Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Partnership Southwark Strategic Board Agenda

Thursday 24th July 2025 | 13:30 – 16:30

Venue: Room G02AB, 160 Tooley Street, SE1 2TZ

Chair: Nancy Kuchemann

Time	Ref	Item	Lead	Enc
13:30	1	• Welcome and Introductions • Apologies • Declarations of Interest • Minutes of the last meeting • Action Log	Chair	Enc 1 – Declarations Enc 1i – Minutes Enc 1ii – Action Log
13:40	2	Deep Dive: Vaccinations and Immunisations	Denise McLeggan / Sarah Robinson	Enc 2
14.10	3	Unplanned Admissions for Over 65-year-olds	Rebecca Jarvis / Claire Belgard	Enc 3
14:40	4	Integrated Neighbourhood Teams update	Darren Summers / Louise Dark	Enc 4
14:55	5	Public Questions	Chair	
15.05		Break		
Business items				
15:20	6	**Strategic Director for Health & Care and Place Executive Lead Report** Reports from sub-committee chairs: • Integrated Governance and Assurance Committee (KP) • Partnership Southwark Delivery Executive (RJ) • Primary Care Committee (KP)	Darren Summers / Katy Porter/ Rebecca Jarvis	Enc 5
16:00	7	Integrated Assurance Report	Adrian Ward	Enc 6
16:25	8	Any Other Business	All	
16:30		Close Meeting	Chair	

Next held in-public meeting: 25/09/2025

Partnership Southwark

Declaration of Interests

Meeting Name: Partnership Southwark Strategic Board

Meeting Date: 24 July 2025

Name	Position Held	Declaration of Interest
Alasdair Smith	Director of Children's Services, Southwark Council	No interests to declare
Ami Kanabar	GP, Co-chair LMC	No interests to declare
Anood Al- Samerai	Director, Community Southwark	No interests to declare
Cedric Whilby	CCPL, VCSE representative	1. Producer of 'Talking Saves Lives' public information film on black men and cancer 2. Trustee for Community Southwark 3. Trustee for Pen People CIC 4. On Black Asian Minority Ethnic (BAME) panel that challenges the causes of health inequalities for the BAME community in Southwark – **Pending email validation**
Claire Belgard	Interim Director of Integrated Commissioning	No interests to declare
Cllr Evelyn Akoto	Partnership Southwark Co-Chair & Cabinet Member for Health & Wellbeing	No interests to declare
Darren Summers	Strategic Director of Health & Care & Place Executive Lead	1. Wife is Deputy Director of Financial reporting at North East London ICB 2. Member of GSTT Council of Governors (ICB representative)
David Quirke-Thornton	Strategic Director of Children's and Adult's Services	No interests to declare
Emily Finch	Clinical Lead, South London & Maudsley	No interests to declare
Eniko Nolan	Assistant Director of Finance for Children and Adult Services	No interests to declare
Graham Head	Healthwatch	No interests to declare
Jeff Levine	Regional Director for London, Agincare	No interests to declare
Josephine Namusisiriley	CCPL, VCSE Representative	**DOI to be reviewed by Board member**
Julie Lowe	Site Chief Executive for Denmark Hill	No interests to declare

Katy Porter	Independent Lay Member	1. Trustee, & Vice Chair, Depaul UK which is a national charity, working in the homelessness sector, and it's head office is based in Southwark. The organisation holds a contract with Southwark. 2. CEO for The Loop Drug Checking Service. The Loop is a national charity developing services across the UK, including London. It operates in the substance use and health sector. – **Pending email validation**
Louise Dark	Chief Executive Integrated and Specialist Medicine Clinical Group	No interests to declare
Monica Sibal	IHL representative	**DOI to be reviewed by Board member**
Nancy Küchemann	Co-Chair Partnership Southwark and Chair of Clinical and Care Professional Leads, Deputy Medical Director, SEL ICB	1. GP Partner at Villa Street Medical Centre. Practice is a member of SELDOC, the North Southwark GP Federation Quay Health Solutions and the North Southwark Primary Care Network. 2. Villa Street Medical Centre works with staff from Care Grow Live (CGL) to provide shared care clinics for people with drugs misuse, which is funded through the local enhanced service scheme. 3. Mrs Tilly Wright, Practice Manager at the practice and one of the Partners is a director of QHS. Mrs Wright is also the practice manager representative on the Local Medical Committee. 4. Mr Shaun Heath, Nurse Practitioner and Partner at the practice is a Senior lecturer at University of Greenwich. 5. Dr Joanna Cooper, GP and Partner at the practice is employed by Kings College Hospital as a GP with specialist interest in dermatology. 6. Husband Richard Leeming is councillor for Village Ward in south Southwark. 7. Deputy Medical Director at SEL ICB
Nigel Smith	Director, Improving Health London	No interests to declare
Olufemi Osonuga	PCN Clinical Director, North Southwark	1. GP Partner Nexus Health Group, Director Quay Health Solutions, Director PCN, North Southwark
Rebecca Dallmeyer	Director, QHS	1. Quay Health Solutions holds contracts for delivery of services through the following contracts commissioned by SEL ICB: New Mill Street GP Surgery
Rebecca Jarvis	Director of Partnership Delivery and Sustainability	No interests to declare
Sabera Ebrahim	Associate Director of Finance, SEL ICB, Southwark	No interests to declare

Sangeeta Leahy	Director of Public Health	No interests to declare
Sarah Kwofie	Director of Homecare (London & South) City and County Healthcare Group	**DOI to be reviewed by Board member**
Sumeeta Dhir	Chair of Clinical and Care Professional Leads	No interests to declare
Winnie Baffoe	CCPL, VCSE representative	1. Director of Engagement and Influence at the South London Mission, which works closely with Impact on Urban Health. The South London Mission leases part of its building to Decima Street medical practice. 2. Board Member Community Southwark. 3. Married to the Executive Director of South London Mission

Enclosure: 1i
Agenda item: 1

PARTNERSHIP SOUTHWARK STRATEGIC BOARD MINUTES

Date: Thursday 22 May 2025 | 13:30 – 16:30
Venue: Walworth Living Room, Surrey Square, SE17 2JU
Chair: Cllr Evelyn Akoto

ATTENDEES

MEMBERS	TITLE AND ORGANISATION
Cllr Evelyn Akoto	Co-Chair, Cabinet Member of Health & Wellbeing, Southwark Council
Dr Nancy Küchemann	GP, Co-Chair Partnership Southwark
Anood Al-Samerai	CEO, Community Southwark
Rebecca Dallmeyer	Quay Health Solutions
Dr Sumeeta Dhir	GP, Chair of Care & Clinical Professional Leads (CCPL)
Sabera Ebrahim	Associate Director of Finance, Southwark, SEL ICB
Rebecca Jarvis	Director of Partnership Delivery & Sustainability, Partnership Southwark
Dr Ami Kanabar	GP, Local Medical Committee (LMC) Representative
Sarah Kwofie	Director of Homecare (London & South) City & County Healthcare Group
Emily Finch	Clinical Lead, South London & Maudsley NHS Trust
Graham Head	Healthwatch Southwark
Katy Porter	Independent Lay Member
Monica Sibal	Improving Health Limited (IHL) Representative
Darren Summers	Strategic Director for Health & Care / Place Executive Lead, Southwark
Cedric Whilby	Voluntary and Community Sector (VCS) Representative
Sangeeta Leahy	Director of Public Health, Southwark Council
Louise Dark	Chief Executive Integrated and Specialist Medicine Clinical Group, GSTT
Julie Lowe	Deputy Chief Executive, Kings College Hospital NHS Trust
Nigel Smith	Director, Improving Health Limited (IHL)
IN ATTENDANCE	
Adrian Ward	Head of Planning, Performance and Business Support, Partnership Southwark, SELICB
Isabel Lynagh	Business Support Lead, Partnership Southwark, SELICB (Minutes)
Louise Lamothe	Business Support Officer, Partnership Southwark, SELICB
Sanil Sensi	Borough Estate Lead (Southwark and Bexley), SEL ICB
Mike Wilson	Executive Director, Pembroke House/Walworth Living Room
Tara Mack	Director of Programmes, Pembroke House/Walworth Living Room
Kate Jones	Director of Major Programmes/Strategy, Evalina London
APOLOGIES	
Alasdair Smith	Director of Children's Services, Southwark Council
David Quirke-Thornton	Strategic Director of Children's & Adult's Services, Southwark Council
Eniko Nolan	Assistant Director of Finance for Children and Adult Services
Josephine Namusisiriley	Care & Clinical Professional Lead (CCPL), VCSE Representative
Jeff Levine	Regional Director for London, Agincare
Claire Belgard	Interim Director of Integrated Commissioning, Southwark Council, SELICS

Winnie Baffoe	Director of Engagement & Influence, South London Mission; Voluntary and Community Sector (VCS) Representative
Dr Olufemi Osonuga	GP, Clinical Director of North Southwark Primary Care Network (PCN)

1.	**Welcome & Introductions**
1.1	The Chair welcomed attendees to the Partnership Southwark Strategic Board held in person.
1.2	Introductions were made and apologies noted.
1.3	**Declarations of interest** There were no additional declarations of interest in relation to matters in the meeting.
1.4	**Minutes of last meeting** Minutes of the last meeting were agreed as an accurate record, with no points of correction noted.
1.5	**Action Log** There are no open actions on the action log.
2.	**Community Spotlight: Showcasing the work of Pembroke House and Walworth Living Room**
2.1	The chair introduced the item and welcomed Mike Wilson and Tara Mack.
2.2	Mike Wilson welcomed board members and members of the public to the venue, providing the history of Walworth Living Room and Pembroke House. Pembroke House is a neighbourhood organisation which has been based in Walworth for over 100 years, working to tackle inequalities and improve life and wellbeing of Walworth residents.
2.3	Tara Mack noted that with many pubs, libraries and other public spaces closing, it is vital to have spaces such as Walworth Living Room. During the pandemic, the space was closed to the public and became a food distribution hub, reopening in 2022. Tara noted that funding then ran out in 2023 and following some fundraising and refurbishment, the space opened again on 11th April 2025.
2.4	Mike Wilson discussed Pembroke House's history of working with health partners, highlighting successful work with a therapist from Talking Therapies Southwark who would walk clients over to the 'lunch club' that was being run by the organisation. Mike emphasised that this was a

	great example of Integrated Neighbourhood Teams in action and led to a three-year pilot with talking therapies.
2.5	Mike highlighted three key lessons learnt from past work: 1. Integration works when a genuine shared interest is identified. 2. Integration only works as well as the quality of the relationships and the trust within those relationships. 3. Scale vs depth of work must be considered.
2.6	Tara shared some of the insights gathered, noting that during the pandemic it was clear that one of the biggest challenges affecting local residents was social isolation. Walworth Living room helps members of the community to form connections and find a sense of purpose and it is also encouraging people to think of health in broader terms. These insights help to shape what and how things are being done at Walworth Living Room.
2.7	Mike emphasised the importance of thinking of horizontal integration and the ways in which NHS and social care can come together at neighbourhood level. Mike noted the importance of committing time to this to support the building of relationships, including building relationships virtually to support unlocking permissions.
2.8	On behalf of the board, The Chair thanked Mike and Tara for the work that they do for the community.
2.9	The Chair opened discussion up to the board for comment.
2.10	Graham Head asked how the organisation define the Walworth neighbourhood. Mike Wilson clarified that this was the area either side of the Walworth Road, between Old Kent Road, and Kennington Road, which consists of 45,000 people.
2.11	Anood Al-Samerai asked how the work of Walworth Living Room and Pembroke House are funded, noting that completing funding applications is a lengthy process. Tara Mack responded that funding is predominantly from foundations, noting that the re-opening was funded by The National Lottery. The organisation owns property and receives rental income and there is also work ongoing to see if providing food could be used as a potential income stream. Tara noted that funding is a struggle and highlighted the difficulty posed by many schemes following a one-year funding cycle.

2.12	The Chair asked if there was any insight of the needs of the local community. Tara noted that common issues heard are regarding housing, accessing health support and food insecurity.
2.13	The board thanked Mike Wilson and Tara Mack for the presentation and **NOTED** the information and insights shared.
3.	**Report from the Integrated Neighbourhood Teams Programme Board**
3.1	Darren Summers introduced the item, noting that the slides will be circulated after the board.
3.2	Darren updated that the presentation was taken to the integrated neighbourhood team programme board last week and focuses on the horizontal integration from primary care to community to acute services in hospitals.
3.3	It was recognised that greater involvement is needed from communities and that there is ongoing thinking about how best to work with the Voluntary and Community sector. It was noted that this work has been described as a 'collaborative group' within the slide pack and Darren recognised that this might not yet be the right language.
3.4	Darren reminded all that at the last Partnership Southwark Strategic Board meeting in March, the geographic footprint of the Integrated Neighbourhood Teams (INTs) was agreed, as well as the high-level model for INTs. Associated challenges for different sectors were also noted.
3.5	The aim is to launch INTs in autumn. Darren shared that there is a lot of work to do, and the first stage arrangements won't be perfect in all parts of Southwark and will need testing and learning to support ongoing improvements. The INT implementation plans are largely in line with the London Target Operating Model that has recently been released.
3.6	Darren shared that a Primary Care task and finish group has been set up and the first meeting has been held adding that there are plans to create similar groups in other sectors.
3.7	Under the new programme structure, there are five agreed workstreams which are detailed within the presentation.
3.8	Darren shared an example of a 'Neighbourhood profile' that has been created which includes details of GP practices, the neighbourhood population, hospital usage and the health of the people in that particular neighbourhood. There is ongoing work to progress and develop these.

3.9	The Chair thanked Darren Summers for the presentation and opened up discussion to the board for comment.
3.10	Graham Head noted that this work will mean changes for people on the ground and highlighted the importance of ensuring that this will not act as a distraction from the delivery of day-to-day care. Emily Finch added that staff need to be brought into this work with a joint vision and a focus on building strong relationships. Louise Dark agreed with this, noting that there needs to be some focus on how to integrate INT working into business as usual.
3.11	The Chair asked if the composition and development of integrated neighbourhood teams would be derived from health teams only and whether other partners would be involved during a second stage. Darren clarified that there would be a phased approach, but the focus of INTs will bring professionals from the relevant community organisations around children with complex needs, adults with multiple long-term conditions and frailty.
3.12	Anood Al-Samerai, Cedric Whilby and Darren agreed that further work needs to happen with the voluntary sector and dedicated time should be set aside to think about how best to engage and involve this sector.
3.13	Darren thanked the board members for helpful thoughts and contributions, noting that not all aspects can be planned at this point, but being clear on the direction of travel.
3.14	The board **NOTED** the updates provided in the presentation.
4.	**Estates Update**
4.1	Sanil Sensi introduced this item sharing that the purpose of the presentation was to share how the Estates strategy fits with our HCP neighbourhood development priority. His presentation was tabled but will be shared with board members afterwards.
4.2	Sanil noted that there is work ongoing to maximise use of estates and tackle underutilised or void spaces and focus on how to use space in a more collaborative and flexible way. In turn, this will increase support provided via community settings and reduce demand for acute services.
4.3	Data was shared regarding the projected population change in Southwark from 2025-2040, noting that the total population is expected to increase by 11.6%, with growth particularly in the Old Kent Road area. Other aspects such as patterns of deprivation and population need will need to be taken into account when planning location and investment into neighbourhood hubs.

4.4	The Estates team would like to work with GP practices to complete site visits to look at the available spaces, to understand what changes GPs would like to see and to understand the needs of the community. Sensors have been used across some buildings, for example Sunshine House, in order to determine the current usage of the space. This data will be used to convert void space into more clinical space.
4.5	The Chair thanked Sanil for the presentation and opened discussion up to the board for comment.
4.6	Cedric Whilby asked about the intentions for the space at Harold Moody. Sanil responded that sensors are due to be installed in June to monitor usage of the space. There are conversations ongoing with Guy's and St Thomas' Trust to open the space to other services. There is also work happening to put details of available space onto online platforms for those outside of the organisation to be able to book.
4.7	Anood Al-Samerai noted that she will continue to advocate for free spaces for charity and community groups to use. Anood also fed back from colleagues that they have found the Tessa Jowell space is not easy to navigate and noted the importance of having a member of the team on site to welcome visitors into buildings. Sanil added that they would encourage voluntary and community groups to contact him to see if they can help to find free space.
4.8	Emily Finch added that mental health services are not always able to predict their demand, which can make it difficult to understand the space required each day.
4.9	Dr Nancy Kuchemann added that she was pleased that Sanil was attending the board meeting to start these conversations, noting that when thinking about neighbourhoods, geographical assets were a good place to start. Sanil shared an example of space in Peckham that is used by five GP practices, which also benefits the neighbourhood in that area.
4.10	The Chair noted the positive social effects of co-location, noting that locating GP surgeries close to gyms, cafés and voluntary groups can help residents view GPs as part of the community.
4.11	The board **NOTED** the updates provided in the presentation.
5.	**Public Questions**
5.1	There were no public questions raised in advance of the meeting.

5.2	A member of the public in attendance at the meeting asked where they would be able to see work around social determinants being discussed.
5.3	The Chair responded that she is the cabinet lead for Health and care in Southwark, and champions this approach in her work. In particular, tackling inequalities and wider determinants of health are the focus of the Health and Wellbeing board and actions to address are included in the five-year health and wellbeing strategy. The Chair welcomed attendance from the public at the next Health and Wellbeing board meeting.
5.4	The Chair also noted that Public Health does a lot of work in this area, noting that they are members of both the PSSB and the Health and Wellbeing board.
5.5	No further public questions were raised during the meeting.
BREAK	
6.	**Strategic Director for Health & Care and Place Executive Lead Report**
6.1	Darren Summers introduced the item, taking the report as read.
6.2	An Ofsted and CQC SEND Thematic Review had been taking place over the past three weeks in Southwark. This is not an inspection so there will not be a rating provided, but good practice will be highlighted in the report produced. Rebecca Jarvis, in her role as Senior Responsible Officer for SEND, shared that so far feedback has been broadly positive with particular mention of partnership working, communication with parents and professionals taking creative approaches to tackle challenging problems. Rebecca shared her thanks to all colleagues involved in and shared that the report should be available in around three weeks' time.
6.3	Darren also noted other items in the report, including the implementation of the action plan in the Maternity Commission group. There is also considerable work going on within Adult Mental Health Complex Care looking at how to improve quality and value for money of placements.
6.4	A report on the Health Inequalities Fund has been provided by the Health Innovation Network (HIN) which should be ready for circulation to all partners imminently. A process has also been agreed for how the remainder of the fund can be committed.

6.5	Darren provided an update on the ICB reductions in running costs, noting that the 'Model ICB blueprint' has now been released, providing detail of the expectations of future functions of ICBs, which focuses on strategic commissioning. Work is ongoing to redesign functions to deliver the best possible services for residents. Confirmation has been received that cost reductions are to be delivered by the end of December 2025. By the beginning of the next financial year, the ICB must be running on the reduced costs.
6.6	The Chair opened discussion up to the board for comment on the report.
6.7	Emily Finch asked for an update on the mental health complex care programme board. Darren clarified that this has been re-convened across Lambeth, Southwark and Lewisham, noting that all three areas are overspending on placements. There is also ongoing work regarding ICB-only funded service users.
6.8	Sangeetha Leahy asked if it was possible that the Health Inequalities Fund may not exist in future years. Darren clarified that the reductions are in running costs, not commissioned services, but noted that NHS and public sector budgets are under enormous pressure and Darren cannot commit to no changes in the future.
6.9	Cedric Whilby noted concerns around the Health Inequalities Fund not existing in future years and emphasised the need for this to be a priority. Cedric suggested that each department commits a percentage of their budget to health inequalities. Darren clarified that the Health Inequalities fund has not been cut this year and noting that he is not able to commit to there being no change in the future year. The Chair added that the Health Inequalities Fund is a small pot of money, however there is also wider work ongoing to address health inequalities and noted that a further discussion can be had after the HIF impact report has been circulated.
6.10	Darren shared that the ICB 50% reductions is likely to have an impact on Partnership Southwark. There is a focus in the blueprint on investing in strategic commissioning, however the blueprint also notes about functions being streamlined, including governance. SEL ICB has a strong commitment to keeping Place structures, which is unique in London. It is not impossible that NHS England will respond to plans and state that they would like something different to this. The Chair added that the board should be prepared for anything, adding that this is a fast-moving process.
6.11	Darren welcomed Rebecca Jarvis and Katy Porter to provide reports from each of the sub-committees.

6.12	Rebecca Jarvis provided an update on the Partnership Southwark Delivery Executive (PSDE), noting that only one meeting has taken place since the last board. Highlight reports for each of the 'Wells' is now a standing item on the agenda and these focus on the progress of delivering the strategic priorities. A key them from the last highlight reports was the availability of meaningful data. Rebecca noted that a data dashboard is in development and the Executive will spend devoted time on this at the next meeting. The CYP and Adult Mental Health priorities were also discussed to ensure that the Committee felt that the right work is being done to achieve the ambition of reducing waiting times. The Committee also looked at the 'End of Phase 1' review for the Frailty pilot and considered the challenges with regards to scaling up.
6.13	Katy Porter provided an update on the Integrated Governance and Assurance Committee (IGAC), noting that only one meeting has taken place since the last board. Katy updated that there was a focus on the end of year financial position and thanked Sabera Ebrahim for the preparation of the end of year report. Katy noted that there are continued challenges in some areas, such as Mental Health and Mental Health placements, where there was an overspend in 2024/25. The Integrated Assurance Report was brought to IGAC in detail and there were discussions had about what is helpful to bring to the board. Katy noted that there is ongoing work with the quality team to determine how available information can be best shared and used.
6.14	Katy Porter also provided an update on the Primary Care Committee. The last committee meeting focused on the primary care dashboard, quality and performance, with Katy updating that the dashboard is now in a good place. There is now a programme in place with the Contracting team for Practice visits, with plans for every Practice in the borough to be visited. Quarterly reports from these visits will be brought to the Primary Care Committee. Ongoing contracts and procurement were also discussed and the Committee looked at how these align to individual estates as well as the estates strategy.
6.15	The Chair thanked Rebecca and Katy for the sub-committee updates, asking Katy to elaborate on what will be looked at during the Practice visits. Katy noted that there will be a template to ensure that there is a standardised approach across all visits. The focus will be on access, family and friends' surveys, standards of care and patient satisfaction.
6.16	The board **NOTED** the updates provided.

7.	**Integrated Assurance Report**
7.1	Adrian Ward introduced the item, noting that the full report had been reviewed at the Integrated Governance and Assurance committee two weeks ago.
7.2	An executive summary of the report was provided, noting key changes. It was noted that there are 19 'red' targets, with seven of these being for child immunisations and 2 for flu vaccinations. There are plans for a 'deep dive' on vaccinations and immunisations at the next Partnership Southwark Strategic Board. This is also on the risk register with an action plan delivered by Southwark immunisation group.
7.3	SMI physical health checks were below target in Q3, there was hope that these would increase in Q4 significantly, but this has not happened.
7.4	There is an SEL place scorecard for 2024/25 and the 2025/26 operational plan will be added. Adrian noted that other sections of the report include a quality scorecard, summary safeguarding report, a new SEND dashboard and a risk register. The risk register includes no severe risks and is due to be reviewed now that it is a new financial year.
7.5	Sabera Ebrahim provided a brief finance summary, noting that for the 2024/25 year end position there was an underspend of £44k against an allocation of £179m.
7.6	The key risk areas are related to mental health and prescribing, where there was an overspend of £1.9m and £1.3m respectively. These risks remain in 2025/26 and there are pressures in these areas.
7.7	Sabera updated that the final budget for 2025/26 includes non-recurrent funding of £3.3m.
7.8	The Chair opened discussion up to the board for comment.
7.9	Emily Finch asked whether the data for SMI physical health checks is from primary care or both primary and secondary care. Adrian clarified that the data is merged, which does create some issues and this is being worked on.

7.10	Emily also asked if the prescribing data within the finance summary included SLaM. Sabera clarified that this is for primary care.
7.11	The Chair noted that it is important that the Integrated Assurance Report is in a format that can be understood and absorbed by members of the board and asked the board for feedback on the report.
7.12	Katy Porter added that this question is also discussed at IGAC and the committee want to ensure that the right information is being shared in the right place, noting that different sections of the report will be of interest to different members of the board.
7.13	Emily Finch and Cedric Whilby fed back that they found the report and the contents interesting noting that it is good to be able to see information from other areas of the system.
7.14	The board **NOTED** the updated Integrated Assurance Report.
8.	**Any Other Business**
8.1	Graham Head shared that he has been invited to take part in a simulation exercise looking at a model London INT, which is being run by the PPL team. Graham offered to share feedback from this work at a future board meeting. The Chair thanked Graham for this offer and noted that suitable slots can be discussed when feedback is available to share with the board.

The meeting closed at 16:10 and the Chair thanked members and guests for their time.

Enclosure: 1ii
Agenda item: 1

PARTNERSHIP SOUTHWARK STRATEGIC BOARD ACTION LOG					
No.	MEETING DATE	ACTION	STATUS	OWNER	COMMENTS

There are no open actions on the action log

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 2
Enclosure: 2

Title:	**Supporting vaccination programmes July 2025**
Meeting Date:	**24 July 2025**
Author:	Sarah Robinson (Senior Programme Manager: Health Protection, Public Health) and Denise McLeggan (Public Health Improvement Programme Manager, Partnership Southwark)
Executive Lead:	Sangeeta Leahy (Director of Public Health, Southwark Council) and Darren Summers (Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

Summary of main points

- There are well established and strong working relationships between all partners including SEL ICB, Public Health, NHSE (London), K&R Trust, LMNS, Evelina and primary care.
- Local oversight of vaccination programmes is via the Vaccination Oversight Group (VOG), jointly chaired by Public Health and the ICB.
- Vaccination programmes are commissioned by NHSE. They are delivered depending on programme:
  - Pre-school and older adult programmes are mainly delivered in primary care
  - School age vaccines are delivered by the Children and Young People Community Immunisation Service.
  - Maternal vaccines are manly delivered by maternity services.
- The commissioning of vaccinations will be delegated to ICBs from 1 April 2026.
- Coverage in all vaccination programmes in Southwark is generally lower than in the rest of England. This picture is mirrored in most London boroughs.
- Coverage in Southwark is usually similar or higher than that in London as a whole. In SEL boroughs, Southwark coverage is usually in the bottom half.
- Recognising the potential increase in vaccine preventable diseases as a result of the decreasing uptake of all immunisations – the Vaccination Oversight Group added the risk to the ICB place risk register in January 2025.
- A lot of work has been undertaken and is on-going across the system to improve coverage and reduce inequalities in the following areas:
  - Community engagement to understand and address barriers.
  - Communication campaigns.
  - Training and awareness raising.
  - Improving access to vaccinations, supporting delivery and outreach.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
	X	X	

Action requested of PSSB

To discuss the following:

- Recognising the work underway to improve coverage, what additional support could Board members, and their organisations offer to help reduce inequalities?

Anticipated follow up

Further reports can be provided as requested.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	
Adult mental health	
Frailty	
Integrated neighbourhood teams	
Prevention and health inequalities	**X**

Item Impact	
Equality Impact	Considering inequalities in vaccination coverage is a principle that underpins all of our work to support vaccination programmes. For each project we aim to deliver a targeted approach in those communities with highest deprivation and most vulnerable communities. The 2019 Southwark Immunisation Strategy, the Immunisation JSNA and the SEL ICB Vaccination and Immunisation Strategy all show that addressing inequalities is at the core of our work. Due to the in-depth assessment of inequalities undertaken in the Immunisation JSNA and Immunisation Strategy, a further equality impact assessment has not been undertaken.
Quality Impact	An overarching quality impact that covers all of the work done to support vaccination programmes assessment has not been undertaken. Some of our projects are evaluated and this is used to determine future service provision. Evidence based interventions are utilised as far as possible in all the work we do.
Financial Impact	Some projects and work undertaken require funding. This is sourced from existing funds within the system including: the SEL ICB inequalities fund and the vaccine hesitancy fund (given to PS during COVID-19 and carried over year on year to fund vaccination projects. This fund is nearly fully spent). There is no ring-fenced funding stream for vaccination support work going forward.
Medicines & Prescribing Impact	None
Safeguarding Impact	We consider the needs of vulnerable children, young people and adults in our work to support and improve vaccination programmes. We have supported our SEND schools, asylum seeker accommodation residents, young carers, Gypsey, Roma, Traveler groups and care homes residents.

Environmental Sustainability Impact (See guidance)	Neutral	Positive	Negative
	X	.	

Describe the engagement has been carried out in relation to this item
We undertake considerable engagement in the work we do to support vaccination programmes in Southwark. The report highlights several areas where we have engaged with communities to understand and address barriers to taking up vaccinations.

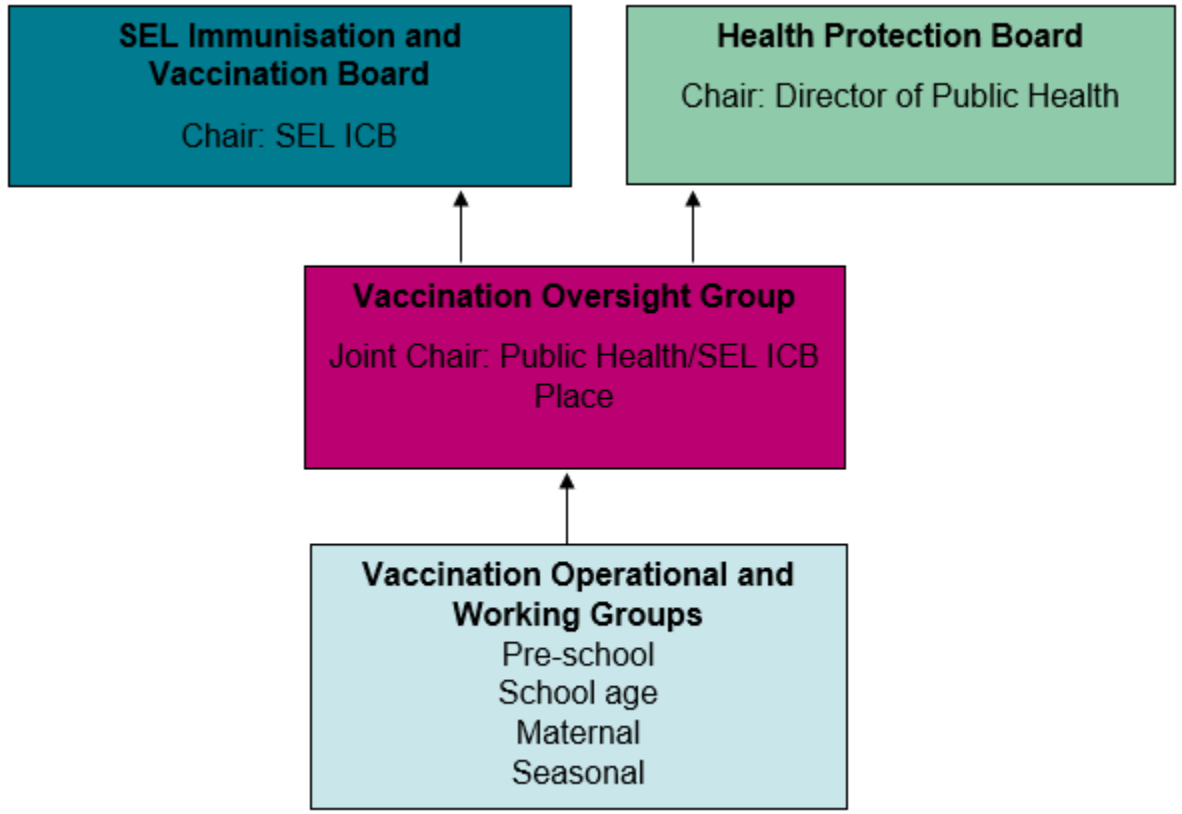
Partnership Southwark Strategic Board

Supporting vaccination programmes

July 2025

Local governance

- Local oversight of vaccination programmes is via the Vaccination Oversight Group (VOG), jointly chaired by Public Health and the ICB.
- Programme-specific working groups sit under and report into the VOG, with relevant partners working to improve coverage, access and tackle inequalities.
- The VOG is accountable to the Health Protection Board, which in turn is accountable to the Health & Wellbeing Board. It also reports into the SEL Immunisation & Vaccination Board and ICB.
- There are well established and strong working relationships between all partners including SEL ICB, Public Health, NHSE (London), K&R Trust, LMNS, Evelina and primary care.
- **The delegation of the commissioning of vaccination programmes will happen by 1 April 2026.** Further information about this is currently unknown.



