South East London Integrated Care System

Developing our shared approach to Neighbourhood development

Board Papers

January 2025

This document

This document outlines how neighbourhood working, and integrated neighbourhood teams within that, will be realised in South East London. This documents responds to and will sit alongside emergent national and regional guidance and related London-wide work on Healthier Communities, ensuring neighbourhood working in SEL both reflects and models wider policy aspirations to:

- **Establish a clear and shared vision for the Neighbourhood Health Service,** so we can communicate what it means for professionals, patients and service users, and communities across SEL.
- **Balance a need for consistency**, building from where we are, and being flexible to local needs
- **Be clear on what good looks like** and the role of national bodies, systems, providers, places and neighbourhoods in delivering this
- **Set out the roadmap** in the short, medium and longer term

This document sets out key definitions, and a delivery framework and roadmap aligned to and building on implementation work already underway across our six Places and their local partnerships; scaling and spreading key existing initiatives such as the 3+ Long Term Conditions (LTCs) focussed work ongoing in at least one Primary Care Network (PCN) per borough.

Places will be responsible for realising this framework at a local level and working through local challenges and delivery nuances – SEL must support and facilitate Places in this endeavour, and in ensuring we are all moving toward the same end point.

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This work has been produced in partnership with PPL, a social enterprise based in Southwark, which is working to improve health and care outcomes across the UK.

Context

- **In response to the national drive to deliver a Neighbourhood Health Service, South East London (SEL) previously committed to working in a more integrated way at the neighbourhood level,** and as part of that, develop Integrated Neighbourhood Teams (INTs) to help balance the provision of consistent access and standards of local care with the variation required to improve population health and address long-standing inequalities.
- **Without this shift in focus, any improvements in delivery of individual services across health, local government and wider partners will continue to be overwhelmed** by growth in activity and demand and will become unaffordable too.
- **Neighbourhood working is a continuation of local, regional and national initiatives** across successive governments that have aimed to bring Primary and Community Care closer together, including the development of integrated care and a more place-based approach to how services are organised, to address the drivers for change:

Social

- Many services are working in isolation, and there is a need for more joined-up, proactive care, which is flexible and able to respond to local needs.
- A consistent approach, clear understanding of what self care and proactive support is available and a strong message that service delivery in partnership with communities is required.
- Recognition that statutory services alone cannot provide all the support people need, particularly with regards to addressing inequalities and reaching underserved communities.

Political

- Government priority to transform the NHS into a 'Neighbourhood Health Service' and shift from hospital to community and sickness to prevention.
- Access issues in primary, community and mental health care, and delays in Emergency Departments and diagnostics.
- Increasing wider social determinants and underinvestment in public health has led to the deterioration of the overall health of the nation.

Economic

- There are significant costs associated with the failure to prevent ill health, to detect and intervene and to mitigate complications.
- Strong and shared economic case especially for the working age adult population – to prevent people becoming economically inactive and to support people back to work.
- Long term sickness is contributory factor to economic inactivity.

Technological

- One of the shifts planned for health and care services nationally – analogue to digital.
- Investment is required to build and maintain effective infrastructure outside of hospitals.
- Finding effective and practical solutions to co-ordinate and share data for planning, delivery and evaluation purposes.
- Utilising technology at scale to improve efficiency and effectiveness.

Neighbourhood working and INTs in SEL

The overarching aim of this work is to develop a shared approach to INT development across SEL, which will bring together services with communities through a population health management approach, at a scale which enables the delivery of genuinely preventative, holistic, locally tailored services.

Neighbourhood working will require a fundamentally different way of working and large cultural shift across the public sector, voluntary and community sector (VCSE), and our local populations; involving new means of collaboration, coordination, and, at times, integration. This reflects a significant transformation of how our system will operate together.

A key (but not the only) element of delivering neighbourhood working will be the establishment of INTs. This document is focussed on this element and presents an overarching framework for INT delivery which Places will be required to develop locally, tailoring to their local population needs and services. This framework will be subject to further socialisation and input before a final document is delivered early this year.

Moving forward, key enablers within the SEL system such as resourcing, workforce, and data analytics, will need to be configured to support the delivery of INTs and neighbourhood working.

What we mean by neighbourhood working

Developing INTs will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health, social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area. INTs will not replace existing, effective multi-disciplinary teams.

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than INTs and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual or group. Collaboration tends to occur at key points, such as meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Representatives from different disciplines (e.g., health, social care, voluntary sector) working as a single team to deliver coordinated and person-centered care to individuals within a defined neighbourhood or locality. They will manage and deliver integrated clinical and operational services, provide continuity of care and work together to shared outcomes. There is an emphasis on continuous collaboration around prevention and pro-active care to improve outcomes, reduce duplication and address complex needs more efficiently. They will reach in and out of the other tiers for specialist input and care planning.

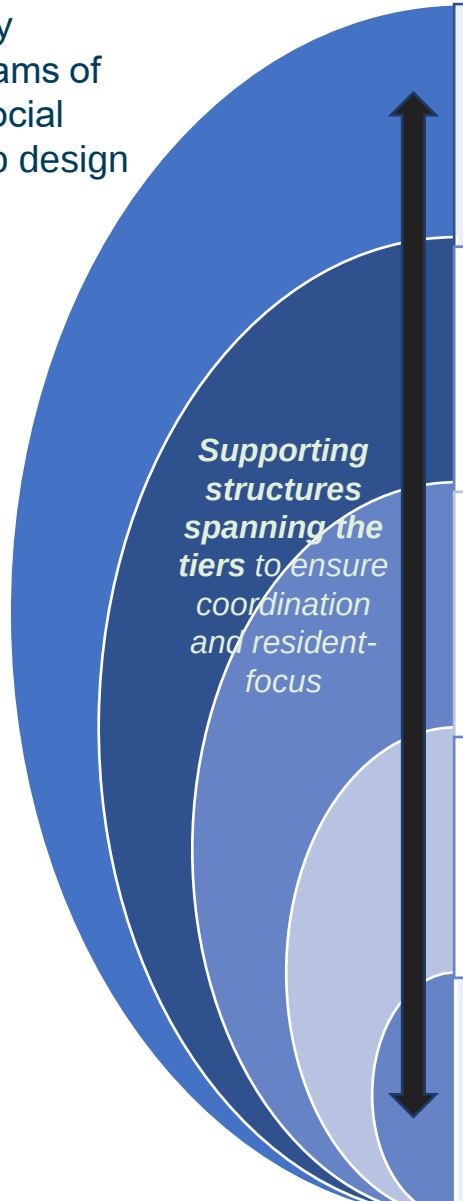
(see p.5 for further detail)

What a SEL INT looks like

Note: The detail required to operationalise each function and how they relate to each other will need to be established at a Place-level.

