTs estates plan
- Development and implementation of INTs digital, data and technology plan

Overall RAG Status	

For the board	
Decision or action required	None
Supporting papers	Greenwich Neighbourhood Health and Care Programme Board papers

Milestone	Due date	Status
Neighbourhood footprint agreed	Q4 24/25	Complete
INT form agreed	Q1 25/26	Complete
Aligned services to neighbourhood footprints	Q3 25/26	On track
First INTs begin work	Q3 25/26	On track
Development of 3+ LTC neighbourhoods	Q3 25/26	On track
Frailty ICP implementation plan	Q2 25/26	On track
Frailty implementation	Q4 25/26	On track
CYP implementation scales	Q4 25/26	At risk
Identification of provider and begin implementation	Ongoing	On track
Ongoing socialisation and engagement with residents, staff and partners	Ongoing	On track

Greenwich

Risk	Action update	Current risk score
Limited number of geriatricians for each of the four neighbourhood MDTs. Pharmacy representation limited.	• Workforce capacity being assessed through service ongoing service reorganisation. This will determine appropriate allocation of specialist services to support neighbourhood teams.	12
Operational teams have limited capacity and are focussed on delivering team priorities. Benefits of integration or preventative outcomes are often not recognised or able to be prioritised.	• Significant cultural and behavioural change is required to support individuals, teams and organisations to work differently. • Removing duplication of activities and creating a shared sense of responsibility. Help build additional capacity within existing workforce. • Continue mapping and aligning individual staff to appropriate teams	9
Data interoperability across system partner organisations including VCSE.	• Further development of London Care Record to support more effective joint-working. • Stone King developing MOU. • Review /update DSAs. • Recommended system is the Greenwich and Lewisham Snowflake enclave within the GSTT Snowflake platform which will securely hold identifiable data for LGT and Greenwich & Lewisham EMIS data to support effective PHM.	12
Estates risks – Greenwich has the highest proportion of 'tail' estates in general practice of any SEL borough, and all partners (most practices and all HGP system partners) are experiencing estates pressures in terms of both quantum and quality of space. There is concern about being able to find: • Appropriate bases for staff (especially to facilitate cross-organisational collaborative working) • Appropriate spaces for community and peer activities, and • Appropriate spaces for clinical exams/appointments (Note the risk on community activities is lower as spaces are available in the community such as churches, community centres, etc; but these require resource which is not currently allocated).	• General practice estates risks have been fully mapped in close engagement with practices, and the ambition is to address these in part through Neighbourhood Hub development in geographies of risk • Planning now for workshops in Feb 2026 to go into greater detail on design of each Neighbourhood Hub, such that strategy/action can be planned in the short/med/long terms as appropriate • Continue working with all partners' estates leads to plan strategically and long term for space transformation and to exploit funding opportunities • As above with Bexley colleagues regarding estates optimisation/planning in the Thamesmead/Abbey Wood areas • Use the opportunity of RBG's Urban Regeneration Framework planning to place health and care as a central priority in place-shaping of the future • Continue to identify opportunities to optimise our estates supporting shared use of estates from across the public, private and VCSE sector to enable co-location of staff and services	16
Sustainability of the funding and how these are aligned with teams supporting the operating model	• Improved collective oversight and visibility of staffing complements available and funding available to support development of INTs. Remains a significant ongoing risk due to complexity of funding streams and conditions associated with usage.	12

Greenwich

Issue (change, problem, other)	Action update	Priority
Implementation of frailty expansion plan	Action plan in development	High
Development of a prevention framework to sit alongside neighbourhood working, including a preventative, community-based approach targeted at people with mild frailty	Options under development. Initial outline for preventative and community-based offer presented at Greenwich NBHD Programme Board in December (see papers attached)	Low
Adult social care service reorganisation to align to neighbourhoods (consultation starting January 2026)	Decision report papers awaiting sign off. Consultation with staff to reorganize around neighbourhoods set to start in January	High
Develop funding and evaluation plan for 3+ LTC approach	This is being prepared and set to be agreed at the Healthier Greenwich Partnership in January	Med
Present options paper to confirm strategic leadership structure for INTs	Options to be presented at January meeting of Greenwich NBHD Programme Board	High
Developing a new MOU to underpin Healthier Greenwich Partnership & integrator duties	Under development as part of a 12-month structured plan of work. Working with Stone King as strategic change partner. Overall purpose and parties initially being confirmed.	Med
Development and implementation of INTs estates plan	Building on the proactive and collaborative General Practice Estates Strategy publication and the detailed Neighbourhood Hub workshops, both driven locally in summer 2025, we now have a plan for Neighbourhood Hub development in each of the four Greenwich Nhoods. This is being progressed in tandem with national/London estates funding opportunities and local Section 106 planning. There has been good system engagement on estates, and some early collaborative working with Bexley colleagues on ambitious plans ahead of the New Towns investment in Thamesmead.	Med
Development and implementation of INTs digital, data and technology plan	Some targeted activity completed to support system interoperability (i.e. recommended use of Snowflake). Next step is to develop a joined-up plan for digital, data and technology across the system	High

Greenwich

Key partners engaged

Appropriate senior leadership representation from:

- Oxleas
- SEL ICS
- Royal Borough of Greenwich
- Lewisham and Greenwich Healthcare Trust
- GP Federation
- Primary Care leaders from general practice and community pharmacy including PCN CDs, LMC and LPC
- Metro GAVS (VCSE system support organisation)

Key learning

Delivering key enablers of joined-up working (e.g. aligned and complementary leadership roles, access to operating systems, co-location, collective oversight of funding etc.) are the activities that are both the highest value and the most complex to deliver. This is because we simultaneously need to develop the capacity, capability and leadership required to deliver these supporting functions on behalf of the partnership, including through the integrator development. The timescales for developing and implementing INTs fully don't always align with the practical reality of the consistent long-term effort it takes to ensure that these enabling functions are at a sufficient stage of maturity. This is what poses greatest overall challenge to the programme due to the level of intentional and complex coordination that is required across the whole system.

Lambeth

Activity summary *(October – December)*

Key activity and decisions in reporting period

- Undertook series of detailed design workshops with partners from all involved organisations including primary and secondary care, community pharmacy, VCSE organisations and residents with lived experience to confirm testing model for INTs against each cohort
- Identified priority cohort of residents will be in the scope, including those who may not usually access or trust health services.
- Agreed testing model for each INT cohort, including evaluation metrics and staffing models
- Established neighbourhood enabler working groups incl. workforce, digital and PHM
- Agreed utilisation of integrator development funding
- Mapped enabler requirements as start of the design process
- Finalised first round of INT outreach engagement led by Healthwatch Lambeth
- Establish Ecology Group to bring together all Thrivings and grassroots leadership in Lambeth

Key proposed next steps

- Restructure community services to align to neighbourhood footprints and review mechanisms to support consultant time within the community
- Finalise neighbourhood leadership structure to support INT delivery
- Hold estates workshop to understand capacity required for neighbourhood delivery models
- Hold strengthening general practice workshop for all practices to review detailed neighbourhood model
- Undertake second round of INT outreach engagement led by Healthwatch Lambeth
- Test readiness and scalability of the INT models with the test and learn approach from December with the view to phase out the delivery of the model across all chosen INTs in from April 2026
- Commence INT prevention proof of concept in Stockwell for scaling across INTs
- Complete business case for future of women and girls hubs across Lambeth
- Complete three year delivery plan for neighbourhoods

Variance from plan

- On track

Dependencies

- Design and development of INT models dependent on neighbourhood resource, data access and analytic capability and stakeholder engagement insights
- NNHIP programme – external deliverables and timelines being determined

Overall RAG Status	

For the board	
Decision or action required	Board is asked to note the progress detailed here.
Supporting papers	N/A

Milestone	Due date	Status
Formation of working groups and governance	September 2025	Complete
Project plans in place	September 2025	Complete
Detailed design of INT models including confirmation of the cohort	December 2025	Complete
Testing proposed INT models in initial neighbourhoods	January – March 2026	Not yet started
Aligned services to neighbourhood footprints	April 2026	On track
Start 3 x INTs in Lambeth	April 2026	On track

Lambeth

Risk	Action update	Current risk score
Engagement of stakeholders and all partners to the delivery of the model. Risk of insufficient partners including patient, VCSE or communtiy representatives involbment would lead to designing a model that lacks local relevance and buy-in	Clear communication of common goals with all the stakeholders about outcomes, one to one engagement with the key partners at the tailored level, involvement in co-design to build commitment, regular communication to stakeholders, visible feedback loops, escalation if needed	10
Workforce availability and skills	Workforce mapping; training and development plan; phased roll-out to match capacity; explore temporary resource.	9
Estates - limited suitable community space in different neighbourhoods, availability of clinical rooms	Early estates gap analysis; engage with Integrator estates teams, explore shared space models	9
Challenges around data sharing across organisational interface	Early data governance agreements needed	9
Change fatigue and competing priorities - partners might be overstretched by multiple programmes and asks of delivery of muliple changes all at the same time which might lead to slow engagement and fatigue	Align timelines with other initiatives; keep meetings focused; demonstrate quick wins; celebrate progress.	9

Issue (change, problem, other)	Action update	Priority
Capacity within system	Significant system pressures – managed through partner engagement	6
Demonstrating impact	Building in evaluation and impact measures to design process	6
Cohort choice	Balancing the system capacity with the impact outcomes	8

Key partners engaged

- Healthwatch Lambeth is delivering patient/public/community engagement; a final report with findings and recommendations has been published and agreed second round of engagement
- Neighourhood leads and Subject Matter Experts (General Practice, Community Services, Acute Trusts, Mental Health, Local Authority),
- VCSFE, Lambeth Ecology Group, Thriving Communities, residents with lived experience.
- Reps from all of the above invited to the co-design workshops

Key learning

- Regular and tailored engagement strategy with all the stakeholders to keep the engagement and commitment.
- Use existing relevant residents' insights to feed into the design of the model and inform if any additional needs assessment is needed to be conducted.

Lewisham

Activity summary *October – November 2025 – Lewisham*

Key activity and decisions in reporting period

Models of care

- Four new INT Clinical Pharmacist Managers in post
- INT assessments co-designed and uploaded to EMIS.
- Recruitment underway for final 3 INT roles
- INTs booking patient appointments and completing patient assessments
- Tested INT dashboard in Healtheintent
- Completed Clinical Governance Framework
- Standard Operating Protocol completed
- Quality Impact Assessment and Equalities Impact Assessment Approved
- Further work to establish estates requirements.
- DPIA and DSPA completed
- Patient-facing materials completed, new promotional materials produced.
- Preventative workstream co-designed with VCS and wider council services
- Continued integration with wellbeing services (e.g. Brazilian Model, PAWS, PCN Health Equity Teams)
- Mapping of Frailty services
- Recruit project officer for Complex Children INT

Partnership

- Partnership/ integrator new governance in place
- Commissioned OD support for Leadership and frontline staff
- Engagement completed with GP and partner on how to create a one Lewisham GP voice within the partnership
- Primary/ secondary care interface programme working well, seeing improved communication and joint working improving

Key proposed next steps

- Continue to deliver INT Programme
- Establish the INT Caseworker co consulting model supported by HIN
- Embedding the Test and Learn/ iterative approach.
- Working together across N2, INT and SlaM mental health services to integrate services.
- Produce tool for measuring patient and staff satisfaction
- Estates workshop of health and wellbeing hubs with PPL
- Agree proposal – new One Lewisham GP voice –

Variance from plan

- Delay in starting Go live in some Neighbourhoods. Revised for January 2026.

Dependencies

- Estates Programme
- Digital Programme
- Workforce and Development

Overall RAG Status	

For the board	
Decision or action required	Note Progress of the INT development in Lewisham. Frailty and Children Int Development is moving forwards. Partnership and creating “One Lewisham Voice is developing well”
Supporting papers	

Milestone	Due date	Status
Estates – agree health and wellbeing hubs	03/26	ongoing
Partnership/ Integrator governance in place (MOU)	02/26	Completed
Complete SOP – Including clinical management arrangements and clinical protocols- LTC	28/07	Completed
Population Health dashboard user acceptance testing	28/07	Completed
Population Health Dashboard Goes Live – LTC, MDMs	11/08	Completed
INT Go Live - LTC	31/12/25	Go live in December
Frailty INT design and implements	31/06/26	
Children with complex needs model of care implement (health model)		

Lewisham

Risk	Action update	Current risk score
Decommissioning HealtheIntent	From the 31st March 2026 HI will cease. Interim arrangements are being set up. A permanent solution will be operational by late summer 2026	L6
Securing location for INT Operation	Working with ICB Estates and PCNs to secure desk space. Weekly mobilisation	L6

Issue (change, problem, other)	Action update	Priority
Estates – Identifying clinical space.	Working with ICB Estates and PCNs to secure desk space and consultation space.	6
INT Implementation	Prioritising Test and Learn approach, Learning from real-time feedback and data Iterative improvements. Review Ratio of Red/Amber Green cohorts.	4

Key partners engaged

Programme to raise awareness of INT model to wider staff groups to support cross-organisational collaboration and joint problem-solving. Initial sessions scheduled September-October with LGT community services and specialist medicine services, primary care managers, further planning underway for adult social care and SLaM services.

Key learning

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

Now in implementation stage. The INT uses a **continuous improvement model**, on a **test & learn** approach.
Enables implementation, evaluation, learning, and adaptation
Focused on improving patient experience, outcomes, staff feedback and data.
Now using real time feedback and data to adapt and refine approach.

Southwark

Activity summary *(November & December 2025)*

Key activity and decisions in reporting period

- Maturity matrix completed, plan for £250K signed off, actions being progressed by integrator.
- Place agreeing non-recurrent funding to pump-prime INT structures (Jan26-Mar27)
- Population cohorts: a) CYP: number of areas identified to progress (e.g.) in parallel with refinement of cohort and service model b) mLTC (NNHIP programme): developed robust cohort methodology, service model, outcome measures and testing plan, engaging with system stakeholders through series of workshops. C) Frailty: cohort /service defined and phased roll out plan developed
- Enablers: active engagement with relevant leads and SEL level work e.g. digital, estates, comms&engagement.
- Programme plan outlining workstreams, milestones and timeframes for delivery in place

Key proposed next steps

- Funding: finalise pump-priming funding and underpinning MoU/monitoring arrangements
- Population cohorts: a) CYP stakeholder workshop in January to refine cohort/model b) mLTC: undertake testing in Q4 to inform wider roll out plan for 26/27 c) Frailty: January stakeholder workshop to update on progress/next steps with phased roll out starting in Q4
- Enablers: estates workshop in February to review current position, consider hubs in each neighbourhood, interim arrangements where appropriate and optimisation of existing space (e.g. TJHC). Ongoing engagement with digital workstream/development of local interim solutions as part of pathway testing. Comms&engagement post to be recruited by integrator

Variance from plan

- On track

Dependencies

- SEL enabler workstreams

Overall RAG Status	

For the board	
Decision or action required	Board are asked to note progress
Supporting papers	

Milestone	Due date	Status
Neighbourhood footprint agreed	Jul25	Complete
Integrator appointed and in place	Aug25	Complete
Cohorts and service model for three population groups agreed	Dec 25/Jan26	In progress
Test and Learn phase complete – underpinned by enablers/metrics	Quarter 4	In progress
Plan for wider roll out in 26/27 developed	Mar26	In progress
Aligned services to neighbourhood footprints	Quarter 4	In progress

Southwark

Risk	Action update	Current risk score
Winter pressures impact on Test & Learn roll out in Q4	Small scale approach being agreed/will be adapted as required	8
Plans for INT roll out in 26/27 not at required scale	To be considered through Transformation Board	8
INT infrastructure not in place	Pump priming funding being agreed/recruitment to start in Jan and agreeing deployment and alignment of wider partners to INTs	6
INT model not able to deliver on ambition due to enablers not being in place e.g. data sharing, EPR	Ongoing engagement with enabler workstreams with local discussions	10

Issue (change, problem, other)	Action update	Priority
Population Health Management functions not effectively supporting INT design e.g. cohort	Locally used available data/methodology to design cohort. Clarify plans at SEL/GSTT level	6
Lack of awareness of INTs amongst wider workforce	Staff activation toolkit developed/requires capacity to roll out	6

Key partners engaged

Partners engaged through various mechanisms including

- Transformation Board (replacing previous INT Programme Executive). This includes GSTT acute and community, King's, SLaM, Social Care, Public Health primary care, VCSE
- Stakeholder workshops held to design cohort and service model for three population cohorts
- Population cohort working groups overseeing design and delivery of INTs include partners
- Integrator Delivery Board membership includes all partners in addition to GSTT and Primary Care Provider Alliance

Key learning

- Importance of
  - Data driven: robust methodology for selection of cohort and data driven approach
  - Outcomes: being clear on short-term aims that need to be delivered (e.g. acute utilisation reductions supporting left shift) versus longer-term and including measures which 'speak' to different partners
  - Partner engagement: engaging with stakeholders through a range of mechanisms and demonstrating how their feedback has been incorporated
  - Start vs end point: agreeing a 'starting point' for both cohort and model based on current data and infrastructure, but not losing sight of broader aspirations, and ensuring Test and Learn methodology supports movement towards this
  - Resident engagement: being clear on purpose of resident engagement throughout process (design to delivery) and putting in place appropriate mechanisms to ensure this is meaningful

South East London Integrated Care System

Workstream highlight reports

PPL

3+ LTCs

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- Refreshed governance of 3+ LTC Place leads group – new Terms of Reference agreed
- Completion of implementation planning for those boroughs still working up finalised model (e.g. Lambeth & Southwark as NNHIP sites)
- Continuation of 3MOC Phase 2 evaluation – contingency issues have delayed expected timeline (Jan 2026) by 4 weeks

Key proposed next steps

- Agreement to provide delivery plans for new 25/26 investment (both recurrent and non-recurrent) in January 2026
- Agreement to confirm a service specification of 3+LTC care model by end March 2026, which will draw out consistency of the 3+LTC model across 6 boroughs
- Finalisation of 3MOC Phase 2 evaluation – now expected to be completed Feb 2026

Variance from plan

- Completion of implementation/ delivery plans – some boroughs still finalising approaches for mLTC INT roll out

Dependencies

- PHM work programme
- Place-based NH development teams
- Modelling and Impact workstream (System Sustainabily P led)

Overall RAG Status	

For the board	
Decision or action required	Future action – for noting (next 3 months) Delivery plans for 25/26 confirmed support funding to be agreed in by end January

Milestone	Due date	Status
Agreement to provide delivery plans for new 25/26 investment (both recurrent and non-recurrent) in January 2026		On Track
Phase 2 Evaluation – Dec completion at risk, revised completion date Feb 2026		On track
Agreement to confirm a service specification of 3+LTC care model by end March 2026, which will draw out consistency of the 3+LTC model across 6 boroughs		Not Yet Started

3+ LTCs

Risk	Action update	Current risk score
Place need to ensure broad consistency to the common 3+LTC model	Development of a clear Service Spec for mLTC model	10/20
Digital-based risks, including robust/ consistent search criteria	Place need to work through local solutions	10/20

Issue (change, problem, other)	Action update	Priority

Key partners engaged

- Place 3+ INT leads
- HIN
- System Sustainability Programme
- CESEL

Key learning

- 3MoC learnings and outputs from Autumn 2025 workshop
- Phase 2 MMMoC evaluation (completed end January 2026)

Comms and Engagement

Activity summary *(November/December)*

Key activity and decisions in reporting period

- Staff activation communications toolkit published. This includes slides, FAQs, messaging (general and staff group specific) and approach. Feedback welcome.
- Healthwatch Lambeth presented on their engagement planning Lambeth at November meeting of SEL engagement practitioners' network.
- Lewisham integrated neighbourhood development marketplace event brought partners together to learn more about the INT model, and share ideas, build connections and explore working more closely to improve health and wellbeing. See website.
- Bexley ageing well hub neighbourhood teams project: comms campaign will precede the full launch of the project in February 2026. Engagement sessions will take place early 2026 to gather feedback and ensure they are addressing inequalities.
- Bexley Child Health team have produced a leaflet to update the public on their offer, designed by Bexley ICB comms team with London Borough of Bexley, Oxleas, Lewisham & Greenwich Trust and Bexley Neighbourhood Health & Care (GP Fed). Leaflet gives details of the new Child Health Neighbourhood Team in the North of the borough, and how to refer for support.
- Greenwich held a comms and engagement workshop with reps from partner organisations. Following this, a Greenwich neighbourhood comms toolkit (adapted from the SEL one) was agreed and circulated for use by partners.
- The Greenwich neighbourhood page on the ICS website has been updated - three case studies added.
- Greenwich OD and communications workshop was planned then postponed due to the doctors' strike. It is being rescheduled for early in 2026.
- New neighbourhood working section for health and care staff published on ICB website (previously 'hidden' pages – links still work). Includes 'news' section. See https://www.selondonics.org/icb/about-us/neighbourhood-working
- ICB comms and engagement leads connected with GSTT in planning C&E resource and activity for NNHIP in Lambeth and Southwark
- Monthly NBCB update published in ICS Newsletter.
- Other neighbourhood news also published in ICS newsletter, eg recent articles on women and girls' health hubs (Lambeth) and GP practice health outreach events in public spaces (Southwark)
- 'Explainer' animations for staff and public currently in production
- First of three videos promoting the '3 shifts' published: CHILDS framework. See https://www.selondonics.org/who-we-are/our-priorities/10-year-health-plan

Key proposed next steps

- Work with GSTT on NNHIP comms and engagement
- Support Workforce team on staff activation
- Continue to evolve website pages and local materials
- Deliver explainer animations

Variance from plan

Dependencies

- []Working with the Workforce Workstream on staff activation

Overall RAG Status	

For the board	
Decision or action required	• Next steps in relation to staff engagement and activation . • Complete the staff/stakeholder web page with regular updates (framework and draft page already developed) • Regular case studies and stories to be shared for further promotion
Supporting papers	Staff activation toolkit FAQs Slide pack for use with staff groups

Milestone	Due date	Status
		Complete
		At Risk
		Not Yet Started

Comms and Engagement

Risk	Action update	Current risk score
That the new webpage for staff and partners will not be accessed by them and contain up to date information	Ensure timely updates from each Board are produced and made available on the site. Place teams to take responsibility for ensuring partners and staff are aware of the page and to promote it in their teams.	Amber

Issue (change, problem, other)	Action update	Priority
Staff activation to be driven locally at place. Resourcing remains a challenge across the system and is a potential barrier to delivery at pace.	Paper on staff activation went to the Board in October.	Medium

Key partners engaged

Place based C&E leads
Workforce workstream

Key learning

CYP

Activity summary *(Q 3 2025/2026)*

Key activity and decisions in reporting period

- Work around the CYP INT framework gathered pace in Q3 with Health integration Partners leading the work
- Focus groups held with LA, VSCE, Provider organisaitons, clinical partners and commissioners. Also, meetings with Place leads, PH leads and PHM and prevention leads for SEL. Engagement with CYP and families held (across Q3 and planned for Q4)
- Development of a CYP INT Framework prepared and a workshop to get stakeholder input held on the 11th December 2025

Key proposed next steps

- Continue engagement with CYP and families, and any other discussions that need to be held into Q4
- After the workshop, to refine the framework and outcomes in preparation for steering group approval
- Planned for presentation at NBC Board in January 2026

Variance from plan

- None at the moment but potential not to finalise the framework within the timescale

Dependencies

- PHM Framework
- Prevention Framework
- Local engagement and sign off

Overall RAG Status	

For the board	
Decision or action required	None (dec 2025)
Supporting papers	None

Milestone	Due date	Status
Phase 1 – data triangulation and insight generation	Oct-Nov 2025	Complete
Phase 2 – co-design and solution building	Nov – Dec 2025	On track
Phase 3 – refinement, and outcomes definition	Dec 2025 – Jan 2026	At risk

CYP

Risk	Action update	Current risk score
Risk of framework not being finalised in time for January board meeting	Continue to work to mitigate the issues	4-6

Issue (change, problem, other)	Action update	Priority
Low engagement with Local authorities in design	Joint commissioners included in starring group	

Key partners engaged

Place based commissioners / integrated commissioners /mental health commissioners for CYP
Place based clinical leads
Community providers
Directors of Children's services
VSCE
Public health consultants
Acute and Community Providers
INT leads at Place (where possible)

Key learning

Digital

Activity summary *(Oct-Dec 2025)*

Key activity and decisions in reporting period

- The Neighbourhood Digital Working group and terms of reference of the group have been established. The NDWG group have met twice so far (Oct and Dec).
- A task and finish group has been established to define the direction of travel to enable digital solutions for interoperability and integration of key strategic EPRs to support at scale neighbourhood health services work aligned to the NHSE 10-year plan through alignment of existing EPRs across primary, secondary and community care settings. This group has been set up based on the nomination received from all places and integrators and is being supported by the PPL team.
- Work has been started to establish Ardens manager as a short to mid term solution for risk stratification and PHM. Plan is to use Ardens manager in short to mid term with an ambition to move to LDS (London data service) offerings. The team is linked with the PHM team around the on-going work with the London Data Strategy to understand how a London Wide PHM can help INT identify population cohorts.
- Continued expansion and adoption of Universal care plan across health and care settings
- Developed a checklist for the INT digital and infrastructure toolkit

Key proposed next steps

- Submission of EPR paper to February Neighbourhood Based Care Board and agree a common approach enable digital solutions for interoperability and integration of key strategic EPRs for the short / medium and long term.
- Consideration to exploring GovRoam to enable single and seamless enhanced wi-fi access across all SEL partner organisations.
- Submission of LCR paper to the LCR(SEL) Governing Group meeting and Digital Governance Group to propose controlled and timebound access of LCR via Web link.
- Complete re-enabling of UCP access for GP practices, PCNs and Federations whose initial implementation was unsuccessful.

Variance from plan ; None

Dependencies

Integrated Neighbourhood operational structure is not yet fully developed which may impact the digital enablement plan

Risk	Action update	Current risk score
Recurring funding and budgets not clearly established which could result in INTs not being digitally supported appropriately	Conversations taking place to understand local and central funding sources to support digital and infrastructure enablement	
The new Lewisham PCN may bring additional challenges which require consideration before go-live	Discussions to identify the EPR / other new instances of platform that may be implemented.	