Vaccination programmes

Cohort	Vaccine	Diseases protected against
Preschool (birth – 4 years)	DTaP/IPV/Hib/HepB (hexavalent/6 in 1) MenB Rotavirus Pneumococcal conjugate vaccine (PCV) BCG (eligible cohort only) Hep B for high-risk babies (eligible cohort only) MMR Live attenuated influenza vaccine (LAIV)	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib), hepatitis B Meningococcal group B Rotavirus gastroenteritis Pneumococcal (13 serotypes) Tuberculosis (eligible cohort only) 2 x additional Hep B vaccines for high-risk babies Measles, mumps, rubella Influenza (each year from September)
School age (Reception to Year 11)	Human papilloma virus HPV (boys and girls) Td/IPV MenACWY Live attenuated influenza vaccine (LAIV)	Cancers and genital warts caused by specific HPV Tetanus, diphtheria and polio Meningococcal groups A, C, W and Y Influenza (each year from September)
Pregnancy	Inactivated flu vaccine Tdap RSV	Influenza (each year from September) Pertussis Respiratory syncytial virus (RSV)
Older adults (65+ years)	Pneumococcal Polysaccharide Vaccine (PPV23) Inactivated influenza vaccine Shingles RSV	Pneumococcal (23 serotypes) Influenza (each year from October) Shingles Respiratory syncytial virus (RSV)
Seasonal (< 75 with weakened immune system, 75+, Older adults care home resident	COVID- 19	COVID-19

See appendix A for vaccination programme breakdown

Complete routine immunisation schedule from 1 July 2025 - GOV.UK

Local coverage highlights

MMR (pre-school)

71.7% (pre-school age) are fully vaccinated

23.1% unvaccinated in IMD1 and **6.8%** in the least deprived deciles (IMD 8–10)

Ethnic groups with lowest uptake include Caribbean (**43.1%)** and 'Not stated' (**54.1%)**

COVID-19

Spring Booster 2025: **7.5%**
Autumn Booster 2024: **19.5%**

10%- 20% of most deprived IMD1 and **20-30%** IMD8-10

Highest uptake in White ethnic group (**77.45%)** and lowest across Unknown (**1.23%)** and Mixed (**1.52%**)

2.62% of 80+ age group declined Spring Booster 2025

Flu

Flu vaccine 24/25: **42.8%**
Flu vaccine 23/24: **44.3%**

10%-20% of most deprived IMD1 and **20-30%** IMD8-10

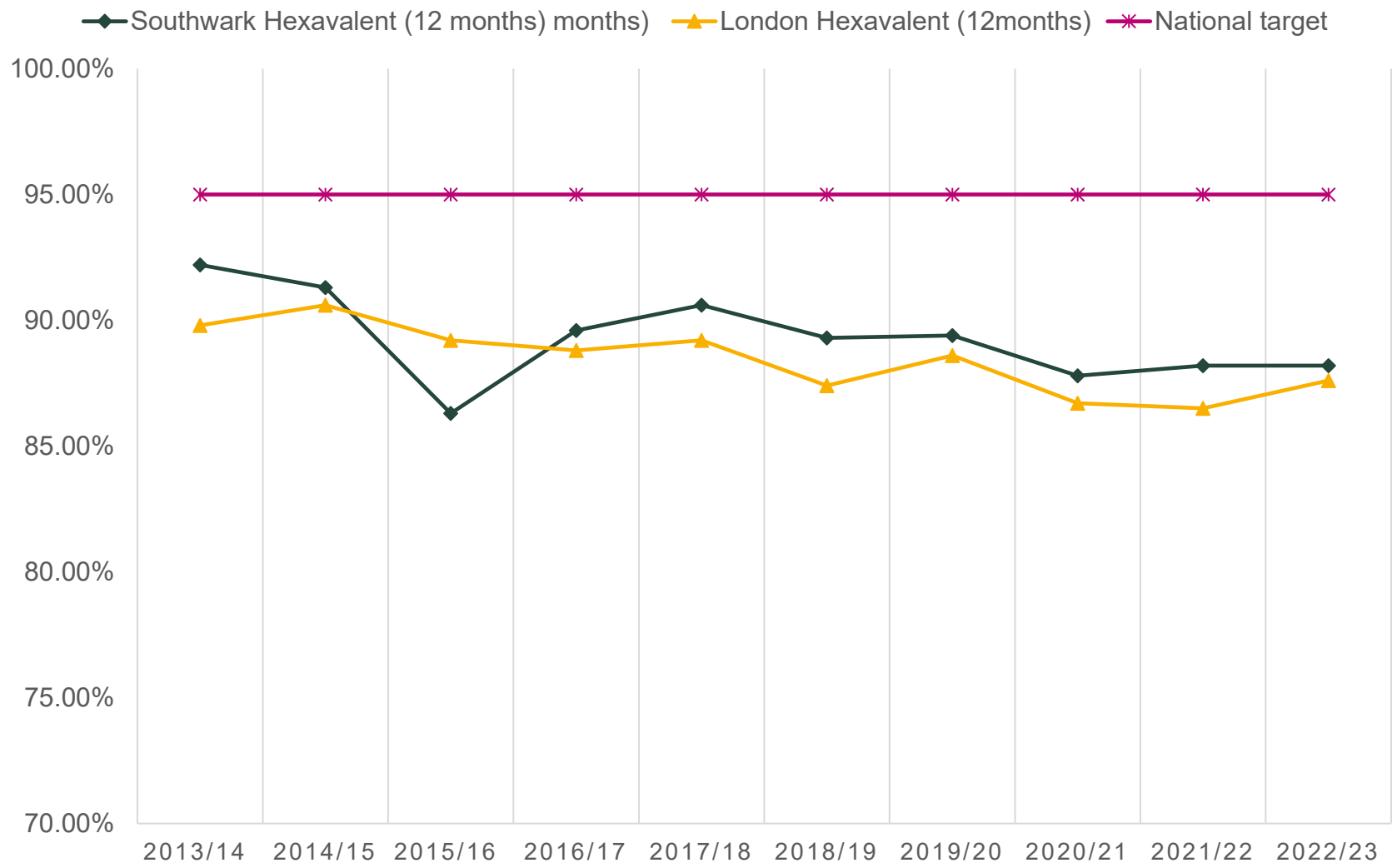
Highest uptake in White ethnic group (**55%**) Unknown (**1.4%**) and Mixed (**2.75%)**

18.8% of 65-69 age group declined flu vaccine 24/25

Sources: SEL COVID & Flu Vaccination Dashboard *(last updated 30/06/2025*)
SEL Summary of MMR Vaccination Uptake *(last updated 30/06/2025)*

Coverage in Southwark: Hexavalent

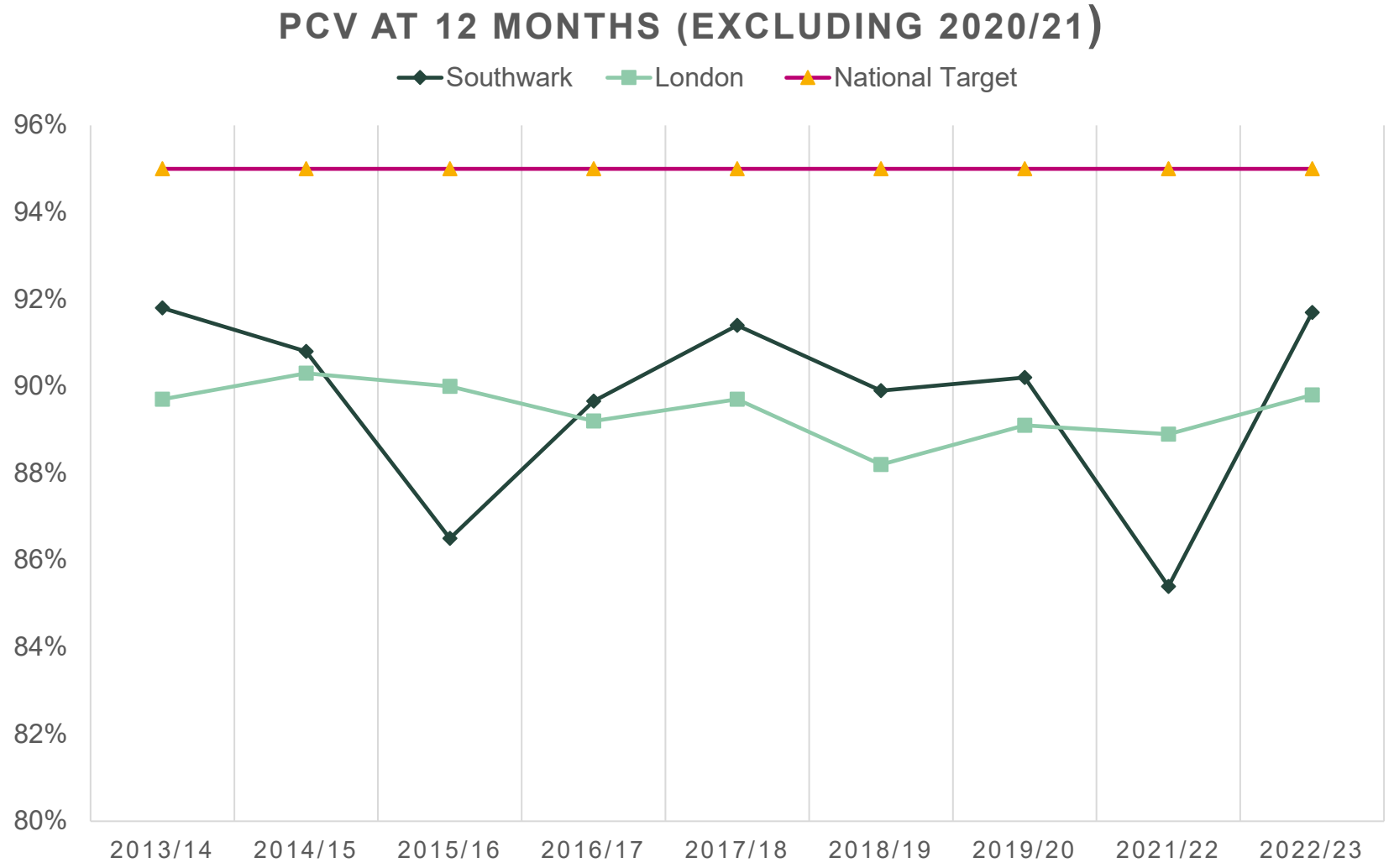
- Southwark's coverage remains consistently below national target and generally similar to or slightly above London's average.
- Uptake varies year to year, with no clear upward trend.



Source: Childhood Vaccination Coverage Statistics – Local Authority Time Series 2022 - 23

Coverage in Southwark: PCV13

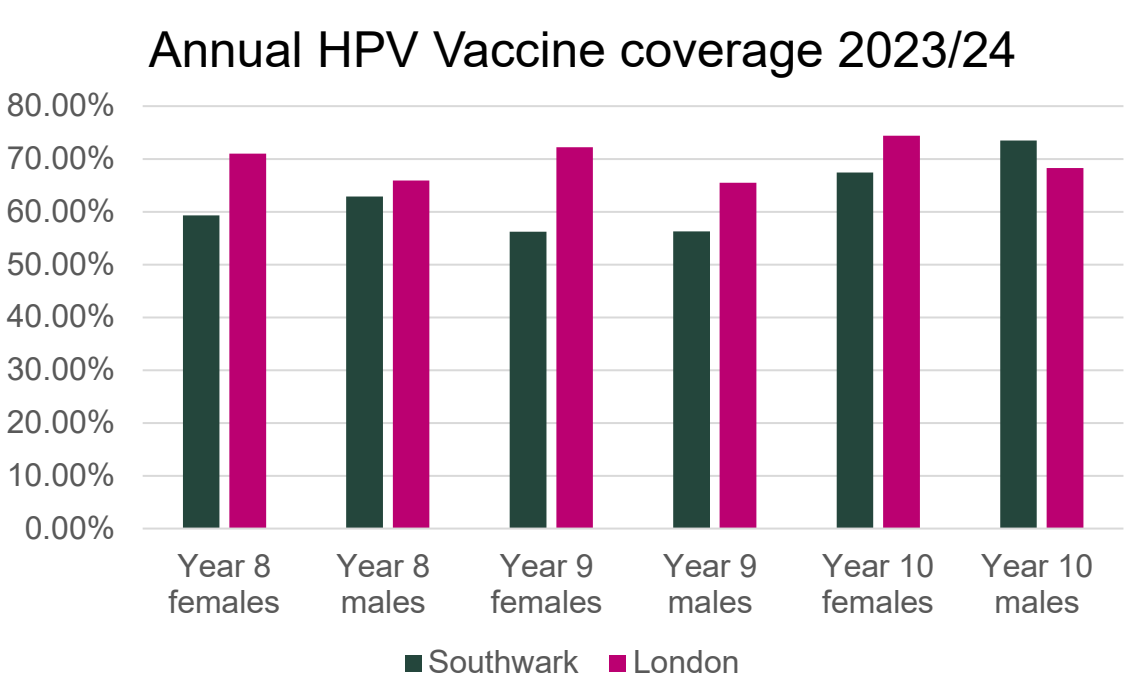
- Southwark consistently falls short of the National Target of 95% and below or similar to London's average.
- Slight recovery (6.3%) in 2022/23 but still below optimal levels.

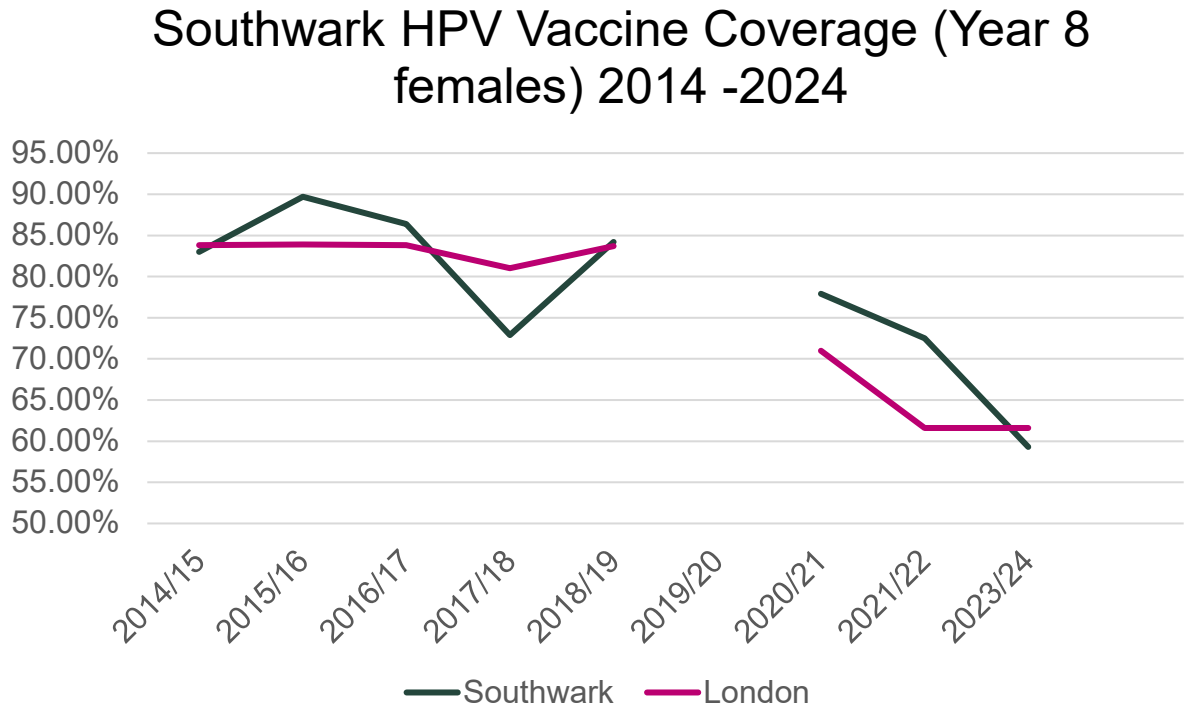


Source: Childhood Vaccination Coverage Statistics – Local Authority Time Series 2022 - 23

Coverage in Southwark: HPV

- The HPV vaccine protects against cancers caused by human papillomavirus, including cervical, anal, and some head and neck cancers. Introduced for girls in 2008 and extended to boys in 2019 in UK schools, typically offered in Year 8 (ages 12–13).
- In Southwark, HPV vaccine uptake remains below national averages and declining year on year in line with London averages.

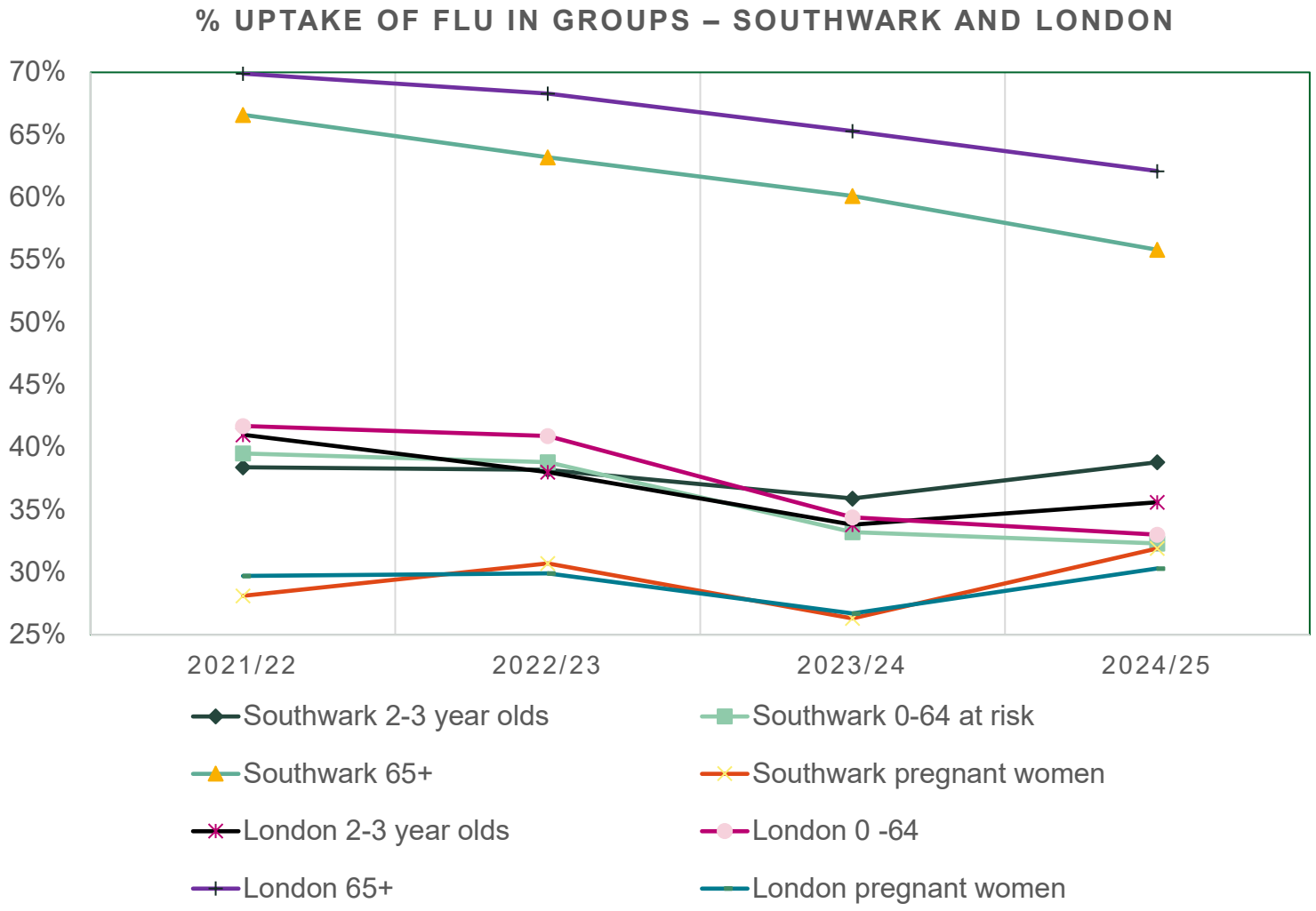




Source: Annual HPV Uptake in England: 2023 to 2024

Coverage in Southwark: flu

- **2–3-year-olds**: Relatively consistent uptake (average 36%)
- **0–64 at risk**: Mid-to-high 30% range, gradual decrease over time.
- **Pregnant women**: 5.6% point increase from 2023/24 – 2024/25
- **65+ adults**: Mid-60% range, steady decline.



Challenges for Southwark

Service provision

- Pushy tones in vaccination messages
- Conflicting immunisation schedules (local v national)
- Appointments accessibility
- Private vaccinations
- Changes in QOF codes to SNOMED codes
- Coding discrepancies
- Delay in receiving vaccination data from external providers i.e. HIT/CYPSIS
- Patient choice to defer vaccinations from routine schedule
- Practice nurse capacity and recruitment
- ICB changes
- Delegation of commissioning to ICBs

Residents

- Mistrust of NHS
- Vaccine hesitancy
- Patient choice to decline
- Concerns with vaccine safety
- Pre and post vaccination skepticism
- Conspiracy theories around vaccinations
- Negative social media stories
- Faith and cultural barriers
- Transient population
- Vaccinated in country with different schedule and not wanting to be revaccinated
- Inability to confirm vaccination status
- Language barriers
- Impact of COVID-19

Local response and work

Recognising the potential increase in vaccine preventable diseases as a result of the decreasing uptake of all immunisations – Vaccination Oversight Group added the risk to the ICB place risk register in January 2025.

Theme 1: Community engagement to understand and address barriers

- Commissioned **Southwark Pensioners Centre** to conduct a community-based research project to analyse the disconnect between existing vaccine campaign messages and the responses from Black African and Caribbean residents aged 65+. The goals of the project were to: identify the unique barriers; develop targeted and actionable recommendations and empower the target groups (Appendix B).
- Partnered with **local VCS organisations** including Latin American Women's Rights group (LAWRS), Indoamerican Refugee & Migrant Organisation (IRMO), Southwark Refugee Communities Forum (SRCF), Flashy Wings and local faith groups to discuss the importance of covid/flu vaccination, to understand and address barriers and support access for marginalised groups (findings from SRCF and Flashy Wings at Appendix C and D).
- Commissioned **Latin America Women's Rights service to undertake survey** for Spanish speaking women, to understand awareness and barriers to vaccinations.
- **Engagement with care home and social care staff** to identify and address barriers, including visits to talk about vaccinations with staff and wider health and wellbeing provision for this staff group.
- Commissioned **Christian and Muslim community organisations**, including Redeemed Assemblies and the Muslim Association of Nigeria, to support with work to engage with faith communities around vaccination.

Local response and work

Theme 2: Communication campaigns, raising awareness and training

- **Why we get vaccinated campaign** and further funding – developed local assets using Community Health Ambassadors to promote vaccinations across the life course (Appendix E).
- Regular **general communications disseminated**, including E-Newsletter articles, Southwark Life, council/ICB webpages and mobile BikeAds.
- **Targeted communications** including:
  - Letters signed by DPH to schools reiterating the importance of vaccinations and working with school vaccination service to ensure the offer is made to all children
  - Communicating provider changes eg offer of injectable flu vaccine (as nasal vaccine contain porcine gelatine).
  - Sharing of vaccination messaging and resources with home schooled children, local nurseries, childminders and children & family hubs
  - Developing vaccination timeline cards and leaflets, available in 13 languages.
- Messaging for COVID-19 and flu vaccinations **shared via the Southwark Faith Forum**.
- Working with our **Community Health Ambassadors (CHAs):**
  - Supporting Primary Care with text message wording
  - Training in measles and MMR
  - Vaccine confidence working group set up with CHAs
- Visits to **warm spaces, TRAs and the Ladies of Virtue Organisation** for Q&As on COVID-19 vaccination.
- Ran **grants project programme with local VSC organisations to promote preschool vaccinations** amongst communities with low vaccination uptake rates.
- Commissioned **Jitsuvax vaccine hesitancy training** for clinical and nonclinical staff, Community Health Ambassadors and local VSC organisations.

Local response and work

Theme 3: Improving access to vaccinations and outreach

- **Ongoing collaboration with primary care and the Health Inclusion Team service** to improve vaccination pathway, inclusion of vaccination history collection, offer at first assessment appointment and provision of regular vaccination catch up clinics for those living in asylum seeker accommodation.
- Partnering with Lambeth Public Health and Evelina community nursing service to deliver a **Community Vaccination Service pilot** to complement primary care delivery to improve the uptake of preschool vaccinations.
- Collaborative project across multiple services (Primary Care, mass vacc centre, VSC organisations, Public Health & ICB) to deliver **Polio booster vaccinations**.
- **Availability of evening and weekend appointments** as part of the Extended Primary Care service delivered via hubs at Tessa Jowell Health Centre (South) and Bermondsey Spa (North).
- Supported school vaccination team with sourcing locations across the borough to **deliver vaccination catch up clinics**.
- Two **community pharmacies assured to provide COVID-19 and MMR** vaccinations to eligible residents aged 5 years+.
- Specific, targeted and **enhanced service delivery and outreach in response to national and regional outbreaks and incidents**, for example, diphtheria in asylum seekers, measles and polio.

Local response and work

Theme 3: Improving access to vaccinations and outreach (continued)

- Numerous **vaccination pop ups and health and wellbeing promotion sessions** delivered across the borough, targeting those areas of high deprivation, low uptake and higher vulnerability, including vaccination pop up clinics in nurseries, libraries and children's centres offering flu and MMR for preschool children.
- Southwark **health promotion outreach service** which aims to engage residents to better understand their own health needs, address health inequalities and improve access to service to support good health, wellbeing, and connection by providing a health and wellbeing advice and services in community settings. This service has:
  - Collaborated with King's College Hospital to deliver supplementary vaccination service offering COVID and flu vaccinations for staff and patients
  - Health and wellbeing event at InSpire Walworth.
  - Health and wellbeing plus vaccination event at two homeless hostels.
  - Annual health and wellbeing plus vaccination event held at Bede House for those with learning disabilities.
  - Ongoing health and wellbeing including flu and COVID vaccination offer at Citizen's Advice Cost of Living Roadshow.
  - Vaccination and health checks offer at Healthwatch Southwark AGM.
  - Ongoing health and wellbeing including flu and COVID vaccination offer as part of Aging Well community service.
  - 2023 – 2024, 362 COVID19, 134 flu and 67 MMR vaccines given.
  - 2024 – 2025, 462 COVID19, 474 flu and 111 MMR vaccines given.

Discussion point

- Recognising the work underway to improve coverage, what additional support could Board members and their organisations offer to help reduce inequalities?

Appendix A: Pre-school vaccinations

- All routine vaccinations given to babies and young children between 8 weeks and 12 months are given in primary care.

- The selective BCG programme for TB is offered to infants under the age of 1 year old by Kingston & Richmond NHS Foundation Trust, delivered in weekly clinics held at Rye Oak Children and Family centre.

- The national schedule is for the second dose of MMR to be given at 3 years 4 months. Southwark, along with several other London boroughs, have offered an accelerated programme for MMR2 vaccine since 2008. This was in response to a measles outbreak in London but was continued to minimise the chance of future outbreaks. National policy is changing from 1 January 2026 to bring MMR2 forward to 18 months.

Changes to the immunisation schedule from 1 July 2025:

- Meningitis B schedule changes to 8 and 12 weeks
- PCV13 moves to 16 weeks
- Hib/MenC is discontinued for any baby born on or after 01/07/2024
- 12-month monovalent hepatitis B dose is discontinued for babies on the selective neonatal pathway

Changes to the schedule from 1 January 2026:

- Introduction of the 18-month dose of hexavalent vaccine
- Second MMR brought forward to 18 months

Complete routine immunisation schedule from 1 July 2025 - GOV.UK

Appendix A: Pre-school vaccinations

0 – 4 years (pre-school)				
Vaccine given	**Total no of doses**	**Diseases protected against**	**Age due**	**Provider**
DTaP/IPV/Hib/HepB (hexavalent/6 in 1)	3*	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib), hepatitis B	8 weeks 12 weeks 16 weeks	Primary Care
MenB	3	Meningococcal group B	8 weeks 12 weeks 12 months	Primary Care
Rotavirus	2	Rotavirus gastroenteritis	8 weeks 12 weeks	Primary Care
Pneumococcal conjugate vaccine (PCV)	2	Pneumococcal (13 serotypes)	16 weeks 12 months	Primary Care
BCG (eligible cohort only)	1	Tuberculosis	<12 months (around 28 days)	CYPCIS**
Hep B for high-risk babies (eligible cohort only)	2	Hepatitis B	At birth 4 weeks	Maternity CYPCIS
MMR	2	Measles, mumps, rubella	12 months 18 months	Primary Care
HiB/MenC (discontinued for babies born after 30/06/24)	1	Haemophilus influenzae type b (Hib) and meningitis C	12 months	Primary Care
Live attenuated influenza vaccine (LAIV)	annual	Influenza (each year from September)	2 & 3 years 6 mnths-4 yrs at risk	Primary Care
dTaP/IPV (preschool booster/4 in 1)	1	Diphtheria, tetanus, pertussis and polio	3 years 4 months	Primary Care

* Hexavalent dose 4 to be introduced from January 2026 at 18 months

** Children and Young Persons Community Immunisation Service (CYPCIS), part of Kingston & Richmond NHS Foundation Trust

Appendix A: School-age programmes

- All vaccinations given to children in the school age programme are delivered by the Children & Young Peoples Community Immunisation Service (CYPCIS). This is part of Kingston & Richmond NHS Foundation Trust.
- Flu vaccination if given in the autumn term, Td/IPV and MenACWY in the spring terms and HPV in the summer term.
- MMR status is checked at each school programme, and MMR offered if missing.
- Two pharmacies are assured to vaccinate 5+ years for MMR.

5 – 18 years (school-age)				
Vaccine given	**Total no of doses**	**Diseases protected against**	**Age due**	**Provider**
HPV (boys and girls)	1	Cancers and genital warts caused by specific human papillomavirus (HPV)	12-13 (year 8)	CYPCIS
Td/IPV (MMR status checked)	1	Tetanus, diphtheria and polio	13-14 (year 9)	CYPCIS
MenACWY	1	Meningococcal groups A, C, W and Y	13-14 (year 9)	CYPCIS
Live attenuated influenza vaccine (LAIV)	annual	Influenza (each year from September)	Reception through to year 11	CYPCIS

Complete routine immunisation schedule from 1 July 2025 - GOV.UK

Appendix A: Older adult programmes

- The RSV vaccine for older adults was introduced in the autumn of 2024 and is available for people aged 75. This can be given at the same time as shingles or pneumococcal vaccines but is generally not recommended to be given at the same time as COVID-19 or flu.
- Older adult vaccinations are delivered in primary care, with some also available in pharmacies.
- Other vaccines are available for people with underlying medical conditions, e.g. shingles for >50s and pneumococcal if immunosuppressed, and hepatitis A and B in those with haemophilia.

Older adult programmes				
Vaccine given	**Total no of doses**	**Diseases protected against**	**Age due**	**Provider**
Pneumococcal Polysaccharide Vaccine (PPV23)	1	Pneumococcal (23 serotypes)	65	Primary Care
Inactivated influenza vaccine	annual	Influenza (each year from October)	65 and older	Primary Care Pharmacy
Shingles vaccine	1	Shingles	65	Primary Care
Shingles vaccine	1	Shingles	70-79 (plus severely immunosuppressed)	Primary Care
RSV vaccine	1	Respiratory syncytial virus (RSV)	75	Primary Care

Appendix A: Maternal vaccination programmes

- Maternal vaccinations are delivered by the maternity services and can be given by primary care if the woman chooses to attend for vaccinations.

Maternal programmes				
Vaccine given	**Total no of doses**	**Diseases protected against**	**Stage**	**Provider**
Inactivated flu vaccine	1	Influenza (each year from September)	Any stage of pregnancy	Maternity Primary Care Mass vaccination centre (Francis House)
Tdap	1	Pertussis	From 16 weeks gestation	Maternity Primary Care Mass vaccination centre (Francis House)
RSV vaccine	1	RSV	From 28 weeks gestation	Maternity Primary Care Mass vaccination centre (Francis House)

Appendix A: COVID-19 vaccination programme

- Eligibility for COVID-19 vaccination has changed over the past three years. This year, the eligibility criteria is the same as for spring 2024, with the addition of immunocompromised people in younger age groups.
- COVID-19 vaccination is given across primary care, local pharmacies and on-site to care home residents.
- In addition, COVID-19 is also offered at some outreach events during autumn and winter.

COVID-19 programmes				
Vaccine given	**Total no of doses**	**Diseases protected against**	**Stage**	**Provider**
COVID- 19	1 twice a year (winter and spring booster)	COVID-19	6 months – 74 with weakened immune system 75+ Older adults care home resident	Primary Care Pharmacy Mass vaccination centre (Francis House)

Appendix B: Southwark Pensioners Centre

COVID-19 Vaccine Hesitancy: Perspectives from BAME residents aged 65+ in five wards in Southwark (Faraday, Borough & Bankside, N Walworth, Peckham, Chaucer). Southwark Pensioners Centre. July 2024 (full report attached)

Main findings:

1. Despite similar demographics, vaccination rates consistently lower in the 5 targeted wards. 56.5% of respondents from these wards received 3+ COVID-19 jabs, compared to 75% from non-targeted wards. Additionally, the 2023 autumn booster rate is 23.4% points lower in targeted wards.
2. There is a notable difference in vaccine information access between targeted and non targeted wards. Targeted wards 10% lower access to autumn booster campaign and 61% relied on doctors and clinics as main source for COVID-19 information compared to 94% in non targeted wards.
3. Research participants reported anxiety and resentment due to lack of information on vaccine side effects. They felt dismissed when raising issues with their GPs and unaware of reporting channels for vaccine issues.
4. Participants perceived the removal of the 15 minutes wait and COVID vaccine cards as unsafe. They raised concerns about the co-administration of COVID-19 and flu jabs, feeling unsafe and unclear about potential implications.
5. Participants reported negative feelings about reminder texts, describing the tone as rude and pushy and the frequency too high.
6. Some residents showed a preference for culturally informed health remedies over conventional western methods and questioned the need for COVID-19 vaccines.
7. All interview and focus group participants were exposed to conspiracy theories about vaccines and took a critical stance towards them.
8. Individuals (BAME, 65+) with physical disabilities or health conditions tend to have higher vaccination rates; those who are carers or have carers show lower rates.
9. Access to COVID-19 or flu vaccines was generally easy for most participants. Residents suggested improvements such as more local pharmacies offering the vaccine, vaccine stations at care centres and home visits for vaccinations.
10. Only 7% of survey participants had heard of the Community Health Ambassadors

Recommendations:

1. Improve effectiveness of communication
    - Culturally-informed collaborative conversations; proactive misinformation management; clear communication on protocol changes; clear co-administration info.
2. Improve complaints management
    - Promote reporting channels (yellow card scheme); inform/support regarding procedures for complaints; culturally sensitive complaints management training.
3. Improve access
    - Convenient vaccs for carers; expand local access (eg pharmacies, vaccine stations at care centres); promote Community Health Ambassadors.