INTs provide the structure for multidisciplinary collaboration through the development of “teams of teams”: integrating services across health, social care, public services, and the VCSE sector to design and deliver holistic, person-centred care.

- **Our model enables local variation tailored to local needs while maintaining a consistent foundation across all neighbourhoods in SEL.** Investment levels will vary depending on each neighbourhood’s starting position and specific needs.
- **Our INTs will be organised using a tiered system**, acknowledging that different functions and services are delivered to residents across a range of different scales.
- **Our INTs will leverage population health data** to proactively identify individuals and populations who would benefit from support earlier and prioritising populations experiencing greatest levels of health inequalities.



Aligned Functions	• The INTs will be augmented by additional specialist input, generalist roles (e.g., geriatricians) and resources tailored to local needs. • While they may not sit directly in the INTs (e.g., because it doesn’t make sense to dedicate their time to a specific INT all the time), clear communication lines and clarity on how they input will need to be established. • They will reach in and out of the other tiers to provide specialist input and care planning.
Tailored Functions	• This will vary between each INT depending on what is available and what helps the INT to meet the needs of the population that it is serving and achieve its specific aims and benefits (e.g., specialists). • They will have consistent presence, dedicated resource and a role specific to the neighbourhood (e.g., integration hubs or specific VCFSE providers).
Consistent Functions	• There will be consistent membership from INT to INT, bringing together primary care, social care, community and mental health services, acute clinicians/specialties, key VCFSE organisations and population health dedicated / allocated to each INT (e.g., district nurses) • They will manage and deliver integrated clinical and operational services, and provide continuity of care and work together to shared outcomes • They will reach in and out of the other tiers for specialist input and care planning.
Hyper-Local Functions	• Services (e.g., community pharmacy, general practices, VCFSEs) that often serve as the first point of contact for residents need to be reached into by / strongly linked with INTs. • They hold deep community knowledge and connection, and play a proactive role in population health management, identifying needs early and escalating complex cases. • Clear shared care protocols will enable seamless coordination with INTs.
Resident	• The resident is at the centre of all neighbourhood working. • INTs need to be strengths-based building on local knowledge, community assets and local needs.

How to enable integration

Why is this important? We recognise that Place will be the key enabling layer for developing neighbourhood working and INTs which will sit at their core. Each Place will be responsible for identifying an "integrator" to host integration "functions" required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level. Acting as a bridge, these integrators will help INTs function cohesively while maintaining flexibility to respond to local needs and adapt as neighbourhoods transition from development to delivery.

This role cannot operate in isolation or replace individual responsibility and accountability from partnering local organisations.

Thoughts on Key Integrator Functions Consistent Across Places

- **Support operational coordination** between sectors and partners across the borough and between INTs, bridging the gap across the current reality of fragmented pathways and services by addressing the practicalities of collaboration (e.g., building interfaces and relationships, supporting workforce planning, and business intelligence).
- **Facilitate population health management** (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes.
- **Address interface issues and share learning** through coordinating discussions at Place level (e.g., sharing resources and managing care transitions) and escalating issues affecting multiple neighbourhoods to ensure system-wide alignment.
- **Drive equity in access and outcomes** using PHM data and working closely with partners (including VCSFEs) to identify and address disparities in access and care delivery, supporting INTs to meet local needs and reduce inequalities.
- **Provide essential infrastructure** supporting people, finance, governance and risk management for INTs in a way which is consistent and cost-effective so that neighbourhood delivery becomes business-as-usual, harnessing existing local assets and resources.

What we want our INTs to do

Our initial focus for INTs is to provide proactive care for higher and rising risk populations, and to work with communities on preventing ill health. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSE and social care, to meet the holistic needs of their local populations. These INTs will be able to easily draw upon specialist input as needed across all levels (from hyper-local to regional).

This is not about minor tweaks or layering on top of what is already in place nor is it about uprooting what is already working. Working at a neighbourhood level in INTs will require a fundamental shift in how we work together as a system, with residents and within communities.

In SEL, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs needs to be wider than health e.g. addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs,** through a combination of integrated working, including regular huddles and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities,** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders,** holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.
- **Ensure that all SEL residents receive the same standards of care**, wherever they live and whatever their individual needs.