Overall RAG Status

For the board

Decision or action required	To note contents of highlight report
Supporting papers	N/A

Milestone	Due date	Status
Submission of the paper to February Neighbourhood Based Care Board and agree a common approach enable digital solutions	19/02/2026	On Track
Ardens manager integration with EMIS PCN/ Community instances	30/11/2025	Delayed 01/03/2026
Enable UCP for all practices, PCNs and Federations EMIS instances via Valida client and other INT settings via UCP web portal	22/12/2025	On Track

Key partners engaged

4 integrators, OneLondon LCR & UCP Programme teams, Local authorities, ICB place leads for INTs, PPL, Community service providers, SEL PHM team

Key learnings

GSTT has started working with Optum to improve visibility between EPIC and EMIS.
App procurement and development need clinical and digital decision and need clearer approach

Issue (change, problem, other)	Action update	Priority
Currently no assigned digital project manager and the digital team have no dedicated project manager to support activities associated with the digital ambition of the INTs	Priorities are being reviewed / resources redirected where possible on a short-term basis. Consideration needed to fill gaps in digital resource to support deliverables.	Critical
The commercial discussion between Optum and Oracle Health on 25th September did not result into a resolution that can support contextual link access to the LCR via EMIS for new services	SEL ICB has escalated issue to region and is continuing to consider alternative solutions for PCNs / INTs to access the LCR where required (i.e. via web portal)	Critical

Estates

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- Pre-meets with Greenwich, Bexley, Southwark and Lewisham taken place to confirm agenda for the neighbourhood hub workshops – some are taking a phase on approach in evaluating hub options with others moving into the functional requirements through using personas
- Dates and venues confirmed for Bexley, Southwark, Lewisham and Lambeth workshops
- Workshop attendee list confirmed for all

Key proposed next steps

- Agree data and venue for Greenwich and re-arranged Bromley workshop
- Hold a pre-meet with Lambeth and Bromley to finalise agenda
- Prepare pre-read and context material for all workshops
- Hold 6 x neighbourhood hub workshops
- Attendance at the London estates TAFG

Variance from plan

- Slight delay to scheduling and delivering the neighbourhood hub workshops with some now moving into February due to the Christmas break and competing priorities

Dependencies

- None

Overall RAG Status	

For the board	
Decision or action required	
Supporting papers	

Milestone	Due date	Status
Greenwich & Lambeth		On track
Bromley & Lewisham – as noted		On track
Bexley & Southwark		On track

Estates

Risk	Action update	Current risk score
INT HUB/Spoke funding	Agree INT funding across SEL	15

Issue (change, problem, other)	Action update	Priority
• Understand commissioning intentions to inform strategic estates decisions and to inform decisions in respect of hub locations • Achieve collective understanding of what an INT comprises of and how will Estates as an enabler function assist in the delivery of an INT	February 2026	
• Confirm Hub locations within each Neighbourhood - North East (Bromley H&WBC), North West (Beckenham Beacon), South East (Orpington H&WBC) have existing hub sites identified. The South West neighbourhood requires an options appraisal to determine the most suitable configuration due to dispersed geography and transport constraints.	April 2026	
• Confirm Hub locations – North (Waldron), bookable void rooms being used, Central (Lee Health Centre) or a number of sites across PCN being utilised, South (Goldsmiths/Downham), confirm whether Goldsmiths will be utilised or moved to Downham, East (Jenner), clarify SLAM and Modality space requirements on first floor.	April 2026	

Key partners engaged

ICB Primary care team
LGT
GP Federation – BHNC
GSTT
GP Federation – IHL/QHS

Key learning

- Neighbourhood Priorities
- Neighbourhood Hub Locations

Frailty

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- [SEL Frailty dashboard – BI colleagues working to update draft, reflecting working group feedback and this will go back to dashboard working group in January
- Agreement with SEL WDH to host any generic frailty training resources via website with no log on requried]
- Lewisham have extended mapping to include local authority and Greenwich aim to complete asset mapping by end Jan 2026. Southwark taking mapping/gap analysis to board December 2025.
- CESEL establishing clinical working group to focus on development of frailty resources that support operationalisation at a local level.
- Feedback provided on neighbourhood 'starter for 10' metrics
- People Programme continue to map existing frailty/EOL training across system
- SEL AHP faculty project to look at B6+ AHP training needs, linked in with SEL WDH frailty training lead to align frailty training opportunities

Key proposed next steps

- [Dashboard working group – decisions regarding vulnerability risk factors, definitions and top 10 frailty outcome measures (either to feed into neighbourhood outcomes or frailty dashboard]
- Review existing training resources
- Analysis of place asset mapping/gaps to identify if any further work that can be completed once for SEL

Variance from plan

- Asset mapping completion across SEL is pushed back to Q4
- First pilot commencing Q4
- Current delivery projection at SEL level:
- Q4 25/26 – asset mapping completed
- Q1 26/27 any frailty pilots rolled out
- Q2 26/27 scaling

Dependencies

- BI colleagues completing updated draft dashboard by 14.1.26[]

Overall RAG Status	

For the board	
Decision or action required	
Supporting papers	

Milestone	Due date	Status
E.g., Neighbourhood footprint agreed		Complete
E.g., INT form agreed		At Risk
E.g., Aligned services to neighbourhood footprints		Not Yet Started

Frailty

Risk	Action update	Current risk score
Shared care records have been identified as a challenge to INTs		HIgh
Ongoing risks associated with change management plans/uncertainty		High
Governance/accountability and clinical risk ownership resulting in need to identify and evolve local work around solutions contributing to workload and potential delays to pilots commencing.		Medium

Key partners engaged

Key learning

Modelling

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- Cleaning and costing of raw data shared by BI team
- Iteration of data request, including outpatient cost centres
- Analysis of Place 'Information Capture', including WTEs, cohorts, and capacity for each Place's INTs
- Continued engagement (see next slide)

Key proposed next steps

- Sign-off of final report with provisional results
- Sharing of provisional results with Places to seek updated information on capacity
- Confirmation of next phase plan (January to March)
- Development of technical and information sharing solution to allow non-SELICB colleagues to interact with tool

Variance from plan

- Final results are provisional to allow for Places to share updated information on current and expected capacity (workforce & cohort size)

Dependencies

- Cost side of model is dependent on Places agreeing expected workforce allocation to INT working

Overall RAG Status	On track

For the board	
Decision or action required	None
Supporting papers	None

Milestone	Due date	Status
Finalise patient-level data request for acute, primary, and community care with SEL BI team	02/09/2025	Complete
Agree approach and assumptions for financial model (acute, primary, community cost implications)	22/09/2025	Complete
Start modelling using patient level data	17/10/2025	Complete
Interim draft report summarising finalised approach, available data, and key assumptions	03/10/2025	Complete
First run data analysis complete	31/10/2025	Complete
First draft set of results shared for feedback with key stakeholders	03/11/2025	Complete
Share final report including next steps to develop modelling approach, toolkit, and engagement with providers	12/12/2025	Complete (provisional)

Modelling

Risk	Action update	Current risk score
Further delays to the patient-level data request will have a knock-on effect on timelines	Latest update is that BI data should flow from 17th October, so on track with our plan	(closed)
Focussing on 'theoretical' commissioner (PBR) costs will lead to objections from providers	Continuous engagement with finance leads to agree timing of engagement with CFO group	2
Information Governance delays	ICB laptops, honorary contracts, DPIA etc all being put in place	(closed)

Issue (change, problem, other)	Action update	Priority
Limited Social care & VCSE data availability, to enable wider impact to be modelled.	Proxy being looked at as part of next phase	Medium

Key partners engaged

- Provider Deputy CFOs
- PC+ Group
- CPO network meeting
- SSG meeting
- Technical group (BI team, LGT PHM team) Deep Dive
- London Region INT Modelling Programme

Key learning

- Improved communication with LGT PHM team required to ensure ongoing work is integrated across all SEL INT modelling work across Places
- Variation in specificity on cohort size and interventions between places, highlights the different maturity and stage of development.
- Coding approach standardisation required across to Places to allow future evaluation and integration of results into future modelling
- Modelling results will continue to evolve as additional 'components' are added and the evidence base develops – this means putting caveats up-front is key

PHM

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- We have split the functions into three parts:
    1. Those related to **Data Architecture**.
    2. *Building on (1)* those related to **Analytics Tools and Data Science**.
    3. *Building on (2)* those related to **implementation support**.
- The focus is currently on the Data Architecture. A strategic direction of travel for GSTT to take on a role holding patient identifiable data for all SEL has broad support. A service specification, costs and business case are being developed/ established to support this direction of travel.
- Replacing the LGT system is a high priority; the PHM Programme is working with LGT to colleagues to understand the steps to do this as quickly as possible, and to facilitate cross-Trust conversations (recognising that the solution is a provider-to-provider decision).
- In parallel, work has begun to set out what support is available for SEL ICS colleagues to support the embedding of PHM, and how we might better signpost to those opportunities.

Key proposed next steps

- The business case for the Data Architecture requirements will be completed. This will need to be considered by multiple partners including the ICB and provider Trusts.
- Once the Data Architecture is agreed (as it is the basis for the available options), the service specification for the Analytics Tools and Data Science will be completed, with a gap analysis of the requirements against the existing/ planned provision (see also Dependencies below). Those functions not held within existing/ planned provision will be tested against a make-share-buy framework, with the intention of developing a specification for those functions under 'buy' and 'share' to aid upcoming conversation.
- A workforce development plan will be established which draws on/ signposts to existing support for colleagues across the ICS and hooks into parallel workforce / organisational development programme.

Variance from plan

- The PID has been updated to reflect the latest timescales; this was agreed by the PHM Delivery Board.
- In contrast to the initial PID, the updated workplan extends to the end of March 2026. This in part reflects the need to work in parallel to the ICB Change Programme (see dependencies below).

Dependencies

- Delivering PHM needs to include, alongside any centralised functions, SEL ICB and Integrators (recognising that the ICB and Integrators will be two key users of PHM). The PHM programme is therefore dependent to some extent on the ICB change programme. This dependency is being managed within the ICB.

Overall RAG Status	

For the board	
Decision or action required	N/A
Supporting papers	A monthly Programme Update is provided to the PHM Delivery Board; this is available on request.

Milestone	Due date	Status
Draft updated workplan	21/10/25	Complete
Draft service specification *Setting out the high-level functional requirements, split into three parts*	29/10/25	Complete
For Data Architecture, set out the strategic direction	31/12/25	Complete
For Data Architecture, set out the costs and business case for recommended option	15/1/26	Incomplete (underway)
For Analytics Tools and Data Science, set out the service specification and gap analysis	31/3/26	Incomplete
Agree workforce development plan	31/3/26 (was 31/12)	Incomplete (underway)

PHM

Risk	Action update	Current risk score
A full risk register is provided within the PID (available on request). The four risks with the joint highest score are provided below.		
Lack of stakeholder buy in	Broad stakeholder engagement and endorsement is required for a subsequent system approach to be successfully adopted and for the benefits of the approach to be realised. There is a risk that this does not happen e.g., due to the need for rapid progress.	12
London Data Store data architecture	There is a risk that the London Data Store does not provide data within an architecture to immediately support local work (i.e., that work is required to 'tidy' the data). This cost would need to be included in the design work.	12
Business case(s) is/are not accepted	The costs for each component are being developed and will be presented as business cases. Relevant bodies (e.g., providers) will need to consider each business case.	12
Lack of technical knowledge	The system contains a limited number of individuals with the required technical knowledge to support the PHM programme.	12
Lack of join up across the three sections	The functions have been split into three sections to enable decision making. However, these must come back together into a coherent whole.	9

Issue (change, problem, other)	Action update	Priority
Change to programme plan to split the functions into three areas (to facilitate quicker decision making).	Agreed at the December PHM Delivery Board	Medium

Key partners engaged

- PHM Delivery Board (incl. representatives from PELs, DsPH, Trusts, primary care, data and digital ICB teams, KHP, and the ICB MDO)
- The AI Centre (now reporting regularly to the PHM Delivery Board)
- Place Executive Leads and Borough PHM meetings as invited
- Directors of Public Health, Public Health Analyst Network and Public Health Away Day
- GSTT, LGT and KCH colleagues
- Prevention Programme (and KHP colleagues through this)
- ICB Digital team and ICB BI team
- SEL Digital Committee, SEL People Committee

Key learning

- The overarching functions required to embed PHM within business-as-usual have been drafted. However, the breadth of these functions (from highly technical through to implementation support) has necessitated grouping these functions into three areas, on which discussions can be progressed.
- The model needs to be tested using real-world examples (e.g., how would a Borough draw on PHM support to update its JSNA? How would a CD in a Trust access support to improve or redesign a service? Etc.). This is now included in the work plan (see previous page).
- There is a need to focus on workforce development in parallel. However, feedback has suggested that this shouldn't be a standalone programme but should hook into other workforce / organisational development programmes to 'ground' PHM within practical work (e.g., within the establishment of INTs). This is also now included in the work plan (see previous page).

Workforce

Activity summary *(reporting period)*

Key activity and decisions in reporting period

- **Clinical Governance** - Workshops held on 29th & 30th September and outputs analysed and shared with delegates and Neighbourhood Based Care Board. Subsequent working groups have been set up to explore the following topics:- Use of honorary contracts; IG clearance; Escalation of serious risk and performance issues; OH requirements and immunisation
- **Culture & OD support** - Set up of OD community of practice for neighbourhoods – to support sharing of learning and templates for OD support for neighbourhoods
- **Leadership development** - HIN actively progressing two pieces of leadership development work and support:
    - Co-Consulting with Lewisham Case Workers - the HIN will deliver a series of 7 co-consulting sessions addressing the need for practical support and providing supported opportunities to problem solve
    - Leadership Development Workshop for Children and Young People Team in Bromley - The HIN will deliver a one-day workshop to help attendees consider approaches and techniques to (further) develop a shared vision and move toward effective integrated working within Neighbourhoods.
- **Staff activation** – sharing of comms toolkit with known stakeholders to spread awareness. Planning for webinar series on neighbourhood health topics, to launch in the new year.
- **Support for ageing well and frailty** – first cut off mapping exercise presented to the ageing well and frailty workstream meeting in November's meeting. Mapping and collating of training offers continues.
- **Stakeholder engagement** - continued engagement with London PPL reps, London ICS CPO's, reps at Place and workforce colleagues leaning into neighbourhood health

Key proposed next steps

- Continued delivery against key activity as outlined in our workforce plan

Variance from plan

- None – we are focusing on aspects of plan as agreed with NCB and People Committee
- Engagement with Place reps have indicated other workforce challenges of immediate attention – which we are working on in parallel to our overall workforce plan

Dependencies

- Communications & engagement workstream – we are actively working with comms colleagues on staff activation parts of the plan

Overall RAG Status	

For the board	
Decision or action required	Note highlight report for update only.
Supporting papers	-

Milestone	Due date	Status
Workforce Plan for Neighbourhood Working agreed		Complete
Stakeholder mapping		Complete
Staff activation plan developed		On track
Clinical Governance workshops		On track
Progress against neighbourhood health workforce plan		Ongoing

Workforce

Risk	Action update	Current risk score
Clinical risk and governance for roles/teams working cross boundaries	• Engaging with regional colleagues to scope 'Once4London' response and legal support • Workshops held on 29th & 30th September to establish the challenges that we need to address, legal advice that would be helpful and potential solutions. Outputs analysed and shared. Working groups on core topics have been set up. • Raised the clinical risk/governance in NH's issue nationally with NHS Employers/Confed	Moderate (4-6)

Issue (change, problem, other)	Action update	Priority
-	-	-

Key partners engaged

- Place reps
- Workforces colleagues in host organisations, leaning into Neighbourhood Health
- SEL People Committee and SEL CPO's
- Workforce leads in local authorities
- SEL Education Collaborative – for specific work on mapping of educational offers
- SEL OD leads

Key learning

- Clinical Governance & Risk, and day to day support for leaders are key priorities
- Team facilitation isn't a requirement across all Places – have made offer available for those who need it, as and when it's requested
- Varying levels of awareness of neighbourhood health in staff groups impacted – which highlights the importance of a good staff activation plan
- Integrator host organisations are actively exploring workforce support needed from an integrator perspective. It is recognised that OD support will be crucial in this transition to a new way of working and we have set up a community of practice to share learning.

South East London Integrated Care System

NHS South East London

Neighbourhood Based Care Board

Title	**South East London Children and Young Peoples Integrated Neighbourhood Working Framework**					
Meeting date	15 January 2026	Agenda item Number	**7**	Paper Enclosure Ref	**5**	
Author	**Alison Roberts, Associate Director of CYP Planning**					
Executive lead	**Sarah Cottingham, Director of Planning**					
Paper is for:	Update		Discussion	☑	Decision	☑
Purpose of paper	This paper is to update the NBCB on the development of a framework for Children and Young people (CYP) Integrated Neighbourhood teams (INTs) in South East London. The board are asked to discuss the framework and agree next steps for its adoption as the SEL ICS framework CYP INTs					
Summary of main points	The framework sets 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 has 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. To note that complex CYP were agreed as a key cohort for INTs across SEL and NBC Board agreed that a SEL framework would be developed to support this work and enable local delivery The guidance on neighbourhood MDT's for CYP sets 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 are not complete INTS. However, the LCHTs can be incorporated into and developed as part of a CYP INT. We also acknowledge that there is 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 10 year plan / medium term plan sets out timelines for neighbourhood implementation by 2029. The framework includes a roadmap to achieving this, while recognising that this will be an ambitious and challenging target to meet. Key questions for NBCB are • Does the framework fit the requirement to deliver a coordinated and consistent, measurable approach to INT's across SEL?					

	• Are the implementation timelines realistic and acceptable considering nationally driven expectations? • Suggested cohorts - How prescriptive should the framework be in defining priority cohorts and minimum standards while balancing local priorities? • Investment in people and process is required to deliver the INT's. While it is expected the much of the funding to enable INTs will come from the redesign of existing services, there may need to be some investment upfront for infrastructure and to test new roles/ways of working. Is this need recognised by all boroughs? • What more do we need to do to socialise this with partners to ensure buy-in and ensure successful delivery?
Potential conflicts of Interest	None identified
Sharing and confidentiality	This framework and assoicated papers are currently in draft. The report been shared with the CYP INT steering group, but has not been shared more widely in its totality.
Relevant to these boroughs	Bexley x, Bromley x, Lewisham x Greenwich x, Lambeth x, Southwark x
Equalities Impact	EQIA is currently with the Equalities team. Each Place will have to develop their own EQIA for their CYP cohorts
Financial Impact	The framework aims to help neighbourhood teams to make a fundemental shift in the way they approach and deliver care for CYP. *Work is being completed by Lambeth and Southwark on demand and capacity which will inform the financial impact of INTs but it is anticpated t*hat the majority of the framework and its ways of working can be delivered within current resources with a small number of new roles required to support the adminstration and coordination of care. However there may be some double running costs and a need to engage arounf different ways of working across providers
Public Patient Engagement	During the framework development, a number of sessions were utlised to hear the views of CYP and their parents. These were facilitated though local provider and Place based CYP groups and with some assistance form Greenwich healthwatch. These are due to be competed in January 2026 (so are currently ongoing).
Committee engagement	The Framework development has been overseen by the CYP INT steering group. Please note that due to the timelines of the framework development, this has not been to place based CYP committees for engagement although place leads have been included in all focus groups and workshops
Recommendation	The Committee are asked to review the framework, outcomes and timelines for implementation and suggest next steps to enable CYP neighbourhood teams to be commenced in 2026/27 before final endorsement in February 2026

South East London
Integrated Care System

NHS
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Attached
SEL CYP Framework summary

Additional reading
SEL CYP Full report

SEL Children and Young People Integrated Neighbourhood Teams (INT) Framework

Summary Report

(to be read in conjunction with the main report)

January 2026

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HEALTH INTEGRATION PARTNERS

South East London Integrated Care System

NHS South East London

Let’s start with Zach’s story

Meet Zack

Zack, 14-year-old male

Academically struggling and is currently on the waiting list for ASD assessment (not picked up in primary school). History of severe bullying at school.

History of asthma, which is challenging to manage and is known to the community nursing team. Multiple sporadic exacerbations of asthma since age 6, requiring hospital admission.

- Father was absent, mother has significant Mental Health issues.
- Substantial financial issues, resulting in risk of eviction.
- Zack is known to Social care, however no current involvement as it was stepped down in the past.
- Referrals to housing have been made but were not successful.

Please note that this person's story is sourced from a combination of multiple real patient scenarios. Names and facts have been altered for patient confidentiality. The main purpose of the story is to highlight the opportunities for improving care in the current system.

Zack's story

Zack has been seen by the GP for asthma reviews; however, he has missed the follow-up appointments. He has previously demonstrated poor inhaler technique and inconsistent medication adherence, leading to multiple hospital admissions for exacerbations.

Zack has been on the waiting list for an ASD assessment for 6 months. During this time, he has experienced increasing difficulties at school, including reduced concentration in lessons and poor performance in assessments, leading to social withdrawal and disengagement from learning.

He has a limited support network and experiences difficulties forming friendships, leading to social isolation and a negative impact on his MH. His mother is unable to support him, due to her own MH challenges and faces additional barriers in accessing services due to language difficulties and limited awareness to available information.

Zack's asthma starts to flare up again in winter. His mother contacts the GP but was unable to get an appointment and did not feel his condition warranted a visit to A&E.

A week later his cough is much worse, and he has developed wheezing. Zack ends up in A&E with another exacerbation of asthma.
Unfortunately, he continues to wait for a formal ASD assessment and doesn't engage well at school.

Observations

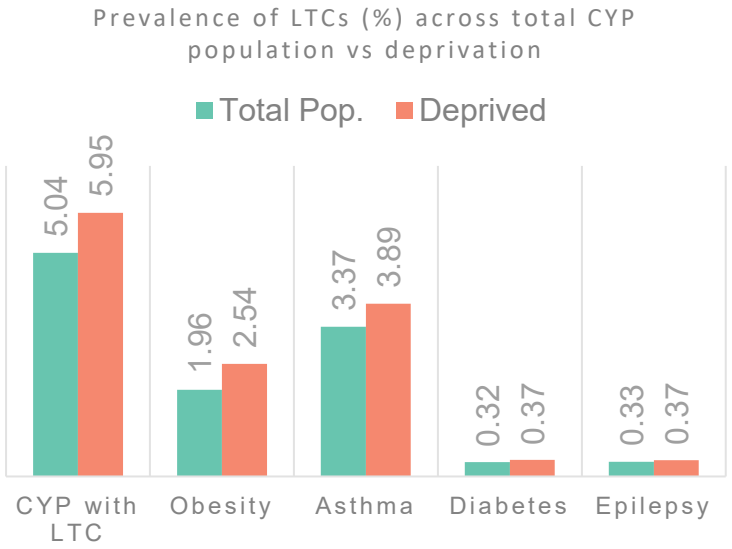
Did not preempt and act: Signs of recurring and increasing issues were an opportunity to act before it was too late.

Multiple siloed pathways: Looking at the child through a health lens, instead of the ability to consider the whole picture of physical and mental health, school and home problems. Lack of person-centred holistic assessment and multi-agency care planning that genuinely address the multifactorial issues faced by the child/family.

No mechanism for coordination between multiple agencies: Agencies not getting to the root of the problems and creating one understanding.

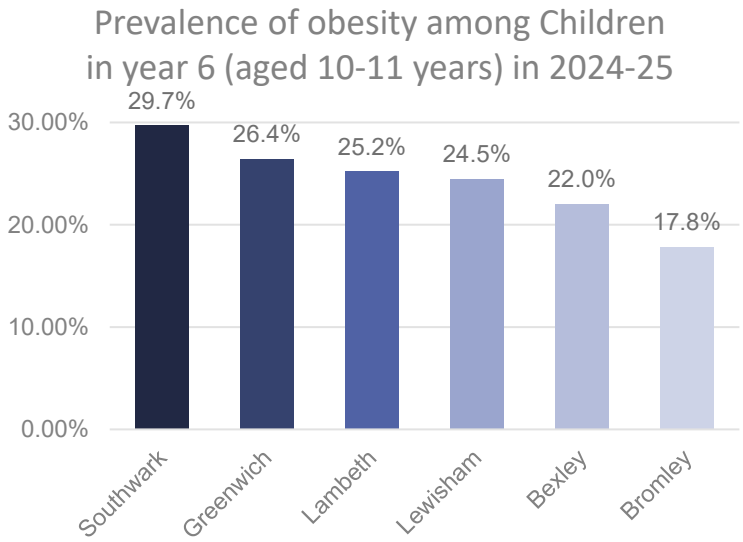
Missed opportunity:
To sum it all up, this child's case shows how we as a system could be far more efficient in providing coordinated and meaningful care.

We have many more stories that resemble Zack's across SEL – children living in pockets of deprivation do not have the best start of life, or those suffering from mental health concerns thrive less well



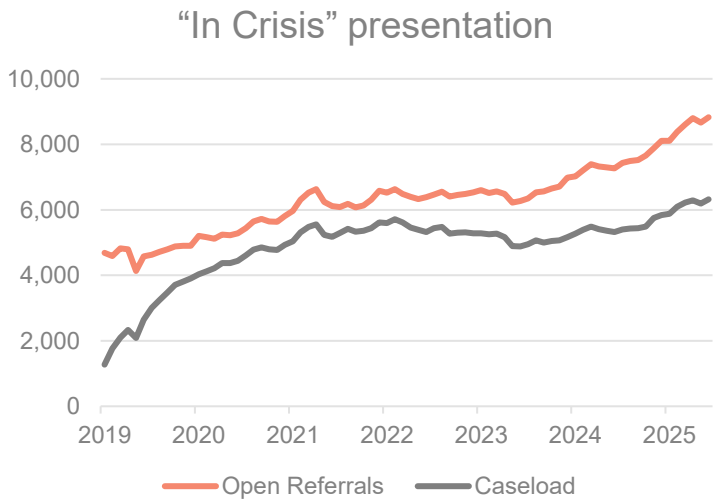
In deprived population, the prevalence of LTC and obesity is markedly higher (18% higher LTC and 30% higher for obesity)

Additionally, over 50% of all the CYP caseload in mental health services across SEL are of those from the 40% most deprived communities (in 2024-25)



Prevalence of obesity is higher than London (23.2%) and National (22.2%) average in 4 out of 6 boroughs in SEL

Childhood obesity clusters with other adverse bio-psycho-social experiences, including deprivation, social services involvement, homelessness risk, and mental health issues.



"In Crisis" presentation of caseload related to mental health issues are a 6 year peak, increasing nearly 3X since 2019.

The number of CYP waiting for their first contact for **over 52 weeks** for mental health services they are referred to, has increased **8X** for "in crisis" presentation, since 2019.

What we heard from children, young people and their families resonated with Zach's story

Lack of coordination

Families experience care as disjointed, each agency expecting others to "fix it", highlighting siloed responsibilities. The call for peer navigators and care coordinators echoes the wider strategic gap around roles to ensure care continuity across multiple agencies.

"We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly"

Information, education and awareness

Front-line professionals lack up-to-date knowledge of local pathways, leading to inappropriate advice or signposting and avoidable escalation. Families also want practical education for employers, schools, siblings, children and parents, ideally delivered by people with lived experience.

"GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day."

Waiting and managing expectations

Long waits for neurodevelopmental and mental health services are not just an access issue; the absence of interim support allows needs to escalate and family resilience to erode. Parents ask for honest information about who is doing what, realistic waiting times, clarity on offer/limits, and better communication.

"Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait."

Environments and experience of care

Families see current emergency pathways as unsafe and traumatising for CYP, particularly neurodiverse children. They need choice of setting (home, community, groups) and psychologically safe environments with follow-up after diagnosis.