Appendix C: Southwark Refugee Communities Forum

Southwark Refugee Communities Forum (SRCF) received a small grant to help improve the uptake of MMR and other childhood vaccinations in Refugee and Asylum Seeker population. The project goal was to overcome barriers by delivering accurate, translated and culturally sensitive vaccination information in accessible formats to empower individuals make informed decisions and foster trust in healthcare services.

Main findings:

1. Most effective and impactful method of engagement was using service users in the production of vaccination awareness videos. One created in Arabic was shared on different digital platforms, amongst friends and family and social networks resulting increased participation and interest in vaccination. Further videos have been produced in the 7 most the most spoken languages of asylum seekers and refugees in Southwark.
2. Vaccination Time Cares very effective asset for stimulating one to one conversation with parents, identifying if vaccines have been missed or due and signpost and support families to GP's and vaccination clinics.500-600 timecards distributed.
3. Workshops led by SCRF alongside HCP delivered in accessible safe space saw 90+ participants engage and ask questions that they may not have otherwise done so. Men were found to be less knowledgeable about vaccinations than women but had same level of interest and appetite to learn more.
4. Vaccine hesitancy: Lack of trust stemmed from misinformation obtained via social media about safety of vaccines, religious belief and ingredients in vaccines (raised by Muslim service users) language barriers, understanding the UK vaccination schedule, and cross-generational trauma experienced with health authorities

Recommendations:

1. Longterm investment in projects working with faith leaders and trusted community organisation would yield better results than short term projects.
2. Multilingual, culturally appropriate ground up communication: Co production of resources with community organisations to develop campaign materials and assets to ensure they resonate with the public.
3. Develop train the trainer programme to build health ambassadors capacity targeting refugee and migrant background with health experience in country of origin to build trust with HCP advocating health (vaccinations and other diseases prevalent in this community)

Appendix D: Flashy Wings Ministry

Flashy Wings Ministry received a small grant to help improve the uptake of MMR and other childhood vaccinations in the Black African and Caribbean community. The aim of the project was to tackle the myths around vaccinations by delivering accurate and culturally sensitive education sessions to empower individuals make informed decisions and foster trust in healthcare services.

Main findings:

1. Most effective approach to engage with the target group was breakfast/ lunch sessions and informal workshops – this facilitated the right environment and atmosphere for debates about vaccinations; benefits verses risks; and guest invitation to HCPs to provide evidence-based information and answer questions.
2. Myths, misinformation, superstitions and conspiracy theories and the safety of vaccines cited as reasons for not vaccinating. Individuals whose beliefs derived from religious concept/theology adopted a cult like perspective, perceiving all matters through religious prisms regardless of the logic or evidence to counter their perception
3. Shift in attitude about vaccinations: Questionnaires completed pre and post debates and workshops found the interventions empowered participants to make informed decisions about vaccinations. 220 participants completed questionnaire pre and post the debates and workshop:
    - Pre intervention, of the 220 participants 88 said yes, they would vaccinate their children, 68 said no and 64 were undecided.
    - Post intervention 111 said yes, they would vaccinate children (increase by 23), 36 said no (positive shift by 32) and 73 were undecided.
4. 33 vaccinations taken up following the intervention; 27 children vaccinated aged between 4 months and of 5 years of age.
5. The use of small freebies encouraged people to stop, talk and complete questionnaires. Engagement with men more successful via the outreach event. Men less knowledgeable about childhood vaccinations and what /if own children had received any vaccinations.
6. Outreach events was more successful engaging with BAME men, they had a significant lack of knowledge about childhood vaccinations and what /if own children received any vaccinations, when compared to women.
7. Creation of resources using familiar faces and service users was a successful tool to engage with underserved populations. Flashy Wings members participated in Why We Get Vaccinated campaign, shared their experiences and used their personal powerful stories to promote and encourage parents to vaccinate their children.

Recommendations:

1. Community education/ Vaccination interactive sessions for all first- time parents, to address conspiracy theories, alleviate concerns and involve more father's immunisation of their child.
2. Celebration of the success and power of vaccinations: Whole system approach: public, voluntary, health, education, private, commercial businesses sectors, museums, transport all create their own intervention to celebrate vaccinations; for example, through pictures/ photography, art, music, dance, theatre/stories, local radio/ new
3. Continue to fund and use community organisation that are experts in and successful at reaching the community and delivering key messages and facilitating change attitudes and behaviors. Project life should be extended to enable message and behaviors to be embedded and normalized.

Appendix E: Why we get vaccinated

“Why We Get Vaccinated” community engagement campaign – a three-year, multi-agency behaviour change initiative, co-produced with London communities, launched autumn 2024.

- The campaign focuses on opening and encouraging conversations about vaccination, with the overall aim to improve vaccination rates in our lowest uptake communities.
- It promotes vaccinations throughout the life course and aims to build trust and understanding between health partners and the communities they serve by featuring real people including residents, healthcare professionals, and community leaders from across London.
- Southwark has funded local campaign assets featuring our own Community Health Ambassadors.

Survey insights include:

- Most respondents agreed that vaccines are effective, and childhood vaccines important for a child’s health, but 40% concerned about serious adverse effects of vaccines.
- The Covid-19 vaccine campaign had the highest recognition (53%), & the childhood imms campaign the lowest (26%). 43% said they hadn’t seen any of the campaigns.
- The top channels for reaching people: social media (24%), TV (24%), and information from GPs (24%).
- The top trusted messengers: GPs (64%), specialist clinicians (62%), government experts (52%). Community/faith leaders were the 2nd lowest trusted messenger (8%).
- Key motivators for uptake of the flu vaccine were health concerns, past experience and protection. Barriers included not feeling at risk, lack of transparency, worry about ‘chemicals’, concerns about cost, efficacy and safety, confusion about eligibility and taking alternative precautions. Evidence of effectiveness is a key driver.
- Most who felt positively about vaccinations ‘believe’ and ‘hope’ vaccines provide protection rather than being certain – may also benefit from messaging to prevent a slip in positive perceptions.
- Responses had emotionally charged language regarding people who choose not to vaccinate – highlighting risk of alienating hesitant individuals.
- Respondents didn’t always understand the consequences of specific illnesses, except for fatality.
- Many prefer single vaccine over combined.

Recommendations for messaging:

- Include personal or relatable stories and emphasise personal protection and protecting vulnerable loved ones.
- Address misconceptions about immunity and vulnerability and well as eligibility confusion and safety concerns.
- Leverage positive terminology from responses, eg ‘precaution’, ‘protect’, ‘prevent’.
- Focus on informing rather than stigmatising non vaccinators.
- Communicate risks and complications of diseases and highlight collective benefits.

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 3
Enclosure: 3

Title:	**Unplanned admissions for over 65 year olds**
Meeting Date:	**24 July 2025**
Author:	Rebecca Jarvis, Director of Partnership Delivery and Sustainability Claire Belgard, Acting Director of Integrated Commissioning
Executive Lead:	Darren Summers, Place Executive Lead/Strategic Director for Integrated Health and Care

Summary of main points
The number of unplanned and/or emergency admissions for over 65s is a key metric in determining the success of much of the work of Partnership Southwark. The data for Southwark appears to show a gradual increase in the rate of emergency admissions for over 65s. This paper sets out the range of work being undertaken across the Partnership to reduce unplanned admissions. The focus is on transformation and improvement initiatives. It does not cover the range of 'business as usual' services (such as intermediate care and other community services) which support residents to stay well and manage their health needs at home, and prevent unnecessary hospital admissions. The aim of this paper is to provide context to support a discussion with Board members on how we can work together to amplify our efforts in reducing unplanned admissions for older people in Southwark.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
		X	

Action requested of PSSB
To contribute to the discussion.

Anticipated follow up
Not known.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	
Adult mental health	
Frailty	**X**
Integrated neighbourhood teams	**X**
Prevention and health inequalities	**X**

Item Impact

Equality Impact	*No negative impact on equality is anticipated as a result of this discussion.*		
Quality Impact	*No negative impact on quality is anticipated as a result of this discussion.*		
Financial Impact	*No negative impact on finance is anticipated as a result of this discussion. Reducing the number of unplanned admissions is likely to reduce costs across the system.*		
Medicines & Prescribing Impact	*No negative impact on medicines and prescribing is anticipated as a result of this discussion.*		
Safeguarding Impact	*No negative impact on safeguarding is anticipated as a result of this discussion.*		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	X		

Describe the engagement has been carried out in relation to this item
Relevant team members across the Directorate have contributed to the paper.

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Unplanned Admissions for Over 65 year olds: An overview of current performance and initiatives to inform a board discussion

Rebecca Jarvis, Director of Partnership Delivery and Sustainability
Claire Belgard, Acting Director of Integrated Commissioning

24 July 2025

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Working together to improve health and wellbeing for the people of Southwark

Introduction

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

The number of unplanned and/or emergency admissions for over 65s is a key metric in determining the success of much of the work of Partnership Southwark. It is reported on in the Integrated Governance and Assurance Report under the Frailty strategic priority and is one of the three 'headline metrics' which are required to be reported on for the Better Care Fund. Reducing unplanned admissions and increasing the number of patients receiving care in community settings is also a key aim of the NHS England Urgent and Emergency Care Plan (2026/26).

The data for Southwark appears to show a gradual increase in the rate of emergency admissions for over 65s. The admission category which appears to have a clear upward trend is respiratory.

A range of services contribute directly and indirectly to admissions avoidance, including primary care, urgent community response, step up intermediate care, same day emergency care, ambulance services etc, hence is a whole system measure.

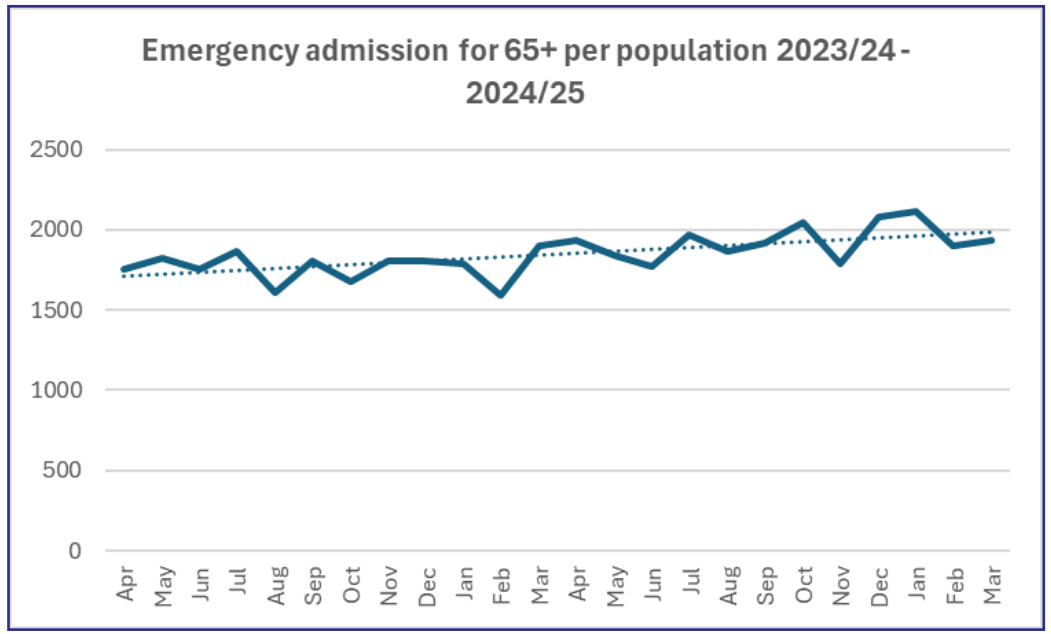
This paper sets out the range of work being undertaken across the Partnership to reduce unplanned admissions. The focus is on transformation and improvement initiatives. It does not cover the range of 'business as usual' services (such as intermediate care and other community services) which support residents to stay well and manage their health needs at home, and prevent unnecessary hospital admissions.

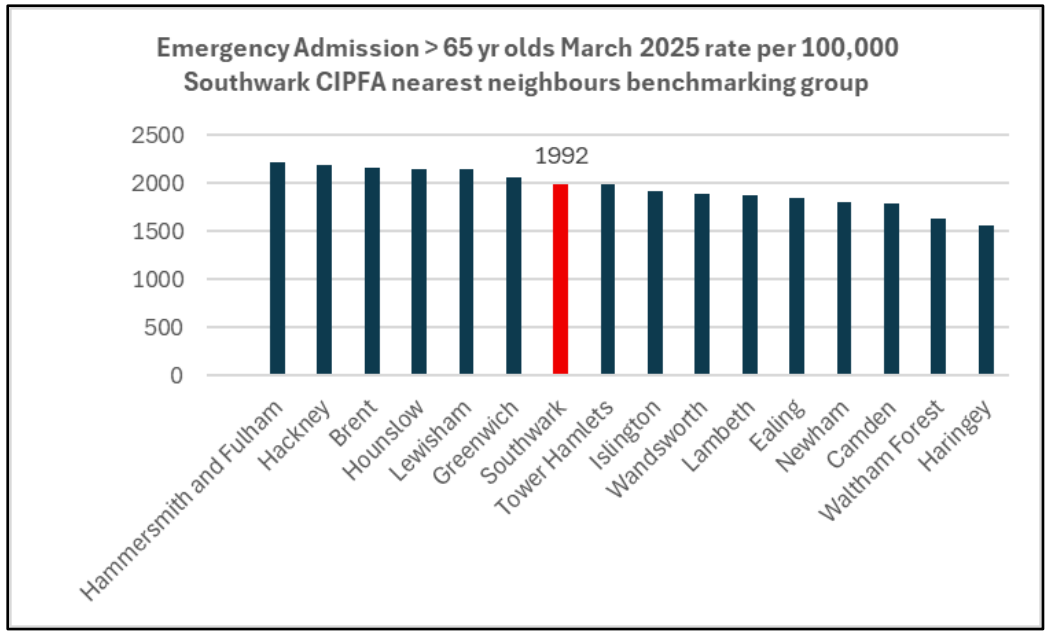
The aim of this paper is to provide context to support a discussion with Board members on how we can work together to amplify our efforts in reducing unplanned admissions for older people in Southwark.

Performance

Partnership Southwark

Emergency Admissions for 65+ per 100,000 65+population in 2023/24 and 2024/25





At the year end 24/25, the average number of emergency admissions for 65+ per 100,000 population over the year was 1,992.

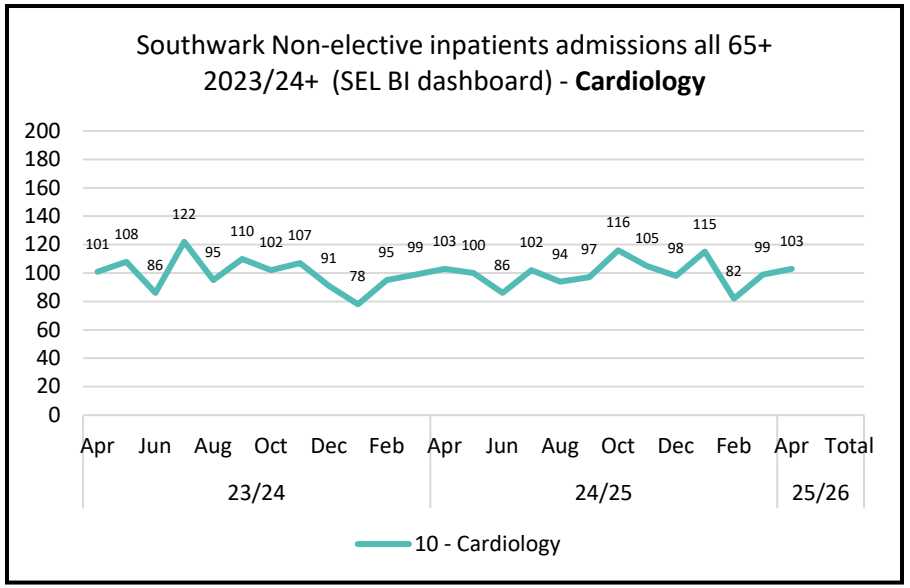
The London average is 1,786.

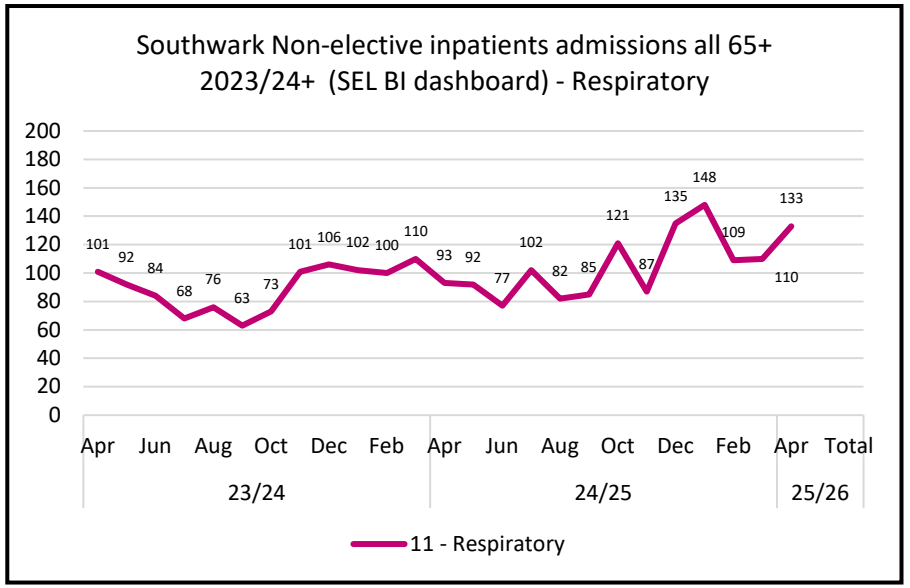
When compared to statistically similar local authorities, Southwark's performance fall towards the middle of the group.

Data source:DHSC BCF dashboard, 30.06.25, also HES raw data NHSE refresh 10.07

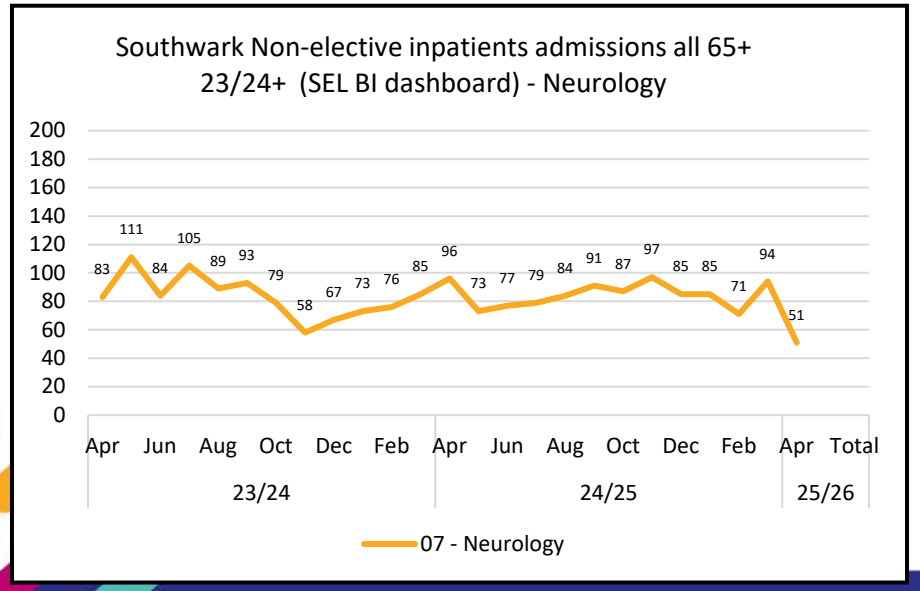
Non-elective inpatients >65 yrs - trends in category of admission (top 8 categories accounting for 81% of total admissions) 1) Cardiology 2) Respiratory 3) Neurology 4) GI

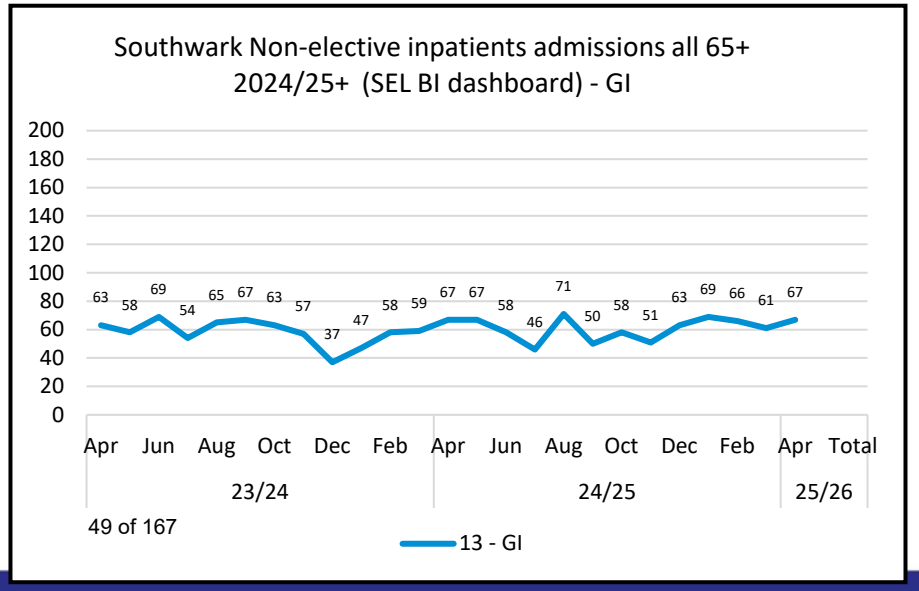
Partnership Southwark





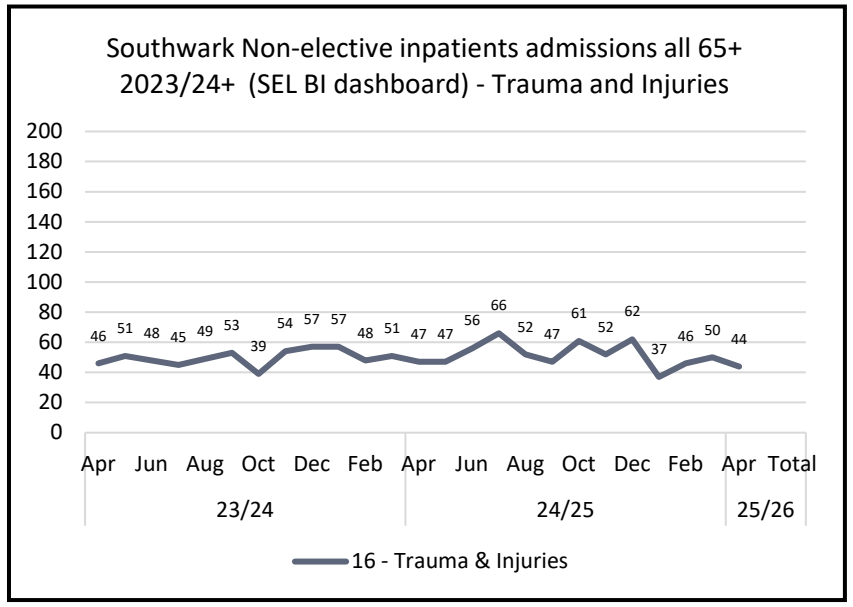
The category which appears to have a clearer upward trend is Respiratory

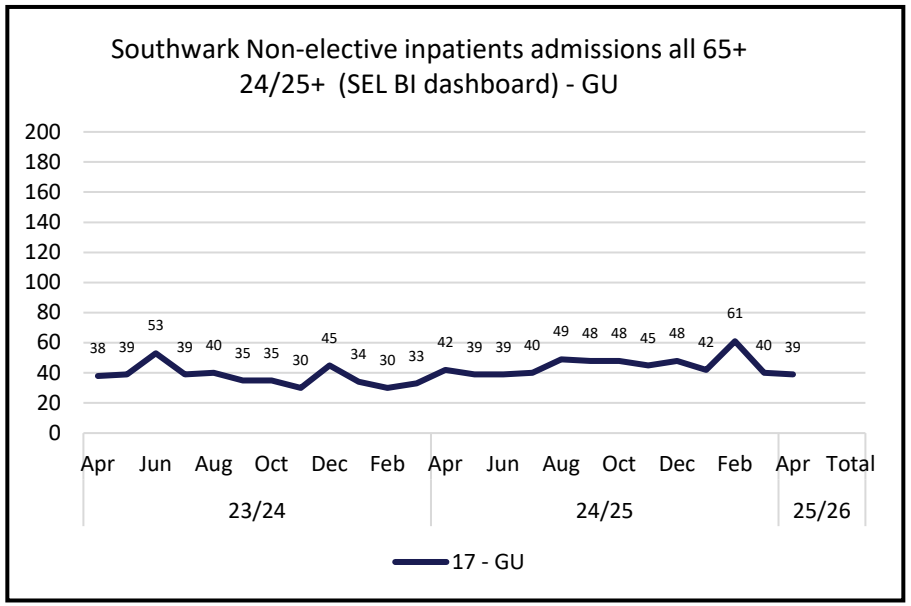


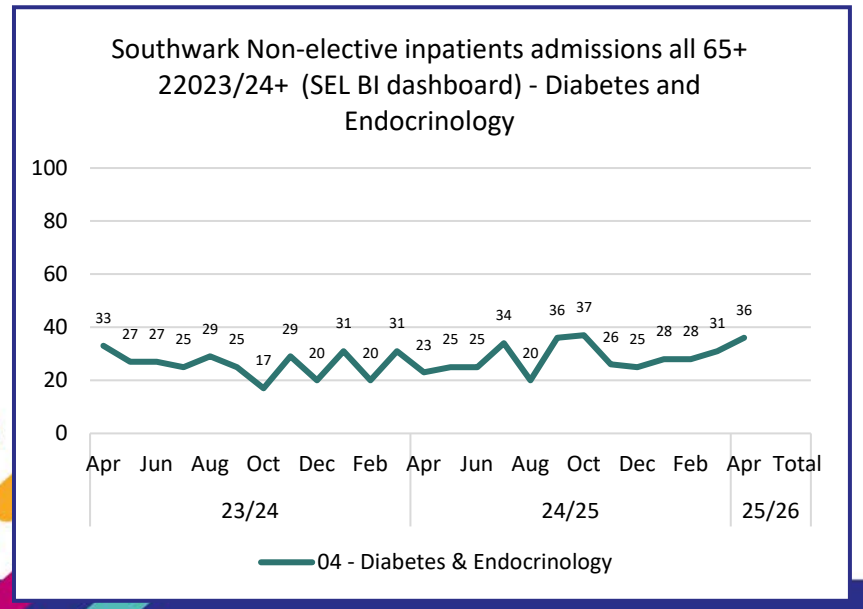


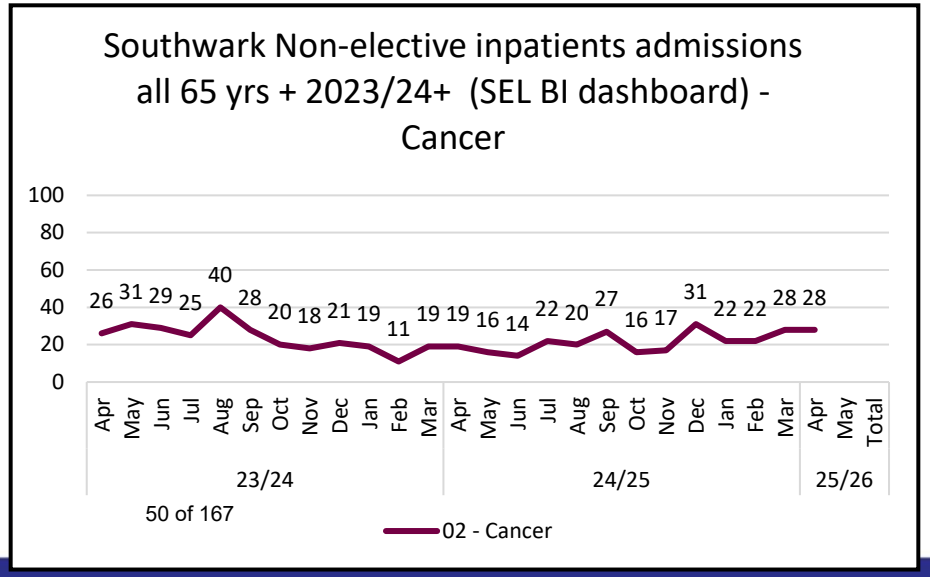
Non-elective inpatients > 65 yrs - trends in category of admission (top 8 categories accounting) 5) Trauma and injuries 6) GU 7) Diabetes and Endocrinology 8) Cancer

Partnership Southwark









Virtual Wards and Hospital At Home (@home)

Partnership Southwark

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What is the initiative?

Virtual wards or Hospital at Home support reducing attendances and admissions to hospital and support reduction in length of stay. Across Lambeth and Southwark providers have worked since Autumn 2023 within an overall programme to develop @Home which now provides 237 beds which allows patients of all ages to safely and conveniently receive acute care at their usual place of residence, including care homes. Data for nine months to Sept 2024 showed nine services operating 3,626 referrals received and 2,143 patients cared for.

How will this contribute to unplanned admissions?

Data for nine months to Sept 2024 showed 1,943 admissions avoided and 48,482 bed days saved. @Home services are available for patients of all ages so this data is not specific to over 65s.

Over what time period?

@Home services across Southwark and Lambeth have been developed as a programme since May 2023 and are now being embedded as a“business as usual” part of the system. @Home services operate from GSTT, KCH, Evelina London and St Christophers. A local maturity assessment was completed in Oct 2024 and from May 2025 the ambition is to scale up, optimise and integrate

.

Remote monitoring

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

Remote monitoring is used for patients in @Home services who have been selected by clinicians as suitable**.** Through a partnership with Doccla we provide observation kit, bluetooth devices to facilitate connectivity, customer services, device delivery, onboarding, patient compliance support, clinical monitoring and support, direct patient messaging and option to videocall. Challenges with remote monitoring include patient ability to use technology and lack of trust in third party providers from both patients and clinicians.

How will this contribute to unplanned admissions?

Doccla remote monitoring wards are part of the overall @Home offer, there are opportunities to expand remote monitoring to other patients which are being explored as part of reviewing the Doccla contract.

Over what time period?

Remote monitoring has developed to the same timescales as @Home though there are opportunities to increase usage in the future

Better Care Fund initiatives

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

Better Care Fund (BCF) provides £57m of funding to a range of schemes that aim to reduce admissions to hospital and to support discharges, this includes funding allocated directly to Care at Home and @Home. BCF also funds some council teams such as the Intermediate Care Team who focus on providing proactive joined up support for people at risk of admission and in need of urgent support and the Home Support Team (OT and Physio) that provide multi-disciplinary team support to care homes

How will this contribute to unplanned admissions?

BCF funded initiatives and BCF funding to other services contribute to the overall system to ensure people can live well in the community.

Over what time period?

BCF funding plans are agreed annually, it is likely that due to cost pressure schemes may need to reduce from 2026

Homecare procurement

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

Southwark deliver Care at Home as part of our social care offer, it is available for adults and children but primarily used by older adults. The service delivers support in residents' homes, including personal care, domestic support, and emotional and social wellbeing support. Each year Southwark provides around 2,000 adult residents with home care services across the borough, equating to nearly one million hours of home care provision each year. Currently Southwark has a number of providers under different contracts but we are about to go out to tender for an ambitious new set of contracts for between 4 and 8 years at a projected annual cost of £31m which includes a new specialist lot for more complex care needs.

How will this contribute to unplanned admissions?

It is anticipated that our new specialist Care at Home service will allow more residents to remain at home and reduce hospital admissions, we are also exploring more @Home type services that may be delivered by Care at Home providers in the future

Over what time period?

4 to 8 years from April 2026

Same day access

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

The aim of this work is to improve access to primary care services so that it is easier for patients to arrange appointments on the same day and to support patients in finding the care that is best suited to their needs. We are working with practices which have a high number of in-hours calls to NHS 111 to understand why these patients are not seen within the practice and to better understand the same day access offers currently in place. We are recruiting a GP fellow to support practices to make improvements, which are likely to include encouraging patients to change their behaviours, increasing the number of appointments available and providing more proactive care for patients with long term conditions.

How will this contribute to unplanned admissions?

Whilst this is not focussed on over 65s it is likely that a proportion of the patients identified will fall into this cohort, so any impact such as more timely interventions, improved pathways and care coordination to prevent emergency admissions will affect this cohort.

Over what time period?

The work is being carried out this year with practices making changes to ways of working by Q4.

Integrated Frailty Pathway

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

The aim is to systematically identify people living in the community with mild, moderate and severe frailty and provide proactive case management and integrated support to help them live healthier and more independent lives for longer, reducing the need for long term care. Data suggests that there are over 10,000 patients identified as being frail in Southwark.* New integrated teams are being formed at a neighbourhood level, by bringing together clinical and non-clinical staff from primary and secondary care, the VCSE and social care. The new Population Health Management contract for primary care at scale which will be introduced in October will place a greater emphasis on proactive case finding and care coordination, to support this approach.

How will this contribute to reducing admissions?

People living with frailty at an earlier stage and receive a Comprehensive Geriatric Assessment (CGA) usually in their own home. CGAs can help identify and address factors contributing to unnecessary hospital admissions. The integrated team is well placed to provide the coordinated care required to keep people healthy and out of hospital.

Over what time period?

The pathway has been piloted in two GP practices in the Camberwell and Walworth Neighbourhood and has just started in a third practice in this neighbourhood. There are plans to spread to the south of the Borough in quarter two of this year. With the implementation of Integrated Neighbourhood Teams later this year there is potential to rapidly spread this initiative across the borough.