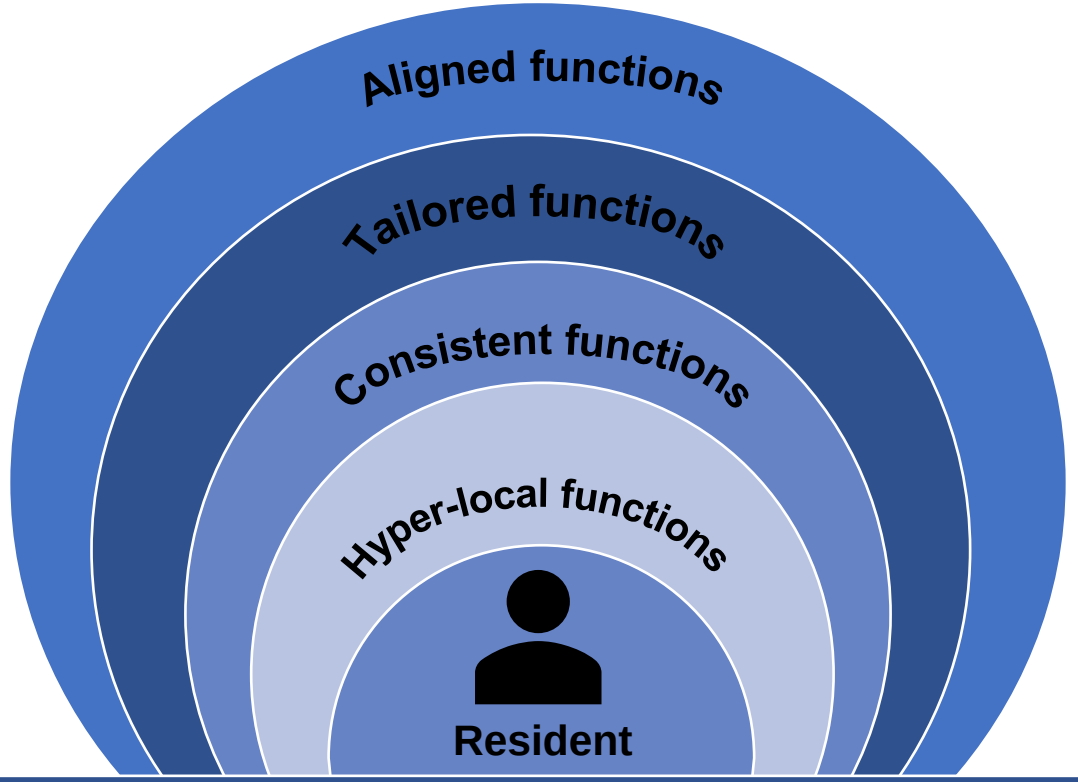
South East London Integrated Care System

NHS South East London

INT delivery framework

Components of our SEL INT Framework

Our SEL INT Framework outlines a shared approach to INT development across Places, and a way in which SEL can increase the proportion of resources used to support people to stay well for longer, and release capacity which is reinvested to scale the model sustainably.



SEL INTs will be underpinned by a number of key ingredients, including a population health management approach and the recognition that we will have to 'test and learn' our approach as INTs develop to ensure they meet population health needs effectively.

Underpinned by key ingredients:

- Organisational development to enable culture shift for system-wide way of working
- Population health management approach
- Shared, clear metrics
- Test and learn approach
- Robust leadership and shared governance
- Interprofessional training infrastructure
- Overarching quality management system
- Alignment with partner and system priorities
- Interoperable digital tools and knowledge
- Contractual mechanisms and human resources (HR) infrastructure to allow joint working
- Geography principles to ensure organised around population needs

What this framework is (and what it is not)

The framework set out is…

- **An overarching structure for INTs across SEL**, providing 'enough' structure to ensure we deliver consistently and in alignment, without being prescriptive, and recognising that local nuances will mean INTs look different in each Place.
- **A commitment from each of our Places** to work ambitiously and intentionally, through a 'test and learn' approach, toward a shared vision for neighbourhood working.
- **Providing a way to build upon, not undo, existing integration successes** recognising that there has been significant progress in recent years and any re-structure takes capacity, time and energy. We do not want to overhaul what is working well, rather we want to develop an adaptable strengths-based way of working.

It is **not**…

- **Static**: this framework will evolve over the coming years as neighbourhood working builds across the SEL system and will be updated to integrate new and effective approaches that have been developed and tested, bringing in learning from previous integration efforts.
- **Exhaustive**: each Place and INT will need to work through local challenges and delivery questions to ensure their INTs work effectively within their local system and are tailored to the needs of their local populations.
- **About just the 'top of the pyramid':** this framework describes a whole system, whole-population approach which strives to improve the lives of all people of all ages across SEL.

Key ingredients

Drawing on learning from other INTs, as well as the conversations we have had to date with stakeholders, key commonalities across models and suggestions for effective neighbourhood working include:

- **Be organised around population health needs** and avoid unwarranted variation. This will involve using population health data to obtain a deep understanding of local communities and use this to proactively identify people who would benefit from support earlier.
- **Be a system-wide way of working and a model of care, and not a programme of discrete projects.** This will include joint workforce and estates planning to enable sharing of assets to best use system resources and promote integration.
- **Eliminate siloed working practices** through equal access to information and flexible models of working. Supporting frontline staff to work in an integrated way—where every connection counts—ensures that teams are equipped to collaborate seamlessly across boundaries. This approach minimises gaps in care and encourage cohesive service delivery, so residents are unaware of how they are being moved through the system to meet their needs.
- **Embed a robust interprofessional training infrastructure.** System leadership training should be a core component of the INT model, with health professionals trained together to strengthen collaboration, build cohesive teams, and foster interprofessional relationships. Training must include data analysis and interpretation to enable INTs to effectively use Population Health Management (PHM) tools for proactive decision-making. This will support succession planning and sustainable leadership within and beyond INTs
- **Have an overarching quality management system** – ideally linked with the quality improvement method – so teams can work in psychological safety, confident in what they are delivering and how they do works and be assured of the impact of the INT way of working.
- **Align to partner and system priorities** to ensure one direction of travel.
- **Shared, clear metrics** expected for INTs will help ensure local decisions are data-driven and ultimately achieve the expected outcomes, even if *what* they do is different to achieve these dependent on local populations and assets. Consistent processes for reviewing outcomes will ensure those which do not see progress over time are understood, addressed, and relevant learning is shared.
- **Release capacity which is reinvested to scale the model sustainably.** This will require routinely measuring impact to understand and embed what works and build a body of evidence.
- **Increase the proportion of resources used to support people to stay well for longer.** This will include offering joined up accessible preventative care, making full use of the knowledge and skills of the team, as well as ensuring the contractual mechanism and human resources (HR) infrastructure is in place to enable this. Commissioners /partners should be able to readily draw on this in relation to job planning/recruitment.
- **Be underpinned by interoperable digital tools and knowledge** that support population data analysis and enable person-based care.
- **Have robust leadership and shared governance arrangements** enabling services to be arranged at neighbourhood level to maximise their ability to engage with local communities and shift investment towards prevention. This includes effective clinical governance that allows genuinely shared care between organisations and professions that make up an INT.