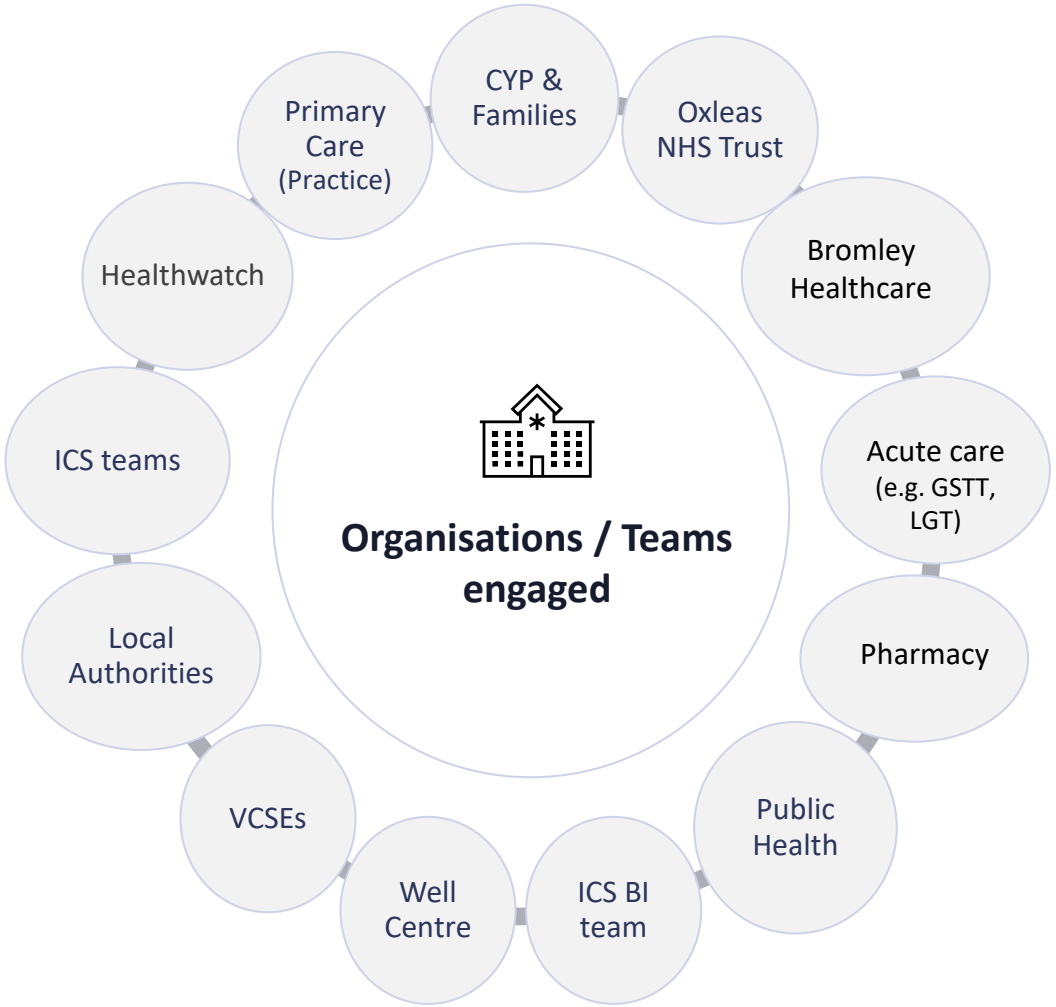
"Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E."

Transition of care to adult services

Transition is experienced as a cliff edge: responsibility abruptly shifts to young people with minimal preparation, reassurance or continuity. Families want transition to be actively managed, with detailed information transfer and practical "hints and tips",

"The attitude it's on you now that you are 18; we won't baby you anymore and so deal with it on your own."

Overall, we engaged with more than 90 stakeholders from across the system, who corroborated the stories of service users and defined what and how we deliver INTs in neighbourhoods



Type Of Stakeholders

- Frontline Practitioners
- Clinicians (CCPLs/GPs/ Paediatricians /Paediatric Nursing
- Operations and Management
- Service Users, Carers & Representatives
- Pharmacists
- Commissioners
- Service Leads
- Voluntary Sector partners

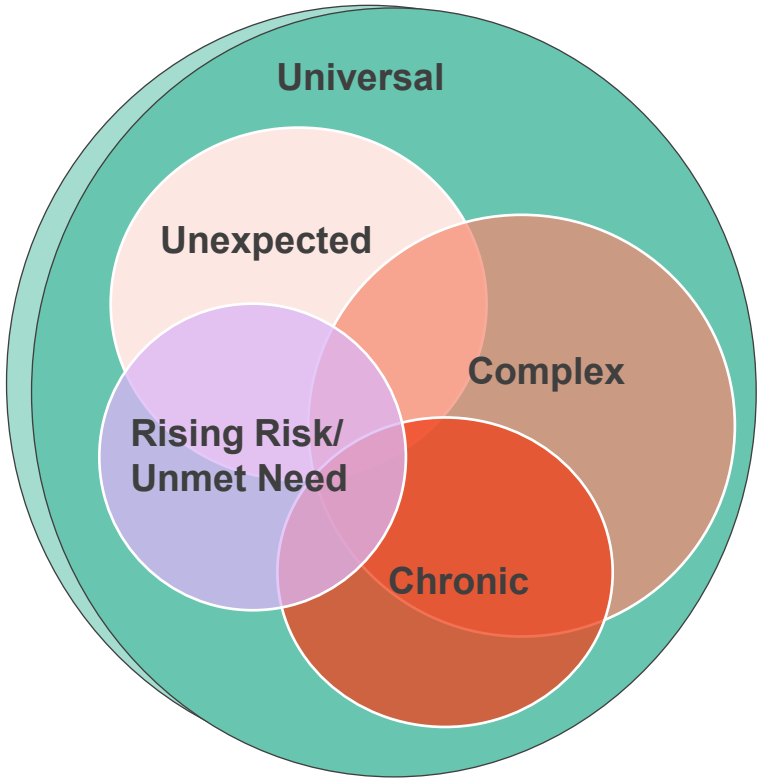
Mechanism Of Engagement

- CYP Steering Group (System Representatives)
- CYP Core Group (Clinical Lead + Commissioning Leads)
- System-wide Workshop
- Local Place Based CYP Forums
- One To One Engagements
- Family / CYP Engagement Forums (In Progress)
- Focus Groups: Local Authorities, Clinicians, Place Based Reps
- Deep Dive Sessions (e.g. SEND, Mental Health)

What does the CYP INT framework look like and how would it make a difference …

Our local clinicians and professionals highlighted the ten key principles that would make a real difference in outcomes and inequalities

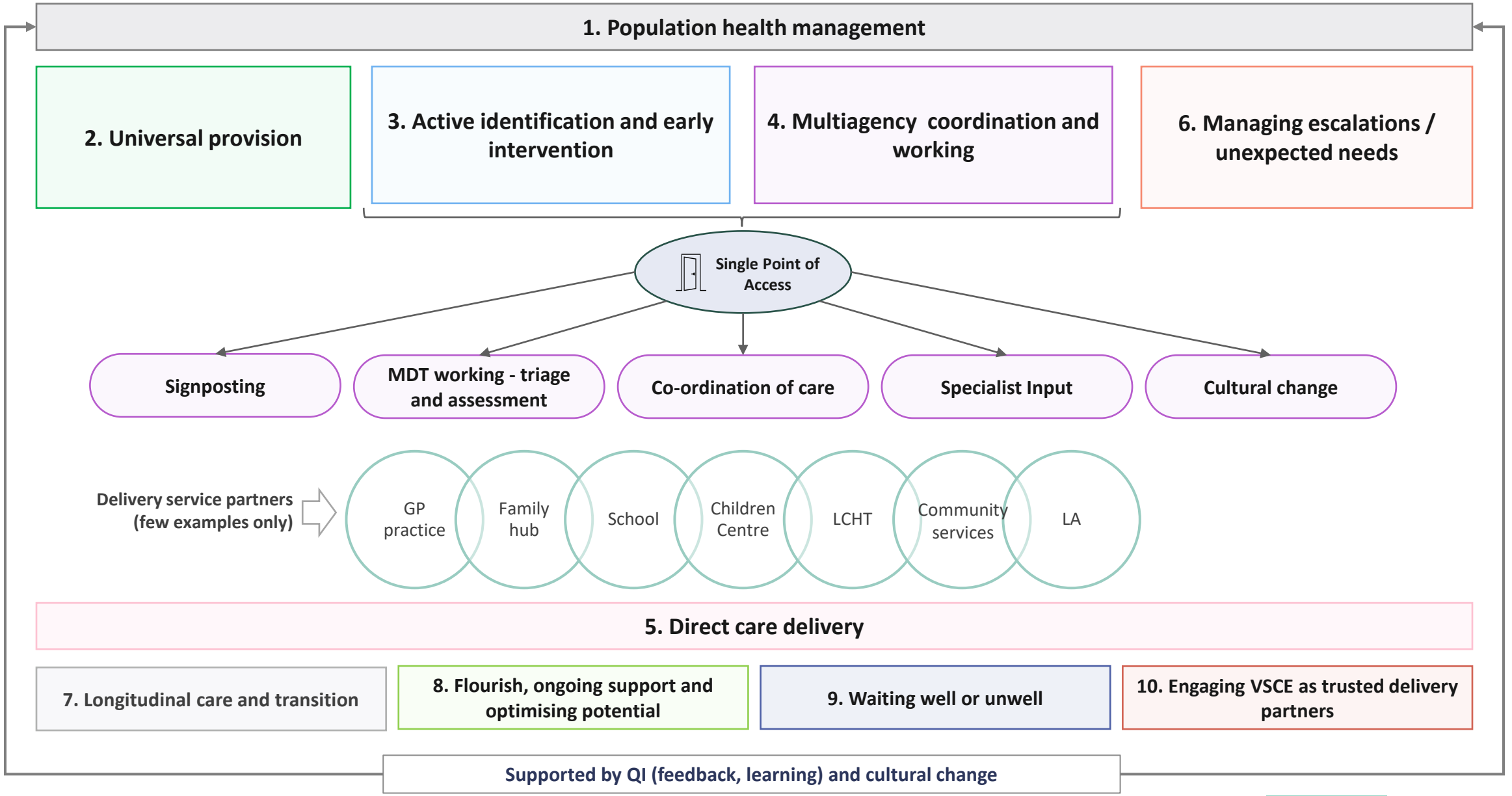
1. Know your population
2. Be needs-led, not diagnosis- led
3. Act early
4. Work holistically
5. Connect, don't silo



6. Empower and enable families and CYP
7. Build trusted relationships, good communication and knowledge sharing
8. Treat people with dignity and respect
9. Embed equity and access
10. Focus on maximising life chances

Neighbourhood working is all about creating a fundamental change in the way we work and connect

SEL CYP INT Framework – key functions / elements



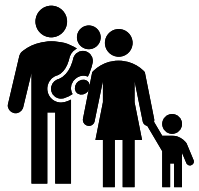
SEL CYP INT Framework functions at a glance

Function	Description
1. Population Health Management	Systematically use data and intelligence, and moving beyond surveillance to actionable insight, informing how we shape delivery.
2. Universal health and care provision	Build Universal health and care provision as the foundation of the neighbourhood model, ensuring every child, young person and family has access to the core entitlements that keep them healthy, supported and connected to community life. Provision of information/knowledge is key.
3. Active identification and family-centred early intervention	Adopt a proactive approach to identifying emerging issues at the earliest possible opportunity, using early indicators and intelligence to inform timely intervention and ensuring access to appropriate services at the right time.
4. Multi-agency coordination and working	Build relational, value-based collaboration, based on a shared vision, accountability and language across agencies so that practitioners understand each other's roles, trust one another, and work as one 'communicative' system.
5. Direct Care	Deliver coordinated multi-agency care that brings together experts to provide holistic and integrated support to improve outcomes and provide better access by bringing services into the community.

Function	Description
6. Managing escalations	Create straightforward, aligned and timely approaches to trigger and manage escalation, agreed and understood between multiagency partners, to prevent issues from becoming critical events.
7. Longitudinal care and transition	Provide coordinated, non-fragmented care over time for individuals with chronic and complex needs, ensuring continuity of support, focusing on what matters to the CYP and their families.
8. 'Flourish;' ongoing support and optimising potential	Actively support CYP and their families to take a leading role in their own care, enabling informed decision making, with a strong focus on promoting holistic wellbeing.
9. Waiting well or unwell	Provide support to those waiting for assessment, diagnosis or intervention, helping them to prevent or address issues that may arise in the interim.
10. Engaging VCSE as trusted delivery partners	Embed VCSE partners as a core to INTs delivery. It's known (and plentiful evidence proves) that the VCSE offer is highly effective for CYP to address the growing prevalence of mental health and neurodiverse challenges that young people face.

Outcomes: how would we know it is working for our population

There are 8 outcome domains with KPIs under each of them



8. Reduction in inequalities

Reducing health inequalities so children, young people and their families achieve equal outcomes across all population groups.

1. Active/early identification and prevention

Children and young people with emerging needs are identified early and supported through targeted preventative interventions, reducing escalation to crisis.

2. Improved access that is based on need

Children, young people and families can access timely, support based on need, reducing escalation to crisis or specialist intervention and improving equitable access for those least likely to self-present, including Core20 groups.

3. Voice of CYP and family

Making every contact count, avoiding repetition and having to tell their story several times. They feel heard in decisions, trust services and experience care as supportive and joined up.

4. Children and families are empowered (able to flourish)

Children, young people and families trust services, can easily access and navigate to the right support, and experience coordinated care as required.

5. Improved health and well-being outcomes

Children and young people are healthier overall, with improved physical and mental wellbeing, fewer crises/ escalations, higher uptake of preventative care and earlier identification and support for additional needs.

6. Improved multi-agency working & cultural change

A positive experience and supportive environment to improve staff wellbeing and job satisfaction overall. Improving multi-agency working by local knowledge of services available within SEL to support CYP.

7. System sustainability

Reducing demand from resource intensive areas such as secondary care, shifting focus into the community and neighbourhood.

What would Zach’s story look like once the SEL CYP INT Framework is implemented …

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

- ✓ Early support and timely intervention: The MH team in Zack's school identifies the rising risk at an early stage, informing the school link worker regarding the issues of bullying, non-attendance, isolation and poor performance.
- ✓ Aware that Zack suffers from asthma and is awaiting an assessment for ASD, the school link worker contacts the child's GP who triggers an MDT discussion.
- ✓ MDT review ensures ensures Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy and a personalised asthma action plan is agreed with Zack.

Key functions

- ❖ **Active identification intervention**
- ❖ **Prevention of escalation**

- ✓ The neighbourhood MDT includes the school link worker, GP, paediatrician, practice nurse, CAMHS, housing, support worker and involvement of Zack and his mother. The focus is holistic care and understanding and addressing issues around asthma, poor school performance, isolation, housing and his mother's mental health problems.
- ✓ The discussion is centred on building trust and fostering open communication to identify root causes and achieve shared buy-in and co-production of a plan with the child and his mother.
- ✓ Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy.
- ✓ A personalised asthma action plan is agreed with Zack supported by a community support worker appointed to coordinate and provide ongoing, hands-on support to the family. The support worker, able to socially prescribe, also liaises regularly with professionals to ensure progress is maintained and actions remained aligned.

Key functions

- ❖ **Multiagency coordination and working**
- ❖ **Direct care delivery**

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

Key functions

- ‘Flourish’, on- going support and optimising potential
- Waiting ‘well’ or ‘unwell’
- Engaging VCSE as trusted delivery partners
- Universal health & care provision

The holistic MDT co-produced plan includes:

- ✓ Initial mental health assessment and access to interim support whilst awaiting ASD assessment e.g. adjustments at school.
- ✓ Signposting to pre-diagnostic workshops e.g. peer support network for families awaiting an assessment.
- ✓ Prompt consultation with practice nurse and follow ups to assess inhaler technique and inhaler adherence.
- ✓ Navigation to local offers including youth/ community clubs to build confidence and reduce social isolation e.g. sports.
- ✓ Strategy agreed with school to address bullying and to support Zack with his performance at school.
- ✓ Investigation by housing into issues leading to eviction and provision of financial/ benefits advice for his mother.
- ✓ Visit by housing to the property to check for possible environmental causes triggering exacerbations of asthma e.g. damp and mould.
- ✓ Consultation with Zack’s mother regarding her mental health assessment for talking therapy and agreeing a plan to prevent exacerbation for both herself and Zack. This includes providing information regarding access, navigation to local community support groups and ability to provide respite care if needed.

Delivery of CYP INT neighbourhood framework is an ambition that will require a concerted effort across the system

Implementation roadmap

This roadmap sets out a phased, **test-and-learn approach** that enables neighbourhood teams to build confidence, embed new ways of working and establish a consistent culture of neighbourhood delivery across South East London

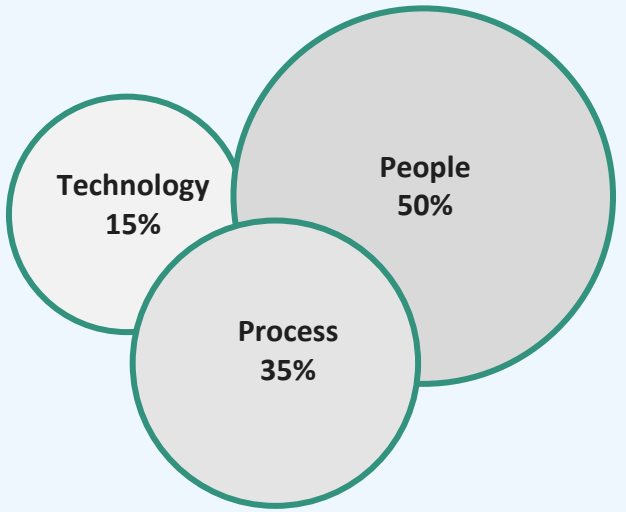
Phase 1: Test
2026/27
Launch test INTs (minimum 1 per Place) for a priority cohort.

Phase 2: Grow
2027/28
Share and learn from pilots and expand across priority cohorts

Phase 3: Embed
2028/29
Full delivery CYP INTs across SEL with clear operating model, governance and outcomes framework

Most healthcare transformations under invest in the human dimension

Proportion of effort showing focus on people led change



Change dominated by process and technology only achieves around a 10% level of adoption – hence the need to ensure we have an approach built around people and relationships

Roadmap for implementation: Neighbourhoods should follow a systematic approach while adapting to different starting points and levels of maturity

Phase 1: Test (2026/27)

1. Socialising the framework at Place

- Bring together system stakeholders, including CYP, families and community representatives.
- Map current practice and local assets against the neighbourhood functions (e.g. active identification, MDT working).

2. Understanding your local population and agree priority for test phase

- Neighbourhoods need to start with a bite-size focus. Year 1 is about testing the concept with one cohort or pathway
- Each neighbourhood to look at their local population data, connect with VCSE, communities, professionals and agree the local priority.
- Priority could be a population cohort (e.g. complex, SEND) or a pathway (mental health crisis, rising risks)

3. Defining the Operating Model

- Each Place and neighbourhood defines how the operating model works locally, building on existing assets (e.g. Family Hubs).
- Work systematically through each function to clarify roles, workflows and interfaces, centered on the agreed priority cohort.

4. Demand and capacity modelling

- For the priority cohort define the baseline for demand and capacity. As neighbourhoods do that, identify the biggest crunch points.
- Use the operating model to define total demand and capacity required to support priority cohort.
- Ramp up demand in stages.
- Define/decide: how do to reallocate existing capacity/resources.
- Final demand and capacity model aligned with the framework operating model.

5. Outcomes dashboard

- Agree a small set of clear outcomes and indicators that demonstrate impact.
- Define system-level dashboards and data points at both Place and SEL level.
- Use regular (e.g. monthly) reporting to support real-time learning and adjustment.

6. Phased implementation plan

- Develop a clear, phased implementation plan with defined stages, deliverables and timelines.
- Establish a robust delivery group representing neighbourhood, Place and SEL partners to support coordination and problem-solving.
- Set out clear expectations for SEL-level enablers and support to Places (e.g. data, learning, facilitation).
- Agree a shared communication approach for transparency and engagement across partners.

7. QI - Test and learn

- Embed a Quality Improvement (QI) approach, including named quality champions, regular QI cycles and monthly learning sessions using a PDSA methodology.
- Put in place proportionate governance and oversight, including meaningful involvement of CYP and family voice.
- Create system-wide learn and share events at SEL and most importantly, acknowledge efforts and celebrate success

Key considerations for the Board

1. Does the framework fit the requirement to deliver a coordinated and consistent, measurable approach to INT's across SEL?
2. Are the implementation timelines realistic and acceptable considering nationally driven expectations?
3. Suggested cohorts - How prescriptive should the framework be in defining priority cohorts and core standards while balancing local priorities?
4. Investment in people and process is required to deliver the INT's. While it is expected the much of the funding to enable INTs will come from the redesign of existing services, there may need to be some investment upfront for infrastructure and to test new roles/ways of working. Is this need recognised by all boroughs?
5. What more do we need to do to socialise this with partners to ensure buy-in and ensure successful support

Potential cohorts – for initial case finding and management / risk stratification

1. Core 20 population
2. CYP living in deprivation
3. CYP with identified mental health issues or emotional and wellbeing concerns and /or are in crisis
4. CYP with persistent school absence including emotionally based school avoidance (EBSA)

SEL Children and Young People Integrated Neighbourhood Teams (INT) Framework

Draft Final Report

January 2026

Supported by

HEALTH INTEGRATION PARTNERS

South East London Integrated Care System

NHS South East London

Contents

1. Executive Summary

Executive Summary

Introduction

The SEL CYP INT Framework was developed between October and December 2025, driven by multiple stakeholders at Place and involving over 100 colleagues from across the SEL system. The Framework builds on the good work already underway at Place such as the development of Family Hubs, Child Health Teams and the Family Help Service. The Framework describes a way of working at neighbourhood that will help to optimise these existing (and emerging) developments. Places can incorporate the Framework as part of local development of INTs, use it to share success across Places and develop a consistent offer for SEL, recognising different starting points and need for local variation.

The Framework mainly considers CYP from school age to young adulthood, although many of the recommended ways of working apply across the whole age range. The Framework is not just health focused. It encompasses the holistic and wider factors that contribute to CYP health and wellbeing. The framework is aligned with the wider work underway in SEL on INTs and aligns with national best practice such as that advocated by the King's Fund and the RCPCH.

Why change is needed

There are compelling reasons for developing a new framework in support of improving care for CYP, for example:

- The case load for MH services attributable to anxiety, depression and neuro-developmental conditions has tripled in 6 years and waiting lists have doubled. The CYP population represent a disproportionately high burden on these services
- There is a high prevalence of obesity in SEL. Obesity is a strong marker of other psycho-socio-economic needs within the family and wider community
- A growing proportion of need cuts across health, education, social care and community settings – yet support remains fragmented and reactive
- CYP and families themselves report difficulty in navigating services, repeated assessments, delayed help without support and lack of clarity about where to go
- Evidence shows that earlier identification, coordinated neighbourhood working and community-based support can prevent escalation, reduce avoidable demand and improve experience – but this requires a different way of working.

Executive Summary

The CYP Framework

Adopting a population health-led and holistic lens, a needs-based segmentation approach underpins the framework in which demographics, complexity and (rising) risk are the key dimensions of segmentation. The Framework is also underpinned by ten fundamental values and principles which include knowing your population, being needs-led, acting early, working holistically, connecting and not working in silos and empowering families and CYP. The Framework comprises 10 key functions or delivery components:

1. Population health management (data, intel and action)
2. Active identification and family-centred early intervention
3. Universal health and care provision
4. Multi-agency coordination and working
5. Direct care delivery
6. Managing escalations, urgent or unexpected needs
7. Longitudinal care and transition at 18+
8. 'Flourish', ongoing support and optimising potential
9. 'Waiting well' or 'unwell'
10. Engaging VCSE as trusted delivery partners.

For each of these function the report describes key ways of working that enable the delivery of timely, holistic and family focused care, accompanied by a real-life example of where this is already in place elsewhere. A single, overarching diagram also captures all 10 functions and other elements that make up the scope of the Framework. 'Zack's story' then provides an illustration of what care and support would look like for a 15-year-old boy once the Framework is implemented, contrasting this with how Zack's care looks today.

A range of enablers have also been identified as critical to the delivery of the framework and a brief description of each is given. These include workforce development, multi-agency teamwork approaches/facilities, meaningful co-production with families, culture change, information governance, IT systems and data and the required commissioning shift.

Executive Summary

How will we know we are making a difference?

Outcomes that can be used to monitor and evaluate the success of the framework have been defined in areas such as active/early identification and prevention, improved access, improved multi-agency working and improved health and wellbeing outcomes. Potential key performance indicators for each outcome are listed, to be refined further.

How will we implement the Framework?

Key success principles for implementing the framework are described, based on learning from elsewhere. The key to successful delivery is a strong focus on people – for example, creating meaning, engaging and taking people on the journey, developing the right skills and motivations and providing strong leadership that inspires and establishes clear accountability. Building blocks for implementation are described including engagement and mobilisation at Place, developing a shared purpose and priorities, demand and capacity modelling and effective measurement.

An implementation roadmap outlines a 3-phase 'test and learn' approach as follows. Phase One (2026/7) sees a neighbourhood model actively tested and in delivery across all Places. Phase Two (2027/28) focuses on growing and strengthening the approach. Phase Three (2028/29) focuses on embedding the change and making continuous improvements. A systematic approach to delivery across all Places is also described, recognising different starting points and levels of maturity. Implementation will need to be supported by a robust project delivery team and clarity on what support will be provided to Places. A QI methodology will be required that enables real-time learning and improvement and sharing of success between Places.

Next steps

Continued work is now required to support Places to adopt the Framework as part of local design, planning and delivery. This includes broadening the engagement and socialisation of the model, Place led self-assessment against the framework to assess gaps / opportunities for development and creation of Place roadmaps for implementation.

Appendices

A set of appendices are provided which include further detail on what we heard from CYP and families and a breakdown of stakeholders who took part in the work.

2. Introduction

Introduction

- This report reflects the work that took place between October and December 2025, involving a wide range of stakeholders across SEL in developing the SEL CYP INT framework. The work to deliver the framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery.
- A great deal of work is already underway at Place to develop care and support for CYP and families. Much of this work is informed by existing initiatives that sit front and centre such as Family Hubs, Child Health Teams, the Family Help Service and the Healthy Child Programme. This framework builds upon that work.
- This report outlines a consistent framework for SEL places to use when developing their INT's and captures key elements and principles expressed by SEL colleagues alongside recognised best practices. It will enable achievement of local aims at an accelerated pace, sharing of 'what good looks like' between Places and greater parity of provision as part of a unified approach – recognising the need for local variation.
- The framework focuses on describing a way of working at neighbourhood that will help optimise and enhance existing (and emerging) developments. The recommendations describe the coordinated functions needed within the CYP INT to deliver more seamless, coordinated care that is truly holistic and family-focused.

"We must improve links between currently fragmented and siloed CYP services. What can we do together to be more proactive, to intervene earlier and respond to the whole picture as one team with clear leadership?'

'We need a shared vision of how we work together to deliver the 'must do's', speaking the same language; all knowing as much as each other'

Objectives

Objectives

Deliver a unified, evidence-based Framework for INTs that:

- Applies across all boroughs.
- Provides clarity on priority cohorts and targeted interventions.
- Builds on existing data, insight, and engagement.
- Enables alignment to deliver better outcomes, reduce inequalities, and strengthen proactive, prevention-focused care.

Guiding Ambition

- Adopt a population health-led and holistic lens.
- Design a family-oriented and outcomes-led approach.
- Tackle inequality and variation while respecting local context.
- Embed recognised best practice and a common understanding of ‘what good looks like’.