* SEL BI (Primary Care Discovery Data), Feb 2025

SEL Ageing Well Framework

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

What is the initiative?

The SEL Ageing Well Framework was developed during January to March 2025, enabling Places to incorporate it as part of their local development. The framework helps us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation.

How will this contribute to reducing admissions?

The focus of the framework is initially on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). It encompasses the wider factors and determinants pertinent to ageing well, such as destigmatising ageing, building age friendly communities, the role of the carer and tackling social isolation. Ageing well is strongly linked to reducing hospital admissions among older adults.

Over what time period?

The framework will be adopted across southeast London over a number of years. Work is currently underway to develop a gap analysis for Southwark.

Discussion

Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

- Are there any other initiatives/what's missing?
- Which ones are most likely to contribute to reducing unplanned admissions?
- Where/how can we amplify our efforts?

Partnership Southwark Strategic Board
Cover Sheet

Item: 4
Enclosure: 4

Title:	**Integrated Neighbourhood Teams Update**
Meeting Date:	**24 July 2025**
Author:	Rebecca Jarvis, Director of Partnership Delivery and Sustainability
Executive Lead:	Darren Summers, Place Executive Lead/Strategic Director for Integrated Health and Care

Summary of main points

One of the 'must dos' outlined the London Target Operating Model for INTs which was released in May 2025 is to nominate an 'integrator' organisation for Southwark to host the integration functions required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level.

The timescales for nominating the integrator were outlined at the Partnership Southwark Strategic Board in May, and the aim was to formally appoint the integrator in July.

A new INT Programme Executive Board was formed in June 2025 to replace the programme board and the Chief Executive Integrated and Specialist Medicine Clinical Group for GSTT stood down as co-chair due to the direct conflict of interest in the process of appointing the integrator.

Potential provider organisations were invited to submit expressions of interest for the delivery of the integrator function in Southwark. One response was received from a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and a new joint venture between Southwark GP Federations: Improving Health Limited (IHL) and Quay Health Solutions (QHS) (attached). The attached response outlines how the proposed integrator will deliver against the forms and functions.

The proposal has been reviewed by the INT Programme Executive Board and the Chief Executive Officer of the SEL ICB. Both are supportive of the proposal. It was formally approved at the ICB Board on 16th July 2025.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
			X

Action requested of PSSB

The PSSB is requested to agree that the partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and a new joint venture between Southwark GP Federations: Improving Health Limited (IHL) and Quay Health Solutions (QHS) is appointed as the integrator for Southwark.

Anticipated follow up

The immediate next steps for the integrator are to design and implement integrated neighbourhood teams in Southwark.

There will be a transitional period where relevant functions currently fulfilled by the ICB and Partnership Southwark are handed over to the Integrator.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	X
Adult mental health	X
Frailty	X
Integrated neighbourhood teams	X
Prevention and health inequalities	X

Item Impact			
Equality Impact	*The aim of Integrated Neighbourhood Teams is to improve access to services and promote early intervention, with the aim of reducing health inequalities. These teams, part of a wider integrated care approach, are designed to address the social determinants of health and ensure a more equitable distribution of resources and opportunities.*		
Quality Impact	*No negative impact on quality is anticipated as a result of appointing an integrator for Southwark.*		
Financial Impact	*Any additional costs for INTs will be considered by the partnership. It is anticipated that all statutory partners will be required to work together to resource the INTs.*		
Medicines & Prescribing Impact	*No negative impact on medicines and prescribing is anticipated as a result of appointing an integrator for Southwark.*		
Safeguarding Impact	*No negative impact on safeguarding is anticipated as a result of appointing an integrator for Southwark.*		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	X		

Describe the engagement has been carried out in relation to this item
Engagement with partners at the PSSB and INT Programme Executive meetings in May and June 2025. The three organisations forming a partnership to deliver the integrator function have engaged appropriately within their own governance structures.

23rd June 2025

By email only

Dear Darren and Andrew,

We are submitting our response to the call for expressions of interest for delivery of the Integrator function in borough. Our response is framed around the specific questions that have been asked, and we look forward to ongoing discussions on the next steps with our Southwark partners.

1. **Which statutory bodies and partners are included within the integrator arrangement being proposed? If the arrangement is a partnership arrangement, which organisation would act as the lead organisation (as set out in the principles related to form)?**

Southwark has agreed that the integrator will be a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) and a new joint venture between Southwark GP Federations: Improving Health Limited (IHL) and Quay Health Solutions (QHS). This partnership arrangement recognises the central role of both organisations in delivering care in the borough, and the importance of these services in supporting the development of a neighbourhood service with our wider partners including Southwark Council, King's College Hospital, South London and Maudsley, the voluntary sector, and the wider network of primary and community care providers.

GSTT will be the statutory body hosting the partnership. We are establishing robust partnership arrangements that allow us to take an equitable approach, held together by key principles which govern our work (expanded on in the following section).

We recognise that the GP leadership arrangements within our Integrator partnership are evolving in response to the external environment. IHL and QHS are undertaking work to establish a joint venture for general practice. We are expecting the process to conclude by October 2025. Due to the immediate ask for the integrator to hold the £250,000 integrator development funding provided by SEL ICB, this will be held by GSTT on behalf of the integrator, with principles for spend being ratified by the partners with oversight of our Partnership Southwark priorities.

2. **What shared decision-making structures are planned to be put in place to support the integrator arrangements, and how is parity of voice being considered to enable effective neighbourhood working?**

We recognise that our work around neighbourhoods will be led by the integrator, but that there will be significant input needed from all partners at an operational and strategic level in order to deliver on our neighbourhood ambitions. As the integrator, we will co-produce and codevelop our work with all relevant stakeholders and effectively communicate these changes throughout our local care partnerships.

The integrator will establish an Integrator Delivery Board (IDB) in July 2025. The IDB will have delegated authority from GSTT, IHL, QHS and North and South Southwark Primary Care Networks (PCN) to make decisions on behalf of the respective organisations and broader partners. The IDB will meet monthly. The integrator will utilise existing partner governance functions to streamline functions and ensure that all Southwark partners are part of the integrator delivery model. IDB will provide progress reports to the Southwark INT programme executive that will also receive proposals that require further review and support from wider system partners. We anticipate the IDB will work

closely with equivalent structures in all SEL boroughs as part of a network of integrators to share best practice. We will maintain close joint working across Lambeth and Southwark to make the best use of local resources and harness the opportunity for synergistic working at scale.

There will be core members from the integrator on the IDB. These will include:

- **GSTT:** ISM CEO, Evelina CEO, ISM Director of Partnerships and Operations, ISM Deputy Medical Director, Population Health Hub Consultant, Evelina Director of Strategy, Evelina Deputy Medical Director
- **IHL and QHS:** IHL Managing Director, QHS Executive Director, NSPCN Clinical Director, SSPCN Clinical Director, Southwark Local Medical Committee
- **Partnership Southwark:** Director of Partnership Delivery and Sustainability (non-voting member that will attend during transition period.

The core principles of the IDB will be:

- Make decisions on allocation of resources within INT models
- Scrutinise and agree models of INT delivery (explored in more detail in following answer)
- Respond to emerging policy developments regarding neighbourhood health
- Demonstrate impact of neighbourhood health models of care
- Receive updates from delivery function

3. **How will the integrator arrangement ensure that resources and leadership are in place to deliver the integrator function and the development of integrated neighbourhood care either through the lead organisation, or via a broader partnership approach? It is recognised that the function will grow over time.**

Our integrator leadership model will include integrator specific governance as well as reporting and engagement with our broader partners. The Integrator Delivery Board's terms of reference will provide a jointly agreed structure for this governance, harnessing the collective resources of the integrator partners.

You will be aware that there is collaborative work taking place across Southwark and Lambeth with shared partners. We are exploring how we keep strong connections between our respective integrator models, whilst retaining the strong identities and attending to the needs in each borough. This work includes harnessing the input from our primary care leadership structures, and also within GSTT via the INT delivery committee, which reports into the Improving the Health of our Populations (IHOP) committee.

We will make the best use of our existing resources to design, develop and deliver an integrated neighbourhood care model. We will do this through agreement with Southwark partners as well as using the initial learning from our models to support discussions around how we work to deliver the national 'three shifts' as models show impact.

We will continue to review our resources as the neighbourhood health model develops to ensure that the function is developing. We also recognise alignment with this and the work taking place around the model ICB structure. The functions and use of partnership resources will formally reviewed within our Partnership Southwark executive structures on an annual basis.

The existing Lambeth and Southwark Primary Care and Acute Interface Forum addresses prioritised interface issues like referrals, pathways and fit notes. We anticipate this group, and potentially other

groups working in the partnership space, will transition into the integrator function to streamline the delivery of the neighbourhood health model.

4. **What will be the first priorities for the integrator arrangements to support effective neighbourhood working, considering the South East London focus on delivery of integrated neighbourhood teams for our three priority populations?**

Our first priorities are to deliver on the national ambitions around integrated neighbourhood teams, centred around the identified cohorts with additional local variation where required. Developing INTs to support care of residents with frailty, multiple long-term conditions and children and young people will provide a framework for our work.

Our key priorities will be to support operational coordination between sectors and partners across the borough and between INTs. This should enable us to identify the gaps across our fragmented pathways and services, and provide the opportunity to build interfaces and relationships, supporting workforce planning and business intelligence. Our principal aims will be to:

- facilitate population health management by promoting the sharing and effective use of data and information across organisations, enabling holistic care for our residents and improving population health outcomes
- collectively provide essential infrastructure supporting people, finance, governance, and risk management for INTs in a consistent way, harnessing existing local assets and resources.
- implement INTs, including recruitment of team managers and clinical leads, and working with local organisations to identify the resources/staff that will be deployed into INTs.The initial priorities for this financial year are as follows:
- establishment of IDB in July 2025
    - each neighbourhood to undertake detailed design work before starting to deliver frontline change, using initial insights and learning to develop the model
    - commence partnership work around data and insights to help develop the future model

We recognise that the INT model is predicated on a population health management approach. Due to the similar integrator model across Lambeth and Southwark, we expect to share the development of this function across both boroughs to ensure an effective and efficient model. This will use resources from the Population Health Hub within GSTT, the data analytical function within the LGPPA and the respective federations in Southwark, and the business intelligence capacity within SEL ICB. The long-term aim of the population health management function will be to develop an integrated data set with a patient-identifiable data set that enables detailed risk stratification across our populations, working with the broader SEL ICS on any relevant ICS PHM tools or procurements. As a short-term aim, the population health management function will work with partner organisations to create overarching data sets to focus our work in neighbourhoods and understand the enablers for data sharing.

We welcome the opportunity to discuss our plans in more detail.

Many thanks,

Louise Dark
Chief Executive Officer
Integrated and Specialist Medicine Clinical Group
Guy's and St. Thomas' NHS Foundation Trust

Rebecca Dallmeyer
Executive Director
Quay Health Solutions
North Southwark

Nigel Smith
Executive Director
Improving Health Limited
South Southwark

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 6
Enclosure: 5

Title:	**Strategic Director for Integrated Health and Care/Southwark Place Executive Lead report**
Meeting Date:	**24th July 2025**
Author:	Darren Summers (Strategic Director for Integrated Health and Care/Southwark Place Executive Lead)
Executive Lead:	Darren Summers (Strategic Director for Integrated Health and Care/Southwark Place Executive Lead)

Summary of main points

This report details key events and activities, that are relevant to Partnership Southwark, that have taken in the past two months, including:

- Further work on the ICB model blueprint
- The publication of the NHS 10 year plan
- The health inequalities fund
- The GP patient survey
- The presentation of the Maternity commission action plan to the Health and Well Being Board in June
- A workshop to consider how we best utilise community estate

As noted in the separate item on Integrated Neighbourhood Teams (INTs), as well as in this report, significant progress has been made over the past two months, including the appointment of an 'integrator' for Southwark – a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT), Improving Health Limited (South Southwark) and Quay Health Solutions (North Southwark). All partners have brought energy and enthusiasm for our workstream to develop INTs, and we are on track to launch these by the end of the calendar year.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
	x		

Action requested of PSSB

To note the report and updates.

Anticipated follow up

N/A

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	**x**
Adult mental health	**x**
Frailty	**x**

Integrated neighbourhood teams	**x**
Prevention and health inequalities	**x**

Item Impact			
Equality Impact	The report includes an update on a number of items that impact on health inequalities including: - Maternity commission update - Health inequalities fund update		
Quality Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes quarterly quality reporting element for the board.		
Financial Impact	The report includes information on financial performance for 2024/25 and an update on the recent additional requirement to reduce ICB running costs.		
Medicines & Prescribing Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes a report from the delegated lead for medicines optimisation.		
Safeguarding Impact	The report refers to the Integrated Assurance Report from the Integrated Governance and Assurance Committee which includes a summary of the Q4 safeguarding report.		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	X The board development seminar on environmental sustainability held in February.		

Describe the engagement has been carried out in relation to this item
N/A

Partnership Southwark

STRATEGIC DIRECTOR OF HEALTH & CARE AND SOUTHWARK PLACE EXECUTIVE LEAD REPORT

This report is for discussion and noting; to update the Board on key highlights on Partnership Southwark and the delegated functions.

ICB Model Blueprint

South East London ICB (SEL ICB) continues to work up its management change proposals in response to the publication of the national model ICB blueprint that sets out the key role of ICBs in the future, with a focus on strategic commissioning to meet the health needs of the local population. The model ICB blueprint further sets out a range of current activities which will not fall to ICBs to deliver in the future with a need to transfer some services to other partners or to cease the activities where they result in system duplication. The national expectation is that ICB management costs reduce as a result of this re-focus with a national average reduction in cost of 50%. SEL ICB's reduction is a lower 35% reflecting its relatively low level of current spend per head of population.

SEL ICB's senior management team has been undertaking work over the last couple of months to take stock of the requirements and ambition set out in the model ICB blueprint, review our current function and form and consider the key changes required to effectively deliver the future role and meet the savings target that has been set. The review process has been undertaken through a series of rapid review sprints to enable the development of a target operating model against which more detailed proposals for change are being developed.

In addition, SEL ICB has been participating in work through which London's ICBs, working with London region colleagues, have shared learning on the interpretation of and thinking in relation to ICBs' future function and form as well as considering opportunities for collaborative approaches to some functions. This could be in relation to the provision of scarce skills and expertise or through the development of once for London polices and frameworks, providing economies of scale, increased efficiency and best value.

SEL ICB has also been working with provider partners to establish the level of interest in taking on those functions listed in the model ICB blueprint as subject to future transfer from ICBs to providers. Initial expressions of interest were received, followed by the provision of more detailed supporting information and joint discussions, with confirmed expressions of interest due to be received in July.

These three main strands of work are currently being brought together to enable the development of proposed functional and structural changes for the SEL ICB, upon which consultation will take place with staff over the summer months. It is hoped that SEL ICB will be consultation ready for early August, subject to any national requirements and authorisation required prior to doing so.

Staff have been regularly updated via all staff briefings, written Question and Answer feedback, HR advice and wider employee assistance and support. It is recognised however that the scale of the organisational change being enacted and the short timeframes to which the ICB is working is impacting on staff, who are facing significant uncertainty. The ICB is

committed to doing everything possible to provide support to staff over the duration of the process.

The ICB has established a Transition Board that will oversee the programme of work, reporting to the Board and chaired by a Non-Executive Member of the Board.

The blueprint outlines expectations that ICBs will streamline their governance. In line with these expectations, proposals will be brought to the September or November Partnership Southwark Strategic Board outlining options for the future governance of our Local Care Partnership in Southwark.

The NHS 10-Year Plan

'Fit for the Future: 10 Year Health Plan for England' was launched by the government on 3 July 2025. The Plan sets out a transformative vision for the National Health Service (NHS), with a focus on shifting from a reactive, hospital-centric model to a preventative, community based, and digitally driven healthcare system. Further core themes revolve around decentralising power to local providers and patients, harnessing technological advancements like genomics and Artificial Intelligence (AI), and ensuring long-term financial sustainability through re-allocated spending and new payment models, improving patient experience and outcomes and addressing health inequalities.

These changes will be driven through a first key shift from current approaches to a neighbourhood health service, providing localised, preventative and community based care that meets the needs of the population. The principle is that 'care should happen as locally as it can, digitally by default, in a patient's home, if possible, in a neighbourhood health centre when needed, in a hospital if necessary'.

A number of underpinning approaches are set out to enable this, including a shift in the pattern of NHS spending to invest in out of hospital care, enhanced GP access, an increased role for community pharmacy, improved dental care and the establishment of Neighbourhood Health Centres (NHCs), which will be established in every community, starting in areas with the lowest healthy life expectancy. These one stop shop facilities will be open at least 12 hours a day and 6 days a week, serving as bases for multidisciplinary teams.

There is a dual focus on patient empowerment, including increases in the provision of care plans, personalised health budgets and easier access to services through the NHS App. The Plan places significant emphasis on moving from analogue to digital and leveraging technology for prediction, prevention, and personalised care as a second key shift. A new Single Patient Record (SPR) will be introduced, the NHS App will improve ease of access to services, the provision of information, clinically validated wearables will be increased plus the widespread use of genomics for key diseases like cardiovascular, renal, and diabetes. The Plan commits to developing AI to support diagnosis, the use of robotics and vaccine development.

The third key shift highlighted in the 10-year Plan relates to prevention and public health, secured through a huge cross-societal energy on prevention, involving collaboration with businesses, employers, investors, and local authorities. The Plan sets out a goal of a smoke-free generation for young people, action to tackle obesity, reduce alcohol consumption and improve environmental health. There is also a link to the neighbourhood health care and digital shift in enabling a greater focus on prevention, early detection and intervention.

Finally, the NHS 10-year Plan sets out an extensive range of enablers, from workforce development to payment reform to drive financial sustainability and innovation, a shift to medium term planning, a new Patient Choice Charter and the development of a new NHS operating model and associated organisational and system architecture changes focussed upon securing a devolved, diverse, high performing and responsive NHS.

SEL ICB's and Partnership Southwark's existing strategic plans align well with the strategic ambition set out in the 10-year Plan, with significant work having been undertaken to take forward an integrated neighbourhood health and care model, including the development of three key integrated care pathways and teams, covering multiple long term conditions and comorbidities, frailty and children and young people.

We will be scheduling a more detailed discussion on the 10 year plan at the September Partnership Southwark Board.

Integrated Neighbourhood Teams

There has been good progress towards neighbourhood working in the last quarter which has involved significant engagement with key stakeholders to identify an appropriate 'integrator' to host the functions required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level. In June the Southwark Integrated Neighbourhood Team Programme Executive agreed to the recommendation for the formal appointment and approval of Guy's and St Thomas' NHS Foundation Trust (GSTT) in partnership with Improving Health Limited (South Southwark) and Quay Health Solutions (North Southwark), who are forming a joint venture as the integrator organisation for Southwark. This recommendation was approved by the SEL ICB Board on 16th July.

The development of an integrated frailty pathway in the Camberwell and Walworth Neighbourhood is expanding to more GP practices to develop improved ways of identifying and supporting people who have severe, moderate or mild frailty. Early findings show this has kept care close to home, eased pressure on hospitals, and improved communication between GPs and hospital teams. Patients have also benefited from medication reviews and the opportunity to record their care preferences in case of future serious illness or incapacity.

Prior to the publication of the 10 year plan, the London region had articulated its approach to the development of the Neighbourhood Health Service through the publication of the Case for Change and a London Target Operating Model for Neighbourhood Health. These have been developed in partnership between London's five Integrated Care Boards, NHS England London Region, and the wider London Health and Care Partnership (London Councils, Greater London Authority, UK Health Security Agency and the Officer for Health Improvement and Disparities in London), with support from London-wide Local Medical Committees. What is outlined in these documents builds on the work that we have been doing in Southwark and across South East London to implement the Neighbourhood Health Service with clear alignment to our Integrated Neighbourhood Team framework and plans.

Alongside the 10 year plan, NHS England are inviting expressions of interest from places to join phase one of the National Neighbourhood Health Improvement Programme (NNHIP)

which will pioneer the shift to the Neighbourhood Health Service. South East London ICB will be working across the six places to submit applications into this programme given our forward work in this area.

Partnership Southwark Workshop: Shaping the 2025/26 Health Inequalities Fund

In June, Partnership Southwark hosted a collaborative workshop aimed at identifying opportunities to reduce health inequalities and inform the spending plan for the 2025/26 ICB Health Inequalities Fund. The event brought together representatives from a wide range of health and care organisations across Southwark, including many from the voluntary, community, and social enterprise (VCSE) sector.

Discussions centred on the needs of six priority population groups highlighted in *The Southwark Annual Public Health Report 2024 – A Fairer Future: Tackling Health Inequalities in Southwark* (Southwark Council factsheet). These groups are:

- Carers
- Residents with disabilities
- LGBTQIA+ individuals
- Asylum seekers and refugees
- Rough sleepers
- Black and ethnic minority communities

A key insight from the workshop was the recognition of significant overlap between these groups. Participants emphasised the importance of considering these intersections when developing spending plans, to maximise impact and ensure more inclusive support.

The Partnership Southwark team is now working to incorporate ideas and recommendations from the workshop into the development of this year's funding plan.

GP Patient Survey

The GP Patient Survey results for 2025 have been released. In North Southwark PCN area 70% of patients described their overall experience of GP practice to be good or very good, reflecting a broadly positive perception of care quality, whilst in South Southwark this was 73%.

However, differences emerged in how easily patients could contact their GP practice: in South Southwark 68% of respondents had a positive experience, while in North Southwark 64% did so. Other questions asked whether respondents 'knew the next step in dealing with a request after contacting their GP practice' and whether they had 'confidence and trust in the healthcare professional at their last appointment'.

A detailed examination by practice will take place at the August Primary Care Committee.

Estates Workshop

On 26th June the Estates team convened a workshop bringing together over 60 professionals from estates, clinical and community backgrounds to discuss how local buildings and premises can be better utilised to support the strategic shift of services from hospital to the community

and the development of Integrated Neighbourhood Teams. Several members of the board attended. Topics considered were wide ranging, with a specific focus on how to learn from the mobilisation of the Tessa Jowell Health Centre as we develop an estates plan for the neighbourhood teams. It was agreed that strong clinical engagement is required to make a success of co-location of neighbourhood services.

An important objective was the issue of improved buildings utilisation and it was acknowledged that when gathering and interpreting utilisation data, clinical input is also essential to offset the risks of unintended impacts on the delivery of services.

Other discussion themes included better use of buildings and digital tools, supporting care in the community, and helping people manage their health earlier and closer to home. People shared great examples of local services already working well and talked about the challenges of moving more care out of hospitals. However it was recognised that cultural issues need to worked on to improve collaborative approaches to estates across the system.

The estates team will develop a plan to progress some of the key themes discussed, and the INT programme will work with the estates team as required to deliver suitable estates options.

Better Care Fund update 2025/26

The Better Care Fund (BCF) for 2025/26 was agreed by the Southwark Health and Wellbeing Board on 19th June. The plan passed the NHSE assurance process and the approval letter was issued on 30th June. There are no Southwark specific conditions set out in the letter, unlike in other boroughs. The BCF is a mandatory pooled budget of £57.6m, which funds a wide range of core community based health and social care services. It should be noted that the current advice from national leads is that 2025/26 was very much a transitionary year with a roll over of current arrangements. It has been indicated that more radical changes may be expected in the 2026/27 planning arrangements, aligning with the NHS Long Term Plan priorities. Locally it has been agreed to review the BCF services well in advance of the planning guidance being produced to ensure desired changes can be implemented at the start of the year. This will include a review of how well the services align with the key 3 targets of the BCF (emergency admissions avoidance, reduced delayed transfers of care and reduced permanent care home admissions) and the key objectives (supporting the shift from sickness to prevention, and supporting people to live independently and the shift from hospital to community).

Maternity Commission

A steering group has been established to oversee the ten recommendations of the Maternity Commission which were approved by the Health and Wellbeing Board in November 2024 following nine months of consultation with over 750 residents, voluntary and community sector representatives, local maternity care service providers and local workforce.

The steering group, which was formed in April 2025 has developed an action plan which was reported to the Health and Wellbeing Board in June 2025. The action plan will be delivered over five years to September 2029 with a mid-year review in 2027 and aims to address the identified themes:

- Tackling discrimination and better supporting women with specific needs.
- Making sure women are listened to and supported to speak up, whatever their language or background.
- Providing women with the right information at the right time in the right way.
- Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
- Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers

Early successes include:

- Completion of a brief needs analysis by public health, using council data, which has highlighted disproportionalities in perinatal mental health needs, maternal obesity, hypertension, and gestational and Type 2 diabetes
- Identification of a good training and development offer available across a range of partners including psychological support to build resilience
- A range of community-based initiatives and targeted campaigns are in place.
- A positive start to the pre-conception campaign being promoted through a number of Southwark locations and on-line

Darren Summers
Strategic Director of Health & Care & Place Executive Lead

Appendix 1 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Integrated Governance and Assurance Committee (IGAC)

Agenda Items of Note

Meeting date 10th July 2025

Agenda item	Items discussed
Finance Report Q1	The committee received a detailed report on the ICB Q1 financial position for 2025/26. As at Month 3, Southwark Place is reporting a year-to-date underspend of £49k and a forecast outturn underspend of £194k. The overall forecast position reported includes overspend in prescribing expenditure and mental health with underspends in delegated primary care, continuing care, corporate costs and community services supporting the overall position. Key risks for delivering the budget are identified as mental health and prescribing. A summary of the report is included in the Integrated Assurance Report on the agenda for the July PSSB.
Savings Plan Update	The report sets out in detail the position on the delivery of the agreed savings programme for Southwark amounting to £4.4m for 2025/26. Several schemes are highlighted as having a high risk of non-delivery which will require mitigating action.
Procurement update	The update sets out recent decisions made on contract extensions for the Care Home GP contract the PACT service and the Mental Health Wellbeing Hub. Updates are also provided on procurement processes in progress. A summary of the report is included in the Integrated Assurance Report on the agenda for the July PSSB.
Mental Health Update	The Head of Live Well Integrated Commissioning presented two updates. Firstly, on the mental health, the 6 key workstreams reporting to the newly established Southwark Complex Care Programme Board were set out. The overall objective is to improve the quality, oversight, and financial sustainability of commissioning arrangements regarding Section 117 aftercare and other complex mental health placements. This is fundamental to delivering a balanced budget in 2025/26. Secondly, the strategy for re-commissioning the mental health well-being hub was presented. The aim is to deliver a step change in how community based and delivered mental health support is accessed, experienced and delivered in Southwark. Both reports were reviewed and final proposals will be further discussed by the Joint Commissioning Oversight Group on 14 July.

Integrated Assurance Report	The committee reviewed the Integrated Assurance Report, noting that at this point in the reporting cycle full quarter 1 data was not available. It was agreed that an executive summary reflecting highlights of the IGAC discussion be tabled to PSSB for the July meeting.

Appendix 2 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Partnership Southwark Delivery Executive

Agenda Items of Note

Meeting date 12th June 2025

Agenda item	Items discussed
Strategic Priorities Dashboard	The Strategic Priorities Dashboard has been developed to enable the partnership to track key metrics that the priorities workstreams are intended to have an impact on. The metrics in the dashboard reflect the success measures set in the Southwark section of the SELICB Joint Forward Plan 2025/26 refresh, for which a small number of key measures against our main priorities were required. It was noted that the dashboard does not currently include targets for each measure. This element is being progressed with input from the Clinical and Care Professional Leads and others.
Adolescent Wellbeing Model	The group received an update on the work being Dr Nicola Hanson, GP and CCPL for Start Well. The update focused on ambitions for developing an adolescent health and wellbeing service, with links to delivery plans under the Children and Young People (CYP) mental health strategic priority. Scalability and opportunities for partnership working to support the model were raised for consideration. Discrepancies around waiting time data were highlighted.
SEL Ageing Well Framework	The group received a presentation on the SEL Ageing Well Framework (see Appendix 4) from Tania Kalsi as SEL Ageing Well Lead. The group heard that the framework was developed between January and March 2025 with multiple stakeholders across the Southeast London system. The focus of the framework is on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). **The Delivery Executive is recommending that the Partnership Southwark Strategic Board APPROVES the framework and proceeds with the actions related to developing the gap analysis and implementation plan for the borough.**
Highlight Report for each of the Wells	The group received a highlight report for Start Well, Live Well, Age & Care Well.
Health Inequalities Fund	The group was informed about an upcoming workshop in June aimed at identifying opportunities to reduce health inequalities and inform the spending plan.

Appendix 3 – Partnership Southwark Strategic Board (PSSB) Sub-Group Report

Primary Care Committee

Agenda Items of Note

Meeting date 12th June 2025

Agenda item	**Items discussed**
Report from the Collaborative	The committee was updated on the key points discussed at the last two primary care collaborative meetings. The Value Based Integrated Care (VBIC) model will be included regularly as an agenda item to allow for Southwark input into the development and implementation of the model. The primary and secondary care interface work continues with a focus on key priority areas: fit notes, onward referrals, call and recall and a single point of access. Other priorities for the collaborative will be delivering 'modern general practice' and delivery of the new GP contract. The Collaborative sought assurance regarding how member practices are being engaged as part of the development of the Southwark integrator
Varenicline PGD	The committee noted and approved the recommendation to ratify locally the Patient Group Direction (PGD) for the supply of Varenicline for smoking cessation. This is a joint project with colleagues across SEL and working with local authority colleagues.
Quality and Performance	The dashboard, showing the performance of Southwark's primary care providers through varied indicators, has been further developed. In Q1, eight practice visits were undertaken and four are still outstanding as part of Q1. A summary report of the outcome of visits will be brought back to the committee at the end of Q2. The committee was updated on the CQC visits. Acorn & Gaumont and Nexus are now rated 'good' from 'requires improvement'. Lordship Lane still has a 'requires improvement' rating; the team have met with CQC, and an action plan is in progress.
Estates	A number of development sites and plans were discussed, including:

	Elephant Park Health Hub: The Committee supported the recommendation to sign a Memorandum of Understanding (MoU) agreement between Southwark Local Authority, SEL ICB and the developers. This commitment provides assurance for the developers whilst the various necessary process on both sides are undertaken to facilitate a lease agreement. Nexus Commercial Way branch site: The committee noted the practice's communication plan and asked for it to be further enhanced with details of patient engagement to date. It was agreed that the chair would pick up outside of the meeting due to the timeline. Since the meeting, approval has been given by the ICB and the site will close 1 August 2025 with all patients being seen at other Nexus sites, including the new Harold Moody Health Centre which opened earlier this year. Discussions are still ongoing between the ICB and Penrose GP Practice regarding the provider's proposal to move to a new premises. A further update will be provided at the next meeting. Utilisation and Modernisation Funding: The committee was updated that five schemes were put forward for Southwark last year when modernisation funding was made available nationally, and the current deadline for delivery of the schemes is December 2025.
GP Contract Update	Tessa Jowell Surgery: The committee discussed the Tessa Jowell Surgery contract extension, given evidence of improvements against a 'requires improvement' CQC rating being brought back to the committee. Since the Committee meeting, CQC have visited and although they haven't formally written and uploaded their report, they have advised the PCBC team that the practice will be rated 'good'. The committee had noted the positive evidence provided by the practice to the PCBC team and clinical lead in lieu of the CQC visit and on that basis agreed in principle to the extension of the contract from 1st April 2026 – 31st March 2029, dependent on the outcome of the CQC inspection.
Primary Care Finance	At year end there was an overspend on the delegated primary care budgets and a small underspend on other primary care contracts after support from SEL ICB. The borough had received non recurrent support from the ICB to manage the large overspend that was being predicted on delegated primary care. A break-even position was reported on both delegated primary care budgets and other primary care at M2.
Procurement Update	Silverlock and Queens Road: The Committee was updated that the closing date for invitations to tender was 20th June 2025. The outcome

	of the procurement is expected to be announced at the end of September/beginning of October. An update will be provided at the next committee meeting. Population Health Management (PHM) contract: The committee supported the recommendation to direct award following the appropriate Provider Selection Regime (PSR) process. Southwark Care Home Practice: The committee approved the recommendation to direct award under the PSR process, subject to confirmation of a further £60K reduction from the provider for 2026 onwards.
Risk Register	The committee noted that work is underway to better align the borough register with the corporate risk register that goes to SEL.