We recognise there will be a level of local variation to ensure each neighbourhood can serve the local population needs. However, the broad approach to integrated neighbourhood working should remain consistent across all population groups and all areas within SEL.

Taking a population health approach

The success of INTs will rest on our ability to develop a deep understanding of our local populations. INTs will be organised around data insights drawn from **Population Health Management (PHM) analyses** - providing the evidence base to tailor services to local need and shift the dial to prevention.

To understand local needs, we will need to define a way to effectively **segmenting our population** (including those who are not registered in SEL general practices) and capturing key priority cohorts. Our segmentation model must:

- **Cohort across all life stages (children to older people) and need status (low- to high-)**, ensuring no one slips through the net
- **Reflect the different factors** that influence a person's needs (e.g., health conditions, psychosocial attributes, wider determinants)

PHM will be used to build up a richer picture of local populations over time, recognising that **data availability may be limited during the mobilisation of INTs** and **processes for continuous learning and adaptation to PHM insights** will ensure INTs remain responsive to changing population health needs.

The voice of residents will be a key input into PHM, essential for completing the picture implied by the data.

How do we get there?

- Agree a common language to describe our population segments to facilitate integrated planning and support collaborative working.
- Agree key metrics to enable a degree of comparability between Places.
- Invest in organisational development to implement new tools, and ensure staff have the ability to effectively use them and integrate insights into delivery and improvement.

A number of our Places in SEL and INTs elsewhere in London are adopting the **Bridges to Health** approach to segmentation. The approach can be tailored to different INT priorities (e.g., around CORE 20 plus 5 and to include social determinants of health). Examples of key areas identified using the Bridges to Health approach in SEL:

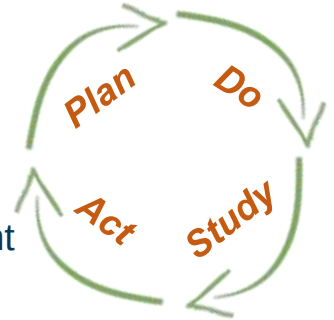
Healthy	Healthy at Risk	Single Illness	Lower Complexity	Higher Complexity	End of Life
	e.g. hypertension low frailty obesity	e.g. single LTC high utilisation mild mental illness	e.g. 2-3 LTCs severe mental illness disability	e.g. 4+ LTCs organ failure dementia high frailty	

Adopting a test and learn approach

We recognise that INTs are a radical change to existing ways of working and will therefore require experimentation through the early implementation phases to understand what is and is not working and explore ways of overcoming challenges.

Over time, our INTs across SEL will also evolve to respond to local population needs. This flexibility will be essential to address local inequalities and deliver services which are genuinely holistic and preventative.

To ensure INTs are delivering impact in the right places, we will adopt a "test and learn" approach to quality improvement which creates space for failure and ensures we understand our impact with each new iteration of the INT model, enabled by:



- **Quality Improvement (QI) metrics aligned to and embedded within the local and SEL-wide vision for INTs.** Metrics must develop our understanding of our impact in key INT priority areas including inequalities and prevention, recognising that preventative interventions demonstrate impact over the long-term, often in diffuse ways.
- **Being expansive and innovative when sourcing data and evidence,** drawing in and learning from ongoing QI insights, while making best use of existing evidence and information collected in the community, regionally, and nationally.
- **A culture of evidence gathering and rigorous and rapid evaluation** to inform future planning, design, and delivery. By building a robust evidence base, our INTs will be able to learn from each other, develop sustainably and target improvement efforts toward what we know works, and demonstrate impact which can secure funding into the future. Evidence gathering should be coordinated at system-level to coordinate efforts and ensure all Places benefit from key learning.
- **Ensuring a degree of comparability between QI metrics for our INTs and Places** so we can understand the drivers of impact across SEL, action system inequalities, and ensure every resident in SEL experiences good quality neighbourhood services.
- **Concise reporting requirements** which are focussed on impact and proportionate to the monitoring capacity of each INT partner.
- **A standard approach to applying PDSA-style (Plan, Do, Study, Act) improvement cycles between INTs**, and embedding learning, evaluation, and improvement.

Geography principles

Designing the geographical footprint for INTs needs to balance local population needs, existing healthcare boundaries, local assets, and operational efficiency. Key components for SEL to ensure boundaries enable effective INT functionality include:

Centre around populations and natural communities. While INTs are expected to naturally coalesce around registered populations linked to GP lists, it is crucial to address challenges such as PCNs engaging in multiple neighbourhoods where INT boundaries do not align and recognise that SEL maintains responsibility for those not registered but living in SEL too. This requires clear differentiation between integrated neighbourhood working and INTs, ensuring alignment without disrupting care continuity.