Core Principles

Collaborative by design
Strong local ownership

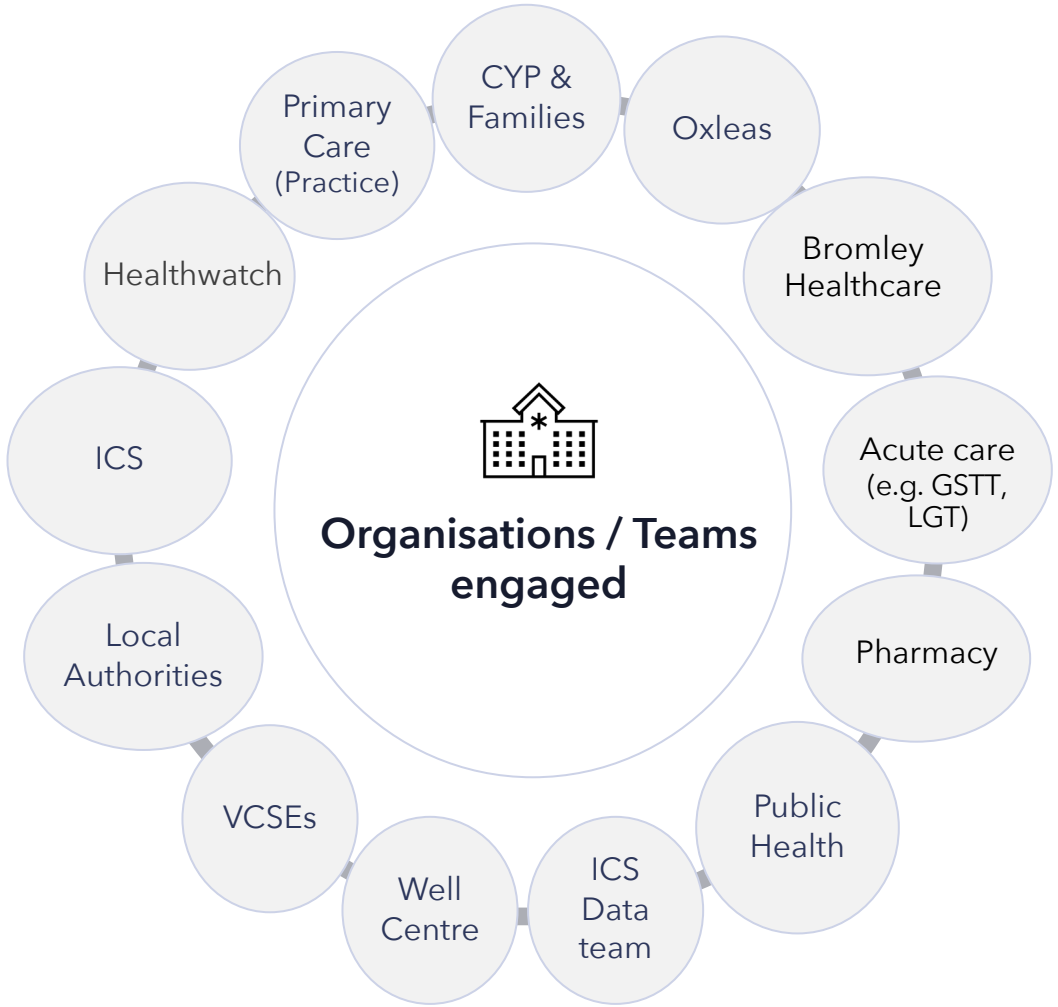
Build on existing progress
Integrate ongoing initiatives and learning

Provider-led and operationally realistic
Deliverable within current resources

Our Methodology: 3 Phases, Co-produced, Evidence-based

Phases	Oct 2025 – Nov 2025 **Data Triangulation & Insight Generation** Establish a shared, system-wide understanding of need, segmentation, and challenges.	Nov 2025 – Dec 2025 **Co-design & Solution Building** Define framework components, interventions, and enablers through deep multi-stakeholder engagement.	Dec 2025 **Testing & Implementation Planning** Refine and test the framework through governance validation and pilot implementation planning.
Core Activities	• Data Analysis and CYP segmentation to identify high-priority cohorts. • Gather qualitative insights from key stakeholders • Review existing plans and guidance.	• Conduct **3 focus groups** (Clinicians, Local Authorities and Place based reps) • Capture voices of CYPs and their families with lived experiences • Explore priorities and barriers using Phase 1 insights. • Ratify framework structure in a **Co-design Workshop.**	• Validate draft framework through governance and feedback. • Develop local adaptation and implementation plans. • Identify pilot sites for initial rollout.
Outputs	• Baseline *as-is* analysis and segmentation summary • Initial insight summary for Steering Group validation	• Draft CYP Framework including vision, principles, priorities, and enablers	• Final, system-endorsed CYP Framework • Implementation plan with delivery milestones, KPIs, and ownership model

More than 100 stakeholders from across the system, including service users, have been engaged the co-design process for the framework



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- Family / CYP Engagement Forums (In Progress)
- Focus Groups
  Local Authorities
  Clinicians
  Place Based Reps
- Deep Dive Sessions (e.g. SEND, Mental Health)

3. What do our SEL residents and parents say?

A range of parallel activities took place involving residents to ensure their voice is reflected in the framework

1. Distilling themes from engagement work done so far

SEL has done significant work around engagement across all age groups and communities in the past few years. It was important that we capture and distill key themes that needed to be incorporated in the framework.

2. Connecting with CYP and their families to understand their needs, pains and priorities

- Meeting with CAMHS service users
- Meeting with parents of CYP in CAHMS
- Focus group with CYP with SEND (f2f)
- Focus Group with CYP with learning disabilities (f2f)
- Meeting with CYP at The Well Centre
- Meeting with Lambeth Shadow Board

Connected with residents across SEL to understand the challenges they face, their experience, expectations and how they want the future services to look like.

3. Continued engagement at Place

There shall be continued hyper local engagement at Place to ensure care delivered locally is in line with the needs of the local population

What we heard from children, young people and their families?

Lack of coordination

Families experience care as disjointed, each agency expecting others to "fix it",, highlighting siloed responsibilities. The call for peer navigators and care coordinators echoes the wider strategic gap around roles to ensure care continuity across multiple agencies.

"We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly"

Information, education and awareness

Front-line professionals lack up-to-date knowledge of local pathways, leading to inappropriate advice or signposting and avoidable escalation. Families also want practical education for employers, schools, siblings, children and parents, ideally delivered by people with lived experience.

"GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day."

Waiting and managing expectations

Long waits for neurodevelopmental and mental health services are not just an access issue; the absence of interim support allows needs to escalate and family resilience to erode. Parents ask for honest information about who is doing what, realistic waiting times, clarity on offer/limits, and better communication.

"Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait."

Environments and experience of care

Families see current emergency pathways as unsafe and traumatising for CYP, particularly neurodiverse children. They need choice of setting (home, community, groups) and psychologically safe environments with follow-up after diagnosis.

"Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E."

Transition of care to adult services

Transition is experienced as a cliff edge: responsibility abruptly shifts to young people with minimal preparation, reassurance or continuity. Families want transition to be actively managed, with detailed information transfer and practical "hints and tips",

"The attitude it's on you now that you are 18; we won't baby you anymore and so deal with it on your own."

4. The need for change

Zack's story

Zack, 14-year-old male

Academically struggling and is currently on the waiting list for ASD assessment (not picked up in primary school). History of severe bullying at school.

History of asthma, which is challenging to manage and is known to the community nursing team. Multiple sporadic exacerbations of asthma since age 6, requiring hospital admission.

- Father was absent, mother has significant MH problems.
- Substantial financial issues, resulting in risk of eviction.
- Zack is known to Social care, however no current involvement as it was stepped down in the past.
- Referrals to housing have been made but were not successful.

Please note that this patient story is sourced from a combination of multiple real patient scenarios. Names and facts have been altered for patient confidentiality. The main purpose of the story is to highlight the opportunities for improving care in the current system.

Zack's story

Zack has been seen by the GP for asthma reviews; however, he has missed the follow-up appointments. He has previously demonstrated poor inhaler technique and inconsistent medication adherence, leading to multiple hospital admissions for exacerbations.

Zack has been on the waiting list for an ASD assessment for 6 months. During this time, he has experienced increasing difficulties at school, including reduced concentration in lessons and poor performance in assessments, leading to social withdrawal and disengagement from learning.

He has a limited support network and experiences difficulties forming friendships, leading to social isolation and a negative impact on his MH. His mother is unable to support him, due to her own MH challenges and faces additional barriers in accessing services due to language difficulties and limited awareness to available information.

Zack's asthma starts to flare up again in winter. His mother contacts the GP but was unable to get an appointment and did not feel his condition warranted a visit to A&E.

A week later his cough is much worse, and he has developed wheezing. Zack ends up in A&E with another exacerbation of asthma. Unfortunately, he continues to wait for a formal ASD assessment and doesn't engage well at school.

Observations

Did not preempt and act: Signs of recurring and increasing issues were an opportunity to act before it was too late.

Multiple siloed pathways: Looking at the child through a health lens, instead of the ability to consider the whole picture of physical and mental health, school and home problems. Lack of person-centred holistic assessment and multi-agency care planning that genuinely address the multifactorial issues faced by the child/family.

No mechanism for coordination between multiple agencies: Agencies not getting to the root of the problems and creating one understanding.

Missed opportunity: To sum it all up, this child's case shows how we as a system could be far more efficient in providing coordinated and meaningful care.

Key gaps and challenges that were identified during engagement with local clinicians and professionals resonated with Zach's story

Gaps

Needs-Led Child Centric Approach
Prioritise child-centred models over health/condition silos or 'labels'

Meaningful Outcomes
Clarify meaningful purpose, benefits, and shared outcomes

Holistic Coordinated Care
Deliver more coordinated care spanning acute/community/LA/VCSE for seamless support.

Strong Navigator Roles
Deploy navigators for signposting, handholding, and coordinating family-wide care.

Family Context Approach
Adopt whole-family lens, avoiding child-parent separation in interventions.

Neurodiversity Specialism
Address growing autism/ADHD/neuro needs through needs-led pre-diagnosis support.

Secure Transitions
Smooth transitions of care, avoiding cliff-edge to adulthood.

Expand VCSE/Faith Role
Leverage VCSE/faith/creative health for MH prevention in underserved communities.

Prevention & Determinants
Target upstream prevention addressing wider social/health determinants proactively.

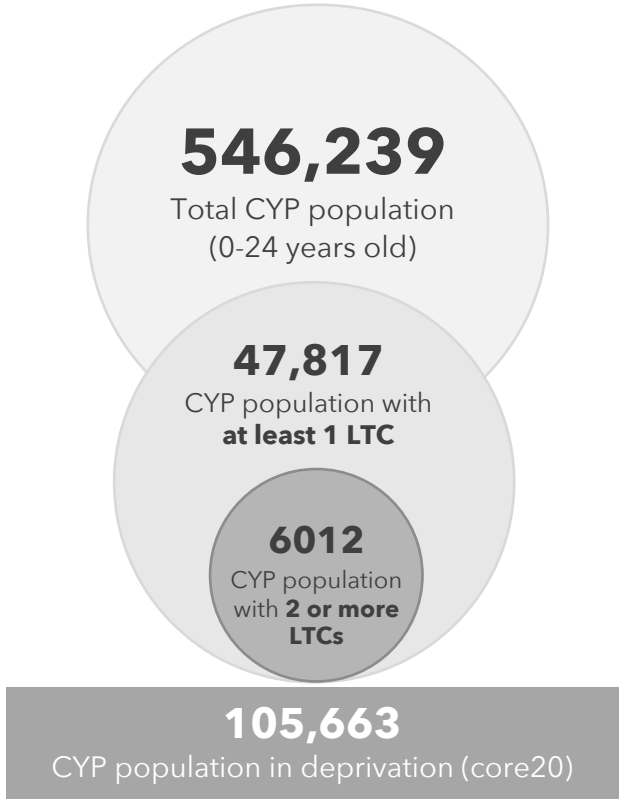
Integrated Contracts and Knowledge
Develop contractual mechanisms and knowledge-sharing for seamless multi-agency working.

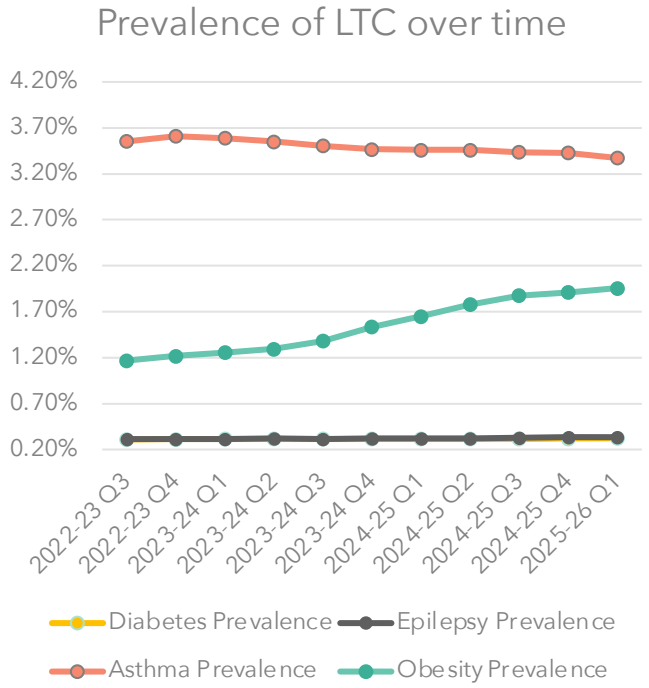
Resources and facilities
Understanding our resources and facilities, how to optimise them and address the gaps

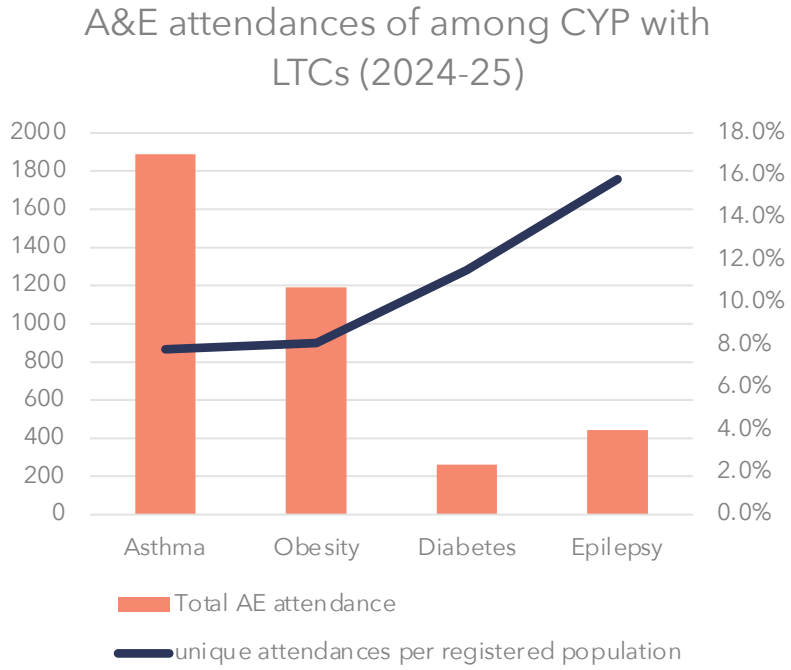
Challenges

- Siloed working lacking coordinator roles
- Pillar-to-post referrals without clarity or continuity
- Poor data flows across health, LA, schools, VCSEs
- Lack of service knowledge, and existing resources and facilities
- High entry thresholds for services
- Fragmented focus on holistic care
- Rising MH/neuro/EBSA demand
- Scaling proven initiatives
- Inappropriate A&E use
- Parental lack of trust in the health service

1 in 13 CYP live with a LTC; Asthma has a high prevalence, Epilepsy has a high rate of A&E attendance







7.5% of all children are living with at least one LTC

(diabetes, epilepsy, asthma and obesity)
It does not include other potential diagnosis

Prevalence of asthma is showing decreasing trend* while obesity is showing increasing trend

*Underdiagnosis and service challenges leading to under-reporting of demand

The overall A&E attendance is high for CYP with asthma and obesity due to their high prevalence.

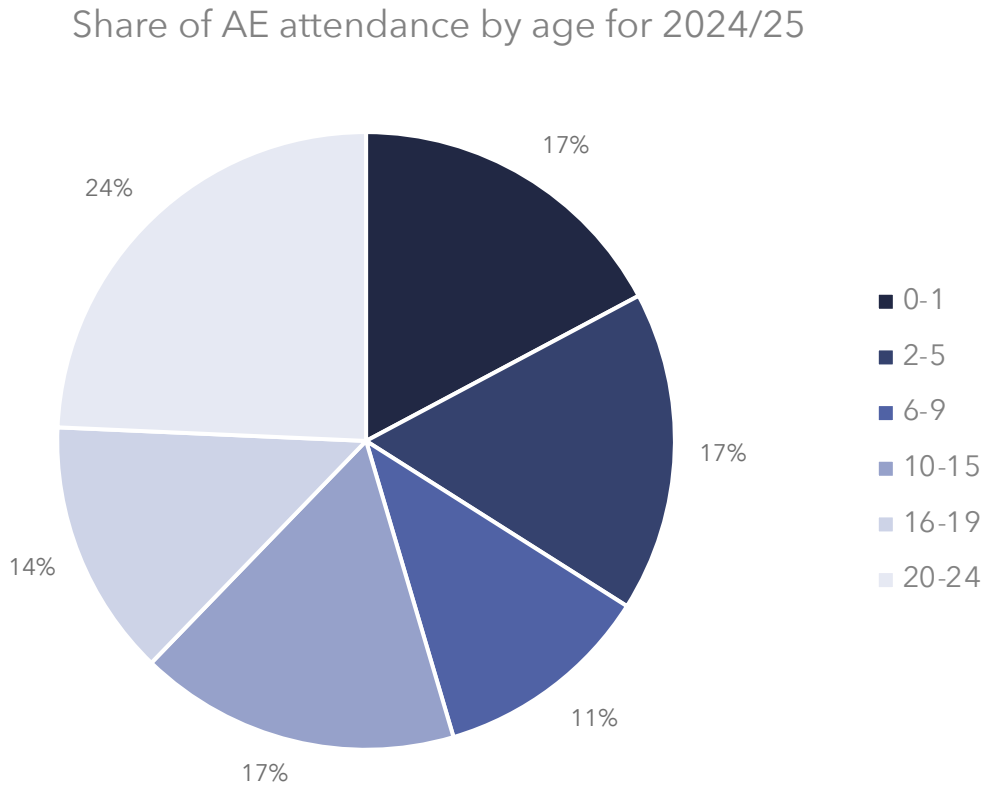
Please note obesity is not a direct cause of A&E attendance but co-exists with other co-morbidities and issues.

Data source: South East London ICB dashboard for CYP

30% of all A&E attendances in 2024-25 were attributed to CYP with fever and abdominal pain being the most common known presentation

60% of the total A&E attendances for CYP in 2024-25 were from 2 to 19 years age-group

Total A&E attendances for CYP population across SEL for 2024-25 were 346,630



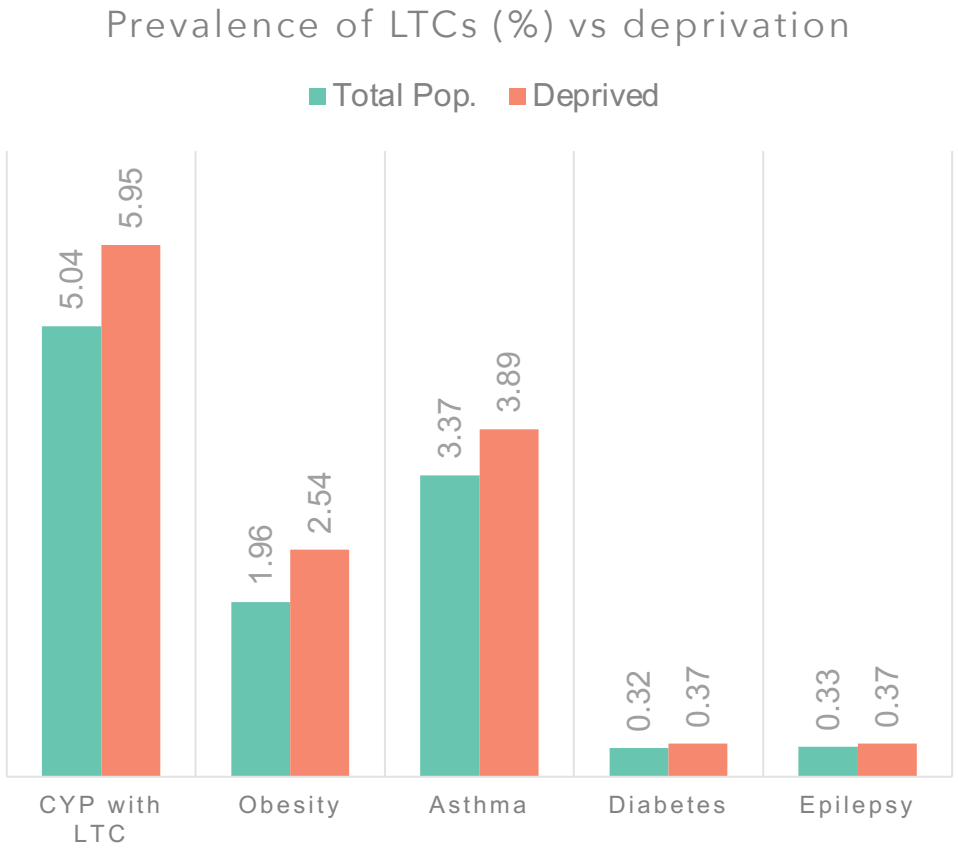
Top 5 reasons for A&E attendance by age group in 2024-25

0-1yrs	2-5 yrs	6-9 yrs
Fever (18%)	**Unknown (16%)**	**Unknown (18%)**
Unknown (13%)	**Fever (16%)**	**Fever (8%)**
Dyspnoea	Cough	Abdominal pain
Eruption	Dyspnoea	Eruption
Vomiting	Injury of head	Injury of lower extremity

10-15 yrs	16-17 yrs	18-19 yrs	20-24 yrs
Unknown (19%)	**Unknown (23%)**	**Unknown (25%)**	**Unknown (25%)**
Abdominal pain (7%)	**Abdominal pain (7%)**	**Abdominal pain (8%)**	**Abdominal pain (9%)**
Injury of upper extremity	Chest pain	Chest pain	Chest pain
Injury of lower extremity	Injury of lower extremity	Sore throat	Injury of lower extremity
Fever	Injury of upper extremity	Injury of lower extremity	Headache

Source: SEL ICB Urgent and Emergency Care Reporting Dashboard

Deprivation significantly amplifies health inequalities for children and young people



In deprived population, the prevalence of LTC and obesity is markedly higher (18% higher LTC and 30% higher for obesity)

- Significant oral health inequalities with 2.8x higher tooth extraction rates in most deprived areas for children
- Higher emergency admission rates in the most deprived areas - up to 3x higher for some

Avg increase in A&E attendances

When comparing per A&E attendance rate (per 1000) for children living with obesity, asthma, diabetes, epilepsy, we see a higher rate of attendance in deprived population. The increase in rate is as follows:

Obesity : 84%	Asthma : 51%
Diabetes : 184%	Epilepsy : 263%

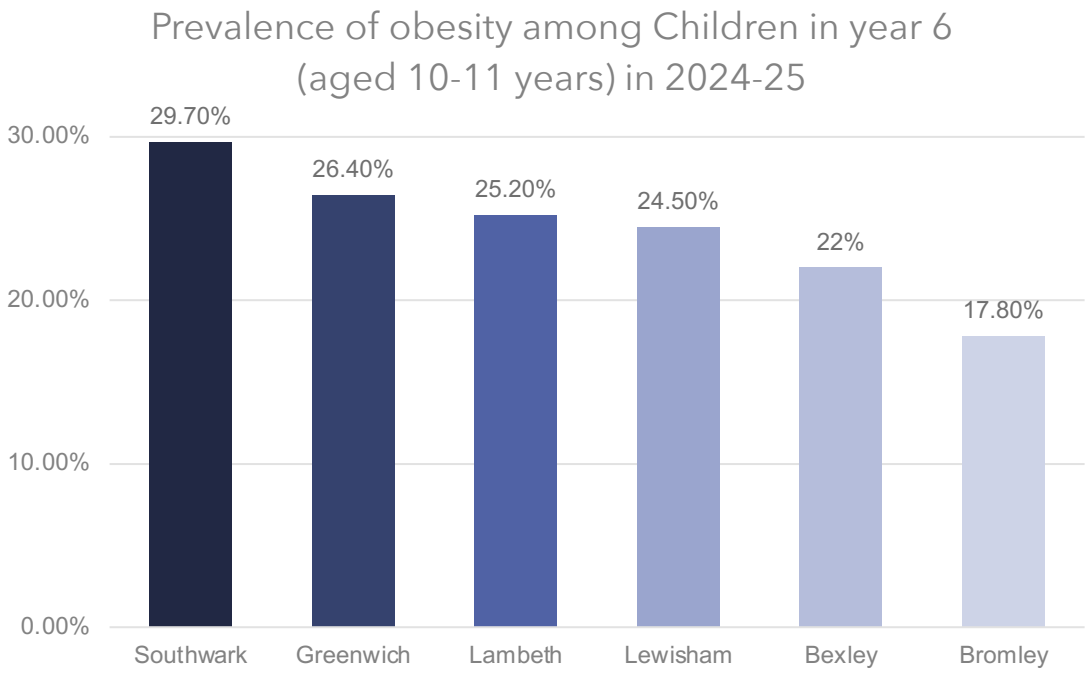
For e.g. children living with diabetes in deprived communities attend A&E 2.8 times more as compared with total population.

As of June 2025

Data source: South East London ICB dashboard for CYP

High prevalence of obesity, particularly among children in year 6 & females

High prevalence of obesity in children (year 6), higher than London (23.2%) and National (22.2%) average noted in 4 out of 6 boroughs

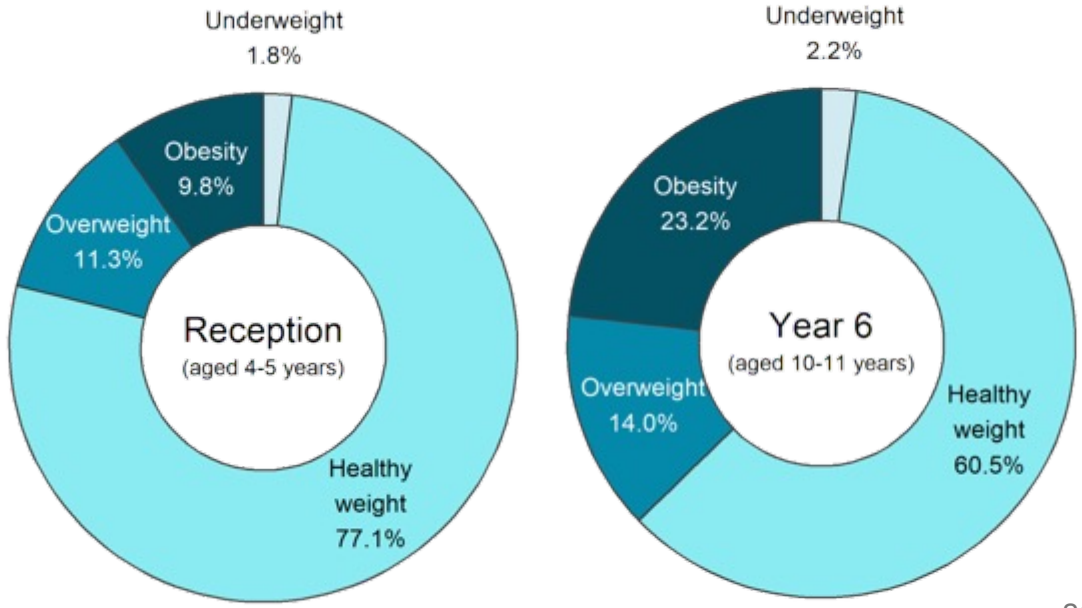


Prevalence of obesity has risen from 1.2% to 2% across Southeast London in last 3 years

(Q3 2022/23 to Q1 2025/26)

1 in 3 children is overweight by the age of 11 years across London

Prevalence of obesity doubles in children in year 6 compared to reception (across London)



Data source: South East London ICB dashboard for CYP, National Child Measurement Programme 2025

Obesity is a marker of other psycho-socio-economic issues within the family and wider community

Deprivation	Children living in the most deprived areas are more than twice as likely to be obese compared to those in the least deprived areas (12.9% vs. 6.0% at school entry), across England.
Family	Parental obesity, mental illness, stress, poor awareness educational attainment, absence of one parent, and punitive parenting are shown to be associated with childhood obesity and its persistence into adulthood.
Wider Community	NHS and government evidence repeatedly highlight that childhood obesity clusters with other adverse experiences, including social services involvement, homelessness risk, and special educational needs.