South East London Integrated Care System

NHS South East London

SEL Ageing Well Framework

'Age without limits: you say, your way'

Final Draft Report
April 2025

Programme supported by:

HEALTH INTEGRATION PARTNERS

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South East London Integrated Care System

NHS South East London

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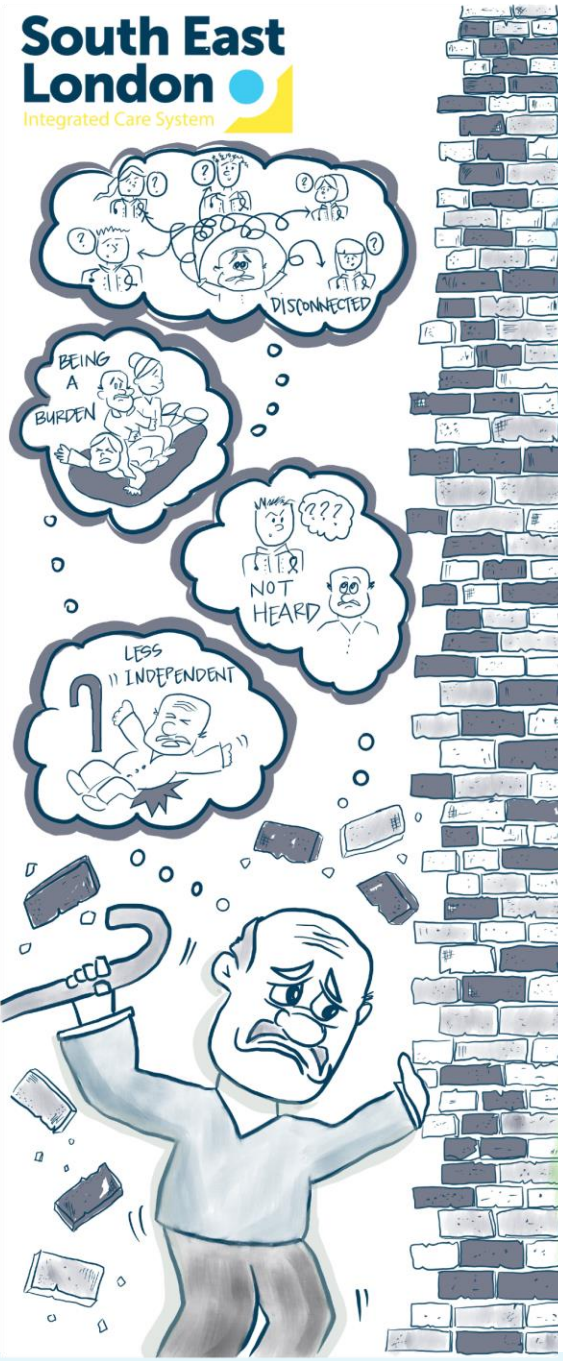
HEALTH INTEGRATION PARTNERS



Executive summary

Introduction

- The SEL Ageing Well framework was developed between January and March 2025 driven by multiple stakeholders at Place and involving colleagues from across the whole SEL system. The framework builds on the good work already underway at Place, enabling Places to incorporate it as part of their local development. The framework will help us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation.
- Over 170 SEL colleagues and stakeholders have been involved in multiple working sessions to develop a shared vision and ambition for the framework with over 70 colleagues taking part in 3 face to face workshops to define the detail.
- The focus of the framework is initially on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). However, it is recognised that many of the elements included apply to younger cohorts showing earlier signs of ageing or frailty. The framework is not just health focused. It encompasses the wider factors and determinants pertinent to ageing well such as destigmatising ageing, building age friendly communities, the role of the carer and tackling social isolation. Definitions of ageing well and frailty were shaped as part of the work to achieve a focus on what would be important.
- The Ageing Well framework is aligned with and enabled by other emerging SEL strategies for example, Integrated neighbourhood Teams, Long Term Conditions and Urgent Community Response; recognising the interplay between these. The framework also aligns with key national directives such as the 2025/26 NHS Operating Guidance, 2025/26 Neighbourhood Health Guidelines and Lord Darzi's investigation in 2024.

Executive summary .. *continued*

Why we want to promote ageing well

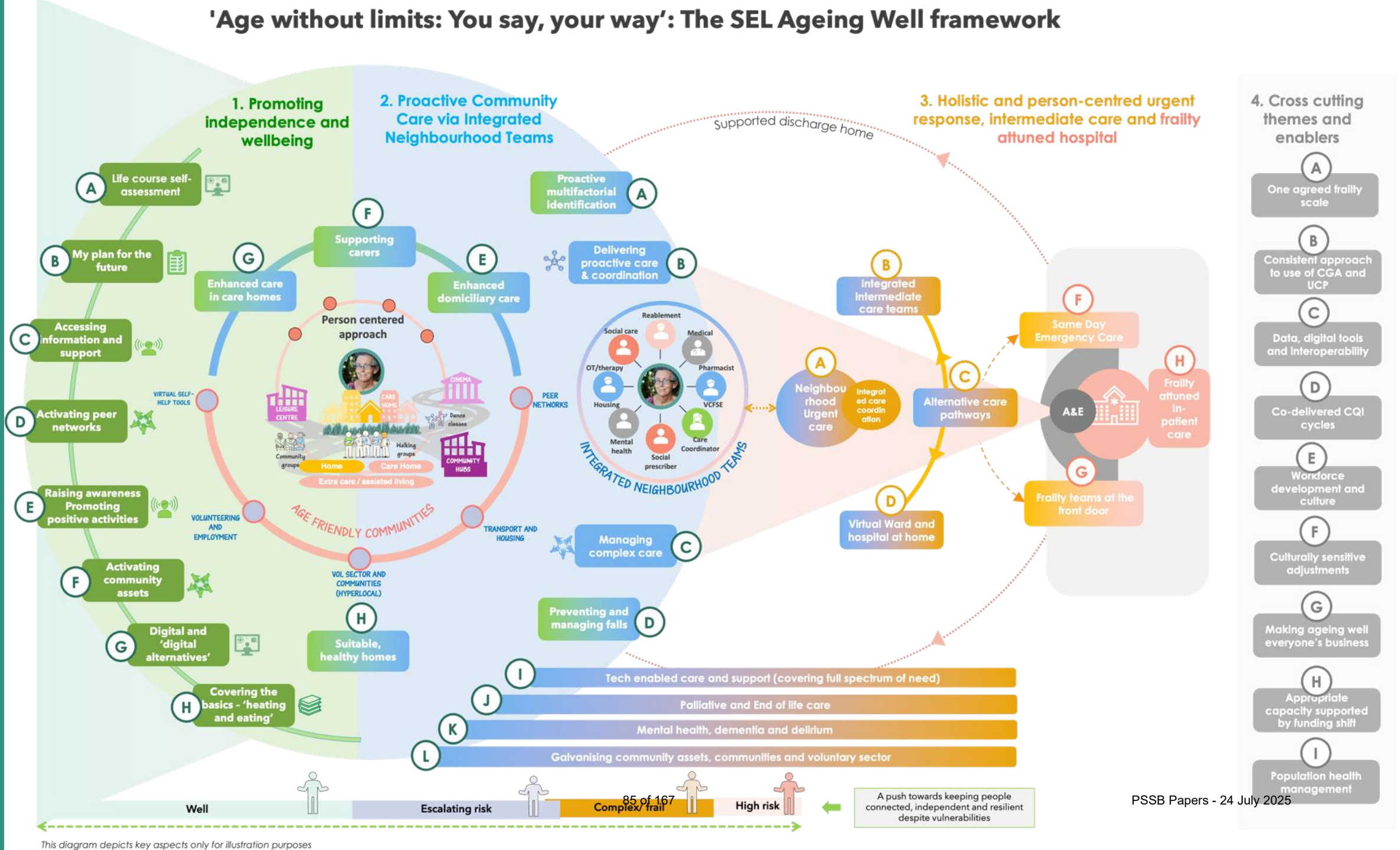
- There are compelling reasons for promoting ageing well in SEL. More than 61% of non-elective beds are utilised by those age 65+ (equivalent to 1594 beds at a cost of over £250m in 2023/4).
- At least 12% of these admissions (154 per day) are due to ambulatory care sensitive conditions and therefore could be avoided with more effective management in the community.
- 50% of frail patients also stay in hospital for over 21 days, adding to the severity (and consequences) of hospital acquired disability.
- For those aged 65 and above admission costs and associated A&E attendance rates are higher in SEL compared to national benchmarks
- By 2028 the SEL over 65 population is expected to grow by 18%, adding to the above pressures. There is therefore a need to shift the focus to earlier identification and prevention – whilst equally supporting those at the other end of the frailty scale.
- The voices of residents also strongly point to the need for change. Over 100 residents were spoken to as part of the work. Their views, along with those captured from existing engagement work have helped inform priorities within the framework. For example, residents highlighted the need to feel more respected, trusted, listened to and believed.
- Residents need more help with the practicalities of life but want to remain independent and resilient despite vulnerabilities. They want purpose and connection and to be seen as 'whole' beings, equal to younger people. They also want to see more joined-up services that intervene with each other on their behalf.
- Unpaid carers want more flexible support and respite opportunities to help them to continue in their roles.
- A graphic has been produced that distills the views and aspirations of residents and is included in this report.

Executive summary .. *continued*

'Age without limits: You say, your way': The Ageing Well framework

- The framework comprises three interconnected zones, enabling people to move easily between zones based on where they are in their journey. The underlying principles and values relevant to all zones are also captured, such as the need for seamless navigation, a focus on active and engaged living and effective self-help.
- Zones are:
  - **Zone 1: Promoting independence and Wellbeing** – Supporting people to age well, maintain independence and social participation
  - **Zone 2: Proactive Community Care via Integrated Neighbourhood Teams** – Early identification of frailty and well-coordinated community-based care/response to exacerbation
  - **Zone 3: Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital** – Neighbourhood based urgent response, step up/step down intermediate care, hospital front door and inpatient care
- Key principles and requirements for the care and support of people living with mental health problems, dementia and/or delirium are also captured for each zone. Palliative and end of life care and support needs are also summarised.
- A single overarching diagram that captures all the key elements of the framework per zone is provided. Each of these elements is then described in a zone summary, followed by more detailed description of each of the elements. These descriptions of each element include the factors and principles considered most important to SEL colleagues and reference some example initiatives already underway in SEL where good outcomes are being achieved.
- A range of enablers have been identified as critical to the development of the framework and a brief description of each is included. Key enablers include moving towards one agreed frailty score, a consistent approach to the use of tools such as Comprehensive Geriatric Assessment (CGA) and the Universal Care Plan (UCP), Workforce Development and Culture and Population Health Management (PHM).

The SEL Ageing Well Framework



Executive summary .. *continued*

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 quality of life, the effectiveness of support provided and whether we are reducing health inequalities for this population. Following review these outcomes have been further refined and prioritised. Potential key performance indicators for each outcome are suggested and an example system-level dashboard is outlined.

How will we implement the framework?

- Key success principles for implementing the framework are described, based on learning from elsewhere. The key to success during delivery is to emphasise a 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.
- An overview implementation road map is provided summarising the key next steps at Place and SEL levels to deliver and embed the framework. As part of this it is proposed that Places assess themselves against the framework to help identify opportunities and priorities for delivery. These can then feed into (existing) local roadmaps for delivery.
- It is recommended that these roadmaps include definition of the ideal local care model and plans for local leadership, resources and project and change management methods. In parallel, demand and capacity modelling can take place to understand the impacts and shape the ‘left shift’ in resources required to invest in delivery. Implementation is likely to be phased and 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.

Executive summary .. *continued*

Next steps

Continued work is now required to support Places to adopt it as part of local design, planning and delivery. This includes:

- Broadening the engagement and socialisation of the model with stakeholders
- Individual Place led self-assessment against the framework, assess gap / opportunity for development
- Creation of Place roadmaps for implementation.

Appendices

- A set of appendices are provided which include a record of key outputs from workshops that have helped in shaping the framework and a summary of external cases studies and recognised best practices from elsewhere.

The picture on the right depicts the vision as defined during the resident and carer engagement sessions. Illustration done by an artist.

2. Introduction

The work to deliver the SEL Ageing Well framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery

This report reflects the work that took place between January and March 2025, involving a wide range of stakeholders across SEL in developing the SEL Ageing Well framework. Continued work is required to refine the framework and support Places to adopt it as part of local design, planning and delivery. A great deal of work is already underway at Place to support residents with ageing well. This framework builds upon that work. It is not a mandated framework, but rather a capture of the most important elements and principles expressed by SEL colleagues alongside recognised best practices. It will hopefully 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 will:

- Help **ensure parity** in the offer we provide to people
- Enable us to **maximise** our collective resources
- Enable us to **share best practice** and the good work already underway at a local level
- Provide a more s**treamlined experience** for people and staff.

Benefits of a shared SEL frailty framework:

- **Consistent approach**: e.g., assessment and care planning tools acknowledged by all partners
- **Collaboration and workforce:** real integration in place-based systems, with an upskilled, flexible workforce
- **People and processes:** Improved consistency of care, and increased focus on prevention and early identification of frailty
- **Measuring impact:** measuring consistent outcomes across the board and knowing what good looks like.

The development of the Ageing Well framework has been led and overseen by colleagues from across SEL

Colleagues from across the SEL system have participated in the development of the framework, including from the ICB, Local Authorities, Public Health, Primary Care, community-based care, VCFSE, acute care and mental health. Colleagues have taken part in **121's, extensive discussions, ongoing working sessions/forums and 3 key workshops each with around 50-70+ attendees** to help shape the recommendations. Four resident workshops were also held and several residents also joined in other forums and workshops:

121 sessions	**Place based meetings**	**3 Workshops**	**Meetings to align with INT/LTC developments**	**Resident and carer voice sessions**
Reference group meetings	**VCSE meetings**	**Housing and Social care meeting**	**4 deep dive meetings for core elements***	**Regular core Group meetings**

* care homes, domiciliary care, palliative and end of life care and mental health, dementia and delirium.

Engagement with multiple stakeholder groups from across the system to build the picture

A list of the names of key stakeholders who participated in this work can be found in the appendices.

The 3 face to face workshops were very well attended and represented all Places

The overall objective of the framework is to pull together our collective ambition for ageing well, building on the work already underway

A great deal of positive work on ageing well and frailty is under way at Place. The development of the framework is an opportunity to pull this together and build on it to define shared principles, key elements and best practices - towards providing consistent care that is equitable, safe and efficient. Objectives include:

- **Forming a co-developed vision with Place to generate local ownership**
- **Understanding current services, success stories and linking into other work at Place e.g. INTs, LTC, enhanced care in care homes**
- **Maximising the value of our collective learning and resources**
- **Encompassing wider factors and determinants e.g. housing, social isolation and building ageing attuned communities**
- **Inclusion of patient stories and involving residents in helping to shaping the framework**
- **Defining ageing well and frailty and addressing the needs of people across the frailty continuum**
- **Inclusion of the role of unpaid carers and family, acknowledging their important role**
- **Bringing together all partners across the system to improve service quality, optimise skills and manage pathways**

The work has taken place over three months, following a structured methodology

December	January	February	March	April
Mobilisation	**Establishing the baseline position and ambition**	**Developing the SEL Ageing Well framework**	**Testing and refinement of the framework**	**Finalising the framework**
• Confirm objectives, scope and outputs • Stakeholder mapping • Request for data and documents • Establishment of core design group • Initial comms, diarising and set up • Workshop dates to be confirmed • Project governance	Defining the 'as is' position and ambition at Place level via questionnaire template Data story board & patient stories Connecting with key stakeholders e.g., executives to create buy-in **Workshop 1** • Definitions of ageing well and frailty • Agree cohesive vision and ambition • Place level 'as is' positions	Place based focus group meetings –10 things Place's want from the framework Connect with resident groups to capture voice National & international best practice learnings **Workshop 2** • Defining the framework and key components • Presentation of the residents' voice	Sub-group meetings to define opportunities to generate ageing well services & communities 1:1's with wider system to fill in the gaps, refine & ratify outputs Governance forums e.g., Ageing Well groups/ UEC to broaden buy-in **Workshop 3** • Finalising the framework • Outcome measures • Developing a mantra • Defining next steps for implementation	• Development Roadmap including overall phasing and timeframes and at Place • Final 1:1 meetings as required • presentation at board meeting(s) • Final sign-off • Final
OUTPUTS 1. **Stakeholder map** 2. **Comms and diarised meetings** 3. **Agreed governance**	1. **Key opportunities around ageing well and frailty** 2. **Cohesive vision and ambition** 3. **Current work at Place** 4. **Definitions**	1. **Framework with unified language** 2. **Clear way forward for social construct elements** 3. **Residents' voice reflected in the framework**	1. **Final report including vision, SEL framework, outcomes, etc.** 2. **Roadmap leading into delivery**	1. **Finalised roadmap** 2. **Finalised report document complete and endorsed**

Definitions of ageing well and frailty were shaped early on to achieve consensus on the core drivers for the work and population in scope

- Around 70 colleagues and 100 residents were asked what 'ageing well' means to them and their views are reflected throughout
- It was agreed that mild, moderate and severe frailty are in scope and the priority focus in on people aged 65+
- However, it's recognised that frailty can occur much earlier (particularly in those prone to health inequalities e.g. lower socio-economic groups, significant mental health disorders) and therefore elements of the framework (such as early identification, prevention and positive ageing) increasingly apply to younger cohorts.

The appendices include a capture of what ageing well means to SEL colleagues and overall definitions for ageing well and frailty - drawn from these views and from recognised national bodies. Excerpts are as follows:

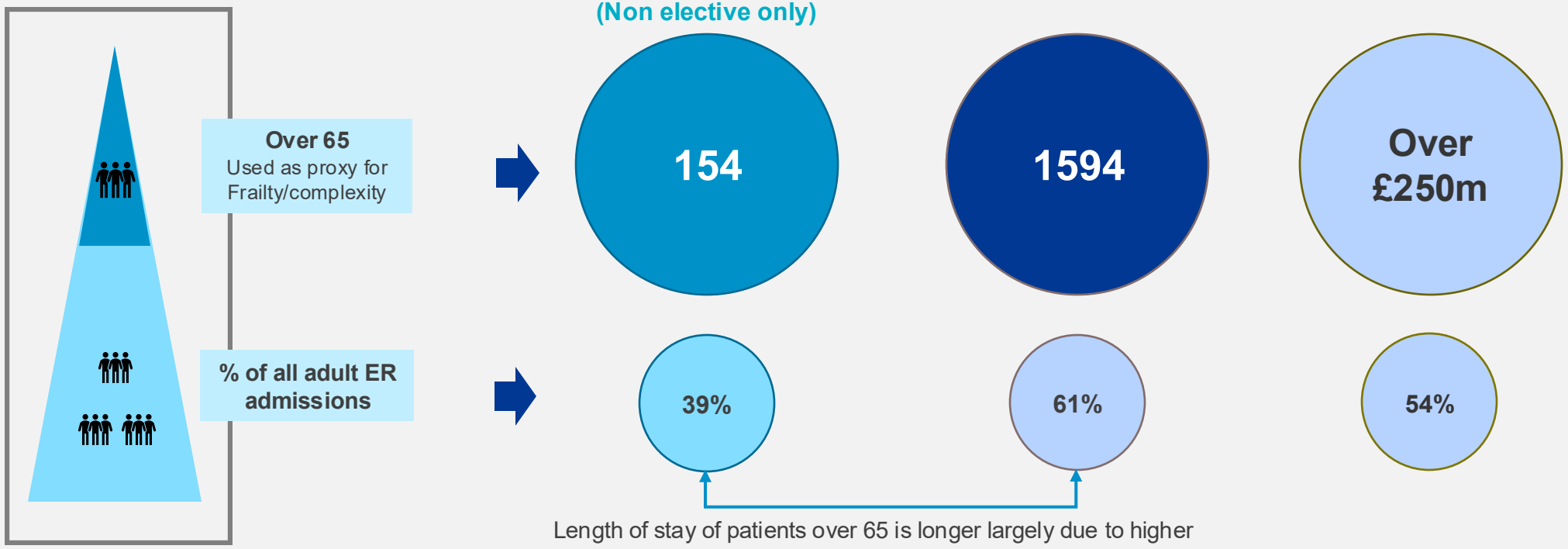
Ageing well *- The ability to maintain low risk of disease-related disability, high mental and physical function, and active engagement with life - including a positive attitude, sense of engagement, purpose and a desire to stay active and healthy in later life, including seeking help when needed and practicing self-care.*

Frailty *- a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves... a state of increased vulnerability resulting from aging-associated decline in reserve and function.*

Ageing well and frailty definitions

3.
Why we want to promote ageing well

Let us understand the scale posed by frailty across SEL: More than 61% of non elective beds are utilised by over 65 (over 65 used as a proxy in absence of frailty data)



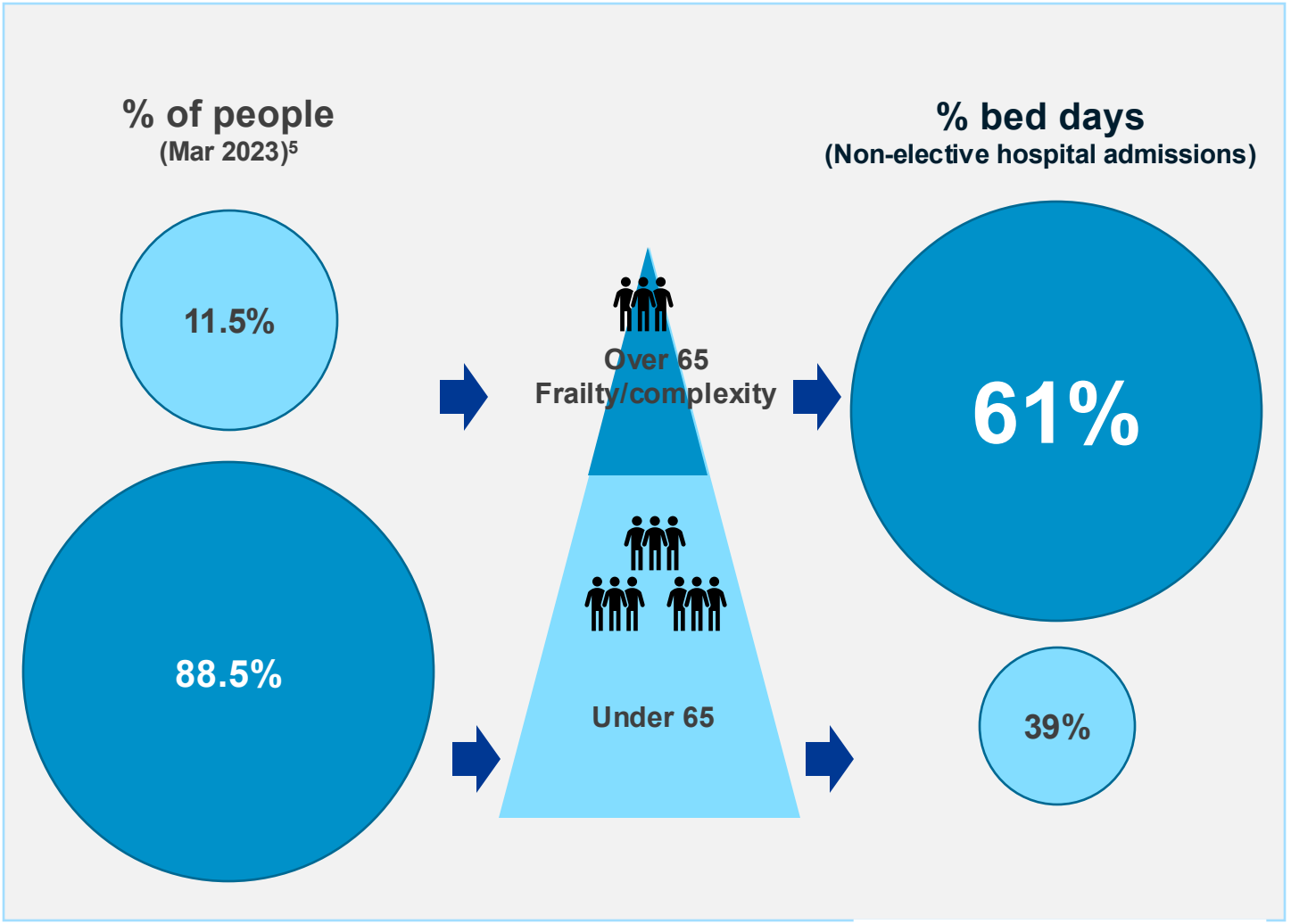
*Please note, data to be validated further
Data source: SUS aggregate download FY 2023/24
[1] Beds utilized calculation (bed-days / 365 and then adjusted for 95% occupancy – BOR)
[2] PBR cost used a proxy for total cost

With increased population growth and composition, the pressure and need for hospital beds will rise

Population growth

By 2028, the population aged 65 and over in SEL is projected to grow by 18%[3]

- **Bexley:** Population 244,247. Up to half of Bexley's population of over 65's are affected by frailty, rising to 65% in those over 90 years of age. There are estimated 23,500 people aged above 50 with frailty[4].
- **Bromley:** Population: second eldest population in London (17.7%), expected to grow to 67,000 over 65's by 2030[4].
- **Greenwich:** 289,100 residents within Greenwich. Number of residents aged over 65 has risen by 15.6% since 2011[4].
- **Lambeth:** 322,000 residents, 50% growth expected in the over 50s in the next 10 years[4].
- **Lewisham:** 200,600 population, 9.5% are aged 65 or over. Younger population, however, it is thought population growth won't be evenly spread across the ages, and there will be an increase in the older population[4].
- **Southwark:** 307,000 residents, comparatively younger population, population will continue to grow with over 17,000 additional people living in the borough by 2030[4].



*Please note, data to be validated further
[3] SEL ICS People strategy 2023/24- 2027/28
[4] South East London 2024/25 Joint Forward Plan
[5] Population and Person Insight data (PaPI)

There are a number of admissions that can be avoided through better proactive care in the community

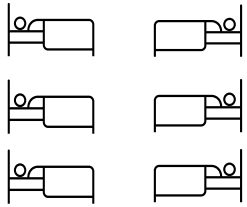
Number of admissions per day (Emergency only)

154

Ambulatory Care Sensitive Conditions (ACSC)

12%

1 ward in each Place



Falls	Sepsis	Pneumonia	UTI	COPD exacerbation
Congestive Heart Failure	Acute Renal failure	Cellulitis	Pneumonitis due to food and vomit	Fracture of neck of femur

Avoidable admissions

ACSC are conditions for which effective management and treatment within the community, should limit emergency admission to hospital.

A few examples include heart failure, COPD, influenza, pneumonia.

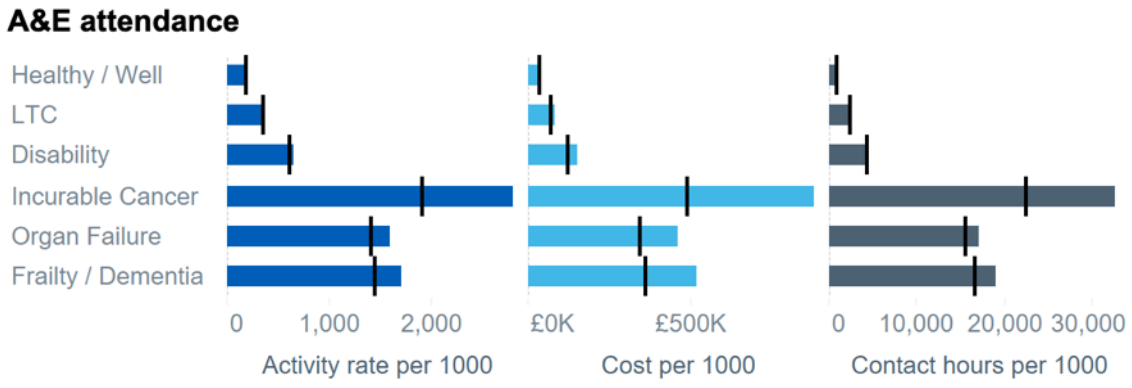
"In 2022/23, within 10 months, there were 1598 avoidable admissions to hospital relating to Ambulatory Care Sensitive Conditions, compared to 2205 in 2021/22. This suggested a 5% reduction target was on course to be met and exceeded.[5]"

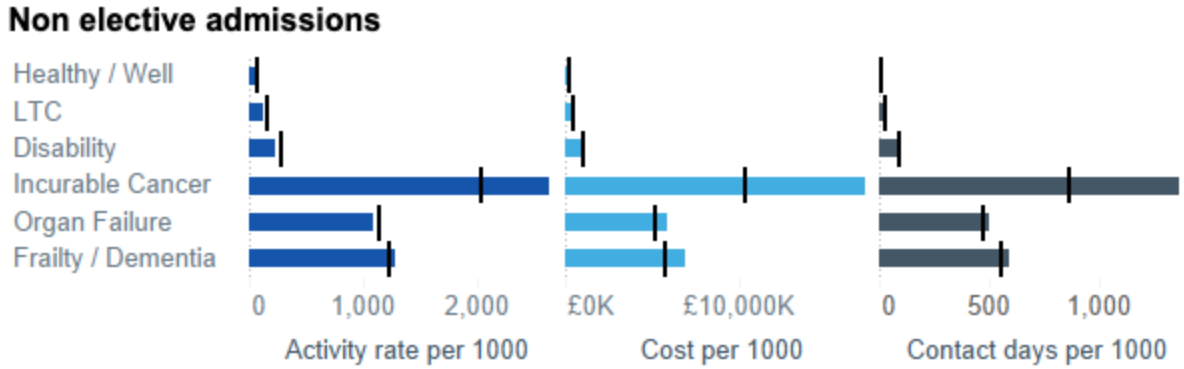
Utilisation of services for those that are frail/ dementia is substantial

For those aged 65 years and above, non-elective admission activity rates per 1000 are higher for SEL when benchmarked against national data[5]:

- SEL 245 per 1000
- England 238 per 1000

Non-elective admissions[5]: Cost per 1000 people in SEL is £1,223,000 which is £250,997 higher than the national benchmark





- For those with frailty/ dementia, in relation to A&E attendance, the activity rate, cost and contact hours are all above national benchmarks.
- The progression from LTC to frailty results in a substantial increase in activity and cost, hence prevention is critical.

We want to draw attention to hospital acquired disability (HAD)

50% of frailty patients stay in hospital for over 21 days[6]

The cumulative impact of extended or complicated hospitalisation among older patients typically results in patients experiencing a decrease in muscle mass and significant functional decline due to a complex process of physiological changes that can affect multiple systems

(Brown, Friedkin, & Inouye, 2004; Brown, Redden, Flood, & Allman, 2009; Chastin et al., 2019).

In a study of hospitalised community-dwelling older people at 6 months after discharge, 43% needed continuing help with medications, 24% were still unable to walk a quarter of a mile, and 45% were still unable to drive. The overall prevalence of HAD across studies has been estimated to be around 30%

National Institutes of Health (NIH)

Studies have observed that at least 30% of older patients hospitalised with an acute medical illness show a persistent decline in their ability to maintain Activities of Daily Living (ADLs)

(BMC Geriatrics)

So significant can the muscle loss be in bedridden seniors that while complete bed rest causes young adults to lose about 1% of muscle mass per day, the elderly may lose up to 5% per day

(Sarcopenia: Loss of Muscle Mass in Older Adults. Mary Ann E. Zagaria, 2010)

It has been estimated that 68 % of patients are discharged from post-acute medical settings below their pre-admission level of function.

(Gill, Gahbauer, Han, & Allore, 2009)

This means that post-hospitalisation, patients are not only recovering from their acute illness but also facing physiological stress and susceptibility to complications not directly related to the cause of their admission.

(English & Paddon-Jones, 2010; Hartley et al., 2019; Kortebein, 2009; Kosse, Dutmer, Dasenmbrock, Bauer, & Lamoth, 2013)

National Audit Office (NAO)

Today's analysis by the National Audit Office reveals that after spending ten days in hospital unnecessarily, a patient's health has deteriorated to such extent their life expectancy has been shortened by ten years - 18th March 2024

'It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs, in people over 80 years old- this may or may not be true to the word but certainly puts things in perspective'.
Dr Amit Arora, consultant geriatrician

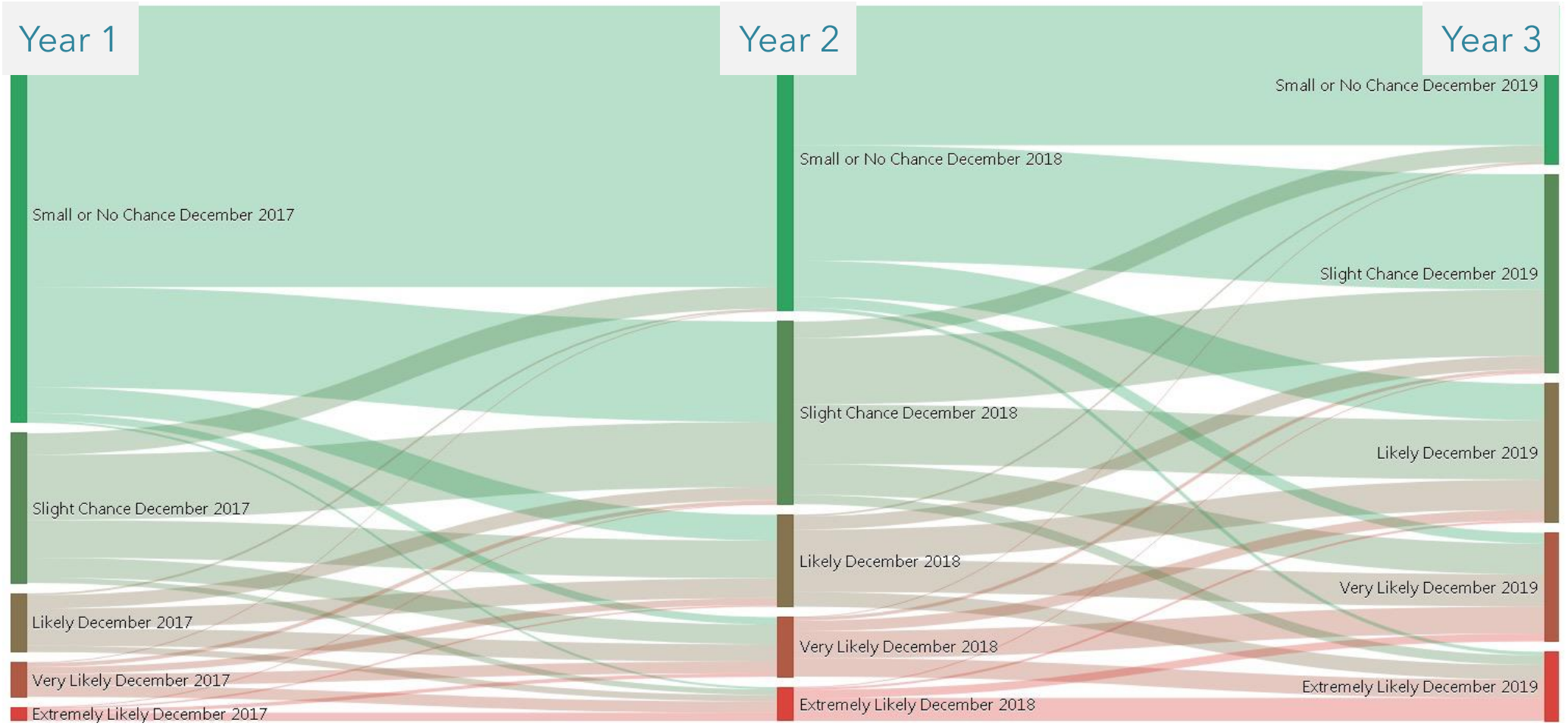
**Please note, data to be validated further. Data source: Frailty and multiple LTC SEL ICB presentation*

How risk/complexity changed over 3 years and why it is critical that we capture people at/before the point of rising risk (example taken from another ICS with pseudonymised data)

The chart shows how risks rose in people across a period of 3 years. Data is only for over 65 across one Place (2 boroughs).