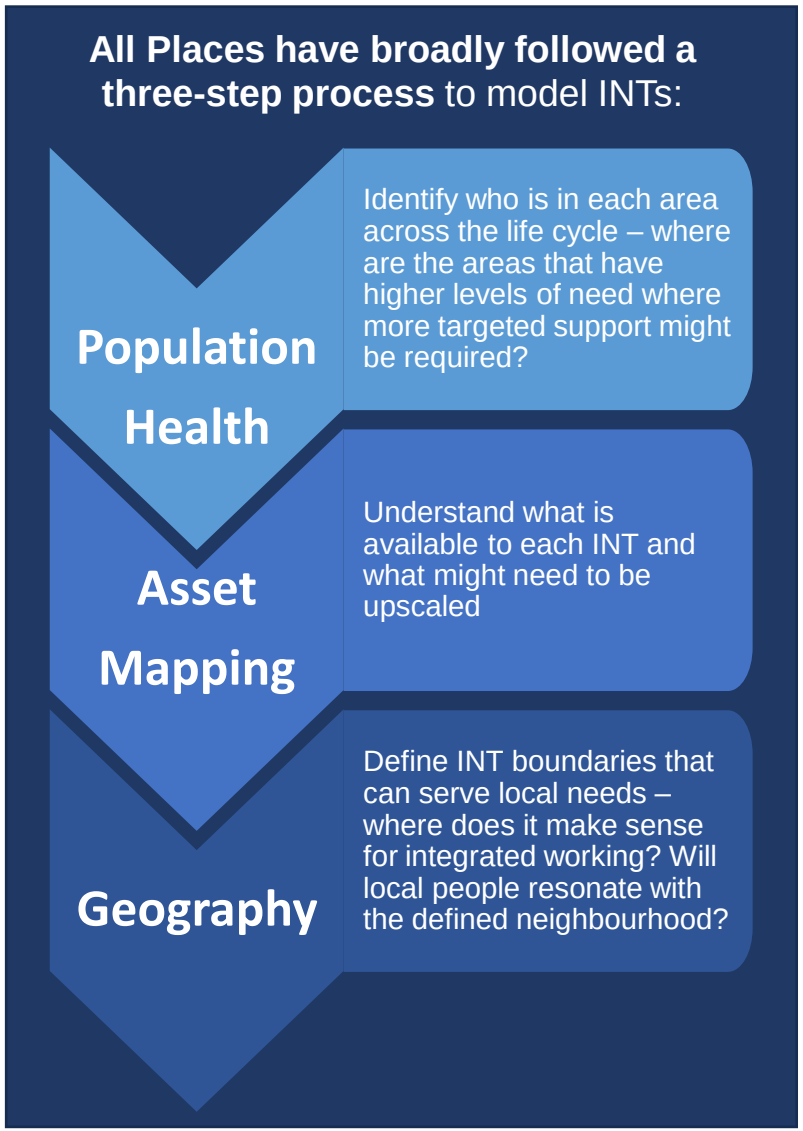
Build on existing networks and local assets. Enhancing integration without requiring new infrastructure where possible is essential to ensure equitable service delivery while maximising existing resources. This will require better use of primary care estates (e.g., community pharmacy consultation rooms) and addressing challenges in engaging community pharmacies with PCNs (particularly those arising from PCN contractual frameworks).

Include population sizes roughly between 50k-100k. Where the population size exceeds 100k, there needs to be consideration of the additional resource required for this area to ensure the size is 'manageable'.

Enable not hinder joint working. The number of INTs must be of a minimum viable scale for team co-ordination; able to be effectively in-reached to by borough-wide services and have appropriate travel times for staff to patients' homes and residents to services.

Adapt footprints based on specific challenges. Areas where there are higher levels of deprivation or inequality require additional, smaller INTs – or at least 'mini-hubs'– for targeted support while larger geographical area could allow for fewer but geographically broader INTs focused on e.g., long-term conditions and frailty. INTs should still pro-actively maintain a degree of demographic and needs variation within INT footprints.

All Places have broadly followed a three-step process to model INTs:



Where there needs to be consistency

Taking a strengths-based approach means there will be local differences. But, beyond working to the same objectives regarding improving health outcomes and addressing inequalities, SEL would expect all to have:

Access to core services: INTs should enable increased service access, and ensure residents have equitable access to essential health and care services within the 'consistent functions' of the INT model (see slide 5) regardless of where they live, proactively identifying and acting on access inequalities.

Proactive care for those with both rising risk and high risk of acute intervention and prevention, beginning with 3+ LTCs, moving along the frailty continuum. This supports overall better outcomes, improved sustainability, and a population well enough to improve access/ address inequalities (e.g., by spotting if there are patterns in service access issues at a level where it can be addressed).

Access to and use of population data: an enabler to the above, population health management (PMH) analysis will drive the composition and priorities of INTs. Each INT will need to identify their baseline position to measure change in outcomes and ability to re-identify patients, as well as a consistent approach and sufficient capabilities to interpret and draw insight from population data.

Data sharing and digital platforms: there needs to be a concentrated effort to ensure INTs are underpinned by interoperable systems and common digital infrastructure to enable co-ordinated care.

Governance and accountability: consistent governance structures across INTs will support clarity in roles, decision-making and accountability. There will need to be clear reporting mechanisms, such as the existing ICB Executive Groups and Local Care Partnerships, and standardised metrics* to report against to share learning, establish effective two-way communication channels, and iterate priorities.

A test and learn approach: recognising that neighbourhood working will take time and will require iteration. INTs should adopt a consistent approach to applying PDSA improvement cycles and embedding learning, evaluation, and improvement.

Coproduction and engagement with communities: communities should experience, understand, and have the opportunity to input into INTs in the same way no matter which INT their locality is served by. Messaging to the public should be consistent to prevent confusion and support proactive engagement and uptake of services.

Common interface with larger / cross-Place providers: e.g., with acute trusts. This will help avoid providers managing an impractical number of different systems.

**Note different Places will want to maintain or develop some specific outcomes measures which speak to major issues on their own patch too.*

Where there will be local variation

Fundamental to our INT model is the need to balance consistency with local variation and taking a strengths-based approach. This means that INTs can effectively meet the differences in local population needs. Emerging thoughts on where there will need to be local variation in INT models include:

Partnering with the voluntary sector: each neighbourhood will have its unique network of voluntary and community sector organisations; leveraging local strengths can amplify the impact of INTs. Consistency in the manner of partnering and engagement, however, should be upheld through common partnering principles.

Interfaces with local authorities: local authorities will have different structures feeding into INT delivery - INTs will need to variously respond and integrate with these to ensure local authority voices are centred in delivery.

Composition of specialist input and resources feeding into each INT: while the core INT will remain consistent from INT to INT, based on local population needs, specialist services should be positioned to flexibly respond to changes in local demand and ensure staff operate on the right spatial level with respect to capacity and demand. Where there is more limited workforce capacity or services, these resources may need to be shared across INTs.