Obesity can have wide ranging physical and psychological effects in children and young people

Emotional & Behavioural

- Stigmatisation
- Bullying
- Low self esteem

Education

- School Absence

Physical Health

- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone & joint problems
- Breathing difficulties

Long Term

- Increased risk of being overweight adults
- Risk ill health and premature mortality

The NHS spends around £6.5 billion a year on treating obesity-related ill health across all age groups in England

Long-term cohort studies show that childhood obesity persists into adulthood (up to 85% remain obese), amplifying health system costs and morbidity over the life course.

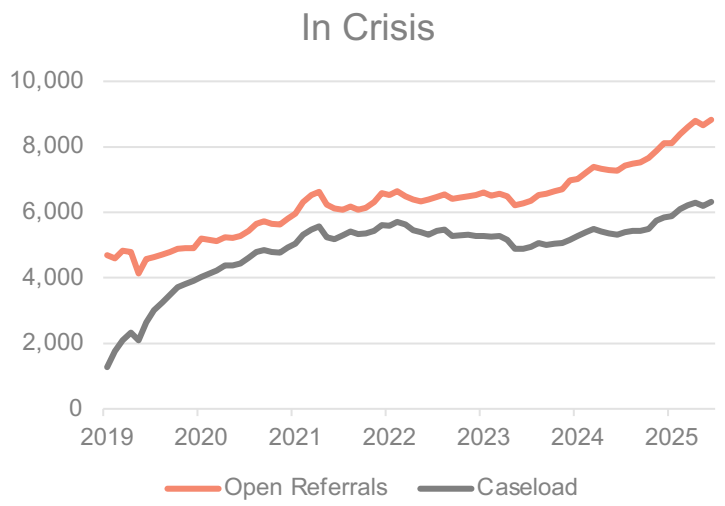
https://research.uhs.nhs.uk/news/soaring-childhood-obesity-from-pandemic-will-cost-uk-billions-study-finds
National Child Measurement Programme report 2025 - https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2023-24-school-year
https://www.bmj.com/company/newsroom/newsroom-2019-2021/22710-2/
https://www.gov.uk/government/news/government-acts-to-tackle-rising-childhood-obesity-epidemic
https://www.england.nhs.uk/2024/09/one-in-eight-toddlers-and-primary-school-aged-children-obese/

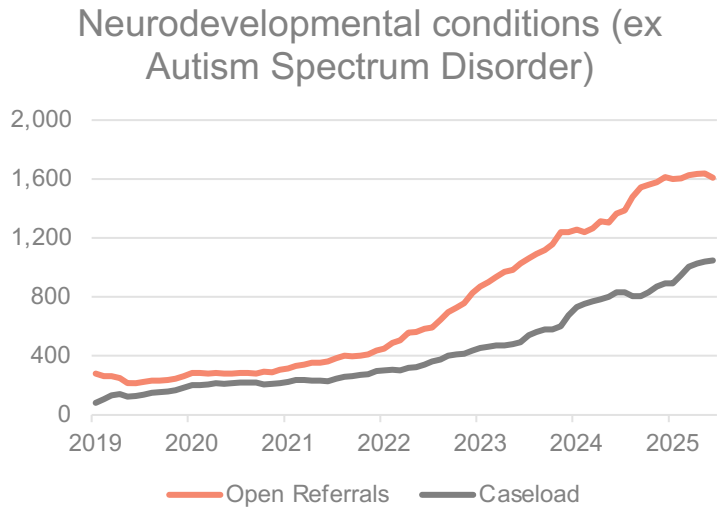
Caseload for mental health services attributed to anxiety, depression, "in crisis" and neuro-developmental conditions have more than tripled in last 6 years

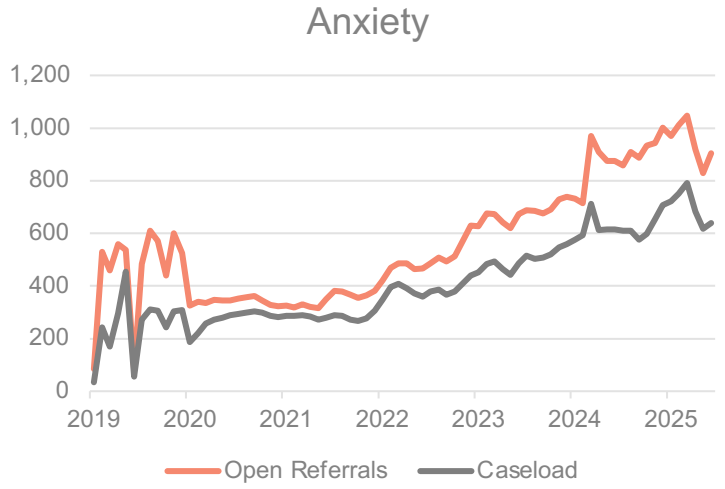
Caseload for these 4 chief complaints is at a 5-year peak as of 2025

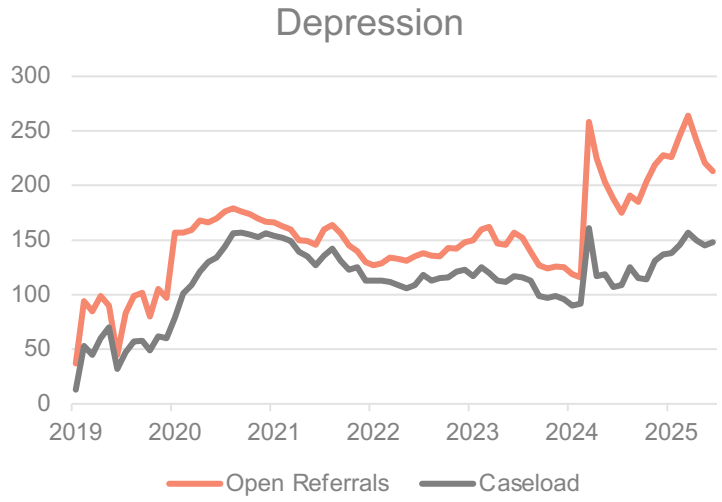
Caseload related to mental health has increased multiple folds for the following chief complaints between 2019 and 2025 –

- **2X** for "In crisis"
- **8X** for Neurodevelopmental conditions (excluding Autism Spectrum Disorder)
- **3X** for Anxiety
- **3X** for Depression









Definitions

Caseload
The number of referrals still open at the end of the month

Open referrals
The number of referrals still open at the end of the month, with at least one contact

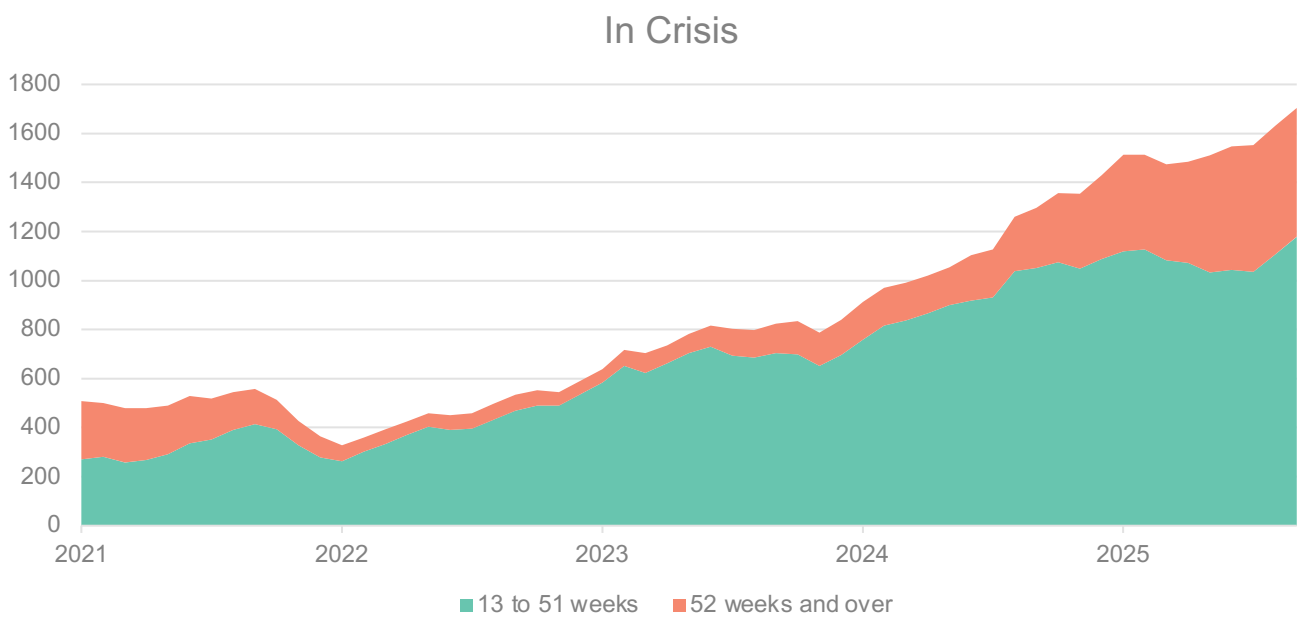
Data source: South East London ICB dashboard for CYP – Mental Health

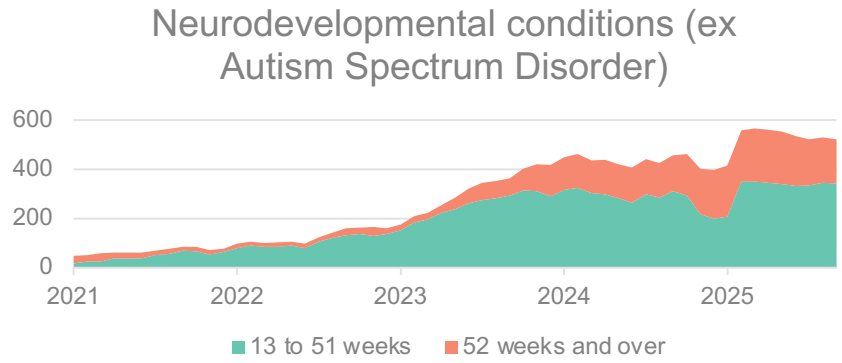
Wait lists for cases for anxiety, depression, "in crisis" and neuro-developmental conditions have also more than doubled in last 6 years

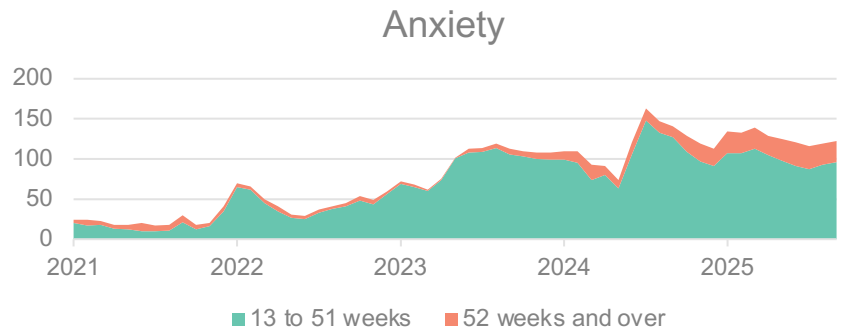
Wait times for these 4 chief complaints is at a 5 year peak as of 2025

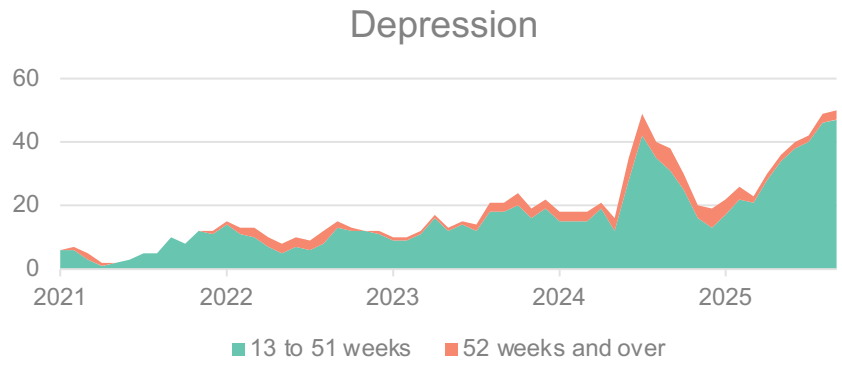
Waiting times as measured by the number of CYP waiting for their first contact for **over 52 weeks** for mental health services they are referred to, has increased multiple folds for the following chief complaints between 2019 and 2025 –

- **8X** for "In crisis"
- **4X** for Neurodevelopmental conditions (excluding Autism Spectrum Disorder)
- **2X** for Anxiety
- **2.5X** for Depression





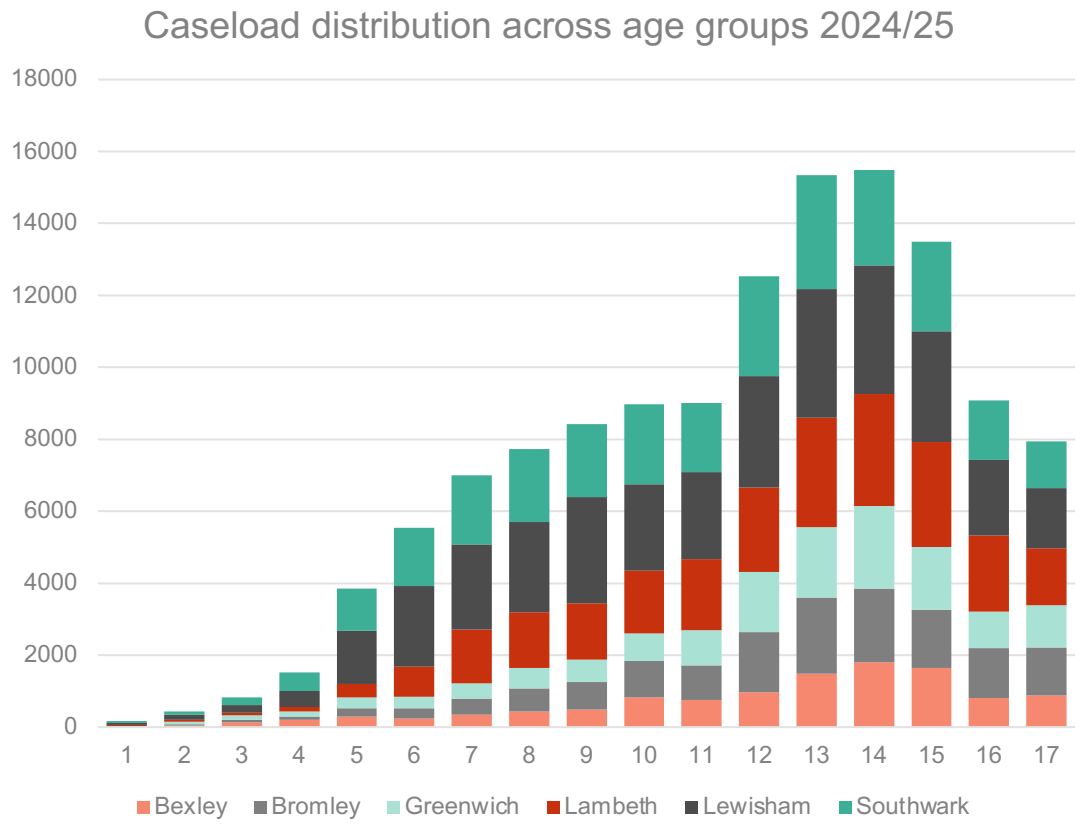




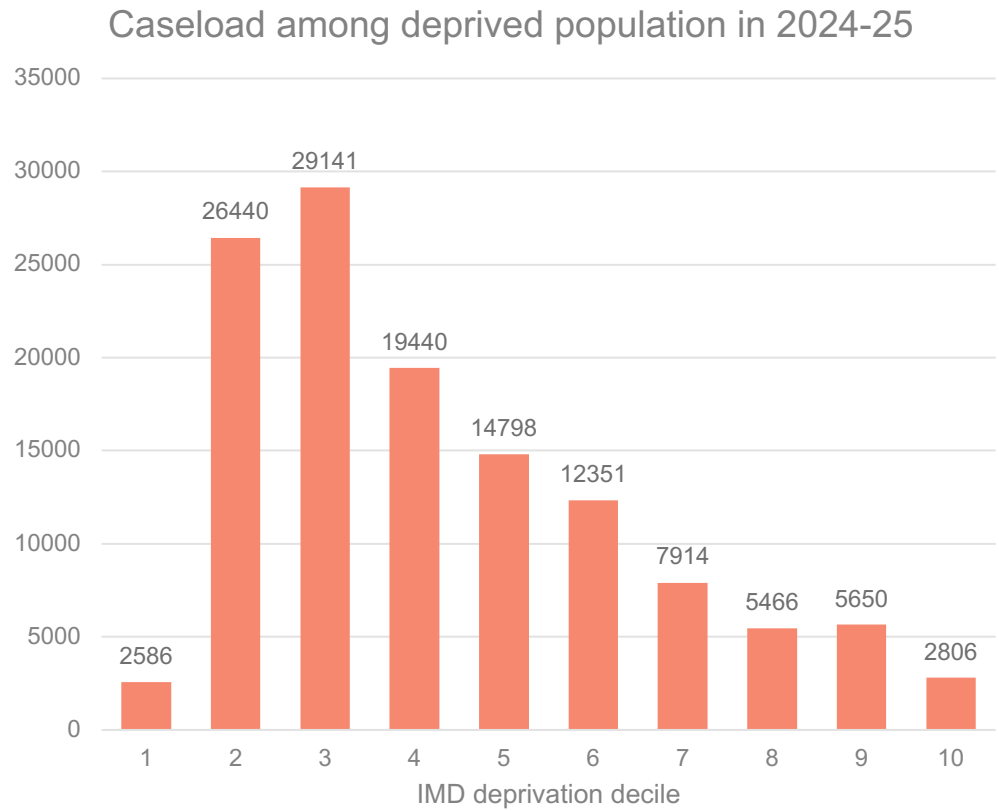
Children aged 10 to 15 years and 40% most deprived CYP population present a disproportionately high burden on mental health services

More than 50% of the all the CYP caseload in mental health services across SEL are of children aged 10 to 15 years

Over 80% of the all the CYP caseload in mental health services across SEL are of children aged 5 to 15 years



Over 50% of all the CYP caseload in mental health services across SEL are of those from the 40% most deprived communities (in 2024-25)



Data source: South East London ICB dashboard for CYP – Mental Health

We need to shift the focus to early proactive prevention

Age 5- 16 years

'Silent disease'....

Consistent reported increases in presentations (not including invisible cases) related to a range of issues including:

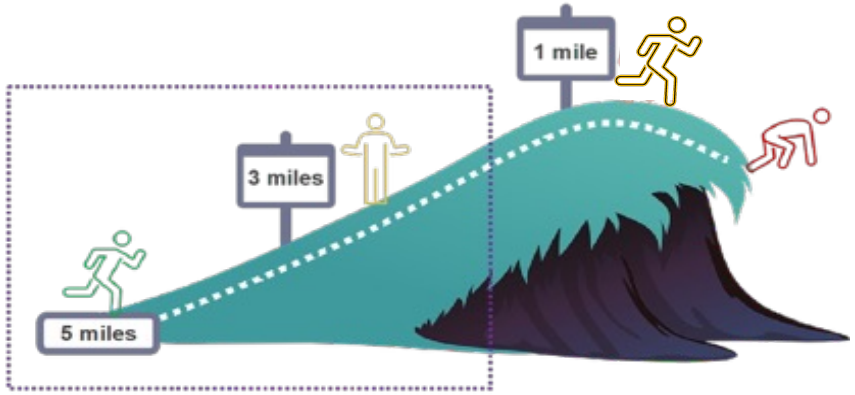
- ***Anxiety***
- ***Non-school attendance***
- ***EBSA***
- ***Behavioural challenges***
- ***Sleep disorders***
- ***Disability***

Age 16- 24 years

One in every seven young people (in UK) ...

- The number of young people aged 16-24 classified as NEET is close to **one million** – an increase of 250,000 in 3 years
- More than a quarter of NEETS cite **long term sickness or disability** as a barrier to participation compared with 12% in 2013-14
- The number young people claiming health related universal credit and employment support has risen by more than 50% in five years with **80% of recipients reporting mental health or a neurodevelopmental condition such as ADHD**

The priority must be to shift the focus to prevention, and to ensure that children and young people receive **timely proactive intervention and support** at the **earliest opportunity,** so they are empowered to remain engaged in the community, education, then employment, or training.



5. CYP Population segments and priorities

Effective segmentation should be grounded in need, while being informed by equity, prevention, and whole-system responsibility.

The SEL CYP ambition is 'CYP will receive proactive, coordinated services across health and care settings which are designed around their identified needs and the wider needs of the population to ensure that they achieve their best outcomes in childhood'

This will be achieved when:

- The environment and services are are purposefully and actively configured around the holistic, bio-psychosocial needs of the CYP population and all its segments/cohorts.
- Responsibility and accountability for CYP population health and healthcare is clear.
- The social, commercial and environmental determinants impacting the health of the population are considered and acted on.
- Relative needs are the basis for service configuration, integration, governance, outcomes, and resource allocation for the population.

Guiding ambition for segments

Population Need as the Foundation

Need—encompassing health, social, and wider determinants—must be the foundation of all segmentation decisions.

Seamless transition across segments

CYP and families should be able to access care close to home with seamless movement between clinical services and transitions to segments.

Be orientated around the child/young person and their family

CYP and families are active partners in decisions, with support shaped around their goals, strengths and lived experience.

Whole-System & Community-Led

Segments should acknowledge CYP health and wellbeing is a shared responsibility requiring multiagency partnership, collective system alignment and local ownership

Demographics, complexity and (rising) risk form the key dimensions for need based segmentation

Demographics

The bio-psycho-social needs of CYP are closely linked to demographics, most obvious of which are age, ethnicity, deprivation (including that which is 'hidden') and geography.

Deprivation	**Age**
Ethnicity	**Geography**

Complexity

Complexity of need determines the complexity of integration/ co-ordination, intervention and services required. Complexity ranges from "universal needs" through to "complex health needs".

Universal	
Chronic	**Complex**
Unexpected	

(Rising) risk

Rising risk is the likelihood of deterioration and/or increased needs and/or increased requirement for integration/ co-ordination, intervention or services. It helps enable targeted preventive interventions and support. At risk groups are *those at rising risk of not being able to live their best and healthiest lives possible.*

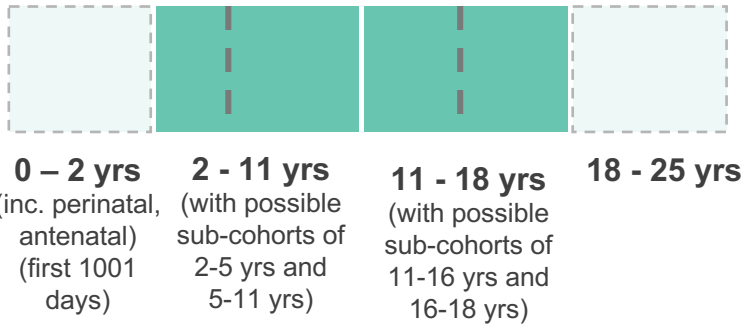
Demographics, Complexity, and (Rising) Risk: Key Dimensions for Needs-Based Segmentation

Demographics

The **bio-psycho-social** needs of CYP are closely linked to demographics, one of the most obvious of which is age.

Age and key life stages – early years, school age, adolescence and young adulthood – each associated with different developmental tasks, risks, and service requirements

Ethnicity shapes patterns of risk, experiences of discrimination, and trust in services, all of which influence access and outcomes.



Complexity

Complexity of need determines the complexity of intervention and services required.

Proposed complexity subdivisions:

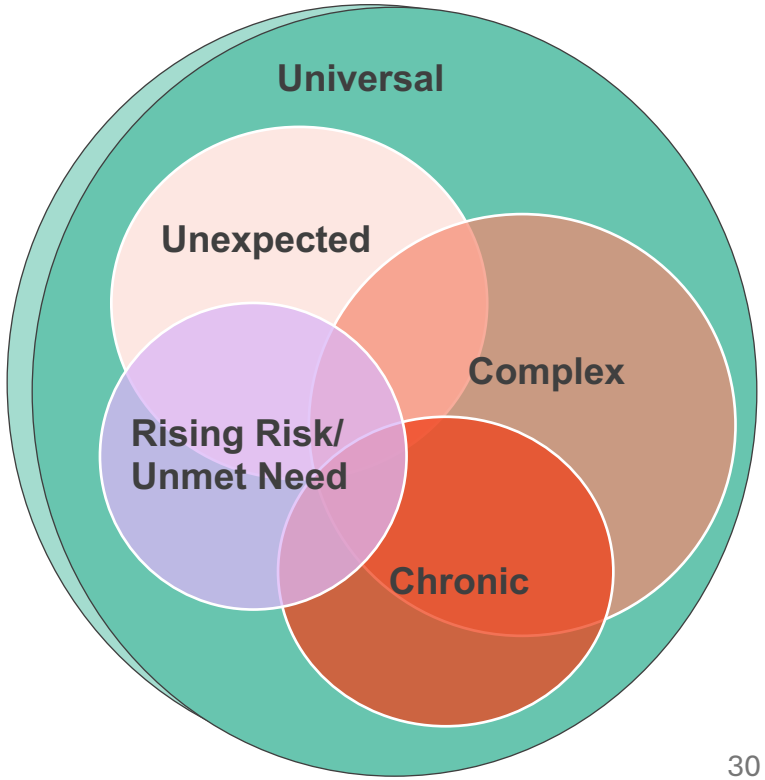
- **Universal** health and care needs – the needs of everyone (including those considered 'well')

Within the population with universal health needs, are three particular groups:

- Those with **chronic** health and/ or care needs
- Those with **complex** health and/or care needs (inc. vulnerable with social needs)
- **Unexpected** injury or illness or other need (requiring UEC) – which can happen to anyone (with two subgroups: mild and severe)

Rising Risk/ Unmet Need

Within each identified segment, particular groups of rising risk are identified as those at rising risk… of not being able to live their best and healthiest lives possible.



Four categories of need complexity

Universal

These are the everyday needs of the whole CYP population, which may be addressed largely through self-care, family and community assets, and universal services.

Domains

- Physical and mental wellbeing
- Social determinants and inclusion
- Primary & Universal Health Care
- Preventive health & care
- Growth & development
- Smooth transition into puberty and adulthood
- Whole family/carer focus

Chronic

These are ongoing needs for instance, linked to one or more long-term condition or disability, manageable through planned, proactive care within the community.

Domains

- Long-term physical or mental health
- Functional abilities for daily living and caring responsibilities.
- Behaviour change and self-management skills.

Complex

These are multi-faceted, interacting and sometimes invisible needs and disabilities, may involve instability, and require a higher degree of coordinated, multi-agency care.

Domains

- Broadened definition of complexity
- Co existing multiple long-term conditions either physical, mental or both
- Social complexity (e.g., housing, domestic abuse, child protection, poverty, caring strain).
- Safeguarding, legal and rights issues

Unexpected

These needs may arise suddenly or out of a crisis and are not necessarily about ongoing chronicity or complexity. They may be mild or severe.