It shows how those who had low risk (green) in Year 1, moved into higher risk segments (red) just within a period of 1 or 2 years.

Risk was measured using ACG algorithm from John Hopkins customised further to improve identification. Includes aspects such as frailty, LTC, H/O, Rx.



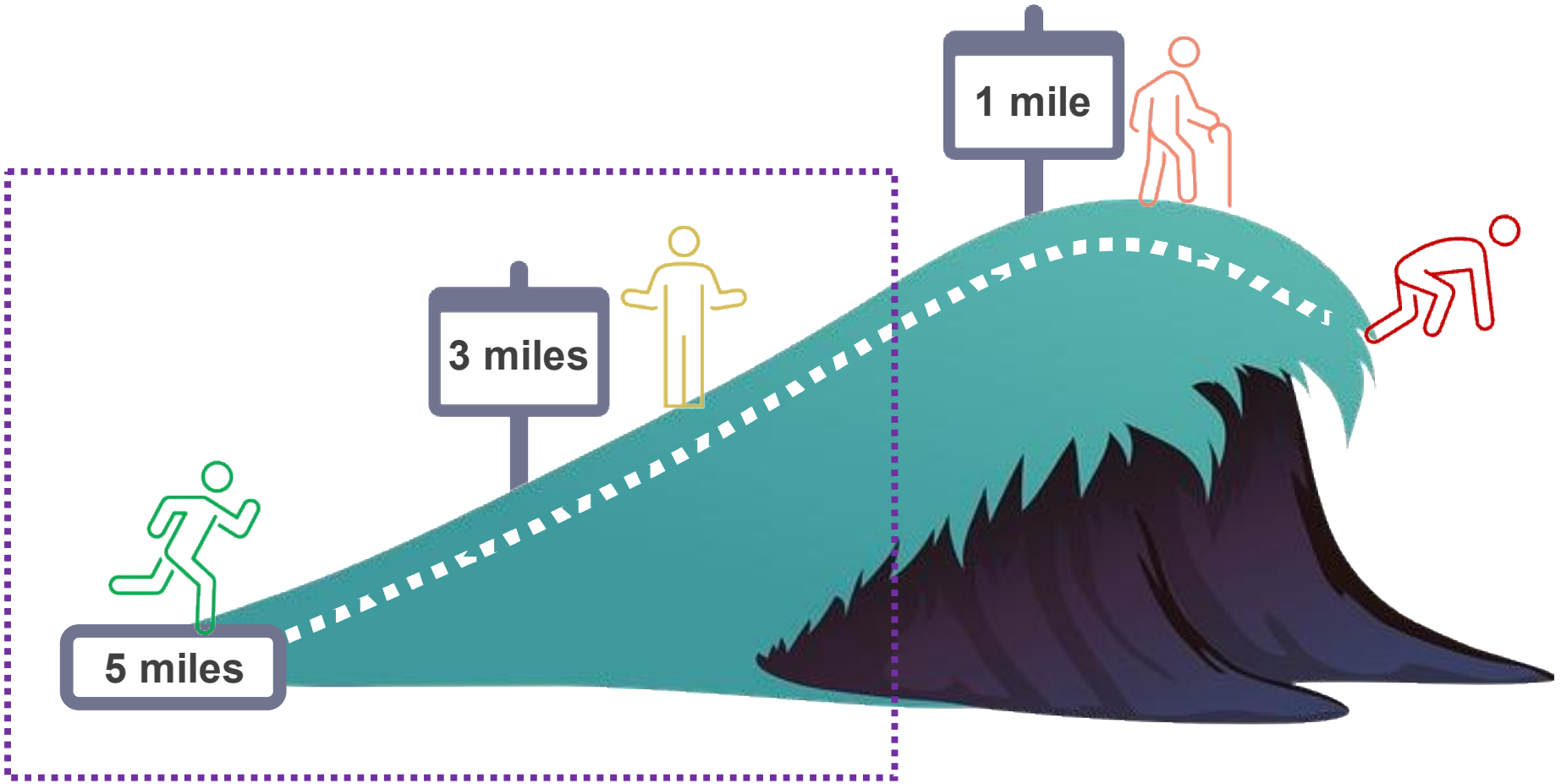
Year 1 profile of exactly the same population – two years ago

Year 2 profile of exactly the same population – one year ago

Year 3 profile of all over 65 who were admitted in hospital/attended A&E

There is a need to shift the focus towards early proactive prevention whilst equally supporting those at the other end of the scale

- Catching people at the '5-mile mark': there is a clear need to continue to shift focus towards early identification, proactive prevention and working with people holistically (health and social care).
- Equally, focusing on initiatives to support people when they are at the other end of the scale, looking at how we can proactively and reactively manage those living with frailty/ complexity.



The Ageing Well framework aligns with and helps meet the drivers and objectives of key national directives

Example national directives:	Examples of how the Ageing Well framework aligns
 British Geriatrics Society Blueprint for preventing managing frailty in older people (2023)	The framework delivers against the key BGS recommendations for the 'seven touchpoints' – from enabling independence and promoting wellbeing through to frailty-attuned hospital care
NHS 2025/26 NHS priorities and operational planning guidance	• Neighbourhood health services models to prevent admissions and improve access to care • Address inequalities and shift towards prevention
NHS England Neighbourhood Health Guidelines Neighbourhood Health guidelines 2025/26	• Integrated working, reducing fragmentation, poor communication and siloed working. Increasing ability to self-care • Shifting focus from hospital to community and from treatment to prevention
 Fuller Stocktake Report 2022	• Providing more proactive, personalised care with support from a multi-disciplinary team • Helping people to stay well for longer and a focus on early identification and prevention • Streamlining access to care and advice
 Lord Darzi's independent investigation of the NHS in England (2024)	• Shifting spend from hospital to community • Listening and responding to the patient voice • Empowering patients • Multi-disciplinary teamwork and working.
National Association of Primary Care: Creating Integrated Neighbourhood Teams. March 2025	• Engaging communities, citizens and patients • Start with staff and equip them to deal with the work • Simplify processes • Enlist hospital specialists

South East London Integrated Care System

NHS South East London

4. What do our SEL residents and carers say?

Quotes captured from primary research and a range of SEL reports providing residents' feedback

HEALTH INTEGRATION PARTNERS

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

1. Distilling themes from SEL and Place - based 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 residents to understand what ageing well means for them

- Blackfriars Settlement
- Bexleyheath in Bexley
- Orpington in Bromley
- Southwark Carers

Connected with residents across SEL to understand what 'ageing well' means to them, their experience and expectations. The engagement is still ongoing and will convert into a graphic. The key themes will be woven into the framework and will influence our priorities for delivery

3. Attendance in co-design workshops

Representatives attended both workshops (1 and 2) to support the co-design of framework

4. Continued engagement at Place

While the framework is being established, there will be continued hyper local engagement at Place to ensure the model of care is defined locally in line with the needs of the local population

Residents highlight the need to destigmatise ageing. They want to feel like they count and are respected and trusted. They place importance on purpose, connection, resilience and independence

1. **Remaining resilient despite physical vulnerabilities. Preventing deconditioning: physical, functional and cognitive**
   Missing out on physical, social and cognitive activities decreases confidence, increases fear and intrinsic capacity to protect myself. Optimising social, physical, functional and cognitive avoids deconditioning.

2. **Hopes and dreams for ageing well**
   Wanting to do things for myself, getting support adds to ageing well, having a sense of purpose, being able to use my previous skills to help others and laughter ☺

3. **Help with how to set yourself up for success to age well**
   Trusted, professional information and advice. **Having peace of mind.**
   Not having to burden friends and family.

4. **Loneliness and participation**
   Need for true human connection and bond between friends and family and opportunities to be part of other groups

LAUGHTER is essential for ageing well, and to share in the laughter with others, and seeing others enables me to focus less on pain and ailments

"Dreams? I don't really have any because I'm just trying to stay alive. I want to be there for my grandkids, but some days I'm just counting the days, and I need to make the most of every day. If I could, I would love to travel and fly, but I can't because I'm immobile."

"For me, ageing well means being able to feel INDEPENDENT. And have the ability to take care of yourself."

"Pensioners aren't necessarily the frail and retiring types of popular imagination. I don't think many people my age (early 60s) will be interested in playing Bingo in our retirement."

"On the whole as people get older, they would prefer not to be seen as a 'category' but simply as themselves ... among all sorts of other humans ... being as active, intelligent, engaged, healthy, friendly and involved as possible. Many frailties and disadvantages and problems are shared across age groups"

Includes excerpts from SEL resident engagement papers e.g., Age Friendly engagement insights – SEL Ageing Well Strategy 2025

Resident voice … continued

5

Reduce fears and increase safety
Need for more police, level pavements fewer blocked pavements due to roadworks, fear of electric bikes as a hazard, easier access to public toilets, more disability toilets.

6

Joined up care, coordination and accurate navigation, seamless continuity and effective coordination
Accurate, consistent signposting and need for more connection / **communication between services** and settings. Ensuring seamless continuity of care and through co-ordination.

7

Primary Care
Need to see the same GP for continuity
Telephone and video calls not being as good as face to face.
Difficulties in getting an appointment, especially online triage.
Having to give their same medical history repeatedly, and not all doctors read it before their appointments

8

Housing
Ability to adapt or change housing to meet changing needs as you age

"There should be a database enabling older people to swap homes to get what they want"

"I was falling but told I couldn't join strength and balance classes because I needed to see a cardiologist. 6 months later I'm still waiting"

"I would like to get advice but it's too hard to navigate"

"Virtual GP appointments only work if I have a Carer with me, otherwise I don't feel seen or heard, I prefer face to face"

"I wanted to join the gym but couldn't get past the questions, form filling and documents required at reception"

"I would like to get advice but it's too hard to navigate"

"We're going to hand over our lives, probably to a white person or a South Asian person but there's no trust between us and those communities"

"When I phoned up on the day, the appointments have already gone. I can't tell you the last time I've actually seen my doctor face to face because I can't get an Appointment."

Resident voice … continued

9

Caring role

Access to more flexible, ad hoc support (including respite) instead of an 'all or nothing' arrangement.

Unpaid carers able to get a GP appointment quicker and at a time they need it. Pre-emptive planning for carer crisis – leading to peace of mind and the right action.

Advocacy and earlier respite for carers.

10

Respect and feeling heard

Considering the person's whole life not just seeing a health problem.

Feeling that you must lie and exaggerate to be seen.

Feeling judged and dismissed as a patient or carer.

"Someone to talk to mum about how to live better in her own home – keeping warm, paying bills, buying a hearing aid, checking for risk of financial abuse."

"Contacted NHS for an eye appointment, chased up for weeks without action....admin was not listening, when final action was taken, I was told that I should have come sooner, leaving me feeling that I can't win, when I tried everything in my power to be seen."

"I get exemplary support from my local GP and the Guys and St Thomas' NHS Trust…"

"I felt like I was dismissed and spoken down to as well. They were still offering me what I said I don't need so I thought it was more or less a box ticking exercise."

"There's also the systemic issue of structural racism. I'm very, very aware of it. I know that doctors are under pressure. I believe that the wider system does, either actively, sometimes disadvantage us or through negligence as Black people."

"Work needs to be done to close the wealth gap, as poorer residents have less positive experiences with ageing."

"You can tell the difference between a doctor who tells you what to do and the one that converses with you right? Someone who takes the time to explain things to you, who listens to you, you know, and takes into consideration your views."

"But being aware of the community that you serve. What does that community that you're serving look like? So then be more educated about them… about foods, about culture, about all those things, because you can then better support. Because when somebody is coming to you, you can show that understanding."

Feedback from unpaid carers highlights practical changes that would make a real difference to their quality of life

"Carers' organisations and carers carry no weight, they should be respected, they should mean something"

"I would have peace of mind as a carer if a plan was in place for what should happen if I am taken ill or go into hospital."

"Mum is not considered bad enough to get help, so I do everything! But something more flexible is needed; even if the voluntary sector helped me out half a day a week. But the current approach is more 'all or nothing"

"No communication between organisations whatsoever – each has its own agenda and won't intervene with the other"

"When carers are coping they should still be allowed some respite; a chance to recharge the batteries. It will mean they can go on caring for longer – it's an investment"

"As a carer it should be easier for me to get a GP appointment. I should be a priority to enable me to keep on caring"

"I can't get my Mum to activities in the community if there is no reliable transport"

"Staff need time to have proper conversations with carers who often know the answers more than anyone"

"My mother needs help with paying bills, making appointments, getting groceries online, sorting glasses and hearing aids, online banking, using parking apps, dealing with chatbots and having her questions answered."

"What if the person I care for won't accept help from anyone else? I need an advocate to help free me up from the trap"

An artist attended the sessions that we held with residents to understand what ageing well means to them – and their voices have been captured in a graphic

Four workshop sessions were held with residents and unpaid carers to understand what ageing well means to them and to capture their experience and expectations of services. The workshop sessions were as follows:

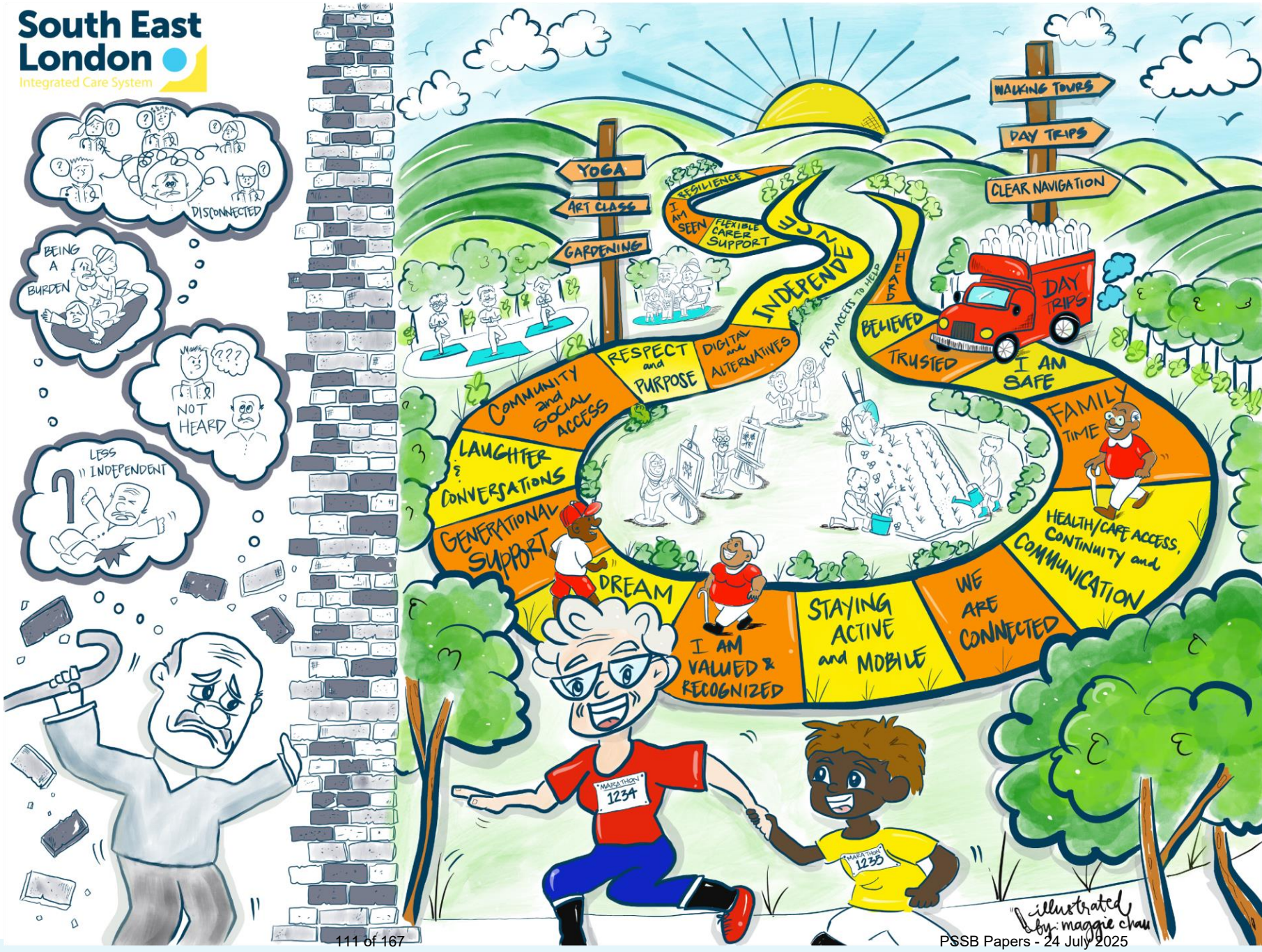
Borough	Resident/Carer organisation	Date of engagement
Southwark	Southwark Carers Cafe	21 February 2025
Southwark/Lambeth	Blackfriars Settlement	11 March 2025
Bromley	Orpington Methodist Church Art Class Group	13 March 2025
Bexley	Bexleyheath Geddes Place Church	10 March 2025

The key themes from the sessions have been woven into the framework to help inform the priorities for delivery. In addition, an artist has produced a graphic depicting the voice of residents and unpaid carers, which can be found on the following slide.

Resident voice

The left-hand side of the graphic captures some of the main challenges residents face when dealing with services.

The right-hand side of the diagram portrays the aspirations, hopes and dreams that residents have including what they like to do and how they would like to feel.



5.
‘Age without limits: You say, your way’
The SEL Ageing Well framework

150+ clinicians and professionals have been engaged and involved in developing the framework, at SEL and local levels - identifying key values and principles that underpin the framework, below

1. Early identification
Understanding who our older and frail population are and identifying them sooner

2. Seamless navigation
Visibility and clarity about what sits where across settings, enabling easier signposting, self-navigation (by problem) and movement between zones and real connection and dialogue between professionals

3. Hyperlocal VCFSE involvement
Stronger connection, Increased visibility, bigger role in healthcare, trust and financial security for VCFSE, especially grass roots offers

4. Improved Accessibility
Removing barriers to accessing amenities and services such as need for form filling, providing documents and overcoming travel, digital and language barriers. Providing alternatives to digital

5. Social Well-being
Fostering environments where people build and sustain lasting friendships and social connections to prevent the loneliness spiral

6. Personalised Care
What it means to the individual e.g., listening, understanding, believing, trusting and respecting. Seeing an active, whole life, not a health problem. Making nuanced decisions based on *'what matters to me'* and accepted shared risk with residents and families.

7. Active & Engaged Living
Focus on exercise, cognitive stimulation, nutrition, hydration, & self-care - enabling purposeful living that creates resilience, connection and independence

8. Positive Ageing
De-stigmatising ageing and promoting positive representations of older people as having a purposeful life to live and a strong contribution to make. Making amenities and services more age and culturally friendly.

9. 'Heating and eating'
Ensuring the basics are supported to set yourself up to age well such as heating, eating, paying bills, getting appointments, using on-line services

10. Equity
Independence and wellbeing of people is of equal importance regardless of setting. Care homes and home care are not separate ecosystems and require an integrated offer that enables equitable access.

11. Wider factors
Addressing the wider things that foster ageing well – e.g., feeling safe on the streets, level pavements, access to shops and public toilets, bus drivers being mindful of older people stepping onto buses

12. Activating self-help
Facilitating communities to help themselves e.g., via peer and expert support groups, volunteering, linking people up with people, allowing people to swap their homes

The Ageing Well framework comprises three inter-connected zones. People move easily in and between zones based on where they are on their journey

The emphasis of the framework is on early proactive prevention but also includes 'what good looks like' for those further along the frailty continuum.

1 Promoting independence and wellbeing- thriving at home

Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

2 Proactive community care via integrated neighbourhood teams

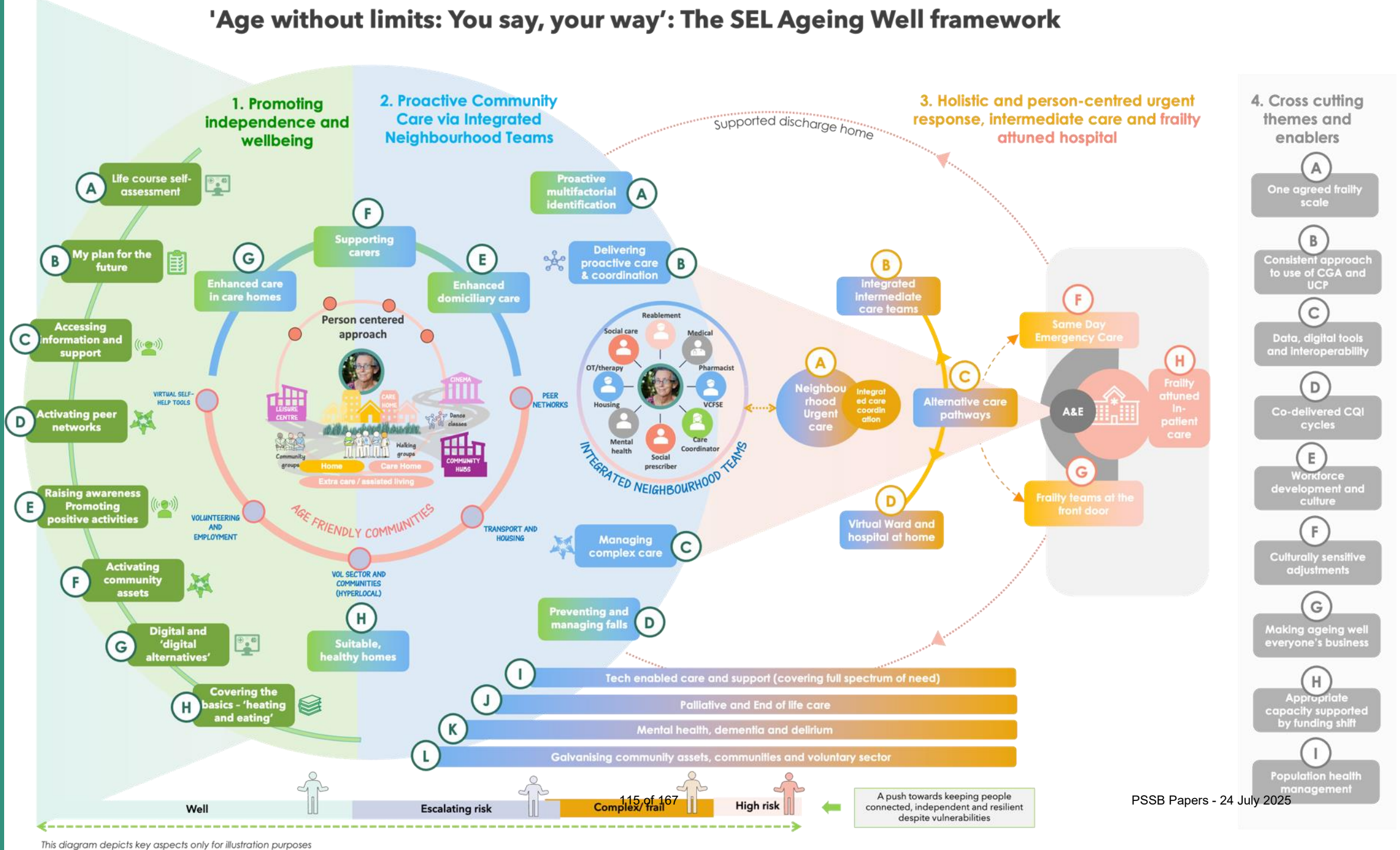
Early identification of frailty and rising risk, working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

3 Holistic and person-centred urgent response, intermediate care and frailty attuned hospital

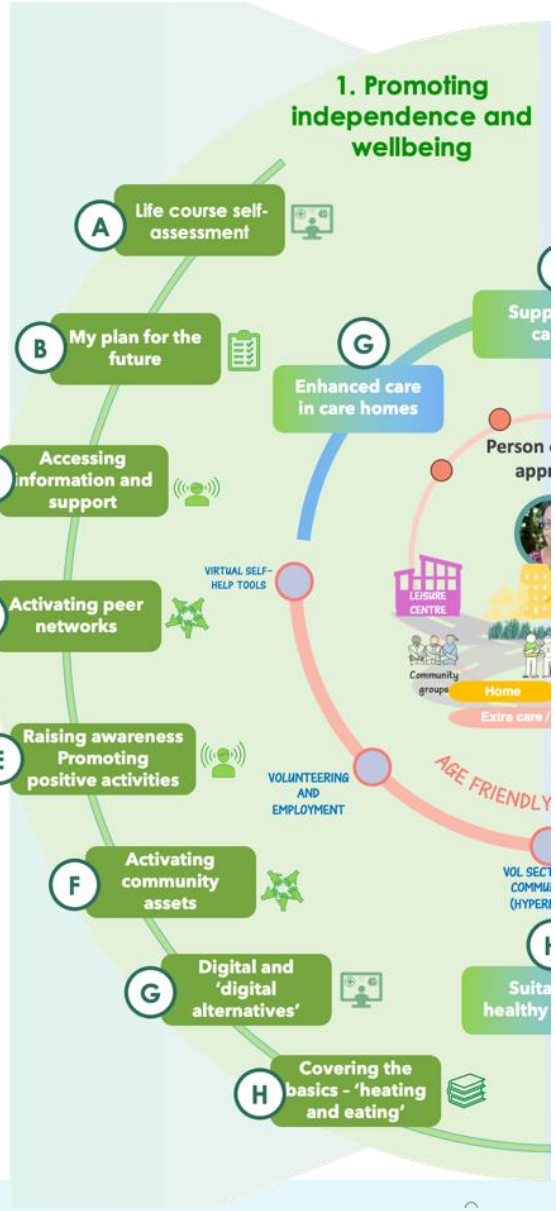
Working closely with zones 2 and 4 to provide holistic and person-centred urgent / timely step-up and step-down community care that helps to avoid unnecessary hospital attendance, admission or readmission and enables timely discharge.

Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and hospital discharge for those who are admitted.

The SEL Ageing Well Framework



Zone 1: Promoting independence and wellbeing - thriving at home



Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

This zone comprises of the following elements:

- Life course self-assessment, empowering people to self-identify goals and take holistic actions based on 'ageing well milestones' This feeds into 'My Plan for the Future' OR "Planning ahead for what matters to me?"
- 'My Plan for the Future', a self-led holistic tool and plan reflecting personal goals and informed by the ageing well milestones including actions I will take to maintain my health and wellbeing, e.g. adopting a healthy lifestyle and preparing for the future. Includes support and resources I will access, e.g. a community exercise programme or other support through voluntary, community, faith and social enterprise (VCFSE) such as managing money. Plan includes end of life. Can be generated digitally and produced with support from a community champion.
- An easily accessible one stop shop ('access hub') that provides and signposts people to information and knowledge about ageing well and helps them to access local services, support and VCFSE sector offers. Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers.
- Building and delivering local community peer support groups and networks that for example, provide opportunities for older people to contribute, share and learn new skills leading to improved social connections and reduced isolation, and that contribute to building age friendly environments. Inter-generational working e.g. bringing students into care homes/older people into schools and utilising industry e.g. professionals being role models or peer mentors to others.

Zone 1: Promoting independence and wellbeing - thriving at home

Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

- Raising awareness of the factors that prevent, slow, and reverse frailty and enable ageing well such as exercise, hydration and nutrition (insights from blue zones). Raising awareness of, normalising and breaking down taboos associated with ageing and dying. Promoting a positive approach and positive representations of older people. Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones as well as other non-digital media
- Incentivising and activating community assets to provide easy, affordable or free (off-peak) access to local activities, events and facilities (including gyms, cinema, yoga classes, leisure centres, education courses). Asset based community development in which communities do it for themselves. Systems taking an active role in local leadership to influence community developments according to local need.
- Improving the accessibility, knowledge and use of digital tools by residents. Supporting access equity where digital access is not achievable for individuals.
- Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness such as a secure home, heating, cleaning, having access to food and that food is being eaten
- Addressing other wider factors that support independence such as ensuring decent housing, well-lit streets, level pavements and easy to read signage.

Zone 1: Promoting independence and wellbeing - thriving at home

A. Life course self-assessment

- The aim is to focus on prevention by doing the right thing at the right time. This can be enabled through supporting people to self-identify suitable goals and actions based on 'ageing well milestones'. The milestones create a shift in perception, empower people and strengthen understanding of actions that should be taken to 'age well'. This may include information such as "at age 75 focus on this type of exercise, diet and lifestyle to keep your bones healthy and reduce risk of falls".
- Milestones will also flag national screening programmes such as the bowel cancer screening kit offered every 2 years for 50–74-year-olds and highlight local resources, e.g. how to access community exercise programmes. It can include continence care information for those over 50.
- Milestones can also help educate younger people (e.g., men in their 40s and 50s to take earlier action to prevent issues as they age.
- The milestones provide a guide to the production of 'my plan for the future'. This should not be a one-off assessment and can form part of the person's universal care plan (UCP).

B. My plan for the future

- A personalised plan, which is self-generated or co-produced with a 'wellness coach' or similar, that captures the person's self-identified goals and actions **they** will take to maintain wellbeing and stay healthy.
- The life course self-assessment (above) will help inform and feed into the plan.
- The plan will also encourage people to think through what matters most to them, and plan what they want to happen in future, for example if they become unwell – and prompt earlier action, e.g. around producing a lasting power of attorney (LPA) or deciding arrangements for care they may need, including what to do should a crisis be looming or occur, and preferences or arrangements for end of life.
- Approach to recognise that changes with ageing can be stressful (e.g. retirement) and therefore be done with empathy.

Zone 1: Promoting independence and wellbeing - thriving at home

C. Accessing local information and support

- An easily accessible (to residents, carers and staff) one stop shop ('access hub') that provides and proactively signposts people to information and knowledge about holistic ageing well and helps them to understand and access local services, support and VCFSE offers.
- Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers. The hub can be co-located with existing community services at Place, with a focus on local health promotion. Hub may also be able to aid professionals with navigation of local resources to support residents.
- Public health involvement to promote prevention, working in partnership with residents and resident-facing professionals.
- Sharing of information on different partner initiatives, across partners e.g. visibility between health and social care about ambitions, innovations and developments (e.g. falls prevention). A resource that enables staff to understand what is provided in the community and how it helps to get home from hospital earlier with better support or avoid unnecessarily going into hospital.
- Sharing self-help information about falls, continence care, mental health and education around diet, hydration and exercise will have a significant impact on quality of life for residents. Practical advice e.g. how to get a hearing check, manage gas and electric, pay bills, get an optician appointment.
- Information is sensitive to cultural and generational challenges.
- Information be provided to the 'access hub' through people e.g. champions and networks.
- Include simplifying existing websites, making them more accessible.

Zone 1: Promoting independence and wellbeing - thriving at home

D. Activating peer networks and intergenerational relationships	• Building local community peer support groups, improving social connections and reducing isolation (therefore improving mental health and reducing depression and anxiety) within the local community. • Utilisation of community champions and creating community networks which are of high value, providing support and resilience. • Creating intergenerational connections to reduce societal ageism barriers e.g. older people mentoring in schools, students volunteering via local VCSFE organisations. • Interventions and activities should be personally relevant (e.g. acceptable in different cultures).
E. Raising awareness and promoting positive activities	• Raising awareness, changing perceptions and activating people to prevent frailty as well as identifying signs of frailty at the earliest opportunity, hence implementing actions to reduce progression. • Early discussions and awareness of palliative care/death literacy. Promoting episodic symptoms support e.g. palliative care. • Raising awareness of the factors that prevent, slow, and reverse frailty (insights from blue zones). • Putting out key messages such as ‘come to us early to prevent illness’ or ‘do this for yourself to take charge of your health’ – or messaging to activate neighbours to look out for older people in their neighbourhood. • Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones and other non-digital alternative media. • Changing the images and photos we use to portray older people, to more positive, breaking down stereotypes.

Zone 1: Promoting independence and wellbeing - thriving at home

F. Activating community assets

- Setting up and running social and exercise classes, including strength and balance training, tai chi, yoga, pilates, walking, circuit training, dance, spin, cheerleading, choir and swimming.
- Easy, affordable/free access to local activities such as leisure centres/cinema/ gyms to improve connections.
- Musical and dance activities from their era, keeping sighted different older people will have grown up in different years and cultures.
- 'Expert patients' teaching e.g. exercise groups, how to use gym equipment or other new skills such as DIY, gardening co-ops (e.g. building gardens in care homes or GP surgeries), men in sheds to maximise peer-peer influence and mentorship.
- Expert patients may also encompass specific co-morbidity and mental health peer support and identifying champions in key areas e.g. falls, hydration, continence, loneliness, hearing loss, etc. As well as death and technology literacy.
- Activating people to contribute to their communities by recognising their contributions and maximising volunteering opportunities and skills.
- Providing recognition, accreditation and awards for both those who lead and those who participate in exercise groups. e.g. NHS 'couch to 5k'.
- Local and community gyms and swimming pools promoting classes
- Corporate social responsibility: connecting with local corporate companies who can support people to age well e.g. local theatre, professionals providing peer mentorship, tapping into philanthropic opportunities.
- Having accessible transport links (volunteering opportunities around this).
- Community assets need to be dementia-friendly and mental health trained
- Consider adopting interventions such the 'paperweight armband'- an easy tool to help identify older people who are at risk of malnutrition, developed by Age UK Salford. Since the introduction of the paperweight armband, Age UK Salford has reported a reduction in hospital admissions, a 50% increase in reporting of underweight BMI in primary care after 1 year and a more appropriate prescribing of oral nutritional supplements).