Community engagement: a critical element of the INT model will involve co-designing services with communities and residents to ensure solutions are shaped by lived experiences and local priorities. Tailored public engagement strategies in particularly diverse areas will ensure that INTs meet the needs of all their residents, especially those historically underserved.

Local health system economics: INT priorities will be informed by and respond to local variance in demand for services and supply– for instance, where there may be high, avoidable utilisation of high-cost placements such as residential care.

Physical infrastructure: like workforce, effective INTs should be built on what is already working well within communities which will necessarily look different in each neighbourhood depending on how residents want to and can engage with health and care and wider public services. This might mean developing integration hubs that e.g., leverage hospitals as in Bexley, build on existing community hubs or form ‘mini-hubs’ as in Lewisham.

Key areas of work to deliver Neighbourhoods

SEL recognises INTs require a big shift in ways of working, and some requirements will take time to fully implement. However, this should not prevent Places from progressing INT implementation. The following describes key areas of work that will be included in the INT implementation plans at Place and SEL levels, that will need to be driven from a local level upwards with support from SEL to ensure that INTs meet local population needs.

Delivery of INTs	Enabling functions delivered once across SEL, building from Place upwards	Enabling functions delivered at Place and across SEL concurrently
• Confirm neighbourhood footprints and align service delivery • Establish Integrated Neighbourhood Teams (INT) • Implement 3+ LTC scheme* • Implement Frailty scheme* • Implement CYP scheme* • Agree and implement integrator function • Utilisation of population health management (PHM) to address health inequalities through neighbourhood working	• Single PHM function for the ICS • Ongoing evaluation of impact • Outcomes framework, using shared metrics • Digital enablement of neighbourhood working including single health and care record	• Flexible workforce models and associated culture change • Comms and engagement • Delivery and implementation of a common QI process to support test and learn approach • Agree governance to understand implications and secure good governance of neighbourhoods • Identify and implement neighbourhood hubs, linking to broader estates planning and community diagnostic centres (CDC) development • Create business cases, linked to SEL sustainability

*To common spec collaboratively developed by the 6 Places and with support from SEL.

South East London Integrated Care System

Where we are now

Overview of where Places are

All six Places have made significant efforts and are focusing on developing their neighbourhoods, and all have best practice examples of integrated working at a neighbourhood level. The challenge will be to move from a set of projects to an embedded, systemic shift in the way of working to provide a tangible impact on patient outcomes, moving towards a preventative more integrated approach.

How do INT models align with the SEL Framework?

The development of INT models across all Places broadly align with the tiered system outlined in the SEL Framework (page 5). All INTs will be centred on neighbourhood-based care, with consistent principles such as population health management, proactive prevention, and integration across health, social care, and voluntary sectors. Collaboration with local authorities, PCNs, and the VCSE sector has been recognised as critical across all Places, ensuring models are tailored to local needs while maintaining alignment with system-wide priorities. There is an emphasis on resident-centred approaches, using population health data to identify and address inequalities.

What will neighbourhood governance look like?

- The strategic direction and associated outcomes for INTs are to be determined by the ICB and Local Care Partnerships, while the INTs will be responsible for their delivery.
- Our INT governance structure at a SEL-level for INTs is in development, but will encourage collaboration and shared accountability across organisations and sectors whilst reducing silos. It will leverage the existing Neighbourhood Based Care Board, Primary Care+ Group and Local Care Partnership Boards to help support working across organisational boundaries, resolving interface issues and balancing autonomy with consistency.
- Many Places have started to or already agreed governance and oversight arrangements for INT design and implementation; with many structured through a neighbourhood strategic leadership function with cross-system membership, reporting to Place-level governance, and with reports including INT and programme-specific working groups.
- Places have sought to align governance arrangements with existing neighbourhood-based programmes (e.g. CHILDs).