Domains

- Acute physical or mental health
- Social or safeguarding
- Timely access to urgent care
- Easy access to signposting information
- Continuing support

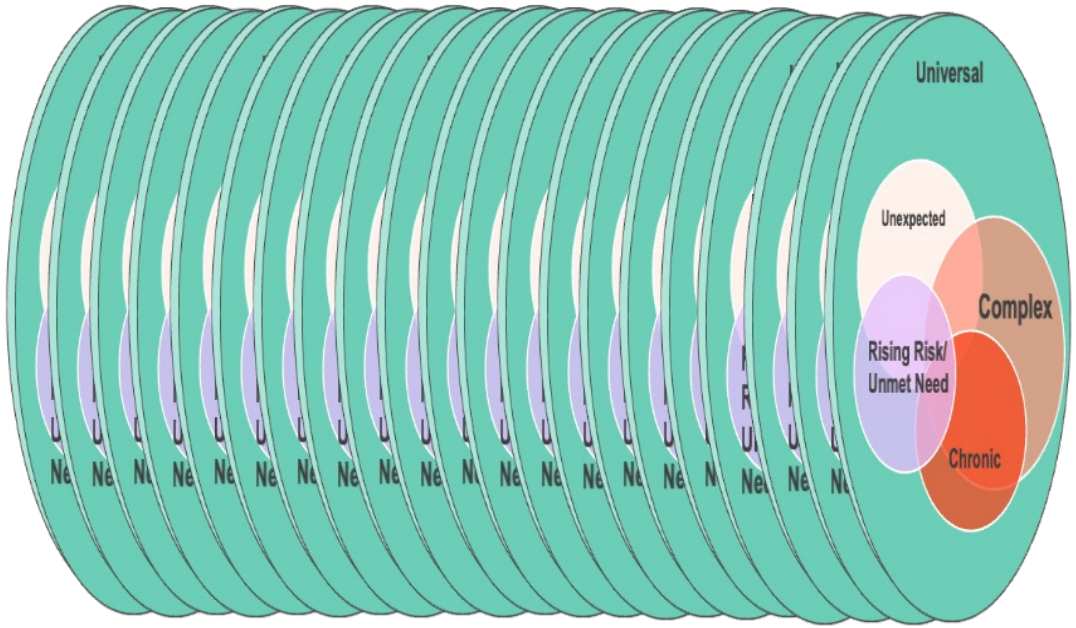
Needs with varying complexities exist across and within each demography

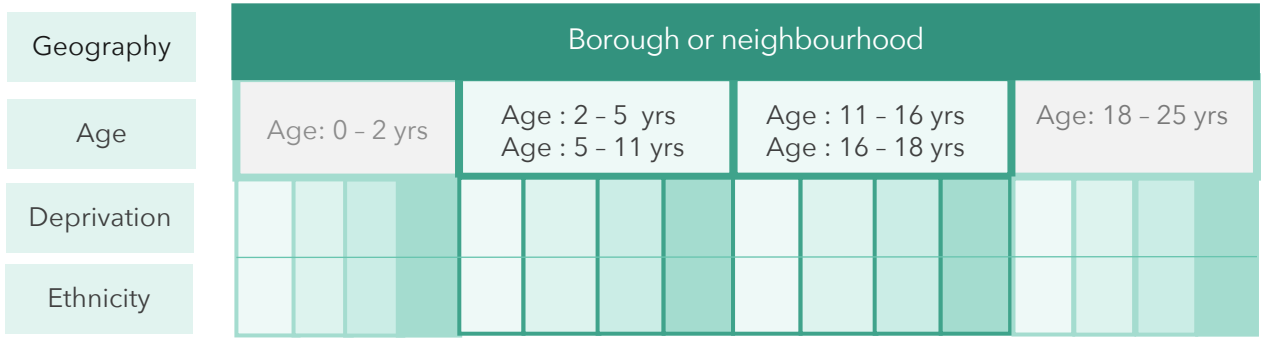
Within any single demographic group, there will be CYP who are generally well and only need universal care and support, while some will have ongoing chronic needs, and some with highly complex physical, mental, and social needs that require intensive, multi agency support. Further, each of these groups can have varying risk profile.

This produces overlapping segments (e.g. “stable LTC”, “neurodiverse with school-based distress”) rather than mutually exclusive groups.

To illustrate, each of the discs (in green) stacked together represent a demography. Within each demography, sub-groups of varying needs and risk not only exist but overlap with each other. (see diagram)

Robust segmentation must therefore accurately reflect this spectrum of need and design proportionate responses.





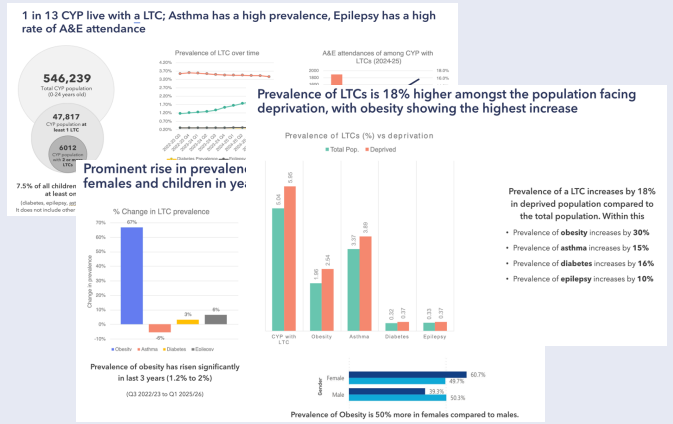
6. CYP INT Framework

CYP INT Framework - things to note

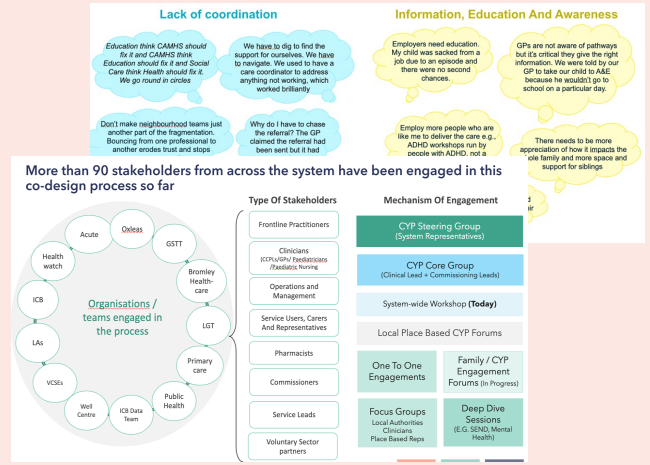
- This framework captures the priorities and ambitions of SEL colleagues and acts as a guide rather than a strict formula.
- Each Borough has existing developments underway and will start from a unique point. The framework describes a way of working at neighbourhood that will help optimise these developments and support a consistent approach.
- Local communities can use the framework to evaluate their current level of development and build upon existing strengths and achievements.
- Implementation will differ; the goal is to tailor the model to the local context instead of duplicating a single approach.
- The process will take time and should be carried out in phases in alignment with The 10 Year Plan.
- Some elements require consideration for a SEL approach, while others can be managed locally.
- Neighbourhoods act as the main delivery units–local areas determine how to put the framework into practice, reallocate resources, focus on early successes, and plan the rollout.

Our approach to developing the SEL INT CYP Framework

Strategic priorities & best practice learnings



Local SEL data



Patient and staff feedback & engagement

The SEL CYP INT Framework was co-designed with over 90 stakeholders and informed by patient and staff experience and feedback, as well as utilising local population data sets to identify priority areas of focus. This was supplemented by a comprehensive review of relevant best practice learnings which were incorporated within the SEL CYP INT framework. The framework integrates these resources to optimise outcomes for the local population, while remaining aligned to the national strategic direction of travel.

Fundamental values and principles that underpin the framework

1. Know your population

Understand need (including invisible need), risk and lived experience.

2. Be needs-led, not diagnosis- led

Get to root causes, avoid medicalising where needs are unmet.

3. Act early

Proactive intervention before escalation through prevention and timely support.

4. Work holistically

Wrap coordinated multi-agency support around children, young people and families.

6. Empower and enable families and CYP

Foster agency, control involvement, choice and the ability to trigger support.

5. Connect, don't silo

Align schools, health, social care, housing and VCSE around shared goals, supported by data/digital tools that connect and provide oversight

7. Build trusted relationships, good communication and knowledge sharing

Between sectors, professionals, families and communities.

8. Treat people with dignity and respect

Listen, tailor support, see care closer to home. Recognise individual's unique identity/culture.

9. Embed equity and access

Reduce variation, shorten waits, make services easy to access and navigate. Recognise how language, culture & socioeconomic factors amplify hidden needs.

10. Focus on maximising life chances

Improve wellbeing, outcomes and long-term potential.

SEL CYP INT FRAMEWORK

1. POPULATION HEALTH MANAGEMENT

A. Data Collation and Intelligence Gathering

B. Two-Way Communication Channels.

C. Building the right infrastructure

2. UNIVERSAL PROVISION

A. Targeted Information

B. Targeted prevention

C. Other ways to connect

Range of CYP services (few examples shown)

- Hospital
- Schools
- SEND
- Early yrs and Early help
- Family Hub
- VCSE
- Primary care (incl GP)
- Housing
- CYP community services

3. ACTIVE IDENTIFICATION

A. Use of Data / MECC / Two-Way Channels

B. Simplified Access

C. Outreach Identification

D. Framework of action

POINT(S) OF ACCESS

Triage / signposting

4. MULTIAGENCY COORDINATION AND WORKING

Specialist Input

Coordination of all Care

Multi-agency working

Cultural change

Local child health teams

Flexible teams wrap around CYP/family

CYP INTEGRATED NEIGHBOURHOOD TEAM(S)

- GP
- Social care
- Specialist
- SEND
- Education
- Housing
- VCFSE
- Mental health
- Social prescriber
- Care Coordinator

Family hubs and Children centres

5. DIRECT CARE DELIVERY

6. MANAGING ESCALATIONS / UNEXPECTED NEEDS

MH urgent care support

A. Recognising the need for escalation

B. Escalation process

C. Escalation response

Interface wirh acute

UEC pathway
(SDEC, CYP-Hospital at Home)

7. LONGITUDINAL CARE AND TRANSITION

D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

The CYP Neighbourhood framework – key functions/delivery components

1. Population Health Management (data, intelligence and action)

2. Universal health and care provision

3. Active identification and family-centred early intervention

4. Multiagency coordination and working

5. Direct care delivery (clinical, psychological, social, environmental, lifestyle support)

6. Managing escalations, urgent or unexpected needs

7. Longitudinal care and transition (18+)

8. "Flourish", ongoing support and optimising potential

9. Waiting 'well' or 'unwell' (needs led rather than diagnosis)

10. Engaging VCSE as trusted delivery partners

Supported by QI (feedback, learning) and cultural change

Function 1

Population Health Management (data, intelligence and action)

Systematically using data and intel, and moving beyond surveillance to actionable insight, informing how we shape delivery (e.g., trigger outreach, shape workforce priorities and target resources to families most at risk).

A. Data collection and intelligence gathering
B. Two-way communication channels
C. Building the right infrastructure
D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

1. Population Health Management (data, intelligence and action)

A. Data Collation and Intelligence Gathering

- Real-time understanding of local children and families (who do and do not access services) by combining linked datasets, public health analysis, school and Family Hub intelligence, VCSE insights, and MDT discussions.
- Not just data collection, it becomes an active learning and decision-making infrastructure for 'finding families'
- In future, finding a mechanism by which all partners across SEL can adopt a unique identifier for CYP.
- Obtaining intel at multiple levels including:
    - Individual patient level: a cross- service view of needs.
    - Neighbourhood: Utilising community driven data intelligence, PHM solutions and EMIS/Ardens searches at neighbourhood level
    - System population health: working across boundaries to provide population view of data.

B. Two-Way Communication Channels

- Build structured channels where partners such as schools can flag emerging risks and promote prevention. Linking services across health, Local authority, VCSE, public health etc.
- Create feedback loops with families, youth workers, digital platforms and frontline services.
- Insight continuously flows into local decision-making and action.
- Linking in community connectors to the right services e.g. health services or family hubs.

C. Building the right infrastructure

- Integrating datasets between heath and care providers to obtain full view of CYP population
- Real-time risk dashboard featuring built-in stratification and algorithms (incl. ability to detect 'hidden' CYP).
- AI-driven algorithm designed to send notifications to the appropriate team or initiate actions and workflows.

1. Population Health Management (data, intelligence and action)

D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

Devolve power to neighbourhoods to act

- Community led intelligence gathering
- Look at intersecting needs and wider determinants to find hidden CYP and families
- Understand what happened in early life that leads to complexity

Turn intelligence into coordinated action to improve outcomes'

Identify quick wins and act

Community led information gathering

- Bringing together people with 'lived experience'.
- Utilising and empowering existing community groups and assets, enabling them to drive change.
- This may in time evolve into a decision-making steering forum.

Enablers

- Information governance: Strategic review of information governance limitations and solutions.
- IG input into the process to improve data sharing across health systems.
- Building trust to share records across health and social care.
- Having strategic offer of support at SEL/ Place to provide activity data and solutions for support with a coordinated approach.
- Strategic commissioning playing a role in the integration of datasets.
- 'Real data' sits with LA and VCSE, therefore need to create a link.

Example

West End Morecambe Big Local

Population Health Management (data, intelligence and action) - Example

- West End Morecambe – Big Local (WEM) is **resident-led community partnership**, working to help improve the local area by tackling the issues the community face, including mental health and poverty.
- Their work is shaped through **local knowledge** and brings about change to **improve the health outcomes** in the community.
- They have created a **youth advisory group**, comprising of 45 members, all aged between 12-18. This group is supported to administer mental health funding for services and engages in **community decision-making**.
- **Partnership of local organisations** has been established, with **projects driven by residents** themselves, and delivered within the local community centre.
- Through tracking health metrics and seeking regular community feedback, Wet End Morecambe Big Local has been able to evidence building social capital and improving health outcomes in the local community, as well as alleviating the impacts of poverty.

https://www.nhsconfed.org/case-studies/west-end-morecambe-big-local
https://westendmorecambe.co.uk/projects-and-work/

Function 2

Universal health and care provision

Universal health and care provision is the foundation of the neighbourhood model, ensuring every child, young person and family has access to the core entitlements that keep them healthy, supported and connected to community life. Provision of information/knowledge is key.

A. Targeted information that reaches resonates and enables action
B. Targeted prevention
C. Other ways to connect
D. Universal service offer

2. Universal health and care provision

A. Targeted information that reaches, resonates, and enables action

Information delivered in culturally sensitive ways
Using language, channels and framing that reflect family identity, youth culture and community values.

Community connectors as trusted messengers
VCSE workers, school staff, midwives, health visitors, Family Hub teams and youth practitioners sharing tailored messages (e.g., oral health, infant feeding, nutrition, emotional wellbeing).

Information that goes beyond 'health topics'
Recognising that issues like housing, finance, isolation or safety often sit behind health needs, so signposting families to the help that truly matters. Providing clear and 'simplified' communication.

Targeted content for specific groups
e.g., teen health, post-birth, families with SEND, migrants and those with language barriers. Working with informal leaders within the community (champions) to drive information e.g., religious leaders.

B. Targeted prevention

Increase visibility and uptake
Understand where preventative services are under-used and target those groups through trusted channels to improve awareness, engagement and reach including GP practice triggered messages.

Proactively identify and work with Core20 and other vulnerable groups
CYP across SEL show concerning levels of mental health needs, obesity, and developmental challenges, with stark inequalities between deprivation quartiles e.g. higher obesity, high ER admission, digital exclusion and cultural diversity. Early experiences of inequality creating lifelong health disadvantages

Target specific needs through schools and community settings
Work with schools to create mechanisms that promote mental wellbeing, provide early support, and enable timely intervention, applying similar approaches for obesity, oral health and other priority areas.

Continued enabling proactive support within the community
To avoid future exacerbation and escalation through an environment of support, regular review and connection back to community groups.

2. Universal health and care provision, cont'd

C. Other ways to connect

Hyper-local social media campaign
A hyper-local social media campaign delivers tailored messages to specific neighbourhood audiences.

Search-driven signposting to local support
Using SEO (search engine optimisation) and SEM (search engine marketing) ensures local families searching online are proactively directed to local community support and services.

Peer networks (allyship)
Creating local peer groups whether for SEND, healthy weight, diabetes or other needs, brings parents together to share lived experience, offer mutual support and build confidence, creating a trusted community resource that complements professional services.

D. Universal service offer

Utilising overarching universal preventative services

- Recognising and advocating the use of existing universal offers that are available to residents, including free school meals, dental services, GP, pharmacies, family hubs, immunisation, etc.
- Building upon the existing universal preventative services, offer and assets.
- Easy and accessible information about local offers (LA websites) and to the Healthier Together website for SEL https://www.healthiertogether.nhs.uk
- Reviewing thresholds for entry to services to enable earlier support

Enablers

- Working across SEL in an agile way, to provide universal health and care interventions at the earliest opportunity e.g., working with minoritised communities to increase uptake of immunisations and/or vaccines.
- Co-production in neighbourhoods with CYP, families and professionals to enable delivery of health services and connection with communities in the right way.
- Building trust by utilising community assets to drive information.
- Understanding the current resources available at Place
- Understanding how hyper-local offers work alongside universal offers to deliver value for money and ensuring there is no overlap or duplication leading to inefficiencies.

Example

Hi Anxiety (Digital Youth Campaign)

Targeted Information that reaches, resonates and enables action

Universal health and care provision - Example

- Launched in 2019 on Instagram and YouTube to help young people manage everyday anxiety.
- Built an audience of more than 200,000 users through relatable, youth-centred content rather than clinical messaging.
- Used pastel visuals and authentic storytelling from influencers to normalise conversations about anxiety.
- Analysed engagement trends to ensure messages reached the right audiences on the platforms they already used.
- Trained community managers responded to comments using a **validate → inquire → refer** model, directing users to helplines, therapy and support resources.
- Evaluation showed the campaign not only raised awareness but triggered **real help-seeking behaviour**.
- Demonstrates how **targeted, co-designed communication can reach, resonate, and activate support pathways,** offering a transferable model for neighbourhood-level messaging and early intervention.

Function 3

Active identification and family-centred early intervention

Adopting a single, proactive approach to identifying emerging issues at the earliest possible opportunity, using early indicators and intelligence to inform timely intervention. Access to services should be clear for CYP and their families, ensuring they are connected to the right practitioner at the right time.

A. Use of Data / Make Every Contact Count / Two-Way Channels
B. Simplified Access
C. Outreach Identification
D. Neighbourhood based framework of action for those identified

3. Active identification and family-centred early intervention

A. Use of Data / Make Every Contact Count / Two-Way Channels

Population level predictive insight

- Use linked datasets, school intelligence, safeguarding trends and attendance patterns. "The right data, at the right time, with the right people". Adopt one shared approach across partners.
- Identify rising-risk cohorts early (hidden CYP and families, non-attenders, high A&E users). Consider utilising additional data sources, such as housing to identify those at rising risk (e.g., children in temporary accommodation). Increase LA involvement in approach.

Learning from early signals: risk detection and proactive case finding

- Track missed appointments, persistent absence from school, housing stress, family breakdown. Treat these as escalation indicators

Opportunistic identification in everyday settings and establishing two-way channels of communication

- Create channels for practitioners (e.g., school nursing) and community connectors to flag concerns directly to neighbourhood teams or via family hubs (exact operating model to be defined locally)
- Intervening and providing information at the earliest opportunity, including across maternity services. Sports clubs and youth centres also play a vital role in opportunitstic identification.
- Conducting home visits to identify health issues, social isolation and needs for other services e.g., housing, benefits (Brazil health model).

SOS/"If You See It, Act On It"

- Equip neighbourhood teams to recognise early signs of risk
- Enable brief intervention, signposting and onward referral through trusted community or professional routes.

3. Active identification and family-centred early intervention

B. Simplified Access

Families know where to go, get held wherever they show up, and reach the right support without friction or delay

Point(s) of access for people

- Bolstering existing routes of entry (in-person and virtual) such as family hubs, well centres. Each Neighbourhood to define whether they bolster their current access points or to create new ones.

Single front door for concerns and referrals

- A clear, visible access point (digital, phone or in-person) where practitioners, schools, VCSE partners or families can raise concerns about rising risk, request support or refer children with more complex needs, without navigating multiple pathways.

No wrong door experience

- Wherever a child or family enters the system (school, GP, Family Hub, youth club, VCSE organisation), they are held, not redirected – and seamlessly guided to the neighbourhood INT without repetition or delay.

Right practitioner, right time

- Triage ensures families reach the most appropriate practitioner early, whether that is a family support worker, mental health, early help worker or GP.

3. Active identification and family-centred early intervention

C. Outreach Identification

Learning from LEAP, where relationships were prioritised, trusted community partners to identify hidden families not in statutory systems - young carers, unregistered migrants or rising risk.
Proactive outreach to complement this by targeting families who do not attend universal offers through doorstep conversations and parent champions.
Neo-natal outreach to identify and address issues

D. Neighbourhood based framework of action for those identified

Information

Multiagency Early Help Huddles and Triage

Weekly or fortnightly neighbourhood huddles (schools + health + social care + VCSE + Family Hub) provide fast, joined-up review of emerging need, with shared planning, rapid decision-making and accountability for follow-through, focused on early risk, not only threshold cases.

Signpost

Enablers

- Information governance and data sharing drives active identification and early intervention, as well as building trust and relationships between services including schools.
- Use of national mandated integrated reviews (progress check at age 2) to identify any issues early.

Example

Community Services: Well Centre - Lambeth

Active identification and family-centred early intervention - Example

- Young person's health and wellbeing hub (11-20 years old), bringing **services together in one place**, enabling easy **simplified access to care**, allowing discussion of health concerns in a safe and confidential space.
- The Well Centre **comprises of multiple professionals** including mental health nurses, GPs, youth workers, occupational therapists, psychiatrists, voluntary sector staff, psychologists, social workers and peer supporters.
- **Open access referrals** come from various sources, including **schools, self-referral**, GPs, social services etc.
- Flexible service delivery helps to support young people with their health and wellbeing, by **providing advice** as well as **signposting** to more specialist organisations, if required. This service offers an opportunity to present confidentially and have their needs assessed.
- A **holistic assessment** and **tailored plan** are developed, additionally allowing for opportunistic questions, hence **uncovering broader issues.** Services include **health education**, interventions around **substance misuse, diet, mental or sexual health** (may need appropriate onward referral).
- **82%** attending the centre have shown improvement in their WHO-5 Wellbeing Index scores.

https://www.thewellcentre.org/
Picture taken from Well Centre org website

Function 4

Multi-agency coordination and working

Effective CYP neighbourhoods will be built on relational, values-based collaboration, not transactional referral routes. The focus is on a shared vision, accountability and language across agencies so that practitioners understand each other's roles, trust one another, and work as one 'communicative' system around the child and family.

A. Access and Referral Into the Neighbourhood
B. Triage and signposting
C. Multi-agency working
D. Coordination of all care and named worker
E. Specialist Input
F. Professional knowledge sharing with wider community and cultural change
G. Establishing enabling factors

4. Multi-agency coordination and working

A. Access and Referral into the Neighbourhood

- One simplified access route ensures CYP and families are not bounced between services.
- Population health insight helps proactively identify those needing support.
- Schools, VCSE, Family Hubs and community actors can flag concerns directly into the neighbourhood.
- Each neighbourhood defines its priority cohort (e.g., rising risk, complex needs, SEND, safeguarding vulnerability) based on local data and context.

C. B. Triage and signposting

- A small neighbourhood coordination team receives referrals, triages cases, and allocates support.
- CYP not requiring multi-agency input are matched to a named worker (e.g., family support worker, youth practitioner, SEND navigator) for brief intervention, guidance or community-based help.
- Cases needing multi-agency input are placed into a shared caseload for discussion within the MDT.
- The aim is right help, first time – signposting, coaching, or escalation without delay.

C. Multi-agency working

- Focus on holistic understanding of need (biopsychosocial), not service-led problem definition. Look at the family as a whole
- Earlier intervention and smoother pathways, reducing “referral bounce” and fragmentation.
- Monthly or fortnightly virtual MDT huddles review cases, triage concerns and agree coordinated action.
- Core membership typically includes GPs, paediatricians, CYPMH/MHST practitioners, Family Hub staff, SEND leads, school nurses and VCSE partners, with members flexed to need.
- CYP/family have one assessment and don't have to tell their story twice.

4. Multi-agency coordination and working

D. Coordination of all Care and named worker

- Each professional is responsible for building relationships and communication needed for coordinating care.
- When required, CYP have a named coordinator, consistent with neighbourhood MDT practice.
- Improves family- and CYP-centredness, continuity, reduces system strain and builds family voice and agency.
- Improving information sharing between teams avoids the family having to 'tell the story multiple times'.
- Having 'connectors' such as family navigators working at all levels is vital.

E. Specialist Input

- Timely access to child health hubs, SEND services, general paediatrics, CYPMH teams, speech and language and nutrition specialists, neurodevelopmental pathways and transition services when required.
- Early access avoids escalation and excessive waits.
- Specialist in-reach to enable care closer to home in familiar setting e.g., paediatrician or specialist nurse clinic in GP surgery – preventing hospital or A&E attendance

F. Professional knowledge sharing with wider community

- Learning loops, shared supervision, networked improvement approaches and reflective practice sessions ensure continual skill growth, aligned with LEAP's finding that holistic practice flourished when infrastructure supported learning.

4. Multi-agency coordination and working

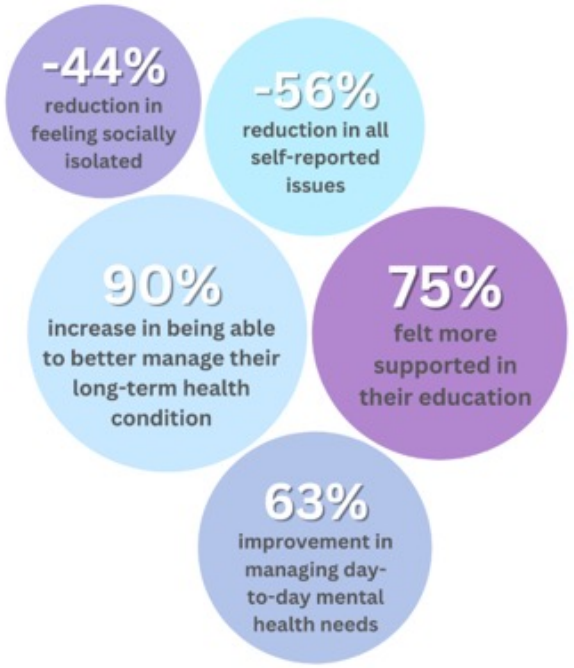
G. Establishing Enabling factors

- Multi-agency case conferencing enables joint analysis, shared solutions and relational accountability.
- Co-location/virtual co-location, integrated working days, job shadowing and informal contact strengthen trust and speed decisions.
- Improving access overall by having services accessible after school hours.
- Requires relational, values-based leadership – modelling behaviours, resolving friction and maintaining shared purpose.
- Building robust relationships with a shared passion, purpose and outcomes, with equity of input and shared buy in.
- Focus on workforce supervision, training, carer pathways and building new skills is imperative to success, enabling staff to feel valued and supported. Training should include understanding each other's roles as well as delivering feedback to improve ways of working.
- Sharing of assets within the neighbourhood, eliminating siloed working.
- Bringing programmes together to drive efficiency (family hubs, family first programme, youth strategy and local child health teams).
- Sharing data/knowledge between teams by use of shared systems and data, with shared governance.