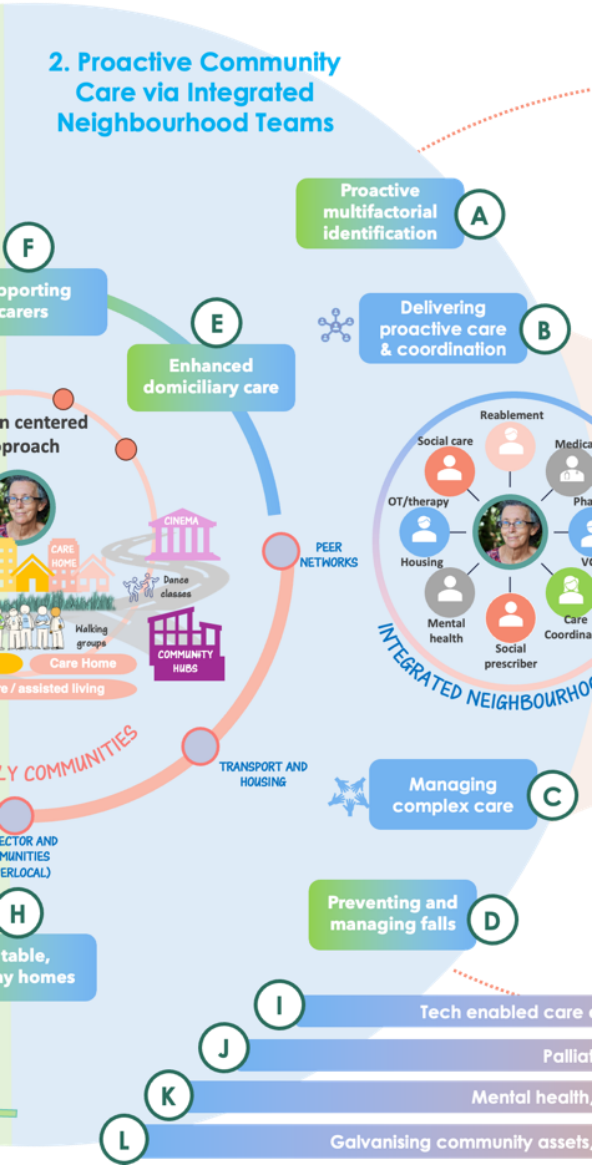
Zone 1: Promoting independence and wellbeing - thriving at home

G. Tapping into the digital world	• Improving accessibility, knowledge and use of digital tools by residents within the local community. This may be achieved through implementing digital 'drop-in' sessions within local libraries or community centres for instance, or that may be supported by local university student volunteers/peer mentors. • Supported by key FAQ leaflets. • Age friendly support available within libraries. • Providing alternatives to digital (e.g. appointment cards, paper diaries) for people with dementia/others who would benefit e.g. dementia, digital poverty, language barriers / others.
H. Covering the basics – 'heating and eating'	• Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness • Examples include a secure home with working locks, minimising drafts, heating, cleaning, having access to suitable food and checking that suitable food is being eaten and managing money. • Whilst services exist that focus on these 'basics' for people with an identified need, the numbers of people living without them are significant and it is incumbent on all to be alert, identify gaps and problems and help address them, which may include being proactive and notifying VCFSE organisations that can support. • Consider an 'older person's' review in their home, "I want... I need.... I can... I can't..." • Consider what population health management (PHM) data we need and what we want to capture to address the 'basics.'

Zone 1: Promoting independence and wellbeing - thriving at home

Wider determinants	• Identifying changes that are required within the wider infrastructure to create an age friendly community (in reference to WHO age-friendly cities framework). • Addressing issues such as pavements, street lighting, access to clean and usable public toilets, access to outdoor seating, support with employment and better transport links. • Uptake of benefits, managing rising cost of living, financial advice and employment support. • Recognising and meeting people's spiritual beliefs, personal values and needs. • Ageing well cafes and death cafes. • Where people are in receipt of extra care, ensuring this is integrated with the wider social/community offer so it supports people to get out and join in rather than become isolated at home.

Zone 2: Proactive community care via integrated neighbourhood teams



Zone 2: Early identification of frailty and working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

Proactive community care focuses on delivering an integrated and coordinated primary and community care-based offer, which is holistic and personalised for people with frailty and/or at rising risk, enabling a good quality of life. Through understanding *who and what matters*, it prioritises what is important to the individual. Key components include:

- Proactive multifactorial identification of people living with frailty and/or at rising risk via consistent means
- A dedicated care team of multi-agency professionals formed within the neighbourhood, including specialists who provide a personalised and holistic approach, with multi-disciplinary team (MDT) interventions and support which includes facilitation of interventions beyond only health and social care.
- Robust, flexible support for unpaid carers, ensuring a carer's assessment is completed, regular reviews occur and signposting to appropriate resources takes place.
- Increased focus on hydration, nutrition, eyesight, hearing to tackle the modifiable risk factors for frailty and falls.
- Multifactorial assessment of frailty including falls and its prevention and continence promotion amongst others using a comprehensive geriatric assessment (CGA) framework for those with moderate/severe frailty.
- Managing people with frailty and escalating complexity via a named care coordinator i.e., someone to holds the case to enable pulling together and coordination of support.
- Enhanced and more integrated domiciliary care which is flexible, high quality and personalised, via well trained and supported staff.
- Defining elements that will improve the way ageing and frailty are managed in care homes, e.g. ensuring all residents have a CGA and proactive planning ahead including end of life.
- Easier access to responsive advice and guidance, with reduced bureaucracy.
- Developing and integrating the use of telecare and telehealth to enable people to stay at home where possible.
- Structured face to face medication reviews resulting in better patient understanding of medications and shared decision-making based on patient-oriented goals
- Increasing the role of VCFE organisations, including more formal, longer-term funding.

Zone 2: Proactive community care via integrated neighbourhood teams

A. Proactive multi-factorial identification	• Proactive multifactorial identification of frailty and its severity (mild, moderate, severe) with a uniform tool across health and social care, e.g. using the clinical frailty scale (CFS) to enable standardisation and one common language. • Using collective local intelligence (wider proactive community flag) to supplement the data e.g. from GP practices in which all system staff (regardless of host organisation) are trained to **help** identify frailty (with a united system language of what we mean by frailty) and connect with others to enable residents earlier access to CGA and help. Making all system interactions count to enabling holistic whole person approach, whether resident accesses help via their GP, secondary care, community pharmacists, social care, district nursing, carers, VCFSE, learning disabilities services, homeless and refugee services, housing, domiciliary care and pharmacy. All partners working together to deliver as an MDT. • No wrong door to an organisation approach. Move organisational navigation from the user to the access point. • Community information hub or 'access hub' to also report and raise concerns about vulnerable people. • Consider an in-reach team with an ageing well skill set (geriatrician, nurse, AHP), working with GPs, allocating whole day going into e.g., sheltered accommodation, Latino centre to test different 'out of the box' ways of finding and responding to people (see Lambeth approach) • Ensuring people with severe mental illness (SMI) and/or dual diagnosis, are not excluded. • Looking at the value of shared records, collected by all, to create a single, shared frailty register. • Use of data and/or artificial intelligence (AI) to identify people with frailty or at a rising risk.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination

- A dedicated care team of multi-agency professionals formed within the neighbourhood, including primary care, allied health professionals (AHPs), including speech and language therapists (SALT), physiotherapists, occupational therapists (OT), substance use, mental health, housing, community nursing and secondary care specialists. Consider establishing a specific frailty neighbourhood team as part of integrated neighbourhood teams (INT) that visits, conducts CGA/tests, plans, delivers and follows up care.
- Frailty neighbourhood team to include CGA & frailty skilled workers working within their scope of practice with support, admiral nurses, social prescriber, pharmacist, council access (social care and housing) as well as geriatrician input feasible to context.
- Focus on individual's holistic needs and preferences, established through 'talking to the person', carers and family on 'what matters to them', enabling nuanced decision-making, as well as and providing a personalised and holistic approach, with MDT interventions.
- Consistent minimum core actions to be carried out at mild/moderate/severe stages of frailty.
- Building a strong social prescribing resource/team who build relationships with individuals.
- Seeing people who are teetering before they reach crisis point and galvanising holistic (not just health) interventions straight away before exacerbation occurs.
- Above arrangements to include making reasonable adjustments for people with mental health needs and dementia or other characteristics that mean care or care pathways need nuance to facilitate equity.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination .. Cont'd	• Close liaison and optimal use of VCFSE organisations, including hyper local offers. • Definition of a strategy for medicines management and de-prescribing including proactive identification of most vulnerable patients with medication issues, structured face to face medication reviews based on shared decision-making and what matter to the person • Access to pharmacists for a second opinion (including via MDTs with social prescribers for non-drug options), • Clear links to community pharmacy to enable bi-directionally MDT working between primary care, frailty teams and community pharmacist to better identify non-concordance, better access to help, information and health education • Provision of help especially post-discharge (e.g., through the New Medicines Services and Discharge Medicines Service), information and education so that patients better understand their medications – and clear ownership of these elements so professionals know 'who does what'. • Existing examples that incorporate some of these aspects are the integrated clinical pharmacy services – GSTT Integrated Local Service Pharmacy team, Lewisham Integrated Medicines Optimisation Service (LIMOS), Bromley Integrated Medicines Optimisation Service (BIMOS).
C. Managing complex care	• Cohort may include homeless, asylum seekers and prisoners, as well as more obvious groups e.g. severe mental health disorders, care homes. • Manage people with frailty and escalating complexity via complex care coordination. • Bring specialist and acute input into the community MDT e.g. SALT, substance use, secondary care experts. • Strong role for social prescribing and use of VCSFE sector. • Explicit medicines management strategy for complex patients with MDTs including prescribers (e.g., GPs), pharmacists and specialists to make balanced decisions about polypharmacy and de-prescribing for complex patients. Guide by patient-oriented goals, so that complex decisions about stopping/starting medications are supported and made and in a timely way – and complex patients are supported with proactive help and advice to optimise concordance (e.g., via referral to community pharmacy to engage with and support complex patients).

Zone 2: Proactive community care via integrated neighbourhood teams

D. Preventing and managing falls	• Falls management model as part of proactive community care. Timely multifactorial assessment for falls addressing additional factors such as eyesight and hearing, for those that are complex and predisposed to falling. • Preventative measures such as activity, strength and balance exercises are highlighted in Zone 1 (Component F).
E. Supporting carers	• Unpaid carer's assessment completed and reviewed regularly. • Earlier, more flexible and episodic, ad hoc support (including respite) for carers (instead of an 'all or nothing' offer). • Unpaid carers able to get a GP appointment at a time they need it, recognising the importance of their role. • Signposting to appropriate services including financial advice and support groups within the community e.g. carers café. • Pre-emptive planning for carer crisis e.g. contingencies if the carer becomes unwell, leading to peace of mind and the right actions taken. • Carer identity card indicating where to find an 'emergency pack' so that urgent and emergency services know where to find everything in the event of a carer crisis. • Providing training for carers to increase their skill and resilience to managing older people with frailty.

Zone 2: Proactive community care via integrated neighbourhood teams

F. Enhanced domiciliary care

- For stable people at home, care which is flexible, high quality and focused on how to support people to achieve their full potential supported by a personalised care plan that is regularly reviewed.
- Redesign recognising the holistic opportunity to keep people at home for longer, prevent escalation and delay admission to a care home. Redesign aligned to the CQC framework.
- Moving from a 'task and time' approach to outcomes; optimising the person, increasing self-sufficiency and encouraging/supporting social engagement and participation.
- Establishing stronger partnership working between domiciliary care providers, informal carers and the health and care system so that issues are identified and acted upon earlier.
- Domiciliary care staff upskilled and supported in proactively identifying signs of deterioration early on and able to make direct referral to the resident's nominated coordinator and be involved in MDT meetings. Uniformity in training needs across the borough, to reduce the variation in care delivered by domiciliary care providers including in skills related to frailty to enable earlier escalation of concerns.
- Provision of coaches to support workers through oversight, giving advice, coaching and training e.g. in practical ways to optimise the person, identifying and managing concerns such as frailty, delirium and behavioural and psychological symptoms of dementia (BPSD).
- Training can be also attended by other formal/informal carers to create local support networks within communities to become the 'eyes and ears' of domiciliary care.
- Option for people to select their preferred wellbeing worker using summary info about their profile (experience, style of working).
- Health visitor role coordinated with domiciliary care to provide enhanced support.
- Ensuring clear expectations are set between wellbeing worker and client at outset e.g. 'I will use my mobile phone as part of my job whilst I am with you'.
- Paying workers the London living wage.

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing)

- Care homes are not a separate ecosystem and residents are to receive equivalent care and support as those in other settings, recognising they are of equal importance and that the model may need nuance to enable equity of access. For example, ensure use of the life course self-assessment in care homes (see Zone 1), and use of CGA, UCP and ACP.
- Care home settings are often poorly understood by health teams. There is a need to shift to a positive approach, listening and championing care home staff and asking them what they most need. Consider a care home champion post per Place.
- Training and support to maintain competency are key, so that care home staff feel confident (recognising they sometimes do tasks infrequently so get out of practise e.g. using a syringe driver). Healthcare should play an active role in supporting health-related training, e.g. in falls prevention, wound care etc.
- Provision of training around early recognition of deterioration with supportive tools (e.g. RESTORE2) and 4AT (screening tool used to assess delirium and cognitive impairment).
- Consider establishing a care home support team (CHS) and/or primary care, to provide a transparent, uniform offer into care homes, supporting e.g. bedside training, clinical supervision (around topics such as falls prevention/management, tissue viability, polypharmacy reduction, nutrition and hydration) to build trust and dissipate fear (see Penninsula Practice, Greenwich as an example). This support to be provided to care home health care assistants (HCAs), not just registered staff.
- Consider a specific care home mental health/dementia team as part of the above provision, to provide training and support to e.g. mental health, dementia, delirium and BPSD.
- Consider a geriatrician in-reach model reaching into care homes to support MDTs, training and to visit specific residents to prevent admission (Whipps Cross Hospital model).

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing) Cont'd	• Regular feedback to relatives regarding the resident's progress and proactively addressing any relative's concerns. • Care homes direct referral pathway to same day emergency care (SDEC). London Ambulance Service (LAS) transfer to SDEC, SDEC provide treatment and LAS return to care home). • Specifically ensure an Alzheimer's support worker supports transitions into care homes to settle the person and resolve issues. • Include care homes within a telecare and telehealth strategy, e.g. providing the opportunity for wearables to be utilised where this shows evidence-base to support its utility. • Involvement of activity coordinators within care homes to keep residents engaged with social activities and group activities and to promote self-help and independence and include accessing the community where possible. • Include a spell in care homes as part of student training, e.g. to enable deeper understanding of frailty. • Align with the national framework for enhanced health in care homes (EHCH).
H. Suitable homes	• Develop processes to swap social homes with others to get a home that meets changing needs and preferences as you grow older (e.g. moving from a high rise flat to a ground floor flat with a balcony if you develop knee problems and have a dream of having a place to sit outside). • Prioritising housing adaptations and changes for people with specific needs via making a link between health, social and housing services - working together to respond to people's changing needs in a coordinated way. • Influencing the design of new build housing and estate infrastructure so that it is suitable for older people's future needs.

Zone 2: Proactive community care via integrated neighbourhood teams

I. Technology enabled care and support (TECS)	• Consider development of an integrated telecare and telehealth strategy and approach that optimises the ability to keep people living with frailty safe and independent at home (aligned to virtual ward offer). • As part of strategy scan the market to identify new products to innovate the offer, move from analogue to digital and upgrade the user experience. • Examples of TECS include community alarms and detectors, door alarms, home activity detectors (e.g. falls), TECS supporting daily activities of living such as picture clocks with visual, audible clues, and wearables (e.g. blood pressure monitors), low tech items like walking sticks also included. • Consider same day TECS delivery to expedite timely discharge of people with frailty from hospital. • Consider VCSFE ability to directly source smaller items themselves to increase speed of response and source at cheaper prices. • Monitor clinical and cost effectiveness outcomes, satisfaction levels and benefits gained as part of rigorous evaluation process.

Zone 2: Proactive community care via integrated neighbourhood teams

J. Palliative and end of life care (PEoLC)

- The narrative should be focussed on what is right for the individual and include shared decision making, not on what is best for the system.
- Recognising 'ordinary dying' – palliative and end of life care should be everyone's business, not just that is the palliative care specialists.
- Build PEoLC skills within the neighbourhood teams to reduce over-dependence on specialists. Recognise the need for a personal navigator role at the end of life.
- Recognising that domiciliary care and district nursing play a vital role at the end of life, alongside GPs and community services.
- Social care plays a huge role in the holistic care for a person – palliative care is not just about medical care needs.
- Palliative care does not just happen at the end of life – it can be episodic and last a number of years.
- Creating a culture where people are more comfortable to talk about death and see it as part of the continuum of care, 'planning for the end'.
- Recognising that advanced care planning (ACP) is not a one-off conversation, rather should be ongoing and it is not the responsibility of a single role – it is everyone's responsibility.
- Embedding early advanced care planning as a standard, before a crisis happens, 'planning for the future is key', particularly for people living with dementia.
- Having difficult conversations regarding PEoLC earlier to enable care, and death, to happen in the person's place of preference, with family members/friends present.
- Outcome measures should be focussed on quality of advance care planning rather than preferred place of death, as well as learnings from national audit of care at the end of life (NACEL), and the emphasis on staff and bereaved carer feedback.
- Timely support to carers is key and gaps in bereavement services need to be filled and offers made more transparent (e.g., in a brochure). (Greenwich public health team undertaking pilot bereavement project).

Zone 2: Proactive community care via integrated neighbourhood teams

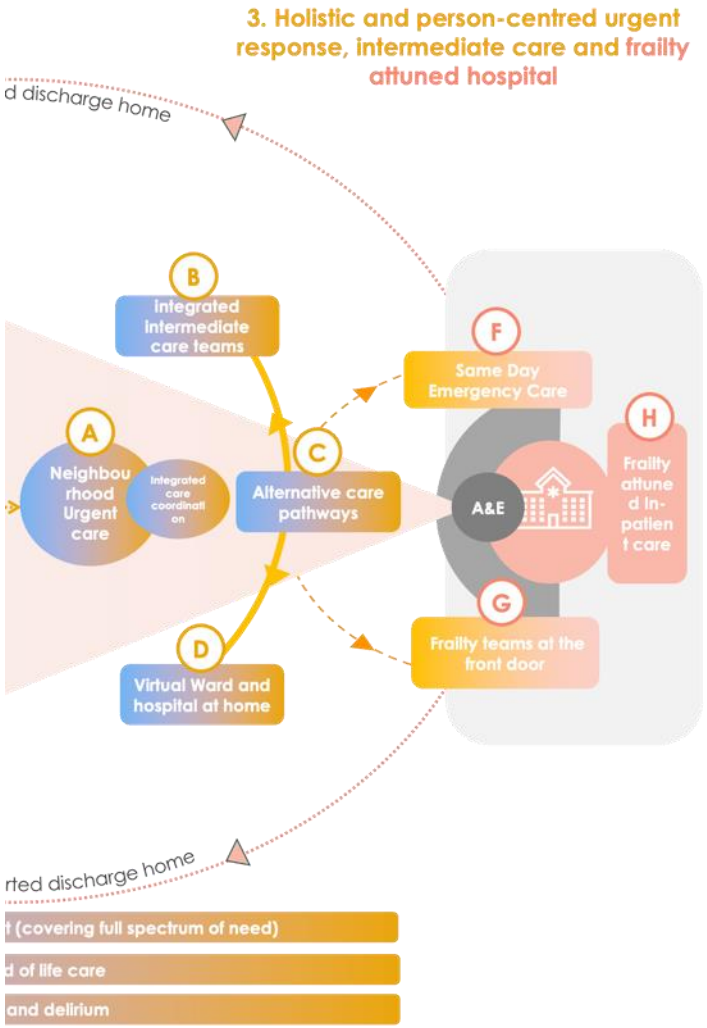
K. Mental health, dementia and delirium	• Please see the next slide that summarises some of the important elements across all zones regarding Mental Health/Dementia & delirium within the framework.
L. Galvanising community assets, communities and voluntary sector	• A key feature of the framework involves increasing partnership working between voluntary, community, faith and social enterprise (VCFSE) sector organisations and the wider system to improve health and care outcomes • Specifically, there is an opportunity to increase the role of voluntary sector organisations who often know residents better than other agencies, are more skilled in supporting their needs and can do so more effectively and efficiently than statutory services • To do this best, voluntary sector organisations need to be 'around the table' from the kick-off, involved in designing solutions and services and require more formalised roles supported by secure, longer-term funding. They also need to be part of the ongoing review and refinement of services • Places are at different points in this journey; effective starting points include helping to build a local collaborative of organisations supported by some practical governance (such as collaborative meeting points, clear leadership, etc.). Identifying a specific aim in terms of shifting budgets to the voluntary sector is also recommended • It is also important to ensure strong participation from hyper-local organisations, helping to build real local knowledge, goodwill and cooperation with residents and resident groups at neighbourhood level • The extent to which the above represents a change in culture and way of thinking is not to be underestimated, so continual challenge to change the status quo is to be encouraged.

Mental Health/Dementia & delirium within the framework

ZONE 1	ZONE 2	ZONE 3
• Knowing exactly who our population with mental health problems and dementia are • Equally promoting independence and wellbeing for people living with mental health problems and dementia ensuring parity of provision for these groups and reducing stigma. • Early identification: spotting and responding proactively to early signs of deterioration. • Supporting people to engage with their health, e.g. to address excessive drinking and resultant low mood. • Early support and advocacy to good decision-making about what to do e.g. post diagnosis • Supporting people to build resilience post-diagnosis • Understanding and acting upon carer risk	• Clear support post-diagnosis (instead of being sent all over the place) • Dementia care home team providing advice, training and coaching to staff e.g. managing BPSD, monitoring hydration, etc. • Upskill domiciliary care workers to reduce avoidable escalation and admission with earlier detection and action to deterioration and delirium. • Strong connections with social care link workers • Pre-planned crisis escalation support (including e.g. giving carers urine pots so testing can be expedited quicker). • Carers as full partners in decision making and effective carer support and respite • Managing behavioural issues associated with dementia (across zones). Understanding people's unmet needs and what they are trying to communicate via their behaviours to keep people in the least intensive setting. • Access to substance use specialists e.g. to take part in MDT discussions • Making reasonable adjustments e.g. providing paper appointment cards, using paper diaries (instead of automation).	• Timely step-up/step-down to intermediate care • Provision of specialist input e.g. speech, language, nutrition. • Integrated, wrap around offer (housing, homecare, domiciliary care). • Speedy return to normal place of residence • Skilled management of emergency presentations to avoid admission. • Timely identification and assessment of dementia/delirium in hospital (4AT). • Strong focus on nutrition, hydration and constipation checks at all stages of the journey. • Minimal ward moves and improving the patient experience • Nuanced decision-making based on what and who matters to the person. • Optimising the discharge process for people with mental health problems and dementia, so they experience parity. • Being more empathetic and proactive when appointments are missed, e.g. following up, taking time to explain and re-setting appointments. • Consider Admiral nurse as part of team to provide support to and help to navigate/coordinate and signpost care for people living with dementia (including support to carers).

Skills and knowledge to respond to mental health issues, dementia and delirium and the interplay between them.
Cohesion and effective communication between teams.
Data and digital interoperability.
Dementia-attuned environments.

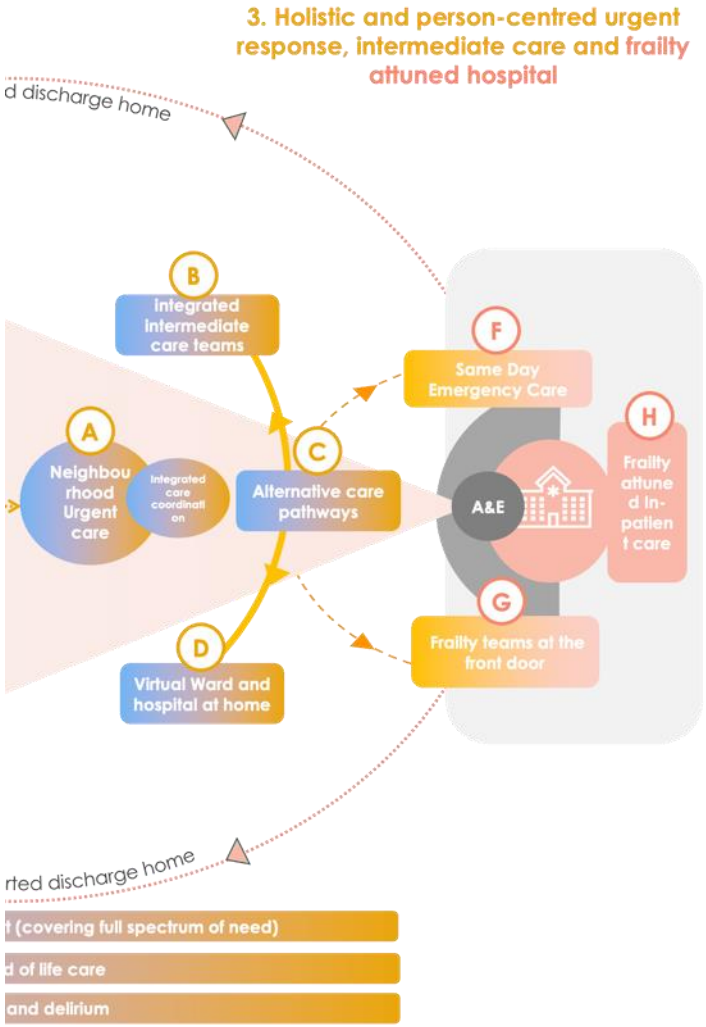
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Neighbourhood-based urgent community care preventing escalation for those at home
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Step-up intermediate care and/or hospital@home helping to avoid unnecessary hospital attendance or admission.
- Step-down intermediate care and/or hospital@home for those at the hospital front door or who have been admitted, enabling timely discharge and avoidance of readmission.
- Strong focus on step-up provision to ensure fewer people are unnecessarily admitted to hospital in the first place.
- Simplified and coherent community escalation attuned to the holistic needs of older people and those living with frailty to keep people at home for as long as possible. Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Provision of timely, strengths-based and coordinated intermediate care (recovery, reablement and rehabilitation) based on people's goals and focused on wellbeing and independence, for those who need a continued period of managed care in the community or following presentation at or admittance to hospital.

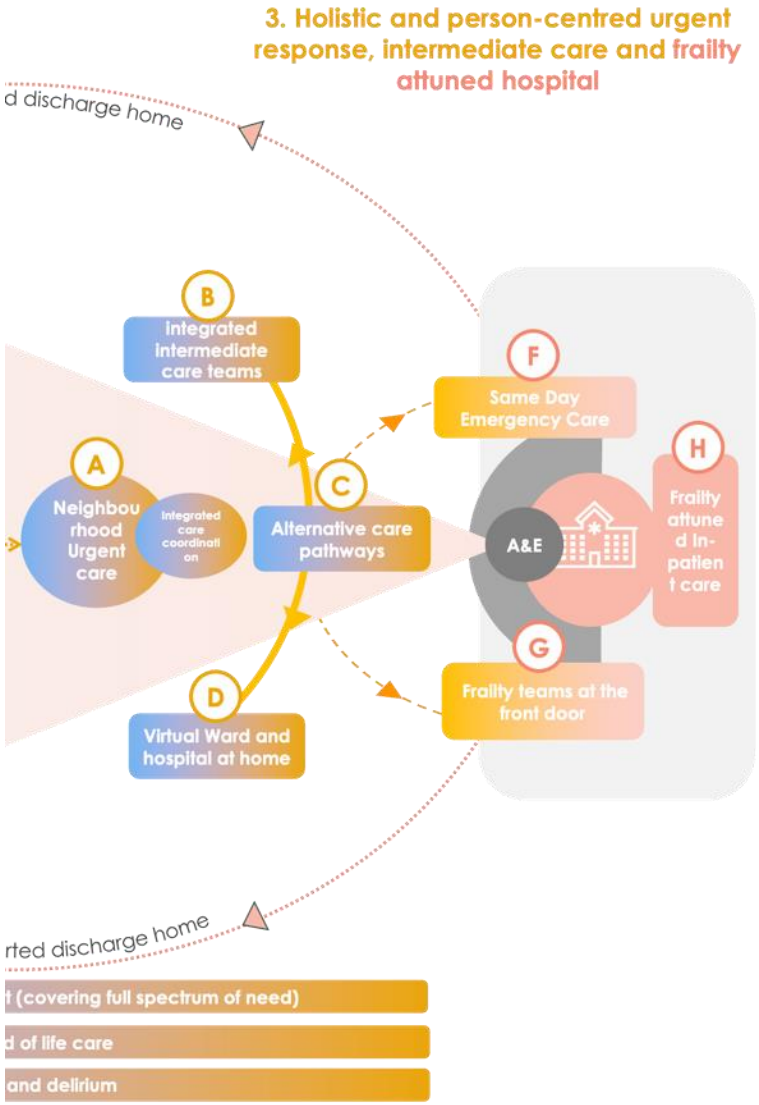
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Intermediate care needs identified in the community or hospital front door escalated into a single point of access for advice or acceptance for rapid therapeutic transfer of care, including real time review of any existing package of care in place.
- Timely delivery of intermediate care and support without delay that would otherwise lead to deterioration at home or deconditioning in hospital, e.g. therapy starts immediately post discharge to avoid person becoming bed bound and to optimise independent living.
- Includes advice and support to help people manage life events such as bereavement, organising care requirements and planning lasting power of attorney.
- Ability to make direct referral to a virtual ward to prevent admission or expedite earlier discharge from hospital.
- Inclusive of direct access to medical support (including via advice and guidance) and a solid out of hours provision.
- The ability to align mental health resources to the more urgent mental health and dementia cases to ensure parity of care for people with mental health problems and dementia. For example, admiral nurse involvement to expedite swifter hospital discharge and provision of a short period of specialised support at home to enable earlier discharge for people with delirium.

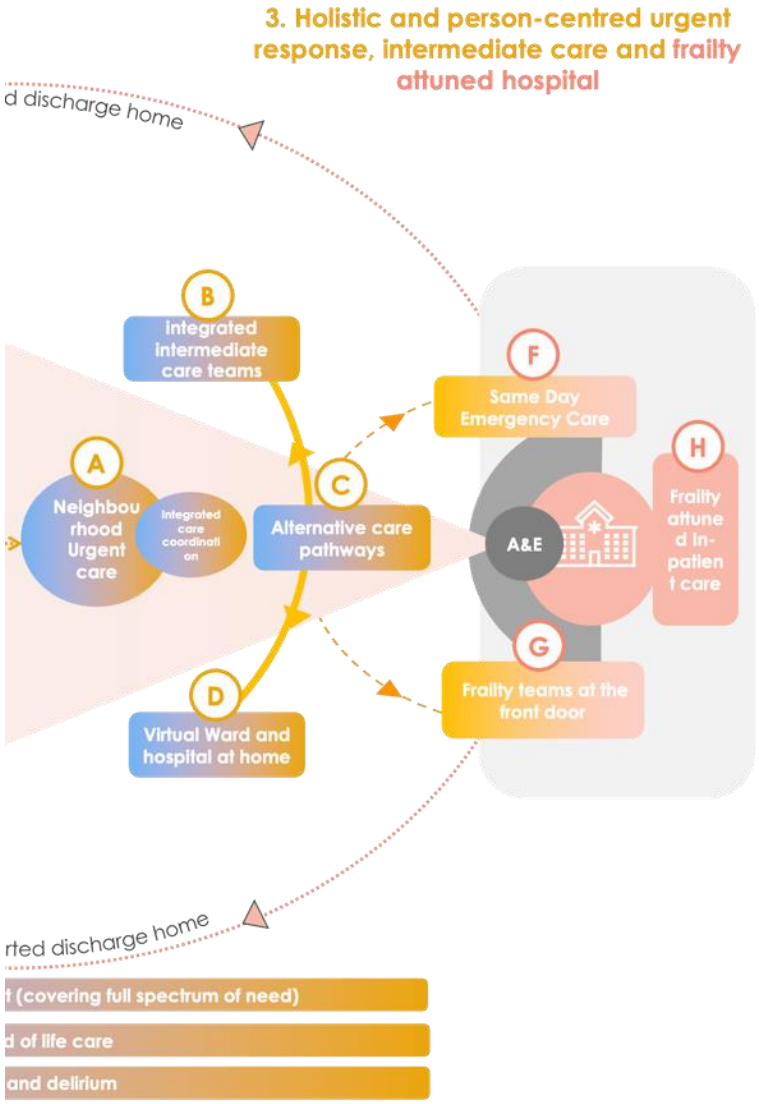
Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and frailty attuned hospital



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams.