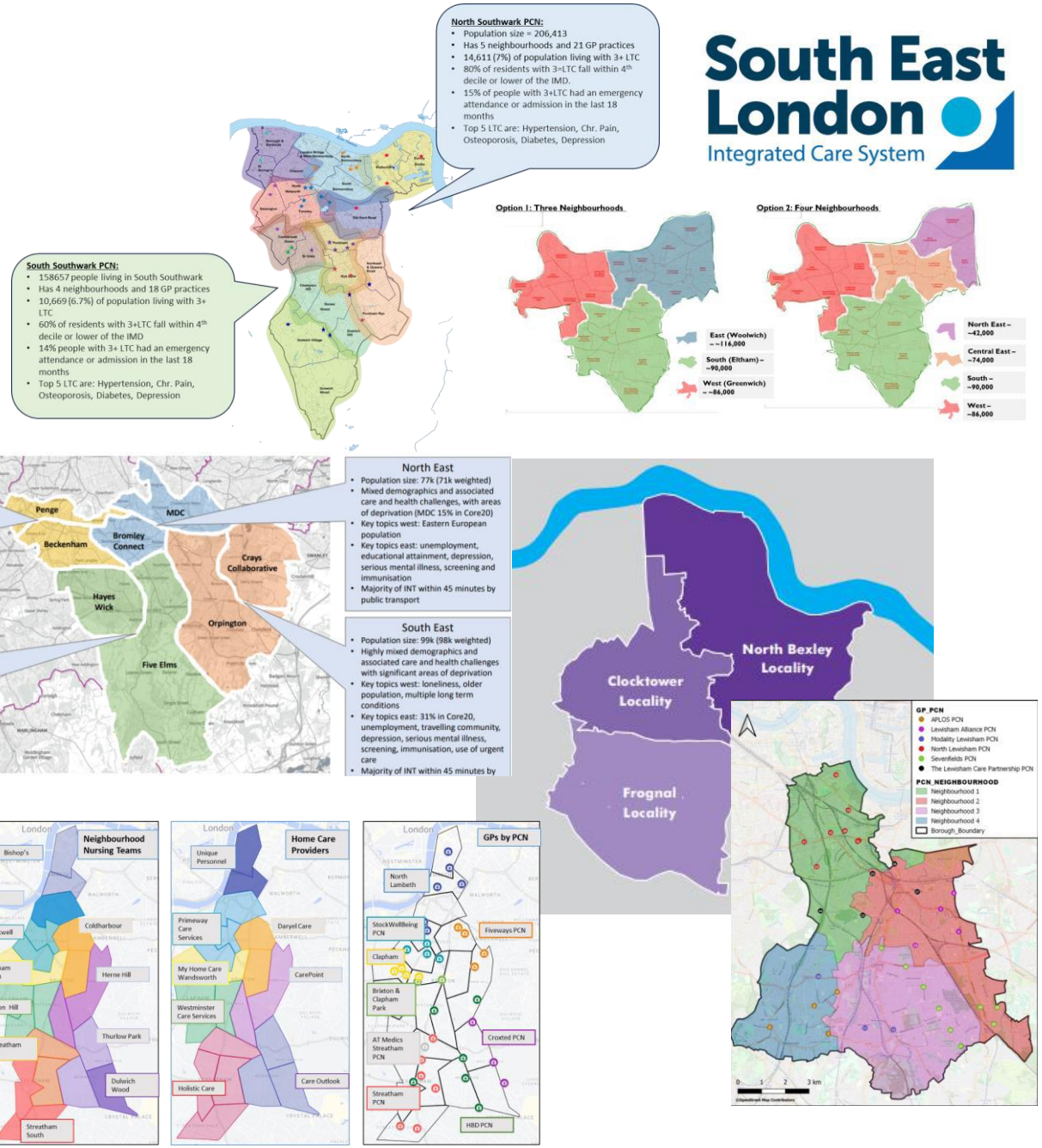
Overview of where Places are

All Places are at the point of reaching consensus on neighbourhood footprints (4 Places have confirmed; 2 are at final stages). It is likely we will have c.27 neighbourhoods across SEL:

- Bexley: 3 Neighbourhoods
- Bromley: 4 Neighbourhoods
- Lewisham: 4 Neighbourhoods
- Lambeth: 8 Neighbourhoods
- Greenwich: TBC – likely 3 or 4 Neighbourhoods
- Southwark: TBC – likely 4 or 5 Neighbourhoods

Neighbourhoods in each Place will adhere to SEL's geography principles (p.13). It is anticipated that some PCNs will have to work across neighbourhood boundaries to provide wrap-around support to all residents.

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



INT initial areas of focus

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.
- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

1. **3+ Long-Term Conditions**
   There are currently pilots in each place, and there is a current cost of £18m, £16 Non-Elective (NEL) admissions per year, £3-6m outpatient opportunities for diabetes alone.

2. **Frailty and those approaching end of life**
   There are examples of best practice already and a current cost of £244m* per year on NEL admissions. This also aligns with how many Places are prioritising Ageing well as a strategic goal over the next six years. This might mean pivoting virtual wards and other admission avoidance initiatives into maximising independence outside of the hospital.

3. **Children and Complex Needs**
   There is an existing model which has demonstrated reductions in GP and outpatient appointments, Accident and Emergency (A&E) attendances and NEL admissions.

- Initial INT rollouts and pilots within each Place will focus on these areas. However, there is an expectation that as INTs develop, they may identify additional specific priorities based on their local population needs.

Key assets and challenges within Places

The following details examples of existing assets that Places are building upon, as well as key challenges that have been identified that Places will look to address as they implement their INTs.

EXAMPLES OF EXISTING ASSETS

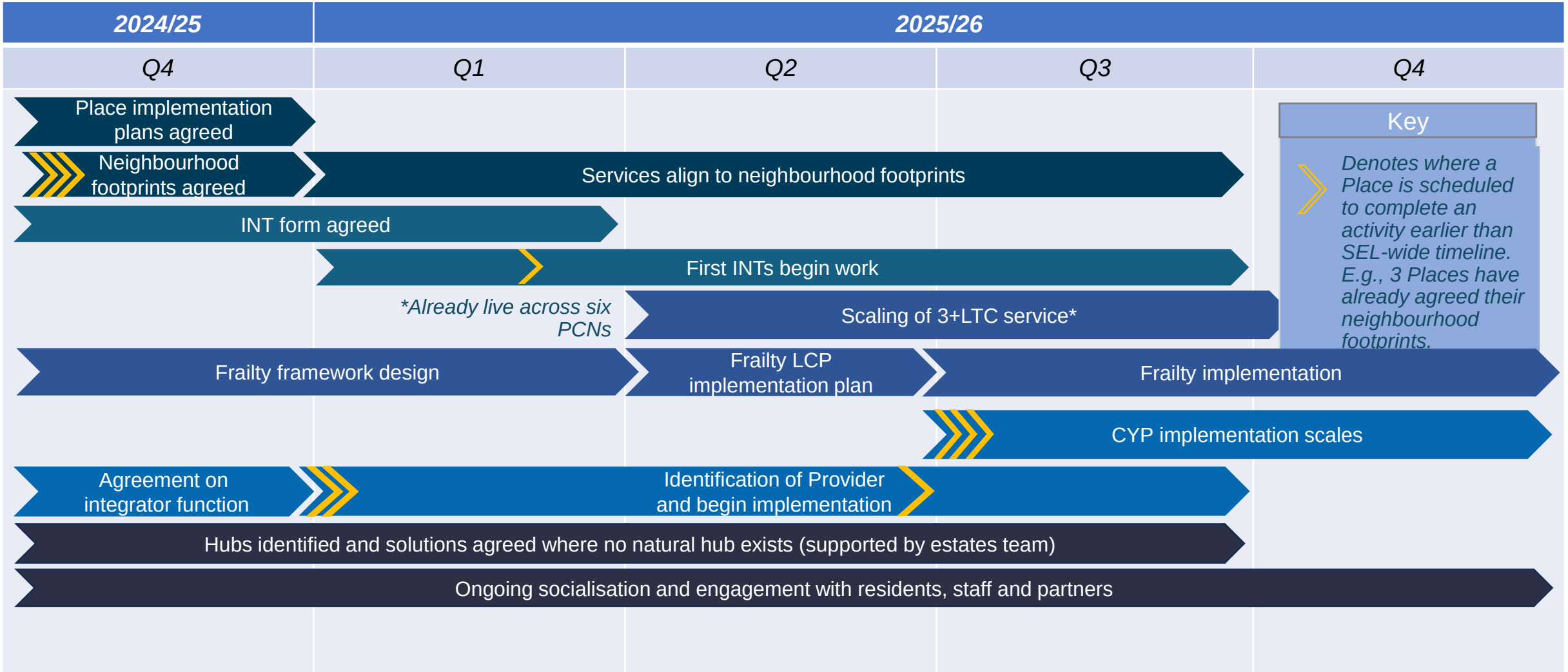
1. **Established PCNs:** In many places, PCNs form the foundation of neighbourhood-based care, providing a structure for GP practices and associated services to work collaboratively within INTs.
2. **Local authority partnerships:** Strong partnerships with local councils are facilitating better integration of health and social care, particularly through joint governance structures and co-designed programmes like housing and benefits support. Local authorities are also providing critical infrastructure for neighbourhood hubs.
3. **Existing community hubs and networks:** Community hubs and voluntary sector organisations have well-established relationships with residents and are being leveraged to provide hyper-local, resident-focused care. Many Places have already trialled co-location of services, which has improved access and coordination in some areas.
4. **Population Health Management (PHM) Tools:** All Places are beginning to use PHM data to proactively identify health needs and target interventions, particularly for underserved populations and those at higher risk (e.g., long-term conditions and frailty).
5. **Proactive approaches to preventative care:** Initiatives such as social connection programmes, support for carers, and community-based activities are being trialled across SEL, building on existing voluntary sector strengths.
6. **Workforce and leadership development:** There is a focus on multidisciplinary training, fostering stronger collaboration across sectors, and building the leadership capacity needed to drive system-wide change.
7. **Digital integration and interoperability:** Progress is being made on shared care records and data-sharing agreements, which are helping to reduce silos and improve coordination.