Example

Connected Care Network (CCN), Birmingham

Multiagency coordination and working - Example



- CCN was established in North Solihull, Birmingham and delivers **integrated, digitally enabled care** across health, education, social care and the VCSE sector, aiming to **deliver holistic, integrated care** within the community, **harnessing local relationships**.
- The service operates by an **open referral** system for professionals via the **Joy App** (primary care, schools, youth justice, VCSEs etc.). There are **weekly multi-disciplinary meetings** with the health and well-being coordinators, GP clinical lead, operational lead and VCSE organisation representatives, thus providing a holistic lens. Outcome plans are shared via the Joy App. All recommended referrals are completed by this MDT.
- **25% fewer referrals** into community CYPMHS, **40% fewer referrals** to autism assessment services, **27% fewer referrals** to community paediatrics.
- Estimated costs (in April 2024) include **569 GP appointments saved** (saving approx. **£17,000**), 5,124 hours of support provided outside clinical and therapeutic support (saving over **£400,000**).

https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

Function 5

Direct Care

Delivering coordinated multi-agency care that brings together experts to provide holistic and integrated support to improve outcomes for CYP. Providing better access by bringing CYP services into the community and enhancing the core offer and support by expert peer led groups and practice champions for example.

A. Joint clinics
B. Access routes
C. Group consultation and group coaching
D. Outreach clinics
E. Practice champions
F. Expert peer led groups
G. Direct care environment
H. Key worker for complex cases

5. Direct care

A. Joint clinics

- Neighbourhood MDT brings together a needs based multi-agency team (GPs, paediatricians, mental health, schools, social care, youth worker, sleep practitioner) for holistic, joined-up care in community settings, especially for complex needs like obesity, EBSA or mental health issues. Clinics reduce hospital waits, providing personalised care.
- Making efficient use of professionals' time by having the right professionals within the 'team of teams'.
- Utilising a 'core team' of experts with access to a wider range of professionals within the neighbourhood MDT, that are tailored to the CYP needs.
- Having 'themed weeks' where the MDT brings Mental health cases, or ASD for example, thereby ensuring the right professionals are present and are making efficient use of their time.

B. Access routes

- Current access routes and thresholds need to be reviewed to enable earlier needs-based care for certain CYP populations. E.g. referral for ASD assessments could also go via schools as opposed to community paediatrics.
- Points of access: utilising care coordinator roles to flag any rising risk and identify review from appropriate teams/ professionals within the multi-agency team.

C. Group consultation and group coaching

- Group consultations/ coaching for a small group of CYP with similar needs to share experiences, learn about self-management, and consult with facilitators, ideally *'who are like me'*. Typical 90 min face to face session, fostering peer support, connection and motivation.

D. Outreach clinics

- Bringing CYP services out into the community, offering support for mental health, physical health and specific CYP groups often at local community spots, preventing hospital stays and supporting independence.

5. Direct care

E. Practice champions

- Internal staff members or volunteers (including adolescents) working in practices championing mental health and wellbeing, connecting services, promoting holistic care, and driving improvements in mental health often focusing on early intervention/health promotion.

F. Expert peer led groups

- Supportive communities with shared experiences (mental health challenges, addiction, or chronic illness) guide each other, leveraging lived wisdom for empowerment, skill-building, and recovery, offering hope, belonging, and practical strategies. These groups provide safe spaces for sharing, reduce stigma, and foster resilience sometimes including trained experts who enhance discussions.

G. Direct care environment

- Waiting rooms that are comfortable, child friendly, with CYP artwork and activities, motivational quotes, soft furnishings, colour and space for the wider family to attend. Avoiding mixed ages and conditions waiting in the same space, which can be unsettling.

H. Key worker for complex cases

- A consistent point of contact responsible for coordinating support across e.g., health, education, social care, youth justice. A bridge between CYP/family and often-complex systems of support, ensuring a personalised and joined-up approach.

Enablers

- Providing information and tools to CYP and their families regarding direct care and the professionals involved.
- Combining functions between professionals with similar roles/ building on current roles to support families more efficiently.

Example

Sparkbrook Children's Zone (SCZ), Birmingham – an integrated Early Help Model

Direct care - Example

- Partnership project between Birmingham Children's Hospital, a local Early Help team and a PCN.
- The pilot offers **co-location** of Early Help support services, mental health service, **improved accessibility** with an out of hours clinic from 5pm-8pm.
- The workforce comprises of specialists including a **paediatric consultant** lead, **GP lead**, **paediatric nurse**, an **Early Help lead** and other professionals from the Early Help team.
    - Identification via EMIS and self-referral via GP. This model enables all cases referred to be **offered direct facing care**.
    - A **well child check**, **oral and health screening**, **immunisation check** and **feeding and toileting concerns** are all addressed, with an extended clinical assessment being carried out by the paediatrition or GP.
    - **A third** of CYP, family and carers are identified to have needs that could benefit from support from the Early Help service (MH, housing, neurodiversity and behaviour or sleep issues).
- Outcomes include:
    - **94% do not require onward escalation to social services support**, hence highlighting how effective this intervention is.
    - Access to a clinic with **paediatric input in 1 week,** a significantly reduced wait compared to 7 months in Birmingham Children's hospital.

https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

Function 6

Managing escalations

INTs need straightforward, aligned and timely approaches to triggering and managing escalation, agreed and understood between multi-agency partners, to prevent issues from becoming critical events. This applies where there are concerns about individual CYP and families (such as deterioration, risk of exacerbation or behaviour such as frequent A&E attendance) and/or about gaps or problems with care delivery itself.

A. Recognising the need for escalation
B. Escalation process
C. Escalation response

6. Managing escalations

A. Recognising the need for escalation

Practical tools for recognising and reporting escalation

Use of Early Warning Scores (EWS), Peadiatric Early Warning System (PEWS), Situation, Background, Assessment, Recommendation (SBAR). Awareness of these early warning tools across the system is required. Dynamic support register for people with a learning disability or Autism who are at risk of admission to hospital.

Clear timely protocols for escalation and data sharing

To be available within and between services (e.g., escalating from primary care to specialist paediatrics team or from health to social care and vice versa). Data sharing between services to ensure consistent messaging to families.

Supporting families and access to information

Direct contact to support families earlier and prevent referrals e.g., consultant connect, Local Child Health Teams. Ease of access to information 24/7 for CYP and their families (who can they contact if in need?).

Health inequalities

Particular focus on health inequalities to be considered which may be achieved through stronger links with schools.

B. Escalation process

Rapid mobalisation of multi-agency team

Ability to quickly mobilise multi-agency team assessment of an escalation where needed, with access to the CYP/family history to support 360-degree decision-making.

Patient centred care and involvement

Involvement of the CYP/family in decision-making and creating management plans with the family and their needs in mind. Ability of the CYP/family to trigger an escalation or MDT meeting.

Local knowledge of teams/ services available to respond in crisis

Up to date knowledge of the teams able to respond to an escalation (e.g., knowledge of safe house, crisis café, SDEC, outreach team) and how to reach them (sharing knowledge about resources and local offers).

6. Managing escalations

C. Escalation response

Timely response to crisis

Timely response e.g., GP needs to speak to acute specialist or community nurse, social worker/VCSE worker need to escalate to a rapid response team – immediate or 2-hour response for urgent issues. Care coordinator to support with this.

Skilled workforce responding to escalation

Skilled and confident staff who can make appropriate and proportionate decisions in response to an escalation and set effective actions in motion.

Interface with secondary care environment

Involvement with bed management is required, to ensure CYP are in the 'correct' spaces within the hospital setting.

Use of technology to enhance support

Use of technology, such as video-conferencing as an alternative to presenting at A&E or need for a CYP to travel to a health setting, especially on public transport when displaying disturbed behaviour.

Enablers

- A culture of open communication, trust and responsiveness is fundamental to managing escalations.
- Ability for individuals and teams to speak up and act on instinct where they are concerned, and to be trusted and taken seriously, without fear of reprisal.
- Mechanism of monitoring and feedback on escalations to ensure continuous improvement.

Example

The Cheshire and Merseyside Tier 4 CAMHS gateway model

Managing escalations - Example

- This is a **clinician-led, multi-agency approach** to respond to the needs of children and young people at risk of admission to tier 4 CAMHS or receiving inpatient mental health care.
- An **SBAR tool** was developed for professionals which provided consistent, evidence-based approach to safeguarding concerns, actions, legal frameworks, contingency planning and timescales.
- **Gateway meetings** took place to discuss SBARs and meet needs of young people with moderate to severe mental health difficulties or those at risk of self-harm and suicide.
- The results show that since Feb 2022, 8 of 9 Local Authority places established Gateway meetings. During this period, 67 Gateway meetings reviewed **138 SBARs with multi-agency discussion.** This **reduced the need for escalation beyond professionals at Place** as the unmet needs are discussed and addressed within the Gateway meetings. This **suggests fewer avoidable admissions**, and this correlation is currently being explored.

https://pmc.ncbi.nlm.nih.gov/articles/PMC10345543/

Function 7, 8 & 9

7. Longitudinal care and transition

Providing coordinated, non-fragmented care over time for individuals with complex needs, ensuring continuity of support and promoting wellness goals, focusing on what matters to the CYP and their families.

8. 'Flourish;' ongoing support and optimising potential

Having a clear understanding of CYP's goals, values and ambitions and embedding these within the care planning and delivery. CYP and their families will be actively supported to take a leading role in their own care, enabling informed decision making, with a strong focus on activities and factors that promote their wellbeing.

9. Waiting well or unwell

CYP may experience extended waiting periods for assessment, diagnosis or intervention, often leaving them at risk of deterioration or escalation. Provision should be made for interim support, helping to prevent or address issues that may arise. This may include specific, tailored short-term interventions and/or navigation to wider support offers making use of community assets that can help promote wellbeing.

6. Longitudinal care & transition (18+)

Longitudinal care

Unbroken coordinated care over time (instead of stop/start episodic or fragmented care) for specific chronic/complex cases to ensure continuity that helps optimise independence, prevent exacerbation/escalation.

- INT produce longitudinal integrated care plan that includes Multi Agency Working arrangements for health, social care and VCSE including response to exacerbation/crisis prevention.
- 'Living plan' is regularly updated. Professionals emphasise wellness goals, relationship building and what and who matters to the CYP and family.
- Empowering parents/ family and keeping them involved, with carers able to access care record (where appropriate and required) to ensure their needs are being reflected.
- Optimising independence by empowering CYP to have their own voice, understand their rights on data sharing, confidentiality and autonomy.

Transition (18+)

Ensuring transition is seamless, well managed and proactively supported with hand-holding and advice so that the CYP/family are not left struggling to confront challenges and join all the dots, including practical help navigating e.g., bureaucracy. Consider a 'passport' for transition.

8. 'Flourish', ongoing support and optimising potential

Longitudinal care

A key function of the CYP INT in addition to addressing immediate care and support needs is to help optimise a CYP's life chances and potential. This is supported by an approach to care that includes:

- Understanding individuals' strengths, goals, values and ambitions and reflecting these in personalised care planning, care interactions and delivery.
- Supporting CYP/families to be in the driving seat of their own care, making their own choices and decisions.
- Encouraging and supporting CYP to take opportunities to build skills e.g., through education and learning opportunities and contributing to the community.
- Connecting CYP to activities that inspire them e.g. creative health, sports and activities offered by youth services.
- Providing emotional support, to enable better management of stress and self-doubt and to build hope.
- Ensuring continuity of relationships that help build trust in professionals and services
- Building in the ability of CYP/families to self-refer to access timely support.

9. Waiting well or unwell

Support while waiting

For CYP facing a long wait for assessment, diagnosis or appointment:

- Provide targeted, timely, open support to prevent exacerbation/escalation, alleviating symptoms by addressing root causes.
- Example issues that lead to 'waits' include MH/anxiety, neurodiversity, school non-attendance, EBSA, difficult behaviours, substance use, isolation, bullying, school problems, sleep problems.

Example interventions/offers include:

- Easier ability for those waiting to talk to professionals (e.g., access to a GP in schools).
- Regular screening while on the ASD waiting list to identify any early support needs.
- Setting clearer expectations with the family about wait times, and what to expect e.g., being on the wait list for an ASD assessment may NOT mean an ASD diagnosis.
- Pre-diagnostic workshops (e.g., peer support network for families awaiting an assessment – Bexley model).
- Short course of CBT e.g., to address increasing anxiety or school problems
- Access to social prescribing and navigation to faith groups, youth and sports groups and VCSE offers (e.g., creative health).
- Access to advice and care e.g., nutrition and sleep, SALT, occupational therapy, MH advice.
- Reduced thresholds for more timely access to CAMHS support for key issues.
- Ability in A&E to directly refer to a waiting well/unwell pathway to avoid long A&E waits.
- Specific role to get ASC/ADHD waiting lists down e.g., Lewisham Band 7 model.
- Educating parents about early warning signs and triggers and how to access the waiting well/unwell offer.
- Ability of professionals to be able to talk to each other about a CYP who does not yet have a diagnosis.

Example

Children and young people's social prescribing service- Stort Valley and Villages PCN

Waiting well or unwell - Example

- Due to CAMHS and other tier 2 services being overwhelmed, Stort Valley and Villages PCN developed the **children and young people's social prescribing service (CYPSPS)** to support people within primary care. This model focuses on being **patient-centred** and provides a non-medicalised approach.
- The **CYPSP has built connections to local services** from MIND, schools, art groups and support for young carers.
- An OT within the MDT, **supports people with traits associated with autism and ADHD**. This isn't a diagnostic service, but is offered to those **who are currently waiting for a diagnosis and require support** with traits such as sensory overload, or trouble concentrating, hence enabling them to best manage while waiting to be seen.
- There is **support available for parents** where possible including a mental health coach to educate them on supporting their children and addressing any behaviour that may be aggravating their condition.
- Results:
  - **Less than 5% of referrals** are being sent through to CAMHS, hence **reducing the strain** on the wider system
  - **Schools have reported improvements** in student's anxiety and performance.
  - **GP workload has reduced**, due to a reduction in repeat presentations for MH.
  - CYP have reported **feeling supported** and **less isolated.**

https://www.nhsconfed.org/case-studies/children-and-young-peoples-social-prescribing-service

Function 10

Engaging VCSE as trusted delivery partners

It's known (and plentiful evidence proves) that the VCSE offer is highly effective for CYP - helping for example, to address the growing prevalence of mental health and neurodiverse challenges that young people face.

A. Embedding VCSE partners as core to INT delivery

10. Engaging VCSE as trusted delivery partners

A. Embedding VCSE partners as core to INT delivery

Change the way we commission:

- Bring all partners together to understand what is out there, agree priorities and best way to leverage these
- Pump prime investment into VCSE to establish a baseline model of support
- Establish longer (2-3 year) and consistent funding cycles, that enable players to build assets and services and more smaller players to take part. Avoid piecemeal, stop/start commissioning
- Leverage economies of scale e.g., through cross-borough VCSE delivery models and arrangements.
- Articulate clear benefits of the offer to change thinking and culture (e.g., in addressing lower intensity needs to prevent escalation)

Develop information on the richness of the offer:

- Create and maintain a directory of VCSE services and give all settings and key roles access to the directory and understanding of how to use it.

Establish clear entry points and access:

- Develop a digital front door for VCSE services
- Train INT staff in the offer, how to utilise it and how to access it (especially link workers and social prescriber roles)

Create the right infrastructure for sustainability and scaling of the offer:

- Bring players together to form a local collaborative that meet regularly, with a shared vision, objectives, agenda and priorities
- Join up VCSE data with health and LA data to create a richer picture (DPIA)
- Define shared, meaningful outcomes and KPIs
- Agree a single continuous improvement / QI approach
- Consider governance e.g., how to manage safeguarding/clinical supervision
- Coordinate VCSE offers to prevent duplication/overlap
- Support professional development of VCSE players e.g., provide OD support, include teams in joint training, use of shadowing, etc.

Example

SPACE Hertfordshire: supporting families of CYP with neurodiverse conditions

Example: Engaging VCSE as trusted delivery partners

Award winning charity supporting families of children and young people who are neurodivergent. An example of how they support families is shown below, detailing the story of a 13-year-old child who was waiting for autism/ADHD diagnosis for over 27months:

Actions taken by SPACE family support

- Regular telephone and email support tailored to family's needs.
- Development of action plan addressing key challenges.
- Information for parents regarding strategies for understanding and managing their child's behaviours including de-escalating techniques.
- Referrals made to CAMHS, PALMS, Children's Services (IFST) and ARC interventions for specialised support.
- Participation in multi-agency meetings to develop a plan for MH support and liaised with various health and service professionals to expedite their needs.

Outcomes following SPACE family support

- An Education, Health, and Care Plan (EHCP) is now in process.
- Family feels more confident and empowered to manage difficult situations.
- The family has had successful experiences that help them prepare for future challenges.
- The mother has engaged in workshops and courses to better understand her child's needs.
- Carer's assessment is in progress, and mentoring support has been commissioned to help the CYP access school and community activities.
- The family is now receiving Disability Living Allowance (DLA) and enjoying more positive moments together.
- SPACE continues to support the family alongside the IFST team.

SPACE Hertfordshire's Impact Report (Financial Year 2023/2024), https://spaceherts.org.uk/2025/05/08/2024-annual-report-and-accounts/

The SEL CYP INT Framework is aligned with the national strategic direction (pls refer to appendix for more details)

NHS Multidisciplinary teams for CYP (2025) [1]

- The aim is to deliver a coordinated, timely and integrated offer that is closer to home, enabling access to paediatric and mental health expertise, through teams led by primary care.
- Reduce referrals to secondary care, A&E and waiting times by strengthening early intervention and prevention.
- 5 core components are: case identification, MDT case discussion and triage, direct care, professional knowledge sharing, engagement and health promotion.
- Extended MDT should be locally determined and include education, social care and VCSE partners to provide holistic support.

NHS 10 year Health Plan (2025) [2]

- Prevention by early intervention e.g. Tobacco and Vapes Bill, restricting junk food advertising, ban the sale of high-caffeine energy drinks to under 16-year-olds, expanding free school meals for those eligible.
- The neighbourhood health service: shifting to a model that is equipped to provide continuous, accessible and integrated care. Bringing care into local communities and professionals into patient-centred teams to end fragmentation and silo working. The aim is to, in the future, provide predictive and preventative care that anticipates need, rather than reactive care.
- Digital shift to encompass care for CYP: Managing children's healthcare through "My children" app.
- Expand mental health support teams in schools and colleges, to reach full coverage by 2029/30.
- Working in partnership with the Department for Education to implement a single unique identifier (NHS number) for every child, enabling proactive and joined up care.

DCMS Your national youth strategy (2025) [3]

The Department of Culture, Media and Sport issued a policy paper in Dec 2025 outlining the 10 key changes planned as part of the national youth strategy. Some examples include:

- Strengthening the workforce: joining up and collaborative working. Improving local offers for services, young futures hubs, investment in more youth workers.
- 'Richer lives' with more high-quality activities including sports, art, music and volunteering, with clearer information about access.
- Health and wellbeing: Mental health support teams in schools and colleges and wellbeing advice in young futures hubs.

We align our approach with national and international strategic priorities, embedding and integrating evidence-based best practice within our SEL CYP INT framework.

1. https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/
2. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
3. https://www.gov.uk/government/publications/youth-matters-your-national-youth-strategy

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

- ✓ Early support and timely intervention: The MH team in Zack's school identifies the rising risk at an early stage, informing the school link worker regarding the issues of bullying, non-attendance, isolation and poor performance.
- ✓ Aware that Zack suffers from asthma and is awaiting an assessment for ASD, the school link worker contacts the child's GP who triggers an MDT discussion.
- ✓ Contacts the child's GP who ensures Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy and a personalised asthma action plan is agreed with Zack.

Key functions

- ❖ **Active identification intervention**
- ❖ **Prevention of escalation**

- ✓ The neighbourhood MDT includes the school link worker, GP, paediatrician, practice nurse, CAMHS, housing, support worker and involvement of Zack and his mother. The focus is holistic care and understanding and addressing issues around asthma, poor school performance, isolation, housing and his mother's MH problems.
- ✓ The discussion is centred on building trust and fostering open communication to identify root causes and achieve shared buy-in and co-production of a plan with the child and his mother.
- ✓ Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy.
- ✓ A personalised asthma action plan is agreed with Zack supported by a community support worker appointed to coordinate and provide ongoing, hands-on support to the family. The support worker, able to socially prescribe, also liaises regularly with professionals to ensure progress is maintained and actions remained aligned.

Key functions

- ❖ **Multiagency coordination and working**
- ❖ **Direct care delivery**

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

Key functions

- ❖ **'Flourish', on- going support and optimising potential**
- ❖ **Waiting 'well' or 'unwell'**
- ❖ **Engaging VCSE as trusted delivery partners**
- ❖ **Universal health & care provision**

The holistic MDT co-produced plan includes:

- ✓ Initial MH assessment and access to interim support whilst awaiting ASD assessment e.g. adjustments at school.
- ✓ Signposting to pre-diagnostic workshops e.g. peer support network for families awaiting an assessment.
- ✓ Prompt consultation with practice nurse and follow ups to assess inhaler technique and inhaler adherence.
- ✓ Navigation to local offers including youth/ community clubs to build confidence and reduce social isolation e.g. sports.
- ✓ Strategy agreed with school to address bullying and to support Zack with his performance at school.
- ✓ Investigation by housing into issues leading to eviction and provision of financial/ benefits advice for his mother.
- ✓ Visit by housing to the property to check for possible environmental causes triggering exacerbations of asthma e.g. damp and mould.
- ✓ Consultation with Zack's mother regarding her MH, assessment for talking therapy and agreeing a plan to prevent exacerbation for both herself and Zack. This includes providing information regarding access, navigation to local community support groups and ability to provide respite care if needed.

7. Enablers

A range of enablers have been identified as critical to the delivery of the framework

Workforce: Staff must feel valued and be supported through professional development that enhances skills by appropriate supervision and training, promotes understanding of roles, and provides clearly defined career pathways. Integrating and expanding overlapping professional roles can further improve efficiency and strengthen support for families. 1

Teamwork: Multi-agency case conferencing facilitates joint analysis, shared solutions and accountability. Co-location (including virtual), integrated working days, job shadowing strengthen trust and accelerate decision making. Building this trust and agile working, enables effective asset sharing across neighbourhoods, reducing siloed working. 2

CYP & Families: Co-production is needed to enable delivery of targeted health services and meaningful community engagement. 3

Information governance: A strategic review of information governance limitations and solutions is required, with early IG input to strengthen data sharing across health systems. Effective information governance supports proactive identification, early intervention, and trusted relationships between services, including schools. 4

IT systems and data: A strategic offer of support at SEL/Place to provide activity data to enable a coordinated approach. As relevant data is held across Local Authority and VCSE partners, improved integration and data sharing is necessary. This should be supported by effective data-sharing agreements and a robust governance framework to enable consistent knowledge exchange across teams. 5

A range of enablers have been identified as critical to the delivery of the framework

6 **Culture:** Strong relationships built on shared purpose and passion with equity of input and collective ownership. A culture of open communication, trust and responsiveness enables individuals to raise concerns and act with confidence, without fear of reprisal.

7 **Culturally sensitive adjustments:** Understanding the barriers to access services and adapting to enable engagement with CYP and their families that we struggle to connect with.

8 **Local knowledge:** A clear understanding of existing Place based resources, and how hyper-local offers complement universal provision, is essential to ensure value for money and avoid duplication or inefficiency.

9 **QI:** Continuous quality improvement cycles, with a mechanism of monitoring and feedback.

10 **Left Shift – Resource Reallocation**: Funding and investment must progressively shift from resource-intensive, reactive services into community-based, preventative and early-intervention support. Delivering this left shift requires robust demand and capacity modelling to understand current system use, identify opportunities for reinvestment, and identify any initial double running and establish a robust business case.

The framework informs the commissioning shift needed to enable a needs-based and outcomes-focused approach to care, delivered through more collaborative, coordinated working

Bringing resources together to focus on longer term, meaningful outcomes for CYP is a core ambition of the framework. The commissioning approach should include:

A joint exercise to understand where existing resources and facilities sit and what opportunities exist to better leverage these resources e.g., through streamlining, simplifying and deduplicating – as well as understanding the gaps

Joint commissioning for longer-term holistic, child-centred outcomes (as opposed to transactional events) that foster collaboration and brings teams together around shared goals

Recognising 'what can be done once for SEL to support neighbourhoods – for example, the delivery of PHM tools and approaches and sorting out IG issues. Doing things once can free up resources to address gaps in capacity at neighbourhood level

Pump priming and adopting 2/3 year commissioning cycles for VCSE, that better empower players, rather than piecemeal stop/start projects (that can also tend to preclude smaller organisations)

Use of pooled budgets including strengthening alignment in the use of Better Care Fund resources

Commissioning that encourages innovation in practice, not just refining what we already do, for example, the use of AI

Developing the right tools to achieve effective oversight of CYP services and how they are performing, in order to inform and improve commissioning

Commissioning 'in the gaps' - for example ensuring provision is accessible for those already on a long waiting list (see waiting well/unwell pathway)

8. How will we know if we are making a difference?

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all boroughs in SEL, encompassing a wide range of professionals (e.g. clinical, social, managerial) and care settings (voluntary sector, local authorities).
- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements of neighbourhoods, however this list will evolve and align with the development of other programmes.
- To keep it practical and meaningful, it is important that there is a finite number of indicators that can show the overall impact in line with the aspirations of the Children and Young People Integrated Neighbourhood Team Framework.

The domains and indicators reflect:

- The core functions of INTs
- National NHS expectations for neighbourhood working
- The SEL ambition to reduce inequality, improve experience and intervene earlier

INTs are expected to:

- Be actively involved in agreeing outcomes for children and young people, including locally defined priority cohorts
- Align neighbourhood activity and multi-agency working to those outcomes
- Routinely review evidence of their contribution, using process and outcome measures

- Overall, this framework provides a practical and consistent way for neighbourhoods in SEL to understand whether INT working is making a difference to the health and wellbeing of children and young people and addressing what matters most to them and their families.

Key outcome domains

1. Active/early identification and prevention

Children and young people with emerging needs are identified early and supported through targeted preventative interventions, reducing escalation to crisis.

2. Improved access that is based on need

Children, young people and families can access timely, support based on need, reducing escalation to crisis or specialist intervention and improving equitable access for those least likely to self-present, including Core20 groups.

3. Voice of CYP and family

Making every contact count, avoiding repetition and having to tell their story several times. They feel heard in decisions, trust services and experience care as supportive and joined up.

4. Children and families are empowered (able to flourish)

Children, young people and families trust services, can easily access and navigate to the right support, and experience coordinated care as required.

5. Improved health and well-being outcomes

Children and young people are healthier overall, with improved physical and mental wellbeing, fewer crises/ escalations, higher uptake of preventative care and earlier identification and support for additional needs.

6. Improved multi-agency working & cultural change

A positive experience and supportive environment to improve staff wellbeing and job satisfaction overall. Improving multi-agency working by local knowledge of services available within SEL to support CYP.

7. System sustainability

Reducing demand from resource intensive areas such as secondary care, shifting focus into the community and neighbourhood.

8. Reduction in inequalities

Reducing health inequalities so children, young people and their families achieve equal outcomes across all population groups.