- Frailty team at the front door to proactively identify frail people, carry out holistic assessment and care planning and where possible transfer directly back to community-based care before the person becomes ‘medicalised’.
- Establishing realistic independence and activities of daily living (ADL) baseline and making nuanced decisions based on this and 'what and who matters to the person'.
- SDEC - assessment and care by specialist clinicians on the day of arrival to hospital as an alternative to admission, ensuring those that would not benefit from hospital admission are discharged back into the community.
- Acute frailty unit - a multidisciplinary assessment unit, to address the urgent medical needs for those that are frail and require a short stay (less than 3 days) in hospital.
- Fracture liaison service - identification of people who have suffered a fragility fracture, providing a bone health assessment to identify future falls risks and to reduce the risk of future fractures.
- An inpatient older people’s ward for those who require a longer inpatient stay due to medical reasons – including a focus on reablement, mobility, exercise and cognitive stimulation to reduce deconditioning during their stay.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams (cont'd)

- Transfer of care hub providing coordinated discharge back to the community, including taking actions from day of admission (as part of discharge planning) to expedite timely discharge without delay.
- Frailty and dementia/delirium skilled and attuned staff in all key hospital roles, so that for example, decision-making about care is more nuanced and driven by *what and who matters* to the person.
- Defined standards for frailty-attuned care for people in other settings such as surgery, oncology and other non-geriatrician led inpatient services.
- Consider use of summary acute medicine indicator table (SAMIT 75+) offering national comparative data for frailty at site level. Metrics cover demand, flow and outcome for both the admission and recovery phases of frailty care.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

A. Neighbourhood urgent care with integrated care coordination

- Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Seamless flow and pathways between services and in-reach into neighbourhoods as a shared resource.
- Core MDT: An MDT approach consisting of paramedics, nurses, OT, dietician, social care professionals, advanced care practitioners and managers.
- Connected teams: Direct interface with health and social care provision such as GP, 111, pharmacy, INT, Virtual ward, LA front door, Housing,
- System collaboration: Access to other professionals including UEC, GP, hospital, mental health, housing, urgent response mental health placement etc
- System integration/technology: ensuring visibility of patients, access to shared records, data transfer between MDT and use of tele-monitoring/tele-care
- Care navigator/ co-ordinator with clear ownership of cases. Strong key relationships and conversations-with clear communication lines
- Holistic approach with focus on prevention, e.g. ensuring that lower-level or emerging social needs are not missed

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

B. Integrated intermediate care teams	• MDT working to deliver a timely step-up and step-down service focused on recovery, wellbeing and independence • MDT comprising of medical, therapy, mental health, nursing, VCSFE, pharmacy, reablement, night carers, handyman service. • Access to extended MDT and/or advice including housing, geriatricians, cardiologists, etc. • Coordinated, proactive support, putting everything in place, working closely with a carer or family where present • Real time review and adjustment of support and ability to increase or decrease care to optimise outcomes • Access to existing CGA or ability to carry out a CGA, aligned to an urgent care plan • Specific liaison role with care homes to ensure proportional access and utilisation of service by care homes • Utilisation of service by specialist palliative care, hospice and end of life care teams • Timely access to equipment to ensure care and support commence rapidly.
C. Urgent community response and alternative care pathways	• Consistent UCR offer across SEL aligned to national standards and population health. Seamless flow/pathways into/in-between ACP :virtual wards, frailty units, SDEC • Intermediate care needs identified in the community, at the hospital front door or at discharge from hospital are escalated into the single point of access for advice, guidance or referral for a rapid, therapeutic transfer of care, including real time review of existing packages of care • Specifically for frailty, which is delivered at a place level, and may differ operationally between places based on local requirements. • Anyone can access and be signposted, including professionals working in zones 1 and 2, care homes, palliative care, etc. • Timely, direct access to reablement and rehabilitation via one and done process (no hand-offs). • A senior experienced clinician and social care led service, with authority and decision-making capabilities. • Rotation of staff within the system for care alignment and development. • Standardisation and simplification of proforma.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and frailty attuned hospital

D. Virtual ward and hospital at home	• Direct referral pathway from intermediate care teams, urgent community response teams, front door frailty teams, SDEC, discharge teams and transfer of care hub (TOCH) to virtual ward. • Virtual ward teams specifically skilled in frailty care and falls management.
F. Same day emergency care (SDEC)	• An MDT led frailty SDEC approach (geriatrician, advanced frailty practitioner, case manager, pharmacist). • Conduct investigations and delivery of short-term treatment e.g. iron infusion. • Assessment of acute issues referred from LAS, community teams, outpatients, care and nursing homes and front door frailty team • Direct link to virtual ward.
G. Frailty Teams at the Front Door	• Proactive screening and identification of frailty in ED through seeing all people age 65+ • Automatic CGA for CFS frailty score 6 and above and for those living in care homes. • An MDT approach: geriatrician, advanced frailty practitioner, physician associate, frailty pharmacist, frailty dedicated physiotherapist, social worker, community advanced nurse practitioner (ANP) and mental health representation. • Assessment and planning, including redirecting people back home, referral to community-based care, falls clinic, intermediate care, fast-tracking to the acute frailty unit or admission. • Providing advice to the ED team. • Geriatrician-led frailty advice line for GPs, community health services and ambulance service. • Good links to community teams, virtual ward, equipment services and voluntary sector (e.g. for meals, shopping, etc.).

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

H. Frailty Attuned In-patient Care	• An acute MDT bed base utilised to address urgent medical needs for those that require assessment and/or a short stay (less than 3 days) in hospital. • Utilised by the frailty at front door team. • Direct and easy referral to intermediate (step down) care. • A dedicated environment providing patient-centred care (and continuity) via a frailty and dementia/delirium trained MDT (including a frailty consultant and access to mental health specialist) that focuses on the patient, carer(s) and families. • Routine screening for delirium (4AT). • Timely access to CGA e.g. to identify/avoid people being constipated, dehydrated, becoming delirious, resulting in falls. • Increased VCSFE involvement, expediting early action to support timely discharge such as making home ready for person to go home. • Focus on food and feeding and hydration. • A focus on reablement, mobility, exercise, continence care and cognitive stimulation on the ward to reduce deconditioning and hospital acquired disability (HAD), helping to minimise the need for packages of care once discharged. • Dementia support worker present with time to have the conversations and help plan and put support in place. • Focus on early discharge recognising every day in hospital has detrimental outcomes and leads to loss of independence.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

Supported Discharge Home

- Frailty attuned, therapeutic transfer of care processes, interfaces, proforma, assessment, out of area arrangements, etc.
- Link to discharge coordination.
- Direct interface with specialist older people's ward, care and nursing homes and intermediate care
- Live view of capacity for frailty-related services.
- Personal health budget in hub to enable discharging the person sooner/on time e.g. via provision of food, towels, and other items required, that were unforeseen or not addressed as part of a discharge plan
- Ability to refer directly e.g. to handyman services e.g. to fit key safe, repair locks or windows, fix the heating
- VCSFE support to unpaid carers/families at point of discharge to navigate the system and achieve a coordinated, timely and worry-free discharge.
- Full sharing and use of CGA and other information with care or nursing homes at point of transfer, recognising that going into a home is a major life event and that a 'discharge letter' is not sufficient to expedite this or achieve a person-centred, therapeutic transfer of care.

(this element does not appear as a numbered item in the overarching framework)

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

The cross-cutting themes and enablers that will support the ageing well/frailty framework include the following:

- One agreed **frailty scale** to be used across the ICS.
- Consistent approach to use of **Clinical Geriatric Assessment** (CGA) and Universal Care Plan (UCP) - develop a technological solution to pull information from clinical systems such as EMIS in primary care into the UCP.
- **Digital tools** and data sharing - enabling digital solutions for patients and obtaining digital equality. Having required data sharing agreements in place to support collaboration
- **Continuous quality improvement cycles** – Formal QI methodology in place co-developed, owned and actioned across partners.
- **Workforce development and culture** – Achieving a universal minimum skill and competency level for ageing well and frailty (ideally including dementia and delirium) across all roles. Supporting the wellbeing of staff to prevent burnout and increase job satisfaction and staff retention. Developing 'employer of choice' status and attracting the best people with a passion for supporting older people to SEL. Achieving a shift in culture so that e.g., older people are respected, trusted and believed as equal citizens living full and well-rounded lives and with hopes and dreams. Supporting a cultural shift to increase pre-emptive thinking and genuine shared responsibility for prevention e.g., through talking to one another and triggering timely action in response to concerns or yellow/red flags, regardless of role. Co-location of teams to support building of strong, authentic teams and relationships
- **Culturally sensitive adjustments** – understanding the barriers to accessing services and wider amenities in the community, which could be real or perceived. Adjusting practices, processes, pathways, measures etc. in response to older peoples' experiences to create inclusion, encourage self-care and meet their needs. Health inequalities – look at how to tackle inequalities not only in access to services but also regarding preferences and limitations due to race, gender, etc.
- **Making ageing well everyone's business.** Ensuring that ageing well/frailty is "everyone's business" including raising awareness and upskilling the workforce to understand ageing well and recognise frailty and early signs of deterioration. Making it "every professional's responsibility" to input into the UCP. Supporting the upskilling and raised awareness of staff in care homes and domiciliary care
- Having a clear and overt strategy in place for **delivering the funding shift** needed to fulfil the ambitions of the framework, supported by a demand and capacity model that sits alongside the framework, pinpointing the capacity needed in each area to successfully deliver the required care and support
- **Population health management** (PHM) - using PHM capabilities such as predictive risk analytics to identify cohorts and further predict the risk of deterioration. Using alerts e.g., to indicate where patient reviews have been missed or need to be undertaken. Access to granular detail, e.g., to enable identification of people with frailty and at risk of deterioration.

South East London Integrated Care System

NHS South East London

6.
How will we know if we are making a difference

Outcomes and measures

HEALTH INTEGRATION PARTNERS

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all Places in SEL, encompassing a wide range of professions (e.g., clinical, social, managerial) and care settings (voluntary sector, local authorities) as well as residents.
- Please note that this list of outcomes is still "in development." Other outcome frameworks, such as those for LTC and neighbourhoods, have already been or are currently being developed. It is essential that we align these outcomes, and as such, the list will evolve alongside the development of other programs.
- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements at three levels: neighbourhood, Place, and South-East London. To ensure practicality and relevance, it is crucial to limit the number of indicators that effectively demonstrate overall impact in line with the aspirations of the ageing well framework.
- 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 ageing well framework.
- The indicators should be SMART and, ideally, based on established data points that can be centrally extracted to support an automated dashboard across the system. This dashboard will be designed to filter by location, population segment, and severity of frailty (mild, moderate, severe). Developing this automated (or semi-automated) dashboard is a key part of the roadmap ahead and will require a task and finish group, including data experts, clinical/professional leads, and executive oversight.
- Considerations for dashboard development includes: (1) availability of and access to viable data points (such as in GP records, HES and LA datasets), (2) creation of repository of joined-up datasets, (3) assessment of data quality, (4) defining key algorithms and definitions, and (5) the development of the dashboard, which will involve testing, refining, and implementing through a quality improvement (QI) process.

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
1	**Improvement in quality of life**	• Are we genuinely supporting in people to age well and thrive? • Are we making a difference to the quality-of-life outcomes of people (residents, patients and carers)?	**At system level:** • Priority: Healthy life span as a marker of ageing well * • Priority: Quality of life of people who use services (ASCOF) • Carer reported quality of life (ASCOF) • Mortality rate of >65 population * **At an individual / cohort level:** • EQ-5D patient reported outcomes-based quality of life score • Set of outcomes defined in INT at the time of care planning and then assessed at defined intervals 1. Achievement of goals defined at the time of care planning 2. Improvement in ADL from baseline (if relevant) 3. Reduction in reported loneliness (if relevant) 4. Improvement on overall mental wellbeing 5. Improvement in clinical outcomes (exact indicator will depend upon the clinical condition of the patient) • Self reported outcomes: Use of simple wellness star. Use of digital / telehealth to monitor wellness scores where possible

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
2	**Supporting people to age well**	• Are we able to reduce risk for individuals and stop or slow their progression into higher frailty zones for e.g. mild to moderate and moderate to severe / reduce manifestations of growing frailty	• Priority: Reduction in number of admissions due to ACSC / avoidable admissions *(avoidable admissions codes to be confirmed locally and monitored against baseline or as a rate of population)* • Priority: Reduction in people with 10+ medications (poly-pharmacy) *(https://www.who.int/docs/default-source/patient-safety/who-uhc-sds-2019-11-eng.pdf)* • Priority: Reduction in people with self reported isolation (ASCOF) • Reduction in number of admissions due to falls *(measure against baseline or as a rate of population)* • Reduction in number of people requiring domiciliary care (new) • Reduction in people who are house-bound *
3	**System sustainability (value-based care)**	• Are we reducing demand from resource intensive areas such as hospital and long-term residential care and shifting focus of care into community	• Priority: Reduction in ED presentations for over 65 or those who are mild/mod/severe frail • Priority: Reduction in % of patients over 65 with a Length Of Stay of 21+ Days • Priority: Reduction in admissions into residential care (nursing and residential care homes) • Priority: Reduction in number emergency admissions to hospital and beddays (measure against baseline and as a rate of population) • Increased SDEC utilisation and reduction in ED utilisation for people with moderate to severe frailty with UCP in place • Reduction in care home conveyances to ED • Reduction in LAS conveyances to hospital

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
4	**Improved resident / carer experience**	• Are the experience of our residents, patients and carers positive. Do they feel supported, seen, heard and respected in their interactions with health and care services. Do they have a positive experience of ageing.	**At system level:** • Priority: Proportion of people who use services who report having control over their daily life (ASCOF measure) • Priority: Social Isolation: Percentage of adult carers who have as much social contact as they would like (ASCOF) • Social Isolation: Percentage of adults who feel lonely often or always **At an individual / cohort level:** • To be delivered at service level such as people supported by Integrated neighbourhood teams • Qualitative survey (person feedback): List of 5 questions - could include aspects like 'ability to self manage', 'improved connectivity' and 'feeling trusted, heard and respected' • Real life stories through deep dive semi-structured interviews (for learning and CQI)

5	**Improved access to community assets**	• Are residents provided with opportunities to access support in the community to support them in ageing well.	• Priority: Proportion of people accessing the green and blue zone such as:
			  • Access into neighbourhood services (e.g. INT), community activities
			  • Access to community-based support and amenities (e.g. exercise classes)

6	**Reduced health inequalities**	• Are the outcomes the same in all resident/population groups ie gender, ethnicity, sexual orientation, deprivation level (IMD), mental health, LD and other exclusion groups such as homeless • Is access to community-based support and neighbourhood equitable	In addition to dissecting the data, survey and interviews above to identify any signs of inequality, the following additional objective measures to be considered: • Priority: Rate of NEL admissions in respective population cohorts • Priority: Access into neighbourhood services (e.g. INT), community activities and amenities (e.g. exercise classes) • Access to suitable housing • Rate of multi-morbidity (4 and more LTC) in respective population cohorts

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
7	**Identification of people with escalating frailty**	Are we identifying people with escalating frailty or complexities before it is late	• Priority: Proportion of people with Moderate frailty who are identified and supported by INT • Dementia diagnosis rate for 65+ years old * • Proportion of people that have been enrolled in neighbourhood care that have been flagged by population health algorithms (future) • Consider: Increased coding of frailty status of population
8	**Positive dying**	Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'	• Priority: PPoC and PPOD from UCP correlated against actual place of care and death • Number of 'Plan for the future' achieved (tbc - % of total population over 65)
9	**Other**		• Priority: Proportion of UCP and CGA completed for people with frailty (mild, moderate and severe) • Number of SMR / polypharmacy reviews

* Indicators that will show impact in the longer term

7.
How we implement the framework

A recommended first principle is that the biggest proportion of effort in implementing the Ageing Well framework should be on people

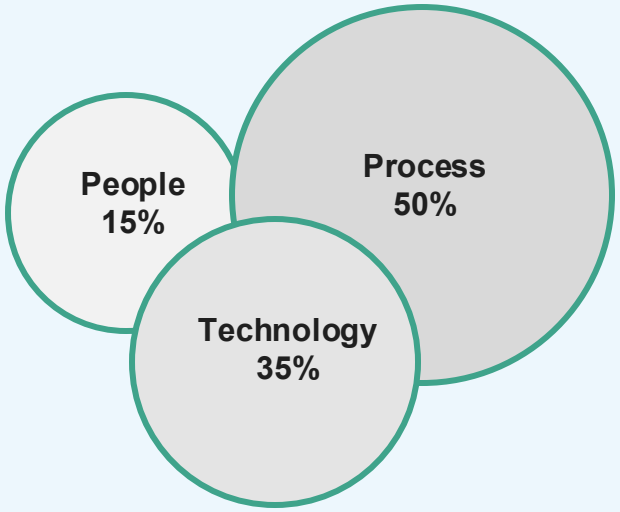
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

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*

This recommended first principle then translates into some further recommendations for how SEL should approach implementation of the framework

Engagement	• Developing a strong 'brand' identity for the framework that conveys not just the 'tasks' bit also the 'spirit and emotion' behind the ambition and embedding this in each Place • Developing a robust approach to engagement at SEL and Place level including executive and front-line buy-in across all partners e.g., health providers, social care, Local Authority, Public Health, VCFSE, private providers e.g., domiciliary care and care homes • Patient, carer and family education, engagement and co-production.
Leadership, resources and skills	• Clarifying programme leadership and project management resources at SEL and Place levels (identifying inspirational leaders) • Putting the resources in place required to deliver the framework • Establishing a multi-professional training and job shadowing/rotational roles skills transfer framework for ageing well and frailty.
Delivery and change management	• Having clarity on what the ICB is doing and what Place is doing and ensuring the ICB provides the required practical support needed to Place (e.g., identifying and agreeing the deliverables that can be done 'once for SEL' that support standardisation, efficiency and avoidance of duplication such as the Life course self-assessment, My Plan for the Future, CGA, UCP, frailty identification/scoring tool and the enablers) • Developing a new, proactive and dynamic approach to change e.g., via establishment of a community of practice and champions to inspire and drive developments, capture and assimilate feedback etc. • Sharing good practice examples across SEL enabled by a single, easy to use communication channel.
Measurement and funding	• Developing clear success measures and minimum standards to be achieved by services and the implementation programme/project itself (and securing a signed agreement to these across providers) • Establishing a holistic, longer-term plan for funding versus a short-term or piecemeal approach • Planning the investment into ageing well and frailty jointly and openly with wider partners, around an approach emphasising people.

Implementation planning – key elements

Change initiation planning at Place

- Review of framework against current Place plans and initiatives underway
- Understanding of gaps and opportunities and what to prioritise from the framework
- Identifying the key interventions to be developed building from what is already underway
- Defining the *how* – including resources, change management approach, requirements for support from SEL
- Production of practical delivery plan of action including stages, phasing, QI cycles, etc.

SEL parallel review

- Parallel review of Place plans and understanding of what can be done at SEL level/practical support Places need from SEL
- SEL level planning (aligned to Place plans) and mobilisation of SEL-level resources to deliver
- Alignment and coordination of plans with wider SEL strategies and initiatives (INTs, LTCs etc.)
- Plans to include SEL level comms and engagement e.g., resident education, launch of brand, etc.
- Plans include laying foundations for investment shift e.g., to upstream prevention, longer term VCSFE funding, etc.

Engagement and mobilisation at Place (building on existing work underway)

- Identifying Place lead(s) who will drive delivery (overall leads and lead clinicians, professionals, etc.)
- Engaging and onboarding of partners/individual stakeholders at Place who will participate in and help lead design and delivery
- Set up of collaboration and sharing across Places e.g., community of practice, shared communication channel, best practice library, change management approaches, etc.
- Establishing/activating resident engagement and co-production approach
- Mobilising the Place-level resources and project to deliver, including comms, engagement, launch of the brand etc.

Implementation planning – key elements

Demand and capacity modelling

- Scoping and mobilising the D&C modelling – SEL and Place levels
- Marrying the modelling to Place plans e.g. Place assumptions, timings, phasing, etc.
- Gaining collaboration with wider partners e.g., agreeing principles/actions for resourcing, investment, investment shift, etc
- Building the SEL and Place level D7C model
- Gaining buy-in to the model across all stakeholders

Creating a dashboard

- Creating a SEL dashboard of outcome measures and KPIs
- Populating the dashboard with baseline assumptions (SEL and Place level)
- Quarterly reporting of progress and achievement of outcomes as change is delivered.

Enablers

- Scoping and detailed specification of enablers required to enable the framework
- Developing a specific plan for delivery of enablers to meet the requirements of the framework
- Aligning the specification and plan with existing work already underway on enablers and adjusting any existing specification and plans as required to ensure delivery meets Place requirements
- Mobilising delivery of enablers, prioritised against plans.

Roadmap for implementation

Stage 1: Establishing the vision and the framework to deliver it

Stage 2: Embedding the framework (SEL–Place-Neighbourhoods) Change initiation planning

Stage 3: Phased QI led implementation

SEL Ageing well framework

- Bringing system stakeholders together
- Resident voice
- Framework for ageing well

Demand and capacity modelling

- System baseline for frailty demand and capacity
- Utilisation hot spots and projections
- Overall shift in demand and capacity with new framework

Defining outcomes

- Key outcomes and indicators to know what we are making a difference
- Define system dashboard for frailty
- Establish data points and beta test live dashboard

1. Self assessment @ Place

- Map services against framework
- Map performance: What is working well & not
- Define - stay as is, scale, enhance

2. Analysis of opportunities

- Identify areas of improvement against framework
- Scope of development – SEL vs Place
- Impact (£, outcomes)

3. Priorities for delivery

- Prioritise based on potential impact, deliverability and strategic alignment
- Roadmap for implementation

6. Change management, OD and enablers

- Identify change leaders
- Engage, inspire, empower frontline
- Requirements; Digital/OD/training
- Change management

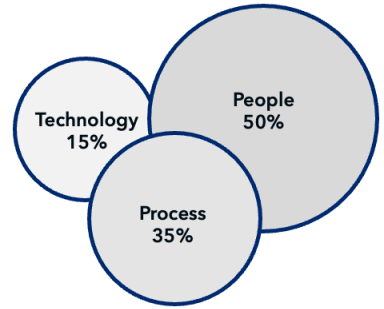
5. Demand and capacity

- Impact on baseline demand and capacity
- Identify shift in resources (Left shift)
- Upfront investment or business case (if req'd)

4. Operating model

- Engage – frontline / clinical / professional
- Define operational model
- Define who/what/how
- Trajectory of implementation

Achieving the right focus for change



Phased implementation

- Robust program delivery team (representing system partners)
- Oversight and governance
- Clarity on SEL-level support to Places
- QI methodology and system-wide learn and share events
- Communication plan

Key tenets of delivery

Regular touchpoints

System-wide cross learning workshops

System governance, oversight and review

- Continued QI cycle
- Test and titrate
- At scale delivery

8.
Appendices
(circulated as a separate document)

Appendices - contents

1. Project Plan
2. Summary of baseline positions at Place
3. Outputs from workshops
    a) Ambition and vision
    b) What must change?
    c) What else must change?
    d) Ageing well and frailty definitions
4. Governance
5. What ageing well and frailty mean in SEL
6. Mantra
7. Case Studies
8. List of stakeholders who participated in developing the framework

South East London Integrated Care System

NHS South East London

Programme supported by:

HEALTH INTEGRATION PARTNERS

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 7
Enclosure: 6

Title:	**Integrated Assurance Report**
Meeting Date:	**24/07/2025**
Author:	Adrian Ward, Head of Planning, Performance and Business Support, SELICB
Executive Lead:	Darren Summers, Strategic Director for Integrated Health and Care/Southwark Place Executive Lead

Summary of main points

Overview

The Integrated Assurance report is considered in detail by the Integrated Governance and Assurance Committee prior to tabling at the Partnership Southwark Strategic Board. The focus of the report is to provide assurance to the board on the delivery of delegated ICB responsibilities, key metrics and other priorities, other than primary care (which will be reported via the Primary Care Committee) and delivery of the Health and Care Plan (which will be reported on by the Partnership Southwark Delivery Executive).

This last report was reviewed by the Integrated Governance and Assurance Committee at its meeting of 10th July and key points discussed have been highlighted in the attached executive summary. At this point in the reporting cycle full quarter 1 data was not available, and this will therefore be tabled at the September board.

Item presented for (place an **X** in relevant box)	Update	Discussion	Decision
	X	X	

Action requested of PSSB

The board is asked to note the Integrated Assurance Report.

Anticipated follow up

An updated Integrated Assurance Report will be presented to the September board meeting.

Links to Partnership Southwark Health and Care Plan priorities	
Children and young people's mental health	**x**
Adult mental health	**x**
Frailty	**x**
Integrated neighbourhood teams	**x**
Prevention and health inequalities	**x**

Item Impact

<table>
<tr><td>Equality Impact</td><td colspan="3" rowspan="5">The Integrated Assurance Report does not have a direct impact on services, however it is a report that that provides information on a range of delegated responsibilities including aspects of quality, health inequalities, finance, safeguarding and medicines optimisation.</td></tr>
<tr><td>Quality Impact</td></tr>
<tr><td>Financial Impact</td></tr>
<tr><td>Medicines & Prescribing Impact</td></tr>
<tr><td>Safeguarding Impact</td></tr>
<tr><td rowspan="2">Environmental Sustainability Impact
(See guidance)</td><th>Neutral</th><th>Positive</th><th>Negative</th></tr>
<tr><td>No direct impact</td><td></td><td></td></tr>
</table>

Describe the engagement has been carried out in relation to this item
The contents of this report were reviewed by the Senior Management Tean and the Integrated Governance and Performance Committee on 8th May 2025.

Integrated Assurance Report

Summary of report and discussion at Integrated Governance and Assurance Committee Report 10/07/2025

Background

The focus of the Integrated Assurance Report is the delivery of delegated ICB responsibilities, other than primary care (which is reported via the Primary Care Group) and delivery of the Health and Care Plan (which is reported on by the Partnership Southwark Delivery Executive). The current scope of the report covers performance and key metrics, progress on delivery of priorities, quality, safeguarding, risk management, finance, continuing health care and medicines optimisation.

As the Q1 reporting cycle was incomplete at the time of writing the report it was agreed to present a summary of key highlights to the July PSSB, returning with a full report at the September meeting.

Summary of key issues and changes since the previous meeting

1. Performance metrics

a) **SMI Physical Health Checks:** IGAC noted an improvement in the SMI annual physical health check rate, which rose from 53% in Q3 to 65% in Q4. However, this remains below the year-end target of 70%, which was achieved last year, indicating a decline in overall performance. This trend was observed across South East London and was recently explored in a deep dive. The review highlighted recurring challenges, including data accuracy and transfer issues between clinical systems, difficulties in completing the phlebotomy component, and the impact of the Synnovis cyber-attack earlier in the year. The report outlines a set of high-impact actions aimed at achieving the target.

b) **Talking Therapies (IAPT):** The Reliable Improvement metric rose by 4% to 66% in April, placing it just 1% below the target. However, the Reliable Recovery rate declined 1% to 42%, falling 6% short of the target, which was met across South East London. This shortfall is a cause for concern. Additionally, the number of discharges from services remains below target. IGAC noted the scope of an in-depth review, to be led by the Live Well commissioning team, aimed at identifying challenges and opportunities to improve performance in 2025/26.

c) **Continuing Health Care assessments:** The rate of Continuing Health Care assessments completed within 28 day timescales increased 2% to 64% in Q4, although this falls significantly short of the 80% target. Performance issues are linked to the availability of social workers for the completion of assessments, and the number of disputed cases. Local data shows some improvement with the target was met in May but dropping to 67% in June.

d) **Primary Care Access:** It was noted that GP appointments seen within 2 weeks of contact have been in gradual decline for several months, and dropped 2% to 86% in April, below the 91% target for 2024/25. This will be examined by the Primary Care Committee,

e) **Dementia Diagnosis** increased by 0.8% to 72.2% of estimated prevalence in May, comfortably above the 67% standard,

2. Quality Report: The next full quality report will be reported at the September meeting.

3. Safeguarding Report: The next safeguarding report will be reported at the September meeting.

4. SEND Report : the dashboard on key ICB measures relating to the health contribution to SEND was reviewed. It was noted that waiting times for community paediatrician input need to improve to contribute to the timeliness of Education Health and Care assessments.

5. Southwark ICB Place Risk Register

IGAC reviewed the latest risk register, noting that following a strategic review of potential threats to the delivery of 2025/26 objectives several new risks had been added to the register in relation to:

- minimising the potential disruption arising from the ICB change management programme
- procurement and contract management systems in need of strengthening to ensure all key milestones are delivered in a timely way
- ensuring sufficient system-wide capacity to deliver the Integrated Neighbourhood Teams programme in a timely way
- health input into SEND services not meeting expected standards
- market failure in social care provision impacting on whole system flow and quality of care

It was noted that for the existing risk around the delivery of the Integrated Community Equipment Services (ICES) the risk scoring had been significant increased following information provided by the current provider about business continuity risks.

Other existing risks that are unchanged relate to adult mental health placements, immunisation rates, financial balance and delivery of savings, and children's mental health waiting times for ADHD diagnosis and CAMHS services.

It was also noted that the risk of ADHD diagnosis overspend had been merged into the existing financial overspend risk, of which it will be a key component.

6. Finance summary report

IGAC receives a detailed Finance report which is reviewed in full. The report to the board includes a summary of the key issues discussed.

Partnership Southwark

Integrated Assurance Report

July 2025

Section 6: ICB Southwark Finance Summary Report

Financial Position – 2025/26 - Month 3 June 2025

NHS South East London

Service Area	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	24	24	0	97	97	0
Community Health Services	9,465	9,253	211	37,858	36,709	1,149
Mental Health Services	2,680	3,338	(657)	10,645	13,284	(2,639)
Continuing Care Services	5,129	4,829	300	20,517	19,532	985
Prescribing	8,787	8,887	(100)	36,208	36,458	(250)
Other Primary Care Services	250	250	0	1,001	1,001	-
Other Programme Services	188	-	188	753	0	753
Programme Wide Projects	65	54	11	259	259	-
Delegated Primary Care Services	19,175	19,127	49	76,701	76,507	194
Corporate Budgets	1,001	955	46	4,002	4,002	-
Total	**46,765**	**46,716**	**48**	**188,043**	**187,850**	**193**

- The borough is reporting an underspend of £48k and forecast outturn underspend of £193k, as at the end of June 25. Key areas of risk continue to be mental health, and prescribing with underspends in continuing healthcare, corporate budgets and community services absorbing some of overspends. The position in mental health and prescribing is an adverse movement from previous month and is mainly as a result of cost pressures in prescribing spend and mental health ADHD/right to choose expenditure and cost per case placements

- The boroughs most significant risk is in Mental Health. We are reporting a year to date overspend of £657k and a forecast overspend of £2.6m. This is driven mainly by overspends in Right to Choose adult ADHD/Autism pathways and placements. Our forecast overspend of £2.6m includes overspend of £1.6m on Right to Choose adult ADHD/ASD. Placements costs for Learning disability continues to be a cost pressures. The position on Right to Choose ADHD/ASD has deteriorated significantly from previous months reported position. . The borough will be undertaking a review of spend reported at the end month 3 in order to ensure forecast expenditure assumptions are accurate and whether the rate of increase in ADHD spend seen in the first three months is likely to continue. Savings plans in mental health are phased to deliver over the last six month's but these are rated as high risk. A structured process of placement reviews with support from clinical leads has been implemented as part of our savings plans for 2025/26.

- Prescribing actual data is provided two months in arrears and the borough is reporting a forecast overspend of £250k as at month 3. The reported position is based on one month's actual data and it is expected that the overspend will increase as it is too early in the year to accurate assess this risk due to only one month of actual prescribing data available. We are also assuming savings plan in prescribing will deliver savings in full.

- Within Community budgets most of the budgets are showing breakeven due to contracts. It is too early in the year to accurately assess risks in community services for those areas which are activity led. However the borough is aware of significant financial risk on its integrated equipment service contract which has not yet been quantified and will be included in month 4 reporting.

- Underspends in continuing care budgets are absorbing some of the overspends. Although Continuing Health care is showing an underspend, price negotiations with providers are on-going, so it is likely that costs will increase as we move through the year.

- Corporate underspends for the first three months of the year are as a result of vacancies. We are however reporting a forecast break even position due to the impact of costs relating to change management process.

- Borough has an efficiency target of 5% which on applicable budgets amounts to £8.8m. Within this figure prescribing savings total £3.6m and most of these phased to deliver after quarter 1. As at month 3 (June) we are reporting a small under achievement and our forecast savings is expected to be in line with Plan.

- In order to mitigate the cost pressures in prescribing and mental health, reserves, uncommitted budgets have been released and growth in community services has been restricted to manage the overall position.

7. Procurement decisions made

Budget Area	Contract name	Commissioning Lead	Annual Contract Value - 2025/26 (£)	Contract Date	Procurement Approach	Procurement process	Progress Comments
Delegated Primary Care & Community Services	Care Home Contract	Katherine Kavanagh	APMS Core Services Contract Indicative Value £290,960 Plus Extended General Practice Services to residents in Nursing and Residential Homes £408,000 - Total Contract Value £698,960	1 April 2026- 31 March 2031 (5+5+5 contract)	Direct Award C	Direct Award C Template will be completed and PSR process followed during quarter 2 .	Contract extension for one year commencing on 1 April 2025 - 31 March 26 agreed following no representation. PEL approved contract variation for 2025/26. Primary Care Committee agreed in June 25 to a direct award contract procurement process for a 5 year APMS contract from April 26. This will be a 5+5+5 year contract.
Mental Health Services	Parent Action (PACT)	Russell Jones	Mental Health Services contract - Annual Contract £65,000	1 Jun 2025 - 31 May 2026.	Contract Extension	Contract extension within current contract terms	Contract extension for one year commencing on 1 June 2025 - 31 May 26 agreed following service review. PEL approved contract extension. Contract variations to be signed.
Mental Health Services	Together Wellbeing Hub Services	Russell Jones	PCN Pilot extended for one year. Contract variation to main contract agreed. £190,000 annual value contract variation to include PCN Pilot	1 April 2025 - 31 March 026	Contract Variation	Contract extension within current contract	Contract variation agreed