EXAMPLES OF KEY CHALLENGES

1. **Geographic and boundary misalignment:** Misaligned PCN and neighbourhood footprints create complexity in planning, cross-boundary coordination, and service delivery for INTs.
2. **Data sharing and interoperability:** Barriers to data sharing between health, social care, and voluntary sectors hinder real-time decision-making and seamless, person-centred care.
3. **Governance and accountability:** Current governance arrangements vary at Place level around INT implementation and alignment with broader system priorities.
4. **Workforce and voluntary sector capacity:** Workforce shortages, cultural change requirements, and reliance on under-resourced voluntary organisations challenge the ability to scale and sustain INTs.
5. **Infrastructure and resource allocation:** Disparities in access to suitable community spaces and inequitable resource distribution hinder efforts to meet the needs of underserved areas.
6. **Cultural and operational alignment:** Aligning organisational cultures and shifting from reactive to proactive, preventative care requires time, effort, and significant mindset change.
7. **Sustainability and resident engagement:** Embedding pilot successes into sustainable models and involving residents in co-design remains inconsistent across SEL, limiting long-term impact.

Next steps: testing, learning and scaling

Each Place is making significant progress towards establishing and embedding their respective INT models. The following timeline sets out when all Places will have delivered an area of work, reflecting the different starting points and assets in each Place.



South East London Integrated Care System

NHS South East London

Roadmap

Initial neighbourhood implementation approach

Each SEL Place is in a different stage of developing their approach to integrated neighbourhood working. The following represents a starter for ten based on initial conversations for the decisions and activities that need to be co-developed with partners and residents locally to ensure neighbourhoods and services delivered are built around and address population needs.

Where we are now

Phase 1
Scope & design

- ✓ **Have a clear shared vision, purpose and high-level outcomes** aligned to SEL vision
- ✓ **Expand scope of what we mean by primary care** to inform development, thinking beyond health to include e.g., social determinants, urban planning, non-health-specific community services
- ✓ **Pull together data** from across health, public health and social care to achieve a clear view on: existing neighbourhood footprints, community assets and population needs, including inequalities
- ✓ **Agree common language** describing our population segments to facilitate integrated planning and working
- ✓ **Define geographies** for neighbourhood footprints, including how PCNs align with neighbourhood teams
- ✓ **Identify initial priority cohorts** for INTs
- ✓ **Align plans with existing** integrated neighbourhood working iniatives (e.g., existing work across PCNs)

Phase 2
Refine design and set up

- ✓ **Identify and agree workforce, skills and resource requirements** of INTs to meet population needs
- ✓ **Assess whether the right resources are in the right place** for integrated delivery. If things need to change, work out how – with population input
- ✓ **Collectively allocate resources** based on identified need, exploring novel arrangements (e.g., contracts, incentives) removing historical integration barriers
- ✓ **Develop population health management** approach to enable proactive identification and management of residents
- ✓ **Establish governance** to ensure clear leadership and accountability, including risk management and clinical governance
- ✓ **Design and agree how INTs will perform integrator functions**
- ✓ **Agree measures of success** and monitoring approach for initial implementation

Phase 3
Test and learn

- ✓ **Develop integrated multi-organisational neighbourhood teams** for a chosen population cohort in an agreed geographic footprint
- ✓ **Embed digital tools and knowledge** that enable a shared, population-health driven approach
- ✓ **Facilitate cross-sector relationships and deploy collective resources** to support workforce, digital solutions, estate utilisation and wider infrastructure
- ✓ **Share learning, capacity and resource across neighbourhoods**, converging around best practice
- ✓ **Use established governance** to continously assess learning, progress and impact and integrate into the development of the full INT implementation
- ✓ **Based on learning, start shifting resources** to enable expanded population coverage and increase resource proportion supporting prevention

Underpinned by…

Ongoing engagement and meaningful participation

with partners and residents to enable cultural change and INTs being built and flexed around residents needs, making full use of the knowledge and skills of the team across organisations and ensuring learning and experience is maximised and shared to continuously improve.