How we will know if we are making a difference

Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
1	**Active/early identification and prevention**	• Children and young people with rising or unmet needs are identified early through population insight, frontline observation and community intelligence, before escalation to crisis or statutory thresholds. • Preventative activity is focused on priority cohorts and neighbourhoods, improving reach to families least likely to self-present and reducing inequalities.	• Improvement in uptake of key preventative activities supported by the neighbourhood (e.g. immunisations, health reviews, screenings). • Proportion of CYP with emerging SEND / neurodevelopmental needs identified and supported earlier (pre-diagnosis). • Greater identification of children with long-term conditions including asthma. • Uptake of community outreach interventions (including those from specific groups including Core20 ethnicities). • Referral to INT from other services e.g. school nursing/ health visiting
2	**Improved access that is based on need**	• Children, young people and families can access support aligned to their level of need, without unnecessary barriers. • Support is timely, enabling early help and reducing avoidable escalation to crisis or specialist thresholds. • Access is equitable, with improved reach into Core20 groups and families least likely to self-present.	• Proportion of CYP triaged to the right level of support first time (no onward referral required). • Reduction in escalations from universal/early help into crisis pathways. • Proportion of children identified and receiving support within an agreed neighbourhood. • Reduction in number of CYP in MH crisis in A&E waiting 12, 24, 48h for onward placement • Reduction in overall CYP A&E attendances and re-attendances. • Reduction in subsequent GP appointments for children and young people who have been discussed in the MDT.

How we will know if we are making a difference

Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
3	**Voice of CYP and family**	• Making every contact count, avoiding repetition and having to tell their story several times. • Children and families feel heard in decisions that affect them, trust services, and experience care as supportive and joined-up.	• Proportion of CYP and families (on INT caseload) reporting they were listened to and involved in decisions about support using qualitative feedback (survey/case reviews). • *Our services have been co-designed with CYP, hence representing their emerging needs and views.*
4	**CYP and families are connected and empowered (able to flourish)**	• Children, young people and families feel listened to, trust services, can easily access and navigate to the right support, and experience coordinated care as required.	• Increased uptake of VCSE e.g. creative health / sports. • Reduced number of children on child protection plans • Reduced number of children going into care • *Parent/carer satisfaction scores (Not an INT marker).*

How we will know if we are making a difference

Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further

5	**Improved health and well-being outcomes**	• Children are physically healthy, with fewer preventable conditions escalating (e.g. asthma exacerbations, obesity-related harm).
		• Children experience improved emotional and mental wellbeing, with fewer crisis presentations.
		• Increased uptake of universal and preventative offers (immunisations, screenings, reviews).
		• Children with additional needs (SEND, neurodiversity) are identified earlier and supported sooner.
			• Healthy Child Programme (HCP) KPIs including
			  • % of new mothers breastfeeding at 6-8 weeks,
			  • % of children achieving developmental milestones
			  • vaccination uptake (e.g., MMR, HPV),
			  • rates of childhood obesity rates/healthy weight achievement,
			  • school readiness scores at entry
			• Increased rates of school attendance.
			• Reduced rates of mental health crisis and presentations.
			• Reduction in prevalence of select conditions e.g. asthma, tooth decay.

6	**Improved multi-agency working and cultural change**	• A more positive experience and supportive environment for all staff. • Improved staff wellbeing and job satisfaction. • Increased knowledge of services that are available locally to support CYP and their families.	• Staff surveys to demonstrate a positive experience working within the team and provide qualitative feedback regularly. • QI learning events. • Increased staff retention.

How we will know if we are making a difference

Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
7	**System sustainability**	• Are we reducing demand from resource intensive areas such as hospital and shifting focus of care into community and neighbourhoods.	• Reduced overall GP attendances. • Reduction in number of acute mental health presentations in crisis. • Reduction in outpatient referrals for certain specialties, such as general paediatrics. • Reduced rates of A&E attendance and non-elective (NEL) admissions. • Reduction in waiting times for outpatient appointments
8	**Reduction in inequalities**	• Are the outcomes the same in all resident/population groups i.e., gender, ethnicity and deprivation level (IMD).	• Rate of use of Neighbourhood offer by population groups. • Rates of immunisation. • Rates of A&E / non-elective (NEL) attendance and outpatient (OP) by population groups. • Increased uptake of VCSE e.g. creative health / sports.

9. How will we implement the framework?

First principle: the biggest proportion of effort in implementing the CYP INT framework should be on people

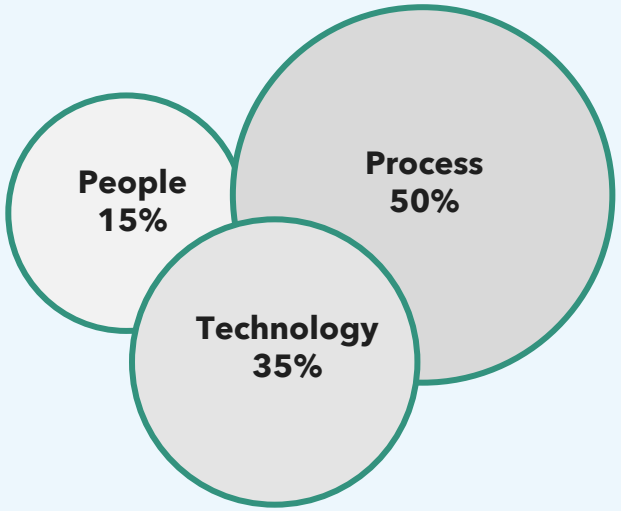
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

- → Creating meaning and purpose
- → Engaging and taking people/partners on the journey
- → Having the right team, skills and knowledge for the job
- → Visible leadership championing the work
- → Tapping into values, feelings and attitudes
- → Creating trust, ownership and accountability
- → Tracking, reporting and promoting success
- → Project methods that drive delivery at scale and pace

Most healthcare transformations under invest in the human dimension

Proportion of effort showing less focus on people led change



Change dominated by process and technology only achieves around a 10% level of adoption [2]

1. *NCBI 2022*
2. *Ian Gotts. Common Approach, Uncommon Results 2007*

Building blocks of implementation

Engagement and mobilisation at Place (building on existing work underway)
Neighbourhoods mobilise existing partnerships, relationships and delivery to engage CYP, families, VCSE, schools and practitioners around shared priorities.

Shared purpose and priority focus
Partners align around a clear shared purpose and agree an initial priority cohort or pathway to focus neighbourhood effort and learning.

Leadership, resources and skills
Strong, values-based leadership supports multi-agency working, role clarity and decision-making at neighbourhood level.

Delivery and change management
Neighbourhoods adopt a phased, test-and-learn approach to implementation, supported by clear delivery ownership and cultural change.

Demand and capacity modelling
D/C modelling to understand current baseline and requirements for new operating model. This informs how existing resources can be reconfigured and where additional capacity or double-running may be required.

System outcomes dashboard
A shared dashboard will bring together a small set of agreed outcomes, indicators and activity measures at neighbourhood and SEL level. Supports transparency, learning and accountability for impact.

Measurement and funding
Measurement focussing on outcomes most directly influenced by neighbourhood working, alongside key process and access measures. Funding and resources to progressively left shift

Working on enablers
Implementation to be supported by system enablers including workforce, data and digital, information governance, culture and quality improvement. SEL-level support to ensure consistency, shared learning and scale.

Implementation roadmap

This roadmap sets out a phased, **test-and-learn** approach to implementation, enabling neighbourhood teams to build confidence, strengthen relationships and embed new ways of working overtime. By the end of year one, a neighbourhood model will be actively tested and in delivery across all Places. While boroughs may take different approaches to reflect local context, the focus is on learning through delivery, consistent practice and a shared culture of neighbourhood working across South East London.

Phase 1: Test 2026/27	Phase 2: Grow 2027/28	Phase 3: Embed 2028/29
• Launch test neighbourhoods in each Place (minimum one per Place). • Define priority cohorts for initial focus, based on local need. • Map existing services, assess demand and capacity, and develop an initial operating model. • Pilot neighbourhood working, MDT arrangements and access routes. • Capture learning to inform refinement.	• Use learning from test sites to refine and standardise the operating model. • Embed multi-agency working, relationships and cultural change. • Expand test sites to widen priority cohorts and bring additional neighbourhoods on board. • Strengthen enablers (workforce, data, governance, funding flows).	• All neighbourhoods come on board across SEL. • Operating model, governance and outcomes framework are fully embedded. • Neighbourhood working becomes business as usual, with continuous improvement in place. • Full delivery at each neighbourhood (March 2029)

Roadmap for implementation: Neighbourhoods should follow a systematic approach while adapting to different starting points and levels of maturity

Phase 1: Test (2026/27)

1. Socialising the framework at Place

- Bring together system stakeholders, including CYP, families and community representatives.
- Map current practice and local assets against the neighbourhood functions (e.g. active identification, MDT working).

2. Understanding your local population and agree priority for test phase

- Neighbourhoods need to start with a bite-size focus. Year 1 is about testing the concept with one cohort or pathway
- Each neighbourhood to look at their local population data, connect with VCSE, communities, professionals and agree the local priority.
- Priority could be a population cohort (e.g. complex, SEND) or a pathway (mental health crisis, rising risks)

3. Defining the Operating Model

- Each Place and neighbourhood defines how the operating model works locally, building on existing assets (e.g. Family Hubs).
- Work systematically through each function to clarify roles, workflows and interfaces, centred on the agreed priority cohort.

4. Demand and capacity modelling

- For the priority cohort define the baseline for demand and capacity. As neighbourhoods do that, identify the biggest crunch points.
- Use the operating model to define total demand and capacity required to support priority cohort.
- Ramp up demand in stages.
- Define/decide: how do to reallocate existing capacity/resources.
- Final demand and capacity model aligned with the framework operating model.

5. Outcomes dashboard

- Agree a small set of clear outcomes and indicators that demonstrate impact.
- Define system-level dashboards and data points at both Place and SEL level.
- Use regular (e.g. monthly) reporting to support real-time learning and adjustment.

6. Phased implementation plan

- Develop a clear, phased implementation plan with defined stages, deliverables and timelines.
- Establish a robust delivery group representing neighbourhood, Place and SEL partners to support coordination and problem-solving.
- Set out clear expectations for SEL-level enablers and support to Places (e.g. data, learning, facilitation).
- Agree a shared communication approach for transparency and engagement across partners.

7. QI - Test and learn

- Embed a Quality Improvement (QI) approach, including named quality champions, regular QI cycles and monthly learning sessions using a PDSA methodology.
- Put in place proportionate governance and oversight, including meaningful involvement of CYP and family voice.
- Create system-wide learn and share events at SEL and most importantly, acknowledge efforts and celebrate success

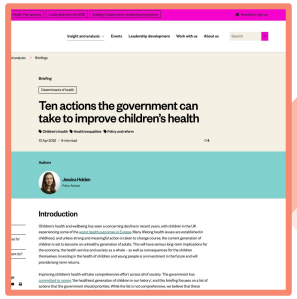
10. Appendices

Appendix I

Good practices and guidance for CYP care

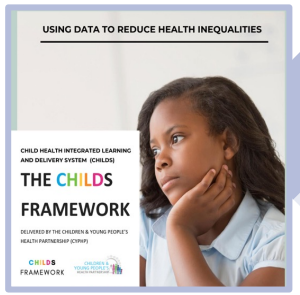
The SEL CYP INT Framework has been developed by embedding learnings from best practice guidance

In recent years, children's health and wellbeing has declined in the UK, leading to some of the worst health outcomes in Europe. Without urgent action, today's children are at risk of becoming an unhealthy adult population, with long term implications for their own health, our economy, our health service and society overall[1]. Leading national and international models, research bodies and policymakers were examined to inform the implementation of evidence-based approaches within the framework, to improve outcomes for children and young people across SEL.



Kings Fund: Ten Actions the government can take to Improve Children's Health (2025) [1]

- Reducing barriers to access e.g., reducing waiting times for children's community and mental health services.
- Addressing health inequalities and allocating a more equitable share of health service funding to children.
- Empowering CYP and families with improved access to information e.g. health and nutrition online information.
- Addressing shortages in workforce incl school nurses, consultant paediatricians & improving staff retention.



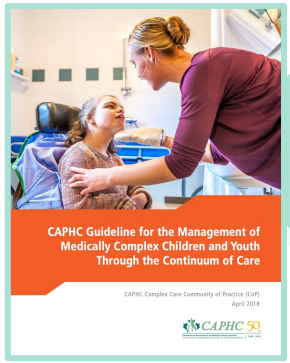
Child Health Integrated Learning and Delivery System (CHILDS) Framework (2025) [2]

- Innovative PHM framework to deliver universal care, targeted risk management & integrated biopsychosocial services.
- Access: LTC care- early intervention and personalised care (use of NHS data and advanced analytics to identify CYP).
- Care planning: biopsychosocial, holistic, person-centred approach, with treatment delivered by a multidisciplinary team.
- Health promotion: support self-management via a health pack – signposting to local resources and helping with housing etc.
- Personalised care: Delivery of care in familiar setting – GP centre, school, youth centre.

Resources:

1. https://www.kingsfund.org.uk/insight-and-analysis/briefings/ten-actions-government-improve-childrens-health
2. https://childsframework.org/childs-framework

The SEL CYP INT Framework has been developed by embedding learnings from best practice guidance



Canadian Association of Paediatric Health Centres (CAPHC) National complex care guideline for management of complex children and youth through the continuum of care (2018) [3]

- Building capacity within the system to deliver holistic, coordinated, family-centred care, that is close to home.
- Key workers to facilitate service planning and care delivery in collaboration with the family.
- Shared care plan, which is accessible with clear ownership.
- Empowering families to develop the skills and confidence to advocate for their child.
- Transition strategy: smooth transitions across settings and life stages.

RCPCH Transforming child health services in England: a blueprint (2024) [4]

- 7 key themes to guide transformational change required nationally:
  1. Fair funding for children.
  2. Prioritise children in ICS.
  3. Support a sustainable workforce.
  4. Improve data and digital innovation.
  5. Reduce pressure on urgent and emergency care.
  6. Reinvest in community health services.
  7. Improve the interface between primary and secondary care.
- This policy report specifically addresses prioritising community services to tackle elective waiting lists and waiting times, developing models of joint working between primary care and paediatric teams, supporting children in all settings (education, LA).

Resources:

3. https://www.childrenshealthcarecanada.ca/media/yzanrkxm/caphc-national-complex-care-guideline-2018_final.pdf
4. https://www.rcpch.ac.uk/resources/transforming-child-health-services-england-blueprint

References and further reading

- Johns Hopkins Patient Needs Groups
- HSE Vision for Children and Young People
- World Health Organisation (April 2023): https://www.who.int/health-topics/child-health#tab=tab_1
- Whole population integrated child health - segmentation model (NHS UK Nov 2021)
- A Population Health System (A Vision for Population Health: Towards a healthier future. Kings Fund, 2019)
- CAPHC Guideline for the Management of Medically Complex Children and Youth Through the Continuum of Care - 2018 (Link)
- London Plus - The Creative Health Impact Framework - 2025 (Link)
- Monetising the impact of culture and heritage on health and wellbeing – 2024 (Link)
- Integrated Care Systems and Youth Voice and action: A national conversation – 2025
- National Academy for Social Prescribing - Connecting the System - CYP Flipbook 2025 (Link)
- Bi-Borough Integrated Delivery Model for CYP
- NHSE Strategic Commissioning Framework 2025 (Link)
- The Best Start for Life - A Vision for the 1,001 Critical Days

Appendix II

Alignment of the framework with SEL ICS INT principles

The INT CYP Framework aligns with core principles that SEL has already developed for integrated neighbourhood team working

1.Holistic, person-centred care: considering the physical, emotional, and social needs of CYP and families

2.Earlier intervention: Early identification and anticipatory intervention, reducing dependency and crisis

3.Integrated multi-disciplinary working: improved coordination between health, care and wellbeing services

4.Community engagement: leveraging assets, empowering families, achieving inclusion and trust

5. Lifelong health: Improved physical/mental health, seamless & coordinated transitions, reduced long-term risk

6.Empowered CYP/families: Active involvement in decisions, services shaped by need and lived experience

7.Access and health outcomes: Closing the gap in variation of outcomes, outreach and inclusive services

8.Data Sharing/ digital enablement: Access to shared records/data to support care coordination and evaluation

9.Sustainable, resilient workforce: secure funding models, training and skills, replication of success across INTs

10. Innovation and Scalability: Space to test and embed and structures to scale new ways of working

Appendix III

What have we heard from CYP and their families?

What have we heard from CYP and their families?

Lack of coordination

Education think CAMHS should fix it and CAMHS think Education should fix it and Social Care think Health should fix it. We go round in circles

We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly

Why do I have to chase the referral? The GP claimed the referral had been sent but it had not.

Employ more people who are like me to deliver the care

Don't make neighbourhood teams just another part of the fragmentation. Bouncing from one professional to another erodes trust and stops engagement

Have peer navigators who steer you and offer support, like ambassadors at school

Please get schools and healthcare to talk to each other. It would be easier to get my child into school if they did.

What have we heard from CYP and their families?

Waiting and managing expectations

Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait

Get rid of separate waiting lists for different needs – they are all connected!

Speed up decision making. Community teams have to accept and endorse things which takes months

Be clear and honest about what a service can offer, what I can expect and what the limitations are – what is going to go on?

Provide parents with clear information on who is doing what and honest waiting times. Knowing when things will happen will reduce our anxiety

Information, Education And Awareness

Employers need education. My child was sacked from a job due to an episode and there were no second chances.

GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day.

Employ more people who are like me to deliver the care e.g., ADHD workshops run by people with ADHD, not a 'teacher'

There needs to be more appreciation of how it impacts the whole family and more space and support for siblings

Run drop-ins for kids and parents to learn about their condition

What have we heard from CYP and their families?

Environments and experience of care

We need a mental health ambulance. I can't get my child to a safe place on public transport if he is having an episode

After the diagnosis there was not much follow up help, no one reached out and I felt isolated

Make waiting rooms more homely and friendly; use young people's art, soft furnishings, simpler information and separate out little ones from older ones

Rushed appointments, not listening to me but talking over me

Provide options for where I receive care – at a centre, at home, in a group setting

Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E

Transition to adult services at age 18

The neighbourhood team must better manage and provide assurance around transition, providing advice, hints and tips. Don't assume we can manage it all – its' major!

The attitude it's on you now that you are 18; we won't baby you anymore and so deal with it on your own

Information passed across to adult services needs to be more detailed

Appendix IV

Governance

Governance

Neighbourhood Based Care Board

Final approval

Steering Group
Representatives from ICB, clinical leadership

Core Group
Representatives from ICB, clinical leadership

Children's Board
Representatives from ICB, clinical leadership

Local CYP Place Forums

Lambeth	Southwark	Bromley
Bexley	Greenwich	Lewisham

Appendix V

Stakeholder Engagement

Stakeholder engagement

Colleagues from across the SEL system have participated in the development of the framework, including from the ICS, Local Authorities, Public Health, Primary Care, community-based care, VCSE, acute care and mental health. Colleagues were involved in extensive discussions sharing valuable insights, perspectives and suggestion. The engagements culminated into a co-design workshop with 48 attendees to help shape the framework. Overall, in the design of the framework -

- A total of approximately 95 colleagues from across South East London were engaged.
- Additionally, approximately 30 children, young people and their parents were also engaged.

13
1-to-1 sessions

Weekly
Core Group meetings

4
Steering Group meetings

6
Place based sessions

3
Focus group sessions#

4
deep dive sessions*

Co-design Workshop

CYP and Parents voice sessions

- Meeting with CAMHS service users
- Meeting with parents of CYP in CAHMS
- Focus group with CYP with SEN (f2f)
- Focus Group with CYP with learning disabilities (f2f)
- Meeting with CYP at The Well Centre
- Meeting with Lambeth Shadow Board

Clinicial and Healthcare professionals, Local Authorities, and Place based representative including VCSEs
* Mental health, SEND, Public Health and Creative arts in mental health support

Appendix VI

List of stakeholders

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
1	SEL ICS	Alison Roberts	AD, CYP Planning
2	SEL ICS	Clive Moss	Transformation Lead
3	SEL ICS	Rupinder Dev	Director CYP, MH
4	SEL ICS	Dr Bhumika Mittal	CYP Clinical Lead SEL And GP
5	KCH NHS Trust	Dr Shahid Karim	Consultant Paediatrician
6	LGT NHS Trust	Dr Ben Cahill	CYP UEC Lead SEL, Paediatrics ED
7	GSTT NHS Trust	Eleanor Wylie	Programme Manager – CHILDS
8	LGT NHS Trust	Dr Brindha Dhandapani	Consultant Community Paediatrician
9	Oxleas NHS Trust	Jenny Ioseliaini	Service Director – Children And Young People Serives
10	Community Services	Dr. Bidisha Lahoti	Clinical Director – Children's Services Ops Director
11	Greenwich	Dr Helen Buttivant	Associate Director – Public Health
12	Lewisham	Pinaki Ghoshal	Director Of Children Services, Lewisham
13	SEL ICS	Tal Rosenzweig	Director Of VCSE Collaboration And Partnerships
14	CYP Engagement	Becks Mortimer	CYP CCPL - Engagement
15	SEL ICS	Nic Morris	AD, Analytics - Business Intelligence
16	Lewisham	Simon Whitlock	Head Of Service - Joint Commissioning CYP
17	Bromley	Anthony Harris	Head Of CYP Commissioning
18	Lewisham	Ann Guindi	CCPL – CYP And Safeguarding Lead
19	Lambeth	David Borland	Director Of Integrated Commissioning
20	SEL ICS	Jacqui Kempen	Associate Director Of Maternity And Neonatal, SEL
21	Lewisham	Simon Boote	Programme Director CYP Alliance
22	SEL ICS	Carol Ann Murry	AD LDA And SEND
23	SEL ICS	Carol Yates	MH Planning And Improvement Manager -CYP

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
24	SEL ICS	Gemma Dawson	Programme Director, Community Provider Network
25	Bromley Healthcare	Victoria Soper	Director Of Children And Young People Services
26	GSTT	Alghali Abdulrahman	General Manager, Children's Community Services
27	Bexley	Dr Mohammad (Asad) Rahman	Clinical Lead - CYP
28	Greenwich	Dr Adebisi Olunloyo	Clinical Lead - CYP
29	Southwark	Nicola Hanson	Clinical Lead - CYP
30	LGT NHS Trust	Dr Joanne Lawrence	Consultant Diabetologist
31	SEL ICS	Jane Waite	Head Of CHC/CYPCC & QIPP
32	GSTT	Sukeshi Makhecha	Consultant Pharmacist In Paediatric Asthma & Respiratory Medicine
33	Pharmacy alliance	Reena Patel	Community Pharmacist
34	GSTT	Chloe Macauley	Paediatrician
35	GSTT	Sarah Henderson	Director Of Strategy
36	Bromley Healthcare	Cait Lewis	Head Nurse - Bromley Healthcare
37	Oxleas	Sabitha Sridhar	Consultant Psychiatrist And Clinical Director CYP, Oxleas
38	VCSE	Fiona Small	Young Mums Support Network
39	Well Centre	Angelika Slon	Service Manager, Well Centre
40	Pharmacy Alliance	Ashfaq Khan	Community Pharmacist
41	Greenwich and Lewisham	Rachel Olanike Lanlokun	Designated Nurse For LAC
42	Southwark	Yvette Newman	Designated Nurse For LAC
43	Greenwich	Jacqueline Alby	Designated Clinical Officer
44	SEL ICS	Rebecca Saunders	SEL Designated Nurse, Safeguarding

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
45	SEL ICS	Margaret Mansfield	SEL Designated Nurse, Safeguarding
46	Lambeth	Dr Raj Mitra	Clinical Lead - CYP
47	Lewisham	Angelique Lewis	Head Of Service - Prevention And Early Help
48	Bromley	Rachel Dunley	Head Of Service, Early Intervention And Family Support, Bromley
49	VCSE	Laura Bassett	Founder – Bug Bears And Director Of Partnerships, Oval Learning
50	SEL ICS	Ann Lorek	Consultant Community Paediatrician & Designated Doctor Safeguarding CYP
51	VCSE	Daniel Fulvio	Director Of Community Partnerships, Rambert
52	Greenwich	Sharne Mcclean	Head Of Early Years & Childcare (Including Family Hubs)
53	Greenwich	Alexander Lee-daniels	Strategic Lead, Children With Disabilities Social Care Teams
54	Lambeth	Daniel Stoten	Director Of Integrated Commissioning
55	Lewisham	Sara Rahman	Director Of Integrated Commissioning
56	Bromley	Johanna Dench	Senior Commissioning Manager – CYP MH & Wellbeing
57	Lambeth	Alex Murphy	Lead Commissioner For SEND And Health (CYP Mental Health)
58	Bexley	Katie Farrer Daniels	CYP Commissioner
59	Lewisham	Paul Creech	CYP Commissioner

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
60	Greenwich	Roneeta Campbell-butler	CYP Commissioner
61	Lambeth	Laura Griffin	CYP Commissioner
62	Southwark	Jubin Mama	CYP Commissioner
63	Greenwich	Samantha Bennett	Public Health Consultant
64	Greenwich	Claire Bennett	Public Health Consultant
65	Bromley	Elliot Ward	INT Lead
66	SEL ICS	Melissa Howie	Maternity Lead
67	GSTT	Dulmini Kariyawasam	Diabetes Consultant, GSTT
68	VCSE	Sandra Igwe	Founder And CEO, Motherhood Group
69	VCSE	Yeukai Taruvinga	Founder And CEO, Active Horizons
70	VCSE	Alex Brierley	Director Of Creative Engagement, Southbank Centre
71	VCSE	Anthony Johnson	Representative from Lambeth's voluntary community groups working with young people
72	VCSE	Sabrine Dixon	Founder And CEO, Social Inclusion Recovery. Group
73	Healthwatch	Joy Beishon	CEO Of Healthwatch Greenwich
74	Bromley	Angela Bhan	Executive Director, Bromley
75	Bromley	Sean Rafferty	Director Of Integrated Commissioning, Bromley
76	Bromley	Mark Cheung	Programme Director - Bromley Local Care Partnership

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
77	Southwark	Darren Summers	Executive Director, Southwark
78	Southwark	Stacey John-Legere	CYP CCPL - Southwark
79	Southwark	Claire Belgard	Director of Integrated Commissioning, Southwark ICS
80	Southwark	Russell Jones	Associate Director integrated commissioning
81	Southwark	Rachel Tebay	Project Manager System Delivery Partnership Southwark
82	SEL ICS	Robert Davidson	Clinical Lead, NHS SEL ICB
83	SEL ICS	Laura Jenner	Director of System Development, South East London ICS (Lewisham)
84	Lambeth	Laura Griffin	Associate Director Integrated Children's Commissioning, Lambeth
85	SEL ICS	Maria Higson	Director of Transformation and Delivery SEL and leads PHM approach for SEL
86	Well Centre	Stephanie Lamb	Clinical Director - The Well Centre, GP lead CHILDS Transformation Programme
87	Southwark	Geetika Singh	Partership Southwark INT lead
88	SEL ICS	Clare Ross	System development manager, Primary Care Lead
89	Bromley	Jenny Selway	Public health Consultant
90	SEL ICS	Jessica Roe	Head of Analytics, BI SEL ICS
91	Greenwich	Dr Elizabeth Palmer	Clinical lead in Greenwich CAMHS and Consultant psychiatrist
92	SEL ICS	Hayley Ormandy	Director, Prevention, Wellbeing and Equity and Long-Term Conditions, SEL ICS
93		Helen Davis	
94	Southwark	Liz Brutus	Consultant in Public Health in Southwark, BCYP Strategic Lead
95	GSTT	Ayesha Ali	Consultant in Public Health and Lead for Population Health Management Hub at GSTT

End of report

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